H.R. 4489, THE FEHBP PRESCRIPTION DRUG INTEGRITY, TRANSPARENCY, AND COST SAVINGS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON FEDERAL WORKFORCE, POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

H.R. 4489

TO AMEND CHAPTER 89 OF TITLE 5, UNITED STATES CODE, TO ENSURE PROGRAM INTEGRITY, TRANSPARENCY, AND COST SAVINGS IN THE PRICING AND CONTRACTING OF PRESCRIPTION DRUG BENEFITS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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CONTENTS

H.R. 4489, THE FEHBP PRESCRIPTION DRUG INTEGRITY, TRANSPARENCY, AND COST SAVINGS ACT

TUESDAY, FEBRUARY 23, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON FEDERAL WORKFORCE, POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m. in room 2154, Rayburn House Office Building, Hon. Stephen F. Lynch (chairman of the subcommittee) presiding.

Present: Representatives Lynch, Towns, Cummings, Clay, Connolly, Norton, Issa, Bilbray, Chaffetz, and Cao.

Also present: Representative Driehaus.

Staff present: William Miles, staff director; Aisha Elkheshin, clerk/legislative assistant; Jill Crissman, professional staff; Jill Henderson, detailee; Dan Zeidman, deputy clerk/legislative assistant; Adam Fromm, minority chief clerk and Member liaison; Howard Denis, minority senior counsel; Ashley Callen, minority counsel; and Molly Boyl, minority professional staff member.

Mr. LYNCH. Good afternoon. The Subcommittee on Federal Workforce, Postal Service, and the District of Columbia will now come to order. I want to welcome Ranking Member Chaffetz, members of the subcommittee hearing, witnesses, and all those in attendance.

The purpose of today's hearing is to examine H.R. 4489, the Federal Employees Health Benefits Program Prescription Drug Integrity, Transparency, and Cost Savings Act. The Chair, ranking member, and subcommittee members will each have 5 minutes to make opening statements, and all statements will be open for 3 days to submit amendments for the record.

Before proceeding, I would like to ask unanimous consent that Representative Steve Driehaus be allowed to join us to ask questions and to offer testimony and appear before the subcommittee here today.

Hearing no objections, that is so ordered.

I would also like to ask unanimous consent that the testimonies of Mr. David Balto, navitist, the Coalition of Government Procurement, and the Pharmaceutical Care Management Association be submitted for the record.

Again, hearing no objection, so ordered.

Good afternoon everyone. Today the subcommittee convenes to examine H.R. 4489, the Federal Employees Health Benefits Program Prescription Drug Integrity, Transparency, and Cost Savings Act. Simply put, the reason I introduced this legislation was to lower the cost of prescription drugs in the Federal Employees Health Benefits Program [FEHBP]. I will try to avoid that acronym as much as possible.

In these economically challenging times it is unacceptable to ask Federal employees and the American taxpayer to put up with some of the irregularities that exist in the pricing and contractual arrangement of the Federal Employees Health Benefits Plan, which accounts for nearly 30 percent of the Federal Government's total spend on the Federal Employees Health Benefits Program.

If the Federal Employees Health Benefits Program wants to remain a model for providing health benefits, then legislative changes that allow for alternative prescription drug benefit contracting and pricing are needed.

H.R. 4489 is the byproduct of nearly a year's worth of work and research. As many of you will recall, the subcommittee conducted an oversight hearing on this very issue back in June. Moreover, last fall we held a public policy forum with key stakeholders and public agencies to further analyze various approaches to fixing what I would describe as an opaque and flawed health benefit plan design.

What we have discovered is that our Federal employees and retirees are not receiving nearly the best benefit at the best price as it relates to prescription drugs. In fact, when comparing Federal Employees Health Benefits Program drug prices to that of other Federal programs such as the Department of Veterans Affairs, the Department of Defense, Medicare, Medicaid, and the Public Health Service 340-B program, the Federal Employees Health Benefits Program is paying substantially more for its drugs. That is despite having 8 million paying members.

Even more alarming is that a recent study on the cost of generic drugs performed by one of our witnesses here today, Change to Win, shows that having no drug coverage beats having coverage under the Federal Employees Health Benefits Program. How can people state that Federal employees have the best health insurance in the country when people with no insurance are paying less for their prescription drugs?

I am also baffled by the fact that even within the program we see larger plans charging far more for prescription drugs in comparison to smaller plans, despite having a sizable difference in the number of enrollees. Does the market-based concept of leverage not apply to Federal Employees Health Benefits Program?

The legislation that my colleagues, Mr. Connolly and Mr. Cummings, and I introduced is intended to not only lower costs of prescription drugs in the Federal Employees Health Benefits Program, but to also provide our Federal employees with a safer, high-quality prescription drug benefit by affording the Office of Personnel Management greater oversight authority in the contracting and pricing of the Federal Employees Health Benefits Program, prescription drug benefits specifically.

Prohibiting certain ownership relationships, requiring pharmacy benefit managers to return 99 percent of all the moneys received from manufacturers for Federal Employees Health Benefits Program business, capping prices paid by the health plan to the average manufactured price [AMP], restricting drug switching by pharmacy benefit managers and requiring enhanced transparency and disclosure of all contract terms and related information.

In this day and age, when every effort is being made to reduce Federal spending and to find money to fund health care reform and other domestic policy priorities, the level of ambiguity around costs and drug prices under the Federal Employees Health Benefits Program is appalling, and this must change.

As chairman of this subcommittee, I am committed to providing the best benefits to our Federal employees to the best price, and whether that is accomplished by the provisions contained in H.R. 4489 or by agency regulation and contractual changes like those issued by the Office of Personnel Management yesterday in the Carrier Call letter makes no difference to me. Let the end justify the means, as long as we aren't simply maintaining the status quo.

I would like to thank today's witnesses for sharing their thoughts, insights, and expertise on this complex issue. I understand that several of you have come quite a way to be here with us today, and I deeply appreciate your willingness in helping the subcommittee determine how best to improve the Federal Employees Health Benefits Program prescription drug benefit for both the Federal employee and the American taxpayer.

Again, I thank you for your participation and I look forward to hearing from today's witnesses.

[The prepared statement of Hon. Stephen F. Lynch and the text of H.R. 4489 follow:]

STATEMENT OF CHAIRMAN STEPHEN F. LYNCH

SUBCOMMITTEE ON FEDERAL WORKFORCE, POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA

Legislative Hearing on H.R. 4489 the, "FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

Tuesday, February 23, 2010

Good afternoon everyone. Today the Subcommittee convenes to examine H.R. 4489 the, "FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act". Simply put, the reason I introduced this legislation was to lower the cost of prescription drugs in the Federal Employees Health Benefits Program (FEHBP). In these economically challenging times, it is unacceptable to ask federal employees and the American taxpayer to put up with some of the irregularities that exists in the pricing and contractual arrangement of the Federal Employees Health Benefits Program (FEHBP) drug benefit, which accounts for nearly thirty percent of the Federal government's total spend on Federal Employees Health Benefits Program (FEHBP). If the Federal Employees Health Benefits Program (FEHBP) wants to remain a model for providing health benefits, then legislative changes that allow for alternative prescription drug benefit contracting and pricing are in order.

H.R. 4489 is the by product of nearly a year's worth of work and research. As many of you will recall the Subcommittee conducted an oversight hearing on this very issue back in June. Moreover, last fall we held a policy forum with key stakeholders and public agencies to further analyze various approaches to fixing, what I would describe as, an opaque and flawed health benefit design. And what we have discovered is that our federal employees and retirees are not receiving the best benefit at the best price, as it relates to prescription drugs.

In fact, when comparing Federal Employees Health Benefits Program (FEHBP) drug prices to that of other federal programs, such as the Department of Veterans' Affairs, the Department of Defense, Medicare, Medicaid and the Public Health Service's 340B Program, the Federal Employees Health Benefits Program (FEHBP) is paying substantially more for its drugs. Even more alarming is that a recent study on the costs of

generic drugs performed by one of our witnesses here today, Change to Win, shows that having no drug coverage beats having coverage under the Federal Employees Health Benefits Program (FEHBP). How can people state that federal employees have the best health insurance in the country when people with no insurance are paying less for their prescription drugs? I'm also baffled by the fact that even within the Program we see larger plans charging far more for prescription drugs in comparison to smaller plans, despite having a sizable difference in the number of enrollees – does the market based concept of leverage not apply to Federal Employees Health Benefits Program (FEHBP)?

The legislation that my colleagues - Mr. Connolly and Mr. Cummings - and I introduced is intended to not only lower costs of prescription drugs in the Federal Employees Health Benefits Program (FEHBP) but to also provide our federal employees with a safer, higher quality prescription drug benefit by affording the Office of Personnel Management (OPM) greater oversight authority in the contracting and pricing of the Federal Employees Health Benefits Program (FEHBP) prescription drug benefit; prohibiting certain ownership relationships; requiring Pharmacy Benefit Mangers (PBMs) to return 99% of all monies received from manufacturers for Federal Employees Health Benefits Program (FEHBP) business; capping prices paid by the health plan to the Average Manufacture Price (AMP); restricting drug switching by Pharmacy Benefit Managers (PBMs); and requiring enhanced transparency and disclosure of all contract terms and related information.

In this day and age, when every effort is being made to reduce federal spending and to find money to fund healthcare reform and other domestic policy priorities, the level of ambiguity around costs and drug prices under the Federal Employees Health Benefits Program (FEHBP) is appalling and must change. As Chairman of this Subcommittee, I am committed to providing the best benefits to our federal employees at the best price. And whether that's accomplished by the provisions contained in H.R. 4489 or by Agency regulatory and contractual changes, like those issued by the Office of Personnel Management (OPM) yesterday in the Carrier Call letter, makes no difference to me. Let the ends justify the means, as long as we aren't simply maintaining the status quo.

I'd like to thank today's witnesses for sharing their thoughts, insight and expertise on this complex issue. I understand that several of you have come quite a ways to be here with us today and I deeply appreciate your willingness in helping the Subcommittee determine how best to improve the Federal Employees Health Benefits Program prescription drug benefit for both the federal employee and the American taxpayer.

Again, thanks for your participation and I look forward to hearing from today's witnesses.

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February 23, 2010

The Honorable Stephen Lynch
Chairman
Committee on Oversight and Government Reform, U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Re: The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act

Dear Chairman Lynch:

I am writing to express my support for your bill to reduce the federal government's prescription drug spending, H.R. 4489, "The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act."

I am a Senior Fellow at the Center for American Progress and have practiced antitrust law for over 25 years, both in the government and in private practice. Prior to entering private practice, I was at the Federal Trade Commission as the Assistant Director of the Office of Policy and Evaluation for the Bureau of Competition of the Federal Trade Commission and attorney advisor to Chairman Robert Pitofsky. At the FTC, I helped direct the first antitrust cases against pharmacy benefit managers ("PBMs"). I have counseled health plans, PBMs, pharmacies, and consumers on PBM competition and consumer protection issues. My comments are based on those decades of enforcement and real world experience.

There is a Tremendous Need for Reform

The need for reform of the role of PBMs in the FEHBP program could not be more urgent. The FEHBP pays between 15% and 45% more for prescription drugs than any other federal program. This costs the federal government over $10 billion annually, and costs are rising. The FEHBP needs a fully competitive market in order to effectively control health care costs and protect the benefits of federal employees and consumers.

PBMs serve an important role in helping to control healthcare costs. But for markets to function effectively three things are required: transparency, choice and an absence of conflicts of interest. In each of these respects the PBM market is broken. The market is oligopolistic with three firms controlling over 80% of the market. There have been rampant consumer protection violations. And between 2004 and 2008, the major PBMs were the subject of a six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients and providers; unjust enrichment

through secret kickback schemes; and failure to meet ethical and safety standards. These cases have resulted in over $370 million in damages to states, plans, and patients so far – including tens of millions returned to the FEHBP. CVS Caremark paid nearly half of that total.

Finally, there is an emerging and disturbing trend of conflicts of interest. Let's be clear about this – the essential function of a PBM is to be an "honest broker" to use the bargaining power of its plans to secure the best prices and highest services for its plans and their members. But when a PBM is owned by a large pharmacy chain – such as CVS' ownership of Caremark (combining the largest pharmacy chain and largest PBM) the opportunity for fraudulent and deceptive conduct skyrockets. That is why OPM has implemented rules to prevent PBMs owned by pharmaceutical manufacturers from participating in the FEHBP. H.R. 4489 appropriately grapples with this problem by prohibiting PBMs owned by pharmacy chains from participating in the FEHB program.

What is the result of the lack of competition, transparency and the conflicts of interest? Today, just three major PBMs dominate the market, and their profits have escalated in recent years in what can only be a demonstration of market power. While consumers have faced rapidly increasing costs and inadequate access to pharmaceuticals, from 2003 to 2007, the three largest PBMs – Medco, Caremark and Express Scripts – nearly tripled their annual profits from $966 million to over $2.7 billion.

The PBM market needs a tremendous infusion of regulation to make the market work. Opponents of H.R. 4489 might claim that the bill goes too far in its requirements, that it will inhibit cost-saving negotiations, and that it will restrain what would otherwise be effective competition. They may call for a less intrusive approach to reducing the FEHBP's prescription drug costs.

However, when a market is fundamentally broken, like the market for PBMs, it is necessary for Congress to act to eliminate practices that prevent plans from being able to make the market function effectively. In the case of the FEHBP, gaining access to pricing and rebate information will allow the various health plans serving federal employees to determine whether or not their PBMs are providing the service they were hired to do: to reduce drug costs.

The Criticisms of H.R. 4489 are Misplaced.

Critics of the bill, who are defenders of the status quo, present several criticisms, but a careful analysis shows that, although they have some theoretical foundation, they are inconsistent with market realities.

Transparency is not harmful.

One of the most puzzling arguments presented by opponents is that transparency is harmful. To an antitrust enforcer or any consumer this seems perplexing. After all, information enables a buyer to determine what is being sold. Assistant Attorney General for Antitrust Christine Varney highlighted the importance of transparency when she said, "I am a firm believer in what Justice Brandeis said in another context: 'Sunlight is said to

be the best of disinfectants; electric light the most efficient policeman.' Markets work better and attempted harms to competition are more likely to be thwarted when there is increased transparency to consumers and government about what is going on in an industry."

A central argument against pricing or rebate transparency rests largely on the assumption that these prices would be widely disclosed and hurt a PBM's ability to negotiate for rebates and discounts. According to this theory, plan sponsors would disclose this information to drug manufacturers who would in turn tacitly collude to fix prices. **I understand this theory, but in my over 15 years as an antitrust enforcer I can recall no occasion where firms disclosed information in this fashion and that led to tacit collusion.** In any case, this theoretical concern falls apart when applied to transparency requirements like those contained in your bill, which require confidentially between the disclosing PBM and the plan sponsor.

The market demonstrates that transparency is helpful and has not led to inadvertent collusion or higher prices. In fact, the opposite has occurred – it is an invaluable tool to lower drug costs. In the past few years, several major corporations and government entities have switched to transparent contracts, giving us a number of examples of the effects of transparency. And the evidence overwhelmingly suggests that transparency does indeed lead to savings: the states of New Jersey and Texas are savings hundreds of millions of dollars on their state employees' prescription drug benefit by requiring transparency of their PBMs; TRICARE and the University of Michigan have achieved significant savings by taking on key tasks, including rebate negotiation; and some of the country's largest and most sophisticated corporations have used their bargaining power to demand transparency of their PBMs.

Restricting conflicts of interest is procompetitive.

Some have raised concern over a provision in your bill that bans FEHBP health plans from contracting with pharmacies owned by PBMs, or PBMs owned by pharmacies. This crucial element of the legislation ensures that the FEHBP will avoid a troubling conflict of interest that can harm plan members and prevents health plans from getting the best deal possible. These plans expect that their PBM will be a tough negotiator with pharmacies and seek the lowest reimbursement rates possible for them. In the case of CVS Caremark, however, the company has no incentive to seek lower reimbursement rates to its own pharmacies, because the plan sponsors covers the cost of each and every prescription. At the same time, the company has a large incentive to get customers into CVS pharmacies, and will go to any length – including restrictive plan designs or aggressive marketing tactics – to achieve that goal, even if it means decreasing service quality or limiting patients' access to crucial medications. That is why the provision is necessary.

Without transparency, the market for PBMs is not competitive.

Some might argue that the forces of competition are vibrant in the PBM market; they are simply wrong. As I have described, a number of characteristics necessary for a competitive market are markedly absent from the market for PBMs. This market is

dominated by three major players who saw their profits climb nearly threefold to almost $3 billion from 2004 to 2007 in a clear demonstration of market power. Without transparency, plan sponsors have no means of verifying what their PBM is saving for them, and true competition cannot break out between various PBMs vying for business. Indeed, retention rates are extraordinarily high in this business – the major PBMs retain well over 80% of their clients annually – suggesting that purely price-based competition does not control the PBM market.

Pass-through pricing is a vital cost control tool.

Your bill takes important steps to reduce waste in the FEHBP's prescription drug spending by eliminating the potential for PBMs to exploit their central role in high-value financial exchanges between the FEHBP, plan carriers, drug manufacturers and pharmacies. First, it eliminates the practice of "spread pricing" by requiring that the FEHBP is not charged more for a prescription than what the pharmacy is reimbursed. Second, it ensures that plan carriers receive the full value of rebates the PBM gathers from drug manufacturers on behalf of plan members. Together, these requirements will reduce waste in the FEHBP program and make drug pricing clear.

Some might say that requiring PBMs to pass on rebates entirely has the effect of diminishing their incentive to bargain for large rebates. They are simply mistaken. The very existence of successful transparent and pass-through PBMs like Argus and Navitus demonstrates how absurd this assumption is. In addition, the "Big Three" themselves have even signed transparent pass-through contracts when their clients demand it, further highlighting that this argument is suspect.

Conclusion

With this legislation, the FEHBP is simply moving in the same direction as other savvy plan sponsors across the country. With transparency, the federal government can monitor its prescription drug spend more closely and seek to curb it. Avoiding PBMs with clear motivations to *increase* the government's prescription drug spend is a crucial step in this process. I applaud you for introducing this courageous and necessary bill, and I urge the Subcommittee to support it.

Please contact me if there is any additional information that I can provide for you on this issue or if there are any questions I can help answer.

Sincerely,

David A. Balto

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Representative Stephen Lynch, Chairman
Subcommittee on the Federal Workforce, Postal Service and the District of Columbia
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Lynch,

I am submitting the following written comments to the Subcommittee on the Federal Workforce, Postal Service and the District of Columbia to be included in the record of the hearing on H.R. 4489 to be held February 10, 2010.

I am the Senior Vice President over sales, marketing and analytics at a pharmacy benefit manager (PBM) known in the marketplace as Navitus.

The *FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act* is a positive step forward in main-streaming a better business model that has been proven to save government agencies and employers significant dollars for their prescription benefit.

Due to the efforts of former New York State Attorney General Elliott Spitzer and others to expose the misguided and improper practices of large PBMs, a new way of managing pharmacy as a benefit has emerged over the past 10 years. This model aligns incentives of both payers and PBM's that pass-through 100% of savings from contracts with pharmacies and manufacturers while allowing these PBM's to receive a fair administrative fee for managing their Rx program. Our company, Navitus Health Solutions, is one such company.

By way of background, Navitus is a wholly owned subsidiary of Dean Health Plan, a Wisconsin based, physician-owned HMO. Operating in a transparent, pass-through model is nothing new to Navitus as the company was formed nearly 7 years ago out of the pharmacy department within Dean to directly serve the needs of the health plan and other payers. Navitus is a full service PBM that maintains its own claims adjudication system, pharmacy contracts, manufacturer contracts, MAC program for generic drugs, clinical programs, account management and member & pharmacy call center. Today, we manage over 1 million lives and are growing rapidly.

Fundamentally, having to pass legislation to ensure that PBM's do the right thing for payers is unfortunate but potentially a necessary step to take. Implementing transparent and ultimately pass-through pricing and disclosure requirements will put the interests of the FEHBP and the federal government, at the center of the pharmacy benefit equation.

In addition to the important measures included in this legislation, we find that having the pharmacy benefit carved in as part of a medical benefit with health plans is not the most cost effective arrangement. Typically health plans use the pharmacy benefit as another source of revenue when offering an integrated medical option to a payer.

Carving out the pharmacy benefit from health plans eliminates additional costs while still providing plans with the necessary prescription data and clinical programs that are important in managing members' health. The State of Wisconsin chose to take this very approach over 6 years ago when they carved out the Rx benefit from 14 different health plans to create a single benefit that Navitus still manages today. According to the state's consultant, Deloitte, Navitus saved the state $157 million dollars in the first 3 years of management of the unified program. Similar results could be achieved by the FEHBP if they chose to take this same approach of carving out pharmacy from their various health plans. However, the initial approach should focus on the carved-out program managed by CVS/Caremark and Medco today.

The only challenge I see with the legislation as it is written is the practicality of trying to mandate sweeping changes to how over 80% of the market controlled by Medco, CVS/Caremark and Express Scripts operate their companies. These proposed changes would be almost impossible for them to achieve because their business model requires them to deliver consistent growth to meet the demands of their shareholders and employees.

These results require these large, publicly-traded PBMs to continue to make an ever increasing amount of profit and revenue either per covered life or per prescription from multiple sources; some known, many unknown. One way or another they will extract what they need from each of their clients to maintain their pristine performance on Wall Street. Having worked for two of the big 3 PBM's in the industry, I can attest this to be true.

An alternative approach to consider would be to reward PBM's that today operate in a pure pass-through way, with a larger number of government contracts. This will ensure that these companies are allowed to thrive which will exert pressure on these traditional PBM's to reconsider how they operate their business'. Eventually, they will either change their business model or go out of business. Trying to legislate them to change their business model would merely create an environment where they will continue to play "Catch Me If You Can" with both the government and employers alike while they continue to shuffle around the money they need to undisclosed sources of revenue.

In general, I support the efforts of this piece of legislation to begin the process of changing the landscape on a larger scale that will allow companies like Navitus to provide fully pass-through services to a wider array of employers and government agencies. That being said, we feel we can continue to be successful in the free market without it, just at a slower pace.

Respectfully,

Byron Mickle
Senior Vice President
Navitus Health Solutions, LLC

The Coalition for Government Procurement

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February 23, 2010

The Honorable Stephen F. Lynch
Chairman, Federal Workforce, Postal Service
and the District of Columbia Subcommittee
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

RE: Legislative hearing on H.R. 4489, "The Federal Employees Health Benefits Program (FEHBP) Prescription Drug Integrity, Transparency, and Cost Savings Act."

Dear Chairman Lynch:

The Coalition for Government Procurement would like to thank you for the opportunity to comment on H.R. 4489, "The Federal Employees Health Benefits Program (FEHBP) Prescription Drug Integrity, Transparency, and Cost Savings Act."

The Coalition for Government Procurement is a non-profit association of over **350 firms selling commercial services and products to the federal government**. Our members comprise small, medium, and large businesses actively engaged in federal business. Our members collectively account for approximately 70% of the sales generated through the GSA Multiple Award Schedules program and about half of the commercial item sales made to the government each year.

H.R. 4489 would increase oversight of pharmaceutical benefit managers (PBMs) and enact strict new regulations for PBMs, including capping prescription drug prices paid pharmacies to the Average Manufacturer Price (AMP); prohibiting PBMs from switching drugs without a physician's approval; and requiring PBMs to return to the federal plan almost all proceeds from rebates and incentives from drug manufacturers, including administrative fees that are paid to compensate PBMs for managing formularies and rebate agreements, as well as other services. The bill also would create stronger disclosure requirements for PBMs and prohibit a pharmaceutical company from owning a controlling interest in a PBM.

The FEHBP is one of our nation's most successful health benefit programs. Federal employees, retirees and their survivors enjoy the widest selection of health plans in the country, and a recent OPM survey found that the overwhelming majority of federal employees are satisfied with their health benefits.

The best model for balancing quality patient care with cost savings is through a robust commercial model which uses the market and competition for patients as the primary means to provide choice. Relying on competition among commercial health plans has proven effective in containing prescription costs.

Pharmacy benefit managers (PBMs) are used extensively in the commercial market and by the federal government to ensure employees have the most affordable, safe, and flexible prescription drug benefits possible. PBMs are deemed essential in both markets because they provide value by lowering drug benefit costs through negotiating discounts from manufacturers and drug stores, saving money with home delivery, and using health information technology like e-prescribing to reduce waste and improve patient safety. Multiple health benefit plans, using PBMs to create and manage formularies, compete for patients by offering access to more drugs at lower prices. Allowing PBMs to apply commercial cost savings techniques, including market share rebates, has successfully kept drug prices down for federal employees.

The Coalition is concerned that this legislation would effectively drive PBMs out of the FEHBP program by denying them the ability to earn a profit. We feel that this is neither in the best interest of government or FEHBP beneficiaries. The government would lose the benefit of a managed prescription program by increasing costs. Similarly, new technologies or other innovations PBMs bring to the table would not be realized in the federal market, making FEHBP a second tier program when compared to commercially available solutions. Without PBMs, the FEHBP program would be in jeopardy. The Coalition believes federal employees deserve the same quality of care, if not better, than their commercial counterparts.

We thank you for your consideration and look forward to working with you on this issue. Please do not hesitate to contact me should you require further information.

Sincerely,

Larry Allen
President

PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

LEGISLATIVE HEARING

H.R. 4489, the "FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

Tuesday, February 23, 2010

STATEMENT FOR THE RECORD

Introduction

The Pharmaceutical Care Management Association (PCMA) appreciates this opportunity to submit our statement for the record of the February 10, 2010 Subcommittee Hearing. 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.

The Federal Employees Health Benefits Program (FEHBP) has long been the gold standard for employer-sponsored health benefits and is a model for health insurance reform efforts at the state and national levels. The hallmark of the FEHBP is consumer choice and competition. FEHBP offers a wide range of health insurance options for federal workers, retirees and their families and is extremely popular, with a recent OPM survey showing that enrollees are satisfied with their benefits by a 7 to 1 margin. Like any large employer, the Office of Personnel Management (OPM) structures benefits to attract and retain talented employees. Comprehensive prescription drug coverage, widely available at retail and mail pharmacies with

reasonable cost sharing, is a key component of benefit design in the FEHBP. Most plans that participate in the FEHBP competitively bid their drug benefit administration to PBMs.

OPM does not negotiate prescription drug prices or discounts directly with manufacturers or pharmacies, but instead uses its leverage with carriers to limit spending on prescription drugs for FEHBP enrollees. OPM through an annual call letter establishes parameters within which the health plans – and by extension, their subcontracted PBMs – must operate. OPM provides additional guidance on specific issues and practices it deems necessary to address. Through this process OPM encourages carriers to innovate and implement new initiatives to address rising costs and stimulate appropriate use of health care goods and services. In recent years, OPM has encouraged plans to explore greater use of therapeutic alternatives including generic drugs, tiered formularies, drug lists, and evidence-based health outcomes measures to control prescription drug expenditures.

This OPM-established model has allowed PBMs, working with health plan clients, to create broad access to prescription drugs while generating significant savings for health plans and enrollees. Just as they do for private-sector health plans and large employers, PBMs participating in FEHBP 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 the amount and type of drugs used. PBMs encourage higher generic utilization, employ more affordable delivery options 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 FEHBP 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.

Adverse Effects of H.R. 4489 on FEHBP Enrollees

H.R. 4489 would impose drastic changes on the FEHBP program with no demonstrated value in either savings or improved quality of care for federal workers or retirees. The bill would rely on government price controls to fundamentally alter the FEHBP model and create the precedent for the program to look more like parts of Medicare and Medicaid --- where price-controlled hospital and physician payments have left Medicaid with unusually high pharmacy dispensing fees and Medicare physicians threatening to pull out of the program due to below-market reimbursements. Part D – the one part of Medicare that most functions like FEHBP does now – has consistently come in under the CBO projections at the time of its enactment.

H.R. 4489 would set the precedent of federally controlling drug prices and dispensing fees within the FEHBP drug benefit, which could lead to similar fundamental shifts in how hospital and physician benefits are provided in FEHBP. This in turn could ultimately shift FEHBP to more closely resemble public programs such as Medicaid and Medicare than anything available through private sector employer and union plans. Such critical changes to health benefits would normally follow a major report or significant findings that benefits are substandard or services are overpriced compared to other employer payers. But that is not the case. Beneficiaries are overwhelmingly satisfied with FEHBP, and benefit levels and premiums are comparable to or better than those received by employees in the private sector.

H.R. 4489 would set in statute contract requirements for pharmacy benefit managers (PBMs) participating in FEHBP. PBMs would be required to disclose proprietary contract terms regarding drug acquisition costs and pharmacy dispensing fees to OPM, carriers, and enrollees, as well as similar information on private-sector contracts outside of FEHBP. The bill would establish drug price controls with reimbursement based on the average price a manufacturer receives from wholesalers for a given drug and require uniform maximum pharmacy dispensing fees determined by OPM. Further, the bill pre-empts state laws governing generic drug substitution and therapeutic interchange.

Impact on Pharmacy Access.

Eight million FEHBP enrollees – federal employees, retirees, and their families – currently benefit from convenient pharmacy access because virtually all of the nation's approximately 60,000 pharmacies participate in FEHBP through nationwide PBM-sponsored pharmacy networks. Changes in PBM and retail pharmacy reimbursement proposed by H.R. 4489 – e.g., carriers could not pay PBMs more than manufacturers, on average, charged wholesalers for the cost of a given drug – could result in payments to pharmacies and PBMs that are less than pharmacy acquisition costs, which could prompt many to reconsider participating in the program. As demonstrated by a retail pharmacy-contested provision of the Deficit Reduction Act (DRA) of 2005 regarding the use and disclosure of Average Manufacturer Price (AMP), such a policy should be carefully considered before disrupting federal workforce coverage.

Impact on Drug Substitution and Patient Safety

H.R. 4489 establishes several restrictions on drug substitution for FEHBP enrollees. Pharmacy and physician prescription practices are generally regulated by the States and developed by professional boards with clinical expertise. For example, the bill would not allow a drug substitution based on safety if the replacement drug were "higher in cost," even if concerns were raised about a generic company's manufacturing practices as has happened in the past. The drug substitution provisions of H.R. 4489 represent a substantial shift in existing law and could significantly compromise patient safety

The bill would also prevent pharmacies from substituting generic drugs without the approval of the prescribing doctor, despite state pharmacy laws requiring such substitution. Extensive patient and physician consultation and approval required by the bill would impose unnecessary obstacles that would substantially restrict dispensing of FDA-approved generic versions of brand equivalents. Generics have proven to be extremely effective at controlling costs and expanding access, which is why many states have implemented mandatory generic substitution laws.

Similarly, the bill would prevent collaboration on federally required post-approval drug market surveillance programs such as FDA drug sentinel programs and the Risk Evaluation and Mitigation Strategy (REMS) required by federal law.

Impact on PBM Competition

H.R. 4489 would prohibit any drug manufacturer or retail pharmacy from having a controlling interest, defined as 20 percent, in a PBM serving the FEHBP and would prohibit a carrier-controlled PBM from earning a profit, which would appear to include making an operating margin. By requiring plans to send enrollees, for every prescription, the prices paid to manufacturers for drugs and to pharmacies for dispensing them, the bill requires PBMs to publicly disclose their negotiated rates. The Federal Trade Commission has said such public disclosure, or "transparency," leads to higher – not lower – prices. These prohibitions and disclosure requirements, combined with an additional requirement that PBMs serving FEHBP disclose specific acquisition costs and other pricing information on their entire book of business, could severely limit the number of PBMs willing to participate in FEHBP.

PBMs may be unwilling to risk losing the pricing concessions negotiated with manufacturers and pharmacies for non-FEHBP accounts because of the disclosures to enrollees, carriers, and OPM required by the bill. Reduced competition among PBMs, with the possibility of only a single PBM administering all FEHBP drug benefits, would leave remaining PBMs with little or no incentive to lower costs.

Impact of Cost-Plus Pricing Controls

H.R. 4489 would require carriers to limit payments for drug charges to Average Manufacturer Price (AMP) minus enrollee cost sharing. AMP is the price manufacturers charge wholesalers. The bill also requires PBMs to pay carriers 99% of all compensation received from manufacturers. Given that 90% of all pharmaceuticals are purchased through drug wholesalers – which to stay in business must charge pharmacies more than the price at which they acquire a drug – requiring reimbursement at AMP would result in PBM reimbursements that are lower

than the pharmacy's acquisition cost. Without a dispensing fee that varied by drug and was high enough both to reimburse the pharmacy for its costs in preparing the prescription and the wholesaler's markup, the pharmacy would carry a loss on every prescription, whether the pharmacy served as the PBM's mail-service pharmacy or was a retail pharmacy. Retail pharmacies are currently contesting a provision of the Deficit Reduction Act of 2005 (DRA) that imposed requirements regarding use and disclosure of AMP, and provisions in both the House and Senate health care reform bills would have made substantially increased the DRA-mandated reimbursement to well above AMP to address pharmacy concerns.

Even assuming the AMP requirement is adjusted to a different benchmark rate, H.R. 4489 would lead to a cost-plus only pricing policy in FEHBP. Large employers, such as OPM, currently have the option to structure contracts using cost-plus pricing and many choose not to do so. Most prefer for the PBM to have an incentive to be aggressive negotiators by allowing PBMs to keep a portion of the savings they negotiate with manufacturers beyond the negotiated price.

Impact of Data Use Controls

H.R. 4489 would also restrict the sale of any FEHBP-related claims or utilization data. Such restrictions on the sale of data would establish road blocks for legitimate real-time use of data. For example, PBMs provide utilization data to pharmaceutical manufacturers for federally required post-market surveillance of drug safety. Specialty pharmacies also use claims data to conduct FDA-required risk-evaluation and mitigation strategies (REMS) for certain drugs. Undue restrictions on PBMs receiving reimbursement for sharing data for research and care management purposes could impede valuable research on the safety and efficacy of drugs and drug benefits.

FEHBP Transparency and Disclosure Standards Already Exist

OPM already has the authority to impose all of the bill's provisions without seeking any new authority from Congress. In fact, OPM routinely uses its existing authority to impose new PBM contract requirements – *when it deems them helpful to the program.* Indeed, OPM has already required FEHBP carriers to insist that their PBMs meet rigorous transparency and cost-savings standards – some quite similar to those in the bill. For example, in Appendix A of the 2010 Call Letter, OPM requires Experience-rated HMOs to meet an extensive set of standards, including disclosure, conflict-of-interest, and rebate pass-through requirements. These requirements are outlined in Attachment 1 to this testimony.

OPM already has the authority to require increased transparency and disclosures, and has exercised that authority as the many requirements in Attachment 1 demonstrate. FEHBP program management and oversight are best addressed through regulation and sub-regulatory guidance, not legislation. Carrier Call letters, FEHBP guidelines, and the FEHB Carrier Handbook are the appropriate vehicles for OPM to guide and monitor the practices of participating carriers and plans as well as their subcontractors.

Conclusion

FEHBP is successful because it relies on market forces and competition to deliver high quality benefits and services to its enrollees. We urge the Subcommittee to consider carefully the provisions in H.R. 4489 that would impose federal price controls on drug products and pharmacy services, pre-empt state laws that assure cost-savings from generic substitution, and require sweeping disclosures of pricing and proprietary business practices that could have the unintended effect of driving prices higher and stifling competition. The adverse impact of such changes on the federal workers, retirees, and dependents who rely on the FEHBP should not be taken lightly.

By using PBMs' management strategies proven in the commercial market, FEHBP carriers have achieved significant savings for their enrollees in their drug benefits and provide wide access to medications and pharmacies at affordable prices. Additional savings for the FEHBP could be obtained if OPM encouraged carriers to adopt even greater use of home delivery, formulary tiering, step therapy, prior authorization and other utilization management tools that facilitate cost-effective medication use.

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

Attachment 1

Requirements for Experience-rated HMOs

From Appendix A of the 2010 FEHBP Call Letter

(1) The PBM is not majority-owned or majority-controlled by a pharmaceutical manufacturing company.

(2) The PBM agrees to credit to the Health Plan either as a price reduction or by cash refund all Manufacturer Payments to the extent negotiated, if such an arrangement exists between the Carrier and the PBM. Manufacturer Payments are any and all compensation or remuneration the PBM receives from a pharmaceutical manufacturer, including but not limited to, discounts; credits; rebates, regardless of how categorized; market share incentives, commissions, and administrative or management fees. The term also includes any fees received for sales of utilization data to a pharmaceutical manufacturer.

(3) If the Carrier has negotiated with the PBM to receive all or a portion of Manufacturer Payments as described in (2) above, the PBM will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a mail order pharmacy, and its retail network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Health Plan or such number of brand name drugs that together represent 75% of the total cost to the Health Plan, whichever is the greater number:

(i) the dollar amount of Total Product Revenue for the reporting period, with respect to the PBM's entire client base. Total Product Revenue is the PBM's net revenue which consists of sales of prescription drugs to clients, either through retail networks or PBM-owned or controlled mail order pharmacies. Net revenue is recognized at the prescription price negotiated with clients and associated administrative fees;

(ii) the dollar amount of total drug expenditures for the Health Plan;

(iii) the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;

(iv) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or

payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers;

(v) the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(4) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible enrollees through the PBM and all financial and utilization information relating to services provided to Carrier.

(5) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. A PBM providing information to a Carrier under this subsection may designate that information as confidential commercial information. The Carrier, in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential. However, this information may be subject to FOIA disclosure under 5 C.F.R. § 294.112.

(6) If the Health Plan's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier appearing in this Section 1.28 shall be deemed to be references to the Underwriter.

(7) The carrier will require that its PBM contractors:

(i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;

(ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and

(iii) Disclose the existence of formularies and have copies of the formulary readily available and accessible.

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111TH CONGRESS
2D SESSION

H. R. 4489

To amend chapter 89 of title 5, United States Code, to ensure program integrity, transparency, and cost savings in the pricing and contracting of prescription drug benefits under the Federal Employees Health Benefits Program.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 21, 2010

Mr. LYNCH (for himself, Mr. CONNOLLY of Virginia, and Mr. CUMMINGS) introduced the following bill; which was referred to the Committee on Oversight and Government Reform

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A BILL

To amend chapter 89 of title 5, United States Code, to ensure program integrity, transparency, and cost savings in the pricing and contracting of prescription drug benefits under the Federal Employees Health Benefits Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be referred to as the "FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act".

SEC. 2. IMPROVED PROGRAM INTEGRITY, TRANSPARENCY, AND COST SAVINGS FOR PRESCRIPTION DRUG BENEFITS IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

(a) CHANGE IN CONTRACTING REQUIREMENTS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

"(p) A contract may not be made or a plan approved under this chapter, with respect to a carrier that is a party to a PBM carrier arrangement, unless the PBM and the carrier comply with the requirements of section 8915. The Office shall terminate such contract or discontinue such plan for failure to comply with such requirements.".

(b) REQUIREMENTS FOR PBMS AND RELATED REQUIREMENTS FOR CARRIERS.—Chapter 89 of title 5, United States Code, is amended by adding at the end the following:

"§ 8915. Requirements for PBM arrangements

"(a) LIMITATIONS ON CROSS-OWNERSHIP.—

"(1) IN GENERAL.—Under a PBM carrier arrangement under this chapter—

"(A) no pharmaceutical drug manufacturer or retail pharmacy may have a controlling interest in the PBM; and

"(B) the PBM may not have a controlling interest in a retail pharmacy.

"(2) COMPLIANCE.—Each carrier shall certify annually to the Office of Personnel Management that any PBM with which it has a PBM carrier arrangement meets the requirements of paragraph (1). The Office shall terminate any contract with a carrier with a PBM carrier arrangement that does not comply with such requirements.

"(3) PROFIT RESTRICTION ON CARRIER CONTROLLED PBMS.—The Office may not permit a carrier that has a controlling interest in a PBM to earn a profit from such interest with respect to a contract under this chapter.

"(b) DRUG SUBSTITUTION RESTRICTIONS.—Under a PBM carrier arrangement under this chapter—

"(1) the PBM shall allow a drug substitution, if it is not a generic drug substitution, only after the prescriber (or another individual authorized to prescribe drugs) provides the pharmacist with an express, verifiable authorization for such substitution;

"(2) to the extent appropriate, the PBM shall consult an enrollee concerning any drug substitution for a drug prescribed to such enrollee;

"(3) the PBM may not propose that the prescriber or pharmacist substitute a prescription drug

that has a higher net cost for a prescription drug in the same class with a lower net cost;

"(4) the PBM may not propose that the prescriber or pharmacist substitute a prescription drug that is a single source drug for a prescription drug in the same class that is a multiple source drug;

"(5) the PBM may not require a drug substitution if the prescriber determines that such substitution will endanger the health of the enrollee for whom the drug was prescribed;

"(6) the PBM will disclose to the prescriber of a drug, the carrier, and the enrollee for whom such drug was prescribed—

"(A) the reason why the PBM is suggesting a drug substitution for such drug; and

"(B) the financial impact of the drug substitution on the PBM, the carrier, and the patient; and

"(7) if a PBM has a controlling interest in a mail order pharmacy, such PBM shall ensure that any drug which is dispensed by such pharmacy to an enrollee as a result of a drug substitution shall be dispensed with a written notice that such drug substitution occurred and that such substitution occurred with the approval of the prescriber.

"(c) REIMBURSEMENT OF CARRIERS.—Under a PBM carrier arrangement under this chapter, by the last day of each quarter of the contract year—

"(1) the PBM shall pay to a carrier an amount that is at least 99 percent of the sum of—

"(A) all compensation that the PBM received during the previous quarter from a pharmaceutical drug manufacturer under a PBM manufacturer arrangement (to the extent such arrangement relates to the PBM carrier arrangement) including compensation that the Office categorizes (regardless of how such compensation is categorized by the PBM) as market share incentives, drug-switch programs, educational support, commissions, mail service purchase discounts, administrative or management fees, and all other forms of compensation (excluding rebates);

"(B) all compensation received by the PBM during the previous quarter for sales of utilization or claims data that the PBM possesses as a result of the PBM carrier arrangement; and

"(C) all rebates paid to the PBM during the previous quarter by a pharmaceutical drug

manufacturer to the extent that such rebates are based on drugs dispensed under the PBM carrier arrangement; and

"(2) the PBM shall disclose to the carrier and the Office, in a form and manner specified by the Office—

"(A) the compensation described in paragraph (1)(A), reported by the amount of compensation for each category recognized by the Office;

"(B) the compensation described in paragraph (1)(B); and

"(C) the rebates described in paragraph (1)(C), reported on a drug-by-drug basis.

"(d) SALE OF UTILIZATION AND CLAIMS DATA.—Under a PBM carrier arrangement under this chapter, if the PBM intends to sell utilization or claims data that the PBM possesses as a result of such arrangement—

"(1) the PBM shall notify the Office before selling such data and shall provide the Office with the name of the potential purchaser of such data and the expected use of any utilization or claims data by such purchaser; and

"(2) the PBM may not sell such data unless the sale complies with all Federal and State laws and

the PBM has received approval for such sale from the Office.

"(e) PRICING.—

"(1) SPREAD PRICING.—

"(A) LIMITATION ON CHARGES TO CARRIER.—The PBM shall not charge the carrier more for a drug that is covered under the PBM carrier arrangement than the amount that the PBM reimburses a pharmacy which dispensed such drug for the drug.

"(B) DISCLOSURES.—

"(i) INITIAL DISCLOSURE.—Before entering into a PBM carrier arrangement under this chapter, the PBM shall disclose to the carrier and the Office—

"(I) the reimbursement basis that the PBM uses (including the type of benchmark price and the source of the data for determining such price) for reimbursing retail and mail order pharmacies; and

"(II) the methodology that the PBM uses to compute reimbursements to retail and mail order pharmacies that dispense the drug.

"(ii) UPDATES.—Not later than 30 days after making a change to the reimbursement basis or methodology under clause (i), the PBM shall disclose such change to the carrier and the Office.

"(iii) TRANSITION RULE.—Under a PBM carrier arrangement under this chapter that is in effect on the effective date of the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act, the PBM shall disclose the information under clause (i) not later than 1 year after such date.

"(2) MAXIMUM PRICE FOR PRESCRIPTION DRUGS.—

"(A) IN GENERAL.—Subject to subparagraph (B), a carrier under a PBM carrier arrangement under this chapter may not pay a PBM an amount for a prescription drug that is more than an amount that is equal to the average manufacturer price for the drug minus any cost-sharing for such drug that is the responsibility of an enrollee.

"(B) RULE OF CONSTRUCTION.—Subparagraph (A) shall not be construed to affect the payment—

"(i) of any applicable cost-sharing to a pharmacy by an enrollee; or

"(ii) subject to paragraph (3), the payment of any dispensing fee to a pharmacy by a PBM.

"(3) MAXIMUM DISPENSING FEE.—

"(A) IN GENERAL.—Under a PBM carrier arrangement, a PBM may not pay to a pharmacy a dispensing fee that exceeds the maximum dispensing fee determined under subparagraph (B).

"(B) DETERMINATION OF MAXIMUM DISPENSING FEE.—The Office shall, with respect to each drug covered by a health benefits plan under this chapter, determine the maximum dispensing fee.

"(f) RIGHT TO EXPLANATION OF BENEFITS.—Under a PBM carrier arrangement under this chapter, not later than 90 days after the date on which a pharmacy dispenses a prescription drug covered under the arrangement, the PBM shall provide (by mail or electronically) to the enrollee to whom such drug was dispensed an expla-

nation of benefits statement that contains the following information:

"(1) The date the claim for such prescription drug was made by the pharmacy.

"(2) The name of such drug and the strength and quantity dispensed to the enrollee.

"(3) The amount paid by the enrollee for the prescription drug.

"(4) The amount paid to the pharmacy by the PBM to reimburse such pharmacy for the prescription drug and the provision of any covered service related to dispensing such drug.

"(5) The amount paid by the carrier to the PBM for such prescription drug.

"(g) NON-DISCRIMINATORY CONTRACT.—Under a PBM carrier arrangement under this chapter, a PBM may not require that a pharmacy participate in a pharmacy network managed by such PBM in order for the pharmacy to participate in another network managed by such PBM.

