U.S. Senator Maria Cantwell

Senate Committee on Commerce, Science, and Transportation Hearing titled,

"Bringing Transparency and Accountability to Pharmacy Benefit Managers"

February 16, 2023

[VIDEO] [AUDIO]

Sen. Cantwell: Today we're here to talk about what's driving up the price of prescription drugs—a life or death matter for Americans who have skyrocketing prices that affect them.

Six out of every 10 adults are currently taking at least one prescription drug, and about one in four of us take 4 or more prescriptions. Rising drug prices have stretched Americans' budgets over the past decade.

Since 2014, prescription drug prices have increased 35%, outpacing increases in wages, gas, internet service, and food. So what is causing this sharp increase?

So today, we're looking at mysterious middlemen in this, the prescription drug benefit market -- the Pharmacy Benefit Managers.

Most Americans I'm sure have never even heard of Pharmacy Benefit Managers, but they dictate the price people pay at the pharmacy and how people get their prescriptions, and—in some cases—what treatments they can even receive.

Diabetics have used insulin to treat their chronic condition for the last 100 years, but in the past 10 years alone, the average [list] price has doubled.

Americans with diabetes can't live without this drug. So when the prices goes beyond what they can afford, they have to take drastic measures.

For example, Molly Stenson, a Washington state resident, used to drive hundreds of miles to Canada to purchase insulin for $100 because the price that shot up in the Unites States to $450 per month.

Now that the state of Washington has temporarily capped the price of insulin at $100 a month, she no longer has to make that lengthy trek.

But millions of Americans face this dilemma. Nearly 3 in 10 Americans report when the cost of their medication goes up, they cut their pills in half, skip doses, or stop taking their medication.

This is not the kind of healthcare choices we want people to make. The evidence suggests that PBMs are part of the high drug cost increase.

Just three PBMs control 80% of the PBM market. Pharmacy chains and health insurers now own the biggest PBMs, giving independent pharmacies, care providers, and patients nowhere else to turn when PBMs increase their price.

Today we'll hear from our colleague, Senator Grassley, a staunch supporter for reigning in PBMs and a cosponsor of legislation that helps to do that.

I am grateful Senator Grassley for his expertise and passion involving this issue and has used the Judiciary Committee for oversight of this PBM market as well.

We will also hear from Ryan Oftebro, CEO of Kelley-Ross Pharmacy Group, a Seattle-based independent pharmacy.

Mr. Oftebro has had to stop serving longtime customers and close a location because of how PBMs dictate the amount his customers pay and what he can charge.

In 2021, a PBM decision increased the copay on one drug from $15.00 to $141.00 for the same 90-day supply.

That same [year] PBM clawbacks cost one of his pharmacies over $538,000 – up from $81,000 in 2018.

Mr. Oftebro will describe how this systematic interference by PBMs in the drug supply chain is picking the pockets of independent pharmacies and driving up consumer costs.

We also hear from Dr. Debra Patt, a practicing oncologist from Austin, Texas.

Her research in clinical decisions support, predictive analytics, health economics, and outcomes research give her unique insight into the relationship here.

Too often, the self-interested decisions of PBMs are overriding the skilled advice of MDs.

Dr. Erin Trish is an associate professor of pharmaceutical and health economics at the USC School of Pharmacy and a nonresident fellow in economic studies at the Brookings Institution.

Her research focuses on the intersection of public policy and these healthcare markets.

And she'll explain how structural reforms needed to address the complex role that [pharmacy] benefit managers and other intermediaries play in the pharmaceutical distribution.

And finally, we have Dr. Casey Mulligan, a professor of Economics at the University of Chicago, who I'm sure will express his views about these issues as well. This gives us the importance to ask and question [him] about PBMs and their structure and their pricing.

This legislation passed out of the Committee, the Cantwell-Grassley legislation in the last Congress by a vote of 19-9. And I hope that today we can have a similar Q&A of our members to ask any questions and hope that we can, not just move this bill out of Committee, but out of the Senate and over to our House colleagues.

Opening Remarks

Witness: Dr. Ryan Oftebro; PharmD, FACA, CEO of Seattle-based independent pharmacy Kelley-Ross Pharmacy Group

[VIDEO] [AUDIO]

Dr. Ryan Oftebro: Good morning, Chair Cantwell and Ranking Member Cruz, and members of the committee.

