PBM's Harmful Impact on Alabama

1. *PBMs hurt Independent Pharmacy and Rural Alabama*

    a. Role of independent versus chain pharmacies in providing pharmacy access: a nationwide, individual-level geographic information systems analysis | Health Affairs Scholar | Oxford Academic (oup.com)

        i. "We measured pharmacy access at the individual level for a nationally representative sample of the US population and found that 59 million US individuals lack optimal pharmacy access. Further, an additional 15 million individuals solely rely on independently owned pharmacies for access. Rural populations, older adults, and low-income households were more likely to rely on independent pharmacies for accessing pharmacy services, which demonstrates the critical role of independently owned pharmacies in ensuring equity in pharmacy access. Our study reveals that the closure of independently owned pharmacies may exacerbate existing inequities in health care access."

    b. Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis - Journal of the American Pharmacists Association (japha.org)

        i. Community pharmacies are highly accessible health care locations for the majority of the U.S. population and may serve as accessible locations for patient-centered, medication management services that enhance the health and wellness of communities. Although chain pharmacies represent the majority of pharmacy locations across the country, access to community pharmacies in rural areas predominantly relies on franchise and independent pharmacies.

    c. The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program - Journal of the American Pharmaceutical Association (japha.org)

        i. Results "Mean A1c decreased at all follow-ups, with more than 50% of patients demonstrating improvements at each time. The number of patients with optimal A1c values (< 7 %) also increased at each follow-up. More than 50% showed improvements in lipid levels at every measurement. Multivariate logistic regressions suggested that patients with higher baseline A1c values or higher baseline costs were

most likely to improve or have lower costs, respectively. Costs shifted from inpatient and outpatient physician services to prescriptions, which increased significantly at every follow-up. Total mean direct medical costs decreased by $1,200 to $1,872 per patient per year compared with baseline. Days of sick time decreased every year (1997-2001) for one employer group, with estimated increases in productivity estimated at $18,000 annually."

2. *How PBM Affiliated Mail Order Pharmacies damage Alabama's Economy*
    a. [Mail Order Fallacies | Pharmacists United for Truth & Transparency (truthrx.org)]
        i. 2022 mail order medication revenue from the 5 largest PBMs combined $170.5 Billion (170,500,000,000)
            1. [Population and Housing: States in Profile (statsamerica.org)]
            2. Alabama estimated 2022 population:

Population over Time	Number	Rank	Percent of U.S.	U.S.
Annual Estimates (July 1)				
2023	5,108,468	24	1.53%	334,914,895
2022	5,073,903	24	1.52%	333,271,411

            3. Estimated revenue sent out of Alabama to the top 5 largest PBM's mail order pharmacies in 2022 = **$2.6 BILLION**

3. *PBM Harmful Practices that impact taxpayers/patients/providers in Alabama* - Committee on Oversight and Accountability
    a. [Comer Releases Report on PBMs' Harmful Pricing Tactics and Role in Rising Health Care Costs - United States House Committee on Oversight and Accountability] (7/23/24)
        i. **The three largest PBMs have used their position as middlemen and integration with health insurers, pharmacies, providers, and recently manufacturers, to enact anticompetitive policies and protect their bottom line.** The Committee found evidence that PBMs share patient information and data across their many integrated companies for the specific and anticompetitive purpose of steering patients to pharmacies a PBM owns. Furthermore, the Committee found that PBMs have sought to use their position to artificially reduce reimbursement rates for competing pharmacies.

ii. **PBMs frequently tout the savings they provide for payers and patients through negotiation, drug utilization programs, and spread pricing, even though evidence indicates that these schemes often *increase* costs for patients and payers.** The Committee identified numerous instances where the federal government, states, and private payers have found PBMs to have utilized opaque pricing and utilization schemes to overcharge plans and payers by hundreds of millions of dollars.

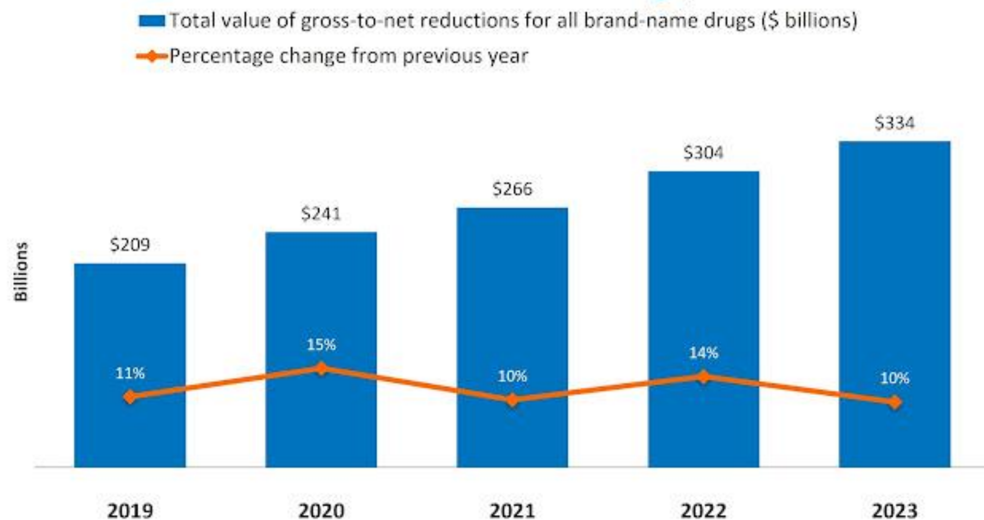
iii. **The largest PBMs force drug manufacturers to pay rebates in exchange for the manufacturers' drugs to be placed in a favorable tier on a PBM's formulary, making it difficult for competing, lower-priced prescriptions (often generics or biosimilars) to get on formularies.** The Committee has found evidence that PBMs regularly place higher cost medications in more preferable positions based on their formularies, even when there are lower-cost and equally safe and effective competing options.