"(h) ACCESS TO PBM CONTRACT INFORMATION.—

"(1) IN GENERAL.—Under a PBM carrier arrangement under this chapter, on the request of the Office of Personnel Management, a PBM shall provide to the Office and to the Office of Inspector General of the Office of Personnel Management full

access to information relating to contracts entered into by such PBM under such arrangement (such as PBM manufacturer arrangements and contracts with pharmacies). Such information shall include—

"(A) corporate-wide rebate receipt aging reports that cover all of the PBM's lines of business;

"(B) information and methodology used to calculate and allocate rebates between the PBM's lines of business;

"(C) information on average wholesale prices, wholesale acquisition costs, and maximum allowable costs;

"(D) information on dispensing fees paid; and

"(E) information and methodologies used to calculate additional administrative and service fees charged to the carrier.

"(2) CONFIDENTIALITY.—Information disclosed by a health benefits plan or PBM under this subsection is confidential and shall not be disclosed by the Office or by a plan receiving the information, except that nothing in this paragraph shall prevent—

"(A) a disclosure requird under the Inspector General Act of 1978; or

"(B) any disclosure which the Office, in its sole discretion, considers necessary in order to carry out this section, if such disclosure is made in a form which does not disclose the identity of a specific PBM or plan or the price charged for a particular drug.

"(3) EXEMPTION FROM FOIA.—Any information obtained under this subsection shall be exempt from disclosure under section 552 (commonly referred to as the 'Freedom of Information Act').

"(i) CIVIL MONETARY PENALTIES.—

"(1) IN GENERAL.—A PBM or a carrier that makes a false statement or false claim to the Government of the United States with respect to the disclosure of information required under this section shall be considered in violation of section 3729 of title 31.

"(2) USE OF COLLECTIONS.—Any monetary penalty collected under paragraph (1) shall be deposited into the Employees Health Benefits Fund under section 8909.

"(j) COLLECTION OF DATA ON AVERAGE MANUFACTURER PRICE.—

"(1) MASTER AGREEMENT.—For quarters beginning on or after January 1, 2011—

"(A) each manufacturer of covered drugs shall enter into a master agreement with the Office under which, not later than 60 days after the last day of each quarter for which the agreement is in effect, the manufacturer reports to the Office the average manufacturer price for the drug during such quarter; and

"(B) unless the manufacturer meets the requirement of subparagraph (A) for a quarter, the manufacturer may not receive payment from a carrier under this chapter or from a PBM under a PBM carrier arrangement under this chapter for the purchase of such drugs dispensed during the period—

"(i) beginning with the second subsequent quarter; and

"(ii) ending with the second quarter after the next quarter for which such requirement is met).

"(2) APPLICATION OF PROVISIONS.—The provisions of subparagraphs (B), (C), and (D) of section 1927(b)(3) of the Social Security Act shall apply to covered drugs and the Office under this section with respect to information required to be reported under paragraph (1)(A) in the same manner as such provi-

sions apply to covered outpatient drugs and the Secretary of Health and Human Services with respect to information required to be reported under subparagraph (A) of such section 1927(b)(3).

"(3) COVERED DRUG DEFINED.—For purposes of this subsection, the term 'covered drug' means a covered outpatient drug (as defined in section 1927(k) of the Social Security Act) for which benefits are payable under a health benefits plan under this chapter.

"(k) DEFINITIONS.—For purposes of this section and section 8902(p):

"(1) AVERAGE MANUFACTURER PRICE.—The term 'average manufacturer price' means the average price for a drug that is paid to a manufacturer by wholesalers, retail pharmacies, and mail order pharmacies that buy directly from the manufacturer.

"(2) AVERAGE WHOLESALE PRICE.—The term 'average wholesale price' means a publicly available, suggested list price for a prescription drug that is provided by a wholesaler to a pharmacy or other entity that provides prescription drugs directly to consumers.

"(3) CONTROLLING INTEREST.—An entity that has a 'controlling interest' in a second entity owns

or otherwise controls at least 20 percent of the second entity.

"(4) DISPENSING FEE.—The term 'dispensing fee' means a fee paid to a pharmacy for the service of filling or dispensing prescriptions (excluding the cost of the drug dispensed).

"(5) DRUG SUBSTITUTION.—The term 'drug substitution' means any change from one prescription drug to another prescription drug that is intended to address or treat the same illness or condition.

"(6) MAXIMUM ALLOWABLE COST.—The term 'maximum allowable cost' means a cost that is set by a PBM as the upper payment limit on the ingredient costs for a multiple source drug.

"(7) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' has the meaning given such term in section 1927(k)(7) of the Social Security Act.

"(8) NET COST.—The term 'net cost' means the final cost of the drug to the carrier (or an enrollee) after all adjustments (including discounts, rebates, associated dispensing fees and administrative fees, and enrollee cost sharing).

"(9) PBM.—The term 'PBM' means a pharmacy benefit manager.

"(10) PBM CARRIER ARRANGEMENT.—The term 'PBM carrier arrangement' means a contract between a PBM and a carrier for the provision or administration of a program of prescription drug coverage under a health benefits plan under this chapter. Such a contract may provide, among other duties, for the PBM to—

"(A) process and pay prescription drug claims;

"(B) provide programs and services designed to—

"(i) maximize the effectiveness of drugs dispensed under such plan; or

"(ii) contain drug expenditures under such plan; and

"(C) engage in other activities related to the administration of such prescription drug coverage.

"(11) PBM MANUFACTURER ARRANGEMENT.—The term 'PBM manufacturer arrangement' means a contract between a PBM and a drug manufacturer for the provision of prescription drugs to enrollees of

health benefits plans with prescription drug coverage that is administered or provided by the PBM.

"(12) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means an entity that contracts with a carrier to provide or administer prescription drug coverage under a health benefits plan under this chapter.

"(13) PRESCRIBER.—The term 'prescriber' means an individual who is authorized under State and Federal law to prescribe drugs and who prescribes a drug to an enrollee of a health benefits plan under this chapter.

"(14) RETAIL PHARMACY.—The term 'retail pharmacy' excludes any mail order pharmacy.

"(15) SINGLE SOURCE DRUG.—The term 'single source drug' has the meaning given such term in section 1927(k)(7) of the Social Security Act.

"(16) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' means a publicly available list price for sales of a drug by a manufacturer to a wholesaler.".

(c) CLERICAL AMENDMENT.—The table of sections for chapter 89 of title 5, United States Code, is amended by adding at the end the following:

"8915. Requirements for PBM arrangements.".

(d) EFFECTIVE DATE; WAIVER; REGULATIONS.—

(1) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 2011.

(2) WAIVER.—The Office of Personnel Management may waive the application of 1 or more of the requirements of section 8915 of title 5, United States Code, but only for contract year 2011.

(3) EXPEDITING IMPLEMENTATION OF REGULATIONS.—Not later than 6 months after the date of the enactment of this Act, the Office of Personnel Management shall issue interim final regulations to carry out this section which may be effective and final immediately on an interim basis as of the date of publication of such regulations. If the Office of Personnel Management provides for an interim final regulation, the Office of Personnel Management shall provide for a period of public comment on such regulation after the date of publication. The Office of Personnel Management may change or revise such regulation after completion of the period of public comment.

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Mr. LYNCH. I would like to yield now to the ranking member, Mr. Chaffetz from Utah, for 5 minutes for an opening statement.

Mr. CHAFFETZ. Thank you, Mr. Chairman. I simply want to thank you for holding this hearing. I want to thank our witnesses for coming and their expertise in sharing candidly their thoughts and perspectives. I, too, want to save money for Federal workers and, importantly, most importantly, the taxpayers' money, and hopefully we can achieve that.

Again I thank you for being here.

I yield back the balance of my time.

Mr. LYNCH. It is the custom of this subcommittee to swear witnesses. We are graced with the presence of Congressman Anthony Weiner. Mr. Weiner has represented New York's ninth Congressional District in the U.S. House of Representatives since 1999. He is currently a member of the Committee on the Judiciary and the Committee on Energy and Commerce, where he serves as the vice chair of the Subcommittee on Communications, Technology, and the Internet. Before entering Congress, Representative Weiner served in the New York City Council.

I am going to ask my friend to please rise and raise your right hand.

[Witness sworn.]

Mr. LYNCH. Let the record show that the witness has answered in the affirmative.

My friend, Mr. Weiner, you now have 5 minutes for an opening statement.

STATEMENT OF HON. ANTHONY WEINER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. WEINER. Thank you very much. I have prepared testimony, but with your indulgence I would just like to submit that for the record and just make a few remarks.

Mr. LYNCH. Without objection.

Mr. WEINER. It is important that we understand that PBMs do an important thing. They are a valuable tool. The way they work is that a big employer who has an insurance company might not want to be in the benefits management business and pharmaceuticals might not know the ins and outs, so they hire a PBM to take that market pool that they have that gives them some clout in the marketplace and have someone manage that clout.

The only question here is: who should benefit from that? Should it be the person that hires the PBM, whether it be a labor union, whether it be an employer, or whether it be in this case the Federal Government? Or should it be the PBM, itself? That is the only question.

The problem that we have is for us to figure out who should derive those benefits, we need to know what benefits there are. We don't have that knowledge right now. For example, if the employees of the Federal Government hire a PBM to go negotiate the best price for Lipitor, we don't know what that best price they are getting is; all we know is that the PBM says, here is the deal we got. It could very well be that there is an extra $2 or $3 a dose that the PBM benefited from. And we may make the decision as taxpayers, you know what, that is OK, we are willing to pay that

price. The PBM is doing a valuable thing; they should get a piece of the action.

Transparency is very important, and that is what your legislation seeks to do. I should point out that if there is a point of consensus in the health care debate—although sometimes my Republican friends don't acknowledge it—is we all agree with the idea of using market-based solutions. For those of us who support a single payer plan, we believe get the biggest possible market to be able to negotiate for lowest prices. All the health care plans that are out there take the idea of having a big market, to use that market strength to negotiate for lower prices, to use that. To do what Wal-Mart does: take their big market pool and negotiate for the lowest prices.

PBMs do help us do that. I don't think that anyone should say that PBMs are not created for that purpose. The question is: are we getting the fullest benefit of it?

Now, in the House version of the health care bill we have PBM transparency for everyone, not just for Federal employees. I believe in the Senate bill it is also in there, with the philosophy being the same thing: we may agree or disagree with what the PBMs are doing, but we should have transparency.

I think if your bill becomes law here is what we will find that will happen: the PBMs will still have every incentive in the world to negotiate for the best prices for taxpayers, but we will have some insight. Did they get an extra rebate here that maybe we want more of? And your legislation, which says that 90 percent of what you save should go back to the taxpayer seems like a reasonable transaction fee. With 10 percent they are still going to do very well for themselves.

So I think that your legislation is very important. I think that all of us should be able to agree. What is the point of having this big buying pool if we are not getting the benefit of it? That is what PBMs are in the business of doing; we just want to make sure they are in the business of doing it for the taxpayer, and that is the philosophy behind your bill and that is why I heartily support it.

[The prepared statement of Hon. Anthony D. Weiner follows:]

Testimony of
The Honorable Anthony D. Weiner
Before the Federal Workforce, Postal Service, and the District of Columbia Subcommittee
On the
FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act (HR 4489)
February 23, 2010

Thank you Chairman Lynch and Ranking member Chaffetz for the opportunity to testify on the importance of transparency within the Federal Employee Health Benefit Plan prescription drug programs.

I have been a longtime advocate of requiring greater transparency for pharmacy benefit managers. In 2005, I, along with Representative Jerry Moran authored the Pharmacy Benefit Manager Transparency Act of 2005, which would have done a number of things including requiring PBMs to annually disclose all compensation received from drug manufacturers and prohibiting PBMs from switching drugs from a cheaper one to a more expensive alternative. Last year, I worked with 7 colleagues to write to the Federal Trade Commission on the merger of CVS and Caremark. Most recently, I sponsored with Representative Mike Ross language in the House health care reform bill that would require PBMs to do a number of things to make their business more transparent and reduce drug costs for consumers. Specifically, our provisions require PBMs to provide all financial information to the health plans it manages regarding its enrollees; disclose to health insurance plan sponsors all the rebates and other discounts they receive from drug manufacturers, disclose when a patient is being switched from a lower drug cost to a more expensive version and requires PBMs that own or are affiliated with a retail pharmacy to disclose when and if they share patient data from a competitor pharmacy with their own retail pharmacy.

As you know, Pharmacy Benefit Managers (PBMs) are the middlemen that administer the prescription drug benefit portion of health insurance plans for private companies, unions and governments. PBMs are responsible for processing and paying prescription drug claims; for developing formularies; contracting with pharmacies; and negotiating discounts and rebates with drug manufacturers.

Yet, PBMs act largely in secret and are unregulated. The clients of PBMs are not told what rebates drug manufacturers, meaning that the PBM can negotiate to purchase the drug from the manufacturer at $12 but require a $15 or $20 copayment from the individual purchasing the drug - leaving the PBM to rake in billions. A 2005 independent study conducted by Winkelman Management Consulting, found that one of the largest PBMs managed to keep 44% of the rebates it processed in one year, totaling about $1.3 billion.

Why is all this important? Because PBMs manage 95% of all prescriptions sold in the United States and billions of dollars in health care spending is being consumed by PBMs. For example,

the profits for the three largest PBMs nearly tripled from $966 million in 2003 to $2.7 billion in 2007.

Greater transparency of PBMs will lead to what we all want: cheaper drug prices for our constituents and savings for employers paying for the drug plan. Recent examples of PBM transparency leading to lower prices shows what is at stake. The Pentagon expects to save approximately $1.67 billion by negotiating drug discounts on its own—instead of using a PBM—for the 9 million individuals covered by the TRICARE program. The State of Texas estimates it would reduce State costs by up to $265 million simply by requiring a transparent PBM contract for state government and university employees.

For these reasons, I am glad to discuss this important issue with you today and be a cosponsor of Chairman Lynch's Federal Employee Health Benefit Plan Prescription Drug Integrity, Transparency, and Cost Savings Act. This legislation will do a number of things to shine a light on the practices of PBMs as they interact with the Federal Employee Health Benefit Plan.

Granting the Office of Personnel Management (OPM) full audit rights and access to data about drug manufacturer rebates, giving OPM more effective oversight of the PBMs is a big setp in the right direction. Included as part of this information will be how the PBM determines its prices and their acquisition costs. It would also prohibit "drug switching" where a PBM switches a patient from one drug to another that they may receive significant rebates for and require PBMs to return 99% of all rebates from drug manufacturers to the FEHBP plans.

In closing, I would like to thank you Chairman Lynch and Ranking Member Chaffetz for holding this important hearing and inviting me to testify. As former Supreme Court Justice Louis Brandeis famously said almost 100 years ago, "sunlight is said to be the best of disinfectants". I believe that this legislation will go a long way towards providing the Office of Personnel Management the tools to shine some sunlight on the FEHBP drug plans.

Mr. LYNCH. Thank you, Mr. Weiner.

I realize that you have other committee obligations.

Mr. WEINER. I am a very busy man, Mr. Lynch.

Mr. LYNCH. All right.

Mr. WEINER. As you know, this health care debate will simply not proceed forward without my presence.

Mr. LYNCH. Exactly. [Laughter.]

That is what I understand. So we are going to excuse you and we are going to accept your testimony in full, and we thank you for your attendance at this hearing.

Mr. WEINER. Thank you for your indulgence.

Mr. LYNCH. And for assisting the committee with its work.

Thank you.

I would like to call our second panel, if we could.

Before we proceed with the second panel, I would like to offer time to my colleagues for a brief opening statement. The Chair now recognizes the gentlelady from the District of Columbia, Eleanor Holmes Norton, for 5 minutes.

Ms. NORTON. Thank you very much, Mr. Chairman.

Mr. Chairman, there are a quarter of a million Federal employees who are not covered by FEHBP at all, much less by its prescription drug program. That is a scandal. I am now talking about people who can't afford to be in a program where the Government presumably pays 70 percent of the cost, although there is great cost shifting in FEHBP. And of these programs, to have a benefit program or prescription benefit program where there is no regulation, no negotiation, and no transparency required by the FEHBP is beyond belief, especially when you consider that prices for drugs for Federal workers have been rising.

I did some work on the FEHBP, which is now modeled for what we want to do in the health reform bill, and even the compact we have has not kept prices down with FEHBP in the picture. So I have no confidence in the prescription drug program, and I think your bill, Mr. Chairman, goes some distance, particularly in the transparency requirement—I would think that is 101 in any Federal bill—in moving us ahead.

Mr. Chairman, I cannot believe. Let us analogize ourselves to the biggest Fortune 500 company. What is it, Wal-Mart? Can you believe that Wal-Mart, as the customer, would be buying drugs from the same set of sources at different prices? Wouldn't it be using its buying power to make sure that if it were, to chase this analogy further, the DOD or the VA, that those who work for the Federal Government were getting the very same deal. That also escapes my understanding.

Mr. Chairman, what you are doing about what you took testimony on at the last hearing concerning the conflict of interest with some pharmacy owners could not be more important in your bill. This has become a matter of national disgrace because it is now all over the media about how these retail pharmacy owned companies are bilking the public.

The time has come, Mr. Chairman, to move on your bill, and I can't thank you enough for, early in the year, bringing us to this point today where we are doing a direct hearing on your bill.

Mr. LYNCH. I thank the gentlelady.

The Chair now recognizes the gentleman from Maryland, Mr. Cummings, for 5 minutes.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Chairman Lynch, I really do appreciate your holding this hearing on the Federal Employees Health Benefits Program Prescription Drug Integrity, Transparency, and Cost Savings Act.

In June of last year, this subcommittee held a hearing to examine the contracting and pricing model used in the FEHBP, as well as trying to determine whether the program's drug benefit program was a good value. We concluded that for both taxpayers and for FEHBP subscribers, changes in the program's contracting and pricing of prescription drugs was necessary in order to ensure that the benefit was being administered in the most fiscally responsible manner.

The FEHBP is the largest employer-sponsored health insurance program in the country, covering over 8 million workers, Members of Congress, and their families. Almost 30 percent of FEHBP premium payments are for prescription drugs. One of the major discussions during the June hearing was around the FEHBP being charged more for its drugs than other Federal and commission programs.

I would agree with you, Mr. Chairman, and certainly Ms. Norton that this is ridiculous.

During that hearing it was disclosed that it was difficult to determine if the FEHBP health plans were receiving a good price for their drug benefits because of the complexity and the lack of transparency in these contracts.

On January 24th, I joined you, Chairman Lynch and Congressman Connolly in sponsoring H.R. 4489, the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act. This bill is designed to do several very important things: create greater oversight authority to OPM relating to prescription drug benefits. It will also require pharmacy benefit managers to return 99 percent of all moneys received from manufacturers to the FEHBP business. It will cap prices paid by the health plan to the average benefit price, and require total transparency and disclosure of all contract terms and related information.

However, I understand that there are some concerns around the bill in its current form claiming a reduction in the choice and competition. Before we pass this legislation, we must look at this bill very carefully from all angles, consider all of the consequences, intentional and unintentional, and what effect it will have on our care and health benefits program.

The subcommittee has worked with several groups with vested interest in the legislation. The hearing will discuss this bill and specific ways to amend the bill going forward and efforts to strengthen it and ensure its intended purpose.

I anxiously look forward to the testimony of today's witnesses and thank the chairman for his leadership.

I also remind all of us that our Federal employees give their blood, their sweat, their tears to support all of us, and in our economy today every dime that they can save on prescription drugs or anything else is very, very important.

So with that, Mr. Chairman, I yield back.

Mr. LYNCH. I thank the gentleman.

The Chair now recognizes the distinguished chairman of our full committee, Mr. Towns of Brooklyn, for 5 minutes.

The CHAIRMAN. Thank you, Mr. Chairman. I don't plan to use 5 minutes, because I am actually here to thank you and, of course, Mr. Chaffetz, for holding this hearing, and to say to you, which is something you probably never heard me say before, I am here to listen.

Mr. LYNCH. I thank the gentleman.

The Chair now recognizes the gentleman from northern Virginia, Mr. Connolly, for 5 minutes.

Mr. CONNOLLY. I thank the Chair and thank the Chair of the full committee. I am privileged and pleased to join with you, Mr. Lynch, and with you, Mr. Cummings, as an original co-sponsor of this legislation, which I think has the opportunity to create enormous efficiencies and to save hundreds of millions of dollars potentially in health care costs—something I think all of us can unite behind.

This legislation does three things. First, it precludes a single company from controlling both the PBM and the retail pharmacy. The regulation is important because vertical integration between the two eliminates market incentives wherein the pharmacist negotiates for lower prices. Eliminating this incentive through consolidation creates market conditions in which prices will rise disproportionately.

Second, the bill prohibits PBM from switching prescription drugs without a physician's consent. This important provision ensures that Federal employees and their doctors, not bureaucrats in the insurance industry, maintain control over health care. For too long, PBMs have been able to switch to more lucrative drugs without the physician approval, even if those drugs are not as efficacious or beneficial to the patient.

Third, the bill requires PBMs to return 99 percent of money received from pharmaceutical manufacturers for business conducted under the FEHBP. This provision ensures that taxpayers' money is not being used to subsidize middle men who don't actually contribute much to health care services. It also protects Federal employees from predatory pricing in which PBMs have reimbursed pharmacies for less than the amount paid for the health care plan.

As Dan Adcock said in NARFE's prepared testimony on this subject, we strongly believe that nothing should be left to chance regarding OPM's ability to access information. For that reason, we believe that transparency should ultimately be legislated. When we had hearings, it couldn't have been clearer that, frankly, we have to tighten up the regulation and oversight of PBMs to make sure that, in fact, they are delivering quality services for our employees and the requisite savings we know are there.

I thank the Chair for holding this hearing and look forward to continued collaboration with him.

[The prepared statement of Hon. Gerald E. Connolly follows:]

Opening Statement of Congressman Gerald E. Connolly

Subcommittee on Federal Workforce, Postal Service, and District of Columbia

"FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

February 23rd, 2010

Thank you, Chairman Lynch for introducing legislation that will finally introduce transparency into the FEHBP prescription drug plan. For too long, Pharmacy Benefit Managers (PBMs) have been allowed to use opaque pricing schemes to maximize profits at the expense of taxpayers and federal employees who pay premiums, profiting from rather than passing along savings from manufacturers. As a result, prescription drug costs under FEHBP have ballooned to $10 billion annually, accounting for nearly a third of total premium expenses. Our Subcommittee held a hearing and a stakeholder workshop last year on FEHBP prescription drug benefits, both of which illuminated policy solutions that can protect federal employee benefits and save taxpayer money. Since Chairman Lynch based H.R. 4489 on what we have learned from federal employee stakeholders, a workshop, and a hearing, this legislation has the strong support of federal employee groups.

The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act, H.R. 4489, would cut wasteful spending and increase transparency while improving federal employees' benefits. First, H.R. 4489 precludes a single company from controlling both the PBM and the retail pharmacy. This regulation is important because vertical integration between a PBM and a pharmacy eliminates the market incentives wherein the pharmacist negotiates for lower prices. Eliminating this incentive through consolidation creates market conditions in which prices will rise disproportionately. Moreover, taxpayers cannot monitor how PBMs and pharmacies may be reaping windfall profits on prescription drug sales because there are currently no effective transparency requirements for prescription drug pricing. The vertical integration of PBMs and retail pharmacies creates such a conflict of interest that the Federal Trade Commission is investigating its anti-competitive characteristics.

Second, H.R. 4489 prohibits PBMs from switching prescription drugs without a physician's consent. This important provision ensures that federal employees and their doctors, not corporate bureaucrats, maintain control over health care. For too long, PBMs have been able to switch to more lucrative drugs without physician approval, even if those drugs are not as beneficial to the patient. In addition, H.R. 4489 requires that PBMs disclose the financial impact of proposed prescription drug changes, ensuring that federal employees are aware of vested financial interests that might drive PBMs to put profit ahead of federal employee health.

Third, H.R. 4489 requires PBMs to return 99% of money received from pharmaceutical manufacturers for business conducted under FEHBP. This provision ensures that taxpayers' money is not being used to subsidize middlemen who don't actually contribute anything to health care services. It also protects federal employees from predatory pricing, in which PBMs have reimbursed pharmacies for less than the amount paid by the health care plan. As Dan Adcock said in NARFE's prepared testimony, "We strongly believe that nothing should be left to chance regarding OPM's ability to access information...For that reason we believe that transparency should ultimately be legislated."

Sometimes we must make a choice between protecting the taxpayer and protecting the income of private companies. This is one of those cases. I do not begrudge these companies the profits they have earned from operating legally under rules that should have been tighter. However, it is clearly our responsibility to tighten up the rules to protect taxpayers and federal employees. I look forward to the opportunity to move forward with H.R. 4489, and thank Chairman Lynch and federal employee groups for their work to develop and build support for this common sense legislation.

Mr. LYNCH. I thank the gentleman.

As with the previous panel, Mr. Weiner, you understand that it is the custom before this committee to swear all witnesses, so I want to welcome our witnesses and ask you all to rise and raise your right hands.

[Witnesses sworn.]

Mr. LYNCH. Let the record show that all of the witnesses have each answered in the affirmative.

What I will do is I will offer a very brief introduction of each of the witnesses, and then we will have testimony from each.

Mr. John O'Brien is the Director of Planning and Policy Analysis at the Office of Personnel Management. He joined with OPM in April 2009. Prior to that, Mr. O'Brien was the deputy director for research and methodology at the Maryland Health Services Cost Review Commission.

Mr. Patrick McFarland was nominated Inspector General of the Office of Personnel Management in 1990. As Inspector General, Mr. McFarland is responsible for providing leadership that is independent, nonpartisan, and objective, and is dedicated to identifying fraud and mismanagement in programs administered by the Office of Personnel Management. Mr. McFarland is also a member of the Council of Inspectors General on Integrity and Efficiency.

Representative Sharon Treat is currently in her fifth non-consecutive term in the Maine State House of Representatives. Previously she serve four terms in the Maine State Senate, including two as Senate Majority Leader. Representative Treat is also the executive director of the National Legislative Association on Prescription Drug Prices, a nonpartisan organization of State legislators working jointly across State lines to reduce prescription drug prices and to expand access.

Ms. Jasmin Weaver is the Healthcare Initiatives legislative director of Change to Win, where she has been working on health care policy, addressing issue including patient privacy, medication errors, and PBM transparency and reform. Before joining Change to Win, Jasmin worked for the Chair of the House Health Care Committee in Washington State and worked on higher education policy issues at Harvard University.

Mr. Jonathan Boehm has been president and chief executive officer of Argus Health Systems, Inc., since 2006. As president and CEO, Mr. Boehm is responsible for all aspects of pharmacy benefit solutions offered to market by Argus Health Systems, including nearly 600 million claims processed annually, and 20 percent of all Medicare Part D claims processed in the United States.

Mr. Richard Beck is the executive director of the Texas Pharmacy Business Council, a new independent pharmacy advocacy organization dedicated to ensuring patient access to quality pharmacy care services. Mr. Beck is also the vice president of Pharmacy Affairs at American Pharmacies, which is a member-owned, independent pharmacy buying co-op.

Welcome to all. Mr. O'Brien, you are now recognized for 5 minutes.

Let me just back up a little bit. You see this little box in front of you? The green light signals that you may proceed with your testimony; a little yellow light will indicate that you should probably

wrap up, you have about a minute; and then the red light would mean that your time has expired.

Thank you.

Mr. O'Brien, 5 minutes.

STATEMENTS OF JOHN O'BRIEN, SENIOR ADVISOR TO THE DIRECTOR, U.S. OFFICE OF PERSONNEL MANAGEMENT; PATRICK MCFARLAND, INSPECTOR GENERAL, U.S. OFFICE OF PERSONNEL MANAGEMENT; SHARON TREAT, ESQ., STATE REPRESENTATIVE FROM MAINE AND EXECUTIVE DIRECTOR, NATIONAL LEGISLATIVE ASSOCIATION ON PRESCRIPTION DRUG PRICES; JASMIN WEAVER, HEALTHCARE INITIATIVES LEGISLATIVE DIRECTOR, CHANGE TO WIN; JONATHAN BOEHM, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ARGUS HEALTH SYSTEMS INC.; AND RICHARD BECK, TEXAS PHARMACY BUSINESS COUNCIL

STATEMENT OF JOHN O'BRIEN

Mr. O'BRIEN. Chairman Lynch, Ranking Member Chaffetz, and members of the subcommittee, I am pleased to be here on behalf of Director John Berry of the Office of Personnel Management to discuss H.R. 4489, the Federal Employees Health Benefits Program Prescription Drug Integrity, Transparency, and Cost Savings Act.

I would like to submit a written statement for the record, and I will summarize briefly here.

OPM commends Chairman Lynch and the subcommittee is continued efforts to strengthen the agency is oversight authority regarding FEHB prescription drug benefits. Prescription drugs represent a significant portion of the $39 billion FEHB program, comprising almost 30 percent of all expenditures, and are a valuable benefit to enrollees. In light of its importance, we are committed to ensuring that the FEHB prescription drug benefit is cost effective, transparency, and provides enrollees with a comprehensive quality coverage.

The bill attempts to expand OPM's authority to regulate drug benefits offered by FEHB insurance carriers, including relationships with pharmacy benefits managers, pharmaceutical manufacturers and pharmacies. The bill outlines a uniform purchasing strategy for all FEHB carriers, including price-based, on-average manufactured price. It prohibits certain ownership relationship, restricts non-generic drug substitutions by PBMs, and requires PBM transparency and disclosure of all contract terms and related information.

OPM agrees with the subcommittee that transparency and ethical business practices are an essential element of an effective FEHB prescription drug program. Since 2005, our carrier contracts have included PBM transparency requirements. These requirements include restrictions and protocols relating to PBM drug substitutions similar to those in the bill.

We are currently in the process of updating these contractual transparency requirements and we are concerned that this bill legislates PBM pricing and purchasing terms for FEHB carriers. Requiring the use of specific contracting models and pricing methods

via legislation will not allow the program flexibility in an industry where business practices are rapidly evolving.

We believe that these models and methods would be better addressed in the contracts with our carriers, allowing the program and its health plans to accommodate changing industry practices.

Additionally, there may be administrative costs for OPM as well as carriers that would be passed on to enrollees as a result of certain sections of the bill. For example, the bill requires PBMs to comply with extensive reporting requirements to the agency, carrier, and the enrollee. While we believe that disclosure is important, a balance must be struck to ensure that these administrative requirements do not impose significant costs upon enrollees and the Government. We do recognize that further efforts are needed to improve cost and pricing transparency related to FEHB prescription drug benefits.

Following the hearing that this committee had last June and going forward, an agency work group, including representatives of the OPM's Inspector General's Office, has been working on contracting requirements using administrative authority currently available to us. The Inspector General's Office was instrumental in developing requirements for large providers, including PBMs, that were incorporated in 2005. Their onsite audit experience has proven very useful to the current work group discussions.

The work group developed a set of transparency principles to be followed when negotiating specific contracts by carriers. These principles were spelled out in OPM's February 22nd carrier letter which was sent out to carriers and has been shared with the committees. One example is requiring pass-through transparent pricing in contracts with PBMs in which the carrier receives the full value of the PBM's negotiated discounts, rebates, and other credits.

We will continue to work with the OPM Inspector General to ensure that FEHB contracts are regularly updated and reflect the changing marketplace, that transparency principles are adhered to and enforceable.

In addition, we are reviewing a broad range of options for improving our current contractual procedures and redesigning how prescription drug services may be purchased. Many of the options that we are investigating were identified by this committee in its September forum. Our goal is to obtain the best and most affordable product for our enrollees.

As the subcommittee continues to examine this important issue, our agency remains willing to work with you. We would be glad to provide technical assistance to address our concerns with the specific issues in the bill.

Thank you for this opportunity to testify on the provisions of H.R. 4489.

[The prepared statement of Mr. O'Brien follows:]

STATEMENT OF

JOHN O'BRIEN
DIRECTOR OF PLANNING & POLICY ANALYSIS
U.S. OFFICE OF PERSONNEL MANAGEMENT

before the

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

on

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM PRESCRIPTION DRUG INTEGRITY, TRANSPARENCY, AND COST SAVINGS ACT

February 23, 2010

I am pleased to be here today on behalf of Director John Berry of the Office of Personnel Management (OPM) to discuss H.R. 4489, the *Federal Employees Health Benefits Program (FEHBP) Prescription Drug Integrity, Transparency, and Cost Savings Act.*

OPM commends Chairman Lynch and the Subcommittee's continued efforts to expand the agency's oversight authority regarding FEHBP prescription drug benefits. This prescription drug benefit represents a significant portion of the $39 billion dollar FEHB Program, comprising almost 30 percent of expenditures, and provides a valuable benefit to enrollees. In light of its importance, we are committed to ensuring that the FEHBP prescription drug benefit is cost-effective and transparent, and provides enrollees with comprehensive and quality coverage.

H.R. 4489 amends the FEHBP governing law by expanding OPM authority to regulate the prescription drug benefits offered by FEHBP health insurance carriers, including relationships with pharmacy benefit managers (PBMs), pharmaceutical manufacturers, and pharmacies. The bill outlines a uniform purchasing strategy for all FEHBP carriers, including pricing based on average manufacturer price (AMP). It prohibits certain ownership relationships and requires PBM transparency and the disclosure of all contract terms and related information.

OPM agrees with the Subcommittee that transparency and ethical business practices are an essential element of an effective FEHBP prescription drug program. Since 2005, our carrier contracts have included PBM transparency requirements. These requirements include restrictions and protocols relating to PBM drug substitutions similar to those in the bill.

While we are currently in the process of updating these contractual transparency requirements, we are concerned that this bill legislates PBM pricing and purchasing terms for FEHBP carriers. Requiring the use of specific contracting models and pricing methods via legislation will not allow the Program flexibility in an industry where business practices are rapidly evolving. We believe that these models and methods would be better addressed in the contracts with our carriers, allowing the Program and its health plans to accommodate changing industry practices.

We agree that PBMs should adhere to transparency standards of the type advocated by other large employers. Companies such as IBM, Caterpillar, and McDonald's are part of a coalition of 60 large employers which have certified those PBMs who have agreed to enter into contracts that comply with standards known as Transparency in Pharmaceutical Purchasing Solutions (TIPPS).

This approach would be more consistent with our current Program model wherein OPM has broad authority to contract with health insurance carriers and to aggressively negotiate for benefits and contract terms similar to other large employer benefit plans. An example of the need for flexibility relates to the bill's requirement for pricing to be based on AMP. We would note that AMP has a longstanding role in the Medicaid rebate program; this legislation appears to establish a separate definition, which could potentially conflict and lead to drug manufacturers reporting different AMPs for Medicaid and FEHBP.

As you are aware, the industry is currently in flux as to the appropriate pricing benchmark in light of recent litigation relating to the industry standard benchmark average wholesale price (AWP). The industry has not yet settled on the appropriate pricing benchmark due to deficiencies in the current alternatives to AWP. If OPM were mandated to use AMP, FEHBP carriers may be disadvantaged in the marketplace, especially if the industry moves to an alternative pricing benchmark, such as wholesale acquisition cost (WAC). Alternatively, if OPM is able to address these issues via contract instead of by statute, the FEHBP carriers would be required to negotiate using the most appropriate pricing benchmark available in the industry at that time.

Additionally, there may be significant administrative costs for OPM as well as for carriers and PBMs that would be passed on to enrollees as a result of certain sections of the bill. For example, the bill requires PBMs to comply with extensive reporting requirements to the agency, the carrier, and the enrollee. While we believe that disclosure is important, a balance must be struck to ensure that these administrative requirements do not impose significant costs upon enrollees and the Government. OPM would likely require additional resources to adequately implement the new responsibilities contemplated by the bill. Furthermore, additional procurement issues would have to be taken into consideration because some drug manufacturers are foreign corporations. This would affect our ability to audit those contracts.

That said, we do recognize that further efforts are needed to improve cost and pricing transparency related to FEHBP prescription drug benefits. An intra-agency workgroup,

including representatives from OPM's Inspector General's office, has been working on contracting requirements using the administrative authority currently available to us. One of the administrative options discussed at the Subcommittee forum held on September 29th, was to change PBM classification from "large provider" to "subcontractor" in our acquisition regulations. The workgroup evaluated the pros and cons of that option and determined that this approach would not provide the pass-through transparency currently envisioned. The Inspector General's office was instrumental in developing the requirements for large providers, including PBMs, which were incorporated into FEHBP contracts in 2005. Their on-site audit experience has proven to be very useful in the current workgroup discussions.

The workgroup is now developing a set of transparency principles that can be used to negotiate specific contract provisions. One example is requiring pass-through transparent pricing in contracts with PBMs in which the carrier receives the full value of the PBM's negotiated discounts, rebates, or other credits. We will continue to work with the OPM Inspector General and ensure that FEHBP contracts are regularly updated to reflect the changing marketplace and that transparency principles are adhered to and enforceable.

Moreover, we are reviewing a broad range of options for improving our current contractual procedures and redesigning how prescription drug services are purchased. Among the proposals that we are considering are those discussed at the forum held by the Subcommittee in September 2009, some of which, as you know, would require legislative action.

Our goal is to obtain the best and most affordable products for our enrollees. As the Subcommittee continues to examine this important issue, our Agency remains willing to work with you. We would be glad to provide technical assistance to address our concerns with the specific issues in the bill.

Thank you for the opportunity to testify on the provisions of H.R. 4489.

Mr. LYNCH. Thank you, Mr. O'Brien.
Mr. McFarland, you are now recognized for 5 minutes.

STATEMENT OF PATRICK MCFARLAND

Mr. MCFARLAND. Good afternoon, Mr. Chairman and members of the subcommittee.

To best serve the committee's goals of establishing transparency and equity in the many protocols of prescription drug costs, my testimony and discussion today will attempt to contrast the work progress of OPM with the intent and vision of your proposed legislation, providing, hopefully, a value-added component for your final decisionmaking.

In our estimation, the single most important FEHBP issue which OPM must resolve is the fact that it is dealing with PBMs from a perspective in which the cost structure of the PBMs are utterly non-transparent. This means that there is no objective basis to determine now or in the future if the terms being offered to an FEHBP carrier by a PBM represent an advantageous arrangement.

From our perspective as the agency's audit component, we find the absence of transparency to be deeply troubling; however, with the recent work progress of OPM, I believe that the agency is now moving with a firm purpose of amendment regarding the PBM industry. For years, real corrective action has been dormant, at best. OPM has certainly not been a strong player in wrestling with the rising cost of prescription drugs.

Today, however, separate entities are responsible for a forward thrust of enthusiasm. Namely, the health care expertise of two senior advisors to the Director of OPM and the strong focus and hard work of this committee to get something meaningful accomplished.

Specifically, OPM, in concert with our office, will advance certain principles that will be incorporated into existing and future contracts with fee-for-service health plan carriers such as the Blue Cross/Blue Shield Association. These principles will require the PBMs pass all discounts, rebates, and other financial incentives or payments through to the carriers, and that the PBM's only remuneration in connection with the contract is from the FEHBP carrier, itself. In effect, the drug cost passed through the carrier would be based on the cost of the drug plus a reasonable fee for the PBM's services, such as administrative fees. All relevant documents, including contracts with drug manufacturers, would be available to my office for audit.

If these principles are quickly and properly implemented by OPM, I believe most, if not all, of my concerns about the lack of transparency in the FEHBP PBM contracts will be resolved; however, as always, the devil is in the details. For example, without additional resources, it is difficult to see how OPM will be able to fully implement these principles. Also, I am concerned that the existing PBM contracts may be allowed to continue for years before the new principles are incorporated. It may be more prudent to require the fee-for-service carriers to comply with the principles no later than 2012 plan year.

Finally, I am concerned that the principles may be changed before they are incorporated into the FEHBP FFS contracts. Presently, there are several proposed contract changes that serve to im-

plement the principles being introduced into the FEHBP's pharmacy benefit program. The revisions are grouped into the following categories: pricing requirements, document access, electronic data access, the selling of utilization data, financial benefit administration, and sanctions.

I have also several minor concerns with the act, itself. For example, OPM may not have the resources or expertise to determine maximum allowable dispensing fees. The heading "civil monetary penalties" is somewhat confusing because the section deals primarily with False Claims Act rather than civil monetary penalties.

The ability of PBMs to retain 1 percent of rebates may result in current discount arrangements being converted to rebates. Providing incentives to PBMs to reduce overall drug cost is an excellent strategy; however, legislation should be careful not to strictly limit incentive options.

It is questionable whether interim final regulations can be issued within 6 months of enactment because of the complexity of the subject matter and the lack of agency resources.

Despite my concerns, the status quo must be changed. I believe that the amendment to the Federal Employees Health Benefits Act on Pharmacy Benefits can be beneficial, particularly if OPM does not quickly require FFS FEHBP carriers to enter into the PBM contracts that require clear, pass-through transparent pricing. A pass-through pricing model, in our opinion, would be easier to administer and fair to all parties.

All this having been said, I would respectfully suggest that during further deliberations this committee might give favorable consideration to the following: that the principles presently being proposed by OPM be also addressed in this legislation. My primary concern for making this request is that if, in fact, OPM may be directed to be an integral part of the health care reform, said inclusion of these stated principles in legislation would guarantee that the issue would remain a high priority.

In closing, I want to express a most noteworthy thank you to this committee for this proposed legislation. Regardless of the outcome, whether it be enacted into law or a decision is made to allow OPM's substantive proposals to prevail, I can state first-hand that this Office of the Inspector General, especially our entire audit staff, applauds this particular pursuit of accountability resulting in better Government.

Thank you.

[The prepared statement of McFarland follows:]

Statement of the Honorable
Patrick E. McFarland
Inspector General
U.S. Office of Personnel Management

before the

Subcommittee on Federal Workforce, Postal Service,
and the District of Columbia

on

"The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

February 10, 2010

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

Good morning. My name is Patrick E. McFarland. I am the Inspector General of the United States Office of Personnel Management (OPM).

Thank you for inviting me to testify at today's hearing. This is the second time in less than a year I have testified to the Subcommittee on the significance of pharmacy benefits manager (PBM) contracts and their lack of price transparency in the context of the Federal Employees Health Benefits Program (FEHBP). The first time was on June 24, 2009, at the hearing aptly titled "FEHBP's Pharmacy Benefits: Deal or No Deal?"

The FEHBP is the largest employer-sponsored health insurance program in the United States. During calendar year 2008, the 266 insurance plans under contract to the FEHBP provided health insurance coverage to approximately 7.7 million people, representing Federal employees, annuitants, and dependents. The FEHBP paid a total of $35.9 billion in premiums to these carriers, of which $29.1 billion went to the fee-for-service plans and $6.8 billion to health maintenance organizations. As reported to OPM in the financial statements of FEHBP carriers, pharmacy costs reflected more than 25 percent of health care costs paid by the fee-for-service plans. Further, according to data furnished by OPM's contracting office, 12 different PBMs provided services to one or more FEHBP plans during 2008.

The initial purpose of contracting with PBMs was to control drug costs and improve the efficiency of the FEHBP pharmacy program. However, in the years since the PBMs began servicing Federal enrollees, health care costs have continued to rise, including prescription drug costs. The Blue Cross and Blue Shield Service Benefit Plan, which covers approximately 50 percent of the FEHBP's enrollees, has incurred a steady increase in its prescription drug costs per FEHBP member since 1999. In 1999, the

claims cost per member was $591. Eight years later, the claims cost per member increased to $1,161; almost twice the amount paid in 1999. Drug cost increases averaged 13.5 percent over the 8-year time period. These steadily rising costs call into question the effectiveness of the large PBMs which the BlueCross BlueShield Association has contracted with in controlling prescription drug costs.

We have continued our efforts to learn about and audit PBMs and have concluded that the most significant issues with which OPM should be concerned do not involve the PBMs' compliance with or performance of their contracts with the FEHBP carriers, but rather the nature of the PBM contracts themselves.

In our estimation, the single most important FEHBP issue which OPM must resolve is the fact that it is dealing with PBMs from a perspective in which the cost structures of the PBMs are utterly nontransparent. This means that there is no objective basis to determine whether the terms being offered to an FEHBP carrier by a PBM represent an advantageous arrangement. From our perspective as the agency's audit component, we find the absence of transparency to be deeply troubling.

Before I discuss the proposed bill let me clarify one point about transparency. The Pharmaceutical Care Management Association (PCMA) testified at the last hearing that transparency would destroy or dilute the ability of the PBM industry to negotiate discounts and rebates with the pharmaceutical manufacturers. I do not know what the impact would be if PBM financial matters were made transparent to the general public but that's not what is being discussed, at least not by me. I am advocating transparency in the FEHBP PBM contracts only to OPM and my office, so that we can properly answer that basic question, "Deal or No Deal."

It should be noted that my office already has access to a large number of discount arrangements between carriers and health care providers. We routinely and confidentially review contract arrangements between carriers and health care providers, such as hospital chains, to ensure contract compliance. The ability of carriers to arrange discounts with health care providers has not been negatively impacted because my auditors review the contracts. In fact, in the few cases where we were contractually permitted to review some of the rebate agreements, no information regarding the rebate amounts negotiated by the PBMs has ever been disclosed by my office. Also, our office has not been notified by these PBMs indicating that their ability to negotiate rebates has been impaired. Maintaining and safeguarding all proprietary information is of paramount importance to my office.

As I discussed in my prior testimony, my office is participating in an OPM working group that is considering initiatives to strengthen the controls and oversight of FEHBP pharmacy programs. Based on what we've seen in the working group, we believe that good progress is being made.

It's my understanding OPM has adopted certain principles that will be incorporated into future FEHBP contracts with fee-for-service (FFS) carriers such as the BlueCross

BlueShield Association. These principles will require that PBMs pass all discounts, rebates and other financial incentives or payments through to the carriers, and that the PBM's only remuneration in connection with the contract is from the FEHBP carrier itself. In effect, the drug costs passed through the carrier would be based on the net cost of the drug plus a reasonable fee for the PBM's services (administrative fee). All relevant documents, including contracts with drug manufacturers, would be available to my office for audit.

