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Before the

Subcommittee on Federal Workforce, Postal Service, and the District of Columbia
on H.R. 4489, "The Federal Employees Health Benefit Program Prescription Drug Integrity, Transparency and Cost Savings Act"

February 10, 2010

Chairman Lynch, Ranking Member Chaffetz, and members of the Subcommittee:

Good morning. It is an honor to be here today to testify on this important legislation. I am Sharon Treat, a member of the Maine House of Representatives, and Executive Director of the National Legislative Association on Prescription Drug Prices, a national nonprofit, nonpartisan organization of state legislators who network across state lines to find ways to reduce prescription drug costs and expand access to medicines.[1]

I hope today to provide a state perspective on H.R. 4489, "The Federal Employees Health Benefit Program Prescription Drug Integrity, Transparency and Cost Savings Act," which I wholeheartedly support, and also to offer suggestions for improvements to the legislation to assure its effectiveness. In the testimony below, I make the following points:

- 18 states and the District of Columbia have some form of PBM legislation, albeit mostly limited in scope
- The states are responding to the nearly absent federal role regulating PBMs, and a PBM business model that relies on secrecy, convoluted payment transactions, and which is rife with conflicts of interest
- Based on the states' experience, regulation of federal PBM contracts will reduce employee health insurance costs and avoid consumer harms caused by drug switching, errors, and conflicts of interest

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[1] The National Legislative Association on Prescription Drug Prices (NLARx) is a 501(c)(4) nonprofit incorporated in Maine in 2000. It is funded primarily with dues from individual legislators and from legislative chambers, and has state legislative membership from across the country. NLARx does not accept funding from pharmaceutical industry sources. For more information go to www.reducedrugprices.org.

- Overall, H.R. 4489 appropriately addresses those aspects of the PBM business model that are most problematic; however, the legislation could be improved with more comprehensive conflict of interest provisions.

Background in PBM issues. Since 2004 I have provided technical assistance to legislators in dozens of states to assist them in drafting and advocating for passage of legislation that provides greater transparency and oversight of Pharmacy Benefit Managers (PBMs). I was also the prime sponsor of Maine's 2003 PBM law, which imposed a fiduciary duty onto PBMs, requiring them to act in the best interest of clients for the purpose of defraying costs for covered individuals, and requiring PBMs to disclose possible conflicts of interest. Of great importance, our law requires PBMs to pass through to their clients (including the State of Maine) the full monetary value of the rebates they negotiate (Maine Revised Statutes, Title 22 §2699).

What are Pharmacy Benefit Managers (PBMs)? They are essentially middlemen between insurers and employer, and drug manufacturers and wholesalers. They manage pharmacy benefits for nearly 95% of all Americans with medical coverage. PBMs are active in all aspects of prescription drug coverage, including: processing claims to pharmacies, drug utilization review (DUR), developing and managing formularies, negotiating with prescription drug manufacturers for rebates, operating mail-order pharmacies to fill prescriptions directly, therapeutic interchange, and reimbursement of providers and patients.

What is the state experience? At least 18 states and the District of Columbia now require oversight and/or regulation of pharmacy benefit managers, including some or all of these provisions: registration, transparency and pass-through of rebates, anti-kickback provisions, a fiduciary relationship, conflict of interest restrictions or disclosure, and annual audits. About a dozen states have pending legislation in 2010 that in some way regulates PBM contracts.

Maine's law remains the most comprehensive; the **District of Columbia** law is very similar. Maine's law has been upheld by the First Circuit U.S. Court of Appeals in a broad decision, and the U.S. Supreme Court refused to consider an appeal. The law was challenged on ERISA, First Amendment and Commerce Clause grounds.[2] The D.C. statute is still in litigation.

Iowa, South Dakota and **Vermont** also have PBM laws that seek to address transparency, conflicts of interest disclosure, greater transparency on rebates and other payments, and include more limited fiduciary language (requiring "fair dealing" or "reasonable care and diligence", "fair and truthful under the circumstances") instead of the more specific and comprehensive, and thus enforceable, fiduciary language in the Maine and D.C. laws. **Louisiana** in 2006 completed a PBM recruitment RFP

[2] Pharmaceutical Care Management Association (PCMA) v. Rowe, 429 F.3d 294 (1st Cir. 2005) cert. denied, 126 S.Ct. 2360 (2006).

process requiring fiduciary responsibility. Several other states have more limited laws governing registration and/or payment provisions including **Maryland**, **Kansas**, **Mississippi, North Dakota, Rhode Island** and **Tennessee**. **Arkansas** and **Georgia** have enacted a "Pharmacy Bill of Rights" which outlines audit and payment requirements.

