



Testimony of Mark Merritt

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Before the

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

“FEHBP’s Prescription Drug Benefits: Deal or No Deal?”

June 24, 2009

Introduction

Good Morning Chairman Lynch, Ranking Member Chaffetz, and Members of the House Committee on Oversight and Government Reform.

I am Mark Merritt, President of the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP).

When managing prescription drug benefits – in either the private or public sectors – PBMs utilize a number of tools and strategies to maximize value for their clients, employers, health plans, federal and state governments, and other payers. A common thread connecting all programs administered by PBMs is that success depends on saving their clients money and offering the best overall value in terms of cost, quality, access, and convenience. To stay in business, PBMs must deliver high-quality prescription drug benefits at highly competitive prices.

In addition to drug rebates, there are several other key reference points for measuring drug cost trends, including pharmacy discounts, dispensing fees, generic substitution rates, formulary compliance rates, use of low-cost delivery channels, and the number and type of prescriptions used by beneficiaries.

Value of PBMs in FEHBP

PBMs have played a major role in creating broad access to prescription drugs while generating significant savings for health plans and enrollees. Just as they do for all payers, in FEHBP PBMs play a key role in negotiating price discounts from manufacturers and pharmacies in order to lower unit drug prices. Given that unit price is just one of many components of overall program costs, PBMs also help manage amount and type of drugs used. They . encourage higher generic utilization, employ more affordable delivery vehicles such as mail-

service pharmacy, negotiate aggressively with retail pharmacies, and help doctors and patients understand when safer, more affordable options are available. Combined, these tools have a profound influence on overall drug costs for both the FEHB program and its beneficiaries. To ensure added value of these services to payers, PBMs provide choice of formularies, broad access to medications, convenient pharmacy options, and other benefits for enrollees.

These methods have proven to be successful in lowering the overall costs of drugs. A *Health Affairs*-published report, “National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998,” found that prescription drug spending growth slowed from 8.6 percent in 2006 to just 4.9 percent in 2007. This was in part due to an increased generic dispensing from 63 percent of prescriptions in 2006 to 67 percent in 2007, which was encouraged by PBMs through lower or waived copayments and formulary compliance programs such as step therapy. Generic dispensing rates are generally higher in plans administered by PBMs than in other federal programs. This is significant, since every 1 percentage point increase in the generic fill rate can translate into a 1 percentage point reduction in drug costs without shifting costs to members.¹

Success in Part D

In Part D, PBMs have played a key role in reducing overall program costs well below expectations by generating high levels of generic utilization, offering broad choice of drugs, access to over 60,000 pharmacies, and attaining a continually high rate of beneficiary satisfaction. As a result of better-than-expected plan savings and lower-than-expected premiums, the Part D program will be 30 percent less expensive for the first 10 years than originally estimated.² According to analysis conducted by PricewaterhouseCoopers, overall savings of PDPs in Part D are also comparable to levels achieved by PBMs in the Federal Employees Health Benefits Program (FEHBP).³

¹ Express Scripts, —Optimizing the Copayment Differential: Impact on Generic Fill Rate,|| available at <http://www.express-scripts.com/industryresearch/outcomes/onlinepublications/>, accessed September 2008.

²Centers for Medicare and Medicaid Services press release, “Medicare Part D Plan Premiums for 2008 Show Continued Impact of Strong Competitions,” August 13, 2007.

³ PricewaterhouseCoopers, “Medicare Part D: An Assessment of Plan Performance and Potential Savings,” analysis prepared for the Pharmaceutical Care Management Association, January 2007.

The Role of PBMs in FEHBP and other Commercial Payers

In 2003, the Government Accountability Office (GAO) found that PBMs were successfully managing drug costs while maintaining high levels of access to FEHBP enrollees. Specifically GAO noted:

- That PBMs contributed to an 18 percent reduction in the average price for brand-name drugs for, Federal Employees Health Benefit Program (FEHBP) enrollees. This, in turn, caused a total annual reduction in drug spending of between 3 and 9 percent for FEHBP plans.⁴
- That PBMs “are central to most FEHBP plan efforts to manage their prescription drug benefits, and PBMs have helped the FEHBP plans reduce what they would likely otherwise pay in prescription drug expenditures while generally maintaining wide access to most retail pharmacies and drugs.”