My name is Dr. Ryan Oftebro, I'm a pharmacist of 20 years and I'm the owner of Kelley-Ross Pharmacy Group in Seattle, Washington. I'm a clinical associate professor at the University of Washington School of Pharmacy, and I'm here today representing pharmacy as a member of the Washington State Pharmacy Association, the American Pharmacists Association, and the National Community Pharmacists Association.

Kelley-Ross pharmacy is a veteran owned small business that has served the Seattle Community since 1925. My father is a pharmacist and has owned Kelley-Ross since 1973. I grew up in the pharmacy and after serving in the Marine Corps, I attended pharmacy school at the University of Washington and took over the practice in 2005.

We currently have four locations providing high quality care for our most vulnerable populations. Independent pharmacies, like Kelley-Ross, provide a crucial public safety role for our communities.

Our ability to care for our patients is under a very real threat from harmful PBM practices that are costing our patients and limiting their access to pharmacy services. I appreciate the opportunity to speak in support of the PBM Transparency Act.

Since 1989, Kelley-Ross pharmacy operated a location in a Seattle neighborhood that was the preferred pharmacy for a labor group made up of both active and retiree members. The retirees were enrolled into a single Medicare Part D plan. This was an uncommon situation for a community pharmacy.

However, it's provided us with some unique insight into how a PBM can manipulate the system at the expense of our seniors.

To illustrate how this happened, we can look at one drug, generic Rosuvastatin. It's an inexpensive medication used to treat cholesterol. Historically, a 90-day supply of Rosuvastatin costs the pharmacy approximately $10, and patient co-pays were set by the PBM at $15 for a 90-day supply.

Things changed in 2021, with patients' costs increasing exponentially. The PBM moved Rosuvastatin from their Tier 1 with a nominal copay to their Tier 3, which historically had been reserved for brand name medications only.

This increased the patient copay, which was set by the PBM, from $15 to $141 for the same 90-day supply. There's no clinical rationale for this change, and there was no increase in drug cost. This simply created unnecessary out-of-pocket spent for the member, while creating a windfall for the PBM through the collection of retroactive Generic Effective Rate, or GRE fees from the pharmacy.

GRE fees are designed by the PBM to recoup "overpayments" from pharmacies.

In this example, the PBM manipulated the patient copay to intentionally overpay the pharmacy, costing the patient an extra $500 a year in out-of-pocket expense, without the PBM contributing a penny to the transaction.

The “overpayment” was then retroactively clawed back to the PBM as a GER fee, this was not returned to the patient.

We saw this happen over 150 times in 2021 with generic Rosuvastatin, and occurred with many other medications as well.

In 2018, our pharmacy had $81,000 clawed back from PBMs in the form of retroactive fees. This is a huge amount for us to incur, but we were able to remain sustainable. In 2021, this increased to over $538,000.

It was largely driven by GER fees assessed by a single PBM, for a single Part D plan, which resulted from artificial patient overpayments created by the PBM.

This location was in the top 1% of all community pharmacies in the country in terms of our Medicare quality ratings for patient adherence, which means that presumably we were experiencing the lowest level of DIR fees.

But because GER fees were assessed in aggregate across the network, there's no way of connecting a fee to a specific claim. But it's clear that PBM was profiting at patient expense, essentially creating an invisible premium.

These patients would have been better off without using their insurance, and that's not right.

There's obviously no way that a business could operate with these predatory and unpredictable fees. So, we made the difficult decision to close this location in 2022.

Unfortunately, this is not the only type of PBM abuse that we've experienced. PBMs will argue that their business practices keep costs down. In reality, their vertical integration with payers and their own competing pharmacies, create massive conflicts of interests and self-serving business practices that are harming patients, increasing cost to employers, and closing community pharmacies.

We need PBM reform, and this bill is a very good start towards providing transparency and protecting consumers in the pharmacies that care for them from these harmful PBM practices that add costs and unnecessary barriers to care.

I would urge you to remove the exemption for PBMs that return rebates to the payer. My example demonstrated how a vertically integrated PBM could meet this exemption requirement, and still cause economic harm to patients.

Thank you for the opportunity to share my story and I look forward to any questions.

Sen. Cantwell: Thank you Dr. Oftebro and thank you for your work at the University of Washington as well.

Sen. Cantwell Q&A

[VIDEO] [AUDIO]

Sen. Cantwell: Thank you very much. I'm reminded this morning of a time when we had a similar issue -- derivatives. And one of our colleagues on the Senate floor said, “We can't regulate derivatives, we don't understand them.” And then shortly thereafter, our whole U.S. economy blew up.

