



October 13, 2023

The Honorable Michael Burgess, M.D.
Chair
Health Care Task Force
U.S. House Committee on the Budget
204 Cannon House Office Building
Washington, DC 20515

[Submitted electronically via: hbc.health@mail.house.gov]

RE: Request for Information (RFI): Solutions to Improve Outcomes, Reduce Federal Health Care Spending in the Budget

Dear Chair Burgess:

On behalf of our nation's over 334,000 pharmacists,¹ representing licensed pharmacists in every state, the American Pharmacists Association (APhA) is pleased to submit the following comments in response to the Health Care Task Force's RFI on solutions to improve outcomes, reduce federal health care spending in the budget, as well as opportunities to build upon the Congressional Budget Office's (CBO) ability to project the impact of health care policies.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA is pleased to provide the following actions Congress could take to improve outcomes while lowering health care spending:

- 1) Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending

HHS has repeatedly recognized the important role that pharmacists play in maintaining and addressing the country's health with multiple temporary authorizations during the pandemic to

¹ <https://www.bls.gov/ooh/healthcare/pharmacists.htm>

test, treat, and immunize Medicare beneficiaries. The HHS Secretary extended many of these medical countermeasures, including certain pharmacy-provided COVID-19 testing, vaccination, and related health care services with the eleventh amendment to the declaration under the Public Readiness and Emergency Preparedness (PREP) Act through December 2024.² HHS' action is the result of public health interventions by pharmacists and teammates during the pandemic which averted >1 million deaths, >8 million hospitalizations, and \$450 billion in healthcare costs.³ Simply put, pharmacists provide health care services in rural and underserved areas at a lower cost and significantly reduce downstream costs to Medicare and the taxpayers.^{4,5,6}

CMS was one of the many federal agencies to recognize the need to utilize our nation's pharmacists to reduce health care costs by preventing expensive hospitalizations. For example, CMS utilized a variety of administrative pathways, including: section 1135 waivers, enforcement discretion, and demonstration authority under section 402 (a)(1)(B)) to expand coverage of pharmacists' services within Medicare Part B to meet our nation's health care needs. CMS has also previously stated, in the CY 2021 PFS final rule, "[w]e agree with certain stakeholders that under the general CPT framework, pharmacists could be considered QHPs or clinical staff, depending on their role in a given service." "We understand and appreciate the expanding, beneficial roles certain pharmacists play, particularly by specially trained pharmacists with broadened scopes of practice in certain states, commonly referred to as collaborative practice agreements. We note that new coding might be useful to specifically identify these particular models of care."⁷

However, physicians have been significantly challenged to utilize pharmacists to provide complex care services under an "incident to" relationship as CMS has limited utilization of pharmacists as "clinical staff," to evaluation and management (E/M code) 99211 which reflects an average total time of 7 minutes, an action that has eliminated most of this team-based care as an option. A growing number of state medical assistance programs, as approved by CMS through state plan amendments, include higher-level E/M office and other outpatient services codes on their pharmacist fee schedule.^{8,9,10}

APhA requests the Committee and Congress work with CMS to remove barriers to fully utilize pharmacists' expertise to address access gaps in care for Medicare beneficiaries and lower Medicare costs to the taxpayer. APhA strongly urges Congress to build upon HHS' previous

² <https://public-inspection.federalregister.gov/2023-10216.pdf>

³ <https://www.sciencedirect.com/science/article/pii/S1544319122002795?dgcid=author>.)

⁴ <https://www.cambridge.org/core/journals/antimicrobial-stewardship-and-healthcare-epidemiology/article/impact-of-vaccination-on-cost-and-course-of-hospitalization-associated-with-covid19-infection/B796C8C2D9E47B60AF6F218C69CCDF92>

⁵ <https://aspe.hhs.gov/reports/hospitalization-cost-savings-covid-19-vaccinations>

⁶ <https://www.forbes.com/sites/johnlamattina/2021/12/21/covid-19-vaccines-are-saving-the-us-healthcare-system-billions/?sh=69f796c1462c>

⁷ <https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>

⁸ <https://hcpf.colorado.gov/pharm-serv>

⁹ https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT91.pdf

¹⁰ <https://portal.ohmits.com/public/Public-Information/Fee-Schedules/Code/RPH/Format/HTML>

work and utilize public health emergency (PHE) authority, enforcement discretion, and demonstration capability to the maximum extent by identifying the full range of E/M services being utilized by pharmacists in the states and any new coding to remove any remaining regulatory barriers to the delivery of, and payment for, the full range of pharmacist-provided patient care services for our nation's Medicare beneficiaries to reduce health care costs.

2) Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes

Due to our increased reliance on our nation's pharmacists as health care infrastructure, we need to get innovative, and activating our nation's pharmacists has proven successful for two presidential administrations to help protect our nation's seniors and avoid unnecessary health care spending.

Congress should work to pass H.R. 1770, the Equitable Community Access to Pharmacist Services Act,¹¹ bipartisan legislation, supported by many members of this Committee, to continue pharmacists' role in providing these vital health care services. H.R. 1770 and similar efforts to increase seniors' access to health care at lower costs at our nation's pharmacies in our rural and underserved communities is a common-sense proposal to reduce health care costs for Medicare, and the taxpayers.

3) Comments on CBO's modeling capabilities on health care policies, including limitations or improvements to such analyses and processes

As the Task Force members likely know, downstream cost savings from preventable health care services are often not scored as a "savings" by CBO. Research generally supports the notion that timely access to preventive care can be life-saving (e.g., an estimated total savings of \$3.7 billion, or 0.2 percent of U.S. personal health care spending (not updated to reflect 2023 dollars)).¹² To develop a "score" for preventive health policy against the budget baseline, CBO follows 3 steps: identify the population affected by the policy, estimate the change in national health spending (which includes both public and private spending) that would result from the policy, and then estimate what budgetary effects the change in national health spending would have and compares that spending estimate to the baseline.¹³ As one example, CBO scored that providing coverage of tobacco cessation services in Medicaid for pregnant women would save Medicaid \$100 million over a 10-year period.¹⁴ APhA urges the Committee to work with CBO to incorporate the downstream impacts to reduce health care costs from preventable health care services provided by pharmacists (disease state and medication management, smoking cessation counseling, health and wellness screenings, preventative services, immunizations, and, family services).

¹¹ <https://www.congress.gov/bill/118th-congress/house-bill/1770?q=%7B%22search%22%3A%22hr1770%22%7D&s=1&r=1>

¹² <https://pubmed.ncbi.nlm.nih.gov/20820022/>

¹³ https://www.americanactionforum.org/insight/cbo-scoring-of-preventive-health-measures-important-considerations/#_ftn8

¹⁴ <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf>

4) Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long-term health costs

APhA is a member of the Future of Pharmacy Care Coalition, representing more than 190 groups supporting federal legislation, H.R. 1770, to ensure senior access to essential pharmacist services.¹⁵ Our coalition has received an analysis, undertaken by former CBO staff at Avalere Health, which estimated the downstream impact would produce \$22 million in health outcomes and federal budgetary savings over 10 years.¹⁶

An accompanying literature review provided clear evidence in 4 research domains:

1. Evidence of influenza and COVID-19 vaccine effectiveness in reducing hospitalization rates among adults aged 65 and older.

COVID-19 Vaccine Findings

Multiple studies have found high vaccine effectiveness (VE) against COVID-19 hospitalizations. One study found VE for adults 65-74 years old to be ~96% for the two mRNA-based vaccines while VE for adults ages 75 and older was reported at 91% for the Pfizer vaccine and 96% for the Moderna vaccine (Moline et al.).¹⁷ A similar finding was reported based on an analysis of the North Carolina COVID-19 Surveillance System, finding VE against hospitalization to be ~96% for the mRNA-based vaccines 2 months post-first dose (Lin et al., 2022).¹⁸ A study modeling the impact of vaccinations on COVID-19 cases and hospitalizations between December 2020 and September 2021 estimates that among adults 65 and older, vaccines prevented 4.6 million infections and 759,000 hospitalizations (Steele et al., 2022).¹⁹ The estimated number of hospitalizations prevented per 100,000 population in individuals 65+ ranged from 34 (95% UI, 30-40) in March 2021 to 484 (95% UI, 389-612) in September 2021, when a larger share of the population was vaccinated.

