Testimony of Ryan Oftebro, PharmD, FACA

Testimony before the U.S. Senate Committee on Commerce, Science and Transportation

Bringing Transparency and Accountability to Pharmacy Benefit Managers

Thursday, February 16, 2023

Good morning, Chair Cantwell, Ranking Member Cruz, and members of the Committee.

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

Kelley-Ross Pharmacy is a veteran-owned small business that has served the Seattle community since 1925. My father, John, is a pharmacist and owned Kelley-Ross since 1973. I grew up in the pharmacy, and after serving in the Marine Corps, I attended pharmacy school at the University of Washington and took over the practice in 2005. We currently have 4 locations providing high-quality care for our most vulnerable populations, including community pharmacy, Long Term Care, and community-based clinical services, and we have repeatedly been recognized for excellence and innovation by our profession.

Independent pharmacies like Kelley-Ross provide a crucial public safety role in our communities. In our rural and island communities, the pharmacist is not only the most accessible but often the ONLY healthcare provider available within miles. Our ability to care for our patients is under a very real threat from harmful PBM practices that are costing our patients and limiting their access to pharmacy services.

I appreciate the opportunity to speak in support of the PBM Transparency Act (S.127). This is a crucial piece of legislation to prevent PBM abuses, such as harmful “claw backs” after a prescription has been dispensed that are harming patients by overinflating their prescription drug costs and eliminating access to their preferred community pharmacies across the country.

I would like to share an example of these abuses, that resulted in a group of Medicare Part D beneficiaries being overcharged hundreds of thousands of dollars and the closure of the community pharmacy that had served them for decades, crushed by retroactive fees.

Since 1989, Kelley-Ross Pharmacy operated a location in a Seattle neighborhood that was the preferred pharmacy for a labor group, made up of both active and retiree members. The retirees were enrolled into a single Medicare Part D plan. This was an uncommon situation for a community pharmacy; however, it provided us with some unique insight into how a PBM can manipulate the system at the expense of our seniors.

To illustrate how this happened, we can look at one drug. Generic rosuvastatin is an inexpensive medication used to treat cholesterol.

A 90-day supply of rosuvastatin cost the pharmacy approximately $10.00 to acquire from our drug wholesaler.

The highly inflated and completely arbitrary Average Wholesale Price (AWP) for this drug was $805.40/90 tablets. This value is set by the manufacturer and used as a contracting benchmark by PBMs.

Historically, for a generic medication available from multiple manufacturers (multisource), we would submit the claim and the PBM would reimburse us at a level based on their proprietary software that determines the average actual acquisition cost of the drug. This is called the Maximum Allowable Cost (MAC) and is written into all PBM/pharmacy contracts. The pharmacy would be paid right around $15.00, and the patients' copay would be $15.00 or less. Because this medication is an inexpensive multisource generic, it was usually found in the lowest copay tier 1 of 4 so the patient copays were nominal.

Things changed in 2021, with patient costs increasing exponentially. The PBM moved rosuvastatin from Tier 1 with a nominal copay to Tier 3 which had historically been reserved for brand-name medications only. This increased the copay from $15.00 to $141.00 for the same 90-day supply. There is no clinical rationale for this change. It simply created unnecessary out-of-pocket spend for the member, while creating a windfall for the PBM through the collection of retroactive Generic Effective Rate, or GER fees, from the pharmacy.

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

In 2021, the PBM set a new Generic Effective Rate at AWP-90%. They then set the pharmacy's reimbursement to intentionally "overpay" at a rate of AWP-83%, which just happens to be $140.50/90-day supply. Because the copay for tier 3 medications was $141.00, the PBM covered none of the prescription cost and the copay for rosuvastatin was $140.50 instead of the $15.00 it was the previous year. A difference of $125/90-day supply or over $500 more for the entire year out-of-pocket for the patient.

The PBM has now created a situation where the pharmacy was "overpaid" (in the form of patient copays) above the guaranteed GER of AWP-90%, at which point the PBM charges the pharmacy the difference (AWP-83% versus AWP-90%). This allowed the PBM to claw back over $80.00 that they never paid to the pharmacy. Extrapolate this over the Medicare population and the PBMs are profiting billions of dollars from patients' copays alone. This is just one of the ways that PBMs are profiting from obscure and completely nontransparent pricing. To make the process even more convoluted and untraceable the GER is not based on a per-prescription basis. It is based on an overall aggregate of all prescriptions across all pharmacies within a pharmacy services administrative organization or PSAO, which interacts with PBMs on behalf of independent pharmacies. That way there is no possible way to attribute the claw-back directly to an individual patient's copay.

This is just for one medication for one patient. We saw this happen over 150 times in 2021 with generic rosuvastatin, and it occurred with several other medications as well.

These patients would be better off without using their insurance and that is not right. In these situations, the pharmacy might be able to offer a much lower cash price, creating a better situation for both the patient and the pharmacy. However, the PBMs have created tools to disincentivize pharmacies from offering a competitive cash price to these Medicare patients. PBMs track patient adherence in the form of Medicare Star Ratings. If pharmacies fail to meet the PBMs expected adherence rate for cholesterol medications, which only happens when the patient's insurance is billed, the PBM penalizes the pharmacy in the form of increased direct and indirect remuneration (DIR) fees across ALL their claims. At the end of the day, the patient is faced with an unnecessarily high co-payment for a lifesaving medication, making it harder for them to take.

In 2018, this pharmacy had $81,000 clawed back from PBMs in the form of retroactive fees. In 2021 it increased to $538,810. This was largely driven by GER fees assessed by a single PBM for a single Part D plan, which resulted from artificial patient overpayments created by the PBM. This location was in the top 1% of all community pharmacies in the country in terms of our Medicare Star ratings for patient adherence, which means we experienced the lowest tier of DIR fees.

This contract move from MAC pricing to a GER also bypasses many pharmacies' ability to appeal a payment under laws enacted in most states typically referred to as MAC Appeals. This approach clearly attempts to circumvent legislative efforts to provide a level and fair playing field for all.

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

Unfortunately, this is not the only type of example of PBM abuses we have experienced.

Conclusion:

PBMs will argue that their business practices keep costs down. In reality, their vertical integration with payer and their own competing pharmacies creates massive conflicts of interest and self-serving business practices that are harming patients, increasing costs to employers and closing community pharmacies. S. 127 is a great step towards providing the necessary transparency on how PBMs administer their pharmacy benefit and holding them accountable when they participate in unfair or deceptive business practices which ultimately harm the patient.

We need PBM reform, and S. 127 is a very good start. We need legislation that provides transparency and protects consumers and the pharmacies that care for them from the harmful PBM practices that add cost and unnecessary barriers to care.

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

Thank you for the opportunity to share my story, and I welcome any questions.