Texas recently enacted a transparency law in 2009 that addresses state contracts and thus is particularly relevant here, where the context is Federal employee contracts. The Texas law was adopted after an audit of all the state's PBM plans found significant discrepancies between spending on enrollees, and a failure of state agencies to exercise appropriate audit rights, adequately protect the personal data of plan members in accordance with federal and state laws, prevent drug-switching and other activities, and procure the best prices available.

Why enact any legislation? Although PBMs can provide a useful service in managing prescription drug benefits, their activities are shrouded in secrecy and replete with questionable and even illegal practices. In their performance of these administrative duties, PBMs independently negotiate with three separate entities: pharmaceutical manufacturers, pharmacies, and health coverage providers, including agencies and programs administered by states and the federal government. Consequently, the terms of all of the contracts PBMs negotiate are known only by the PBMs, resulting in incomplete information for government and other employers and health care providers. The result has been a sorry history of gaming transactions to the advantage of the PBM, with those who contract with the PBM in the dark about what is really going on. Examples of this gaming, which are well documented in various legal consent decrees, include:

- **Accepting rebates from manufacturers in return for placing higher priced medications on the formulary.** By not disclosing these rebates to the clients, PBM can retain some or all of the rebates while charging clients higher prices.

- **"Playing the spread" between the prices paid by clients and the price paid at the pharmacy.** Since PBMs negotiate contracts with employers and pharmacies separately, asymmetric information permits them to charge their employers more than the PBM actually pays to the pharmacy. For example, one investigation found that a PBM charged an employer $215 for a generic prescription but paid the pharmacy only $15. The PBM pocketed the $200 spread at the expense of the employer.

- **Favoring higher priced drugs that provide PBMs with greater incentives and switching customers from low-cost to the higher-cost medication.** PBMs may ask a health professional to permit them to switch medications, knowing that the switch serves the sole purpose of earning a higher rebate for the PBM. Drug-switching became the cause of action in the 20-state lawsuit against Medco when the PBM persuaded more than 71,000 doctors to switch patients from lower priced Lipitor, made by Pfizer, to more expensive Zocor, made by Merck. Similar allegations of drug-switching were made against Advance PCS, for encouraging doctors

to switch patients from a generic ulcer drugs to Celebrex, which cost over ten times more. A drug-switching lawsuit also commenced against Express Scripts for accepting $500,000 from AstraZeneca to call 22,000 doctors to switch patients from Prilosec to Nexium. These lawsuits illustrate the prevalence of drug-switching when PBMs are left unmonitored.

In upholding the Maine PBM law, the Federal District Court decision addressed the advantages of regulation. The court noted that *"(w)hether and how a PBM actually saves an individual benefits provider money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider."* The court stated:

> *This lack of transparency also has a tendency to undermine a benefits provider's ability to determine which is the best proposal among competing proposals from PBMs. For example, if a benefits provider had proposals from three different PBMs for pharmacy benefits management services, each guaranteeing a particular dollar amount of rebate per prescription, the PBM proposal offering the highest rebate for each prescription filled could actually be the worst proposal as far as net savings are concerned, because that PBM might have a deal with the manufacturer that gives it an incentive to sell, or restrict its formulary, to the most expensive drugs. In other words, although PBMs afford a valuable bundle of services to benefits providers, they also introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs.*[3]

PBM transparency standards will make the marketplace more competitive. Enacting PBM transparency, conflict of interest and audit standards will remove this "layer of fog" and make the PBM marketplace more competitive by insuring that those hiring PBMs actually have enough information to evaluate responses to RFPs and to compare PBM contracts and know whether they are getting a good deal for the service provided or, to put it bluntly, are being ripped off. Such laws also protect patients' health by discouraging practices such as drug-switching and certain formularies that are designed to enhance drug maker and PBM profits, not promote medical outcomes.

Regulating PBM practices will save money. With pharmacy costs making up 25 percent of the FEHBP fee-for-service plans – a very large percent compared to health costs nationally – it makes sense to focus on the pharmacy contracts and implement practices to insure that the federal government is getting value for its dollars. We are starting to see cost savings from state PBM transparency and fiduciary requirements.[4] **South Dakota** saved $820,000 in state health insurance costs in a single year

[3] Pharmaceutical Care Management Association (PCMA) v. Rowe, Civil No. 03-153-B-H (April 2005), at 4-5.