If these principles are quickly and properly implemented by OPM, I believe most if not all of my concerns about the lack of transparency in the FEHBP PBM contracts will be resolved. However, as always, the devil is in the details. For example, without additional resources it is difficult to see how OPM will be able to fully implement these principles. Also, I am concerned that the existing PBM contracts may be allowed to continue for years before the new principles are incorporated. It may be more prudent to require the FFS carriers to comply with the principles no later than the 2012 plan year. Finally, I am concerned that the principles may be changed before they are incorporated into the FEHBP FFS contracts.

Now let me turn my attention to the proposed FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act. I do have some areas of concern regarding the Act, but first let me thank the Subcommittee for devoting so much time and attention to the issue of PBM transparency in the FEHBP. Thank you especially for your time and diligence to resolve this issue. I feel confident that the attention of the Subcommittee has focused the agency's interest and resources on this matter.

My first concern with the Act is of a philosophical nature. The more detailed a statute is the harder it is for the agency implementing the statute in a highly complex area such as this to adapt to changes occurring over time. All things being equal, it is often better to allow the agency room to exercise its discretion on how to structure the program. However, I understand the reluctance to give that discretion if it appears the agency is not doing enough to resolve the matter itself. In this case I know OPM hasn't been as quick as many hoped to address the PBM transparency issue. I hope that OPM now implements its proposed transparency and pass-through principles quickly and efficiently.

In addition, the Act does not distinguish between the different types of FEHBP carriers. FFS carriers operate very differently from community-rated HMO carriers. Imposing the same pricing and contracting rules on both is not appropriate. My concern on lack of transparency focuses on the FFS carriers since the full PBM cost is passed through to the Federal government and FEHBP subscribers. These plans comprise about 80 percent of the total cost of the FEHBP. Rate development for community-rated HMOs differs significantly from that of FFS carriers. The premiums for community-rated HMOs are based on what other similarly sized subscriber groups are paying for the benefits, not the actual cost of the benefits. The Act doesn't really fit the community-rated HMO model.

My next concern is the use of the average manufacturer price (AMP), which based on my understanding, sets a ceiling price for prescription drugs. The Act would also require that

OPM enter into master agreements with drug manufacturers to determine AMP. This will impose a great strain on OPM resources. In addition, while it is unlikely some drug manufacturers may choose to not enter into the master agreement, and thus could eliminate their drugs from reimbursement under the FEHBP. This would be detrimental to FEHBP enrollees.

AMP appears to be the same as the average manufacturer price that is required to be reported to the Secretary of Health and Human Services (HHS) before purchase of that drug can be reimbursed by Medicaid or Medicare Part D (HHS AMP). The Deficit Reduction Act of 2005 requires that HHS make the HHS AMP publicly available. My understanding is that HHS is currently enjoined from doing so because of a pending lawsuit. If the lawsuit is successful and HHS is permanently enjoined from making the HHS AMP publicly available, it would create significant additional expense and administrative burden for OPM under the Act.

Use of AMP as a ceiling price under the Act means that claim payments by PBMs will need to be compared to the AMP and, if higher, the price is adjusted to the AMP. Since OPM would be required to maintain the AMP, it would also be responsible for ensuring that this analysis is completed for each prescription drug claim payment. This would require a large increase in OPM resources, including a large sophisticated claims data processing system, and substantial expertise to make such adjustments. Alternatively, OPM could provide the AMP to the FEHBP PBMs to allow them to correctly compute the price. However, if the HHS AMP is not publicly available because of the lawsuit, the PBMs contracting with FEHBP carriers will have a competitive advantage over other PBMs that do not have contracts with FEHBP carriers because they will know the AMP of drugs.

Furthermore, the Act will potentially prohibit one of the largest PBMs from contracting with an FEHBP carrier because of the PBM's relationship with a major retail pharmacy chain. The FEHBP is based on competition. Prohibiting one of the largest PBMs from program participation is contrary to the concept of competition in the FEHBP and may result in a higher cost to the enrollees and the Federal government. This is not to say that the danger posed to the FEHBP by a PBM/retail pharmacy chain combination is non-existent. In a cost pass-through model, such as the one being considered by OPM, it is assumed the retail pharmacy cost incurred by the PBM is a cost negotiated with an independent third party without ties to the PBM. If the PBM and retail pharmacy are related, the structure would have to be ignored and costs of the PBM computed on the actual costs of the retail pharmacy purchasing the drug for resale.

I note in passing that there are many ways the relationship between a PBM and retail pharmacy or drug manufacturer under common control can be structured, but the Act only envisions a few. If this restriction on PBM ownership remains in the Act, broadening the possible ways the two entities can be under common control should be considered.

I also have several minor concerns. For example:

- OPM may not have the resources or expertise to determine maximum allowable dispensing fees.
- The heading "Civil Monetary Penalties" is confusing because the section deals with the False Claims Act rather than a Civil Monetary Penalty.
- The ability of PBMs to retain 1 percent of rebates may result in current discount arrangements being converted to rebates. Providing incentives to PBMs to reduce overall drug costs is an excellent strategy. However, legislation should be careful not to strictly limit incentive options.
- It is questionable whether interim final regulations can be issued within six months of enactment because of the complexity of the subject matter and the lack of agency resources.

Despite my concerns, the status quo must be changed. I believe that an amendment to the Federal Employees Health Benefits Act on PBM benefits can be beneficial, particularly if OPM does not quickly require FFS FEHBP carriers to enter into PBM contracts that require some sort of pass-through transparent pricing. A pass-through pricing model, in our opinion, would be easier to administer and fair to all parties.

The private sector and other public plans have also recognized this lack of transparency as a problem and are moving toward more transparent pricing and contracts. FEHBP enrollees and taxpayers must have confidence that FEHBP premiums are reasonable and fair, especially in times of premium increases. Without transparency in FEHBP PBM contracts, OPM can not give any assurances that the premiums are reasonable and fair.

Thank you again for inviting me here today. I would be happy to respond to any questions you may have.

Mr. LYNCH. Thank you, sir.

Representative Sharon Treat, I bid you welcome. You are now recognized for 5 minutes.

STATEMENT OF SHARON TREAT

Ms. TREAT. Thank you very much.

Chairman Lynch and members of the subcommittee, my name is Sharon Treat. I am an attorney, a Member of the House of Representatives in the State of Maine, and director of the National Legislative Association on Prescription Drug Prices, where I work with over 400 legislators who receive our electronic newsletter and provide information around the country on a variety of prescription drug legislation, but a good deal of it focused on pharmacy benefit managers.

I hope to provide a bit of a State perspective on H.R. 4489, which I wholeheartedly support, and also to offer a few suggestions which I think would improve the legislation and assure its effectiveness.

In 2003 I sponsored Maine's PBM law, which was the first in the country to very comprehensively regulate pharmacy benefit managers, imposing a fiduciary duty and requiring PBMs to disclose possible conflicts of interest and pass through to their clients, including the State of Maine and the State Employee Health Plan, the full monetary value of the rebates that they negotiate.

At least 18 States and the District of Columbia now require oversight and/or regulation of pharmacy benefit managers. These vary from very prescriptive legislation to fairly minimal registration provisions. The States are responding to the nearly absent Federal role regulating PBMs and the PBM business model that relies on secrecy, convoluted payment transactions that virtually no one can understand, and a model that is rife with conflicts of interest.

I note that the Maine legislation that I worked on I did with our then Attorney General, Steve Roe, at a time when we had a consent decree ongoing with Medco, which imposed many of the same provisions into the consent decree.

The Federal District Court decision which upheld the Maine law, which actually went all the way up to the U.S. Supreme Court, which denied cert, stated, I think particularly well, what the problems are with the PBM business model, and it addressed the advantages of regulation. The court stated: whether 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. This lack of transparency also has a tendency to undermine a benefit provider's ability to determine which is the best proposal among competing proposals from a PBM.

For example, if a benefits provider has 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 benefit providers, they also introduce a layer of fog to the

market that prevents benefit providers from fully understanding how best to minimize their net prescription drug cost.

I would note that H.R. 4489 appropriately addresses many of these issues, including drug switching, failure to pass through the value of rebates and other discounts, discriminatory practices toward independent pharmacies, and lack of transparency.

Based on the State's 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.

Nonetheless, I believe there is room for improvement in this legislation. One thing I would just parenthetically note, in reading through the background materials on this legislation, pharmacy costs making up 25 percent of this Federal health employee plan, the fee-for-service plan, is a very high percentage spent on pharmacy. It is really out of whack when you look at what the percentage is in other programs, other policies nationwide, in terms of a percentage of health care costs, and also Medicaid.

So specifically what I think this legislation should be doing, though, in addition is that I think that the conflict of interest provisions need to be tightened up. It is great that the legislation prevents conflicts that involve a controlling interest; however, there are many conflicts of interest built into the PBM business model which result in higher prices or have other negative impacts which don't rise to a controlling interest. At the very least, H.R. 4489 should explicitly require PBMs to disclose in writing "any activity, policy, or practice that directly or indirectly presents any conflict of interest." This is language currently in Maine law, so you won't be breaking any ground.

And then, in addition, we would ask that you consider adding a fiduciary duty provision to ensure that a PBM is actually acting on behalf of the plan. For example, Maine law requires a PBM to perform its duties with care, skill, prudence, and diligence in accordance with the standards of conduct applicable to a fiduciary in an enterprise of like character with like aims.

In conclusion, I commend the sponsor for tackling this important and rather difficult issue and taking a comprehensive approach. We look forward to working with you and making sure that comprehensive legislation is enacted that will cut the cost of prescription drugs for Federal employees.

Thank you.

[The prepared statement of Ms. Treat follows:]

N L A Rx
National Legislative Association
on Prescription Drug Prices

STATEMENT OF SHARON ANGLIN TREAT
MAINE STATE REPRESENTATIVE
EXECUTIVE DIRECTOR
NATIONAL LEGISLATIVE ASSOCIATION ON PRESCRIPTION DRUG PRICES

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

[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:

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[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.

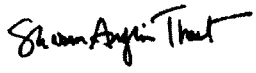
- ***Reasonable*** – This is the same standard that applies to real estate agents, lawyers, and even voluntary library board trustees – to carry out one's duty with care, prudence, and diligence and not to benefit one's personal interest. If we agree that it is unacceptable for a trustee of the local 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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Mr. LYNCH. Thank you, Representative.

Ms. Jasmin Weaver, you are now recognized for 5 minutes.

STATEMENT OF JASMIN WEAVER

Ms. WEAVER. Good afternoon, Chairman Lynch and members of the committee. My name is Jasmin Weaver, and I am the healthcare initiatives legislative director at Change to Win, a 6 million member partnership of five unions: SEIU, UFCW, Teamsters, the Laborers, and the Farm Workers. Four of our five affiliate unions represent Federal workers, and our members across the country are facing rising prescription drug costs, so we have a strong interest in improving the FEHBP and the PBM industry.

We are thrilled to be here today to voice our unqualified support for H.R. 4489. We believe this bill will save Federal workers and the Federal Government hundreds of millions of dollars, and we thank Chairman Lynch and the subcommittee for your work on this important issue.

This bill is necessary because, although PBM can provide a useful service, they are also in a position of trust that makes it possible for them to engage in a variety of troubling practices.

First, many PBMs provide virtually no transparency to the health plans that they serve, refusing to disclose such basic information, as you have heard today, as how much they pay for the drugs that they help to provide.

Second, some PBMs engage in spread pricing, charging the health plans they serve more for the drugs than they paid pharmacies that then distribute those drugs to patients.

Third, PBMs may also switch a patient's drug to a drug other than the ones their doctor prescribed, a drug more expensive for the health plan and the patient, because that PBM is getting rebates from drug manufacturers.

And, finally, some PBMs have merged with retail drug stores or drug manufacturers, creating serious conflicts of interest.

This bill addresses all of these problems. It totally enhances transparency, it bans spread pricing, it prohibits drug switching that is designed solely to enhance the profits of the PBM, and it reduces conflicts of interest in FEHBP drug contracting by extending OPM's current ban on PBM contracts that are with a PBM that is owned by a drug manufacturer, to also extend that ban to PBMs that are owned by retail drug stores.

By fixing these problems, this bill should significantly reduce drug costs for Federal employees and the Federal Government. Although the FEHBP is the largest employer-sponsored health plan in the country, and thus should receive the best prices, as you have heard today it is currently spending 15 to 45 percent more for prescription drugs than other Federal programs. Many other Government plans and private employers have saved millions by switching to more transparent PBM contracting. The Federal Government cannot afford to pass up these savings, as the FEHBP currently spends over $10 billion a year on prescription drugs for the FEHBP.

Change to Win recently released a report that further highlights the need for this bill. Our report focused on CVS Caremark, a PBM drug store combination that currently manages 80 percent of the

pharmacy benefit within the FEHBP. CVS offers a generic discount program that any person can sign up for. After paying $10, you get access to hundreds of generic drugs for $9.99. So we compared this $9.99 price to the price that Federal employees and the Federal Government pay under the Blue Cross/Blue Shield Federal employee program, which is the largest health plan within the FEHBP. What we found is that, remarkably, FEP members and the Government together pay more than $9.99 for 85 percent of the drugs on this discount generic list, and sometimes far more—up to $200 more for the exact same drug. Thus, FEP members and the Government are actually made worse off by using their insurance to buy these drugs.

This underscores the need for greater transparency in the FEHBP. It is hard to imagine that OPM and Federal employees would agree to this situation if they knew what they were really being charged. In fact, a recent poll of FEHBP members found that 74 percent of them think that more should be done to lower the cost of their prescription drugs, and 73 percent of plan members surveyed would support legislation to do this.

In conclusion, the reforms in this bill take the FEHBP a huge step forward, and that is why we wholeheartedly support it.

Thank you for your time.

[The prepared statement of Ms. Weaver follows:]

CHANGE to WIN

Testimony of

Jasmin Weaver
Healthcare Initiatives Legislative Director
Change to Win

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

Hearing on

H.R. 4489, "The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

February 23, 2010

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

My name is Jasmin Weaver and I am the Healthcare Initiatives Legislative Director at Change to Win, a six million member partnership of five unions: the Service Employees International Union, United Food and Commercial Workers International Union, International Brotherhood of Teamsters, Laborers' International Union of North America, and United Farm Workers of America. Four of our five affiliate unions represent federal workers, several hundred thousand in total, so you can understand why we have a strong interest in improving the Federal Employee Health Benefits Program's (FEHBP) contracting practices to ensure that federal employees get the best possible drug coverage at the best price. We also have a strong interest in reforming the pharmacy benefit management industry generally, because our members pay more and more for prescription drugs every year, and we think that reforming the FEHBP can make it a model for how to provide quality, affordable drug coverage.

Given these goals, we are thrilled to be here today to testify in support of H.R. 4489. We believe this bill will save federal employees and the federal government hundreds of millions of dollars, reduce conflicts of interest in FEHBP drug contracting, increase privacy protections for federal employees, and strengthen OPM's oversight of the FEHBP. The bill has our unqualified support, and we thank Chairman Lynch and the members of the subcommittee for your work on this issue.

Background on Pharmacy Benefit Managers (PBMs)

To make clear why this bill is necessary, let me provide a little background on how pharmacy benefit managers, or PBMs, operate. Health plans hire PBMs to manage their prescription drug benefits, and PBMs establish a network of pharmacies for distributing drugs, negotiate with pharmacies and drug manufacturers to establish drug prices, help determine which drugs will be covered by a health plan and which will not, and provide disease management and clinical programs. While PBMs can provide a useful service, they also are in a position of trust that can easily be abused.

One of the basic problems with PBMs is a severe lack of transparency, as many PBMs refuse to tell their customers how much they pay for the drugs they help provide. The OPM Inspector General has said that "the single most important issue which OPM must resolve is the fact that . . . the cost structures of the PBMs are utterly nontransparent."[1]

This lack of transparency causes many problems. For example, PBMs often charge the health plans they serve more for drugs than they pay the pharmacies that distribute those drugs to patients (this is above and beyond a per drug dispensing fee that the PBM pays the pharmacy).[2] This is known as "spread pricing." Nothing in current FEHBP rules prohibits spread pricing, and in 2005 Caremark, which manages 80% of pharmacy benefits for health plans within the FEHBP, paid $137 million—including $54.6 million to the FEHBP[3]—to settle a false claims suit brought by the government alleging, among other things, that Caremark's predecessor, Advance PCS, "devised elaborate schemes which paid pharmacies at a much lower rate than it in turn billed its customers, including government programs."[4]

PBMs also may switch patients to a drug other than the one their doctor prescribed, sometimes a drug more expensive for the health plan and patient, to take advantage of rebates the PBM receives from drug manufacturers, which can be hidden from the PBM's customers.[5] In a 2008 case brought by 28 states and the District of Columbia, Caremark paid $38.5 million to settle claims alleging a broad range of deceptive business practices, including drug switching and drug promotions to maximize payments from drug manufacturers.[6]

How Transparency Could Benefit the FEHBP

Greater transparency in the FEHBP's PBM contracts could save the government money. Although the FEHBP is the largest employer-sponsored health plan in the country,[7] and thus should receive the best prices, it spends 15-45% more than other federal programs for prescription drugs.[8] Many other large government plans have achieved savings through transparency requirements, including TRICARE and Medicaid,[9] and many states and large private employers have also saved millions by switching to more transparent pricing.[10] PBMs often cite Medicare Part D as a model drug benefits program, and argue that the FEHBP should not be changed because it operates in a similar way to Medicare Part D,[11] but a 2008 study by the House Oversight and Government Reform Committee found that if Medicare Part D paid the same drug prices as Medicaid, taxpayers would save over $156 billion in the next ten years.[12]

Change to Win recently released a report (attached) that further highlights the need for greater transparency in FEHBP PBM contracts. Our report, titled **CVS CAREMARK'S GENERIC RIP OFF**, demonstrates that CVS Caremark has failed to offer its lowest price on hundreds of generic drugs to the federal government and federal employees, even though the federal government is CVS Caremark's largest customer.

Specifically, we found that CVS Caremark offers lower prices on hundreds of generic drugs to people who simply sign up for its retail generic discount program than it does to the federal government and federal employees under the Blue Cross Blue Shield Federal Employee Program (FEP)—in fact, the total price for drugs to plan participants and the government (and thus taxpayers) was higher for 85% of the drugs on CVS Caremark's generic discount list. This is so hard to believe that it bears repeating in a different way: **for the vast majority of the drugs on CVS's generic discount list, a person with no insurance who joins its discount program pays *less* than a federal employee and the government together pay under the FEP; thus, when purchasing hundreds of generic drugs, FEP members and the government would actually be better off if they did not use their insurance and instead simply used the CVS generic discount program.**

The price differences involved here are often substantial. For example, CVS offers a 90-day supply of the antacid Ranitidine for **$9.99** through its discount generics program, but CVS Caremark charges FEP plan participants and the federal government up to **$217.74** for a 90-day supply of the same drug under the FEP plan. That is, the FEP price is more than twenty times the CVS generic discount price. Ironically, this same drug was at the center of improper drug switching allegations against CVS that led to a $37 million settlement in March 2008 with Attorneys General in 23 states, the District of Columbia, and the federal government.[13]

Our report suggests that if CVS Caremark charged the FEP and plan participants the same price it offers to members of its discount program for just **three** commonly prescribed drugs, federal employees and the government could save tens of millions of dollars every year. And if CVS Caremark offered its lowest price for generic drugs to the government for all the drugs that are part of its discount program, federal employees and the government could save hundreds of millions of dollars.

The price differentials revealed by our research point to a broader lack of transparency and accountability and underline the need for PBM reform in the FEHBP. It is hard to imagine that OPM and federal employees would agree to the situation I have described above if they knew what they were really being charged. Why is the government paying CVS Caremark to reduce its drug costs when CVS Caremark is failing to provide its lowest prices on generics at the retail pharmacies it owns?

The Benefits of H.R. 4489

This bill addresses all of the problems I have discussed: it prohibits spread pricing, it requires greater transparency, it bans drug switching that is designed solely to enhance profits for a PBM, and it should significantly reduce drug costs for federal employees and the government.

Moreover, the bill gives OPM greater power to audit and oversee FEHBP PBM contracts, which will make it easier for OPM to root out waste, fraud, and abuse in FEHBP contracts.

The bill also takes another key step: while OPM already prevents some conflicts of interest by refusing to hire PBMs that are owned by drug manufacturers, this bill would extend that ban to also cover PBMs that are owned by retail drugstores (and vice versa). PBM-drugstore combinations, such as CVS-Caremark, bring together two businesses that have inherent conflicts of interest. PBMs are supposed to save health plans money by negotiating lower drug prices with manufacturers and pharmacies, while drugstores are incentivized to drive plan participants into their stores to fill the maximum number of prescriptions and have little incentive to help save health plans money. By extending the existing ban on PBM-manufacturers to also cover PBM-drugstores, this bill will prevent these conflicts of interest.

I am sure you will hear opposition to this bill from some PBMs. Some may say that this bill will reduce their profits, reduce choice for consumers, or push up prescription drug costs. I can't deny that this bill will likely reduce PBM profits, but that is an inevitable result of getting a better deal for the federal government and federal employees. And the notion that this bill might reduce choice or increase prices by causing some PBMs to abandon the FEHBP is absurd. Many PBMs already operate under conditions similar to those imposed by this bill.

Argus Health Systems, which you will also hear from today, agrees to fully transparent pricing. Many other PBMs, including many that currently contract with the FEHBP, have agreed to some contracts that require transparency, pass through of rebates, and other rules similar to those contained in this bill. Even PBMs that are opposing the transparency provisions in this bill have demonstrated that they can do just fine when subject to rules like those in this bill. In fact, as a result of multi-million dollar settlements with the Departments of Justice and Health and Human Services for allegations that included misconduct in contracts with the FEHBP, both CVS Caremark and Medco, two of the largest PBMs operating in the FEHBP, are governed by consent decrees that address issues like spread pricing, drug manufacturer rebates, drug switching, and plan audit rights. If PBMs can comply with these consent decrees, they can also operate under the rules imposed by this bill. These consent orders will expire soon, enhancing the need for this legislation to permanently regulate these activities.

Some may argue that the reforms implemented by this bill go too far, and will cause too many disruptions in the FEHBP. But as I have just explained, many PBMs already operate under conditions similar to those imposed by this bill. More importantly, the government spends over $10 billion annually on prescription drugs via the FEHBP, so the notion that the potential savings achieved by this bill would not be worth the trouble it may cause doesn't hold water.

In conclusion, this bill would be a huge step in the right direction for the FEHBP. It could save federal employees and the federal government hundreds of millions of dollars, it will reduce conflicts of interest and opportunities for fraud, it will prohibit inappropriate drug switching, and it will give OPM greater power to audit and oversee FEHBP PBM contracts. These would be major achievements, and that is why we wholeheartedly support this bill.

Thank you for your time. I would be happy to respond to your questions.

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[1] Testimony by Patrick E. McFarland, Inspector General, U.S. Office of Personnel Management before the Subcommittee on the Federal Workforce, Postal Service, and District of Columbia on "FEHBP's Pharmacy Benefits: Deal or No Deal?" 24 June 2009.

[2] Garis, Robert I. and Bartholomew E. Clark. *The Spread.* Prime Therapeutics. "Prime Therapeutics Supports CMS Proposal to Limit Spread Pricing in Medicare Part D Administration"; Sipkoff, Martin. "PBMs Raise the Curtain." See also, Sipkoff, Martin. "PBMs Raise the Curtain"; *United States ex rel. Brown v. CaremarkPCS, Inc.*, No. 02-9236, E.D. Pa., 31 Mar. 2005 (Second Amended Complaint ("SAC")): at pp. 18-19; *SEPTA v. CaremarkPCS Health L.P.*, Amended Complaint: at p. 4.

[3] U.S. Office of Personnel Management, Office of Inspector General, Semi-annual Report to Congress, April 1, 2005 – September 30, 2005, pp. 13-14, available at <www.opm.gov/About_opm/reports/InspectorGeneral/pdf/OPMSAR33.pdf>.

[4] *United States ex rel. Brown v. CaremarkPCS, Inc.*, No. 02-9236, E.D. Pa., 31 Mar. 2005, SAC: at ¶51.

[5] U.S. Government Accountability Office. *Federal Employee Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies.* Report to the Honorable Byron L. Dorgan, U.S. Senate. GAO-03-196. Jan. 2003: at pp. 25-28, available at <http://www.gao.gov/new.items/d03196.pdl>; Martin, Steven S. "PBM Industry Today: Who's Managing Drug Costs?"; see also: *State of Ohio v. Caremark Rx, L.L.C.*, Complaint: at p. 5; *United States ex rel. Brown*, SAC: at p. 11; Drury, Susan. "Drug Pushing."

[6] Miller, James P. "CVS Caremark settles deceptive-practices complaint for $38.5 million: Deceptive practices alleged by 28 states." *Chicago Tribune.* 15 Feb. 2008.

[7] U.S. Office of Personnel Management Website at <http://www.opm.gov/insure/health/reference/handbook/fehb01.asp>.

[8] Welcome Packet for the U.S. House of Representatives Subcommittee on the Federal Workforce, Postal Services and District of Columbia Forum. "Prescribing the Right Solution: A Discussion on Improving FEHBP's Drug Benefit." September 2009: at p. 3.

[9] A 2007 U.S. House of Representatives Report found that drug manufacturer rebates negotiated by the government reduce Medicaid drug spending by 26%, and that the Department of Veterans Affairs (VA) negotiates average manufacturer drug discounts of 50%. In addition, a 2008 GAO report on TRICARE's prescription drug benefit program found that the program not only benefits from Federal Supply Schedule pricing to get the best price for drugs, but has also achieved significant savings since 2005 by leveraging its uniform formulary, avoiding about $450 million in drug costs in 2006 and $916 million in 2007. See: U.S. House of Representatives, *Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage.* Majority Staff, Committee on Oversight and Government Reform, Oct. 2007: at pp. 9-11, available at <http://oversight.house.gov/documents/20071015093754.pdl>; U.S. Government Accountability Office, *DOD Pharmacy Benefits Program.* Report to Congressional Committees. GAO-08-327. Apr. 2008: at p. 4, available at <http://www.gao.gov/products/GAO-08-327>.

[10] For example, in August 2009 the State of New Jersey announced that it would enter into a new contract with Medco Health Solutions to provide pharmacy benefits for approximately 670,000 state employees, dependents, and retirees. CVS Caremark previously managed the $1 billion annual contract with Horizon Blue Cross Blue Shield. The new contract is projected to save the state $559 million over five years through a transparent, pass-through pricing model. The state decided on the pass-through option because it "satisfies dual goals of attaining the greatest cost savings while achieving transparency in a time when that keyword is paramount to business operations in the public sector." See State of New Jersey, Department of Treasury, Purchasing Bureau. "Award Recommendation, Employee Benefits: Pharmacy Benefit Management, Reference Number: 10-X-20899, T2679." 4 Aug. 2009. For savings from transparent contract, see pp. 3-4, and p. 46. In addition, in June 2009 New York's Metropolitan Transportation Authority voted to end its relationship with CVS Caremark and expects to save $50 million under a new PBM contract with Innoviant. In its Request for Proposals, the MTA placed a priority on transparent pass-through pricing and financial guarantees. MTA Staff Summary Report on Contract Number 0819983 with Innoviant, Inc., at p. 2. See also Wessel, David, Bernard Wysocki Jr., and Barbara Martinez. "As Health Middlemen Thrive, Employers Try to Tame Them." *The Wall Street Journal.* 29 Dec. 2006: at p. A1.

[11] Testimony by Mark Merritt, President & Chief Executive Officer, Pharmaceutical Care Management Association before the Subcommittee on the Federal Workforce, Postal Service, and District of Columbia on "FEHBP's Pharmacy Benefits: Deal or No Deal?" 24 Jun. 2009.
[12] U.S. House of Representatives, *Medicare Part D: Drug Pricing and Manufacturer Windfalls*. Majority Staff, Committee on Oversight and Government Reform. Jul. 2008: at p. 10.
[13] Won Tesoriero, Heather, and David Armstrong. "CVS Caremark Reaches Settlement"; *United States ex rel. Lisitza*, Settlement Agreement: at p. 5.

Mr. LYNCH. Thank you.

Mr. Boehm, you are now recognized for 5 minutes.

STATEMENT OF JONATHAN BOEHM

Mr. BOEHM. Good afternoon, Chairman Lynch and members of the subcommittee. Thank you for inviting me to testify today.

Again, my name is Jonathan Boehm, and I am president and CEO of Argus Health Systems. Argus is one of the largest pharmacy benefit administrators, processing over 500 million claims in each of the last 4 years. This total includes a significant portion of Medicare Part D. We process 24 percent of all Part D claims in the United States. We process claims for customers with 5 million Part D members and 25 million commercial members.

Our business model, however, is very different than many of our competitors. We generally offer services on a fee-for-service, fully disclosed, auditable basis. We refer to our model as a transparent model, and we have been doing business this way since 1999.

To provide context regarding transparency in the pharmacy benefit, let me define what I mean by transparency. David Calabrese stated in the May 1, 2006, issue of Managed Care Executive, "True transparency is a model in which all PBM revenue streams are fully disclosed to the payer, the full value of retail and mail order pharmacy discounts is passed on to the client, data is shared with the client, and the client is given ultimately decisionmaking control over its drug benefit design and formulary management." At Argus we embrace this business model and this definition.

In our transparent model we provide fully auditable access to data, enabling our customers to comprehensively manage their business for the benefit of their members. Consistently our customers have told us when they transitioned to our model from a traditional PBM they save 8 to 10 percent on their drug spend day one.

Our customers achieve generic dispensing rates of well over 70 percent, compared to mid-60 percent industry averages, because access to their data enables them to make more-informed decisions and work with providers and members to achieve the desired expense and health outcomes.

Another difference in the Argus transparent model is that we do not own a mail order facility or drive members to mail order; rather, we support 90-day prescription strategies that support mail order and 90 days at retail, whatever method the member deems most convenient for them. This is a significant difference from PBMs that own mail order and drive utilization to this distribution method, regardless of member preference.

There clearly are divergent views regarding the impact of transparency on managing the pharmacy benefit. This committee has heard and I have reviewed testimony from both sides of the argument. After reviewing available Federal-Government-related material, it is clear there is no consensus regarding the impact of transparency on ultimate cost. There have been reports of estimated increased costs, unknown impact on cost, and the CBO recently scored the Cantwell transparency amendment as budget neutral.

The position that the disclosure of sensitive price information would negatively impact negotiating leverage of pharmaceutical

manufacturers and pharmacies appears to be predicated on the premise that this information would be generally available for public consumption. This bill clearly treats this information as confidential and could only be used by OPM, and I think invalidates the premise that it would raise costs.

The final point that I would make regarding the importance of transparency is I would suggest that it is more important in the pharmacy benefit management than even in other industries, and that is because the products and services are not procured at a specific price but rather a pricing construct. Without visibility into the true cost and rebate arrangements, the pricing construct cannot only not be validated or audited, but it is invalid by the premise that it is based on the unknowable.

The Inspector General, Patrick McFarland, testified before this committee in June and reiterated again today that the single most important issue which OPM must resolve is that PBMs are utterly non-transparent. He went on to say that we find the absence of transparency to be deeply troubling.

In conclusion, it is my view that effective management of pharmacy benefits is fundamental to reducing prescription drug costs and improving the quality of health care outcomes in both the public and private sector. Effective management of this benefit is dependent on transparent access to the relevant information.

Chairman Lynch, it is my view, given our customers' experience as well as my research into the issues, that your proposed legislation will be beneficial to OPM by enabling them to have access to information so better decisions regarding health care costs and outcome management can be made on behalf of the Federal employees and ultimately the taxpayers. The confidentiality provision that you have included will mitigate the risk that disclosure of sensitive price information will result in increased costs to administer prescription benefits.

Thank you.

[The prepared statement of Mr. Boehm follows:]

ARGUS™

Testimony of
Jonathan J. Boehm

PRESIDENT & CEO
ARGUS HEALTH SYSTEMS, INC

Before the United States House of Representatives Committee on Oversight and Government Reform
Subcommittee on Federal Workforce, Postal Service, and The District of Columbia on

The Federal Employees Health Benefits Program (FEHBP)
Prescription Drug Integrity, Transparency, and Cost Savings Act

February 10, 2010

Introduction

Good morning Chairman Lynch, Ranking Member Chaffetz, and Members of the House Committee on Oversight and Government Reform. Thank you for inviting me to testify today. Chairman Lynch, I also would like to applaud your introduction of H.R. 4489, the FEHBP Prescription Drug Integrity, Transparency and Cost Savings Act. This legislation would provide the Office of Personnel Management (OPM) with the oversight it needs to be able to more effectively manage the prescription drug benefits for FEHBP beneficiaries.

I am Jonathan Boehm, President and CEO of Argus Health Systems, based in Kansas City, Missouri.

Argus is one of the largest pharmacy benefit administrators processing over 500 million claims in each of the last four years. This total includes a significant portion of the Medicare Part D claims nationally. In 2008, we processed 20% of the claims volume for Part D. We currently process claims for 50 customers with 5 million plus Medicare Part D members and 25 million commercial members. Argus supports some of the largest and most sophisticated health plans in the country as well as smaller to mid-size health plans. We have contracted with over 66,000 pharmacies in our pharmacy network, and we support CMS' access requirements for Part D customers.

Our business model, however, is different than most of our competitors'. We generally offer services in a cost-effective fee-for-service, fully disclosed and auditable manner. We refer to our model as a transparent model, and we have been doing business this way since 1999.

I am not here today to go into detail about our competitors' business model. I will tell you that I think effective management of the pharmacy benefit is dependent upon transparent access to relevant information. Transparency allows an understanding regarding sources of payments made to a PBM on behalf of a health plan and is critical to managing the benefit. I believe that Pharmacy data belongs to whoever is paying for the benefit. Your proposed legislation supports greater transparency in the pharmacy benefit and therefore should help the OPM control prescription drug spending within the FEHBP.

Definition of Transparency

To provide you context regarding transparency in the pharmacy benefit, let me further define what I mean by transparency. I like the definition of transparency that David Calabrese stated in the May 1, 2006 issue of *Managed Care Executive*. He wrote, "Transparency is a form of business practice involving full disclosure of costs and revenues, allowing the customer to make more well-informed decisions regarding purchases. In the PBM industry, transparency lays the groundwork for more simplified PBM-client business relations, more accurate financial modeling and performance metrics

and a greater comfort level among PBM consumers. 'Transparency,' however, is a relative term used freely in the marketing efforts of many PBMs. The genuine commitment to transparency lies in the actual business practices the PBM invokes to support this claim. 'True transparency' is a model in which all PBM revenue streams [drug-level rebates, funding of clinical programs, administrative fees, service fees, management fees, research/educational grants, etc.] are fully disclosed to the payer; the full value of retail and mail order pharmacy discounts is passed onto the client; data is shared with the client; and the client is given ultimate decision-making control over its drug benefit design and formulary management. It is this commitment to true transparency which has begun to differentiate newer PBMs."[1] At Argus, **we embrace this definition and business model.**

Argus' Transparency Model

In Argus' transparent model, we provide data to our customers in support of their business. As an example, our customers receive unaltered claims data as submitted by the Pharmacy. This fully auditable access to data enables Argus' customers to comprehensively manage their business for the benefit of their members. Consistently, our customers have told us that, when they transition to the Argus model from a traditional PBM business model they receive a reduction in prescription drug expense of between 8% to 10% on Day 1. After implementation, they have the information and tools to manage their annual drug spending trend 1% to 3% below the published industry data that suggests the annual drug spending trend is between 3% to 6% annually[2]. The cumulative impact of the decrease in trend is financially more significant than the initial savings. We believe that these differences are the result of the fact that our customers own and have full access to their data. This allows them to have the information they need to manage the prescription drug expense on behalf of their members more effectively while still maintaining quality outcomes.

Interestingly, by implementing an Argus model, our customers achieve a generic dispensing rate of over 70% versus low to mid 60% industry averages[3] because access to their data enables them to make informed decisions and to work with providers and members to achieve desired expense and health outcomes.

Another difference in Argus' transparent model is that we do not own a mail order facility or drive members to mail order. Rather we support 90-day prescription strategies for mail order AND at retail pharmacies through whichever method that the member deems is the most convenient for them. This is a significant difference from PBMs that own mail order facilities and drive utilization to this distribution method regardless of member preference.

Other Views of Transparency

There are clearly divergent views regarding the impact of transparency on managing the pharmacy benefit. I have considered the views of others who take the position that transparency in the

pharmacy benefit model will raise the cost of prescription benefits, and I have come to a different conclusion. If one reads the available federal government related materials[4], it is clear that there is not a consensus regarding the impact of transparency on ultimate cost. This committee has heard, and I have reviewed, the testimony from both sides of this argument. The argument that the disclosure of sensitive pricing information would negatively impact negotiating leverage with pharmaceutical manufacturers and pharmacies appears to be predicated on the premise that this information would be available for public consumption. This bill clearly treats this information as confidential and it can only be utilized by OPM, thus invalidating the premise.

There have been numerous governmental reports that have estimated increased cost, unknown impact on cost and the CBO recently scored the Cantwell transparency amendment as budget neutral. Rather than debate the assumptions in the various reports, I thought it would be constructive to review observations from other industries.

In retail markets, it is well documented that transparency drives down costs. There are articles written to help companies determine how to combat the affects of transparency. The Harvard Business Review published a report entitled, "Cost Transparency: The Net's Real Threat to Prices and Brands," by Indrajit Sinha, a Washburn Research Fellow at the Fox School of Business, Temple University. In his article, he wrote, "Cost transparency threatens both retailers and manufacturers." He goes on to write, "Sellers have a natural interest in keeping their costs opaque to the outside world...Buyers, on the other hand, have a natural interest in knowing a seller's costs for a product or service – after all, they want to know if they are paying a fair price for what they are receiving." Mr. Sinha also notes that "Cost transparency severely impacts a seller's ability to obtain high margins." In this article, he attempts to help companies understand the negative impact that cost transparency may have on their businesses. He reviews actions companies can take to mitigate the impact of cost transparency including bundling services to keep buyers from seeing or determining the cost of individual items. An example he provides is that Gateway Computers bundles its internet service and computers to combat plunging computer prices.[5] It is evident when one reads his article that cost transparency results in lowering prices and reducing margins. While pharmacy benefit management is much different than the retail market, it is also clear that bundling valuable services and keeping costs opaque to the outside world are strategies employed by many PBMs.

The final point regarding the importance of transparency is that I would suggest that it is more important in pharmacy benefit management than other industries, because the products and services are not procured at a specific price but rather a pricing structure. Without visibility into true costs and rebate arrangements, the pricing construct can not only not be validated or audited, but is invalid by the very premise that it is based on the unknowable.... The inspector General of OPM, Patrick McFarland, testified before this committee in June that "...the single most important issue which OPM must resolve is that PBMs are utterly nontransparent. This means that there is no objective basis

whether the terms being offered to an FEHB carrier by a PBM represent an advantageous arrangement... we find the absence of transparency to be deeply troubling..."[6]

Conclusion

In conclusion, it is my view that the effective management of pharmacy benefits is fundamental to reducing prescription drug costs and improving the quality of Health Care outcomes in both the public and private sector. Effective management of this benefit is dependent upon transparent access to the relevant information. Transparency allows understanding regarding the magnitude and sources of payments made to a PBM on behalf of a health plan and is critical to managing the pharmacy benefit. The baseline issue is that the pharmacy claim data "belongs to" whoever is paying for the benefit. This is significant because a health plan sponsor has the inherent right to full transparency of all pricing related data communicated between the PBM and the Pharmacy. Since the data is owned by the health plan sponsor, it means that the PBM cannot use this data for any purpose for which they have not been authorized. True Transparency must include the payments to pharmacies mentioned before, the payments from pharmaceutical manufacturers and the business processes regarding formulary management and drug switching. Any action that improves transparency for OPM and other payers will help curtail the rising prescription drug costs in the Federal Employee Health Benefits Program.

Chairman Lynch, it is my view given our customers' experience as well as my research into this issue that your proposed legislation will be beneficial to OPM by enabling it to have access to information so better decisions regarding pricing and outcomes management can be made on behalf of federal employees and ultimately the taxpayers. The confidentiality provision that you have included will mitigate the risk that the disclosure of sensitive pricing information will result in increased costs to administer prescription benefits.

Endnotes

1 David Calabrese "The new PBM: PBMs step up as leaders call for true transparency", *Managed Care Executive*, May 1, 2006.
http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=322942

2 The drug trend figures were published in the 2009 Drug Trend Reports for CVS/Caremark, p 4, ExpressScripts, p 3 and Medco, p 20 based on 2008 data.

3 Lawrence W. Abrams, Ph.D., "De-Capitation: Express Scripts' Unspoken Plan for its Wellpoint PBM Acquisition" White Paper, May 11, 2009.

4 Sources include: CRS Report for Congress, *"Does Price Transparency Improve Market Efficiency? Implications for Empirical Evidence in Other Markets for the Health Sector"*, D. Andrew Austin and Jane G. Gravelle, April 28, 2008; Congressional Budget Office, "Cost Estimate: S 1, Prescription Drug and Medicare Improvement Act of 2003," page 15. July 22, 2003; US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004.

5 Indrajit Sinha, *"Cost Transparency: The Net's Real Threat to Prices and Brands"*, Harvard Business Review, March-April 2000, pp 43-50.

6 Testimony of Patrick E. McFarland, *"Statement of the Honorable Patrick E. McFarland, Inspector General U.S. Office of Personnel Management before the Subcommittee on the Federal Workforce, Postal Service and District of Columbia, on FEHBP's Pharmacy Benefits: Deal or No Deal?"*, June 24, 2009.

Mr. LYNCH. Thank you, Mr. Boehm.
Mr. Beck, you are now recognized for 5 minutes.

STATEMENT OF RICHARD BECK

Mr. BECK. Good afternoon, Chairman Lynch and members of the subcommittee. My name is Richard Beck, and I am testifying here before you today on behalf of the National Community Pharmacists Association in support of H.R. 4489. NCPA represents the interests of pharmacists, owners, managers, and employees of more than 22,700 independent pharmacies across the United States. We appreciate the opportunity to address the topic of pharmacy benefits management regulation. I am also executive director of the Texas Pharmacy Business Council, which represents approximately 1,700 community pharmacies in Texas.

Today I will share with you the reasons we support this bill, as well as some of our experiences and lessons learned from our PBM advocacy activities in the State of Texas.

Both NCPA and TPBC have long championed the need for both Federal and State oversight of pharmacy benefit managers. That is because our members and their patients continue to face significant problems in dealing with these unregulated entities. PBMs have been permitted to operate virtually unchecked since their inception, slowed only by the increasing amount of litigation alleging fraudulent and deceptive practices filed against the PBMs each year, including the Federal Government.

First I would like to speak in support of H.R. 4489, a crucial piece of legislation that would provide OPM with greater insight into the inner workings of the various PBMs that currently manage the prescription drug benefits for FEHBP. That is a tough one, isn't it, Mr. Chairman. We strongly support H.R. 4489 for many reasons. It would require the reporting and pass-through of the rebates that PBMs receive from manufacturers. It would expose some of the questionable practices that PBMs frequently engage in, including repackaging and assigning different reimbursement rates for drugs dispensed by their own mail order pharmacies.

It would prohibit PBM ownership of retail pharmacies, thereby eliminating the inherent conflicts of interest that results in higher costs and impaired quality of care. One has to look no farther to justify this prohibition than looking at the anti-competitive and anti-consumer activities exhibited by the CVS Caremark Corp. merger.

Let me now talk about our experiences in the State of Texas and how our legislature and Governor have been supportive of PBM transparency in State contracts.

A few years ago the State of Texas concluded that the disclosure of the business practices of PBMs in their dealings with government entities is essential to ensuring that the government entity is receiving high-quality, cost-effective services. In 2006, a joint legislative committee issued a report that detailed many of the questionable drug prices used by the PBMs and recommend the State take steps to ensure that they were getting the most bang for their buck with regard to PBM services. Representative Treat testified before that committee.

The State auditor followed up with its own study in 2008 and delved more deeply into the specific PBM contracts held by various State agencies. The results of the study clearly indicated that the State agencies needed to include in all future PBM contracts provisions that clearly specified the costs, discounts, and other fees associated with services provided by the PBM, as well as provisions that would preserve their ability to audit the PBM.

In 2009, after several years of considering various pieces of legislation, the legislature passed PBM transparency legislation. The passage of Senate Bill 704 now enables Texas State agencies to share the terms and conditions of their PBM contracts with other State agencies, as well as grant them full audit rights over those contracts. In Texas we plan to pursue followup legislation to buildupon the 2009 legislation.

The Texas PBM studies and consideration of related legislation has provided an invaluable education to State legislators and decisionmakers, alike, about the need for PBM regulation, and has had a positive impact on the content and terms of subsequent PBM contracts to the State of Texas.

The Texas State Employees' Retirement System, who initially, along with CVS Caremark, opposed the 2007 PBM transparency legislation in Texas, recently reported that the terms of their contract include many of the elements of that legislation, including 100 pass-through of rebates, and is projecting a $260 million savings over 4 years.

Curiously, although CVS Caremark has apparently agreed to these contract provisions, they and other large PBMs still continue to oppose legislation to recognize these same principles in State and Federal law.

In conclusion, I strongly urge you to pass the bill before you today. The PBM industry, as they have done in Texas, is likely to use scare tactics in an effort to convince you and the American taxpayers that transparency may be harmful and expensive and that they require secrecy to administer the drug benefits of FEHBP. There is simply no credible evidence that transparency has increased costs or will do so in the future.

I urge you to reject this paradoxical reasoning and insist that OPM be afforded the disclosures necessary to negotiate a fair contract in order to curb unnecessary prescription drug spending.

Thank you.