Flu Vaccine Findings

In the Centers for Disease Control and Prevention's (CDC's) review of influenza vaccine effectiveness during the 2019-2020 flu season, vaccination was found to be 42% effective in the prevention of influenza H1N1 and 34% effective in the prevention of influenza B/Victoria. This VE is estimated to have prevented approximately 56,000 hospitalizations. (CDC, 2022).²⁰

One study considered the interactive effects between influenza vaccines and COVID-19, finding that individuals who had received an influenza vaccine were less likely to be hospitalized and

¹⁵ <https://pharmacycare.org/>

¹⁶ <https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=XWbTkRBxTfA%3d>

¹⁷ <https://doi.org/10.15585/mmwr.mm7032e3>

¹⁸ <https://doi.org/10.1056/NEJMoa2117128>

¹⁹ <https://doi.org/10.1001/jamanetworkopen.2022.20385>

²⁰ <https://www.cdc.gov/flu/about/burden-averted/2019-2020.htm>

had shorter stays (Conlon et al., 2021).²¹ The odds ratio (OR) of hospitalization for COVID-19 among those who had received a flu vaccine compared to those who hadn't was 0.58 and the OR for mechanical ventilation was 0.45.

2. Prevalence of hospitalizations for upper respiratory infections in unvaccinated and vaccinated adults aged 65 and older.

A retrospective observational study leveraging health records of individuals seeking care at University of California Health Centers found that COVID-19 vaccination status was associated with higher survival and a decreased frequency of several respiratory features (Hughes et al.).²² In particular, the OR of unvaccinated patients to present with an acute upper respiratory infection was 1.28 compared to vaccinated patients during the Delta wave, and 1.72 during the Omicron wave. Unvaccinated patients were also observed to have a higher OR for acute respiratory failure (2.04 during Delta, 1.34 during Omicron) and pneumonia (1.62 during Delta, 1.26 during Omicron).

3. Estimated number of influenza or COVID-19 infections, hospitalizations, and deaths prevented among vaccinated adults aged 65 and older.

Influenza-Related Findings

Studies highlighted under Domain 1 demonstrate the benefits of influenza vaccines, and models further suggest that the addition of pharmacies as vaccination locations in addition to traditional locations, such as hospitals, clinic/physician offices, and urgent care centers, have had significant clinical and economic outcomes, particularly with the more severe epidemic. In an average influenza season, data suggests adding pharmacies with typical business hours as vaccination locations averted at least 11.9 million symptomatic influenza cases, between 23,000 to 94,000 deaths, \$1.0 billion in direct (vaccine administration and healthcare) costs, and between \$5.2–\$45.3 billion in overall costs for all ages (Bartsch et al., 2018).²³ In a more severe season, pharmacist vaccination can avert 16 million cases, 35,000 to 141,000 deaths, and \$7.8–\$67.3 billion in overall costs. These impacts increase with expanded operating hours. Even operating under typical hours and conditions, modeling found that pharmacies could increase the total number of vaccines administered by 30.6 million, compared to traditional locations alone. Additionally, the model found that volume would shift toward pharmacies, which would provide approximately 5.6 million more vaccinations than traditional locations and accommodating these efforts was found to be economically dominant (i.e., saved costs and provided health benefits) compared to vaccination at traditional locations only.

²¹ <https://doi.org/10.1016/j.ajic.2021.02.012>

²² <https://doi.org/10.1038/s41598-023-31761-y>

²³ <https://doi.org/10.1016/j.vaccine.2018.09.040>

In more recent years, when vaccination has been 30-40% effective in preventing influenza, it is estimated vaccination prevented roughly 615,000 illnesses, 344,000 medical visits, 56,000 hospitalizations, and 5,200 deaths among adults 65 years and older (CDC, 2022).²⁴ Even in seasons of less severity, vaccination with a vaccine that is ~30% effective in preventing influenza is estimated to have averted more than 149,000 symptomatic illnesses, 83,000 medical visits, 13,000 hospitalizations, and 800 deaths among adults ≥65 years (CDC, 2023).²⁵

COVID-19-Related Findings

A non-systematic review of published literature suggests that from February 2020 to September 2022, in addition to plausibly providing more than 50% (~270 million) of all US COVID-19 vaccines, pharmacists also provided more than 50 million other immunizations, including but not limited to influenza and pneumococcal vaccines (Grabenstein, 2022).²⁶ Efficient and timely COVID-19 vaccination has also averted a significant number of COVID-19 infections, hospitalizations, and deaths.

