February 5, 2024

The Honorable James Comer  The Honorable Jamie Raskin
Chair  Ranking Member
Committee on Oversight and Accountability  Committee on Oversight and Accountability
U.S. House of Representatives  U.S. House of Representatives
2157 Rayburn Office Building  2242 Rayburn Office Building
Washington, DC 20515  Washington, DC 20515

Dear Chairman Comer and Ranking Member Raskin,

The Value & Access Collaboration, convened by the National Forum for Heart Disease & Stroke Prevention, commends you for exploring how large, vertically integrated pharmacy benefits managers’ (PBMs’) business practices affect consumers’ access to healthcare.

The Value & Access Collaboration represents patients, clinical providers, public health, payers, purchasers & pharma/biotech, who share the goal to “Enhance health and well-being by supporting people’s access to evidence-based care that is appropriate for them.” The Value & Access Collaboration stands for:

- Optimizing cardiovascular health and well-being for people throughout society
- Preventing cardiovascular disease (CVD) risk factors for people throughout society
- Ensuring people have access to therapies for CV risk factor reduction, and people with CVD can get the evidence-based treatments they need, regardless of socioeconomic status, geography, or genetics, and
- True transparency in costs of healthcare services and products

Patient access is fundamental to quality, equitable healthcare. Focusing on the base of the Health Value Triangle maximizes economic value and benefit.
The Value & Access Collaboration provides the following input for your consideration:

- Eighty percent of U.S. consumers’ medication access is regulated by the big three PBMs, which are largely unregulated entities.
- Some PBMs’ business practices reduce people’s access to the therapies they need.
  - PBMs’ business practices can interfere with clinician-patient decisions about the right treatment and providing such therapies to the right patients at the right time. These practices include:
    - Non-medical switching
    - High consumer out-of-pocket costs
    - Prior Authorization (PA) requirements and practices that can be onerous and confusing for consumers and clinicians. Some PBMs’ PA requirements and reasons for denial lack transparency. When a PBM would cover a similar drug on the formulary (while denying a drug not on the formulary), the denial letter should state the alternative that would be approved. Instead, some PBMs leave this to clinicians and patients to figure out for themselves.
    - PA requirements that do not align with current clinical guidelines. The establishment of PA criteria should include experts in the disease areas treated by the drugs under consideration. There should be a clear communication channel for professional societies and patient organizations to request a review and recommend changes.
    - Patient steering to PBM-owned pharmacies via network limitations established by PBMs.
    - Restricting drug formularies which can limit patients’ medication access.
    - Limiting the number of drugs at pharmacies (bulk purchases).
    - Forcing patients to use higher priced brand drugs that generate higher rebates for the PBM and higher PBM fees charged to the pharmacy.
  - Certain PBM practices have forced community pharmacies out of business, such as setting unpredictable reimbursement rates and imposing retroactive Direct and Indirect Remuneration (DIR) fees. Pharmacy price concessions, net of all pharmacy incentive payments, grew more than 107,400 percent between 2010 and 2020.
    - Due to the lack of transparency by PBMs, pharmacies are often reimbursed less than it costs to acquire the drug, and below the cost the medication is dispensed to the patient, making community pharmacy business models difficult to sustain.
    - This reduces access to needed medications and undermines health equity for people in places with limited numbers of pharmacies, such as rural areas, thus raising their risk of deteriorating health, heart attacks, strokes, and kidney failure, and the need for more costly treatments.
- PBMs’ sources of revenues and expenses should be transparent.
  - There is currently no transparency, notwithstanding assertions by the PBM industry.
  - The flow of rebate dollars should be transparent. Today, contracts that prohibit disclosure preclude transparency.
- Even as rebates paid to PBMs by manufacturers increase, ostensibly reducing net prices of medications, consumers’ costs can (and do) increase.

- In a fully transparent model, when a PBM functions as a fiduciary, the drive is to achieve the lowest net cost for the overall pharmacy spend – not to maximize the multiple sources of revenue of which rebates may be the largest.

The Value & Access Collaborative urges Congress to illuminate how various types of PBMs work, what the rebates and DIR fees are, how they are allocated, and where the money goes. We encourage Congress to ask PBMs to demonstrate how money is being saved and where the money is going. Congress may also consider setting limits on the profit margins received by PBMs as exists for health plans.

Respectfully,

John M. Clymer
Executive Director

Members of the Value & Access Collaboration:
National Forum for Heart Disease & Stroke Prevention (convener)
American Association of Heart Failure Nurses
American College of Cardiology
American Heart Association
American Pharmacists Association Foundation
American Society for Preventive Cardiology
Association of Black Cardiologists
Association of State and Territorial Health Officials
BallengeRx Consulting
Family Heart Foundation
Global Healthy Living Foundation
Independent Health
Institute for Patient Access
Mended Hearts
National Alliance of Healthcare Purchaser Coalitions
National Lipid Association
Partnership to Advance Cardiovascular Health
Partnership to Improve Patient Care
Preventive Cardiovascular Nurses Association
University of Michigan Center for Value-Based Insurance Design
WomenHeart