[The prepared statement of Mr. Beck follows:]

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

Statement of

Richard Beck
Executive Director, Texas Pharmacy Business Council
Austin, Texas

on behalf of

National Community Pharmacists Association (NCPA)

Hearing on

H.R. 4489, the *FEHBP Prescription Drug Integrity, Transparency and Cost Savings Act.*

United States House of Representatives
Committee on Oversight and Government Reform
Subcommittee on Federal Workforce, Postal Service, and the District of Columbia

Tuesday, February 23, 2010

THE VOICE OF THE COMMUNITY PHARMACIST

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Statement of the National Community Pharmacists Association (NCPA)
United States House of Representatives Subcommittee on
Federal Workforce, Postal Service, and the District of Columbia
H.R. 4489, the *FEHBP Prescription Drug Integrity, Transparency and Cost Savings Act.*

Chairman Lynch, Ranking Member Chaffetz and Members of the Subcommittee. My name is Richard Beck and I am testifying here before you on behalf of the National Community Pharmacists Association (NCPA) in support of H.R. 4489. NCPA represents the interests of pharmacist owners, managers and employees of more than 22,700 independent community pharmacies across the United States and we appreciate the opportunity to address the topic of Pharmacy Benefits Management (PBM) regulation.

NCPA has long championed the need for both federal and state oversight of pharmacy benefit managers (PBMs) due to the problems our members and their patients continue to face in dealing with these unregulated entities. PBMs have been permitted to operate virtually unchecked since their inception—slowed only by the increasing amount of litigation alleging fraudulent and deceptive business practices filed against the PBMs each year.

I am also the Executive Director of the Texas Pharmacy Business Council. This is a new organization that is a collaborative effort between American Pharmacies, an independent buying co-op and the Academy of Independent Pharmacists--Texas and we represent approximately 1700 community pharmacies in Texas. As an organization, we have been strong advocates for PBM transparency legislation in our state legislature, and I will share with you in my testimony today, some of our experiences and lessons learned from our advocacy activities.

First I would like to speak in support of H.R. 4489, a crucial piece of legislation that would provide the Office of Personnel Management (OPM) greater insight into the inner workings of the various PBMs that currently manage the prescription drug benefits for the 270 different FEHBP health plans. Armed with this vital information, the federal government would be able to make more informed decisions about the services—and the true costs of such services—that are being provided by the PBMs to the FEHBP, and in turn, federal employees.

The state of Texas has conducted two studies examining the value of transparency in PBM contracts and has concluded that the disclosure of the business practices of PBMs in their dealings with government entities is essential to ensuring that the agency—be it state or federal—is receiving high quality, cost effective services from their PBM.

We strongly support the following highlights of the bill:

Requiring Reporting and Pass Through of Manufacturer Rebates: This bill would grant OPM access to crucial data including reports on the rebates collected from manufacturers. It would require that PBMs disclose and pass through 99% of rebates and other compensation earned on behalf of plan members. This will prohibit PBMs from amassing excessive profits at the expense of patients, federal employees and the Federal government, while retaining market incentives for PBMs to negotiate the highest rebates possible.

Exposes PBM Mail Order "Gaming": We also support the provisions of the bill that would expose the games that PBMs play by using different reimbursement bases for prescriptions dispensed by mail order pharmacies compared to retail pharmacies. Using repackaged drugs in many cases, PBMs assign their own price to these mail order drugs.

This enables the PBMs to "play the spread" to the detriment of plan sponsors and patients alike. This practice gives the illusion that they are giving better discounts to FEHBP plans, when, in fact, the base price may be artificially inflated. Because of undisclosed lucrative manufacturer rebates, PBMs have strong incentives to push higher-cost brand drugs through their own mail facilities, rather than lower-cost generics.

Assures Patients Receive Necessary Medications: The bill will also ensure that beneficiaries receive the prescription drugs actually prescribed to them by their physician. It would prohibit the PBM from "drug switching"-- requiring patients to take an alternate drug for which the PBM receives a significant rebate -- unless the change is approved by the provider and results in actual savings to the plan and ultimate consumer.

Prohibits PBM Ownership of Retail Pharmacies: This bill would eliminate the conflicts of interest that are inherent when a manufacturer exerts a controlling interest in a PBM or when a PBM owns a controlling interest in a retail pharmacy. Nowhere is the need for a prohibition on this type of ownership more apparent than in the recent CVS Caremark merger.

This PBM monolith is a primary provider of pharmacy benefits to the FEHBP program. The Federal Trade Commission (FTC) recently opened an investigation of the anti-competitive and anti-consumer practices of this PBM, which have been well documented through hundreds of examples collected by pharmacists and patients. The bill would also prohibit the PBM from forcing participating pharmacies into certain contract terms as a condition of participating in a particular pharmacy network.

Texas PBM Studies Indicate Need for Transparency and Oversight

In the past few years, the state of Texas conducted two separate studies that have examined PBM business practices and the need for transparency and accountability in PBM contracts. In December 2006, Lieutenant Governor David Dewhurst called for an interim study of PBM issues by a joint committee made up of members of the State Affairs and Health and Human Services Committees in the Texas Senate.

This body issued a report detailing many of the questionable drug pricing practices used by the PBMs and recommended that the state take steps to ensure that they were getting "the most bang for their buck" with regard to their pharmacy benefit management services. The joint committee specifically recommended a closer examination of state PBM contracts to ensure they were truly delivering the cost savings promised to the state. The joint committee also recommended the consideration of legislation that would prohibit unnecessary delays in dispensing prescription medications to consumers and prohibit abusive auditing of pharmacies by the PBMs.

In response, the Texas State Auditor's Office conducted a study of state PBM contracts and issued a report in 2008 entitled, *Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions*. This report looked at the PBM contract agreements entered into by the Teacher Retirement System, the Employees Retirement System, the University of Texas System and the Texas A&M system.

The results of this study clearly indicated that the state agencies needed to ensure that their PBM contracts did not unduly restrict their rights to audit the PBM and that the contracts needed to clearly specify costs, discounts and other fees associated with the services provided by the PBM to ensure that the agencies clearly understood the true costs and discounts associated with their plans. This report also went on to specify that state PBM contracts should clearly specify whether any "drug switching" would be permissible, the steps that would be taken to protect the personal data of plan members and whether the PBM would be permitted to sell any form of plan data. The report indicated that the PBM should disclose any policies, practices or business relationships that could conflict with their obligations to the plan sponsor.

Texas PBM Legislation Had Significant Positive Effects on Patients and Generated Savings

During the 2007 Texas legislative session, H.B. 3454, a PBM transparency bill that bears a striking resemblance to H.R. 4489-- currently under consideration before you-- passed both House and Senate Committees and the full Senate but ultimately failed due to time constraints.

This bill would have required 100% pass through of manufacturers rebates to state plan sponsors, the disclosure of any conflicts of interest, the protection of confidential plan member information and full audit rights for plan sponsors. This bill enjoyed bipartisan support but was vigorously opposed by the PBM industry who claimed that such transparency would surely raise costs.

Building on the concepts enumerated under the 2008 Report, and the legwork that had gone into the 2007 legislation, the Texas Pharmacy Business Council worked with a Texas Representative to introduce H.B. 4596 in 2009. This bill would have implemented the Texas State Auditor's recommendations by establishing uniform contracting criteria for PBM services, thereby significantly improving the negotiating position of the state and benefitting taxpayers.

This bill was poised to pass the House easily but was derailed due to a constitutionally mandated end of session. When it became apparent that the bill would not have sufficient time to pass, the Texas State Business Council turned to SB 704, a limited PBM transparency bill that sprang from the same 2008 Texas State Auditors Report. We were able to amend some elements from H.B. 4596 into this bill which ultimately did pass. This bill allows Texas state agencies to share the terms and conditions of their PBM contract with other state agencies as well as grants the agencies full audit rights.

In Texas, we plan to pursue follow-up legislation to build upon the transparency bill that we were able to pass in 2009. Specifically, we hope to pass legislation with many of the same provisions that you have before you in H.R. 4489. In addition, we plan to include provisions that would protect pharmacies from unfair auditing practices by the PBMs and that is something that we would recommend could also be added to H.R. 4489. We are hopeful that H.R. 4489 could set a standard and serve as an example for all future state PBM transparency legislation.

The two PBM studies conducted by the state and the various pieces of related legislation that have been considered have had a positive impact on content and terms of subsequent PBM contracts in the state of Texas and have provided an invaluable education to state legislators and decision makers about the critical need for PBM regulation. The Texas State Employees Retirement System (ERS), who initially along with CVS Caremark opposed the 2007 PBM legislation, has reported that they have incorporated the elements of that legislation (including the 100% pass through of rebates) in their PBM contract with CVS Caremark and were projecting a $260 million savings over four years. Curiously, although CVS Caremark has apparently agreed to these contract provisions, they and the other large PBMs continue to oppose state and federal legislation to recognize these fundamental principles in state and federal law.

The measures included in H.R. 4489 are all ones that have been recognized by the Texas state agencies and legislators that we have worked with as critical to ensuring that the government entity, and in turn the taxpayers, are receiving a fair return on their investment.

Also, passage of this bill would ensure a degree of consistency in all of the PBM contracts that fall beneath the FEHBP. This is a concept that was recommended by the Inspector General's Office of OPM in their testimony before this committee in June of 2009. In addition, the Texas bill that recently passed the state legislature promotes this same contract coordination in that it permits state agencies to share details of their PBM contracts with other state agencies.

Areas for Further Discussion

The current language in the bill establishes that the amount that the carrier plan may pay a PBM for a prescription drug may not exceed the drug's average manufacturer price (AMP). The use of AMP as a pricing benchmark for the carrier, and in turn the pharmacy provider, is problematic for community pharmacies. If AMP were to be used it would need to be significantly redefined and increased in such a way that truly reflects the retail pharmacy acquisition cost of a prescription drug, as well as updated to be a more real-time benchmark. However, we understand the Committee is willing to discuss this aspect of the bill and we remain confident that a compromise benchmark can be reached that will satisfy the needs of all parties. Also, we suggest that the committee consider including some provisions to protect pharmacies from the egregious and aggressive auditing practice of PBMs.

Conclusion

In conclusion, I strongly urge you to pass the bill before you today. The PBM industry—as they have done in Texas-- is likely to use scare tactics and attempt to convince you and the American taxpayers that transparency could be harmful and expensive and that they "need" secrecy to administer the drug benefits for the federal government. There is simply no credible evidence that transparency has increased costs. In fact, evidence suggests to the contrary. I urge you to reject this paradoxical reasoning and insist that OPM be granted the disclosures and necessary terms to ensure a fair contract to curb unnecessary prescription drug spending. Thank you for your leadership and for the opportunity to testify at today's important hearing.

Mr. LYNCH. Thank you, Mr. Beck.

I want to thank you all for your very helpful testimony. Let me begin. I yield myself 5 minutes.

It is confounding, at best, to listen to the arguments of some of the opponents of this bill to say that, as they have in the past, that transparency is over-rated, and that somehow if we let people know what things cost, then prices are going to go up.

Ms. Treat, you have been terrific in offering some very helpful suggestions to improve our legislation, and we really do appreciate that. Let me ask you, you hit right on the point of fiduciary responsibility, and putting fiduciary responsibility on our PBMs so that their duty is clear and the duty is enforceable on the part of the subscriber, in this case the Federal employee.

How do you see this conflict that we have here, at least in the case of CVS Caremark, where we have the PBM owned—the PBM which I believe even now, without the legislation, has a duty to the Federal employee to get the best price, while at the same time they are owned by a pharmacy chain that is trying to drive people in the door to maximize profit, which is clearly a fine and noble and capitalistic motive, but it seems, at least to me, that those interests are in conflict. I think that your suggestion of imposing a fiduciary responsibility on the part of the PBM gets right at that conflict. Could you offer your own thoughts on that?

Ms. TREAT. Yes. Thank you for the question.

I sponsored the legislation back in 2003. It took several years in and out of the courts, actually, and it was the fiduciary provision that was litigated, and it related to ERISA plans, something you don't have a problem with in this case. Nonetheless, we won that litigation. But that bill came out of a similar situation involving a drug manufacturer, Merck, which at that time owned MedCo, and so you had a conflict of interest between a manufacturer with whom the PBM was supposedly negotiating good discounts and rebates on behalf of whoever hired them and a drug company, which had an appropriate goal of maximizing its profits.

I think that there is a very similar problem now where you have retail pharmacies and PBMs which also their ownership overlaps.

We see now that one of the fastest growing segments of the pharmaceutical drug spend is for specialty drugs, and there is a real effort on the part of a number of entities to get into that market and to have controlling or partial interest in the specialty drug pharmacy area. There are a number of areas where there could be conflicts of interest that would perhaps dissuade a PBM from perhaps negotiating the toughest deal they could with those entities.

Mr. LYNCH. Right.

Ms. TREAT. I think the reason that I am really recommending looking at the language that you use in asking for disclosure on conflicts of interest and perhaps having something of a catchall provision with the fiduciary language is that we cannot know today what new business models are going to be dreamt up tomorrow.

Mr. LYNCH. Right.

Ms. TREAT. We often know that legislation that we pass and regulation that we pass end up, a response is, well, what is a good way to get around that to do something different. I think the value of the Maine language is that it is designed to not enumerate every

single possible conflict of interest in advance, but to have general enough language that, if something arises in the future, it will be addressed.

Ms. TREAT. Right. That is great. Thank you very much.

My time is pretty much expired. I was neglectful, however, in failing to recognize the gentleman from California, Mr. Bilbray, earlier for an opening statement and questions, so, Mr. Bilbray, you are recognized.

Mr. BILBRAY. Thank you, Mr. Chairman.

Just curiosity, Representative Treat. What is the population of Maine today, just for my own information?

Ms. TREAT. It has been hovering around 1.3 million for the past decades, many decades.

Mr. BILBRAY. Thank you. Everybody keeps moving out and coming over to visit us in San Diego. Just shows you how the shift has gone. Our county is 3.5 million, but the population the way it shifts, I am just trying to remember the sizes here. As a local legislator, I am interested in a lot of how these work and how the process works through different levels.

Mr. LYNCH. I thank the gentleman.

The Chair recognizes the gentlelady from the District of Columbia, Ms. Eleanor Holmes Norton, for 5 minutes.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. McFarland, you have in your testimony some claims costs per member. You note them increasing almost twice the amount paid in 1999. Compared to what? How would that compare to claims costs for other programs? Are there figures that would allow us to measure those increases? You say, for example, drug costs increase is an average 13.5 percent. That is cost as opposed to claim cost per member. But in either case, how do those compare with those not in a program like the prescription drug program of the FEHBP? Mr. O'Brien.

Mr. O'BRIEN. In terms of the pharmacy cost for the FEHBP program compared to other programs that would exist, one issue that needs to be clear is it was stated earlier that the FEHBP share of pharmacy spend compared to a large private employer appears very high. That is always the case, because the FEHBP program includes the coverage of Federal retirees, which a typical private program would not.

Ms. NORTON. The Federal program is what?

Mr. O'BRIEN. The Federal program includes Federal retirees, in which case most of their costs are, in fact, drug costs, so our percentage of drug costs relative to a large company——

Ms. NORTON. Most of whose costs are drug costs? I am sorry?

Mr. O'BRIEN. Most Federal retirees, those who are over 65.

Ms. NORTON. Oh, because of retirees?

Mr. O'BRIEN. So our drug cost——

Ms. NORTON. Wasn't that true for many programs, retirees as well as current employees are in the same program?

Mr. O'BRIEN. The FEHBP program is somewhat unique in that when you look at our total costs, the retiree cost is with all the other costs in there, so the statement that our pharmacy spend as a percentage is very high is really comparing apples and oranges.

Ms. NORTON. I see. Since they are all in the same program.

Mr. O'BRIEN. Yes.

Ms. NORTON. I understand. I am somewhat confused by your testimony, Mr. McFarland, because it seems to say let us do it, we are doing it, but there is a section of the testimony where it does say that we will need some legislation, and you seem to oppose legislation mostly because there were administrative costs, which leads me to ask what about the administrative costs that are built into what OPM does with FEHBP.

Mr. MCFARLAND. Well, my understanding of——

Ms. NORTON. I mean, are you, in fact, doing what the Lynch bill does, perhaps stimulated by the Lynch bill? Or do you concede that we do need legislation?

Mr. MCFARLAND. As I said in my testimony, the previous testimony that is on record and the shortened version that was made today, is that I would suggest that what OPM is presently doing—and that is that they are identifying the principles that are very important to making transparency happen—that those principles per se be considered to be put in the legislation that we are presently discussing. So in no way did I say that we shouldn't have legislation.

Ms. NORTON. So you are saying it is important enough to have them and to have them in statutory language?

Mr. MCFARLAND. Well, and my particular reason for suggesting that is that if, by chance, the direction is given to OPM to be an integral player in the health reform act, then I think that so much could fall between the cracks, and if it is in legislation I think that probably would be very helpful to maintain its priority.

Ms. NORTON. In DOD and VA, are there multiple plans to choose from, as with FEHBP?

Mr. MCFARLAND. No, I don't believe that they have the same program that we do.

Ms. NORTON. I am sure they don't, but I am saying they buy as a single customer. I am asking that, for those who subscribe, is there one plan and only one plan for DOD and for VA?

Mr. MCFARLAND. Well, I think the DOD and the VA have different approaches to their prescription drugs than what we are talking about for the FEHBP.

Ms. NORTON. Mr. Chairman, I realize my time is up, but I do need to know whether or not——

Mr. LYNCH. I will give you another 2 minutes.

Ms. NORTON. Thank you.

I do need to know if veterans, if the largest part of the bureaucracy, the DOD, maybe they are so different that they really are apples and oranges. If so, I would like you to explain.

Mr. MCFARLAND. Well, the DOD and the VA, they each have their separate plans.

Ms. NORTON. I understand. Staff says—is it VA that has three or four plans?

Mr. MCFARLAND. They have regional plans, like four regional.

Ms. NORTON. What I am trying to find out, if they have multiple plans, is—and perhaps this information could be transmitted to the chairman. I am wondering how they do transparency, how they assure.

Mr. MCFARLAND. Well, I am not sure at all that they are able to identify transparency.

Ms. NORTON. Well, then, I would ask you to find out. That is to say I am very bothered by the fact that such a large percentage of the prescription drug dollar is, in fact, in another section of the Federal Government. I simply want to know if there is something we can learn from them or if we are reinventing the wheel here. And, if so, then that has to be the case.

Mr. O'Brien.

Mr. O'BRIEN. Congresswoman Norton, thank you. Again, urged on by this committee, OPM staff has, in fact, met with DOD and the individuals who run the Tri Care program to try and learn about how their pharmacy program works. It is much more of a single contract for pharmacy benefits that they run nationwide with separate regional sub-contracts. Again, we are actively studying it, and we have had some very good feedback from the Tri Care folks, and it is a very interesting model that we are learning a lot more about.

Ms. NORTON. And you think that some of that model may be transferrable to some of what you are trying to do today?

Mr. O'BRIEN. Again, we are actively studying that, as well as the other options that were offered by this committee in its forum in September. We haven't completed our analysis, but we are actively looking at it, and when we have completed it we look forward to working with you more on those issues.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. O'BRIEN. But thank you, Tri Care is a very useful model for us to look at.

Ms. NORTON. I thank you, and I thank you, Mr. Chairman, for the additional time, because it is becoming more and more difficult, given the scarcity of Federal dollars, for us to rationalize different treatment of large sections of the Federal budget for essentially the same purpose.

Thank you, Mr. Chairman.

Mr. LYNCH. I thank you.

I yield to myself 5 minutes.

Mr. O'Brien, part of your testimony is more than a little disappointing, I think, for us in that previous testimony from OPM has been of a similar vein. At one point one of the witnesses from OPM said that "transparency is over-rated." That is a tough thing for an oversight committee to hear.

We are intensely interested in getting to the bottom of what costs actually are for our health care system, and I know that you came out with a very positive carrier letter yesterday, though, in advance of this hearing. Sometimes I feel like I am pulling you folks along toward the road of reform, and I just wish we were working more closely together trying to get to the same object, and that troubles me somewhat, and I am concerned that the agency has become captive to the current system and is resistant to change.

As you heard Mr. McFarland say, the most troubling aspect of the current FEHBP program is the utter lack of transparency, how it is so opaque and so complex. We are not mapping the genome here. We are selling pharmaceuticals to Federal employees. In my other capacity on the Financial Services Committee, I am dealing

with complex derivatives, currency to fall swaps, credit to fall swaps, financial engineering that is increasingly and incredibly complex. It pales in comparison to what we have going on here in selling pharmaceuticals to Federal employees.

That is all we are doing here, and we have this construct that is just mind boggling and mind numbing. I think that is exactly why it was constructed the way it is, to resist change. It resists the threat of being understood by its complexity. We are trying to drill down and straighten this up. We need your help. We really do.

This current system, we have just got to blow it up and get rid of it and get on to something else, because this is not working for the American taxpayer. I think the estimate that Ms. Weaver has put out there of several hundred millions of dollars in savings, that is probably conservative, what I see here.

I think it is probably closer to $1 billion what we can save. In light of the difference in formularies that we pointed out here this morning, what we are paying, we have 8 million participants and we don't use that collective clout, that buying power, at all in our systems, and we allow these PBMs to really abuse what I think is honorable service by our Federal employees. We are just letting them take advantage of us, and we cannot do that any more. Our budget will not allow it. So we have to find some savings, and if we are looking for waste, fraud, and abuse, the FEHBP is a target-rich environment because of the arrangements that we have going on here.

This stinks. If I was a hound dog, I would be pointing right here. Here is where some savings are. Here is where some waste, fraud, and abuse is going on and I know it, and we are trying to dig down and get at it.

We can save the taxpayer a ton of money. We could bring a more competitive model and better serve. We have wonderful Federal employees. I am an advocate for Federal employees. They do wonderful work. They provide a valuable public service. We cannot let this go on. This is just unacceptable. We can't do this any more.

So I am really looking for your help. I know we have a new Director over there, Mr. Berry, who is on the right. He is part of the solution. He is not part of the problem, he is part of the solution. But we have some inertia over there. Inertia, at best, and then resistance, at worst, and we have to get at it.

Since I am the chairman and there are no other witnesses, I am going to extend myself another 5 minutes.

Let me ask you, Mr. Boehm, you have been terrific on this and you have a unique perspective. In terms of transparency, you addressed this in part in your original testimony about the concern that has been raised by the PBMs that if people know what they are paying for then prices will go up and it will destroy competition, but can you talk a bit more about your own experience, and also about some of the protections in the bill so that this is not publicly available information that would undermine their competitive advantage?

Mr. BOEHM. The argument, as I understand it, they put forth is that if the information is publicly available that the competitors, the manufacturers, and the other chains would actually increase their prices because they would have more information available.

It is a difficult argument to debate because it is not publicly available now. In many other industries I think we have seen transparency lowers costs, not raise it.

But rather than debate that particular topic, I think the most important thing is you have provisions in your bill that make it only available for OPM's use. It is not posted on Web sites, so the manufacturers can't see what the deals are, so I don't think there is any risk in the way you have constructed your confidentiality that it would be publicly available information.

And then I would question, even if it was publicly available, whether that really would increase costs, because, again, I think you can go through a number of retail markets. You can look at computers on the Internet. You can look at cars as more transparent pricing information has been made available. Costs generally go down in those environments. But rather than debate the economic principle, I think you can just protect them against the disclosure of the information.

Mr. LYNCH. OK. Mr. Beck, you mentioned that your experience in Texas, $260 million in 4 years. We have 8 million participants. What is the size of the market there?

Mr. BECK. Mr. Chairman, I am not real sure. I know it is extremely large. I think that estimate is low. I agree with you. I think that the estimate is a little short at half a billion. I think it is over a billion.

Mr. LYNCH. Yes.

Mr. BECK. One thing I wanted to mention. Back in 2002 there was a lawsuit brought by the FEHBP and I believe the mail carriers, I was reviewing it this morning, against Advance PCS, which is——

Mr. LYNCH. Was that Mail Handlers?

Mr. BECK. Mail Handlers. Yes, sir.

Mr. LYNCH. OK.

Mr. BECK. Advance PCS, which is now no longer. It was bought by CVS Caremark. And out of that was $179 million settlement. In addition to that, there were provisions in the settlement that was a 5-year requirement for transparency standards to be followed. That has now expired. So basically, your legislation just extends that Federal lawsuit settlement and puts it in legislation that has to do with all PBM contracts.

Mr. LYNCH. Yes. Thank you.

Ms. Weaver, I think you mentioned some of this in your testimony about drug switching and the abuses. You laid out that very cogent analysis between what folks were paying for that formulary, the $9.99 comparison. Can you drill down that a little bit and elaborate on that analysis that you came up with?

Ms. WEAVER. Absolutely. So essentially, what we did is we took CVS's generic discount program, which is a list of over 300 drugs that they offer for $9.99. As everybody said today, it is very hard to figure out what drugs cost, right, so you need a baseline to figure out if you are getting a good deal. So one of the reasons we decided to look at this is this is a baseline. It is the walk-up price. You pay $10 to join this program, and anybody can get access to 300-plus generic drugs for $9.99.

So what we wanted to do was look at Blue Cross/Blue Shield's FEP program. It is the largest plan within the FEHBP. We can compare the prices that the Government and those Federal employees are paying for every single one. We tested every drug on that list. What we found, as I mentioned, was that 85 percent of the drugs on the list cost the Federal Government or Federal employees—and/or, sometimes both. It depends on the cost structures—more than that $9.99 price. So it was a little bit——

Mr. LYNCH. So the people with insurance are paying more than the people without insurance?

Ms. WEAVER. Exactly, for 85 percent of the drugs on the list.

Mr. LYNCH. How wacky is that?

Ms. WEAVER. It is pretty wacky.

Mr. LYNCH. Yes. Unbelievable.

Ms. WEAVER. And we have heard from Federal employees that actually don't use their insurance when they go into a retail store because they know that they can get a better deal. That is pretty absurd, as well, because those people are paying premiums that are supposed to give them prescription drug coverage.

Mr. LYNCH. Right. They are paying premiums.

Ms. WEAVER. It is really sad.

Mr. LYNCH. And the American taxpayer is paying 72 percent of that plan, in addition to what the user is paying. So that is what has me absolutely furious over what is going on here.

Mr. McFarland, I appreciate your work on this. This has been tough, and you have expressed at earlier hearings your frustration in being able to determine what we are getting for our money and whether there is an advantage here being had by the Federal Employees Health Benefits Plan and its 8 million participants in our arrangement with these PBMs. Is there anything that is not in the bill that you think might help your position in terms of understanding what is going on behind the scenes and the real cost between all these relationships, the commissions, the rebates, and that whole relationship between manufacturers and PBMs and pharmacies, as well?

Mr. MCFARLAND. No, Mr. Chairman. I don't think that there is anything in particular that should be additionally placed in the bill. I think it is very complete as it is. That doesn't mean that there might not be, after further deliberation, some more thinking about add-ons. But at this point I wouldn't say anything specific. What we are dealing with, I think, your bill clearly covers.

If I can, let me make a point on something that was presented to me earlier today when we were discussing, as we have been for a few weeks, preparing for the testimony today.

Mr. LYNCH. Please.

Mr. MCFARLAND. This is just a little excerpt from the audit staff, what they noticed after the large provider agreement was brought into effect, I think in 2005, and that simply meant to us that we were able then to get into those PBM contracts. But as it turned out, it was only in a compliance mode. We still could not get to where we needed to be with that large provider requirement. And my understanding of large provider agreement was simply whoever ends up paying at least 5 percent, then they would consider large

provider. Of course, the prescription drugs, 25 or more percent. So that was an easy identification there.

But here is what was given to me. This is from the audit staff. We have noticed a distinct shift in how the PBMs have contracted with FEHBP carriers. What we saw as pass-through pricing initially with administrative fees and rebates returned, did a complete 180 degrees. After the large provider agreement, the contracts became based on a percentage off of the average wholesale price for the drugs, with no administrative fees charged and the PBM keeping most, if not all, of the rebates.

Because the drugs are priced off a percentage of AWP, our audits consisted of verifying the price charged to the FEHBP; however, we could not compare that price to the actual price paid by the PBM.

Mr. LYNCH. Right.

Mr. MCFARLAND. So it was just obvious——

Mr. LYNCH. Yes. I understand what they are doing there. The average wholesale price is a moving target. It means something different to everybody, so you don't have a solid benchmark there by which you can make that determination.

What we are actually looking for here is the actual price.

Mr. MCFARLAND. Yes.

Mr. LYNCH. How much the actual cost is and how much we are being charged. That is all we want to know. We just want a fair deal. That is all. And one we can understand on behalf of the people that we represent, and we can't get there with the way this thing is working right now.

Mr. MCFARLAND. Well, we presently receive confidential proprietary information from the PBMs as a data base on prescription claims, and we protect that with our heart and soul.

Mr. LYNCH. Yes.

Mr. MCFARLAND. We make sure that is as safe as possible in our particular environs. But then, on the other hand, they are saying, "But you don't need to see our financial records, but we can give you the personal identification information of our claims people." So it is saying one thing and doing another.

Mr. LYNCH. That is right. That is exactly right. Some of the information that is being sold out there and marketed is quite detailed, so it is counter-intuitive that they can't give it to you in a form that you can use.

All right. I think you people have suffered enough. I want to thank you on behalf of the committee. We have a lot going on here today. As you know, there are a few major hearings going on here. I want to thank you for coming before this committee and helping us with our work. I would like the opportunity to continue to work with you.

Look, I am not saying that our legislation is perfect. Not by any means. That is why we are having this hearing and that is why we are trying to get input from you. I think actually you have all been helpful in making this legislation better. We appreciate your testimony and your help with this. We are going to allow Members who may have had questions to offer you inquiries that you will, if you are willing, would have to have you respond in writing within 5 days if Members so choose. But other than that, I want to

thank you for your attendance today and you are free to go. Thank you.

Can we ask our third panel to come up?

Good afternoon. I am sorry if we have delayed you with the length of the previous panels. I do appreciate your attendance here.

It is the custom of this committee to swear all witnesses who are to offer testimony, so could I please ask you all to rise and raise your right hands?

[Witnesses sworn.]

Mr. LYNCH. Let the record indicate that all of the witnesses each has answered in the affirmative.

As with the previous panel, we will offer a brief introduction before we ask witnesses to offer testimony.

Mr. Daniel Adcock is currently legislative director of the National Active and Retired Federal Employees Association. Before going outstanding that Association, Mr. Adcock worked for the House Committee on Education and Labor's Subcommittee on Employment Opportunities and its Subcommittee on Human Resources and was an Executive Assistant to the Assistant Secretary for Aging, Jeanette Takamura.

Dr. Jacqueline Simon is the public policy director for the American Federation of Government Employees [AFGE]. AFGE watches over the rights of some 600,000 Federal and D.C. Government employees. An economist by training, Ms. Simon has worked to protect the interest of Federal employees at AFGE for over 20 years.

Ms. Colleen Kelley is the president of the National Treasury Employees Union, the Nation's largest independent Federal sector union, representing employees in 31 different Government agencies. President Kelley, a former IRS revenue agent, was first elected to the union's top post in 1999.

I do want to add my condolences and that of the committee. We understand, Ms. Kelley, the incident last week where your colleagues' offices were attacked in Austin, TX. I am aware that your organization suffered a loss of Vernon Hunter, a Social Security Administration Manager who was killed in that attack in Austin, so our prayers are with your members and especially the Hunter family. I understand they had six kids, and I know that Mr. Hunter's wife also is an IRS employee, as well.

Ms. KELLEY. Yes.

Mr. LYNCH. That makes it even more difficult, but we do offer our condolences in that respect and we appreciate the fact that you were down there helping with those employees. I know we had quit a few injured, as well.

Mr. John E. Calfee is a resident scholar at the American Enterprise Institute for Public Policy Research who studies the pharmaceutical industry and the Food and Drug Administration. He previously worked at the Federal Trade Commission Bureau of Economics, and has also taught marketing and consumer behavior at the Business Schools of the University of Maryland at College Park and Boston University.

Mr. Larry McNeely is a U.S. Public Interest Group's health care advocate, advocating the organization's Federal level advocacy, communication, and organizing on health care reform. Mr. McNeely lobbies Congress for legislation that will tame rising health care

costs and offer consumers better choices in the health care marketplace.

As was indicated earlier, the little box there in front of you will be green when you should be speaking, yellow when you should think about wrapping up, and red when you should stop offering testimony.

Mr. Daniel Adcock, you are now recognized for 5 minutes.

STATEMENTS OF DANIEL ADCOCK, LEGISLATIVE DIRECTOR, NATIONAL ACTIVE AND RETIRED FEDERAL EMPLOYEES; JACQUELINE SIMON, PUBLIC POLICY DIRECTOR, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; COLLEEN KELLEY, NATIONAL PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION; JOHN CALFEE, RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE; AND LARRY MCNEELY II, HEALTH CARE ADVOCATE U.S. PIRG

STATEMENT OF DANIEL ADCOCK

Mr. ADCOCK. Chairman Lynch, I appreciate the opportunity to testify. I am Daniel Adcock, legislative director of the National Active and Retired Federal Employees Association.

Two important issues to our membership are access to the latest in pharmaceutocology technology and ways to manage the costs associated with life-saving and life-enhancing drugs.

Under the expected technological revolution in medicines, 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 means drugs will be more likely to treat our ailments while mitigating side effects and drug interactions.

Many women suffering from breast cancer had been prescribed tamoxifin have already been the beneficiary of this new age of medicine. This is only the beginning.

The medicine bottle 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 family member may be able to know if the bottle was opened and your daily dose removed.

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

The role the PBM will play in this evolutionary change will only become more critical in providing access to cutting-edge drugs while containing costs. Transparency and oversight will become even more important. We can accept the cost of advanced drugs as long as we can be assured that 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 enrollees. We are pleased that H.R. 4489 tackles this issue.

We are heartened to see that the President's budget emphasizes and continues the responsibility of OPM's Inspector General in auditing reprimand benefits and the role of 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 more information from carriers as they contract with PBMs for their services. Let us hope this brings further information to OPM and the beneficiaries.

Drug pricing is very complex. With the 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.

Still, OPM is not alone in seeking greater transparency. In fact, human resource professionals outside Government are developing transparency standards to ensure the PBMs are sharing manufacturer rebates and negotiating the lowest possible cost of specific drugs. This experience could be helpful to OPM.

It appears that some of what has been proposed in H.R. 4489 could be implemented under OPM's regulatory authority. For that reason, 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.

Still, we strongly believe that nothing should be left to chance regarding OPM's ability to access PBM information. 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 information from OPM or the Congressional Budget Office on cost savings, formulary development, and administrative costs that might arise from such regulatory or legislative initiatives. Beyond H.R. 4489 we believe that the FEHBP plan should buy prescription drugs for enrollees at the discount mandated by the Federal supply schedule. However, if the FSS were to be used, FEHBP plans must have the option of buying off-formulary medications.

NARFE would also support your proposal to designate FEHBP PBMs as subcontractors under Federal acquisition rules.

We commend you for your interest in fair prescription drug pricing in the FEHBP, and we look forward to working with you on this issue. Your prescription for the future of our health insurance program is a welcome addition, and we thank you for your effort.

[The prepared statement of Mr. Adcock follows:]

STATEMENT BY
DANIEL C. ADCOCK
LEGISLATIVE DIRECTOR
NATIONAL ACTIVE AND RETIRED FEDERAL EMPLOYEES ASSOCIATION

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

National Active and Retired Federal Employees Association
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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.

Mr. LYNCH. Thank you, Mr. Adcock.
Dr. Simon, you are now recognized for 5 minutes.

STATEMENT OF JACQUELINE SIMON

Ms. SIMON. Chairman Lynch, thank you very much for the opportunity to testify today.

Focusing on the operations of pharmacy benefit managers is an excellent place to begin improving the affordability of FEHBP, since the costs they impose are a big cause of the program is continuously rising prices and its lack of affordability for so many of our members.

Although AFGE strongly supports H.R. 4489, I would like to focus my statement today on one provision of the bill that, if altered slightly, could have a significant impact on the cost of FEHBP. Specifically, that provision involves limiting the prices that PBMs can charge to FEHBP carriers. The maximum price for prescription drugs in the bill it says would be an amount that is equal to the average manufacture price for the drug as disclosed by the manufacturer. However, given the size of FEHBP, AFGE believes that the Government and plan participants should receive the full advantages of their purchasing power, and that means a better bargain than average prices.

The PBMs may be currently 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. We would recommend limiting these prices 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, the General Services Administration [GSA], delegates authority to negotiate these prices and has done so for DVA. There is no reason why the same authority could not be extended to OPM with regard to FEHBP, but it would be far more efficient for OPM to simply use the VA prescription drug pricing schedule.

We have heard the arguments from the organized pharmaceutical industry that extending statutory pricing schedules to additional Federal health care 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 all call their bluff. 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 still save money. FEHBP is large enough that a substantial decrease in its drug prices could offset retaliatory price increases that the drug companies might try to impose.

A final concern involves pricing transparency, which has been discussed a lot here today. AFGE believes that in order for the legislation to have meaningful price transparency, the requirements of TINA, the Truth in Negotiations Act, should be applied to the program. Both FEHBP carriers and PBMs utilized by the carrier should be required to make available to Government agencies all

cost and pricing data relating to the purchase or reimbursement of prescription drugs by these entities. They provide it to other Federal agencies in other contracting situations, and there is no reason they shouldn't be required to provide that same data in this context.

In addition, AFGE believes that the application of cost accounting standards 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 fiscal year 2011 budget proposal 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 percent of FEHBP's costs and will total $11 billion next year. The benefits of more thorough auditing should be substantial.

Requiring FEHBP carriers and the PBMs to adhere to the cost accounting standards will give the OPM IG the tools it needs to carry out these audits in a way most advantageous to taxpayers and enrollees.

This concludes my testimony, and I would be happy to answer any questions you may have.

[The prepared statement of Ms. Simon follows:]

STATEMENT BY

JACQUELINE SIMON
PUBLIC POLICY DIRECTOR

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE SUBCOMMITTEE ON THE FEDERAL WORKFORCE, POSTAL SERVICE, AND THE DISTRICT OF COLUMBIA

HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

REGARDING

FEHBP PRESCRIPTION DRUG INTEGRITY, TRANSPARENCY AND COST SAVINGS ACT

FEBRUARY 23, 2010

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.

Mr. LYNCH. Thank you, Dr. Simon.

President Kelley, you are now recognized for 5 minutes.

STATEMENT OF COLLEEN KELLEY

Ms. KELLEY. Thank you very much, Chairman Lynch.

I am here on behalf of NTEU members who participate in FEHBP and diligently pay their ever-rising premiums for health insurance only to receive reduced coverage and higher co-pays and coinsurance costs for their prescription drugs. We were very pleased to participate in the subcommittee's drug pricing forum last September that aptly highlighted the incongruity in FEHBP, a program with one of the largest enrollee pools of 8 million people, as we have heard, yet one that gets the worst prescription drug prices in Government.

H.R. 4489 takes a giant step forward in addressing the problems of why OPM has been unable thus far to better leverage what should be a significant advantage. According to OPM's Inspector General, as we have heard, the cost structures of the pharmacy benefit managers in FEHBP are utterly non-transparent. Because the contracts cannot be audited properly under the current system, OPM does not have all of the information it needs to make any substantive improvements. Common sense dictates that U.S. taxpayers, and especially FEHBP enrollees, who saw their premiums rise roughly by 9 percent this year or 15 percent if they were a single enrollee in the popular Blue Cross/Blue Shield standard plan, deserve better than that.

H.R. 4489 says if a PBM and carrier want to participate in FEHBP, certain conditions need to be met. NTEU supports this approach and the accompanying goals of transparency and accountability.

A tentative transparency and accountability is increased disclosure. Just as the administration calls for greater disclosure in Government through information and data sharing by Federal agencies and individuals, it is only fitting for these billion dollar private companies who make a profit from Government business to become more transparent through disclosing relevant information, as well. If PBMs want to participate in FEHBP, they should be held accountable, as H.R. 4489 proposes to do.

Therefore, NTEU supports section 2(H) of the bill, which would allow OPM to access information on arrangements that PBMs have with manufacturers and pharmacies. The range of information that OPM would have available through these kinds of disclosures would include corporate-wide rebate reports, rebate allocation methodology, benchmark pricing, and various fees at different stages. These will all put the agency in a position to better do its job. We are not advocating public dissemination of proprietary information, but we are advocating disclosure to OPM as needed so it can monitor the Federal program.

We also support the bill's approach to prescription drug rebates in section 2(C) and believe the language could be clarified even further to improve FEHBP. PBMs were originally intended to handle administrative functions associated with drug claims; now PBMs negotiate for discounted drug rates and receive hidden payments

and rebates from manufacturers, as well as other fees and payments from carriers.

Under section 2(C), with 99 percent of rebates and fees being returned to the insurance carriers, NTEU would also recommend additional clarifying language to ensure that the funds recaptured will be dedicated to the FEHBP program and be used to keep enrollee costs down, as we understand, DOD's Tri Care health plan does. Under Tri Care, rebates are put back into the insurance program and the PBM receives an administrative fee for services.

NTEU also believes the consumers protections in H.R. 4489 are a very positive step, the ones on drug switching and on selling claims data and on timely explanation of benefits. The PBM does not know what is best for patients, so the drug switching issues should go away, and the only way that should be able to occur is with appropriate medical input. We support an end to that practice.

Now, on selling claims, while we question the practice of selling FEHBP claims data at all, at a minimum OPM's concurrence should be a part of that process.

On EOBs, FEHBP enrollees will benefit from this added disclosure of prescription drug costs, enhancing their ability to choose the best plans for their needs.

Finally, NTEU would support adding language to H.R. 4489 to provide a pilot test of statutory pricing. We have long believed that OPM should investigate the possibility of buying prescription drugs off of the Federal supply schedule, as we have heard that the VA and Defense do. Their drug prices are substantially lower than FEHBP. Ten years ago I testified before Congress in favor of a small pilot that OPM had approved for the SAMBA health care plan to allow access to the Federal supply schedule for its mail order drug program. SAMBA argued it could save 3 percent annually in enrollees' premium shares by directly buying from the Government. Overall savings would have been $2.4 million annually, and that was back in 2000 dollars.

Despite OPM's approval, the pharmaceutical industry, whose profits 12 years ago were estimated at $26 billion, pulled out and they refused to participate in the plan. NTEU would support a demonstration project to examine hard numbers associated with the direct purchase of drugs through the FSS and we would support adding a provision to H.R. 4489 to make that happen. I believe this approach offers a real opportunity for cost savings.

I thank you for the opportunity to testify today and will be glad to answer any questions.

[The prepared statement of Ms. Kelley follows:]

NTEU
The National Treasury Employees Union

Testimony of

Colleen M. Kelley
National President

National Treasury Employees Union

House Subcommittee on Federal Workforce, Postal Service and the District of Columbia
House Oversight and Government Reform Committee

On

H.R. 4489, the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act

February 23, 2010

Chairman Lynch, Ranking Member Chaffetz, and members of the Subcommittee, I appreciate the opportunity to appear before this distinguished subcommittee on the important issue of prescription drug pricing in the Federal Employees Health Benefits Program (FEHBP). As president of the National Treasury Employees Union (NTEU), representing more than 150,000 federal employees in over 31 different agencies and departments throughout the government, I am here to say we have a direct interest in ensuring that enrollees in FEHBP – whether currently working or retired – continue to have access to the prescription drugs and health care coverage they need, at affordable prices. I hear from NTEU members on a regular basis who diligently pay their ever-rising premiums for health insurance, only to receive reduced coverage and higher co-pays and co-insurance costs for their prescription drugs.

Chairman Lynch, I want to commend you for introducing H.R. 4489, along with Representatives Cummings and Connolly. Your bill addresses one of the root causes of the rising costs of insurance premiums – skyrocking prescription drug prices – and the accompanying out-of-control process for obtaining drugs in the FEHBP program. The Subcommittee's June 24th hearing, and the subsequent Drug Pricing Forum last September, aptly highlighted the incongruity of having one of the largest enrollee pools –8 million people –yet obtaining the worst prescription drug prices in government. FEHBP falls behind Medicare, Medicaid, DOD, the VA and others. NTEU was pleased to participate in last September's forum to help find innovative solutions to this dilemma and we are here today to pledge our continuing commitment to work with the subcommittee.

H.R. 4489 takes a giant first step toward containing costs in FEHBP. The transparency and controls proposed by your bill show enormous promise in bringing openness and sense to a process that is surrounded by secrecy and needless confusion, a process I will discuss later in this testimony. Similar transparency language was approved in both the House and Senate comprehensive health reform bills that are pending before Congress.

We were happy to see language in the Administration's FY 2011 budget calling for continued audits of FEHBP's prescription drug component by OPM's Office of the Inspector General (OIG), including oversight of pharmacy benefits managers. OPM estimates that approximately $11 billion will be attributable to prescription drugs in the FEHBP program in 2011. *(FY 2011 proposed budget Appendix, p. 1189).* Continued OIG oversight should continue to be a force against fraud and for program improvement.

It is no secret that there is great controversy surrounding the pharmacy benefits managers (PBMs), and the way they operate. Coalitions of labor and consumer groups along with independent pharmacies have taken on this industry, and understandably so. Some PBMs have been investigated or sued because of their hidden negotiations and rebate policies. Some PBMs have been dropped by state programs for not opening up their contracts for review.

While we agree with many others who have a stake in seeing this industry called to account, I want to make clear that NTEU, as the largest independent federal government union, has one goal – to reduce costs in FEHBP for federal employees and retirees, and correspondingly to lower premiums. According to OPM's testimony, nearly 30 percent of its total claims

expenditures are attributable to prescription drugs. *(Kichak, June 24, 2009)* With a pool of 8 million people, FEHBP must ensure that it gets the best prices possible and ensure that savings are directed to the program. It is clear that something is radically wrong with the system when FEHBP faces the worst drug prices in government despite its huge pool of participants. OPM has been unable, thus far, to better leverage what should be a significant advantage.

The pharmacy benefits managers (PBMs) – who negotiate drugs for FEHBP carriers – are essentially middlemen in a complicated pricing process. In addition to retaining rebates and discounts from drug manufacturers, PBMs can pay pharmacies a different price for those drugs and are able to keep the difference. OPM's own Inspector General testified before this subcommittee that an investigation of PBMs was initiated originally in 2003 because of concerns for enrollees' health and safety by PBM practices. *(McFarland, June 24, 2009)* These included unauthorized switching of drugs, manipulation of receipt dates, use of non-pharmacy personnel, and dispensing violations.