As noted in Domain 1, vaccination between December 2020 and September 2021 was found to be between 82%-93% effective in reducing risk of hospitalization among adults ≥65 years, based upon type of vaccine received (Lin et al., 2022).²⁷ Vaccination was even more effective in reducing the risk of death, ranging between 83%-98%. Given such efficacy, it is estimated that in that same time period for the older adult age group, COVID-19 vaccination prevented 4.6 million infections, 759,000 hospitalizations, and 154,000 deaths (Steele et al., 2022).²⁸ The rate of prevention/averted burden varied throughout that time period, based upon circulating strain severity, with findings suggesting that in September 2021, vaccination was estimated to have prevented 52% of expected infections, 56% of expected hospitalizations, and 58% of expected deaths.

4. Evidence of avoidance of hospitalization in adults aged 65 and older after early testing and treatment for COVID-19, influenza, RSV, or streptococcal pharyngitis.

While the role of pharmacists as vaccinators in the prevention of these respiratory diseases is well-characterized in the literature above, studies were also reviewed to understand the impact of early testing and treatment to avert more costly medical encounters, such as hospitalization. Findings of studies focused on COVID-19, flu, and RSV are summarized below.

The U.S. national strategy, particularly during the COVID-19 pandemic, encouraged broad implementation and use of early intervention and treatment approaches (such as Paxlovid) in

²⁴ <https://www.cdc.gov/flu/about/burden-averted/2019-2020.htm>

²⁵ <https://www.cdc.gov/flu/about/burden-averted/2021-2022.htm>

²⁶ <https://doi.org/10.1016/j.japh.2022.08.010>

²⁷ <https://doi.org/10.1056/NEJMoa2117128>

²⁸ <https://doi.org/10.1001/jamanetworkopen.2022.20385>

an effort to prevent hospital crowding (Dryden-Peterson et al., 2023).²⁹ Increased access to testing and treatment is particularly critical among populations that may choose not to vaccinate. Additionally, the control and containment of infectious disease through early testing and treatment is likely to occur in a less costly and more effective manner when individuals are given the option of pharmacist-provided and over-the-counter options.

Influenza-Related Findings

Prior to the COVID-19 pandemic, pharmacist provision of influenza-related services was commonplace, and studies suggest pharmacies were well-equipped to implement standardized diagnostic testing protocols, with high percentages of eligible, influenza-positive patients receiving early treatment prescriptions (Hardin et al., 2020).³⁰ Even without a current structure to appropriately bill and be reimbursed for these services, early implementation of such models didn't appear to negatively affect patient or pharmacist willingness to participate, allowing for more widespread access to acute outpatient care as opposed to potentially delayed care and hospitalization.

COVID-19-Related Findings

Hospitalizations during the COVID-19 pandemic continued to stay at high levels, even through fall 2022, as roughly 1,300 individuals ≥ 65 years were hospitalized weekly (Silcox et al., 2023).³¹ Analyses of Medicare Fee-For-Service claims data found that reducing the number of COVID-19 hospitalizations by just 25% in this age group, through accessible and efficient testing programs, would save Medicare over \$30 million monthly (Centers for Medicare and Medicaid Services (CMS, 2023)).³²

Together with vaccination, evidence suggested treatments such as antivirals and monoclonal antibodies also averted more medical encounters and hospitalizations than the standard of care (Reis et al., 2022).³³ While the proportion of people who received Paxlovid compared to the eligible population was relatively low (37.9% among individuals ≥ 65 years), older adults who were prescribed treatments were less likely to be hospitalized (Shah et al., 2022).³⁴ Among individuals ≥ 65 years, the risk of COVID-19-associated hospitalization decreased between 16%-49% due to Paxlovid use, with a greater reduction in risk relative to the number of underlying health conditions (Shah et al., 2022). Significantly decreased likelihood of hospitalization following early treatment with Paxlovid was also observed among individuals who were fully vaccinated. An analysis by Dryden-Peterson et al., 2023, found that among adults 50 years of age and older who were vaccinated per Advisory Committee on Immunization Practices recommendations, use of Paxlovid decreased risk of hospitalization (aRR=0.60) or death

²⁹ <https://doi.org/10.7326/M22-2141>

³⁰ <https://doi.org/10.3390/pharmacy8040182>

³¹ <https://healthpolicy.duke.edu/publications/testing-respiratory-infections-beyond-covid-19-public-health-emergency>