In fact, the Office of Personnel Management concurred with the GAO’s findings, stating that “PBMs do help keep costs down while offering excellent access to prescriptions for our consumers.”

The Office of Personnel Management (OPM) has implemented rigorous oversight and transparency requirements on PBM contractors and consistently audits and reviews all details of the pharmacy benefit contract and practices. The information provided by the PBMs to OPM includes financial and utilization information related to the benefit, information on pharmacy network fees, and remunerations received by manufacturers including detailed manufacturer rebate information on a drug by drug basis.

⁴ Government Accountability Office, “Federal Employees’ Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies,” GAO-03-19, January 2003.

The balance that OPM has struck with respect to transparency and competition has enabled protection and maintenance of proprietary information. The Federal Trade Commission (FTC) and Congressional Budget Office (CBO) both have demonstrated that ensuring confidentiality of proprietary information – e.g., the drug acquisition prices and rebate information –are critical to maintaining price competition among drug manufacturers.⁵

The Federal Trade Commission (FTC) has warned several states that legislation requiring the wrong type of disclosure could increase costs and “undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford.”⁶ In addition, the Department of Justice and the FTC issued a July 2004 report noting that “states should consider the potential costs and benefits of regulating pharmacy benefit transparency” while pointing out that “vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms.”⁷

Congress also rejected the inclusion of a PBM disclosure mandate as part of the Medicare Modernization Act when the Congressional Budget Office determined such a mandate would cost taxpayers \$40 billion over 10 years.⁸

Comparing Manufacturer Rebates of Commercial Coverage and Part D to Medicaid and VA

When comparing unit price discounts achieved by PBMs to the discounts of other government administered programs such as Medicaid and the VA, it is important to remember that drug manufacturers are required by law to provide these programs with discounts equal to the best price concessions they offer to large buyers in the commercial sector:

⁵ US Federal Trade Commission & US Department of Justice Antitrust Division, “Improving Health Care: A Dose of Competition,” July 2004 and Congressional Budget Office, “Cost Estimate: S 1, Prescription Drug and Medicare Improvement Act of 2003,” page 15. July 22, 2003

⁶ Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004)

⁷ US Federal Trade Commission & US Department of Justice Antitrust Division, “Improving Health Care: A Dose of Competition,” July 2004

⁸ Congressional Budget Office, “Cost Estimate: S 1, Prescription Drug and Medicare Improvement Act of 2003,” page 15. July 22, 2003

- The Medicaid program receives a legally required unit price discount from drug manufacturers that is tied to the best prices manufacturers provide to their commercial sector clients or a statutory minimum discount.
- The VA program receives unit price discounts based on Federal Supply Schedule (FSS) drug prices which, like Medicaid, are statutorily tied to the best discounts manufacturers provide large private-sector clients. In addition, the VA is a closed, vertically integrated system that purchases, takes possession of, and dispenses drugs itself.

The linkage of manufacturer price discounts in federal programs to the best discounts received in the commercial sector has had the effect of shifting costs from government to private purchasers. Research suggests that Medicaid rules substantially increase prices for non-Medicaid consumers:

- When Federal Supply Schedule (FSS) prices were included in the calculation of the Medicaid best price in the early 1990s, the VA experienced related price increases on brand name drugs.⁹ Congress subsequently passed legislation to exempt FSS from the Medicaid best price formula.
- CBO estimates that a Medicaid-style “best price” system in Part D “would put upward pressure on prices paid by the VA, Medicaid, and private purchasers” and “would encourage drug manufacturers to reduce private-sector discounts.”¹⁰
- One study found that a ten percentage-point increase in the market share of the Medicaid program was associated with a 10 percent increase in the average price of a prescription.¹¹

⁹ Congressional Budget Office. “Pricing for Brand-Name Drugs Under Selected Federal Programs,” June 2005.