While these specific issues appear to have been resolved, they stand as a reminder of the critical importance of vigilantly overseeing these private sector interests who play a direct role in enrollees' pharmaceutical needs. The 2003 investigation underscores the underlying tenet of the problem in drug pricing. That is, OPM is not aware – and does not have access to -- the contractual arrangements between the PBMs and their customers. According to the Inspector General, "....the single most important issue which OPM must resolve is the fact that it is dealing with PBMs—which handle claims representing over 25 percent of fee-for-service health benefits costs—from a perspective in which the cost structures of the PBMs are utterly

nontransparent." According to the testimony of Susan Hayes of Pharmacy Outcomes Specialists, who testified at the subcommittee's June 24 hearing , "...even when the federal government does negotiate a fair contract with a PBM, PBMs paralyze the ability of the Federal Government to audit and make sure contracted provisions are truly met."*(Hayes, June 24, 2009)*

FEHBP is a government run program made up of private sector plans. If part of the program – in this case the prescription drug component—cannot be audited, it is indeed not transparent. Common sense dictates that U.S. taxpayers, and especially FEHBP enrollees who saw their premiums rise by nearly 9 percent on average this year, or 15 percent if they were a single enrollee in the popular Blue Cross/Blue Shield standard plan, deserve better.

1. Increased Disclosure of Information.

By amending Title 5, H.R. 4489 essentially says if a PBM and carrier want to participate in FEHBP, certain conditions need to be met. NTEU supports this approach.

How can OPM to do its job and be a good steward for the public when it does not have access to the very information that will enable it to do so? NTEU supports requiring greater disclosure from the PBMs to safeguard against the kinds of secrecy highlighted by OPM's IG and others.

Disclosure and the accompanying transparency are not new phenomena. The current Administration has required greater disclosure in government in general. The President's FY

2011 budget proposes information and data sharing by federal agencies and individuals. It is only fitting for these billion dollar private companies who make a profit from government business to become more transparent. If PBMs want to participate in FEHBP, they should be held accountable, as H.R. 4489 proposes to do.

NTEU supports Sec. 2(h) of the bill entitled ACCESS TO PBM CONTRACT INFORMATION.

This section of H.R. 4489 will enable OPM to obtain the information it needs from the PBMs to determine why prescription drugs are unduly costly in FEHBP. Under Sec. 2(h) PBMs would be required to provide full access to their contracts with health insurance companies and plans. OPM could access information on arrangements the PBMs have with manufacturers and pharmacies. The plethora of information that OPM would have available through these kinds of disclosures —including corporate-wide rebate reports; rebate allocation methodology; bench mark pricing and various fees at different stages—will put the agency in a position to better do its job. We are not advocating public dissemination of proprietary information, but we are advocating for disclosure to OPM, as needed, so it can monitor the federal program.

2. Prescription Drug Rebates

On the issue of rebates, Mr. Chairman, your hearing brought out the fact that rebates on the purchase of drugs can be as high as 50 percent of the manufacturer's cost, yet rebates often go to the PBMs, rather than to the insurance plans or FEHBP. PBMs were originally intended to

handle administrative functions and perform duties associated with drug claims. In today's world, however, PBMs negotiate for drugs at discounted rates, and then receive hidden payments and rebates from manufacturers in addition to other fees and payments from health insurance carriers.

Other government-run health programs do not rely on various PBMs in the way that FEHBP does. It is our understanding that the Department of Defense TRICARE program which serves 9.6 million enrollees, including 7 million who use the prescription program, receives 100 percent of the rebates. TRICARE uses one PBM, and pays an administrative fee for its services. The rebate money is essentially recycled into the operations of the program. Under Medicaid, manufacturers are required by law to return certain rebates, and those who wish to have their drugs available for Medicaid enrollees are required to enter into rebate agreements with the federal government on behalf of the states. *(GAO-10-201 p.20)* We believe the current rebate arrangement under FEHBP needs to be adjusted.

NTEU's views on Sec. 2 (c) REIMBURSEMENT OF CARRIERS.

Under H.R. 4489, 99 percent of the monies received by the PBMs from pharmaceutical manufacturers for FEHBP business would be returned to the carriers. This includes rebates, market share incentives, drug switching programs, educational support, commissions, administrative or management fees, mail service purchase discounts, and the sale of utilization and claims data.

Mr. Chairman, this certainly is an improvement over the existing murky world of rebates and discounts on the part of PBMs. While Sec. 2 (c) will require the rebates to be returned to the insurance companies, NTEU would recommend additional clarifying language to ensure that funds recaptured will be dedicated to the FEHBP program to be used to keep enrollee costs down. NTEU will be happy to work with you on language to ensure that the funds which are now slated to be returned to the carriers are, in fact, funneled back into FEHBP, and that OPM has authority to monitor the process.

3. Consumer Protections in FEHBP

Many FEHBP participants are simply unaware of practices that affect the drugs they take, and the claims that have their names on them. While the field of health care is continually changing and technology is constantly advancing, consumers of health care deserve certain information and should not be in a situation where a large company that is buying drugs on their carrier's behalf is determining whether they get the drug their doctor prescribed, or making other health related decisions without their knowledge. NTEU supports several sections of H.R. 4489 that are consumer friendly.

NTEU supports the following provisions: Sec. 2(b) on drug switching; Sec. 2(d) on selling claims data; and Sec. 2(f) on timely explanation of benefits.

Drug switching – Provisions under this section prohibit a PBM's ability to require a switch to another drug without the prescriber's involvement, and unless a net savings to the carrier,

government, and patient is realized. We acknowledge that sometimes less costly drugs are available and can be appropriate. However, the PBM does not know what is best for the patient, and should not be switching drugs without the appropriate medical input. We support an end to that practice.

Selling claims data –OPM needs a stronger role in overseeing the sale of utilization and claims data by PBMs. While we question the practice of selling FEHBP claims data at all, at minimum, OPM's concurrence should certainly be a part of the process before information is sold by private companies.

Explanations of benefits—Many FEHBP enrollees are used to seeing EOBs from their insurance carriers, but not from PBMs about their prescription drug prices. In addition to information about the specific drug, the section's requirements concerning the drug's price at various points in the process could enhance an enrollee's comparative shopping for health insurance under FEHBP during the annual open season period.

4. NTEU Proposal

NTEU has long believed that OPM should investigate the possibility of buying prescription drugs off the Federal Supply Schedule (FSS), as the Veterans Administration (VA) and Department of Defense do. Their drugs prices are substantially lower than FEHBP's.

Ten years ago, I testified before Congress in favor of a small pilot that OPM had approved, for the Special Agents Mutual Benefits Association (SAMBA) health care plan which would have allowed the small plan of 17,000 members access to the FSS for its mail order prescription drug program. SAMBA argued it could save 3 percent annually in enrollees' premium share by buying directly from the government as the VA was doing. Overall savings would have been $2.4 million annually for the plan in 2000 dollars.

NTEU supported it, OPM approved it and it was ready to go … until the pharmaceutical industry – whose profits 12 years ago were estimated at $26 billion -- pulled out, and refused to participate in the plan.

NTEU is interested in revisiting this issue and finding a way to require a pilot or demonstration project to take another look at statutory pricing. NTEU would support such a demonstration project to examine hard numbers associated with the direct purchase of drugs from the FSS through FEHBP, and we would support adding a provision on this to H.R. 4489. I believe this approach shows cost-savings promise.

Conclusion

In summary, we have a long way to go to bring prescription drug prices under control and reduce FEHBP's costs to the taxpayers, and enrollees.

However, NTEU believes that H.R. 4489 takes a giant step forward in addressing underlying contributing factors to FEHBP's rising health insurance costs. With better

transparency, accountability, standards, and increased OPM oversight, the legislation is on track to reduce cost and deliver a better deal for our federal employees and retirees. We stand ready to work with the subcommittee on this.

Mr. LYNCH. Thank you.
Mr. Calfee, you are now recognized for 5 minutes.

STATEMENT OF JOHN CALFEE

Mr. CALFEE. Thank you, Mr. Chairman. It is a privilege to speak at these hearings. The views I present are my own, not those of any organization, including the American Enterprise Institute, which does not take institutional positions on specific legislation, litigation, or regulatory proceedings.

H.R. 4489 focuses on the role of pharmacy benefit managers [PBMs], as we have heard, in Federal Employees Health Benefits Plans. On the whole, the provisions of H.R. 4489 would do far more harm than good for consumers and patients, and it would increase health care costs.

This bill is based on the assumption that competition does not work well in the PBM market. The facts belie this premise. Competition is vigorous and multi-faceted. Stand-alone PBMs compete among themselves and also compete with retail pharmacies, large health insurance plans, large employers, and even pharmaceutical manufacturers, themselves.

In this highly competitive environment, employers and insurance plans have negotiated a rich variety of PBM contracts that reflect the specific preferences of the contracting parties.

Another indicator of vigorous competition is the fact that a detailed investigation by the FTC, the Federal Trade Commission, found very little evidence of favoritism or self dealing on the parts of PBMs, regardless of who owned the PBMs.

H.R. 4489 would force nearly complete transparency in the financial arrangements between PBMs and their partners. This would be difficult to achieve. But if the legislation does bring this kind of transparency, it would undermine the incentives of PBMs to negotiate discounts from pharmaceutical manufacturers. This has been recognized by the FTC staff and by other economists.

H.R. 4489 would also require PBMs to pass on virtually all the savings they realize from aggressive cost cutting. This would undermine the incentives to cut costs in the first place. This cost cutting comes primarily from negotiating rebates from pharmaceutical manufacturers. Undermining these incentives would raise cost. This adverse consequence of regulation has also been recognized by FTC economists and by others.

H.R. 4489 would also establish price controls, which rarely, if ever, does good in competitive markets. The prohibition on negotiating a spread between payments to manufacturers and to pharmacies would discourage PBMs from seeking to reduce drug prices and costs. Giving OPM the power to set ceilings on pharmacy dispensing fees would require OPM to uncover the true costs and benefits of dispensing for pharmacies. This is not easily done, and it could easily disrupt access or even increase costs.

H.R. 4489 would prohibit health plans from reimbursing more than what is called the average manufacturer price [APM], and OPM would be granted new oversight powers on drug pricing. There is no reason to think this would reduce price directly, and prices directly, because manufacturers can adjust prices outside of the FEHBP system, but this measure could easily set the stage for

direct price controls over pharmaceuticals, as we have already heard. This would have extremely adverse consequences for researching and developing new drugs and new uses for approved drugs.

H.R. 4489 would also impose restrictions on who can own a PBM. This would tend to reduce competition. In addition, these restrictions would deprive the marketplace of the benefits of vertical integration. For example, ownership restrictions would sometimes add extra steps in the pricing of drugs as they proceed through various channels from manufacturers to patients.

H.R. 4489 would also expand regulation of drug formularies. Little, if any, evidence indicates that PBMs harm patients through the design and operation of formularies. New restrictions are more likely to raise costs than to improve health.

Finally, H.R. 4489 would grant OPM the power to prevent PBM from selling information on drug utilization and sales. This would be unfortunate. This kind of information can play an important role in the larger task of improving pharmaceutical targeting and use. And, again, there is little, if any, evidence of consumer harm from these practices.

For all these reasons, I respectfully urge this committee to reconsider H.R. 4489. There is no reason to prevent employers, health plans, and pharmaceuticals from negotiating whatever arrangements they wish with PBMs.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Calfee follows:]

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Written testimony
Before the
United States House of Representatives
Committee on Oversight and Government Reform
Subcommittee on Federal Workforce,
Postal Service, and the District of Columbia
Public Hearings on
"H.R. 4489, the FEHBP Prescription
Drug Integrity, Transparency, and Cost Savings Act,"

February 23, 2010

I would like to thank the Subcommittee for inviting me to testify in these hearings on H.R. 4489, "The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act. I am a Resident Scholar at the American Enterprise Institute for Public Policy Research, where I have conducted research on pharmaceutical and health care markets. I have also occasionally consulted for firms in the pharmaceutical and related industries. The views I present are my own, not those of any organization including the American Enterprise Institute, which does not take institutional positions on specific legislation, litigation, or regulatory proceedings.

H.R. 4489 focuses on a specific market: prescription drug coverage for federal employees. The legislation would impose a wide variety of restrictions, controls, and mandates,

most of them involving the operations of pharmacy benefit managers (PBMs) in the FEHBP drug benefit. The legislation's most important provisions fall into several categories:

(1) *Cross-ownership:* PBMs that own retail pharmacies, or are owned by a retail pharmacy or a pharmaceutical manufacturer, or are owned by a health plan that would earn a profit from the PBM's FEHBP business, would be prohibited from FEHBP.

(2) *Financial transparency:* New transparency rules would be applied to financial relationships among PBMs, health plans, drug manufacturers, retail pharmacies, and patients. PBMs would also be required to supply the Office of Personnel Management (OPM) with detailed information on their contracts with health plans.

(3) *PBM price controls:* PBMs would be required to turn over to health plans practically all rebates and other monies received from pharmaceutical firms. PBMs could not reimburse pharmacies less than the amount they receive from health plans. OPM would set the maximum dispensing fee paid to retail pharmacies. In addition, PBMs could not require pharmacies to participate in other networks organized by the PBM.

(4) *Drug price controls:* Health plans would be prohibited from reimbursing PBMs more than the Average Manufacturer Price (AMP) for drugs; while manufacturers would be required to provide AMP data to OPM.

(5) *Prescription drug substitution controls:* New restrictions or disclosures would be required in connection with prescription drug "substitutions" arranged by PBMs.

(6) *Restrictions on the use of prescription drug data for marketing purposes:* PBMs could not sell utilitzation and claims data without OPM approval.

H.R. 4489 would disrupt long-standing practices in the FEHBP drug benefit. Essentially the same practices are common in the Medicare Part D drug benefit and throughout most of the much larger private sector. In all these markets, health plans, payers, pharmacies, and PBMs have been free to negotiate a nearly infinite variety of arrangements. The proposal to upend these practices in the FEHBP drug benefit raises three questions. First, is there a basis for thinking that the current system works badly? Second, would this legislation succeed in the

difficult task of improving upon such a complex system without generating offsetting adverse consequences? The third question is about the potential effects on pharmaceutical R&D if H.R. 4489 succeeds in its obvious goal of reducing drug prices and therefore limiting the returns to drug development.

Does Competition Work Badly for the FEHBP Drug Benefit?

H.R. 4489 largely rests upon two assumptions. One, addressed here, is that competition works poorly in the drug benefit portion of FEHBP, particularly in connection with the operations of PBMs. The second assumption, addressed in the next section, is that H.R. 4489 would improve the FEHBP drug benefit without causing offsetting adverse consequences.

Competition in the PBM sector is vigorous and multi-faceted. It arises directly from the many services offered by PBMs. Prominent among those services is the assembling of dense networks of retail pharmacies; the operation of mail-order pharmacies; the handling of prescription drug insurance claims; the construction of formularies to determine which drugs are covered in various circumstances; the design and administration of "disease management" plans to deal with chronic medical conditions; the dissemination of information to physicians and patients in conjunction with formularies, disease management, and other matters; the design and use of copayment schedules and other tools to control costs, especially the use of generics; the design and administration of tools to address drug interactions and treatment compliance; and the collection and analysis of massive databases.

Most of these activities invite competition. Three large national PBMs compete more or less everywhere. They are typically joined by dozens of regional or specialty firms. Several large health insurance firms, such as WellPoint, Aetna, and Cigna, operate their own PBMs (FTC 2005, p. iii). Large retail pharmacies, such as Walgreens and RxAmerica, have long operated PBMs (FTC 2005, p. iii). Some retail pharmacies, including Wal-Mart and Walgreens, sometimes bypass PBMs completely by negotiating directly with employers and health plans to provide many services normally provided by stand-alone PBMs (*Wall Street Journal*, May 4, 2009). Large employers have also experimented with working directly with drug manufacturers and pharmacies while also contracting for high levels of transparency; notable examples include Caterpillar, Perdue, and the University of Michigan (*Wall Street Journal*, Dec. 29, 2006).

Finally, drug manufacturers can also bypass PBMs and deal directly with health plans, pharmacies, and doctors.

Thus PBMs compete with each other and with retail pharmacies, large health plans, large employers, and even pharmaceutical manufacturers. As documented in the 2005 FTC report (which examined hundreds of contracts in effect for years 2002 and 2003), the result is a highly diverse set of arrangements. The basic tool is freely negotiated contracts. Some contracts provide for much of what would be required by H.R. 4489, such as pass-through of payments from drug manufacturers, and transparency on payments or on spreads between reimbursements levels. Other contracts conform to the usual view of this market, with health plans concerned mainly with bottom-line results -- such as what they actually pay for drugs rather than the details of intervening arrangements and transactions – while leaving it up to PBMs to work out the best deals they can. Basic market discipline is provided by the simple fact that unsatisfied parties, including health plans and employers, can seek alternative terms from competing PBMs and other entities more or less annually.

These circumstances make it unlikely that PBMs have been able to distort drug benefit markets substantially and inappropriately in their favor. Much evidence bears this out. The 2005 FTC staff report explored potential conflicts of interest arising from PBM ownership of mail-order pharmacies (or mail-order ownership by firms that own PBMs). Specifically, the FTC looked for discernable effects on drug prices; on dispensing generic vs. branded drugs; on switching patients from lower-priced to high-priced drugs; on the use and pricing of repackaged drugs (which were rarely used at all); and especially on various indicators of the strength of competition generally in the FEHBP drug benefit. In the course of their work, FTC staff looked into virtually every aspect of PBM operations, based partly on the analysis of a large body of proprietary data for years 2002 and 2003.

In essentially every case, the FTC found little evidence of favoritism or "self-dealing." Total drug prices were actually lower at PBM-owned mail-order pharmacies than at non-PBM-owned ones (FTC 2005, p. vi). Financial agreements between PBMs and manufacturers reflected the dynamics of competition in the relevant drug class; they rarely extended to other brands sold by the same manufacturer (p. ix). (Such product-by-product pricing in the face of competition is typical of many markets involving "channels" or intermediaries; see Coughlin, et al. 2001, p. 360 ff. and citations therein). Agreements on formulary and market share payments

were typically devised in a manner that incentivized PBMs to control health plan's costs, with little regard to whether the PBM was large or small, insurer-owned or retailer-owned, and so on (p. ix). The size and ownership of PBMs had little effect on generic dispensing rates, with the most noticeable disparities apparently explained by such factors as copayment structure, physicians' tendencies to specify "dispense as written," and the occasional PBM's ability to negotiate a brand price below the corresponding generic price (p. x-xi). Switching of patients from one brand to another was extremely rare for all kinds of PBMs (p. xii).

In general, the deeper the FTC probed into the operations of PBMs and related entities, the more reassuring were the results. This was largely attributed to complex, robust, far-reaching, negotiation-driven competition. Reports from other federal agencies, while far less detailed and more reliant upon secondary literature rather than original data analysis, have reached largely consistent conclusions. Among these are three reports from the Congressional Budget Office (CBO 2007a, 2007b, and 2008) and two from the Government Accountability Office (GAO 2003 and 2009). The 2003 GAO report, for example, found that FEHBP enrollees paid the lowest prices for 30-subscriptions when purchasing through PBM-owned mail-order pharmacies.

Is H.R. 4489 Likely to Improve the FEHBP drug benefit?

H.R. 4489 would greatly narrow the choices available to health plans and other market participants. Given the complexity of the FEHBP drug benefit market and the freedom with which sophisticated parties can negotiate nearly any arrangement they desire, a natural question is whether H.R. 4489 is likely to improve the market by preventing health plans from doing what they would sometimes prefer to do. Unfortunately, the main interventions proposed in H.R. 4489 are more likely to burden FEHBP drug beneficiaries than to help them.

The plan to force transparency upon drug price negotiations and other financial relationships raises two problems. One is that in the PBM market, many prices involve bundles rather than a single clearly defined item. This is typical of intermediaries or channels (i.e., "middlemen") in many if not most large markets, such as grocery retailing. Often, what appears to be a price for a specific product also includes various services (delivery, carrying charges, etc.) which are not separately priced (Coughlin, et al. 2001; Monroe 2003, p. 409-421). The

same is true of rebates, which are also common in channels (cf. Coughlin, et al. 2001, p. 241, on grocery retailing). As the FTC staff notes in its 2005 report, seemingly simple data on drug reimbursement levels may reflect the inclusion of certain services (p. vii-viii). Any attempt to make prices transparent will therefore require delving deeply into the operations of health plans and others. The second problem with mandated transparence is that economic reasoning strongly indicates that price transparency would invite price-matching by other firms, the prospect of which would eliminate the advantages that manufacturers and PBMs could gain from negotiating discounts. This would undermine incentives to engage in price discounting in the first place (e.g., FTC Sept. 7, 2004).

Also inimical to competition, including competitive discounting, would be a requirement for PBMs to pass through essentially all rebates and other monies received from pharmaceutical manufacturers. This would leave little incentive for PBMs to negotiate rebates – which amount to price discounts – and would essentially turn that task over to health plans and others, who may be far less effective.

Explicit price controls, which rarely do good in non-monopoly markets, are unlikely to provide benefits in the PBM sector of FEHBP. H.R. 4489 would prohibit PBMs from negotiating a "spread" between what they pay for drugs and reimbursement levels to pharmacies. This would discourage PBMs from seeking to reduce dispensing fees or seeking lower prices from drug manufacturers, both of which normally reduce health care costs. In addition, the enforcement of this provision would provoke excessive market intervention in order to disentangle the various services that are often bundled with the provision of drugs to pharmacies (see FTC 2005, p. vii-viii, on pricing and bundling). (Disputes over fees and prices are endemic in channels; see Coughlin, et al. 2001, and Iyer and Villas-Boas 2003). On the other hand, H.R. 4489's provision for OPM to set a maximum dispensing fee paid to pharmacies would require OPM to unravel the true costs of drug dispensing (along with bundled ancillary services) and then set a ceiling without disrupting the entire prescription drug distribution system. There is no reason to think this would reduce costs or improve access.

The ownership restrictions that would be imposed by H.R. 4489, particularly the effective prohibition on retail pharmacy-owned PBMs, would limit competition and reduce efficiency by depriving the market of the advantages of "vertical integration." In a market as competitive as that for the services provided by PBMs, there are compelling theoretical and empirical reasons to

think that vertical integration is far more likely to reduce prices than to increase them (FTC 2005, p. v-vi). This is partly due to the efficiencies that motivate vertical integration in the first place, and also to the ability of vertically integrated organizations to avoid the "double marginalization" that increase prices unduly as products pass through unnecessary levels of independent firms.

In adding new regulations to the design and operation of drug formularies, again, there is little reason to expect H.R. 4489 to bring improvements for patients. Formularies are typically designed by independent pharmacology experts in consultation with health plans and payers. When therapeutic efficacy is involved, as when encouraging patients to move from one cholesterol-reducing drug to another, the primary tool is differential co-payments and appeals to physicians, leaving physicians and patients free to make decisions. State laws largely prevent more aggressive measures. Little evidence has emerged of problematic formularies designed by PBMs. In its Sept. 7, 2004 letter, the FTC staff emphasized that unwise restrictions on PBMs could discourage useful, cost-saving drug substitutions.

Finally, there is the matter of PBM sales of utilization and claim data without OPM approval. Should OPM balk at such sales – as seems likely, simply because the drafters of H.R. 4489 took the trouble to include this provision in the bill – the probable effect would be to inhibit useful activities including better targeting of drugs and information about drugs.

H.R. 4489 and Pharmaceutical R&D

One apparent goal of H.R. 4489 is to reduce the prices paid to drug manufacturers. Health plans would be prohibited from reimbursing more than average manufacturer prices (AMP). AMPs are based on economy-wide sales prices, not just those in FEHBP. Whatever the intention effects of the AMP provision, H.R. 4489 would probably fail to reduce overall drug prices because manufacturers would probably respond by adjusting prices throughout the market. This is clear from experience with "best-price" regulation in Medicaid, where the net effect of forcing a gap between Medicaid and non-Medicaid drug prices was to increase non-Medicaid prices (Morton 1997).

Nonetheless, by controlling the relationship among prices in different markets, H.R. 4489 would invite scrutiny of drug prices from the perspective of OPM. That agency is likely to be far

more interested in reducing drug prices than in motivating the development of new drugs or new uses for existing drugs. I am unaware of any evidence that American branded drug prices are too high and therefore induce too much R&D. With price controls being prevalent in all other advanced economies, the U.S. market is the only large market in which largely unregulated competition among pharmaceutical buyers and sellers shapes and rewards drug development. The fact that H.R. 4489 tends to upset that situation is cause for worry.

Conclusions

H.R. 4489 contains many provisions that would inhibit rather than enhance basic functions in the FEHBP drug benefit. Restrictions on cross-ownership between PBMs and retail pharmacies, health plans, and drug manufacturers would reduce efficiency without providing tangible benefits in terms of health care costs or patient welfare. Broad transparency requirements would inhibit competition to reduce drug costs, again without providing significant benefits. Finally, controls over pricing by PBMs, pharmacies, and health plans would bring detailed intervention by OPM, would disrupt many of the most efficient arrangements now prevailing in the FEHBP drug benefit market, could easily raise costs, and would open the door to the suppression of formerly market-based drug prices and therefore threaten R&D incentives.

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Mr. LYNCH. Mr. McNeely, you are now recognized for 5 minutes.

STATEMENT OF LARRY MCNEELY II

Mr. MCNEELY. Thank you, Mr. Chairman.

Mr. Chairman, members of the committee, I very much appreciate the opportunity to come before you today and testify about this bill and its effort to control the cost of drugs in the Federal Employees Health Benefits Program.

As I said, my name is Larry McNeely. I am the health care advocate with the U.S. Public Interest Research Group. U.S. PIRG, as we call it, is a national federation of State-based consumer advocacy organizations. We have a 35-year history of standing up for consumers, and we are convinced that both strong competition and strong consumer protection are essential to the functioning of any market. Unfortunately, the pathway for pharmaceutical delivery in this country, the market for pharmaceutical benefit managers [PBMs], lacks that adequate competition and it lacks the consumer protections that are required, and that is why the reforms envisioned in H.R. 4489 are so necessary to help bring down costs.

In explaining the benefits of transparency, I think a lot has been said in this panel and in previous panels. I just want to refer to the comments of assistant attorney general for Antitrust, Christine Varney, who highlighted its importance when she said: I am a firm believer in what Justice Brandeis said in another context: Sunlight is said to be the best of disinfectants; electric light the most efficient policeman. Markets work better and attempted harms to consumers are more likely to be thwarted when there is increased transparency to consumers and Government about what is going on in an industry. I could not say it better.

In my written testimony I go into more detail, but, just to outline a couple of the essential points, if the three essential elements of any competitive marketplace are choice, transparency, and a lack of conflict of interest, the PBM market actually lacks each one of those three. It is highly concentrated. We actually have some evidence which I detail in here of legal action to stop deceptive and fraudulent practices. And we continue to see these practices of drug switching and self-dealing, which are not only unfair to Federal employees in this particular context, but are spread more broadly across the health care market and we really think needs addressing in other legislation.

We believe enacting H.R. 4489 will lead to significant cost savings for taxpayers. The proposed legislation will actually lead to a reduction in pharmaceutical costs by requiring the pass-through of rebates and prohibiting the practices of drug switching and spread pricing, and it will protect employees and taxpayers by preventing conflicts of interest that we have run into in cases like CVS Caremark, where a PBM is owned by a retail chain.

These assertions are backed up by a growing body of evidence that demonstrates that plan transparency does allow plan sponsors to monitor and curb their prescription drug spending. I detail a number of examples, but in one case in New Jersey when they switched to a pharmaceutical benefit manager contract that was transparent for 600,000 covered employees, they are now projected to find $558.9 million in savings over 6 years. If we are talking

about 8 million Federal employees, certainly a substantial amount of resources are available.

And just to sum up, I think our attitude and why we are, I think, so grateful to the sponsors of this legislation for moving it forward is that without the protection afforded in H.R. 4489 it is as if the pharmaceutical benefit management industry is saying to taxpayers, saying to Federal employees, give us $10 billion of your money and trust us. The PBM industry, as a whole, as we have demonstrated in some of the lawsuits I detail in my testimony, has not earned that trust, and we should make sure—I hope this legislation gets favorable consideration by the committee.

Thank you.

[The prepared statement of Mr. McNeely follows:]

Testimony of Larry McNeely
Health Care Advocate
U.S. Public Interest Research Group

Before the House Committee on Oversight and Government Reform
Subcommittee on the Federal Workforce, Postal Service
and District of Columbia

"A Path to Lower Costs for Federal Employees and Taxpayers: Sunshine for the Pharmacy Benefit Managment Industry"

February 23, 2010

Testimony of Larry McNeely
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"A Path to Lower Costs for Federal Employees and Taxpayers: Sunshine for the Pharmacy Benefit Managment Industry"

February 23, 2010

Chairman Lynch, Ranking Member Chaffetz and other members of the Subcommittee, I appreciate the opportunity to come before you today and testify about efforts to control the costs of drugs in the Federal Employee Health Benefits Program (FEHBP). My name is Larry McNeely. I am the Health Care Advocate with the United States Public Interest Research Group. U.S. PIRG is a national federation of state-based consumer advocacy organizations. As an organization with a 35 year history of standing up for American consumers, U.S. PIRG is convinced that both strong competition and strong consumer protection are essential to the functioning of any market. Many aspects of the delivery of drug benefits are competitive, especially the retail drug market. Unfortunately, the pathway for prescription pharmaceutical delivery – the market for Pharmacy Benefit Managers (PBMs) – lacks adequate competition or consumer protections. That is why the reforms envisioned in H.R. 4489 are necessary so that federal employees and the federal government receive the greatest benefits at the lowest cost.

My testimony will focus on the importance of transparency to make any market function effectively, and particularly for the market for PBMs. Assistant Attorney General for Antitrust Christine Varney highlighted the importance of transparency when she said, "I am a firm believer in what Justice Brandeis said in another context: 'Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.' Markets work better and attempted harms to competition are more likely to be thwarted when there is increased transparency to consumers and government about what is going on in an industry." Today, I hope to highlight the potential benefits of transparency when it comes to the pharmacy benefits for our federal employees.

Here are the essential points of my testimony:

- **The market for PBMs is inherently flawed as a result of regulatory neglect.** Three essential elements of a competitive market are choice, transparency and a lack of conflicts of interest. The PBM market lacks each of these elements. The market for PBM services is highly concentrated, and the major PBMs routinely engage in deceptive and fraudulent practices that allow them to maintain their

dominant positions in the market, denying their customers additional choices. A lack of transparency and a total lack of federal regulation of PBMs allow this anticompetitive conduct to continue. Moreover, the ownership of PBMs by major pharmacy chains, such as CVS Caremark, raises significant conflicts of interest and harm consumers.

- **Consumer harm is rampant when PBMs improper market behavior is left unchecked** PBMs are the only unregulated segment of the health care market and this permits them to engage in a variety of deceptive and fraudulent practices, including drug switching and self-dealing. A coalition of over 30 states has brought major enforcement actions securing to date over $370 million in damages. It's past time to put an end to these anticompetitive and fraudulent practices.
- **Enacting H.R. 4489 will lead to significant cost savings for taxpayers and protect government workers.** The proposed legislation will lead to a reduction in pharmaceutical costs by requiring pass-through of rebates and prohibiting drug switching and spread pricing. It will protect federal employees and taxpayers by preventing PBM tactics such as drug switching which may force the consumer to pay more. And it will protect the FEHBP and employees by preventing conflicts of interest by prohibiting plans from contracting with PBMs that are owned by retail chains.
- **Public and private plan sponsors have realized significant savings by requiring transparency of their PBMs.** A growing body of evidence demonstrates that transparency allows plan sponsors to monitor and curb their prescription drug spending.
- **OPM should set in place a variety of consumer protections and establish the position of an ombudsman to address complaints.** To take advantage of its increased oversight capabilities, OPM should strengthen the consumer protections in the FEHBP for the pharmacy benefit in particular by establishing an ombudsman and other measures.

Regulating PBMs and strengthening the FEHBP program is more than a matter of dollars and cents. Because of the complexity of PBM operations, they create a tremendous opportunity for fraudulent and deceptive conduct. This is particularly true where PBMs are owned by pharmacy chains, such as CVS Caremark. That merger combining the largest pharmacy chain with one of the largest PBMs pose significant risks for millions of consumers including federal employees. CVS Caremark takes advantage of the closed loop between its PBM and pharmacy operations to exploit plan sponsors, oftentimes putting the ultimate consumer in danger while in pursuit of profits. Below are examples of situations where CVS Caremark sought to drive its own market share at the expense of the health plan it serves and individual patients. By taking on more oversight authority and avoiding the fundamental conflict of interest of a joint PBM-pharmacy like CVS Caremark, the government and other plan sponsors can avoid situations like these documented by the Center for American Progress' Senior Fellow David Balto:

- Susan, a 98-year-old patient in Texas, was released from the emergency room for bleeding ulcers. Her daughter picked her up and immediately stopped at the

closest pharmacy to pick up the three prescriptions she needed. Of these three, one critical prescription – and the most expensive – was denied by her CVS Caremark insurance. Susan was told she needed to visit a CVS pharmacy for this particular drug. Her daughter drove the 40-minute round trip to pick up her medication.

- Rebecca, a federal employee, is required to use her plan's mail order specialty pharmacy for a particular high-cost drug she takes. The drug requires special care and must be refrigerated upon delivery. Because she prefers to keep her condition private from her coworkers, she must wait at home for deliveries; when deliveries arrive late, she takes an extra day off work. When the delivery is late, she must go without the medication, sometimes resulting in such extreme pain that she must visit her pain doctor at a high cost to the federal plan.

This is why enactment of H.R. 4489 is vitally necessary.

PBM Markets Lack Choice and Transparency, and are Subject to Anticompetitive and Deceptive Conduct

I have a simple and vital message for this Committee: there is a tremendous need for PBM reform. The fundamental elements for a competitive market are transparency, choice and a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access and securing adequate information may be difficult.

Why are choice, transparency, and a lack of conflicts of interest important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire.

When dealing with intermediaries like PBMs, it is particularly critical that there are no conflicts of interest. . In the PBM market, the service a PBM provides is that of being an "honest broker" bargaining to secure the lowest price for drugs and drug dispensing services. When a PBM has a relationship with either a drug company or a pharmacy, or has its own operations, it is effectively serving two masters.

Only where these three elements – choice, transparency, and lack of conflicts of interest – are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Unfortunately, in all three respects, PBM markets do not function as effectively as they could. **Few markets are as concentrated, opaque and complex and subject to rampant anticompetitive and deceptive conduct as PBM markets. As important, PBMs are the only unregulated segment of the health care market.**

The lack of choice.

First, the PBM market is highly concentrated among three major PBMs (CVS/Caremark, Express Scripts and Medco), which now have over 80% of the national PBM market.[1] The FTC has not undertaken any enforcement activity in the face of this market consolidation. In fact, the past two substantial PBM mergers – Caremark's acquisition of AdvancePCS and CVS's acquisition of Caremark – were approved without a significant investigation, despite leading to a significant increase in market power. **While consumers have faced rapidly increasing costs and inadequate access to pharmaceuticals, from 2003 to 2007, the three largest PBMs—Medco, Caremark and Express Scripts—nearly tripled their annual profits from $966 million to over $2.7 billion.**[2] These rapidly increasing profits are clearly a sign that these three PBMs have market power.

Increasing conflicts of interest.

Today the Committee will hear testimony of the problematic conduct CVS has engaged in after acquiring Caremark. This combination of the largest pharmacy chain with the largest PBM poses significant competitive concerns. The pharmacist testifying today is not alone in expressing these concerns. Consumer groups including the Consumer Federation of American and US PIRG, Change to Win (a coalition of unions), and the National Legislative Alliance on Prescription Drugs (a bipartisan group of state legislators) have called on the FTC to investigate allegations of anticompetitive and deceptive conduct that have increased prices and reduced choices for consumers, and the FTC has responded by opening an investigation.

The concerns raised about the CVS/Caremark alliance bear a striking and disturbing resemblance to the issues raised by last year's scandal surrounding Ingenix and its role in creating exorbitant out of network rates for basic medical services like a physician or an ER visit. In order for the health insurance system to function effectively, there needed to be an honest, independent broker to determine usual and customary rates for out of network service. That was the purpose of Ingenix, which was created to survey those rates. However, Ingenix was owned by United Health, a major health insurer.

United's ownership of Ingenix, however, distorted that relationship and created a conflict of interest. Under the ownership of United, Ingenix deflated those usual and customary rates, forcing consumers to pay more for out of network services. That is why

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1 American Antitrust Institute. "The Next Antitrust Agenda: The American Antitrust Institute's Transition Report on Competition Policy to the 44th President of the United States." See Chapter Nine: Competition in the Unhealthy Health Sector. See page 324.
http://www.antitrustinstitute.org/archives/files/Health%20Chapter%20from%20%20AAI%20Transition%20Report_10 0520082050.pdf

2 See Medco, Express Scripts and CVS Caremark annual 10-K filings for 2003 to 2008.

the New York Attorney General required United to divest its holdings in IngenixIngenix and mandated the creation of a non-profit entity to perform its function.[3]

Similarly, CVS' ownership of Caremark distorts Caremark's incentive and ability to be an honest broker. There is a clear conflict of interest and an ability to manipulate the relationship to harm CVS' rivals (other pharmacies) and consumers. Moreover, controlling health care costs and health care reform is dependent on PBMs being honest brokers. Caremark, because it is a CVS subsidiary, is unlikely to function as an honest broker.

Ongoing fraudulent and deceptive conduct.

More generally, PBM consumer protection issues have an important impact on the potential for the government to control health care costs while protecting employees. Chairman Lynch's legislation appropriately addresses the practices that allow PBMs to exploit plan sponsors. For example, PBMs are able to "play the spread" between pharmaceutical manufacturers, pharmacies and the health care plans. As the union coalition Change to Win noted, "A lack of transparency is one of the key problems in the pharmacy benefit management industry. For example, PBMs often charge the health plans they serve significantly more for the drugs than they pay the pharmacies that distribute the drugs to patients. PBMs also may switch patients to a drug other than the one their doctor prescribed sometimes a drug more expensive for the health plan and patient to take advantage of rebates the PBM receives from drug manufacturers, which are often hidden from the PBM's customers."[4] Thus, PBMs can artificially decrease the level of reimbursement to pharmacies. This conduct is clearly similar to the types of fraudulent and deceptive conduct that United Healthcare engaged in with its Ingenix subsidiary. H.R. 4489 bans this practice outright.

A number of other secretive practices by PBMs make it difficult for a plan sponsor to enjoy the reduced costs competition between PBMs would otherwise product. Some PBMs secure rebates and kickbacks in exchange for exclusivity arrangements that may keep lower priced drugs off the market. More recently, there have been a series of acquisitions by PBMs to acquire specialty pharmaceutical companies. These specialty pharmaceuticals are higher-priced drugs that need special handling. After these acquisitions, many of these PBMs rapidly increased the price of these specialty pharmaceuticals.[5] With transparency, a plan sponsor can monitor their PBM's activities and ensure that they will not be subject to deceptive practices like these.

No other segment of the health care market has such an egregious record of consumer protection violations. In the past several years, a coalition of over 30 state

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3 Cook, Bob. "Final health plan reaches settlement over Ingenix database." American Medical News. July 6, 2009. Accessed at http://www.ama-assn.org/amednews/2009/06/29/bisc0629.htm.

4 Change to Win, Letter to Chairman Lynch and the members of the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia, Committee on Oversight and Government Reform. June 24, 2009. Available at http://federalworkforce.oversight.house.gov/documents/20090625153554.pdf.

5 Freudenheim, Milt. "The Middleman's Markup." The New York Times. April 19, 2008. http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63

attorneys general have brought several cases attacking unfair, fraudulent and deceptive conduct by PBMs. Between 2004 and 2008, the three major PBMs have been the subject of six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. **These cases listed below, resulted in over $371.9 million in damages to states, plans, and patients so far.**

- United States v. Merck & Co., Inc., et.al – $184.1 million in damages for government fraud, secret rebates, drug switching, and failure to meet state quality of care standards.
- United States v. AdvancePCS (now part of CVS/Caremark) – $137.5 million in damages for kickbacks, submission of false claims, and other rebate issues.
- United States v. Caremark, Inc. – pending suit alleging submission of reverse false claims to government-funded programs.
- State Attorneys General v. Caremark, Inc. – $41 million in damages for deceptive trade practices, drug switching, and repacking.
- State Attorneys General v. Express Scripts – $9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans.

A group of state attorneys general and the DOJ are continuing to conduct several investigations of the three major PBMs, and several private actions challenging their conduct have been brought by unions and other customers. The current concentration of the national full-service PBM market only exacerbates these problems, increasing the need for government enforcement and potential regulation of the industry.

PBMs' promise of controlling pharmaceutical costs has been undercut by a pattern of conflicts of interest, self-dealing, deception, and anticompetitive conduct. As a bipartisan group of state legislators noted:

> We know of no other market in which there have been such a significant number of prominent enforcement actions and investigations, especially in a market with such a significant impact on taxpayers. Simply put, throughout the United States, numerous states are devoting considerable enforcement resources to combating fraudulent and anticompetitive conduct by PBMs. This is because those activities are taking millions of taxpayer dollars and denying government buyers the opportunity to drive the best bargain for the state.[6]

In an important decision upholding state regulation of PBMs, one federal court observed "[w]hether and how a PBM actually saves an individual benefits provider

6 Letter from Mass. State Senator Mark Montigny to FTC Chairman Deborah Platt Majoras. May 11, 2005.

money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider." The court elaborated:

> This lack of transparency also has a tendency to undermine a benefits provider's ability to determine which is the best 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.**[7]

The Demonstrated Savings from PBM Transparency

The information provided by transparency allows a plan sponsor to curb both fraud and waste. In addition to revealing and eliminating the deceptive and fraudulent practices the major PBMs routinely engage in, transparency gives plan sponsors the tools to monitor their prescription drug spending and reduce it.

A number of public and private plan sponsors have required transparency of their PBMs and realized significant savings as a result. Richard Beck has testified today on the savings Texas expects since they have consolidated their various state, employee and retiree prescription benefit plans and enacted transparency. The State of New Jersey recently opted for a transparent, pass-through contract with Medco, one which bans spread pricing much like H.R. 4489 does. The state anticipates savings of over $550 million.[8] Similarly, the University of Michigan has saved nearly $55 million by managing its own pharmacy benefit for the past six years, managed by a single PBM which gives the university more control over the plan.[9]

The Provisions of H.R. 4489 are Necessary to Make PBM Markets Work for the FEHBP

The major PBMs have paid hundreds of millions of dollars in damages for a variety of anticompetitive and anti-consumer conduct, including failure to meet ethical

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7 Pharm. Care Mgmt. Ass'n v. Rowe, 2005 U.S. Dist. LEXIS 2339, at *7-8 (D. Me. Feb. 2, 2005), aff'd, 429 F.3d 294 (1st Cir. 2005).

8 State of New Jersey. Department of the Treasury. Purchase Bureau. Award Recommendation. Reference Number 10-X-20899, T2679. August 4, 2009.

9 See Appendix A of this document for more examples of the savings from transparency.

and safety standards. In these instances, state attorneys general exposed the problematic conduct and addressed it directly. For the most part, however, PBMs conduct business with plan sponsors behind a veil of secrecy. Transparency requirements remove this veil: they give plan sponsors greater control over their plan members' experiences, and provide an essential intermediary between individual patients and the PBMs' policies and practices that might put them in danger.

Each of the provisions of H.R. 4489 are necessary to protect federal employees and give FEHB plans and OPM the tools necessary to reduce drug costs and prevent anticonsumer conduct.

Section 2A of the bill prevents a pharmaceutical manufacturer or a retail pharmacy from owning a PBM used by a FEHB plan. The purpose of the restriction is straightforward – to prevent the conflict of interest from these types of cross-ownership. OPM regulations already prohibit PBMs from being owned by pharmaceutical manufacturers; this extends the restrictions to retail pharmacies.

As discussed earlier, the key to PBM services is for the PBM to be an honest broker – securing the best price for the plan, from both pharmaceutical manufacturers and retail pharmacy chains. But there is increasing evidence of significant harm from pharmacy chain ownership of PBMs, primarily CVS' ownership of Caremark. When the deal was announced CVS Caremark CEO Tom Ryan stated that the company would be "agnostic" about what pharmacy would be used and would treat CVS and non-CVS pharmacies alike.[10] The company also has stated they would have a firewall separating CVS and Caremark operations.[11] But both of these promises seem to be regularly violated. There have been dozens of allegations that CVS is using Caremark to drive consumers away from other pharmacies to CVS stores by increasing co-pays, misusing confidential information, or through deceptive marketing practices.[12]

Moreover, a plan sponsor cannot expect Caremark to aggressively with negotiate or audit CVS stores when they are owned by the same parent. CVS Caremark has no incentive to bargain down CVS' reimbursement rate when higher rates are paid entirely by the plan sponsor and enjoyed entirely by CVS. Nor will Caremark be a very effective "cop on the beat" when policing harmful practices by CVS. That is why the prohibition on cross-ownership is necessary.

Section 2B of the bill prevents PBMs from engaging in certain types of drug switching without the physician's approval or to a higher-cost drug. Without transparency, the major PBMs routinely engage in drug switching, encouraging or requiring a patient to switch from one drug to an equivalent simply so the PBM can earn

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10 Day, Kathleen. "CVS, Drug Benefit Manager to Merge." The Washington Post. November 2, 2006. http://www.washingtonpost.com/wp-dyn/content/article/2006/11/01/AR2006110100881.html

11 Davidson, Joe. "FTC propping CVS Caremark's prescription drug practices." The Washington Post. February 9, 2010. http://www.washingtonpost.com/wp-dyn/content/article/2010/02/08/AR2010020803379.html

12 Bartz, Diane. "Pharmacies ask U.S. to reassess CVS, Caremark Merger." Reuters. May 13, 2009. http://www.reuters.com/article/idUSTRE54C7AK20090513

greater rebates.[13] This takes away from the patient's autonomy to choose, with their physician, an appropriate medication, and introduces a new variable into their drug regimen, increasing the likelihood of lack of adherence. Ultimately this may threaten their health. When the switch to a higher-cost drug affects a patient's co-pay, this practice can affect patient's out-of-pocket costs. And when Medicare Part D plans engage in drug switching at a higher cost to the plan, a patient's access to drugs is threatened if the patient hits their "donut hole" gap in coverage as a direct result of the PBM's decision to switch their drug.