[4] Lawsuits halted implementation of the Maine PBM law until after the 2006 Supreme Court denial of certiorari, and contract information is not public, so it is difficult to measure its effectiveness in cutting costs. A 2009 report by the Maine State Auditor found that most state agencies were not applying the law's provisions to the contracts they entered into with

as the direct result of the more transparent business model required by its law.[5] In **Arkansas**, savings to the state employees' health program achieved through an audit of the PBM managing the benefit. The audit determined the State was overcharged almost $500,000 in just a 3 month period of time. The State ultimately issued a new transparent RFP for state business, lowering pharmacy expenses and directly saving the state over $13 million.[6]

Wisconsin switched to a transparent PBM, Navitus, and saved over $150 million. For nearly a decade, Wisconsin had experienced annual increases of 15% on its prescription drug spending. After switching to Navitus, they actually saved money, despite rising drug costs across the country.[7] **Maryland**, in 2007, started a transparent plan with Catalyst Rx after ending a 10 year relationship with Caremark. [8] In rejecting Caremark, the state noted that Caremark's "commitment [to transparency] seemed vague."[9]

In another measure of potential costs savings, the **University of Michigan**, in an attempt to deal with skyrocketing drug costs, dropped the five benefit managers it had been working with, hired a single new manager that has less control over how the drug plan is administered, and imposed strict new rules. These changes enabled UM to hold its drug spending to $43 million in 2003, or $8.6 million less than it would have paid under the previous plans.[10] **New Jersey** plans to switch to a transparent contract for its 600,000 covered employees, dependents and retirees in 2010. By receiving full manufacturer rebates and by not paying Medco more for a prescription than the amount Medco

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PBMs and could not determine PBM compliance with the law's provisions. Pending legislation, LD 1339, would provide for PBM registration with the Superintendent of Insurance and greater oversight of contracts by the State Auditor.

[5] Email communication between Deborah Bowen, then South Dakota Insurance Commissioner, and RxPlus Pharmacies, February 2006; confirmed in telephone communication between Debra Bowen, now SD Social Services Director, and Ann Woloson of Prescription Policy Choices (August 7, 2006 email communication from Ann Woloson).

[6] Presentation by Mark Riley of the Arkansas Pharmacists Association to the National Conference of State Legislatures Health Committee, August 6, 2007, Boston, Massachusetts, posted at www.ncsl.org.

[7] Guy Boulton, "State gets prescription for savings", Milwaukee Journal Sentinel (June 7, 2005).

[8] "State of Maryland's CVS Caremark Contract Audit Reveals More than $10 Million in Potential Overpayments, Undisclosed Rebates, Improper Drug Switching, According to CtW", Reuters (March 6, 2009), *available at* http://www.reuters.com/article/pressRelease/idUS179408+06-Mar-2009+BW20090306.

[9] Maryland State Board of Contract Appeals, Opinion by Chairman Burns in the Appeals of Caremark Under DBM Solicitation No. F10R6200071 at p. 21 (Mar. 2007), available at http://www.msbca.state.md.us/decisions/2007/pdf/caremarkpcs.pdf.

[10] Katz, David. "Drug Discount Peddlers" CFO.com 10/28/05 http://www.cfo.com/printable/article.cfm/5079733?f=options and Saxl, Michael, "Making PBMs Work for North Dakota" http://www.legis.nd.gov/assembly/59-2005/docs/saxlpresentation.ppt

reimburses the pharmacy which handles that claim, the State projects savings of $540 million over the next five years.[11]

Several reports commissioned by state Governors and agencies have also pointed to the value of transparency requirements in achieving savings. A plan prepared for the Governor of Oregon by the Heinz Family Philanthropies recommended **Oregon** "require the greatest level of transparency possible" as well as annual audits of the PBMs and insurance companies the state contracts with to insure that rebates are passed through.[12] A report to the **Illinois** Commission on Government Forecasting and Accountability recommended the state stop using PBMs entirely, or at a minimum require a fiduciary relationship. By directly negotiating pharmacy benefits in its state employee health plan instead of paying a PBM $2.81 per enrollee per month to negotiate on its behalf, the report estimated savings of $1.35 per claim or about $10 million per year.[13] The **Texas** Auditor estimates savings of $265 million by switching to a transparent PBM contract.[14]

Overall, H.R. 4489 appropriately addresses those aspects of the PBM business model that are most problematic; however, the legislation could be improved with more comprehensive conflict of interest provisions. The legislation addresses the major problems that have been the subject of litigation against PBMs, including drug switching, failure to pass through the value of rebates and other discounts, discriminatory practices towards independent pharmacies, and lack of transparency.