¹⁰ Congressional Budget Office. Letter to the Honorable Debbie Stabenow, April 16, 2007.

¹¹ Duggan, Mark G. and Scott Morton, Fiona M., “The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing” (November 2004). NBER Working Paper No. W10930. Available at SSRN: <http://ssrn.com/abstract=622874>

Based on this experience, Congress exempted the prices PDPs negotiate in Medicare Part D from the calculation of Medicaid best price. CBO estimated that this exemption – which freed manufacturers to negotiate below best price – reduced spending in the Part D program by 1.6 percent.¹²

According to CBO, “For HHS to use the greater market share of the entire Medicare population as a source of leverage to secure deeper price discounts and greater cost savings, it would probably have to threaten similar exclusions and limitations on coverage for that entire population,”¹³ or, in other words, institute a national formulary for Medicare beneficiaries. Likewise, CBO notes that “under current law... PDPs have both the incentives and the tools to negotiate drug prices that the government [does not currently have].¹⁴”

Biogenics: A Policy That Saves Consumers and Payers Money

Additional savings are possible in managing prescription drug costs using common-sense measures that can be implemented by Congress and OPM. These include establishing a clean regulatory pathway for biogenics removing loopholes that prevent generics from entering the market and enhancing mail service pharmacy options. PCMA and the PBM industry look forward to working with you on these and other measures that would provide high levels of access, improve efficiency, and save money for FEHBP and its beneficiaries.

With spending on biologics expected to double from \$54 billion to \$99 billion by 2010, creating an effective regulatory pathway to approve generic biologics would save FEHB, DOD, VA, Medicare, and Medicaid billions of dollars. PCMA looks forward to working with you to help pass H.R. 1427, the Promoting Innovation and Access to Life-Saving Medicine Act. This legislation meets what we believe to be the most important criteria for any biologics legislation Congress considers by:

¹² Avalere Health. “Follow the Dollar: Understanding Drug Prices and Beneficiary Choices Under Medicare Part D,” April 2006.

¹³ Congressional Budget Office. “A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit,” July 2004.

¹⁴ Congressional Budget Office. Letter to the Honorable John D. Dingell, Chairman of the House Energy and Commerce Committee, January 10, 2007.

- Empowering the FDA to use its expertise to determine on a case-by-case basis what scientific data they need to approve comparable and interchangeable products;
- Being free of administrative barriers that impede the FDA’s ability to approve safe and effective biogenerics; and
- Providing a clear and timely resolution to patent disputes and prohibits frivolous suits that restrict access and delay competition.

Mail-Service Pharmacies Provide Additional Savings Opportunity

Mail-service pharmacies provide the Medicare program and its beneficiaries with another opportunity to achieve greater overall savings. While seniors with short-term acute needs must obtain their prescriptions from local pharmacies, those with chronic conditions such as high-blood pressure can be more affordably served for their long-term maintenance medications by mail-service pharmacies.

As a result of high levels of automation and efficiency, prescriptions filled through a mail-service facility cost approximately 10 percent less than equivalent retail pharmacy prescriptions.¹⁵ Today, about 20 percent of prescription volume in Medicare Part D flows through mail-service pharmacies. If this were to increase to 50 percent, the Medicare program and its beneficiaries could save more than \$40 billion over the next ten years.¹⁶

Conclusion

By using PBMs’ proven strategies within FEHBP, the commercial market and the competitive Part D framework, these payers have achieved significant savings and value for their

¹⁵ The Lewin Group. “Mail-Service Pharmacy Savings: A Ten Year Outlook for Public and Private Purchasers”, report prepared for the Pharmaceutical Care Management Association, August 2005.

¹⁶ Ibid.

beneficiaries in their drug benefits, which provide wide access to medications and pharmacies at affordable prices.

PCMA looks forward to working with this Committee and Congress to find additional ways to promote savings while continuing to deliver the highest quality prescription drug benefits for all payers.

Mr. Chairman, this concludes my testimony. Once again I appreciate the opportunity to appear before this panel today. I am happy to answer any questions that you may have. Thank you.