³² <https://www.cms.gov/research-statistics-data-systems/medicare-covid-19-hospitalization-trends>

³³ <https://doi.org/10.1002/14651858.CD015395.pub2>

³⁴ <https://doi.org/10.15585/mmwr.mm7148e2>

(aRR=0.29) compared to people without a prescription, and this finding was also significant among older adults (≥ 65 years: aRR=0.55). In addition to preventing hospitalization and death, risk of post-COVID-19 conditions and sequelae (often referred to as "Long COVID") was 20% less likely in veterans between the ages of 61-70 years who received early treatment with Paxlovid and 34% less likely in individuals ≥ 70 years (Xie et al., 2023).³⁵

Further, the role of pharmacists in increasing testing and treatment parity is critical. Pharmacists' increased accessibility through widespread coverage and amenable operating hours are particularly valuable in socially vulnerable communities (Prakash et al., 2023).³⁶ Though federal and state distribution of Paxlovid was equitable, actual utilization differed in counties with low, medium, and high Social Vulnerability Indexing (SVI), as calculated per CDC standards. In general, counties considered to be less vulnerable with lower SVI values had higher rates of Paxlovid uptake, averaging between 1.4-1.8 times higher than in highly vulnerable communities. This disparity is likely driven by limited awareness of treatment availability, benefits of treatment, and access to prescribers, all of which may play a role in increased risk of hospitalization and death from COVID-19 among Black, Hispanic, and Indigenous individuals, who are more likely to live in underserved communities compared to white individuals in the U.S.

Overall, the role and contributions of pharmacists was significant in the provision of interventions to help control and mitigate the pandemic, likely leading to a significant reduction in the number of potential hospitalizations. This was through efforts not simply related to vaccination, but also increased testing and treatment. Again, from February 2020 to September 2022, pharmacists and their teammates conducted more than 42 million COVID-19 tests, and then prescribed, dispensed, and administered a significant number of antibody products and antiviral medications, to care for at least 5.4 million inpatients and even more outpatients (Grabenstein, 2022).³⁷ Through conservative estimates, pandemic interventions by pharmacists and pharmacy staff likely averted more than 1 million deaths, more than 8 million hospitalizations, and at least \$450 billion in healthcare costs.

RSV-Related Findings

Though RSV vaccines for individuals ≥ 65 years will enter the market fall 2023, data suggests approved and recommended vaccines will significantly prevent avoidable and costly hospitalizations. Reviewing data from respiratory virus seasons in 2015–2018, older adults were hospitalized due to RSV at a rate 7.0–9.0 times the rates of adults 18-64 years of age (Nowalk et al., 2022).³⁸ At that rate, studies estimate healthcare systems could expect 120,000 RSV-associated respiratory hospitalizations for American adults in this age group annually (Zheng et al., 2022).³⁹ Between 2015 and 2018, that overall hospitalization rate among all adults ≥ 18 years

³⁵ <https://doi.org/10.1001/jamainternmed.2023.0743>

³⁶ <https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0019>

³⁷ <https://doi.org/10.1016/j.japh.2022.08.010>

³⁸ <https://doi.org/10.1016/j.vaccine.2022.05.077>

³⁹ <https://doi.org/10.1186/s41479-022-00098-x>

amounted to a total of approximately \$182 million due to RSV hospitalizations, the large majority (\$122 million) was attributable to older adults who comprised 70% of those hospitalized with RSV (Nowalk et al., 2022).⁴⁰ As recently as the 2018 season, an analysis of a sample of Medicare Advantage and commercial claims found that the average weekly costs for patients 65 and older in the 2-8 weeks prior to an RSV diagnosis are \$1,731, which then increase to \$3,067 during the week before diagnosis, and further increase to \$12,866 in the week following RSV diagnosis (Mesa-Frias et al., 2022).⁴¹ Therefore, prevention at even a small degree could have a significant economic impact. As these costs vary seasonally, they have become more pronounced among individuals ≥ 65 years and even more so among those ≥ 85 years, especially during more recent years.