So, I guarantee you, we can look at this market, and we can understand what's going on, and we certainly can benefit from more transparency.

Since I served on the Judiciary Committee for a short period of time, and then started this work with Senator Grassley, we were able, in the Affordable Care Act, to give CMS (Center for Medicare & Medicaid Services) and the Department of Justice, the ability to look at these numbers without disclosing them.

And it’s that kind of policing in the market that we expect people to do so that consumers, from the vertical integration that's happened, don't suffer from the concentration.

So, I love the Costco model. In fact, I'm trying to drive it into some other healthcare decision making because if you buy in bulk, yes, you should get a discount.

The question here is; who is getting the discount? Is the consumer getting the discount, or the very [insurers] who own the PBM is getting the discount and pocketing it?

And when we looked at this issue when it was Merck Medco, that's exactly what was happening.

People were negotiating with King County and a union, just like you discussed, and saying, ‘okay, we negotiated a 35% discount, they gave the union 5% of the discount, and the company and the drug manufacturer pocketed the [30%.] The very people who own the drug.

These are the practices that are driving Americans crazy, and they want some transparency. So I want to go back to you, Dr. Trish, since you're the resident expert here on the long study of this, what has changed?

All the witnesses mentioned the vertical integration, so what's happened here is fewer people own the ability to create competition and by the price. So, I want you to explain what's changed over the last decade about that, that has allowed this concentration of power.

And then if you could also explain why this discount isn't being passed on, and why now it's squeezing Oftebro, because he has no recourse. He's a buyer. He’s buying the drugs, but then he's not getting reimbursed for the price of the drug. So that's what's going on here.

So why is this market power and concentration been accelerated over the last, whatever period of time it is, I'm saying it's 10 years, but maybe it's shorter or longer, I don't know.

Dr. Trish, PhD, Co-Director, Leonard D. Schaeffer Center for Health Policy & Economics Associate Professor of Pharmaceutical and Health Economics, Mann School of Pharmacy and Pharmaceutical Sciences University of Southern California:

Absolutely. So if you look at the history, what we've seen is a considerable degree of integration in this industry, where PBMs are no longer freestanding entities, but instead, all of the three

biggest PBMs are integrated or owned by a health plan or health insurer. Many of them also own or have a footprint in the pharmacy market, or at least in the Specialty Pharmacy market, and some in the healthcare provider market as well.

And so that is now an entrenched set of incentives where they can, you know, have an incentive to essentially steer funds to themselves, preferentially over to other independent pharmacies or other examples like that.

So, if you look at a world where, you know, there are certainly examples where vertical integration can improve the way that markets function, but it also raises questions about incentives, right?

And so, if you're a PBM, that is integrated or affiliated or owned by a health insurer, and you're thinking about, "do I want to preferentially have my contract benefit my health insurer, relative to the other health insurers in the market?" That's the type of question that we need to better study.

Likewise, if you own the pharmacy, or a set of pharmacies, and you want to have more favorable reimbursement terms to the pharmacies that you own, or that are affiliated with, or steer the business there, that can harm the independent pharmacies that are not affiliated.

And that's exactly the type of contract structure that we need more insight into to understand how this is playing out in the market.

Sen. Cantwell: I definitely don't want a concentration of power. There are some, and there's some who are even these companies [that] just want all mail order. That's what they want. And I can tell you, I believe in the pharmacist, I believe in the interaction that they have with the patient.

I believe that it's a consult that's valuable to keep in our community. But that aside, it's the consumer who's not getting the discount.

If you're buying on my behalf, whether it's a plan for the US government, a county, or a business, I'm hearing complaints now from big businesses in my state who are saying, "I these people are cornering the market."

It's affecting big employer plans because they're doing the same thing. They have that much concentration of power.

We have no transparency on to what discount - do you have any idea what kind of discounts are being driven? Do you have an idea about what percentages?

Dr. Trish: What we do know, I can tell from the work, especially in the insulin space, where there's a bit more transparency thanks to some of the state efforts and other things that have happened.

What we have seen is that over time, PBMs have in fact been effective at lowering the net prices that those insulin manufacturers are receiving.

But that, as you just described, is not the price that we as people or patients actually care about. What we care about is how much we are spending on these products.

And the research that we've done has shown that that's roughly been flat over time, but what's happening is the share of those dollars that are going to the supply chain have increased rather than the dollars that are going to the manufacturers. But you're right that the consumers themselves aren't benefiting.