Statement by

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House Committee on Oversight and Government Reform

Regarding

FEHBP Prescription Drug Integrity, Transparency and Cost Savings Act

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Mr. Chairman and Members of the Subcommittee: My name is Jacqueline Simon and I am the public policy director of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the more than 600,000 federal employees represented by our union, I thank you for the opportunity to testify today.

AFGE applauds you and the bill's cosponsors for the introduction of H.R.4489, "*The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act.*" While enactment of any of the competing national healthcare reform bills would ease some of the cost pressures on FEHBP, many of the most serious would remain. In particular, without legislation such as this, prescription drug price inflation would continue to plague every plan in the FEHBP, and continue to make the program prohibitively expensive for far too many federal employees. We appreciate the fact that this Subcommittee has not succumbed to the temptation to put everything on hold regarding FEHBP while national healthcare reform has been debated, because federal employees need relief from FEHBP prices immediately.

Focusing on the operations of Pharmacy Benefit Managers (PBM) is an excellent place to begin improving the affordability of FEHBP. PBMs are the middlemen in health insurance. They make their large profits by "buying cheap and selling dear." They provide prescription drug benefits to health insurance plans, after buying drug dispensing services from pharmacies and drugs from manufacturers. They receive enormous discounts and rebates from the manufacturers that they do not share with insurers or enrollees. Within the FEHB

program, PBMs have operated in the shadows, without oversight or regulation because they sell to private insurance companies, not directly to the government. Even so, the costs they impose on the FEHBP are an enormous factor in the program's continuously rising prices.

H.R. 4489 would dramatically increase the transparency of PBM operations and set limits on the prices they can charge FEHBP plans. The legislation would also require PBMs to return to FEHBP carriers 99% of all rebates, market share incentives, drug-switch programs, educational support payments, commissions, administrative or management fees, mail service purchase discounts, and income from the sale and utilization of claims data they receive through their FEHBP business.

Upon enactment of H.R. 4489, PBMs would also no longer be able to switch a patient's drug without the patient's doctor's approval. Currently, PBMs can unilaterally switch a patient's drugs, including mail order drugs, without the patient's or doctor's consent. Under the proposed legislation, the PBM would no longer be able to "propose" that a doctor or pharmacist prescribe its preferred "single source drug" when there are "multiple source drugs" in the same class available. This change should lower FEHBP's prescription drug costs, keeping patients away from reliance on expensive, nominally "new" or unique drugs that have identical but more cost-effective alternatives as competitors. In addition, if a PBM wanted to change a patient's prescription drug, it would have to disclose its reason for attempting the switch and the amount of money the PBM would earn as a result of any such change. AFGE strongly supports these requirements,

and believes that they might be the second most effective cost-containment measure in the legislation.

One the primary sources of PBM profits is compensation from drug manufacturers for promotion of their products. This compensation comes in the form of "market share incentives, drug-switch programs, educational support, commissions, mail service purchase discounts," and other "kickbacks" as well as rebates on the sale of drugs through their FEHBP contracts. PBMs also earn money selling claims and/or utilization data they receive in the course of fulfilling their services to FEHBP plans. The proposed legislation would require PBMs to return "at least 99 percent" of these monies to FEHBP plans and disclose these amounts to OPM. It would also require OPM notification prior to the sale of claims and utilization data. AFGE supports these provisions, understanding that enforcement will require a far greater degree of attention to FEHBP contract administration than OPM has shown in the past.

The bill also addresses the practice of "spread pricing" which refers to the difference between what the PBMs actually pay for the drugs, and the amounts reimbursed by the carriers and any co-payments. For example the PBM might pay $11 for a prescription, but charge the carrier $10 and the employee a $3 copayment. Thus, the PBM has recovered $13 for something that only costs them $11. Some of the spreads can be quite dramatic. For example, the PBM might now require an enrollee copayment of $15 on a prescription that the PBM purchases for $10. The bill tries to reduce FEHBP's costs by prohibiting the PBM from charging FEHBP plans more than they charge pharmacies for the same

drug. PBMs would be required to inform both OPM and the FEHBP plans with which they contract how much they pay both regular and mail order pharmacies for drugs, and the methods they use for calculating these reimbursement rates. AFGE endorses this provision.

The most promising cost saving strategy in the proposed legislation is the effort to limit the prices that PBMs can charge to FEHBP carriers. The "Maximum Price for Prescription Drugs" as limited by Sec. 2, paragraph (e)(2)(A) of the proposed bill would be "... an amount that is equal to the average manufacturer price for the drug ..." as disclosed by the manufacturer. But given the size of the FEHBP, AFGE believes the government and plan participants should receive more of an advantage from their purchasing power. That PBMs may currently be charging FEHBP *higher* than average prices for drugs is unconscionable. AFGE supports a much stronger pricing standard than that which is set forth in the proposed legislation. Specifically, we would recommend limiting these costs to the amounts provided for in the prescription drug price schedules used by the Department of Veterans Affairs (DVA). Alternatively, the legislation could limit the maximum reimbursement to a "most-favored customer" pricing model. Technically, General Services Administration (GSA) delegates the authority to negotiate these prices and has done so for DVA. There is no reason why this same authority should not be extended for OPM with regard to FEHBP, but it would be far more efficient for OPM to simply use the DVA prescription drug pricing schedule.

We have heard the arguments from the organized pharmaceutical industry that extending statutory pricing schedules to additional federal healthcare programs will result in higher prices for all government purchasers. They seem confident that no one can or will expect pharmaceutical companies to accept lower aggregate profits. AFGE believes that we should call their bluff. But even if the drug companies do succeed in raising prices for all federal purchasers as the "price" of selling to all federal programs at a uniform price, it is likely that the government will save money. FEHBP is large enough that a substantial decrease in its drug prices can offset retaliatory price increases that the drug companies might try to impose.

A final concern involves pricing transparency. AFGE believes that in order for the legislation to have meaningful pricing transparency, the requirements of the Truth in Negotiations Act (TINA), 41 U.S.C. § 254b, should be applied to this program. Both FEHBP carriers and PBMs utilized by the carriers should be required to make available to government agencies all cost or pricing data related to the purchase or reimbursement of prescription drugs by these entities. In addition, AFGE believes that application of the Cost Accounting Standards (CAS) required by 41 U.S.C. § 422 should specifically be applied to the FEHBP carriers and PBMs, in order to ensure that accounting for the pricing and reimbursement of prescription drug costs is performed in a uniform and consistent manner.

The President's FY 2011 Budget indicates that OPM's Office of the Inspector General intends to "develop" its ability to audit PBMs. The budget cites

OPM estimates that prescription drugs make up 26% of FEHBP's costs and will total $11 billion next year. The benefits of more thorough auditing should be substantial. The budget promises that "(t)hrough these audits, OIG helps the FEHBP recover inappropriate charges, negotiate more favorable contracts, control future cost growth, and improve benefits provided to program enrollees..." Requiring FEHBP carriers and PBMs to adhere to the Cost Accounting Standards will give OIG the tools it will need to carry out these audits in a way most advantageous to taxpayers and enrollees.

This concludes my testimony. I will be happy to answer any questions that members of the Subcommittee may have.