H.R. 4489 also directly addresses conflicts of interest, but only with respect to where there is a manufacturer or retail pharmacy with a "controlling interest" in a PBM. While this is an excellent provision, there are many conflicts of interest that fall far short of a "controlling interest" yet result in higher prices or have other negative impacts on patients. Maine law comprehensively addresses these conflicts through a "catch-all" fiduciary duty provision and additional disclosure of other relationships or agreements that "directly or indirectly presents any conflict of interest." The relevant language in Maine law is as follows:

[11] State of New Jersey, Department of the Treasury, Purchase Bureau, Award Recommendation. Reference Number 10-X-20899, T2679 (August 4, 2009).

[12] The Oregon Blueprint: Coordinated Contracting of Prescription Drugs – A Fiscal and Policy Strategy for the State of Oregon," by Jeffrey R. Lewis, Heinz Family Philanthropies (July 2006) at 11-12.

[13] "Potential for Savings on Pharmacy Benefit Management Costs," Illinois Commission on Government Forecasting and Accountability, prepared by Winkelman Management Consulting (April 2006) at 11-16.

[14] "An Audit Report on Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions," (August 2008), accessed online at: http://www.sao.state.tx.us/reports/main/08-042.pdf

> *22 MRSA §2699, Subsection 2. Required practices. A pharmacy benefits manager owes a fiduciary duty to a covered entity and shall discharge that duty in accordance with the provisions of state and federal law.*
>
> > *A. A pharmacy benefits manager shall perform its duties with care, skill, prudence and diligence and in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims.*
> >
> > *C. A pharmacy benefits manager shall notify the covered entity in writing of any activity, policy or practice of the pharmacy benefits manager that directly or indirectly presents any conflict of interest with the duties imposed by this subsection.*

The most effective legislation includes a fiduciary duty requirement. PBMs' secret financial deals with drug companies lead to higher drug costs. A fiduciary duty simply means the PBM must serve the client's interest in getting the lowest price for drugs, and not the PBM's own financial interest, or those of drug companies. That will lead to lower cost for drugs because the PBMs will be less able to siphon away money for themselves that could go instead towards lower drug prices for the client. The fiduciary language is effective because it is:

- ***Enforceable*** - The fiduciary concept is a basic principle of common law and states have centuries of legal precedent to look to in interpreting this legal concept. Therefore, PBMs won't get far by trying to evade its provisions through legalistic wordsmithing.

- ***Comprehensive*** - The fiduciary concept is a catch-all standard that will cover PBM dealings that are not enumerated elsewhere in statute. It makes sure that the law doesn't have loopholes exempting new but equally reprehensible practices that simply haven't been imagined yet by legislators or PBMs.

- ***Reasonable*** – This is the same standard that applies to real estate agents, lawyers, and even voluntary library board trustees – to carry out one's duty with care, prudence, and diligence and not to benefit one's personal interest. If we agree that it is unacceptable for a trustee of the local library to solicit or accept a kickback from a local contractor seeking a building contract, shouldn't we hold PBMs, whose actions such as in drug switching could have life and death consequences, to the same standard?

Conclusion. I commend the sponsor for tackling this important issue and taking a comprehensive approach in H.R. 4489. The experience of states regulating PBM contracts provides support for the benefits of federal action. Passage of H.R. 4489 would have beneficial impacts well beyond the 7.7 million persons covered by the FEHBP, because the contracting standards enunciated in this legislation would require major changes in PBM practices nationally. Given the piecemeal nature of regulating state-by-state, the limited number of comprehensive state PBM laws, and the aggressive

and expensive litigation that is inevitable when states pass such laws (as in Maine and D.C.), federal regulation of PBMs is surely needed. While H.R. 4489 is aimed at controlling federal health care costs and protecting federal employees, passage may well provide a model for future action to comprehensively regulate PBM practices.

Thank you again for the opportunity to present today.

Respectfully submitted,

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