Plans cannot anticipate the way their costs will go up due to PBMs' secretive drug switching strategies. By prohibiting drug switching unless it results in a net benefit to the plan, and by making all rebates pass through to the plan, the plan sponsor can better anticipate their overall drug spend. This allows for more consistent premiums in the long term.

Section 2C of the bill requires full pass-through of any rebates received by the PBM. A major source of cost savings that PBMs receive are rebates drug manufacturers give to be placed on the PBM drug formulary.[14] In effect, the PBM is able to leverage the "lives" it represents into higher rebates and lower drug costs. Since the PBM is basically leveraging the bargaining power of the FEHBP, the government should receive the full benefit of that bargaining power.

Section 2E of the bill eliminates "spread pricing" – the practice of charging the plan sponsor more for a prescription than what the PBM pays the pharmacy. Such spread pricing does not benefit plan sponsors in any fashion. As an honest broker, the PBM should pass on the benefits of its negotiating power to the plan.

Section 2H of the bill gives OPM full audit rights and access to data, ensuring that there will be adequate oversight. OPM has previously testified about its concerns over the lack of transparency and it is important for OPM to have all the tools necessary to audit PBMs and make sure that the federal government can effectively control costs.

I strongly recommend that H.R. 4489 be enacted to protect both the federal government and federal employees. To supplement that action I suggest two additional reforms.

- **OPM should appoint an ombudsman to field complaints from various plan members and address their concerns.** This ombudsman should have direct authority to override policies or restrictions in the federal employee's plan which might be inappropriate to that plan member's needs.

- **OPM should require plans to establish protocols to ensure that patients get their drugs when needed.** Should the plan have restrictions on the pharmacies a

13 See State Attorney General v. Caremark, Inc. and State Attorney General v. Express Scripts.
14 Freudenheim, Milt. "The Middleman's Markup." The New York Times. April 19, 2008. http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63

customer can use on particular drugs, the plan should take certain measures to notify the patient of these restrictions well in advance of the time they might need those drugs. Should a patient use mail order for a particular drug, they should have access to a local pharmacy for emergency refills when a delivery is delayed or damaged. Moreover, patients should be granted exceptions to mail order policies.

Conclusion

Throughout the debate on health care reform, it has become clear that transparency is a critical tool for reducing waste and fraud. A variety of plan sponsors have learned that requiring transparency of their PBMs is a vital step in curbing prescription drug spending. Today, the FEHB spends more on prescription drugs than any other federal program; by enacting transparency, the federal government has the opportunity to achieve significant savings.

Strengthening OPM's oversight will also benefit the federal employees who would otherwise subject to the major PBMs' fraudulent, deceptive and otherwise problematic practices. Drug switching or mail order requirements, for example, might benefit the PBM while harming the ultimate consumer.

Attachment A
The Demonstrated Savings from Transparency

Below is just a sample of the many examples of the cost savings that transparent PBMs offer plan sponsors, from small employers to large corporations, state governments and TRICARE.

- **TRICARE anticipates savings of $1.67 billion by negotiating its own drug prices, including rebates, rather than going through a PBM.** Following the National Defense Authorization Act of 2008, TRICARE, which provides health care coverage to over 9 million Uniformed Services members, dependents and retirees, will administer its own pharmacy benefit through the Department of Defense. This process began in 2004 by negotiating a contract over which TRICARE had greater administrative power, even though they did not have access to federal discounts. In 2007 alone, TRICARE saved $976 million by using one uniform formulary and centralized management to negotiate drug prices and rebates with manufacturers.
- **Texas estimates savings of $265 million by switching to a transparent PBM contract.** Texas decided to enact transparency legislation after an audit of all the state's PBM plans found huge discrepancies between spending on enrollees. While the state's Teacher Retirement System plan administered by Medco cost only $994 per member in 2007, the same plan administered by Caremark cost fully $2737 per member, nearly three times the cost under Medco's plan.[15] The Employee Retirement System anticipated savings of $265 million by enacting transparency in their contract with CVS/Caremark.[16] These savings would come from lower reimbursement rates to mail order and retail pharmacies and from additional rebates awarded to the ERS rather than CVS/Caremark. Based on these findings, Texas enacted legislation in 2009 to make all state PBM contracts transparent.
- **The University of Michigan has saved nearly $55 million by administering its own plan for the past six years.** The University of Michigan chose to cancel its five contracts with major PBMs in 2005, citing the lack of transparency in their plans. The University has since hired a single new PBM, InformedRx, which offers transparency and allows the University administrative control over the plan and spending.[17] In the program's Annual Report, the University announces that their per member per year total drug costs are decreasing at a rate of 2.22% annually, and program initiatives have saved nearly $1.5 million in plan costs. Overall, by comparing their spending with national drug trend surveys, the

15 State Auditor's Office. "Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions." August 2008.
16 Letter from Ann S. Feulberg, Executive Director, Employees Retirement System of Texas, to Representative Hopson, Texas House of Representatives. April 8, 2008.
17 http://www.reuters.com/article/pressRelease/idUS213844+03-Mar-2009+BW20090303

University estimates it has saved nearly $55 million through its self-administered drug plan in just six years.[18]

- **The State of New Jersey projects savings of $558.9 million over six years when it switches to a transparent contract for its 600,000 covered employees, dependents and retirees.** The state ended its contract with CVS/Caremark and recently chose a transparent, pass-through pricing contract with Medco. The state will save this money by receiving rebates in full from the manufacturer and by not paying Medco more for a prescription than the amount Medco reimburses the pharmacy which handles that claim.[19]
- **DC-37, New York City's largest public employee union, signed a contract in 2006 with Innoviant, a transparent PBM, and saved $50 million.** Their new contract, which allowed patients to use whichever pharmacy they choose and is transparent, saved this amount on their 274,000 enrollees.
- **The State of Wisconsin saved over $30 million by switching to Navitus, a transparent PBM.** 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. Navitus charges a flat free for its management services and is transparent to plan sponsors.[20]
- **Successful transparency legislation saved over $800,000 in a single year in South Dakota.** South Dakota passed PBM transparency legislation in 2004. In a single year, the state saved over $800,000.[21]
- **Maryland switched to a transparent PBM after finding it had overpaid $10 million to CVS/Caremark.** The State of Maryland conducted an audit and discovered that it had paid Caremark over $10 million in potential rebates and other savings. In 2007, Maryland canceled its contract with CVS/Caremark and started a transparent plan with Catalyst Rx.[22]
- **The California Health Care Coalition found that Catalyst Rx, a transparent PBM, could save members between $3 and $6 *per prescription*, and chose Catalyst Rx as its recommended PBM.** [23] These savings come from the fact that Catalyst's revenues are based solely on customer service fees, not from "undisclosed deals with drug companies." In addition, 'Catalyst passes 100 percent of the price discounts and rebates it negotiates with suppliers... on to clients."

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18 University of Michigan Benefits Office. 2008 Prescription Drug Plan Annual Report. Executive Summary. January 16, 2009. Accessed at http://benefits.umich.edu/forms/2008drug_plan_annual_report.pdf.
19 State of New Jersey. Department of the Treasury. Purchase Bureau. Award Recommendation. Reference Number 10-X-20899, T2679. August 4, 2009.
20 Guy Boulton. "State gets prescription for savings." Milawukee Journal Sentinel. June 7, 2005.
21 Prescription Policy Choices. "PBM Fiduciary Duty and Transparency." Accessed at http://policychoices.org/documents/PBMTransparency_FastFacts.pdf
22 Reuters. "State of Maryland's CVS Caremark Contract Audit Reveals More than $10 Million in Potential Overpayments, Undisclosed Rebates, Improper Drug Switching, According to CtW." March 6, 2009. Accessed at http://www.reuters.com/article/pressRelease/idUS179408+06-Mar-2009+BW20090306
23 California Health Care Coalition. "CHCC Develops New Pharmacy Program." Accessed at http://www.chccnet.org/files/CHCC_Pharmacy_Program_1018.pdf

- **Privately-run Medicare Part D plans do not save as much on prescription drug costs as do Medicaid or VA plans.** A July 2008 report to the House Committee on Oversight and Government Reform compared the prescription drug spending on dual eligible beneficiaries, each of whom transferred their drug coverage from Medicaid to Medicare Part D when the program started in 2006. On average, Medicare Part D plans received rebates and discounts that reduced these enrollees' drug costs by 14% in 2006 and 2007. Had they remained under Medicaid coverage, however, Medicaid would have cut their drug costs for those same drugs another 30%. Those PBMs which manage Medicare Part D plans clearly do not pass all their potential savings on to consumers or plan sponsors.[24]
- **The Lear Corporation saved over $1.1 million on a $3.6 million budget by switching to a transparent PBM.** The Lear Corporation's switch to CatalystRx, a transparent PBM, led to a 4% increase in generic utilization paired with a drop in average price for generics, from over $36 each to under $30. Together, these led to savings of $1.1 million dollars per year on a $3.6 million budget.
- **Local Funds of the Sheet Metal Workers' International Association saved up to 30% in their first year after switching to a transparent PBM.** Local affiliates of the union who chose to switch their contracts experienced savings in a year when prescription drug prices were going up 12% across the country.[25]
- **The HR Policy Association estimates that use of a transparent PBM contract saves employers up to 9% annually.** The HR Policy Association Pharmaceutical Purchasing Coalition has laid out guidelines for PBM transparency. Manufacturer rebates must be passed on to the plan sponsor in full, and the PBM cannot charge a plan sponsor more than the amount they are reimbursing a pharmacist for a given claim. The coalition, which is made up of some of the country's largest companies, announced that using PBMs certified as transparent under these guidelines could save plan sponsors up to nine percent of their prescription drug costs annually.[26]

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24 U.S. House of Representatives Committee on Oversight and Government Reform. Majority Staff. "Medicare Part D: Drug Pricing and Manufacturer Windfalls." July 2008. Accessed at http://oversight.house.gov/documents/20080724101850.pdf

25 Business Wire. "Envision Pharmaceutical Services 'Lives Up to the Promise' at Sheet Metal Workers' International Association 2006 Business Managers Conference." August 31, 2006.

26 *redOrbit*. "Aetna Pharmacy Management Selected by the HR Policy Association for Meeting Transparency Guidelines." August 10, 2005. Accessed athttp://www.redorbit.com/news/health/203682/aetna_pharmacy_management_selected_by_the_hr_policy_association_for/

Mr. LYNCH. Thank you, Mr. McNeely.

I now yield myself 5 minutes.

I want to thank you all for your testimony. I really appreciate your willingness to come before the committee.

Mr. Calfee, I have great respect for the American Enterprise Institute. They have long been advocates of good Government, I think. I am a little puzzled. I know that you testified previously before the House Energy and Commerce Committee to the effect that prescription drugs in the Medicaid program should more closely reflect cost.

Now, here in today's hearing, you have heard both Republican and Democratic Members express the frustration that we cannot determine what the costs are of the drugs in the FEHBP program. We have heard from the customers, the users, that they cannot determine what the costs are of the drugs offered in the FEHBP program. We have heard from the Office of Personnel Management responsible for oversight of the FEHBP program, that they, indeed, cannot determine what the costs are of the drugs in the FEHBP program.

We have heard from the Inspector General of OPM who says—and he is principally responsible for the oversight here—that he cannot determine what the costs are in the drugs for the FEHBP program, and we even have an example of a program where 300 drugs are offered to the general public with no insurance, with no insurance, and they are paying less money than insured individuals are paying through their pharmacy benefit managers in the FEHBP program, which is funded on an average 72 percent by the taxpayer, roughly 28 percent by premiums paid for by the individual.

Why would you support the principle that Medicaid drugs should be as closely as possible priced based on cost, and yet your testimony here today seems to be at variance with that, if not directly opposed to it.

Mr. CALFEE. You are referring to my own testimony in connection with Medicaid?

Mr. LYNCH. Yes.

Mr. CALFEE. I am trying to remember what I said, but I imagine what I said was that Medicaid should pay market prices rather than getting a special fixed discount from market prices. But they should go out in the market.

Mr. LYNCH. You testified in 2005 before the House Energy Commerce Committee that says closely reflect cost.

Mr. CALFEE. By cost I was referring to market prices. Certainly I was not referring to the cost of manufacturing the drugs, because those costs are very, very small compared to any prices.

But my understanding, especially from the testimony of Mr. O'Brien earlier today, is that all of these plans are free to reach contracts with PBMs that do provide for disclosure. In fact, I believe that is what Argus Systems specializes in. And so my understanding is if a plan wants to have transparency, if they want to have the rebates passed through to them, they can arrange for that through contracts.

So I think the issue here is whether or not they have their freedom to either have a contract that does provide for transparency

and pass-through rebates or to have a contract that doesn't do that. And what we have heard in the private sector outside of FEHBP is you get both kinds of contracts. You get contracts with transparency, ones without, etc. The plans experiment with different ones. Sometimes they save money from when they switch from one approach to another, and sometimes they don't.

Mr. LYNCH. But, sir, in this case we are the customer. I am a Federal employee. I am an oversight officer on behalf of the Federal employees. It is not as if we said we want a contract with no transparency. We are demanding transparency and we can't get it, nor can the Office of the Inspector General. We can't get that transparency. Nor can the Office of Personnel Management. We can't get that. The PBMs and the contracting parties are saying that it is a matter of proprietary advantage and they don't want to disclose that.

So we have had instances where it has gone to court, in the State of Maine example, where I think the heat of that litigation broke the case open for the State of Maine, and that was a great advantage. But absent that urgency and the consent decree that was rendered in that case, that transparency would not be forthcoming.

So it is not like, oh, we'd prefer transparency or we would not prefer transparency; we are demanding it and we cannot get it. That is the truth of the matter here on behalf of everyone that I mentioned, Republican and Democrat, so far.

Mr. CALFEE. Again, I know in the private sector outside of FEHBP it is fairly common. It is not the rule, but it is fairly common. It does happen that a plan will have a contract for transparency, such as with Argus Systems that we heard about earlier.

But if you think about negotiating, a PBM negotiating with a drug manufacturer, if it wants to get a discount on a certain drug, and if that manufacturer knows that any discount he provides will instantly be communicated through the plans to other drug manufacturers and the other manufacturer will probably offer to match that price, then what the manufacturer knows during the negotiating process is there really isn't much to be gained by the manufacturer by providing a discount because they will end up having to give that discount to everyone.

So I think economic reasoning does suggest that if you force transparency you can make these negotiations more difficult, discounting more difficult to obtain, and I think that is fairly close. I wouldn't call it a consensus, but I would say the bulk of economists follow that line of reasoning, including specifically the Federal Trade Commission and also the CBO.

Mr. LYNCH. I appreciate that, but I think we did hear testimony here today, and in my bill specifically it is not requiring public dissemination of proprietary interests here. We are talking about you need to tell the Office of the Inspector General for OPM. They already receive proprietary information. They guard that jealously. In fact, if that information got out, it would hurt their credibility enormously and effect negatively their ability to do their job. So that is why we are suggesting it just be limited disclosure.

Let me go on, though. Mr. Adcock, I know that you mentioned earlier the number of NARFE employees that are included under the FEHBP program. Let me ask you, what is the general assess-

ment in terms of your own members' attitudes toward the current FEHBP program, specifically toward OPM's oversight of prescription drug programs within the FEHBP?

Mr. ADCOCK. Well, I think it is kind of a love/hate relationship. On one hand, I think that they are happy that they have health insurance that is equivalent to what other large employers provide, but I think they hate the fact that they are paying premiums in the double digits for the last several years.

With regard to prescription drugs, I mean, I think they understand very clearly that is one of the huge cost drivers in the program and is responsible for huge premium increases. Now, I think that over the years, because of the fact that several years ago they were encouraged through cost sharing to start using mail order prescription drugs and thereby pharmaceutical benefit managers, they are now accustomed to doing that.

I think that where there are concerns that we hear most often is that when we hear examples that individuals that don't have any insurance at all can go into a drug store and get a better price on a specific type of drug than they can through the insurance, that is troublesome to them. When they hear about that State Attorney Generals all over the country are involved with legal action against pharmaceutical benefits, that is troublesome.

So, on one hand, I think that when you are talking about customer service that they have with pharmaceutical benefit managers and arranging for their drugs to be purchased, I think a lot of these PBMs have very good customer service, but when they hear about these stories they want to know what is going on behind the curtain. That is why I think for a lot of them they are very interested in the subject matter of this legislation and transparency.

Mr. LYNCH. Dr. Simon, could I ask you the same question? I know the American Federation of Government Employees has a tremendous amount of employees affected, as well. What are the attitudes? I don't know if you are close to that level of feedback.

Ms. SIMON. I am, but I just want to say, especially in light of the oath that we took at the beginning of the panel here, I never finished my dissertation so I am not Dr. Simon.

Mr. LYNCH. OK.

Ms. SIMON. But in any case——

Mr. LYNCH. All right. We won't hold that against you.

Ms. SIMON. But thank you for the presumption.

In fact, AFGE is holding its annual legislative conference this week, and during the issues briefing this weekend I don't think there was any subject that raised peoples' hackles more than what has been going on in FEHBP.

Mr. LYNCH. Wow.

Ms. SIMON. Part of that is because of the national health care reform bills that would impose a so-called Cadillac Tax on their FEHBP plans, and I think today's hearing shows that there is nothing about the benefits that make it a Cadillac. It is the fact that we pay too much. The price is too high, but the benefits aren't necessarily luxurious or comprehensive. And so, if that goes forward, they would get hit again for something that is completely beyond their control.

We often, when we testify on FEHBP, note the fact that we don't know the number exactly, but there are at least a couple hundred thousand, if not more, Federal employees who are eligible to participate in FEHBP but don't participate and don't have insurance from another source because they can't afford the premiums that are on average now 30 percent for the enrollee, and they keep going up.

And so, many of our members work in veterans' hospitals or in prisons and DOD medical facilities where they may be providing these prescription drugs to inmates or patients, veterans, or patients in the DOD hospitals, and they know that the same Government that is paying for their health insurance through FEHBP is paying one price if they were prescribed that drug and a completely different price when they are dispensing it in a VA hospital or a prison or through the Indian Health Service.

They are very, very aware of the fact that FEHBP has not been run in a way that would minimize the cost to taxpayers or enrollees. And as it gets more and more expensive, and each year a higher and higher percentage of overall premiums is shifted onto the employees, they are livid. They are livid. They are getting a small pay increase and their FEHBP premiums are going up, up, up, and they like this legislation.

Mr. LYNCH. OK. Thank you.

President Kelley, I know you have a pile of employees that are also affected all over the place, right?

Ms. KELLEY. We do. We do, Chairman Lynch. But it does come down to the single issue of the cost of the plan, because everything points to the fact that these annual increases are so directly tied to the cost of prescriptions.

I would also say that the forum that you held last September, on this issue, for those who did not know about the Federal supply schedule and the prices that were being paid so differently at DOD and VA, they know that now and they have more questions about why that would be allowed to continue to happen and why OPM—the question has always been what OPM will do to better leverage the 8 million enrollees. Of course, like I said, it always comes back to the prescription drugs as the one element that is always pointed to when the annual prices, the annual increases are announced each year.

Mr. LYNCH. Let me ask you about that, then. We had this forum. I guess I had an inclination to try to do the simplest thing, which we have a Government purchasing system under the FSS, that Federal supply schedule, and it is well known. It is well used. It is established. It is used in general Government purchasing. And it is fairly transparent. You put out there what you are going to charge the Government for providing a certain material or service. And it is competitive.

My thought was, rather than this very, very Rube Goldberg-type construction that we have for Federal employees health benefits on the pharmacy side, let's just put it out there like we would for widgets, and you offer your price to the Government and we accept it or reject it. We can consider quality and level of service. Let's just do that. The PBMs were the loudest critics of that system because it would eliminate them from the whole process, basically.

Now, that is a very crude solution to our problem. It simplifies things, but I will take for granted that widgets are not the same as pharmaceuticals being recommended by a physician for the health care of that individual. There are some important differences there.

However, when you look at the VA system that is out there that works pretty well, they have a fixed formulary, however, so there is a more limited choice, although there are waivers under certain circumstances.

How would your members respond to that if there was a fixed formulary, because that is going to reduce, conceivably, it is going to reduce some level of choice for some of these exotics or some of these less commonly used pharmaceuticals? It is going to be a limitation on choice. How are they going to balance the likes and dislikes of a system that might have a fixed formulary but a much lower price across the board?

Ms. KELLEY. I don't know how they will react to change in general, but any kind of a positive change I think would be received. But one of the things that NTEU has recommended is that this be done as a pilot, that it not just be an across-the-board, because then all of the benefits that we already know exist, such as the transparency, for those who oppose it, it is already there. The obstacles that they are raising have already been overcome with the use of the FSS.

Mr. LYNCH. Yes.

Ms. KELLEY. So let's try it in a pilot and one or two of the plans in the program and see exactly what kind of an impact it would have and if there are other issues that are created that haven't been thought about.

Mr. LYNCH. Like I said, there are waivers or there are ways, if something is not on the formulary, if you make a showing that this is needed then there is a way to get around that, but it does put sort of a gatekeeper on the formulary.

Mr. McNeely, you had some great testimony earlier on about competitiveness and transparency. Are there items, as you look from U.S. PIRG's standpoint, that should be added to this legislation that we may have forgotten or that you might think would be helpful?

Mr. MCNEELY. Yes, and we would be happy to work with you, but we generally believe that there are some steps that are to be taken to strengthen the consumer protections within FEHBP by establishing an ombudsman and some other measures which I would be happy to work with the committee in terms of those suggestions.

Mr. LYNCH. Yes. An ombudsman in what respect? With appeals to which body, the carrier, the pharmacy, the PBM? That is OK. I am getting a little deep in the weeds here and I don't want to put you on the spot.

Mr. MCNEELY. OK. Thank you.

Mr. LYNCH. Are there any other matters that we have overlooked here in terms of trying to—as I said at the outset, this legislation is not etched in stone, and we have heard from all three panels I think constructive recommendations that we could improve our bill, and we are happy to do that. But are there other items? How about the suggestion that was made by Representative Treat from Maine

about importing a standard of fiduciary responsibility on the part of the PBM to act as fiduciary on behalf of the plan, of the insured, the participants? Any thoughts on that?

Mr. ADCOCK. Imposing a fiduciary duty on the insurance carrier or on the PBM?

Mr. LYNCH. PBM.

Mr. ADCOCK. On the PBM. I guess I don't know enough about what kind of responsibilities that would involve and what the checks would be in terms of the oversight on the employer to ensure that they were actually complying with those fiduciary duties. I mean, obviously, as an employer you are a fiduciary or should be, at least, a fiduciary of your health plan on behalf of your employees and retirees, but I am not sure exactly how that would work with a PBM.

Mr. LYNCH. I think what they are trying to get at is this: you are hiring a pharmacy benefit manager to get you the best deal. That PBM goes out there, negotiates a deal for you as your agent, but, unbeknownst to you because of the way the system works right now, they pocket part of the advantage that you paid them. You have already paid them as your agent to go out there and get a good deal. Then they get you a good deal, a great deal maybe, but then they pocket part of the advantage and come back to you and give you some measure less than what you paid them to get you.

And so, that sort of gives a little bit of a snapshot on the problem here, that these deals are all going on and you never know the real cost. As Mr. Weiner testified, you never know what that bottom-line cost was, but with a fiduciary responsibility it would make it clearer that the benefits flow to you, that PBM is out there negotiating for your benefit as your agent, and it would require full disclosure of any advantageous relationship that they engaged in that may be in contravention of your own interest.

Mr. ADCOCK. I guess my question would be is if there is such a fiduciary duty what sanctions would be made against the PBM if they breached that duty.

Mr. LYNCH. Well, there is a great deal of case law that has been developed around the responsibility of fiduciary responsibility, and I think that would all be imported. Those standards would be applied if we import the fiduciary relationship with respect to a PBM and the people that you represent.

I just want to ask you each if you have anything that you would like to add. We have a series of roll calls. I would rather be able to dismiss the panel and adjourn the hearing than come back. I think we are probably at that point anyway. You have suffered enough.

Ms. Simon.

Ms. SIMON. I just would say very quickly I think that this idea of imposing fiduciary responsibility on the PBM makes it even more important that we would have the cost and pricing data that would be triggered by application of TINA, the Truth in Negotiations Act. We would find out what prices they were charging to all their customers and what the actual cost of production of these drugs is, in many cases when you are buying drugs it is a sole source contract, and that is what triggers the applicability of TINA,

where you find out this data—again, proprietary data that would be held by the agency, so it wouldn't be made public, but it would allow the Government to enforce this fiduciary standard on the PBM. So either way we need this data. We need this information.

Mr. LYNCH. OK. Great. President Kelley.

Ms. KELLEY. I will be looking more at the Maine experience and at that language, but it just seems to me that language on fiduciary responsibility would add to the transparency, which is the goal of the legislation, and that would be an enhancement to it.

Mr. LYNCH. Yes. That is my reading, as well.

Mr. Calfee, please?

Mr. CALFEE. Yes. I would suggest that the most dangerous and counterproductive part of this legislation is the pass-through. If you say to a PBM we want you to go out and negotiate a really good discount, negotiating discounts is not a straightforward thing. If anyone can walk into a pharma firm and say give me a 25 percent discount and they would give it to them, everyone would get the discount. It is a tricky business.

If you say to the PBM, We want you to go out there and do all this work and negotiating a discount and figure out these clever things, working with formularies and so on, and then give all the returns to us, you are not going to get any discounts.

What it really does is it puts the onus on the plan to negotiate the discount. If they can do that, fine. Sometimes they can. But sometimes they can't.

Mr. LYNCH. OK. Mr. McNeely.

Mr. MCNEELY. Yes. I just wanted to weigh in on the fiduciary responsibility piece.

We would have to take another look at the Maine legislation, but I think we are generally inclined to support that direction if that is the direction the committee moves with.

Mr. LYNCH. Great. Thank you.

As you notice, we have several hearings going on at one time, and I am going to leave the record open in case any of the Members have any questions for members of the panel.

I do want to thank you very, very much for your willingness to come before the committee and help us with our work. This is tough stuff, very complicated, but I think you are each in a position that has a unique perspective, and it is very helpful to us in trying to figure out what the intended and unintended consequences might be.

I want to thank you for your testimony here. You are free to go. This hearing is now adjourned.

[Whereupon, at 4:33 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Edolphus Towns and additional information submitted for the hearing record follow:]

Statement by Congressman Edolphus Towns (NY-10th), Chairman of the House Committee on Oversight and Government Reform
Before
The Subcommittee on the Federal Workforce, Postal Service, and the District of Columbia Hearing on H.R. 4489, "The FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act"

February 23, 2010

Chairman Lynch, Ranking Member Chaffetz, I commend you, Subcommittee Members and staff on this important legislative hearing on **H.R. 4489: "The Federal Employee Health Benefits Program Prescription Drug Integrity, Transparency, and Cost Savings Act"**, which Chairman Lynch introduced.

H.R. 4489 seeks to address increases in the drug prescription costs for subscribers enrolled in the Federal Employee Health Benefit Program. Our Committee needs to know if FEHBP subscribers are getting a raw deal on their drug prescriptions and if so, the best approach to deal with this challenge. Reports indicate that in 2008, the 270 plus different FEHBP plan choices servicing over 8 million subscribers saw prescription drug spending spiraling above $10 billion dollars. That year, FEHBP premium payments were $35 Billion. There seems to be universal agreement that significant problems exist.

As Chairman of the full committee of which this subcommittee sits, it is my role to fully evaluate what the evidence from today's hearing suggests in terms of identifying the nature of the problem and what solution may be most prudent to address such challenges. Thus, Mr. Chairman and Ranking Member, I am in a listening mode. However, I certainly want to thank you, Mr. Chairman and Ranking Member, for seeking informed perspective on the critical nature of prescription drug cost challenges faced by FEHBP subscribers.

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INTERNATIONAL CONVERGENCE OF CAPITAL MEASUREMENT AND CAPITAL STANDARDS (July 1988, UPDATED TO April 1998)[1]

Introduction

1. This report presents the outcome of the Committee's work over several years to secure international convergence of supervisory regulations governing the capital adequacy of international banks. Following the publication of the Committee's proposals in December 1987, a consultative process was set in train in all G-10 countries and the proposals were also circulated to supervisory authorities worldwide. As a result of those consultations some changes were made to the original proposals. The present paper is now a statement of the Committee agreed by all its members. It sets out the details of the agreed framework for measuring capital adequacy and the minimum standard to be achieved which the national supervisory authorities represented on the Committee intend to implement in their respective countries. The framework and this standard have been endorsed by the Group of Ten central-bank Governors.

2. The document is being circulated to supervisory authorities worldwide with a view to encouraging the adoption of this framework in countries outside the G-10 in respect of banks conducting significant international business.

3. Two fundamental objectives lie at the heart of the Committee's work on regulatory convergence. These are, firstly, that the new framework should serve to strengthen the soundness and stability of the international banking system; and, secondly, that the framework should be fair and have a high degree of consistency in its application to banks in different countries with a view to diminishing an existing source of competitive inequality among international banks. The Committee notes that, in responding to the invitation to comment on

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[1] This document contains the July 1988 text of the Basle Capital Accord amended to reflect five textual changes:

- the November 1991 amendment (concerning general provisions) to paragraphs 18-21 of the main text and Annex I, paragraph D;
- the July 1994 amendment (concerning the qualification for the OECD risk weighting) to paragraph 35 and to footnote 2 of Annex 2;
- the April 1995 amendment to Annex 3 (concerning certain off-balance-sheet items) and claims collateralised by securities issued by OECD non-central government public-sector entities;
- the April 1998 amendment to Annex 2 (concerning the list of assets eligible for a 20% risk weighting);
- the removal of references to transitional and implementation arrangements.

The text has not been changed to reflect the market risk amendment introduced in January 1996. That amendment appears as issued in Volume II of the Compendium.

its original proposals, banks have welcomed the general shape and rationale of the framework and have expressed support for the view that it should be applied as uniformly as possible at the national level.

4. Throughout the recent consultations, close contact has been maintained between the Committee in Basle and the authorities of the European Community in Brussels who are pursuing a parallel initiative to develop a common solvency ratio to be applied to credit institutions in the Community. The aim has been to ensure the maximum degree of consistency between the framework agreed in Basle and the framework to be applied in the Community. It is the Committee's hope and expectation that this consistency can be achieved, although it should be noted that regulations in the European Community are designed to apply to credit institutions generally, whereas the Committee's framework is directed more specifically at banks undertaking international business.

5. In developing the framework described in this document the Committee has sought to arrive at a set of principles which are conceptually sound and at the same time pay due regard to particular features of the present supervisory and accounting systems in individual member countries. It believes that this objective has been achieved.

6. In certain very limited respects (notably as regards some of the risk weightings) the framework allows for a degree of national discretion in the way in which it is applied. The impact of such discrepancies on the overall ratios is likely to be negligible and it is not considered that they will compromise the basic objectives. Nevertheless, the Committee intends to monitor and review the application of the framework in the period ahead with a view to achieving even greater consistency.

7. It should be stressed that the agreed framework is designed to establish *minimum* levels of capital for internationally active banks. National authorities will be free to adopt arrangements that set higher levels.

8. It should also be emphasised that capital adequacy as measured by the present framework, though important, is one of a number of factors to be taken into account when assessing the strength of banks. The framework in this document is mainly directed towards assessing capital in relation to credit risk (the risk of counterparty failure) but other risks, notably interest rate risk and the investment risk on securities, need to be taken into account by supervisors in assessing overall capital adequacy. The Committee is examining possible approaches in relation to these risks. Furthermore, and more generally, capital ratios, judged in isolation, may provide a misleading guide to relative strength. Much also depends on the quality of a bank's assets and, importantly, the level of provisions a bank may be holding outside its capital against assets of doubtful value. Recognising the close relationship between capital and provisions, the Committee will continue to monitor provisioning policies by banks in member countries and will seek to promote convergence of policies in this field as in other regulatory matters. In assessing progress by banks in member countries towards meeting the

agreed capital standards, the Committee will therefore take careful account of any differences in existing policies and procedures for setting the level of provisions among countries' banks and in the form in which such provisions are constituted.

9. The Committee is aware that differences between countries in the fiscal treatment and accounting presentation for tax purposes of certain classes of provisions for losses and of capital reserves derived from retained earnings may to some extent distort the comparability of the real or apparent capital positions of international banks. Convergence in tax regimes, though desirable, lies outside the competence of the Committee and tax considerations are not addressed in this paper. However, the Committee wishes to keep these tax and accounting matters under review to the extent that they affect the comparability of the capital adequacy of different countries' banking systems.

10. This agreement is intended to be applied to banks on a consolidated basis, including subsidiaries undertaking banking and financial business. At the same time, the Committee recognises that ownership structures and the position of banks within financial conglomerate groups are undergoing significant changes. The Committee will be concerned to ensure that ownership structures should not be such as to weaken the capital position of the bank or expose it to risks stemming from other parts of the group. The Committee will continue to keep these developments under review in the light of the particular regulations in member countries, in order to ensure that the integrity of the capital of banks is maintained. In the case of several of the subjects for further work mentioned above, notably investment risk and the consolidated supervision of financial groups, the European Community has undertaken or is undertaking work with similar objectives and close liaison will be maintained.

11. This document is divided into three sections. The first two describe the framework: Section I the constituents of capital and Section II the risk weighting system. Section III deals with the target standard ratio.

I. The constituents of capital

(a) Core capital (basic equity)

12. The Committee considers that the key element of capital on which the main emphasis should be placed is equity capital[2] and disclosed reserves. This key element of capital is the only element common to all countries' banking systems; it is wholly visible in the published accounts and is the basis on which most market judgements of capital adequacy are made; and it has a crucial bearing on profit margins and a bank's ability to compete. This

[2] Issued and fully paid ordinary shares/common stock and non-cumulative perpetual preferred stock (but excluding cumulative preferred stock).

emphasis on equity capital and disclosed reserves reflects the importance the Committee attaches to securing a progressive enhancement in the quality, as well as the level, of the total capital resources maintained by major banks.

13. Notwithstanding this emphasis, the member countries of the Committee also consider that there are a number of other important and legitimate constituents of a bank's capital base which may be included within the system of measurement (subject to certain conditions set out in sub-section (b) below).

14. The Committee has therefore concluded that capital, for supervisory purposes, should be defined in two tiers in a way which will have the effect of requiring at least 50% of a bank's capital base to consist of a core element comprised of equity capital and published reserves from post-tax retained earnings (tier 1). The other elements of capital (supplementary capital) will be admitted into tier 2 up to an amount equal to that of the core capital. These supplementary capital elements and the particular conditions attaching to their inclusion in the capital base are set out below and in more detail in Annex 1. Each of these elements may be included or not included by national authorities at their discretion in the light of their national accounting and supervisory regulations.[3]

(b) Supplementary capital

(i) Undisclosed reserves

15. Unpublished or hidden reserves may be constituted in various ways according to differing legal and accounting regimes in member countries. Under this heading are included only reserves which, though unpublished, have been passed through the profit and loss account and which are accepted by the bank's supervisory authorities. They may be inherently of the same intrinsic quality as published retained earnings, but, in the context of an internationally agreed minimum standard, their lack of transparency, together with the fact that many countries do not recognise undisclosed reserves, either as an accepted accounting concept or as a legitimate element of capital, argue for excluding them from the core equity capital element.

(ii) Revaluation reserves

16. Some countries, under their national regulatory or accounting arrangements, allow certain assets to be revalued to reflect their current value, or something closer to their current value than historic cost, and the resultant revaluation reserves to be included in the capital base. Such revaluations can arise in two ways:

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[3] One member country, however, maintains the view that an international definition of capital should be confined to core capital elements and indicated that it would continue to press for the definition to be reconsidered by the Committee in the years ahead.

(a) from a formal revaluation, carried through to the balance sheets of banks' own premises; or

(b) from a notional addition to capital of hidden values which arise from the practice of holding securities in the balance sheet valued at historic costs.

Such reserves may be included within supplementary capital provided that the assets are considered by the supervisory authority to be prudently valued, fully reflecting the possibility of price fluctuations and forced sale.

17. Alternative (b) is relevant to those banks whose balance sheets traditionally include very substantial amounts of equities held in their portfolio at historic cost but which can be, and on occasions are, realised at current prices and used to offset losses. The Committee considers these "latent" revaluation reserves can be included among supplementary elements of capital since they can be used to absorb losses on a going-concern basis, provided they are subject to a substantial discount in order to reflect concerns both about market volatility and about the tax charge which would arise were such cases to be realised. A discount of 55% on the difference between the historic cost book value and market value is agreed to be appropriate in the light of these considerations. The Committee considered, but rejected, the proposition that latent reserves arising in respect of the undervaluation of banks' premises should also be included within the definition of supplementary capital.

(iii) General provisions/general loan-loss reserves

18. General provisions or general loan-loss reserves are created against the possibility of losses not yet identified. Where they do not reflect a known deterioration in the valuation of particular assets, these reserves qualify for inclusion in tier 2 capital. Where, however, provisions or reserves have been created against identified losses or in respect of an identified deterioration in the value of any asset or group of subsets of assets, they are not freely available to meet unidentified losses which may subsequently arise elsewhere in the portfolio and do not possess an essential characteristic of capital. Such provisions or reserves should therefore not be included in the capital base.

19. The supervisory authorities represented on the Committee undertake to ensure that the supervisory process takes due account of any identified deterioration in value. They will also ensure that general provisions or general loan-loss reserves will only be included in capital if they are not intended to deal with the deterioration of particular assets, whether individual or grouped.

20. This would mean that all elements in general provisions or general loan-loss reserves designed to protect a bank from identified deterioration in the quality of specific assets (whether foreign or domestic) should be ineligible for inclusion in capital. In particular, elements that reflect identified deterioration in assets subject to country risk, in real estate lending and in other problem sectors would be excluded from capital.

21. General provisions/general loan-loss reserves that qualify for inclusion in tier 2 under the terms described above do so subject to a limit of 1.25 percentage points of weighted risk assets.

(iv) Hybrid debt capital instruments

22. In this category fall a number of capital instruments which combine certain characteristics of equity and certain characteristics of debt. Each of these has particular features which can be considered to affect its quality as capital. It has been agreed that, where these instruments have close similarities to equity, in particular when they are able to support losses on an on-going basis without triggering liquidation, they may be included in supplementary capital. In addition to perpetual preference shares carrying a cumulative fixed charge, the following instruments, for example, may qualify for inclusion: long-term preferred shares in Canada, titres participatifs and titres subordonnés à durée indéterminée in France, Genussscheine in Germany, perpetual debt instruments in the United Kingdom and mandatory convertible debt instruments in the United States. The qualifying criteria for such instruments are set out in Annex 1.

(v) Subordinated term debt

23. The Committee is agreed that subordinated term debt instruments have significant deficiencies as constituents of capital in view of their fixed maturity and inability to absorb losses except in a liquidation. These deficiencies justify an additional restriction on the amount of such debt capital which is eligible for inclusion within the capital base. Consequently, it has been concluded that subordinated term debt instruments with a minimum original term to maturity of over five years may be included within the supplementary elements of capital, but only to a maximum of 50% of the core capital element and subject to adequate amortisation arrangements.

(c) Deductions from capital

24. It has been concluded that the following deductions should be made from the capital base for the purpose of calculating the risk-weighted capital ratio. The deductions will consist of:

(i) goodwill, as a deduction from tier 1 capital elements;

(ii) investments in subsidiaries engaged in banking and financial activities which are not consolidated in national systems. The normal practice will be to consolidate subsidiaries for the purpose of assessing the capital adequacy of banking groups. Where this is not done, deduction is essential to prevent the multiple use of the same capital resources in different parts of the group. The deduction for such investments will be made against the total capital base. The assets representing the investments in subsidiary companies whose capital had been deducted from that of

the parent would not be included in total assets for the purposes of computing the ratio.

25. The Committee carefully considered the possibility of requiring deduction of banks' holdings of capital issued by other banks or deposit-taking institutions, whether in the form of equity or of other capital instruments. Several G-10 supervisory authorities currently require such a deduction to be made in order to discourage the banking system as a whole from creating cross-holdings of capital, rather than drawing capital from outside investors. The Committee is very conscious that such double-gearing (or "double-leveraging") can have systemic dangers for the banking system by making it more vulnerable to the rapid transmission of problems from one institution to another and some members consider these dangers justify a policy of full deduction of such holdings.

26. Despite these concerns, however, the Committee as a whole is not presently in favour of a general policy of deducting all holdings of other banks' capital, on the grounds that to do so could impede certain significant and desirable changes taking place in the structure of domestic banking systems.

27. The Committee has nonetheless agreed that:

(a) individual supervisory authorities should be free at their discretion to apply a policy of deduction, either for all holdings of other banks' capital, or for holdings which exceed material limits in relation to the holding bank's capital or the issuing bank's capital, or on a case-by-case basis;

(b) where no deduction is applied, banks' holdings of other banks' capital instruments will bear a weight of 100%;

(c) in applying these policies, member countries consider that reciprocal cross-holdings of bank capital designed artificially to inflate the capital position of the banks concerned should not be permitted;

(d) the Committee will closely monitor the degree of double-gearing in the international banking system and does not preclude the possibility of introducing constraints at a later date. For this purpose, supervisory authorities intend to ensure that adequate statistics are made available to enable them and the Committee to monitor the development of banks' holdings of other banks' equity and debt instruments which rank as capital under the present agreement.

II. The risk weights

28. The Committee considers that a weighted risk ratio in which capital is related to different categories of asset or off-balance-sheet exposure, weighted according to broad categories of relative riskiness, is the preferred method for assessing the capital adequacy of banks. This is not to say that other methods of capital measurement are not also useful, but they are considered by the Committee to be supplementary to the risk-weight approach. The

Committee believes that a risk ratio has the following advantages over the simpler gearing ratio approach:

(i) it provides a fairer basis for making international comparisons between banking systems whose structures may differ;

(ii) it allows off-balance-sheet exposures to be incorporated more easily into the measure;

(iii) it does not deter banks from holding liquid or other assets which carry low risk.

29. The framework of weights has been kept as simple as possible and only five weights are used - 0, 10, 20, 50 and 100%. There are inevitably some broad-brush judgements in deciding which weight should apply to different types of asset and the weightings should not be regarded as a substitute for commercial judgement for purposes of market pricing of the different instruments.

30. The weighting structure is set out in detail in Annexes 2 and 3. There are six aspects of the structure to which attention is particularly drawn.

(i) Categories of risk captured in the framework

31. There are many different kinds of risks against which banks' managements need to guard. For most banks the major risk is *credit risk*, that is to say the risk of counterparty failure, but there are many other kinds of risk - for example, investment risk, interest rate risk, exchange rate risk, concentration risk. The central focus of this framework is credit risk and, as a further aspect of credit risk, country transfer risk. In addition, individual supervisory authorities have discretion to build in certain other types of risk. Some countries, for example, will wish to retain a weighting for open foreign exchange positions or for some aspects of investment risk. No standardisation has been attempted in the treatment of these other kinds of risk in the framework at the present stage.

32. The Committee considered the desirability of seeking to incorporate additional weightings to reflect the investment risk in holdings of fixed rate government securities - one manifestation of interest rate risk which is of course present across the whole range of a bank's activities, on and off the balance sheet. For the present, it was concluded that individual supervisory authorities should be free to apply either a zero *or* a low weight to claims on governments (e.g. 10% for all securities or 10% for those maturing in under one year and 20% for one year and over). All members agreed, however, that interest rate risk generally required further study and that if, in due course, further work made it possible to develop a satisfactory method of measurement for this aspect of risk for the business as a whole, consideration should be given to applying some appropriate control alongside this credit risk framework. Work is already under way to explore the possibilities in this regard.

(ii) Country transfer risk

33. In addressing country transfer risk, the Committee has been very conscious of the difficulty of devising a satisfactory method for incorporating country transfer risk into the framework of measurement. In its earlier, consultative, paper two alternative approaches were put forward for consideration and comment. These were, firstly, a simple differentiation between claims on domestic institutions (central government, official sector and banks) and claims on all foreign countries; and, secondly, differentiation on the basis of an approach involving the selection of a defined grouping of countries considered to be of high credit standing.

34. The comments submitted to the Committee by banks and banking associations in G-10 countries during the consultative period were overwhelmingly in favour of the second alternative. In support of this view, three particular arguments were strongly represented to the Committee. Firstly, it was stressed that a simple domestic/foreign split effectively ignores the reality that transfer risk varies greatly between different countries and that this risk is of sufficient significance to make it necessary to ensure that broad distinctions in the credit standing of industrialised and non-industrialised countries should be made and captured in the system of measurement, particularly one designed for international banks. Secondly, it was argued that the domestic/foreign split does not reflect the global integration of financial markets, and the absence of some further refinement would discourage international banks from holding securities issued by central governments of major foreign countries as liquid cover against their Euro-currency liabilities. To that extent a domestic/foreign approach would run counter to an important objective of the risk-weighting framework, namely that it should encourage prudent liquidity management. Thirdly, and most importantly, the member states of the European Community are firmly committed to the principle that all claims on banks, central governments and the official sector within European Community countries should be treated in the same way. This means that, where such a principle is put into effect, there would be an undesirable asymmetry in the manner in which a domestic/foreign split was applied by the seven G-10 countries which are members of the Community compared with the manner in which it was applied by the non-Community countries.

35. In the light of these arguments, the Committee has concluded that a defined group of countries should be adopted as the basis for applying differential weighting coefficients, and that this group should be full members of the OECD or countries which have concluded special lending arrangements with the IMF associated with the Fund's General Arrangements to Borrow. This group of countries is referred to as the OECD in the rest of the report. Any country which reschedules its external sovereign debt is, however, precluded from the defined group for a period of five years.