Medication Management

According to a report to the U.S. Surgeon General that evaluated the cost-efficiencies of pharmacist-delivered patient care, effective patient care services related to medication management can yield a return on investment of as high as 12:1 (and averaging 4:1) from reduced hospital admissions, unnecessary or inappropriate medication use and reduced emergency department admissions and overall physician visits.⁴²

Adherence

Studies have shown that the effective use of pharmacists can improve medication adherence by as much as 30%, reduce 30-day hospital readmissions by 24% and reduce ED visits by 30%.⁴³

Deprescribing

Roughly 10% of adults (30% in those 65 years old or older) in the U.S. are prescribed inappropriate medication therapy resulting in an added cost of \$36 billion per year. Pharmacists using structured criteria can reduce overprescribing by 14.6%, according to one study.⁴⁴

Transitions of care

The cost for unnecessary 30-day hospital readmissions is \$26 billion a year for Medicare alone, of which \$17 billion a year is preventable. Many medication-related problems arise when patients transition from one level of care to another. A 2018 study found that pharmacists, using a transitions-of-care model, saved \$2,139 in total healthcare costs over six months, on average, for every patient referred to them as a high risk for readmission.⁴⁵

⁴⁰ <https://doi.org/10.1016/j.vaccine.2022.05.077>

⁴¹ <https://doi.org/10.18553/jmcp.2022.21459>

⁴² <https://www.hfma.org/operations-management/how-pharmacists-can-play-a-role-in-curtailling-the-rising-cost-of/>

⁴³ doi: 10.1097/01.mlr.0000163641.86870.af. PMID: 15908846

⁴⁴ doi: 10.1038/clpt.2011.44. Epub 2011 Apr 20. PMID: 21508941

⁴⁵ <https://doi.org/10.2146/ajhp170255>

5) Recommendations to reduce improper payments in federal health care programs.

As the Committee understands, inequitable reimbursement of pharmacies by pharmacy benefit managers (PBMs) in the U.S. has grown out of control, with misaligned incentives that neither benefit the patient nor lead to better health outcomes. These misalignments are causing pharmacies across the country to shut their doors, leaving patients, particularly those in rural and underserved areas, without access to their local pharmacies.

Unfair and anti-competitive practices from PBMs include clawbacks (known under Medicare as direct and indirect remuneration (DIR) fees which PBMs often assess weeks, or even months, after Part D beneficiaries' prescriptions are filled, resulting in pharmacies realizing only long after the prescription was filled that they did not recoup their costs), spread pricing (overcharging the payer, underpaying the pharmacy and keeping the spread), patient steering to PBM-owned pharmacies, mandatory mail-order raising patient safety concerns, and many other concerning practices.

Under Medicare alone, pharmacy DIR fees have increased by more than 107,400 percent!⁴⁶ The Medicare Payment Advisory Commission's (MedPAC) March 2023 report found that pharmacy DIR payments to PBMs in Medicare Part D were an astounding \$12.6 billion for 2021 — which represents a \$3.1 billion (+33%) increase from the 2020 figure of \$9.5 billion.⁴⁷

Despite these clear and documented issues to patients' access to pharmacies, Congress has yet to pass the multi-committee, bipartisan Lower Costs, More Transparency Act,⁴⁸ which includes many bipartisan reforms championed by this Committee. Congress must not miss this chance to begin to put a stop to these anticompetitive PBM business practices and their enormous impact on taxpayers as they contribute to inflated prices and decreased access for patients to medications reimbursed under public health plans. For example, a recent study found that PBM tactics forced Oregon Medicaid to overpay \$1.9M on a single drug, where PBMs marked up the drug by 800 percent!⁴⁹

Conclusion

APhA thanks the Task Force for your continued leadership in examining key drivers of our nation's health care spending and solutions to improve health outcomes while bending down the debt curve. Please contact mbaxter@aphanet.org if you have any additional questions or need additional information.

⁴⁶ <https://www.federalregister.gov/documents/2018/11/30/2018-25945/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses>

⁴⁷ https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf#page=427

⁴⁸ https://d1dth6e84htgma.cloudfront.net/LCMT_Act_Section_by_Section_9_8_23_432347079b.pdf

⁴⁹ <https://oregonpharmacy.org/2022/10/27/oregon-report/>

Sincerely,

Michael Baxter

Michael Baxter

Vice President, Federal Government Affairs

Cc: Rep. A. Drew Ferguson IV, D.M.D
Rep. Lloyd Smucker
Rep. Buddy Carter
Rep. Blake Moore
Rep. Rudy Yakym III
Chair, Rep. Jodey Arrington
Ranking Member, Rep. Brendan Boyle