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Hearing:Pharmacy Benefit Managers and the Prescription Drug Supply: Impact on Patients and Taxpayers
Chairman Wyden, ranking member Crapo and members of the Finance Committee, thank you for the opportunity to provide you with my written testimony.

My name is Matthew Aaron Gibbs, and I am a Doctor of Pharmacy, also known as a Pharm.D. I have been in the Pharmacy Benefit Management ("PBM") and managed care industry for over 20 years serving in various roles, including managing clinical strategy, sales leadership, negotiating contracts with pharmaceutical manufacturers, mail service and specialty home delivery operations, and most recently serving as a member of the Executive Team at Capital Rx, where I am the current President of the company. I have been at Capital Rx for nearly three years, and before joining Capital Rx, I served as President of another mid-market PBM for four years. I have also managed two of the Nation's largest pharmacy consulting groups advising Fortune 100 companies on their procurement strategies for selecting PBM partners. Additionally, I have pharmacy expertise in all the relevant lines of business: Medicare, Medicaid, Commercial insured plans, ACA/Exchange, and self-funded employers of all types.

I am honored and humbled to address this Committee regarding growing concerns around prescription drug pricing in the United States.

We must first take a step back to truly understand the problem and think through solutions. Since PBMs emerged in the 1990's they have played a critical role in the pharmacy and overall healthcare supply chain. PBMs were at the forefront of technology, connecting all pharmacies in the US via a single and uniform communication logic known as The National Council for Prescription Drug Programs (NCPDP). This logic allows pharmacies, regardless of owner or chain name, to communicate safety edits, drug-to-drug interactions, disease-to-drug interactions, and patient payment information related to out-of-pocket costs. This happens within milliseconds and is arguably the most efficient transaction in all of healthcare. Through the early 2000s PBMs gained in marketshare, but the business model was still simpler than today – they generally collected a fair and equitable per-claim transaction fee that was disclosed and understood by the payer. As PBMs grew in scale and brand drug inflation increased, they began to negotiate directly with pharmaceutical manufacturers on rebates for preferred placement on the PBMs' formularies. While this approach likely saved payers significant dollars initially, the dollars related to rebates became the lifeblood of every PBM. Additionally, PBMs created different definitions around what is considered a "rebate." There were new terms such as administrative fees, market basket fees, data aggregation fees, etc. With this development came a web of complex layers of rebate payment terms and definitions, which created an opaque matrix of financial terms that became impossible for any employer or government entity to truly understand or track.

These rebate payments, or as I like to say, "pharmaceutical revenue," were not enough for the PBMs in terms of what they needed to optimize revenue. The market shifted in an interesting and arguably suspicious direction by choosing consolidation over innovation. It is no secret to anyone on the Committee that 1) around 70%-80% of the PBM market share is controlled by three major organizations; 2) each of these has either been purchased by an insurance carrier or has purchased an insurance carrier themselves; and 3) the major PBMs also own dispensing assets for mail service and Specialty home delivery, and in certain circumstances a retail pharmacy chain. This "all-in-one" option has narrowed the

marketplace and forced even more consolidation and fewer options for payers. I'll stop there and leave the issue in the capable hands of the Federal Trade Commission, which is presently reviewing these concerns.

Last and certainly not least is the fact that nearly all payers utilize what I can only characterize as a “less than ideal” pricing benchmark as the standard for all drug pricing in the United States. This pricing benchmark, known as Average Wholesale Price (AWP), was the primary source of a class action lawsuit that required one of the major publishers of AWP to stop production of the benchmark no later than September 2011. AWP is not related to the retail acquisition cost of a pharmaceutical product. There was hope in the market at the time that a new industry benchmark would emerge. Unfortunately, most PBMs migrated to another publishing index available on the market, and AWP survived.

