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THE SUBCOMMITTEE ON THE FEDERAL WORKFORCE, THE POSTAL SERVICE AND THE DISTRICT OF COLUMBIA
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON
H.R. 4489, "THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) PRESCRIPTION DRUG INTEGRITY AND COST SAVINGS ACT"

FEBRUARY 23, 2010

Chairman Lynch and members of the subcommittee, I appreciate the opportunity to express NARFE's views about H.R. 4489. Indeed, we applaud your commitment to prescription drug pricing transparency, prescription decisions made by physicians and cost containment in FEHBP.

According to the Kaiser Family Foundation, "although prescription drug spending has been a relatively small proportion of national health care spending (10 percent in 2006, compared to 31 percent for hospitals and 21 percent for physician services), it has been one of the fastest growing components, until recently growing at double-digit rates compared to single-digit rates for hospital and physician services."

Part of the growth in prescription drugs costs can be attributed to the expense of developing advanced drugs. That is why I will discuss two of the most important issues to our membership: access to the latest in pharmaceutical technology and ways in which our members might manage the costs associated with life-saving and life-enhancing drugs. Our interest in this subject directly affects the best way to oversee drug pricing.

I use the word "technology" because our medicines are about to undergo a revolution similar to the kind of change that has completely retooled our phones, our cars, our appliances and our ways of daily living. Diseases that were once fatal or debilitating will become chronic and manageable. Ailments once requiring surgeries or stays in hospitals or nursing homes will be treated by pharmacology at home.

Due to advances in human genomics, our medicines will now be tailored to our own DNA. This personalized therapy means we will be prescribed drugs more likely to treat our ailments while mitigating side effects and drug interactions because our medicines will match our own natural chemistry. Many women suffering from breast cancer and prescribed Tamoxifen have already been the beneficiary of this new age of medicine.

And this is only the beginning. No longer will one simply open a bottle and wash down a pill. The bottle cap itself, once cursed by everyone who ever tried to open a medicine bottle, will dispense information as well as its contents. The cap may be able to tell your cell phone or home computer where you mislaid the bottle or alert you if a child or other unauthorized person has opened it. Your doctor's office or a family member may be able to know if the bottle was opened and your daily dosage removed.

Then there is the pill itself. Embedded in the very tablet is likely to be a computer chip that reminds you or someone else that you took the medicine, in the correct dosage and whether it was metabolized correctly.

My point here is to illustrate that the world of medicines is going to get more complex and perhaps more expensive, as new drugs roll out. And as medicines replace surgeries and allow more individuals to remain independent longer, the pharmaceutical component of total FEHBP cost is likely to grow, too. No longer will it be a simple relationship between doctor and pharmacist and patient. Everyone from genetic counselors to software engineers and wireless systems will become a part of the patient's pharmaceutical infrastructure.

This evolutionary change will have to be managed by professionals with a unique skill set. The role that Pharmaceutical Benefit Managers (PBMs) (or some entity like them) play now both in FEHBP and the private sector will become more critical in providing access to cutting edge drugs while containing costs for taxpayers and federal workers, annuitants and their dependents. Transparency and oversight will become even more important as PBMs take on this difficult challenge. Many of our members can accept the cost of technologically advanced drugs as long as they can be assured they are safe and effective and that the process of pricing such drugs is fair. That is why NARFE is particularly interested in guaranteeing that the savings achieved by PBMs are passed on to FEHBP enrollees. We are pleased that H.R. 4489 tackles this issue.

In order to address this evolutionary change, we urge that the Office of Personnel Management (OPM) develop the best possible oversight system for monitoring prescription drugs, even though the contractual arrangement under FEHBP is between the insurance carrier and the pharmaceutical management company. We were pleased to see that the President's budget emphasizes and continues the responsibility of OPM's Inspector General in auditing prescription drug benefits and the role of the PBMs. Hopefully, this will improve the contract negotiation process, hold costs in check and ensure against fraudulent claims.

For the 2010 FEHBP contract year, OPM has now requested much more information from the carriers as they contract with PBMs for their services. Let us hope this brings further information to OPM and the beneficiaries. We look forward to the results from this year's new data.

We encourage more transparency and information on drug delivery, as well as the costs and the make-up of the drug formulary. Drug pricing is very complex, with processes that involve the drug formulary and the choices between generics and brand names, plus the costs associated with disease management and patient information. Although drug formularies can help to contain costs, they can also prevent patients from getting the most efficacious medication. For that reason, we are glad that H.R. 4489 gives physicians the final say on which drugs should be dispensed.

We know that not only is OPM looking for methods to achieve greater transparency, but that human resource officers around the country outside government are developing standards for transparency and pharmaceutical purchasing in which they can certify their PBMs' compliance with these rules. This might be another guide that OPM and this subcommittee might want to investigate.

It appears that much of what has been proposed in H.R. 4489 could be implemented under OPM's regulatory authority. With consideration given to the private sector's best practices, OPM could get a jump start on enhancing its oversight of PBMs before H.R. 4489 becomes law and codifies the additional authority that would be provided to the agency. However, we strongly believe that nothing should be left to chance regarding OPM's ability to access PBM information to ensure that drug pricing is fair. For that reason we believe that transparency should ultimately be legislated.

As we continue to work with you on this important legislation, NARFE would be interested in any empirical data from OPM, the Congressional Budget Office or any other government research unit that gives us an idea of the cost savings, formulary development and administrative costs that might arise from such regulatory or legislative initiatives.

Mr. Chairman, you said during the Subcommittee's June 2009 hearing that you are interested in other ways to contain FEHBP drug costs.

Indeed, while we applaud PBMs on contract to FEHBP carriers for containing costs, we also know their leverage to negotiate drug discounts from manufacturers is limited since they are spread out among the hundreds of different plans that are offered by FEHBP. That is why FEHBP plans should finally be allowed to buy prescription drugs for enrollees at the discount mandated by the Federal Supply Schedule (FSS). However, if drugs purchased through the FSS are subject to a closed formulary, FEHBP plans must have the option of buying off-formulary medications to ensure that enrollees have access to the most medically efficacious drug, as determined by their physicians.

NARFE would also support your proposal to enhance transparency and oversight by designating FEHBP PBMs as subcontractors under federal acquisition rules.

In addition, NARFE supports legislation to:

- ✓ Allow pharmacies to buy prescription drugs from pharmaceutical manufacturers for Medicare beneficiaries at the same average discount available in industrialized countries;

- ✓ Permit drugs made in the United States or other industrialized countries, and exported to third-party industrialized countries, to be reimported, or imported, to the United States; and

- ✓ Prevent pharmaceutical manufacturers from limiting the sale of drugs to other countries for the purpose of discouraging reimportation.

Mr. Chairman, we thank you for your work in bringing these issues to the federal beneficiary community and to the Office of Personnel Management. We appreciate the opportunity to work with you and OPM on this issue throughout the coming year.