36. This decision has the following consequences for the weighting structure. Claims on central governments within the OECD will attract a zero weight (or a low weight if the

national supervisory authority elects to incorporate interest rate risk); and claims on OECD non-central government public-sector entities will attract a low weight (see (iii) below). Claims on central governments and central banks outside the OECD will also attract a zero weight (or a low weight if the national supervisory authority elects to incorporate interest rate risk), provided such claims are denominated in the national currency and funded by liabilities in the same currency. This reflects the absence of risks relating to the availability and transfer of foreign exchange on such claims.

37. As regards the treatment of interbank claims, in order to preserve the efficiency and liquidity of the international interbank market there will be no differentiation between short-term claims on banks incorporated within or outside the OECD. However, the Committee draws a distinction between, on the one hand, short-term placements with other banks which is an accepted method of managing liquidity in the interbank market and carries a perception of low risk and, on the other, longer-term cross-border loans to banks which are often associated with particular transactions and carry greater transfer and/or credit risks. A 20% weight will therefore be applied to claims on all banks, wherever incorporated, with a residual maturity of up to and including one year; longer-term claims on OECD incorporated banks will be weighted at 20%; and longer-term claims on banks incorporated outside the OECD will be weighted at 100%.

(iii) Claims on non-central-government, public-sector entities (PSEs)

38. The Committee concluded that it was not possible to settle on a single common weight that can be applied to all claims on domestic public-sector entities below the level of central government (e.g. states. local authorities, etc.) in view of the special character and varying creditworthiness of these entities in different member countries. The Committee therefore opted to allow discretion to each national supervisory authority to determine the appropriate weighting factors for the PSEs within that country. In order to preserve a degree of convergence in the application of such discretion, the Committee agreed that the weights ascribed in this way should be 0, 10, 20 or 50% for domestic PSEs, but that PSEs in foreign countries within the OECD should attract a standard 20% weight. These arrangements will be subject to review by the Committee in pursuit of further convergence towards common weights and consistent definitions in member countries.

Commercial companies owned by the public sector will attract a uniform weight of 100% inter alia in order to avoid competitive inequality vis-à-vis similar private-sector commercial enterprises.

(iv) Collateral and guarantees

39. The framework recognises the importance of collateral in reducing credit risk, but only to a limited extent. In view of the varying practices among banks in different countries

for taking collateral and different experiences of the stability of physical or financial collateral values, it has not been found possible to develop a basis for recognising collateral generally in the weighting system. The more limited recognition of collateral will apply only to loans secured against cash, and against securities issued by OECD central governments, OECD non-central government public sector entities, or specified multilateral development banks. These will attract the weight given to cash or the securities used as collateral. Loans partially collateralised by these assets will also attract the equivalent weights on that part of the loan which is fully collateralised.

40. As regards loans or other exposures guaranteed by third parties, the Committee has agreed that loans guaranteed by OECD central governments, OECD public-sector entities, or OECD incorporated banks will attract the weight allocated to a direct claim on the guarantor (e.g. 20% in the case of banks). Loans guaranteed by non-OECD incorporated banks will also be recognised by the application of a 20% weight, but only where the underlying transaction has a residual maturity not exceeding one year. The Committee intends to monitor the application of this latter arrangement to ensure that it does not give rise to inappropriate weighting of commercial loans. In the case of loans covered by partial guarantees, only that part of the loan which is covered by the guarantee will attract the reduced weight. The contingent liability assumed by banks in respect of guarantees will attract a credit conversion factor of 100% (see sub-section (vi) below).

(v) Loans secured on residential property

41. Loans fully secured by mortgage on occupied residential property have a very low record of loss in most countries. The framework will recognise this by assigning a 50% weight to loans fully secured by mortgage on residential property which is rented or is (or is intended to be) occupied by the borrower. In applying the 50% weight, the supervisory authorities will satisfy themselves, according to their national arrangements for the provision of housing finance, that this concessionary weight is applied restrictively for residential purposes and in accordance with strict prudential criteria. This may mean, for example, that in some member countries the 50% weight will only apply to first mortgages, creating a first charge on the property; and that in other member countries it will only be applied where strict, legally-based, valuation rules ensure a substantial margin of additional security over the amount of the loan. The 50% weight will specifically not be applied to loans to companies engaged in speculative residential building or property development. Other collateral will not be regarded as justifying the reduction of the weightings that would otherwise apply.[4]

[4] One member country feels strongly that the lower weight should also apply to other loans secured by mortgages on domestic property, provided that the amount of the loan does not exceed 60% of the value of the property as calculated according to strict legal valuation criteria.

(vi) Off-balance-sheet engagements

42. The Committee believes that it is of great importance that all off-balance-sheet activity should be caught within the capital adequacy framework. At the same time, it is recognised that there is only limited experience in assessing the risks in some of the activities; also that for some countries, a complex analytical approach and detailed and frequent reporting systems cannot easily be justified when the amounts of such business, particularly in the newer, more innovative instruments, are only small. The approach that has been agreed, which is on the same lines as that described in the Committee's report on the supervisory treatment of off-balance-sheet exposures issued to banks in March 1986, is comprehensive in that all categories of off-balance-sheet engagements, including recent innovations, will be converted to credit risk equivalents by multiplying the nominal principal amounts by a credit conversion factor, the resulting amounts then being weighted according to the nature of the counterparty. The different instruments and techniques are divided into five broad categories (within which member countries will have some limited discretion to allocate particular instruments according to their individual characteristics in national markets):

(a) those which substitute for loans (e.g. general guarantees of indebtedness, bank acceptance guarantees and standby letters of credit serving as financial guarantees for loans and securities) - these will carry a 100% credit risk conversion factor;

(b) certain transaction-related contingencies (e.g. performance bonds, bid bonds, warranties and standby letters of credit related to particular transactions) - a 50% credit risk conversion factor;

(c) short-term, self-liquidating trade-related contingent liabilities arising from the movement of goods (e.g. documentary credits collateralised by the underlying shipments) - a 20% credit risk conversion factor;

(d) commitments with an original maturity exceeding one year (the longer maturity serving broadly as a proxy for higher risk facilities) and all NIFs and RUFs - a 50% credit risk conversion factor. Shorter-term commitments or commitments which can be unconditionally cancelled at any time, it is agreed, generally carry only low risk and a nil weight for these is considered to be justified on de minimis grounds;

(e) interest and exchange rate related items (e.g. swaps, options, futures) - the credit risk equivalent amount for these contracts will be calculated in one of two ways (see below and Annex 3).

43. Special treatment is needed for the items in (e) above because banks are not exposed to credit risk for the full face value of their contracts, but only to the cost of replacing the cash flow if a counterparty defaults. Most members of the Committee accept that the correct method of assessing the credit risk on these items is to calculate the current replacement cost by marking to market and to add a factor to represent potential exposure

during the remaining life of the contract. Some member countries, however, are concerned about the consistency of this method in relation to the rest of the system which only makes broad distinctions between relative risks for on-balance-sheet items, particularly for banks where these off-balance-sheet items currently constitute only a very small part of the total risks. They would prefer to apply an alternative approach consisting of conversion factors based on the nominal principal sum underlying each contract according to its type and maturity. The Committee has concluded that members will be allowed to choose either of the two methods. The details of the two alternative methods are set out in Annex 3.

III. A target standard ratio

44. In the light of consultations and preliminary testing of the framework, the Committee is agreed that a minimum standard should be set now which international banks generally will be expected to achieve. It is also agreed that this standard should be set at a level that is consistent with the objective of securing over time soundly-based and consistent capital ratios for all international banks. Accordingly, the Committee confirms that the target standard ratio of capital to weighted risk assets should be set at 8% (of which the core capital element will be at least 4%).

Annex 1

Definition of capital included in the capital base

A. Capital elements

Tier 1 (a) Paid-up share capital/common stock
(b) Disclosed reserves

Tier 2 (a) Undisclosed reserves
(b) Asset revaluation reserves
(c) General provisions/general loan-loss reserves
(d) Hybrid (debt/equity) capital instruments
(e) Subordinated debt

The sum of tier 1 and tier 2 elements will be eligible for inclusion in the capital base, subject to the following limits.

B. Limits and restrictions

(i) The total of tier 2 (supplementary) elements will be limited to a maximum of 100% of the total of tier 1 elements;

(ii) subordinated term debt will be limited to a maximum of 50% of tier 1 elements;

(iii) where general provisions/general loan-loss reserves include amounts reflecting lower valuations of asset or latent but unidentified losses present in the balance sheet, the amount of such provisions or reserves will be limited to a maximum of 1.25 percentage points;

(iv) asset revaluation reserves which take the form of latent gains on unrealised securities (see below) will be subject to a discount of 55%.

C. Deductions from the capital base

From tier 1: Goodwill

From total capital: (i) Investments in unconsolidated banking and financial subsidiary companies.

N.B. The presumption is that the framework would be applied on a consolidated basis to banking groups.

(ii) Investments in the capital of other banks and financial institutions (at the discretion of national authorities).

D. Definition of capital elements

(i) **Tier 1**: includes only **permanent shareholders' equity** (issued and fully-paid ordinary shares/common stock and perpetual non-cumulative preference shares) and **disclosed**

reserves (created or increased by appropriations of retained earnings or other surplus, e.g. share premiums, retained profit, general reserves and legal reserves). Disclosed reserves also include general funds (such as a fund for general banking risks in certain EC countries) of the same quality that meet the following criteria:

- allocations to the funds must be made out of post-tax retained earnings or out of pre-tax earnings adjusted for all potential tax liabilities;
- the funds and movements into or out of them must be disclosed separately in the bank's published accounts;
- the funds must be available to a bank to meet losses for unrestricted and immediate use as soon as they occur;
- losses cannot be charged directly to the funds but must be taken through the profit and loss account.

In the case of consolidated accounts, this also includes minority interests in the equity of subsidiaries which are less than wholly-owned. This basic definition of capital excludes revaluation reserves and cumulative preference shares.

(ii) **Tier 2: (a) undisclosed reserves** are eligible for inclusion within supplementary elements provided these reserves are accepted by the supervisor. Such reserves consist of that part of the accumulated after-tax surplus of retained profits which banks in some countries may be permitted to maintain as an undisclosed reserve. Apart from the fact that the reserve is not identified in the published balance sheet, it should have the same high quality and character as a disclosed capital reserve; as such, it should not be encumbered by any provision or other known liability but should be freely and immediately available to meet unforeseen future losses. This definition of undisclosed reserves excludes hidden values arising from holdings of securities in the balance sheet at below current market prices (see below).

(b) Revaluation reserves arise in two ways. Firstly, in some countries, banks (and other commercial companies) are permitted to revalue fixed assets, normally their own premises, from time to time in line with the change in market values. In some of these countries the amount of such revaluations is determined by law. Revaluations of this kind are reflected on the face of the balance sheet as a revaluation reserve.

Secondly, hidden values of "latent" revaluation reserves may be present as a result of long-term holdings of equity securities valued in the balance sheet at the historic cost of acquisition.

Both types of revaluation reserve may be included in tier 2 provided that the assets are prudently valued, fully reflecting the possibility of price fluctuation and forced sale. In the case of "latent" revaluation reserves a discount of 55% will be applied to the difference between historic cost book value and market value to reflect the potential volatility of this form of unrealised capital and the notional tax charge on it.

(c) General provisions/general loan-loss reserves: provisions or loan-loss reserves held against presently unidentified losses are freely available to meet losses which subsequently materialise and therefore qualify for inclusion within supplementary elements. Provisions ascribed to identified deterioration of particular assets or known liabilities, whether individual or grouped, should be excluded. Furthermore, general provisions/general loan-loss reserves eligible for inclusion in tier 2 will be limited to a maximum of 1.25 percentage points of weighted risk assets.

(d) Hybrid (debt/equity) capital instruments. This heading includes a range of instruments which combine characteristics of equity capital and of debt. Their precise specifications differ from country to country, but they should meet the following requirements:

- they are *unsecured, subordinated* and *fully paid-up*;
- they are *not redeemable* at the initiative of the holder or without the prior consent of the supervisory authority;
- they are *available to participate in losses* without the bank being obliged to cease trading (unlike conventional subordinated debt);
- although the capital instrument may carry an obligation to pay interest that cannot permanently be reduced or waived (unlike dividends on ordinary shareholders' equity), *it should allow service obligations to be deferred* (as with cumulative preference shares) where the profitability of the bank would not support payment.

Cumulative preference shares, having these characteristics, would be eligible for inclusion in this category. In addition, the following are examples of instruments that may be eligible for inclusion: long-term preferred shares in Canada, titres participatifs and titres subordonnés à durée indéterminée in France, Genussscheine in Germany, perpetual subordinated debt and preference shares in the United Kingdom and mandatory convertible debt instruments in the United States. Debt capital instruments which do not meet these criteria may be eligible for inclusion in item (e).

(e) Subordinated term debt: includes conventional unsecured subordinated debt capital instruments with a minimum original fixed term to maturity of over five years and limited life redeemable preference shares. During the last five years to maturity, a cumulative discount (or amortisation) factor of 20% per year will be applied to reflect the diminishing value of these instruments as a continuing source of strength. Unlike instruments included in item (d), these instruments are not normally available to participate in the losses of a bank which continues trading. For this reason these instruments will be limited to a maximum of 50% of tier 1.

Annex 2

Risk weights by category of on-balance-sheet asset

0%	(a)	Cash[1]
	(b)	Claims on central governments and central banks denominated in national currency and funded in that currency
	(c)	Other claims on OECD[2] central governments[3] and central banks
	(d)	Claims collateralised by cash of OECD central-government securities[3] or guaranteed by OECD central governments[4]
0, 10, 20 or 50% (at national discretion)	(a)	Claims on domestic public-sector entities, excluding central government, and loans guaranteed by or collateralised by securities issued by such entities[4]
20%	(a)	Claims on multilateral development banks (IBRD, IADB, AsDB, AfDB, EIB, EBRD)[5] and claims guaranteed by, or collateralised by securities issued by such banks[4]
	(b)	Claims on banks incorporated in the OECD and claims guaranteed[4] by OECD incorporated banks
	(c)	Claims on securities firms incorporated in the OECD subject to comparable supervisory and regulatory arrangements, including in particular risk-based capital requirements,[6] and claims guaranteed by these securities firms

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1 Includes (at national discretion) gold bullion held in own vaults or on an allocated basis to the extent backed by bullion liabilities.

2 For the purpose of this exercise, the OECD group comprises countries which are full members of the OECD (or which have concluded special lending arrangements with the IMF associated with the Fund's General Arrangements to Borrow), but excludes any country within this group which has rescheduled its external sovereign debt in the previous five years.

3 Some member countries intend to apply weights to securities issued by OECD central governments to take account of investment risk. These weights would, for example, be 10% for all securities or 10% for those maturing in up to one year and 20% for those maturing in over one year.

4 Commercial claims partially guaranteed by these bodies will attract equivalent low weights on that part of the loan which is fully covered. Similarly, claims partially collateralised by cash, or by securities issued by OECD central governments, OECD non-central government public-sector entities, or multilateral development banks will attract low weights on that part of the loan which is fully covered.

5 Claims on other multilateral development banks in which G-10 countries are shareholding members may, at national discretion, also attract a 20% weight.

6 i.e. capital requirements that are comparable to those applied to banks in this Accord and its Amendment to incorporate market risks. Implicit in the meaning of the word "comparable" is that the securities firm (but not necessarily its parent) is subject to consolidated regulation and supervision with respect to any downstream affiliates.

(d) Claims on banks incorporated in countries outside the OECD with a residual maturity of up to one year and claims with a residual maturity of up to one year guaranteed by banks incorporated in countries outside the OECD

(e) Claims on non-domestic OECD public-sector entities, excluding central government, and claims guaranteed by or collateralised by securities issued by such entities[4]

(f) Cash items in process of collection

50% (a) Loans fully secured by mortgage on residential property that is or will be occupied by the borrower or that is rented

100% (a) Claims on the private sector

(b) Claims on banks incorporated outside the OECD with a residual maturity of over one year

(c) Claims on central governments outside the OECD (unless denominated in national currency - and funded in that currency - see above)

(d) Claims on commercial companies owned by the public sector

(e) Premises, plant and equipment and other fixed assets

(f) Real estate and other investments (including non-consolidated investment participations in other companies)

(g) Capital instruments issued by other banks (unless deducted from capital)

(h) all other assets

Annex 3

Credit conversion factors for off-balance-sheet items

The framework takes account of the credit risk on off-balance-sheet exposures by applying credit conversion factors to the different types of off-balance-sheet instrument or transaction. With the exception of foreign exchange and interest rate-related contingencies, the credit conversion factors are set out in the table below. They are derived from the estimated size and likely occurrence of the credit exposure, as well as the relative degree of credit risk as identified in the Committee's paper "*The management of banks' off-balance-sheet exposures: a supervisory perspective*" issued in March 1986. The credit conversion factors would be multiplied by the weights applicable to the category of the counterparty for an on-balance-sheet transaction (see Annex 2).

Instruments	Credit conversion factors
1. Direct credit substitutes, e.g. general guarantees of indebtedness (including standby letters of credit serving as financial guarantees for loans and securities) and acceptances (including endorsements with the character of acceptances)	100%
2. Certain transaction-related contingent items (e.g. performance bonds, bid bonds, warranties and standby letters of credit related to particular transactions)	50%
3. Short-term self-liquidating trade-related contingencies (such as documentary credits collateralised by the underlying shipments)	20%
4. Sale and repurchase agreements and asset sales with recourse,[1] where the credit risk remains with the bank	100%
5. Forward asset purchases, forward forward deposits and partly-paid shares and securities,[1] which represent commitments with certain drawdown	100%

[1] These items are to be weighted according to the type of asset and not according to the type of counterparty with whom the transaction has been entered into. Reverse repos (i.e. purchase and resale agreement - where the bank is the receiver of the asset) are to be treated as collateralised loans, reflecting the economic reality of the transaction. The risk is therefore to be measured as an exposure on the counterparty. Where the asset temporarily acquired is a security which attracts a preferential risk weighting, this would be recognised as collateral and the risk weighting would be reduced accordingly.

6. Note issuance facilities and revolving underwriting facilities	50%
7. Other commitments (e.g. formal standby facilities and credit lines) with an original maturity of over one year	50%
8. Similar commitments with an original maturity of up to one year, or which can be unconditionally cancelled at any time	0%

(N.B. Member countries will have some limited discretion to allocate particular instruments into items 1 to 8 above according to the characteristics of the instrument in the national market.)

Forwards, swaps, purchased options and similar derivative contracts

The treatment of forwards, swaps, purchased options and similar derivative contracts needs special attention because banks are not exposed to credit risk for the full face value of their contracts, but only to the potential cost of replacing the cash flow (on contracts showing positive value) if the counterparty defaults. The credit equivalent amounts will depend inter alia on the maturity of the contract and on the volatility of the rates and prices underlying that type of instrument. Instruments traded on exchanges may be excluded where they are subject to daily receipt and payment of cash variation margin. Options purchased over the counter are included with the same conversion factors as other instruments.

Despite the wide range of different instruments in the market, the theoretical basis for assessing the credit risk on all of them has been the same. It has consisted of an analysis of the behaviour of matched pairs of swaps under different volatility assumptions. Interest rate contracts are defined to include single-currency interest rate swaps, basis swaps, forward rate agreements, interest rate futures, interest rate options purchased and similar instruments. Exchange rate contracts include cross-currency interest rate swaps, forward foreign exchange contracts, currency futures, currency options purchased and similar instruments. Exchange rate contracts with an original maturity of 14 calendar days or less may be excluded. Gold contracts are treated the same as exchange rate contracts for the purpose of calculating credit risk except that contracts with original maturity of 14 calendar days or less are included. Precious metals other than gold receive a separate treatment and include forwards, swaps, purchased options and similar derivative contracts that are based on precious metals (e.g. silver, platinum, and palladium). Other commodities are also treated separately and include forwards, swaps, purchased options and similar derivative contracts based on energy contracts, agricultural contracts, base metals (e.g. aluminium, copper, and zinc), and any other non-precious metal commodity contracts. Equity contracts include forwards, swaps, purchased options and similar derivative contracts based on individual equities or on equity indices.

The current exposure method

The G-10 supervisory authorities are of the view that the best way to assess the credit risk on these items is to ask banks to calculate the current replacement cost by marking contracts to market, thus capturing the current exposure without any need for estimation, and then adding a factor (the "add-on") to reflect the potential future exposure over the remaining life of the contract. It has been agreed that, in order to calculate the credit equivalent amount of these instruments under this current exposure method, a bank would sum:

- the total replacement cost (obtained by "marking to market") of all its contracts with positive value; and
- an amount for potential future credit exposure calculated on the basis of the total notional principal amount of its book, split by residual maturity as follows:

Residual Maturity	Interest rate	Exchange rate and gold	Equity	Precious metals except gold	Other commodities
One year or less	0.0%	1.0%	6.0%	7.0%	10.0%
Over one year to five years	0.5%	5.0%	8.0%	7.0%	12.0%
Over five years	1.5%	7.5%	10.0%	8.0%	15.0%

Notes:

1. For contracts with multiple exchanges of principal, the factors are to be multiplied by the number of remaining payments in the contract.
2. For contracts that are structured to settle outstanding exposure following specified payment dates and where the terms are reset such that the market value of the contract is zero on these specified dates, the residual maturity would be set equal to the time until the next reset date. In the case of interest rate contracts with remaining maturities of more than one year that meet the above criteria, the add-on factor is subject to a floor of 0.5%.
3. Forwards, swaps, purchased options and similar derivative contracts not covered by any of the columns of this matrix are to be treated as "other commodities".
4. No potential future credit exposure would be calculated for single currency floating/floating interest rate swaps; the credit exposure on these contracts would be evaluated solely on the basis of their mark-to-market value.

Supervisors will take care to ensure that the add-ons are based on effective rather than apparent notional amounts. In the event that the stated notional amount is leveraged or enhanced by the structure of the transaction, banks must use the effective notional amount when determining potential future exposure.

The original exposure method

At national supervisory discretion,[2] banks may also use a simpler alternative method for interest rate and foreign exchange-related contracts, whereby the potential credit exposure is estimated against each type of contract and a notional capital weight allotted, no matter what the market value of the contract might be at a particular reporting date. The original exposure method may be used until market risk-related capital requirements are implemented, at which time the original exposure method will cease to be available for banks supervised according to this Accord.[3] Banks that engage in forwards, swaps, purchased options or similar derivative contracts based on equities, precious metals except gold, or other commodities are required to apply the current exposure method.

In order to arrive at the credit equivalent amount using this **original exposure method**, a bank would simply apply one of the following two sets of conversion factors to the notional principal amounts of each instrument according to the nature of the instrument and its maturity:

Maturity[4]	**Interest rate contracts**	**Exchange rate contracts and gold**
One year or less	0.5%	2.0%
Over one year to two years	1.0%	5.0% (i.e. 2% + 3%)
For each additional year	1.0%	3.0%

Bilateral netting

Careful consideration has been given to the issue of **bilateral netting**, i.e., weighting the net rather than the gross claims with the same counterparties arising out of the full range of forwards, swaps, options and similar derivative contracts.[5] The Committee is concerned that if a liquidator of a failed counterparty has (or may have) the right to unbundle netted contracts, demanding performance on those contracts favourable to the failed

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2 Some national authorities may permit individual banks to choose which method to adopt, it being understood that once a bank has chosen to apply the current exposure method, it would not be allowed to switch back to the original exposure method.

3 Where appropriate, national supervisors may allow an additional transition period, but in no case longer than 12 months.

4 For interest rate contracts, there is national discretion as to whether the conversion factors are to be based on original or residual maturity. For exchange rate contracts and gold, the conversion factors are to be calculated according to the original maturity of the instrument.

5 Payments netting, which is designed to reduce the operational costs of daily settlements, will not be recognised in the capital framework since the counterparty's gross obligations are not in any way affected.

counterparty and defaulting on unfavourable contracts, there is no reduction in counterparty risk.

Accordingly, it has been agreed for capital adequacy purposes that:

(a) Banks may net transactions subject to novation under which any obligation between a bank and its counterparty to deliver a given currency on a given value date is automatically amalgamated with all other obligations for the same currency and value date, legally substituting one single amount for the previous gross obligations.

(b) Banks may also net transactions subject to any legally valid form of bilateral netting not covered in (a), including other forms of novation.

(c) In both cases (a) and (b), a bank will need to satisfy its national supervisor that it has:[6]

(1) a netting contract or agreement with the counterparty which creates a single legal obligation, covering all included transactions, such that the bank would have either a claim to receive or obligation to pay only the net sum of the positive and negative mark-to-market values of included individual transactions in the event a counterparty fails to perform due to any of the following: default, bankruptcy, liquidation or similar circumstances;

(2) written and reasoned legal opinions that, in the event of a legal challenge, the relevant courts and administrative authorities would find the bank's exposure to be such a net amount under:

- the law of the jurisdiction in which the counterparty is chartered and, if the foreign branch of a counterparty is involved, then also under the law of the jurisdiction in which the branch is located;
- the law that governs the individual transactions; and
- the law that governs any contract or agreement necessary to effect the netting.

The national supervisor, after consultation when necessary with other relevant supervisors, must be satisfied that the netting is enforceable under the laws of each of the relevant jurisdictions;[7]

(3) procedures in place to ensure that the legal characteristics of netting arrangements are kept under review in the light of possible changes in relevant law.

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[6] In cases where an agreement as described in (a) has been recognised prior to July 1994, the supervisor will determine whether any additional steps are necessary to satisfy itself that the agreement meets the requirements set out below.

[7] Thus, if any of these supervisors is dissatisfied about enforceability under its laws, the netting contract or agreement will not meet this condition and neither counterparty could obtain supervisory benefit.

Contracts containing walkaway clauses will not be eligible for netting for the purpose of calculating capital requirements pursuant to this Accord. A walkaway clause is a provision which permits a non-defaulting counterparty to make only limited payments, or no payment at all, to the estate of a defaulter, even if the defaulter is a net creditor.

For banks using the **current exposure** method, credit exposure on bilaterally netted forward transactions will be calculated as the sum of the net mark-to-market replacement cost, if positive, plus an add-on based on the notional underlying principal. The add-on for netted transactions (A_{Net}) will equal the weighted average of the gross add-on (A_{Gross})[8] and the gross add-on adjusted by the ratio of net current replacement cost to gross current replacement cost (NGR). This is expressed through the following formula:

$$A_{Net}=0.4*A_{Gross}+0.6*NGR*A_{Gross}$$

where

NGR=level of net replacement cost/level of gross replacement cost for transactions subject to legally enforceable netting agreements[9]

The scale of the gross add-ons to apply in this formula will be the same as those for non-netted transactions as set out in this Annex. The Committee will continue to review the scale of add-ons to make sure they are appropriate. For purposes of calculating potential future credit exposure to a netting counterparty for forward foreign exchange contracts and other similar contracts in which notional principal is equivalent to cash flows, notional principal is defined as the net receipts falling due on each value date in each currency. The reason for this is that offsetting contracts in the same currency maturing on the same date will have lower potential future exposure as well as lower current exposure.

The **original exposure** method may also be used for transactions subject to netting agreements which meet the above legal requirements until market risk-related capital requirements are implemented. The conversion factors to be used during the transitional period when calculating the credit exposure of bilaterally netted transactions will be as follows:

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[8] A_{Gross} equals the sum of individual add-on amounts (calculated by multiplying the notional principal amount by the appropriate add-on factors set out in this Annex) of all transactions subject to legally enforceable netting agreements with one counterparty.

[9] National authorities may permit a choice of calculating the NGR on a counterparty by counterparty or on an aggregate basis for all transactions subject to legally enforceable netting agreements. If supervisors permit a choice of methods, the method chosen by an institution is to be used consistently. Under the aggregate approach, net negative current exposures to individual counterparties cannot be used to offset net positive current exposures to others, i.e., for each counterparty the net current exposure used in calculating the NGR is the maximum of the net replacement cost or zero. Note that under the aggregate approach, the NGR is to be applied individually to each legally enforceable netting agreement so that the credit equivalent amount will be assigned to the appropriate counterparty risk weight category.

Maturity	Interest rate contracts	Exchange rate contracts
One year or less	0.35%	1.5%
Over one year to two years	0.75%	3.75% (i.e. 1.5% + 2.25%)
For each additional year	0.75%	2.25%

These factors represent a reduction of approximately 25% from those originally set out in the Accord when it was issued in 1988. For purposes of calculating the credit exposure to a netting counterparty during the transitional period for forward foreign exchange contracts and other similar contracts in which notional principal is equivalent to cash flows, the original credit conversion factors[10] could be applied to the notional principal, which would be defined as the net receipts falling due on each value date in each currency. In no case could the reduced factors above be applied to net notional amounts.

Risk weighting

Once the bank has calculated the credit equivalent amounts, whether according to the current or the original exposure method, they are to be **weighted** according to the category of counterparty in the same way as in the main framework, including concessionary weighting in respect of exposures backed by eligible guarantees and collateral. In addition, since most counterparties in these markets, particularly for long-term contracts, tend to be first-class names, it has been agreed that a 50% weight will be applied in respect of counterparties which would otherwise attract a 100% weight.[11] However, the Committee will keep a close eye on the credit quality of participants in these markets and reserves the right to raise the weights if average credit quality deteriorates or if loss experience increases.

[10] Which were: for a maturity of one year or less 0.5% for interest rate contracts and 2.0% for exchange rate contracts; for a maturity of over one year to two years 1.0% for interest rate contracts and 5.0% for exchange rate contracts; and for each additional year 1.0% for interest rate contracts and 3.0% for exchange rate contracts.

[11] Some member countries reserve the right to apply the full 100% weight.

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March 31, 2010

Representative Stephen Lynch, Chairman
House Subcommittee on Federal Workforce, Postal Service, and the District of Columbia
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Lynch,

I am writing in response to your letter of March 3, to answer Representative Connelly's question regarding examples of excessive prescription drug prices under the current FEHBP pharmacy benefit contracting structures. First, thank you for your question and this opportunity to provide supplemental information to my testimony in support of H.R. 4489. There are a number of examples that illustrate how the PBM model currently in use by the FEHBP can result in excessive prescription drug prices. Just as important, the lack of transparency under the present system prevents adequate tracking of drug prices so that it is impossible to determine whether promised contract savings are being delivered. The combination of cost-saving measures and increased disclosure requirements contained in H.R. 4489 will help remedy both of these problems. The two examples below underscore why the reforms included in H.R. 4489 are so important.

1) **Currently, PBMs serving FEHBP plans may be allowed, depending on the terms of their specific contract, to retain rebates, engage in spread pricing and switch drugs in ways that may not generate a financial benefit for FEHBP.**

   These practices have been the subject of litigation because PBMs have allegedly used them to increase their profits without passing savings on to their clients. For example, in 2005 Caremark (now CVS Caremark), which manages 80% of pharmacy benefits for health plans within the FEHBP, paid $137 million—including $54.6 million to the FEHBP[i]—to settle a false claims suit brought by the government alleging, among other things, that Caremark's predecessor, Advance PCS, "devised elaborate schemes which paid pharmacies at a much lower rate than it in turn billed its customers, including government programs."[ii]

   Additionally, audits completed by OPM in 2006 identified over $13 million in administrative fees collected from the FEHBP between 2000 and 2005 by Caremark and AdvancePCS that should have been considered drug rebates and returned to the FEHBP as the contract specified.

2) **FEHBP's largest PBM vendor does not provide its lowest price on generics.**

   Change to Win recently released a report demonstrating that CVS Caremark has failed to offer its lowest price on hundreds of generic drugs to the federal government and

federal employees, even though the federal government is CVS Caremark's largest customer (the report can be downloaded at www.AlarmedAboutCVSCaremark.org).

The report compares drug prices for federal employees covered by CVS Caremark through the Blue Cross Blue Shield Federal Employees Program (FEP)—the largest health plan within the FEHBP covering approximately 60% of participants—and prices for participants in CVS's walk-in generics discount program. The comparison revealed that for a vast majority of drugs, FEP participants as well as the underwriters of the health plan – U.S. taxpayers – are not getting the best deal available from CVS Caremark. Specifically, under the FEP Standard Option, CVS Caremark charges higher prices for 295 generic drugs, 86 percent of the 342 drugs priced, than CVS charges walk-in customers through its generics discount program. In the FEP Basic Option, CVS Caremark charges higher prices for 277 generic drugs on its generic's discount list, or 85 percent of the 325 drugs priced. **Thus, regardless of which plan option FEP participants choose, the total cost for hundreds of generic drugs is higher than the cost for a person who simply walks in off the street and signs up for the CVS discount generics program. This is true even though CVS Caremark is being paid to reduce federal employees' drug costs.**

Without data on how many prescriptions are filled for each generic drug under the Basic and Standard Options of the FEP, it is not possible to measure exactly how much more the government pays under CVS Caremark-managed drug plans than it would if CVS Caremark charged FEP participants the lowest generic drug prices it offers. However, a portion of these cost differences can be estimated by assuming FEP members use generics at the same rate as national utilization rates and making cost comparisons for specific generic drugs on this basis.

Using data on three of the most commonly utilized generic drugs and assuming national utilization rates, Table 1 shows the difference in estimated costs between the employer sponsored FEP Basic and Standard Options and the CVS discount generics program. These drugs – Levothyroxine, a thyroid medication; Lisinopril, which combats high blood pressure; and Metformin, a diabetes drug – are among the top five most-prescribed drugs in the country overall, brand name or generic.

For Levothyroxine, the most commonly-taken generic drug in the United States, FEP plan participants and the federal government, together, pay up to an estimated $27.5 million annually. But if CVS Caremark charged FEP participants the same price it offers through its generics discount program, the total drug cost for Levothyroxine would likely be closer to $8.5 million annually. Hence, switching from filling Levothyroxine prescriptions using the FEP plans to the CVS generics discount program could result in an estimated annual savings of $19 million for this single generic drug. Moreover, taking these three drugs together, the federal government and plan participants could save an estimated $32 million annually if CVS Caremark charged FEP members the $9.99 generic discount price. Imagine, then, how much the government could save if CVS Caremark offered the government the same $9.99 price for all the generic drugs available through the discount program. While it is

impossible to say for certain, the savings would likely be in the hundreds of millions of dollars.

Table 1
Annual prescription drug costs for three of the most commonly prescribed generic drugs extrapolated to the FEP population.[1]

	Levothyroxine [a]	Lisinopril [b]	Metformin [c]	Total
Basic and Standard FEP Options				
Patient cost [2]	$10,483,464	$4,921,028	$5,936,508	$21,341,000
Employer cost [2]	$16,980,496	$7,378,448	$8,902,648	$33,261,592
Total cost	$27,463,960	$12,299,476	$14,839,156	$54,602,592
CVS discount generics program				
Patient cost [3]	$8,473,284	$8,251,968	$5,630,736	$22,355,988
Employer cost	$0	$0	$0	$0
Total cost	$8,473,284	$8,251,968	$5,630,736	$22,355,988
Difference between FEP and CVS generics discount program total cost	$18,990,676	$4,047,508	$9,208,420	$32,246,604

Note: For a detailed discussion of these extrapolations, please refer to Appendix A.

1 Drug utilization rates for the FEP plans assume the plan participants use the indicated drugs at the same rates as the national population. Extrapolation made to a full-calendar year, consisting of four 90-day prescription fills.

2 The employer and patient costs for a 90-day supply at retail under the FEP plans vary by Basic or Standard Option; see Appendices B and C for specific prices.

3 The price of a 90-day supply at retail in the CVS generics program is $9.99.

a Levothyroxine's national utilization rate is 4.4%; extrapolating to the FEP plans translates to 53,011 and 159,033 Levothyroxine takers among the FEP Basic and Standard Option plan participants, respectively.

b Lisinopril's national utilization rate is 4.3%; extrapolating to the FEP plans translates to 51,626 and 154,879 Lisinopril takers among the FEP Basic and Standard Option plan participants, respectively.

c Metformin's national utilization rate is 2.9%; extrapolating to the FEP plans translates to 35,227 and 105,682 Metformin takers among the FEP Basic and Standard Option plan participants, respectively.

Please do not hesitate to contact me if you have any additional questions. You can reach me at 202-721-6068, or Jasmin.Weaver@changetowin.org.

Sincerely,

Jasmin Weaver
Healthcare Initiatives Legislative Director
Change to Win

[i] U.S. Office of Personnel Management, Office of Inspector General, Semi-annual Report to Congress, April 1, 2005 – September 30, 2005, pp. 13-14, available at: <www.opm.gov/About_opm/reports/InspectorGeneral/pdf/OPMSAR33.pdf>.
[ii] *United States ex rel. Brown v. CaremarkPCS, Inc.*, No. 02-9236, E.D. Pa., 31 Mar. 2005, SAC: at ¶51.

NTEU
The National Treasury Employees Union

March 18, 2010

Stephen F. Lynch
Chairman
Subcommittee on Federal Workforce,
Postal Service, and the District of Columbia
B-349A Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman:

In reply to your March 3rd letter which forwarded a question for the hearing record submitted by Representative Gerry Connolly after the subcommittee's prescription drug pricing hearing, I have enclosed a response.

It was a pleasure to testify on February 23rd, and I look forward to our continuing work together on H.R. 4489, the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act.

Sincerely,

Colleen M. Kelley
National President

Enclosure

Q. Sometimes it seems like there are clear cut cases where one side loses and one side wins. Right now, it seems like PBMs are profiting at the expense of federal employees, and that this legislation would protect federal employees by reducing the excessive profit margins of PBMs. Is this an accurate characterization of the legislation?

A. Yes, PBMs serve as the middlemen in negotiating for drug prices and their excessive profits continue to rise, yet FEHBP continues to get more expensive for federal employees and retirees through premium and copay increases despite reduced benefits. In 2008, the top three PBMs saw combined revenues of $128 billion. What federal employees saw was more cost for fewer benefits. In 2010, the average increase among all the FEHB plans was 9 percent. It was 15 percent for the popular Blue Cross/ Blue Shield single option, or 13 percent for Blue Cross family plans. H.R. 4489 will help get costs under control by requiring PBM transparency and cost controls. Instead of seeing PBMs realize excessive profits from hidden discounts and fees, its provisions will require an auditable pricing process, financial controls, and prescription drug savings for the FEHB program. Federal employees will get a better deal if H.R. 4489 becomes law.

Ensuring patient access to quality pharmacy care services, the viability of community pharmacy and the pharmacy profession.

April 7, 2010

The Honorable Stephen F. Lynch
Chair, Subcommittee on Federal Workforce,
Postal Service, and the District of Columbia
221 Cannon House Office Building
Washington, D.C. 20515

Dear Representative Lynch:

In response to the questions submitted to the record by Congressman William Lacy Clay following the hearing on H.R. 4489, I submit the following responses:

1. "To my understanding, mail order pharmacies are at least part of the proposed solution in providing federal employees with less expensive drugs. What affect will these changes to the PBM structure have on mail order pharmacies? Will increasing the use of mail order prescriptions help curb the price of these prescription drugs? If so, how can we implement this alternative?

There have been no peer reviewed studies demonstrating that mail order pharmacies are less expensive than community pharmacies. Pharmacy benefit managers that own their own mail order pharmacy have been largely responsible for perpetuating this belief. Community pharmacies typically have higher generic utilization rates, and mandatory mail order plans have in many cases increased the rate of prescription drug waste. Community pharmacies play a critical role in promoting the optimal use of prescription drugs and encouraging a higher rate of medication adherence. Despite the important distinctions between mail order and community pharmacy, PBMs earn more money for prescriptions dispensed through mail order pharmacies than those dispensed through community pharmacies. PBMs therefore have a strong financial interest at stake in promoting the growth of mail order pharmacies. However, nothing in H.R. 4489 would prohibit the FEHBP from offering mail order pharmacy services to beneficiaries as a choice they may utilize.

2. Many fear that these new regulations will remove choice from the FEHBP because pharmacies will not participate in the FEHBP under these new rules. What will the financial ramifications of these regulations be for participating community, mail order, and retail pharmacies? Will community and other smaller pharmacies be affected differently than large retail chains? If so, how?

1001 Congress Avenue, Suite 250, Austin, TX 78701 Telephone: 512-992-1219 Fax: 512-992-1391

H.R. 4489 will not remove choice from the FEHBP and I believe that more pharmacies will be willing to participate in FEHBP plans as a result of the changes. The bill simply requires the Pharmacy Benefit Manager to disclose to the health plan (or federal government) certain necessary business practices that ultimately affect the cost to the plan and to the ultimate consumer, as well as treat all participating pharmacies fairly. This bill would prohibit the use of a PBM that has a controlling interest in a retail pharmacy. When the PBM owns a retail pharmacy (or pharmacy chain) such as CVS Caremark, the PBM can essentially steer all plan beneficiaries to their retail pharmacy to the detriment of all other pharmacies—chain, independent or mail order. CVS Caremark is currently under investigation by the Federal Trade Commission (FTC) for exactly this type of alleged anti-competitive conduct.

There is one aspect of the bill in which we would encourage some further consideration. The current language establishes that the amount that the PBM may charge to the carrier may not exceed average manufacturer price (AMP). The use of AMP as a pricing benchmark for the carrier, and in turn the pharmacy provider, is problematic. AMP needs to be significantly redefined or increased in such a way that truly reflects the retail pharmacy acquisition cost of a prescription drug. In addition, each manufacturer can define average manufacturer price differently and is highly incentivized to report the lowest price possible. We have shared these concerns with the committee and are confident that we will be able to reach compromise language that will suit the needs of all parties.

Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Richard E. Beck, R.Ph.
Executive Director

cc: John Coster, R.Ph., Ph.D.
Senior VP, Governmental Affairs
National Community Pharmacists Association

Joe Harmison, R.Ph.
President
National Community Pharmacists Association

Bruce Rogers, R.Ph.
Chair
Texas Pharmacy Business Council

March 26, 2010

Honorable Stephen F. Lynch
Chairman
Subcommittee on Federal Workforce, Postal Service,
And the District of Columbia
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Dear Chairman Lynch:

Reference is made to your letter of March 3, 2010. As always, I am happy to answer the questions of the Subcommittee on Federal Workforce, Postal Service and the District of Columbia. First though I would like to thank the Subcommittee, and you personally, once again for your interest in the important issue of pharmacy benefit manager (PBM) transparency in the Federal Employees Health Benefits Program (FEHBP) and for all of the support given to the program and the Office of the Inspector General.

Before I answer the questions I'd like to reemphasize that my concern regarding the PBMs that are participating in the FEHBP is their lack of transparency. For my office to even start to understand all of the pricing issues there has to be transparency sufficient to determine the reasonableness of the PBM contracts and an open marketplace available for comparative analysis to determine cost fairness issues.

I would also like to share with you my understanding of the actions the Office of Personnel Management (OPM) is taking to implement the transparency principles it adopted in its FEHB Program Carrier Letter No. 2010-04, Subject: Pharmacy Benefits Management (PBM) dated February 22, 2010. OPM is drafting a contract clause to implement the transparency principles in fee-for-service contracts. This new contract language will be included in the 2011 contracts.

Now I will address the follow-up questions from Subcommittee members regarding the February 23, 2010 hearing on H.R. 4489.

Question from Chairman Lynch:

We have heard from opponents of this bill that the FEHBP is a highly successful health program and that there is no credible evidence that there is a problem with FEHBP drug purchasing cost or drug management (i.e. if it ain't broke don't fix it). How do you respond to that? Can you

please explain some of the problems your office has faced in trying to analyze the prescription drug benefit?
OIG Response: While all agree that the FEHBP is a highly successful health program and that FEHBP enrollees are generally satisfied with their coverage, the FEHBP is not perfect. Many enrollees are justifiably unhappy with the latest premium increases. For example, our largest plan, the Blue Cross Blue Shield Association, increased its premium cost 12 percent for contract year 2010. I cannot say whether that increase was warranted because the PBM cost, which is about one third of the total contract cost, is not transparent.

Our current audits of the FEHBP PBMs have been limited, by the PBM contracts themselves. We have been unable to analyze the effectiveness of the carrier's contracting method because we have not been allowed access to the PBMs contracts with pharmacies and manufacturers. Additionally, where the carriers' contracts with the PBMs do not return rebates, we have not been able to determine if our pricing arrangement is advantageous compared to what we would have received had we benefited from the return of rebates.

Question from Congressman William Lacy Clay:

Do you believe that the increase of oversight by OPM is a fair solution to the problems presented by this hearing and previous hearings on this issue? What kind of increased oversight could OPM perform to solve these problems, if any? Would increasing this oversight pose difficulties for OPM?

OIG Response: The fundamental problem is the lack of transparency. Thus, it is really not a question of increased oversight but one of effective oversight. This lack of transparency basically limits our ability to properly audit as much as 30 percent of the FEHBP costs (i.e., prescription drug benefits).

Therefore this "effective" oversight allowed by better PBM transparency will permit my office to:

- Determine whether all financial benefits (i.e., rebates and other manufacturer payments paid to the PBM by drug manufacturers) earned as a result of FEHBP drug utilization were properly calculated and returned.
- Perform detailed claims analysis for both retail and mail order pharmacy charges, to include auditing back to the original source data (e.g., manufacturer billings) to identify improper payments due to both claim payment errors and possible fraud.
- Review PBM administrative costs charged to the FEHBP to ensure that they are reasonable, allocable, and allowable.

We anticipate that OPM will be able to use the results of our audits to understand the value of the program's current prescription drug benefit and ultimately explore new and innovative solutions to better contain the cost of this program. The only difficulties OPM might have going forward is aligning the appropriate resources to ensure that the FEHBP prescription drug benefit is both cost effective and meets the needs of its beneficiaries.

Honorable Stephen F. Lynch

Questions from Congressman Gerald Connolly:

1) Dan Adcock of NARFE suggested that purchasing prescription drugs through the Federal Supply Schedule would be beneficial to federal employees who use those prescription drugs. Would you anticipate cost savings resulting from use of the Federal Supply Schedule?