iv. **As many states and the federal government weigh and implement PBM reforms, the three largest PBMs have begun creating foreign corporate entities and moving certain operations abroad to avoid transparency and proposed reforms.** The Committee found that these PBMs have created group purchasing organizations (GPOs) to centralize the negotiation of rebates and fees in Switzerland and Ireland. They have also created companies in Ireland and the Cayman Islands to manufacture and market certain highly profitable generics and biosimilars. The creation of entities in locations well known for their lack of financial transparency and movement of operations that would be subject to impending regulations only heightens concerns that PBMs will do anything to avoid transparency.

v. **The largest PBMs' use of tools such as prior authorizations, fail first policies, and formulary manipulations have significant detrimental impacts on Americans' health outcomes.** The Committee found that the use of these tools enables PBMs to slow the market uptake of cheaper generics and biosimilars. Furthermore, the Committee found that these tools often delay and negatively impact patient care.

vi. **The anticompetitive policies of the largest PBMs have cost taxpayers and reduced patient choice.** The Committee found that PBMs have intentionally overcharged or withheld rebates and fees from many taxpayer-funded health programs. Additionally, the Committee found that in these taxpayer-funded health programs, PBMs use their position as middlemen to steer patients to the pharmacies they own rather than pharmacies that may have closer proximity or provide better care.

4. *PBMs Hurt Alabamian Consumers*: Drug Channels: PBM Power: The Gross-to-Net Bubble Reached $334 Billion in 2023—But Will Soon Start Deflating

    a. 

    b. A manufacturer's **gross revenues** equal its revenues from sales at a brand-name drug's WAC list price. **Net revenues** equal its revenues from sales at a drug's net price, i.e., the actual revenues received and reported by the manufacturer after rebates, discounts, and other reductions.

    Drug Channels Institute coined the term **gross-to-net bubble** to describe the dollar gap between gross sales and net sales. We use "bubble" to characterize the speed and size of growth in the total dollar value of manufacturers' gross-to-net reductions.

c. The biggest issue: **Patients are still fully or partially exposed to the undiscounted list price of their prescriptions**.

5. *How PBMs Hurt Alabamian Employers and Payors*

    a. Spread Pricing

    a. **Spread Pricing 101 | NCPA**

        i. PBMs are pocketing millions of dollars by using opaque business practices, such as spread pricing.

        ii. States have found that an excessive amount of taxpayer dollars remain with pharmacy benefit managers (PBMs).

            1. The Congressional Budget Office (CBO) determined that banning spread pricing in state Medicaid managed care programs would save federal taxpayers $1 billion over 10 years.

            2. The Centers for Medicare and Medicaid Services is concerned that PBMs' use of "spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers," and CBO estimates that moving to transparent pharmacy reimbursements will save $1 billion over 10 years.

            3. Pennsylvania: Between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion.

            4. Ohio: the state Auditor found that, of the $2.5 billion that's spent annually through PBMs on Medicaid prescription drugs,

PBMs pocketed $224.8 million through the spread alone during a one-year period.

5. Kentucky: In response to a state report that found state PBMs keep $123.5 million in spread annually, the Attorney General has launched an investigation into allegations that the PBMs have overcharged the state and discriminated against independent pharmacies.
6. Louisiana: PBMs retained $42 million that was incorrectly listed as "medical costs."
7. New York: An audit found the state unnecessarily paid $605 million to Medicaid managed care organizations and their PBMs over a four year period, because "MCOs typically work with their PBMs to conduct their own clinical reviews to identify drugs that provide the greatest value to THEM and therefore should be placed on the drug formulary."
8. Michigan: Drug price manipulation allowed PBMs to overcharge Michigan Medicaid by at least $64 million.
9. Virginia: A state-commissioned report on Medicaid found PBMs pocket $29 million in spread pricing alone.
10. Maryland: A state Medicaid report found PBMs pocket $72 million annually in spread pricing alone.
11. Florida: A report found PBMs steer patients to PBM-affliated pharmacies, and "when it comes to dispensing brand name drugs, MCO/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."1F
12. Arkansas: A state-commissioned report found that PBMs in the Medicaid program reimbursed national chain pharmacies more (defined as greater than 5% difference) than regional chain and independent pharmacies for the same drug.