However, in response to many State Medicaid plans, Center for Medicare and Medicaid Services (CMS) did something great and started the process of creating and establishing the National Average Drug Acquisition Cost (NADAC) index. This new benchmark was initially published in draft form in 2012. It is based on voluntary survey data from retail pharmacies that report their invoiced acquisition costs at the drug level to CMS. This is performed as frequently as weekly and is available on a free public website. It should be noted that AWP data, by comparison, is a subscription-based service, and anyone wishing to review and audit AWP may have to purchase a license to examine their own drug cost benchmark data.

Founded in 2017, Capital Rx set out to change the way drugs are priced and patients are cared for to create enduring social change. We are over 1 million members strong across payers, including employers, union trusts, municipalities, school districts, Commercial health plans, Medicare, and Managed Medicaid clients. As a proud member of our Executive Team, I can confidently say Capital Rx has both financially and clinically aligned interests with its clients. In fact, Capital Rx is the only full-service PBM serving all lines of business and one of the relatively few healthcare companies that have earned B Corp™ certification, to my knowledge. This is the ultimate testament to aligning the company's interests with the patient and committing to “being a force for good” for society.

Our pricing model abandons the traditional AWP model and utilizes NADAC as the primary pricing benchmark. We have a Single-Ledger model that aligns our “books” - the drug manufacturer and pharmacy side of the house always aligns with the accounting on the client side of the house. We do not retain rebates or “spread” from any pharmacy or manufacturer contract. We are paid a fair administrative fee which is disclosed in our client contracts and appears as a line item on every client invoice. In full transparency, we also receive disclosed fees for additional clinical services that we may provide to a client as well, but the point is that there’s no gray area. Everyone can 1) see the price of the drug; and 2) clients don’t have to question if all “other” revenue is passed through to them or they paid a fair price.

The best way to describe what we do is to give a real-life example to which everyone can relate. If you have a headache and go to a pharmacy to pick up an over-the-counter option to get some relief, you’ll see quickly that your options - Tylenol, Advil, Aleve, the generic options - have a price on the shelf, and you know what you are going to pay when you go to the register. However, if you walk to the back of the store to pick up a prescription, you’re spinning a roulette wheel and hoping for the best based on what you know about your benefits; or, if you’re uninsured or underinsured, what you’ve read about the price online. You cannot see or know what you will have to pay for that medication. That’s because of AWP and the aforementioned contract complexity. It doesn’t have to be like that. Today’s pricing framework does not empower the pharmacist to explain why a drug costs one amount one month and then costs

something different the next month. We have all been conditioned that "this is how it is and has to be." It's simply not true.

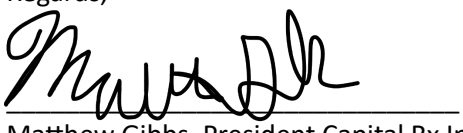
In my opinion, the traditional PBMs have trained everyone to believe that drug pricing is unstable, but they are utilizing complex algorithms to minimize their contractual reimbursements to pharmacies while at the same time not sharing the "savings" from this reimbursement reduction with the patient or the payer. This spread pricing game must stop. And while Medicare specifically prohibits this practice, most Commercial and some Managed Medicaid contracts still allow it to continue. One solution is to use NADAC as a publicly available benchmark price as the source of truth for drug costs. Is it perfect? No. Is it fundamentally better than the AWP industry standard? Absolutely. Are there ways to make it even better? Again, absolutely.

My simple message is this: every drug should have a price that is available for all to see and creates equity, thereby improving access for all Americans. It should be reported by all pharmacies, including retail, mail, and specialty home delivery, so patients and payers have day-to-day transparency on drug costs.

I'll leave you with a final message. I have worked my entire career to drive transparency into the pharmacy supply chain. We are at a pivotal moment in history where we can finally change what is broken and bring rational drug-level pricing to the American people. The fix is simple because the mechanisms are in place to allow both sides of the transaction – anywhere in the US – to see the price of a drug.

Thank you Chairman Wyden, ranking member Crapo and this Committee, for your time on this crucial issue.

Regards,



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