

“Making Health Care Affordable Again Part 2: Perspectives from Employers, Patients, and Providers.”

Chairman Cassidy, Ranking Member Sanders, and distinguished Members of the Committee: thank you for coming to Louisiana and for the opportunity to testify today about the skyrocketing cost of healthcare. My name is T.J. Woodard and my wife, Aimee, and I are both pharmacists who own and operate 2 independent pharmacies in Baton Rouge, Prescriptions to Geaux. I am uniquely situated in this discussion, as a Patient, a Provider, and an Employer. I have seen the cost of care increase exponentially, while quality and access have decreased. Like many providers, I spend way too much time navigating the unnecessarily complicated pharmacy benefits model; time that would be better spent on patient care or efficiently running my small business. The bad news is that this is a universal problem that affects every community in America and is an enormous expense to families, employers, states, and the federal government. The good news is there is a tremendous opportunity to right the ship.

In pharmacy, we love acronyms. There's AWP, NADAC, DIR, GER, PSAO, and numerous others. I won't bore you by explaining these things that contribute to the “unnecessarily complicated” model that I just mentioned. Today, the only acronym that matters is PBM, or Pharmacy Benefit Managers. They are the single biggest problem in the prescription supply chain and a major contributing factor to the exploding cost of healthcare in America. To be fair, not all PBMs are bad actors and the concept behind their creation was somewhat valid, to streamline the process for efficiency and cost-savings. That is certainly not what they have evolved into today; at least the Big 3, CVS Health, Optum-United, and Express Scripts-Cigna, who control 80+% of the prescription drug market. They are vertically integrated monopolies who dictate every aspect of patient care in America, and it is almost never for better care or lower costs.

“Good PBMs” are those that simply streamline the process, are transparent, and charge a fee for their service. Think of using a credit card at a large department store to buy an assortment of products. They provide a valuable service and are paid a nominal fee for doing so.

Unfortunately, the “Bad PBMs” are the overwhelming majority of the market, and their offenses are too numerous for my introduction. Not only are they driving up costs and negatively affecting patient care, they are putting pharmacies out of business at an alarming rate. This is a real threat to access for millions of Americans, and it isn't just independent pharmacies; ask Rite Aid, Winn Dixie, or Target. This is truly a bipartisan issue that affects every community and many struggling small business pharmacies in each of

your communities. Not only can we put healthcare back where it belongs, in the hands of patients and their providers, we can do it at an enormous cost-savings, which will Make Healthcare Affordable Again.

I find it best to explain how devastating their behavior is by listing some of these activities and giving specific examples. Taken individually, they're obviously unfair trade practices. Taken together, they've created a healthcare climate that is unsustainable for most independent pharmacies in America. If you don't believe me, ask any independent pharmacist in any of your states.

Vertical Integration: If I had to rank the PBMs' activities, this would be the most concerning. I worked at CVS when the merger with Caremark happened. I remember vividly that there would be a "firewall" between the two companies. Today, this is laughable, but it's much worse than we could have ever imagined. The "Big 3" PBMs that I mentioned are all vertically integrated and control an enormous percentage of the overall healthcare market. UnitedHealth Group generates more revenue than Ford and General Motors combined. The specific part of their vertical integration that is most troubling is that they are both PBM and Pharmacy, whether it's a brick-and-mortar store, or a mail-order pharmacy. This creates an obvious conflict-of-interest, when I submit claims for payment to a PBM that also owns a pharmacy that directly competes with mine. In what world would we allow someone's direct competitor to dictate their payment terms and perform invasive on-site audits? I'm happy to elaborate on this concern, but in short, a company should be a PBM or a pharmacy, but not both. What we've seen in Arkansas, Louisiana, and now Tennessee is that they will go to extreme lengths to prevent this from happening. They've repeated the claim that if their vertical integration is prohibited, they will be forced to close pharmacies, leaving pharmacy deserts. This is quite telling that they would choose to close the pharmacies, that often provide critical life-saving care, to keep the PBM. The PBM is obviously the more profitable segment of their business.

Steering: As I mentioned, we must submit Patient Health Information to the PBM to process the pharmacy claim. The PBMs often use this HIPAA-protected information to market to their competitors' patients and incentivize the use of their own pharmacies. This is specifically prevented in some states, including Louisiana, but they do it anyway. Often under the guise of ERISA pre-emption.

Which takes me to another common tool they use, ERISA pre-emption. We have passed many good laws in Louisiana, but our Insurance Commissioner can't enforce many of them because they are prevented by overriding Federal law. The intent behind ERISA, which was passed in 1974, was sound, but it is now being used as something of a get-out-of-jail-free card by the PBMs. I suggest it should be reviewed and adjusted to fit the current landscape,

which has changed significantly in the last 50 years. If it isn't, soon, seniors with Medicare Advantage plans will have a pretty card in their wallet that no pharmacy or doctor can afford to take. The Medicare Advantage plans are an enormously over-inflated cost to the federal government and an enormous driver of profit for the PBMs, which is why every other daytime commercial is an NFL Legend selling you on their plan.

This is a segue to another topic that I'd like to bring to your attention, auditing Tricare. Tricare, via Express Scripts, provides pharmacy benefits to nearly 10 million active-duty military personnel, retirees, and their beneficiaries. Express Scripts has administered the program for years and, to my knowledge, has never been audited. This is concerning and, I think, potentially offers an enormous cost-saving opportunity for the government payor of this program. Not only does Tricare prevent many independent pharmacies from participating in their network, but we also know they bill the federal government significantly more for some drugs than they're paying our pharmacies. We've seen Express Scripts pay itself over \$3,000 for ondansetron, a common anti-nausea medication that should cost about \$20. This should be audited and investigated.

After preventing vertical integration, the second most important step that should be taken is "delinking." This is essentially delinking a PBM's compensation from the price of the drug. This is a perverse incentive that often leads to a much more costly drug being placed on a PBM's formulary, and quite clearly is baked into the overall cost of the medication. If a manufacturer must pay a "rebate," which would be called a "kickback" in any other situation, to be included on a PBM's formulary, this will necessarily increase the cost of that medication. This defies logic, other than it is a major profit driver for the PBMs and the manufacturer must pay a sort of "sin tax" to ensure their drug is covered in the market.

For the sake of brevity, I'll stop there and simply list some of the numerous other PBM activities that stifle competition and a fair market and undoubtedly drive up the cost of healthcare: Spread Pricing, Steering, Audits, GPOs or "rebate aggregators," Prior Authorizations, Specialty Drugs/Pharmacies, Predatory Contracts, Closed Networks, Below-Cost Reimbursements, etc.

In a world that is, unfortunately, bitterly divided, there is a real opportunity in PBM reform. It is truly a bipartisan issue that affects every demographic and every community in America. If we really want to address the skyrocketing cost of healthcare, we must address the runaway trains that some of the PBMs have become. We should demand a free and fair market where costs go down and quality goes up. Breaking up their vertically integrated monopolies and delinking their compensation from the cost of the medication are two things that would show immediate results.

I am happy to answer any questions and provide any specific examples. I represent myself and nearly 20,000 other independent pharmacies in America that are in real danger of being driven out of business by a few, but very powerful, bad actor PBMs. We are begging you for help. We're simply asking for a level playing field and a chance to run our small businesses and take care of our communities.

Thank You.