OIG Response: Currently the lack of transparency hinders our ability to compare the PBM pricing structures with the Federal Supply Schedule (FSS). However, studies by the U.S. Government Accountability Office (formerly U.S. General Accounting Office) have found that the FSS prices tend to be around 40 to 50 percent less than the Average Wholesale Price.[1] Based on my understanding of the contracts between PBMs and several large FEHBP plans, this discount is significantly higher than what the FEHBP is receiving. However, the FSS prices do not include the cost of dispensing the drug or interacting with enrollees.

We are currently working on a project to compute the average price paid in 2008 and 2009 for the most popular prescriptions in the largest FEHBP plan's mail order program. This effort, which has taken a substantial period of time and amount of resources, will help us better answer the question when we compare the prices the FEHBP and its subscribers paid to the FSS pricing for the same time frames. I will provide you with our findings when the project is complete. Baring any major complications, we expect to complete this analysis in the next eight to ten weeks.

2) I believe OPM proposed a pilot or other program in 2000 or 2001 to procure prescription drugs from the Federal Supply Schedule. I have heard different reasons as to why that effort failed. Why do you think that effort failed? Would you support a similar effort today?

OIG Response: It is our understanding that in 2000, the Special Agents Mutual Benefit Association (SAMBA) entered into discussions with OPM regarding use of the FSS by the SAMBA FEHBP plan. The U.S. Department of Veterans Affairs (VA), which administers the FSS, agreed to work with OPM to make it available to SAMBA. Despite the cooperation of VA, OPM and SAMBA were forced to abandon the pilot. Three major companies in the pharmaceuticals market, Pfizer, Merck and Parke-Davis, decided not to fill orders. They each refused to supply their products to SAMBA from the FSS. Without that cooperation, the pilot project was not viable and was dropped.

If you have any additional questions, please feel free to contact me.

Sincerely,

Honorable Stephen F. Lynch
Patrick E. McFarland
Inspector General

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[1] See General Accounting Office, VA and DoD Health Care: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges, GAO-02-969T (July 22, 2002), Table 1, p.5. See also General Accounting Office, Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes, GAO/HEHS-00-118 (August 7, 2000), Table 2, p.12.

March 10, 2010

The Honorable Stephen F. Lynch
Chairman
Subcommittee on the Federal Workforce, Postal Service and the District of Columbia
B-349A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Lynch:

I am writing to respond to your request that, as part of the record on the subcommittee's February 23, 2010 hearing regarding H.R. 4489, "The Federal Employees Health Benefits Program Prescription Drug Integrity, Transparency, and Cost Savings Act," I answer questions asked by Congressman Gerald E. Connolly.

To follow are Congressman Connolly's questions and my responses:

Congressman Connolly: "In your written testimony, you suggested that purchasing prescription drugs through the Federal Supply Schedule would be beneficial to federal employees who use those prescription drugs. Would you anticipate cost savings resulting from the use of the Federal Supply Schedule?"

NARFE's response: *Yes, we would expect that there would be significant cost savings if prescription drugs covered by Federal Employees Health Benefits Program (FEHBP) plans were purchased through the Federal Supply Schedule (FSS). The Departments of Veterans Affairs, Defense, the Public Health Service and the Coast Guard presently use the Federal Supply Schedule to buy listed prescription drugs at a 24 percent discount. 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.*

Congressman Connolly: "I believe OPM proposed a pilot or other program in 2000 or 2001 to procure prescription drugs from the Federal Supply Schedule. I have heard different reasons as to why that effort failed. Why do you think it failed? Would you support a similar effort today?"

NARFE's response: *The two-year pilot project was designed to contain high prescription drug costs in FEHBP's Special Agents Mutual Benefit Association (SAMBA) health plan by using the FSS. The Office of Personnel Management (OPM) dropped the pilot project when three major pharmaceutical corporations -- Pfizer, Merck and Park-Davis -- decided not to fill orders for SAMBA enrollees. The drug manufacturers argued they did not have to provide SAMBA drugs at the Federal Supply Schedule discount because, unlike the Department of Defense and the Department of Veterans Affairs, the employee organization plan, while part of FEHBP, was not a government agency. At the time, some FEHBP insurance carriers also opposed the SAMBA demonstration, particularly Blue Cross/Blue Shield.*

NARFE's Legislative Program for the 111th Congress supports "the use of the Federal Supply Schedule by FEHBP plans to purchase prescription drugs on behalf of enrollees."

Congressman Connolly: "Sometimes it seems like there are clear cut cases where one side loses and one side wins. Right now, it seems like PBMs are profiting at the expense of federal employees, and that the legislation would protect federal employees by reducing the excessive profit margins of PBMs. Is this an accurate characterization of the legislation?"

NARFE's response: *We would agree that there is a clear cut case that federal workers and annuitants lose when individuals not enrolled in the Federal Employees Health Benefits Program (FEHBP) pay less than FEHBP enrollees for prescription drugs simply by using a retail pharmacy discount card. However, it is less apparent if workers and annuitants are losing when watchdogs like the OPM Inspector General say that "the cost structures of Pharmaceutical Benefits Managers are utterly non-transparent," and as a result, "there is no objective basis to determine whether the terms being offered to an FEHBP carrier by a PBM represent an advantageous relationship."*

It is our hope that, at the very least, the Chairman's legislation would provide OPM with the transparency tools necessary to determine whether cost savings achieved by PBMs are being passed through to FEHBP enrollees. Federal workers and annuitants would also be protected by provisions in the bill which guarantee that the savings achieved by PBMs are passed on to FEHBP enrollees.

Please let us know if there is anything else NARFE can do to be helpful. Thank you again for the opportunity to testify. We look forward to working with you and your colleagues on this important issue.

Sincerely,

Dan Adcock

Dan Adcock
Legislative Director

Statement of:

National Association of Chain Drug Stores

On:

H.R. 4489, The Federal Employees Health Benefits Program (FEHBP) Prescription Drug Integrity, Transparency, and Cost Savings Act

To:

U.S. House of Representatives
Committee on Oversight & Government Reform
Subcommittee on Federal Workforce, Postal Service and District of Columbia

February 24, 2010

Introduction
Chairman Lynch, Ranking Member Chaffetz, and members of the Subcommittee, the National Association of Chain Drug Stores (NACDS) is pleased to have this opportunity to submit a statement on H.R. 4489, The Federal Employees Health Benefits Program (FEHBP) Prescription Drug Integrity, Transparency, and Cost Savings Act.

The National Association of Chain Drug Stores (NACDS) represents 154 traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate 37,000 pharmacies, and employ more than 2.5 million employees, including 118,000 full-time pharmacists. They fill more than 2.5 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States.

Fair and Accurate Pharmacy Reimbursement
We have reviewed H.R. 4489, and would like to comment on the sections pertaining to pharmacy reimbursement. The legislation establishes a maximum reimbursement to pharmacy benefit managers (PBMs) for prescription drugs, as well as a maximum dispensing fee for pharmacies. NACDS has significant concerns with these provisions.

Specifically, the legislation sets maximum reimbursement for PBMs at a drug's average manufacturer price (AMP). This is troubling, since setting a PBM's maximum reimbursement at AMP will result in reimbursement to pharmacies that contract with the PBM at below AMP levels.

AMP was created to determine manufacturer rebates in the Medicaid program, and has never been used as a reimbursement benchmark. While the use of AMP to determine maximum pharmacy reimbursement for generic drugs in the Medicaid program was required by the Deficit Reduction Act of 2005 (DRA), the unlawful regulation published by the Centers for Medicare and Medicaid Services (CMS) to implement AMP under the DRA was challenged and enjoined over two years ago pursuant to litigation by NACDS and the National Community Pharmacists Association (NCPA). In addition to the preliminary injunction, Congress also acted to delay the use of AMP as a reimbursement benchmark, including a provision in the Medicare Improvements for Patients and Providers Act (P.L.110-275) to temporarily halt its implementation.

These actions to delay the use of AMP in determining pharmacy reimbursement were prompted because the benchmark, as defined by the CMS final rule, will result in insufficient payment to pharmacies. Several government studies have confirmed that the reimbursement policy created by the DRA would result in reimbursement to pharmacies that is, on average, below their costs to obtain prescription medications.[1]

Use of AMP as a benchmark for reimbursement requires several critical policy changes, including: an accurately defined AMP, use of weighted average AMP to determine reimbursement for generic drugs, and a sufficient multiplier to accommodate for delays in updating data as well as the variance in prices paid by pharmacies for drugs.

Definition: A federal court has determined that the CMS rule defining AMP does not comply with the statutory definition of AMP contained in the Social Security Act, which defines AMP as the average price paid by wholesalers to manufacturers for covered drugs distributed to the retail pharmacy class of trade. As a result, the AMPs currently reported to CMS by drug manufacturers do not reflect the statutory definition of AMP. If AMP is to be used for pharmacy reimbursement, it should not include

[1] GAO-07-239R Medicaid Federal Upper Limits

rebates, discounts and sales that are not part of the retail pharmacy class of trade. These entities obtain discounts and rebates not available to retail pharmacies.

Weighted Average AMP: CMS has interpreted the DRA to mandate the use of lowest AMP to set federal upper limits (FULs) for generic drugs. Use of the lowest AMP, required by DRA, fails to take into account the wide range of market prices for generic drugs. Moving to weighted average prevents reliance on the prices of small generic suppliers. Use of these AMPs would obviously result in market prices that are not widely and generally available to retail pharmacies.

Multiplier: One of the most difficult aspects of creating a fair and accurate AMP-based reimbursement system is determining an appropriate multiplier – that is, an appropriate "mark up" above the cost of a product to cover pharmacies' costs and make a reasonable return. Determining the correct multiplier is challenging since average manufacturer price data are not publicly available, and because an AMP that accurately reflects the average price paid by wholesalers for drugs distributed to the retail class of trade is not currently being reported to CMS.

Because of the challenges presented with the use of AMP as a reimbursement benchmark, NACDS urges the consideration of Wholesale Acquisition Cost (WAC). WAC is currently in use by both private and public payers. Aware that the publication of average wholesale price (AWP) might be limited, the Department of Defense (DoD) selected WAC as the benchmark for its most recent pharmacy contract for the TRICARE program, after extensive analysis of available benchmarks.

WAC values are readily available from commercial database vendors. In addition, WAC values are updated on a daily basis, which is of critical importance to reflect constant price changes in the marketplace. Since WAC approximates wholesalers', rather than pharmacies', acquisition costs, a markup is necessary in order to reflect retail pharmacies' acquisition costs.

There are two components of pharmacy reimbursement – product reimbursement as well as a dispensing fee - to cover the costs of dispensing a medication. In addition to requiring the use of AMP for product reimbursement, H.R. 4489 also sets a maximum dispensing fee that PBMs may pay pharmacies. NACDS understands the desire by policymakers to create a system where reimbursement for drug product closely reflects the pharmacy's cost to acquire prescription medications. However, we would also like to stress the importance of fair and accurate reimbursement for the cost to dispense prescription medications. A national study conducted by the accounting firm Grant Thornton found that the actual cost to dispense is approximately $10.50. When determining reimbursement for pharmacies, it is critical to consider both drug product and dispensing costs.

Conclusion

Thank you for the opportunity to submit this statement. We look forward to working with the Committee on legislation that results in reimbursement levels that encourage pharmacy participation in the FEHBP program, helping to maintain access to pharmacies for FEHBP beneficiaries.

February 9, 2010

The Honorable Stephen F. Lynch
Chair, Subcommittee on Federal Workforce, Postal Service, and the District of Columbia
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Lynch and Members of the Subcommittee:

I understand that you are holding a hearing on Wednesday, February 10, 2010, on H.R. 4489, a bill to regulate the pharmaceutical marketplace in America by amending the statute authorizing the Federal Employees Health Benefits Program. This is to provide my analysis of that bill, and to request that these comments be included as part of the record on that hearing.

I am a long-standing consumer advocate, and an expert on the FEHBP program, on Medicare, and on prescription drug benefits in Federal programs. I am the author of *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, a book published by the American Enterprise Institute (AEI) last fall. For three decades I have been the primary author of the annual *CHECKBOOK's Guide to Health Plans for Federal Employees*. I was a consultant to the Centers for Medicare and Medicaid Services (CMS) on implementing the Medicare Advantage Program and the Medicare Prescription Drug Program. As a Federal employee, I headed staff work for an initiative that advised the Secretary of Health and Human Services on reforming the payment for prescription drugs in the Medicaid program. For many years I was responsible for reviews of all proposed HHS regulations to assure that they were both effective and minimally burdensome. Views expressed in this letter are my own, not those of AEI, CHECKBOOK, CMS, or HHS.

I have testified a number of times before this Subcommittee and other Congressional Committees on the FEHBP, on Medicare, and on health-related consumer information. In my recent book, I demonstrated that the consumer-driven FEHBP program has for five decades outperformed original Medicare in cost control, benefit generosity, fraud prevention, protection from catastrophically high health care expenses, avoidance of pork barrel earmarks, and customer service to enrollees. H.R. 4489 would jeopardize all these achievements. I believe it to be a sincere effort to improve the FEHBP program, but an effort fatally flawed by undue reliance on advocacy groups and alleged experts who fail to understand either the program or the legal, economic, and behavioral forces that affect the ability to control health care costs in America today.

I am concerned that in H.R. 4489 the Congress may enact legislation that would seriously damage the FEHBP and the 8 million Americans who depend on that program, with additional and serious adverse effects on other Federal programs and on all Americans who rely on a competitive marketplace for prescription drugs. I have grouped my analysis into three categories:

- The absence of credible evidence that there is a problem in FEHBP drug purchasing costs or drug management practices that justifies legislation, i.e. "if it ain't broke, don't fix it;"

- The burdens and damaging effects that a massive regulatory program would place not just on the FEHBP but also on other Federal programs and the private marketplace (and that would far exceed OPM's ability to administer), without achieving any consequential savings or other benefits; and
- The availability of alternative reform options that address real problems in coordination of premiums and benefits between Medicare and the FEHBP, that would save billions of dollars to both taxpayers and enrollees without burdensome regulations (reforms that are well within OPM's ability to administer).

A. There is no credible evidence that spending on prescription drugs in the FEHBP is wasteful or is higher than in other Federal programs, and hence no defensible rationale for enacting a "reform" to solve a nonexistent problem.

T*he FEHBP plans and their PBM contractors have successfully managed prescription drug benefits in recent years in ways that have generated major savings to the program and that have substantially outperformed programs such as Medicaid and TRICARE in containing prescription drug costs*. The Medicare Part D prescription drug program was modeled in large part after the FEHBP, and has been an outstanding success in reducing spending on drugs by almost 40 percent from the original projections of the Congressional Budget Office and the Medicare actuaries. Both FEHBP and PDP have been successful in restraining costs through consumer-driven competition among plans, and the various techniques participating plans use to manage drug reimbursement, including tiered copays that reward selection of less of expensive drugs, use of mail order to reduce costs of maintenance drugs, judicious formulary decisions, and use of Pharmacy Benefit Management Firms to bargain aggressively with drug manufacturers, bargain with retail pharmacy stores, and handle the complexities of processing and paying millions of drug claims with near-perfect accuracy.

If there are suspicions that money is being wasted despite the record of overall success in these programs, *the first and only sensible step is to obtain expert and objective studies on the amounts and causes of waste, and useful remedies for any such waste* ***before, not after****, enacting legislation that would drastically alter the program in ways that might increase rather than decrease spending on drugs, and disrupt the entire prescription drug marketplace*. The General Accounting Office (GAO), the Congressional Budget Office (CBO), and the Office of the Inspector General (OIG) at HHS are all fully capable of comparing drug spending in the FEHBP to drug spending in other Federal programs that serve large numbers of enrollees through retail pharmacies, notably Medicare Part D, the Medicaid program, and insurance of civilian dependents and military retirees under TRICARE. (Neither the VA nor TRICARE procurement for Military Facilities should be used for comparisons, since these programs obtain their savings by using highly restrictive formularies that would never be accepted by Federal employees or retirees, and deliver their medicines at government facilities rather than through local pharmacies.) In this regard:

- The GAO has in recent years performed two general assessments of the methods used by FEHBP plans and their PBM contractors to manage drug costs (most recently the 2003 study "Federal Employees Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies"). *Both GAO studies found that the virtually unanimous opinion of the many stakeholders consulted was that the FEHBP was managing its drug benefits successfully and frugally, with substantial savings to the program and broad access of enrollees to needed medicines and convenient pharmacies*. The importance of the latter factors is highlighted by the decision of some one million

veterans eligible for free drugs from the VA to voluntarily pay premiums to Medicare Part D plans to improve their access. While these GAO studies did not provide the detailed research and analysis that would be needed in an authoritative cross-program and multi-year evaluation, *the GAO studies did provide persuasive evidence that current FEHBP pharmacy arrangements are effective and efficient.*

- The union partnership organization, Change to Win, has just published a study entitled "CVS Caremark's Generic Rip Off." This is neither an expert nor objective study. The study's estimates of the total cost of alleged waste are badly flawed and greatly exaggerated because it erroneously assumes that all generic drugs are purchased at local pharmacies. In fact the great majority of generic drugs used by Blue Cross standard option enrollees are purchased through mail order, at prices to both enrollees and the plan that are significantly lower than at retail pharmacies. As another major failing, the Change to Win study fails to mention, let alone adjust its calculations to reflect, the Blue Cross standard option's innovative benefit feature that provides free generic drug replacements for the first four prescriptions after switching from a name brand drug. Blue Cross standard is many times larger than Blue Cross basic option in the number and cost of prescriptions paid. *Hence, the overall conclusion of the study that hundreds of millions of dollars are wasted on drug purchases by the Blue Cross plans is completely unsupported by the analysis and clearly erroneous.* In addition, the study is artfully worded to mislead readers by implying that consumers are paying more than they should for drugs, when in fact Blue Cross enrollees need pay the regular copayment for prescription drugs only if it is lower than the pharmacy price. Hence, consumers who buy drugs at bargain CVS prices get just that—a bargain.

Most of the testimony to this Subcommittee at the Hearing held in June of 2009 and the Change to Win study commit another fallacy that is common to studies that focus only on ingredient costs of drugs. *The big savings in prescription drug management under programs that provide wide choices of drugs to enrollees come from either generic or therapeutic substitution, not from saving small fractions on drug acquisition costs.* Consider a plan that pays $5 for a generic drug and $100 for the name brand drug that is chemically identical. Another plan pays $4 and $80, a 20% saving on both versions. If the first plan succeeds in getting two thirds of its enrollees to switch to the generic, and the second plan succeeds with only one third, the first plan spends an average of about $35 per enrollee and the second plan about $55 per enrollee, almost twice as much. The seeming saving hides massive unnecessary waste. The strength of the FEHBP program and of the similar Medicare Part D program lie primarily in the ability of plans and their PBMs to provide incentives and mechanisms for such substitutions. *No analysis of drug costs in the FEHBP or any other program can be complete, or accurately calculate overall savings or excess costs, without dealing with actual utilization of lower cost drugs as replacements for higher cost drugs, or without focusing on total spending per enrollee over time.*

The Subcommittee's hearing on FEHBP prescription drug costs in June of 2009 obtained *testimony from critics that, carefully read and properly interpreted, failed to provide any evidence of waste in FEHBP drug spending.* The hearing record shows that:

- A witness from the Department of Defense testified on drug costs in the TRICARE program. The testimony indicated that this program had engaged in a series of reforms in recent years to bring down the rate of increase in TRICARE drug spending. Those reforms notwithstanding, his testimony stated that during the period 2000 through 2008 total pharmacy program expenditures grew from $1.6 billion to $6.9 billion, more than

fourfold (Hearing page 77) and far, far more than the increase in drug prices in this period. During this period TRICARE enrollment rose very modestly, hence per enrollee spending also increased about fourfold. Yet the OPM Inspector General testified that from 1999 through 2007, per enrollee spending on prescription drugs in the Blue Cross plan had only doubled (Hearing page 27). While there are doubtless adjustments that would be needed for a fully accurate comparison, *the data provided to your Subcommittee last June demonstrates the overwhelmingly superior performance of the FEHBP's largest plan in controlling drug costs in comparison to TRICARE.* Moreover, the CBO in a recent study (June 2009, "The Effects of Proposals to Increase Cost Sharing in TRICARE") estimated that even after recent reforms, the program could actually have reduced its prescription drug spending by over $1 billion dollars a year in 2009 had it used more aggressive cost sharing techniques to encourage substitution, similar to those used in most FEHBP plans.

- A supposedly expert witness testified that she was "surprised to see that your invitation letter to me stated that Federal [employee and retiree] costs for pharmacy benefits are 30 percent of total health care spending. Normally, I would see pharmacy costs as 20 percent of total health care, and I would conclude that your program is really, no deal" (Hearing page 32). Obviously, this witness was unfamiliar with the FEHBP program and unaware that the great majority of FEHBP drug costs are for elderly annuitants, a much larger group in the FEHBP than in private employer plans. Elderly people have many times higher drug costs than younger people, and the FEHBP has been by far the primary source of drug coverage for Federal annuitants. The great majority of retirees over 65 are covered by Medicare Parts A and B, which together pay roughly four-fifths of total hospital and physician costs. As a result, the major category of spending left for these enrollees in FEHBP plans is prescription drugs. *Accordingly, there should be nothing surprising about the 30 percent figure (actually, it is 25 percent) when comparing the FEHBP to private plans. That the figure is not far higher demonstrates the successful efforts to control the pharmaceutical costs of annuitants by FEHBP plans.*

In summary, the evidence that FEHBP drug spending is somehow wasteful or excessive is essentially nonexistent. No one has even performed the most important kinds of analysis, such as comparing total and per enrollee FEHBP spending over time on prescription drugs for age 65 and over enrollees, age 55 to 65 enrollees, and younger enrollees, with the corresponding enrollees in Medicare Part D, Medicaid, and TRICARE. Until such studies are conducted, there is no evidentiary basis for supposing there is any substantial waste in FEHBP drug spending.

B. The proposed bill would create a pervasive Federal regulatory program encompassing the entire prescription drug marketplace, with massive effects, most negative, not only on the FEHBP, but also on all public and private drug programs. The price control and other regulatory responsibilities it would place on OPM far exceed any present or likely future capabilities of that agency.

The proposed bill would require OPM to become an economic regulatory agency, with a scope of responsibilities for price controls and antitrust policy perhaps not seen in this country since World War II. Even were such a program otherwise justified, its proper locus is not the FEHBP and the Office of Personnel Management is manifestly unqualified to administer it. Moreover, each major section of the bill would create uniquely serious problems.

The bill would essentially prohibit CVS Caremark from doing business with the Federal government, by making it illegal for a firm that combines retail pharmacy with pharmacy benefit management to contract with any FEHBP carrier to perform PBM functions. Other Federal agencies and plans that operate under other Federal programs such as Part D would find it difficult to not to follow suit. This bill would appear to force either a corporate divestiture, a radical antitrust remedy that is rarely used in modern times and never used absent evidence of abusive monopoly powers, or to debar CVS Caremark from at least the FEHBP market. There is no apparent reason why such an extreme remedy should be imposed by the Federal government against this company or any of the smaller companies that are organized in this fashion. There are two Federal agencies, the Justice Department and the Federal Trade Commission, that have jurisdiction over antitrust issues. There are press reports that the FTC is conducting an investigation of CVS Caremark. *It would be a radical departure from good government and due process for the government to mandate such a divestiture or debarment while the responsible agency is investigating and before it has reached any conclusion as to either problems or appropriate sanctions, if any.* Banning this corporation from PBM arrangements with FEHBP plans would remove a major competitor to other large PBM firms such as Medco and Express Scripts. As a result, the FEHBP plans would likely face higher costs in their PBM contracts than they would if there were greater competition.

Quite apart from due process, there is no apparent substantive reason why this corporation should be singled out and debarred from doing business with FEHBP plans. The Change to Win campaign cites many examples of corporate mistakes, but most of the claimed bad behaviors seem to be accidental mistakes, minor misdeeds, or in some cases nothing but normal practices of plan sponsors and the PBM firms they hire (e.g., in one of a number of You Tube film clips apparently sponsored by Change to Win, the alleged misdeeds are substituting a generic drug for a chemically identical name brand drug, and encouraging or possibly requiring use of mail order for repeat prescriptions, as shown at http://www.youtube.com/watch?v=YAth43nhA6M.). If these are misdeeds, then almost all FEHBP plans are "guilty" and their PBM contractors are the wrong targets. In the June Hearing (page 11), the National Community Pharmacists Association, an organization with a long history of opposition both to mail order pharmacy and to tight ceilings on ingredient prices (such as the AMP price ceiling proposed in H.R. 4489) makes a number of antitrust allegations, but those are precisely the issues under investigation by the FTC. If there is some compelling rationale as yet undisclosed, it is not clear why such a debarment should not apply equally to Medicare Part D plans and private insurance plans.

The bill would impose drug substitution restrictions. This would inject the Federal government into an area that has long been the exclusive regulatory domain of the States. It therefore raises major Federalism questions. Furthermore, State anti-substitution laws already prohibit pharmacists from making non-generic substitutions under all but rare circumstances. It is hard to believe that there is a problem so severe as to warrant Federal legislation that would encroach on States' authority in this area. (The 2005 report of the FTC, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," found that therapeutic switching was rare, and that therapeutic interchange usually lowered costs to insurance plans.) *If there is such a problem it is not an FEHBP problem, but far broader. Again, it is hard to understand why any such legislation should, if justified, not apply to Medicare Part D and Medicaid, and arguably to private sector health insurance. And wherever a Federal oversight function for pharmacy practice might belong, it is certainly not with OPM.* Finally, the bill as drafted would prohibit PBMs from "proposing" therapeutic substitutions to physicians, an infringement not only on free speech, but also on one of the major expert functions performed by PBMs and one of the most

important methods of reducing drug costs as well as of educating physicians on both efficacy and side effects of alternative medicines.

The bill would mandate an immediate 99 percent pass through to carriers of all rebates, discounts, and other remuneration received by the PBM from drug manufacturers, to the extent such sums "relate to" the FEHBP carrier's contract. This would be a major intrusion into the details of business arrangements. It would require the carrier, the PBM, and the manufacturer to follow this model without regard to their other legal or contractual obligations, or the practical realities of the marketplace. It would also encourage creative accounting to evade this straitjacket, and place OPM in charge of a massive set of accounting issues, far exceeding any existing OPM skills or responsibilities. Again, there is no reason to think that any such requirements, if justified, should be limited to the FEHBP and not extend to Medicare Part D and Medicaid under a common statutory scheme, particularly since these and other Federal programs have rebate policies that are not handled as proposed in this bill. Moreover, it is quite unlikely that this provision would reduce costs to the program, and it might even raise costs:

- *Such a pass through would reduce incentives of PBMs to bargain for discounts, offsetting possible savings to the FEHBP. In combination with the AMP price ceiling discussed below, FEHBP plans might effectively be forced into a "cost plus" mode of contracting, with predictable increases in prices paid.*
- Manufacturers could avoid these restrictions by selling to FEHBP carriers through wholesalers rather than PBMs, thus effectively forcing the plans to return to the antiquated and more costly business models of decades ago, and lose the efficiency and expertise provided by PBMs. The Congress could presumably modify the statute to close this way of escaping onerous regulation, but in doing so would risk even worse outcomes.
- *Because manufacturers have substantial discretion as to how they market to PBMs, including the ability to reduce rebates and compensate PBMs for this reduction through lower administrative fees, there is no reason to think that they would not make these adjustments to minimize or negate any losses and hence any FEHBP savings.*
- Again, there has been no credible showing from expert sources that there is a serious problem that would justify the Federal government intervening to create a "one size fits all" set of business practices for the prescription drug sector of the economy.

The bill would make it onerous and costly for PBMs to sell utilization or claims data, and allow any state what amounts to a veto power over such sales. Quite apart from other legal, economic, and Federal role issues, this would disrupt one of the most valuable methods of obtaining vital information used by the Federal government itself. National aggregations of claims information are used in analyzing drug costs and patterns of usage by agencies such as GAO, CBO, and HHS, and in detecting and analyzing drug interactions and infrequent side effects not detectable in Phase 3 drug trials, by the Food and Drug Administration and a wide range of medical researchers at NIH and in academia. Again, OPM would become the regulator—tasked with approving each individual sale of such data from a PBM—despite no expertise or staffing to perform such a function. *Again there is no credible evidence that there is any serious problem requiring Federal regulation of any kind (other perhaps, than to prevent States from interfering with this valuable interstate market), and certainly no discernable connection to problems, if any, unique to the FEHBP.*

The bill would set "Average Manufacturer Price" (AMP) as a ceiling on carrier payments for drug ingredients. AMP prices are set by manufacturers, and can be lowered or raised by manufacturers to maximize revenues (higher prices lose sales, but may increase dollar revenues).

This is a stringent price ceiling and one that could make it difficult for independent pharmacies to participate in the FEHBP. It is yet another area in which other Federal programs use different standards, where laws and practices may conflict across programs, and where OPM has no expertise. A predictable effect of such a limitation (assuming that manufacturers did not evade it in ways discussed above) is that manufacturers would simply raise AMP prices to offset revenue losses. This is not a hypothetical outcome. A quarter century ago, the (Senator) Boren amendment to Medicaid drug payment rules tied Medicaid reimbursement levels to the lowest prices at which products were sold. Manufacturers promptly refused to continue to give VA such deep discounts, and the ensuing multi-hundred million dollar hit (in today's dollars) to the VA budget led an embarrassed Congress to rapidly exempt not just VA but also many other public entities from being included in the legislated formula. *If manufacturers find too many dollars riding on existing AMP prices, they can raise them, with potentially substantial cost increases to the Federal Supply Schedule, TRICARE, and VA.*

There are numerous other provisions that would create jurisdictional, administrative, and unintended side effects problems similar to those described again. Of special note, OPM would become a major arbiter of pharmacist wages, by setting dispensing fees. While these powers under the bill would apply only to FEHBP contracts, they would likely have major spillover effects. OPM would become an agency in charge of both wage and price controls affecting a large segment of a three hundred billion dollar sector of the economy, and subject to all the lobbying and political interventions that wage and price controls necessarily create. *Dispensing costs and pharmacy remuneration is yet another area of great complexity where OPM has no expertise.* Of special note, there are numerous defensible methods for allocating "joint" pharmacy costs to dispensing, and hence a wide range of essentially arbitrary outcomes for which OPM would become responsible. In Medicaid, where States set dispensing fees, these range from several dollars per scrip to ten dollars or more. (The economists' term for this problem is "joint cost allocation" and an Internet search will quickly disclose the complexities involved and the absence of any objective methods that are not arbitrary in practice—which explains the wide range of dispensing fee outcomes in Medicaid.)

Under the bill, *FEHBP enrollees would also be drowned in a sea of confusing information about prices charged from carriers to PBMs, and from PBMs to pharmacies, prescription by prescription.* This requirement is easily understood by analogy to groceries or clothing. Instead of the consumer getting only a sales slip with the price he paid for each item, he would get an additional sales slip by mail showing not only his price but also the price the store paid the wholesaler and the price the wholesaler paid the farmer (or manufacturer). This information would be required to be provided for every single drug purchase, many millions of times a year, to solve an undisclosed consumer information problem. The FEHBP program has far better options to spend tens of millions of dollars in postage to mail information to enrollees, not least of which is to require plans to mail annuitants a copy of OPM's annual *Guide to Federal Benefits for Federal Retirees and Their Survivors*. And consumers do not want this deluge of information. They already have the price information that matters to them for drugs, in sharp contrast to their inability to get price information for medical and hospital prices.

Finally, the bill would require PBMs to provide OPM voluminous information on sales prices, contracts, rebates, accounting methods, and much more, on every line of business. That is, OPM would request and receive essentially all financial information in the possession of each PBM firm not only on its FEHB contracts, but also on Medicare Part D, Medicaid, VA, TRICARE, and every private client (e.g., Fortune 1000 companies and tens of thousands of smaller

employers). What OPM could possibly do with this mountain of information is unclear. Presumably the purpose would be to audit the books to make sure FEHB rebates were properly calculated and allocated, on the grounds that OPM would have to see data on all rebates to make sure the FEHBP share was properly calculated. *Sorting through and actually analyzing every single piece of financial information for dozens of PBM firms, each with hundreds or thousands of clients would be a practical impossibility even if OPM hired hundreds of auditors.* Virtually any provision for collecting and using such data that the Subcommittee might craft would potentially conflict or overlap with audit provisions in the Social Security Act that apply to Medicare Part D, so again there are implications that go far beyond the FEHBP. In addition, despite the bill's prohibitions against disclosure of this sensitive and vital business information—vital because disclosure would undermine the ability of PBMs to bargain effectively by pitting one manufacturer against another to reduce the costs of drugs—the addition of OPM to the small group of agencies with access to such data would greatly increase the risk of disclosure. Most importantly, as I argue above, a focus on ingredient costs really misses the point. It is total drug spending per enrollee that should be the primary focus of evaluating prescription drug spending in a program such as the FEHBP. And drug spending is driven by many factors of far greater importance than ingredient rebates, or even total ingredient costs.

In summary, the cumulative burdens and problems created by these proposed provisions are immense, and the likely benefits small or nonexistent. One side effect seems almost a certainty: some PBMs would simply refuse to do business with the FEHBP rather than subject themselves to such massive and intensive interference, resulting in higher costs to the program as carriers increasingly found themselves unable to obtain attractive bids. Likewise, some health plans would likely leave the program, particularly those for whom the FEHBP is only a small part of their business. The responses of manufacturers are harder to predict, but if any appreciable number refused to sell under these conditions to FEHBP-participating PBMs, the entire regulatory apparatus would collapse. Most importantly, these provisions are certain to have substantial effects on other Federal functions, other Federal budgets, private health insurers, and the entire private sector pharmaceutical marketplace.

There is a larger issue here as well. The FEHBP model has for five decades produced impressive results in cost control, benefits, and access with only the lightest regulatory hand. Competing health plans make independent business decisions, and finding the right mix among lower costs, better benefits, better access, and better service is rewarded by success in attracting enrollees. This consumer-driven model works extremely well, despite design deficiencies which the Congress has neglected fixing, and the Congress should not lightly throw it away. The Congress should certainly not throw it away based on the anecdotal assertions and sometimes erroneous information it has received from a handful of witnesses and a handful of outside parties with vested interests at stake.

Variants of the regulatory scheme encompassed in this bill could be extended to physicians, hospitals, devices, dentists, and other health care providers and services doing business with FEHBP carriers. We already have a Federal program that operates under such a command and control system. It is original Medicare. And we know that despite all the ingenuity that the Congress and CMS have lavished on micromanaging this program over the years, original Medicare is outperformed by the FEHBP in all important respects. The new Medicare drug program, modeled on the FEHBP, has produced impressive results in controlling costs while responding to consumer preferences. Why on earth would the Congress want to take steps that might destroy this superior, proven, approach?

C. There are major FEHBP reforms that could produce genuine savings reaching billions of dollars annually. Prominent among these are better coordination with Medicare, not only for hospital and physician costs, but also for prescription drug benefits. CBO recently scored a Medicare coordination reform I proposed as saving one billion dollars a year. That reform, expanded, could reduce FEHBP costs for prescription drugs as well as for hospitals and physicians.

The FEHBP program is showing its age. Its design has withstood the test of time remarkably well, but is frayed around the edges in several areas. In testimony at a hearing of this Subcommittee in December 2008 on "FEHBP Financial Problems and Blue Cross Benefit Reductions and Premium Increases" (http://oversight.house.gov/images/stories/documents/20081203144040.pdf) I dealt with a number of these problems and useful reforms to reduce them. In *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, I focused on those and additional reforms. In this letter I focus on one issue—Medicare coordination—and on proposals that would reduce taxpayer costs by improving Medicare coordination, similar to proposals made in those writings.

Almost all of the national fee-for-service plans in the FEHBP offer age-65 retirees a seemingly wonderful benefit enhancement. The plans promise that if the retiree has both Medicare Parts A (hospital) and B (physician) as primary insurance, all hospital and physician care will be free under the FEHBP plan—no deductibles, no coinsurance, and no copayments. Not only that, all this medical care will be free whether or not the enrollee uses preferred providers—network constraints go away. What could be wrong with this wonderful benefit enhancement? It comes at a high price. In 2010, the most popular plan choice in combination with Medicare, Blue Cross standard option, will cost a retired couple $7,130 in FEHBP and Medicare premiums. This is a "for sure" expense, whether or not they ever see a doctor.

This same couple was most likely enrolled in that same Blue Cross option until age 65, and was satisfied with its good benefits, despite its "pricey" premium. What changed upon turning age 65 that impelled them to pay an extra $2,300 a year for two Part B premiums? The answer is that this decision is sensible for that couple only because the existing system for coordinating premiums and benefits is irrational.

Of great importance to the FEHBP, Medicare, and the United States Treasury, that couple's decision is expensive. That retired couple and the providers they use have no incentive to be frugal in any way in making decisions about any kind of health care other than prescription drugs and dental care. Unlimited provider visits to expensive specialists are free. The most discretionary surgical procedure is free. Durable medical equipment is free. Every conceivable medical test is free. Thousand dollar MRI and CAT scans are free. If an additional scan might add just a touch of reassurance, the price of zero is just right amount to justify the second scan. A recent *New Yorker* article (June 1, 2009) by Atul Gawande probed the costs of medical care in McAllen, Texas. His main example of bad decisions was a medical condition that could almost always be cured by inexpensive drugs over a period of several months, or cured immediately by a safe but moderately expensive surgical procedure. He thought the inexpensive drugs should be tried first. But for most FEHBP retirees (and apparently many other McAllen patients) the surgical procedure is a free as well as a fast cure, the drugs a modestly costly and a slow cure. Why would any enrollee, or any physician, opt for more cost and lesser benefit? The cumulative effect of such perverse incentives, whose algebra is created by "free" care under immensely

generous insurance benefits, has been estimated to cost the nation more than $500 billion a year in unnecessary health care spending.

Based on research findings on the effects of cost sharing incentives, on average each person enrolled in a wraparound FEHBP plan and Medicare Parts A and B costs the Federal government somewhere on the order of 25 percent or more in spending than a person without such "free" care and facing significant cost-sharing, according to CBO estimates. With approximately 1.5 million individuals enrolled in both Medicare and the FEHBP, the Federal government loses as much as $3 billion a year or more in wastefully increased utilization under the current system. Most of this cost falls on Medicare (which pays first) but half a billion dollars a year or more falls on the FEHBP. And it falls disproportionately on plans like Blue Cross standard option, because they attract a disproportionate number of Medicare enrollees.

Meanwhile, it appears that increasing numbers of age-65 retirees are deciding not to enroll in Medicare Part B. They calculate, correctly, that they will save substantially in most years by not having to pay two sets of premiums. This trend will accelerate as more and more higher income retirees face the Medicare income-tested Part B premium penalty. Every such decision actually saves the Federal government money by reducing incentives for wasteful overutilization, but those savings accrue primarily to Medicare. The effect on the FEHBP is to raise premiums overall, and especially in those plans that disproportionately attract retirees. FEHBP plans individually and the program as a whole would see reduced costs if more Medicare-eligible enrollees sign up for Part B. Most of this saving would, however, be offset by wasteful overutilization if current benefit design remains unchanged.

There is a major alternative that would not only reverse this trend, but reduce unnecessary spending substantially. Instead of enriching benefits to eliminate all hospital and physician cost sharing, in a decreasingly successful effort to induce Medicare participation, plans could instead directly subsidize Medicare Part B premiums, paying half or more and possibly the entire cost. Ideally (from a government-wide and taxpayer perspective) plans would be strongly discouraged or even prohibited from improving physician and other ambulatory cost sharing, but instead limited to premium subsidies or allowed only to add benefits that are not covered by Medicare, such as vision care, dental care, and hearing aid coverage. That OPM's longstanding policy of discouraging dental benefits in health plans would be reversed should be of no concern since hundreds of millions of dollars in real savings to both enrollees and the taxpayer would be involved. Alternatively, the dental subsidy could be directed towards paying premiums for OPM's standalone dental plans.

Viewed from a beneficiary perspective, a better result than the current system would be no-cost Part B coverage, generous hospital, medical, and drug benefits that are identical pre- and post-age 65, and modest additional benefits (such as a dental subsidy) not available pre-Medicare. Take-up would be near 100 percent (why would anyone decline a free benefit?), and almost all enrollees would directly gain more than they do under the current wrap-around scheme, as well as retaining the ability to go out of network should they so choose, either using the Medicare Part B benefit or, if plans so chose, receiving regular benefits without network restrictions.

Among the other benefits of such a reform, it would encourage retirees to remain in HMO plans, since there would no longer be an advantage for enrolling in national fee-for-service plans. As a result, the FEHBP would benefit from the superior cost control exercised by HMOs. (At present, one third of employees enroll in HMOs, but most retirees migrate to the "free" care of the

national plans, so that only one tenth of annuitants are enrolled in HMOs.) Even more importantly, it would reduce the risk segmentation problems that plague HMOs such as the Kaiser plans and national plans such as Blue Cross standard option, and let them compete more fairly and evenly with plans that have fewer elderly enrollees, thereby improving the workings of the competitive FEHBP system as a whole.

For reasons lost in history, a quarter century ago the Congress quietly inserted an unprecedented constraint on the FEHBP into the Medicare statute. Under Section 1840 of the Social Security Act, no FEHBP plan is allowed to subsidize the purchase of Part B, unless the funds involved come from (nonexistent) sources other than FEHBP premiums. (Section 1840 (d) reads, in pertinent part: "A plan described in section 8903 or 8903a of title 5, United States Code [i.e., an FEHBP plan], may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part [i.e., the Part B premium] if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions [FEHBP premiums] described in section 8906 of such title.") The Federal government is now perhaps the only employer in America that cannot defray the cost of Medicare Part B for its retirees. Were FEHBP plans allowed, encouraged, or required to pay Part B premiums, reducing current wraparound coverage on an actuarially comparable basis, the plan budgets would benefit substantially from net *increases* in Part B enrollment, and from net *decreases* in unnecessary health care utilization.

In 2008 I suggested to the CBO that it take a look at this idea. CBO agreed that my proposal would save the government a good deal of money—approximately $1 billion a year and $11 billion over ten years. The CBO analysis of its version of my proposal (not exactly the same as I propose here) can be found as Option 94 in *Budget Options Volume 1: Health Care*, December 2008. CBO estimated that almost all the savings would accrue to Medicare. My own estimate is that the FEHBP would retain about 20 percent of the savings, roughly in line with the proportion of spending that the FEHBP plans pay as secondary insurers.

This reform can be substantially improved by adding prescription drugs to the mix. At present, only GEHA among FEHBP plans offers a concrete incentive to retirees to enroll in the Medicare Part D Prescription Drug benefit. GEHA combines a relatively weak drug benefit in its own plan with a guarantee that if the retiree enrolls in Part D, which pays first, GEHA will pay 50 percent of whatever costs are not covered by the Part D plan. As a practical matter, this means that enrollees choosing this combination of benefits typically pay only token sums for generic drugs, no more than 15 or 20 percent for most name brand drugs (depending on the specifics of the Part D plan's benefits), and never more than half. For almost all other FEHBP plans, enrollees are told only that "you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage ... however, if you choose to enroll ... your FEHB plan will coordinate benefits with Medicare" (found in brochures on the inside front cover). This namby-pamby language actually discourages dual enrollment, since the plans make no firm benefit commitment.

My present proposal is that FEHBP plans be encouraged or required to offer a benefit similar to GEHA's, and in addition be required to pay the entire Part D premium, up to $30 a month, for any enrollee who signs up for any Part D plan. For couples, the subsidy would be doubled. Wherever enrollees live, $30 a month is enough to pay the entire 2010 Part D premium for one (or usually many more) low cost Part D plans. The effect of this would be to shift about $1,000 per enrollee of prescription drug costs (net of premium payment) from FEHBP to Medicare. From a government-wide, taxpayer perspective this is essentially a wash. However, assuming a

50 percent take up rate, it means that *the FEHBP would save perhaps a half billion dollars a year in drug spending*. Taken together with the Part B change, and depending on exact design details, the Medicare and FEHBP programs would share roughly equally in the overall savings from improved coordination. Enrollees would often but not always gain, and never lose (they could refuse to enroll in Part D). This reform could be implemented in part without legislation, and in time for the 2011 plan year, if OPM were to require this spring that all plan bids include concrete improvements in prescription drug cost sharing for enrollees who joined Part D.

(A similar payment of the Parts B and D premium could also be offered to age 65 military retirees, with some differences in benefit supplementation reflecting the particular structure of TRICARE for Life. Since current copayments for drugs are very low in that program, retirees would need an additional incentive to enroll in Part D. One option might be government payment of the dental premiums that the program otherwise requires of enrollees, along with payment of the Part D premium, in return for modest Part D supplementation leaving retirees with higher out of pocket costs for drugs than under present arrangements. According to CBO estimates, increasing the enrollee share of drug benefits is vital to increasing substitution that would reduce overall drug costs to the TRICARE program (recall that TRICARE drug spending has quadrupled in recent years, and that CBO estimates show that at least a billion dollars a year is wasted under present cost sharing arrangements). CBO estimates of savings from proposals to introduce modestly higher cost sharing for hospital and physician costs in TRICARE are also in the billions of dollars. But past proposals were "dead on arrival" because there was no quid pro quo for military retirees. Paying the Part B premium offers a very substantial "for sure" monetary benefit to offset modest increases in cost sharing.)

The FEHBP coordination reforms proposed above would advantage enrollees, plans, the FEHBP program as a whole, and taxpayers. All will benefit both employees and retirees in both the short and long run, by holding down unnecessary spending and thereby reducing premium costs for the entire program. I urge this Subcommittee to think "out of the box" in assessing the current state of the FEHBP and possible reform options like these. There is plenty of practical and analytic help to be found in the CBO, OMB, GAO, and OPM, as well as from the FEHBP carriers. I wish you success in crafting useful reforms that would actually succeed in improving the performance and reducing the costs of this vital program. The FEHBP needs genuine reform, not regulatory schemes of doubtful efficacy and great cost, promoted by outside parties whose expertise and vision are both limited, and whose interests do not coincide with those of FEHBP stakeholders.

Sincerely,

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cc: The Honorable Jason Chaffetz, Ranking Member

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