



Senate Finance Committee
Hearing on
Pharmacy Benefit Managers and the Prescription Drug Supply Chain:
Impact on Patients and Taxpayers
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Thank you, Mr. Chairman and esteemed members of the Committee, I am honored to be here today to address an issue that is burdening patients, taxpayers, and those trying to help them.

The supply chain for medicine is riddled with perverse incentives, and marked by sky-rocketing prices. we see persistently rising prices on the medications people depend on, day after day, to treat widespread problems such as diabetes, high blood pressure, high cholesterol, and opioid addiction.¹ Key aspects of the problem can be traced to the industry that lies at the center of drug pricing—pharmacy benefit managers, or PBMs.²

¹ See CTR. FOR MEDICARE & MEDICAID SERV., FACT SHEET, DRUG SPENDING INFORMATION PRODUCTS (2018), <https://www.cms.gov/newsroom/fact-sheets/drug-spending-information-products-fact-sheet> (listing the ten drugs with highest annual price increases from 2012 to 2016 covered by Medicare); CAL. OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT, [PRESCRIPTION DRUG WHOLESALE ACQUISITION COST \(WAC\) INCREASES](#) (2019) (detailing wholesale price increases of more than 16% for hundreds of drugs between 2017 and Q2 of 2019); Feldman, Devil, *supra* note 1, at 2.

² For additional information on pharmacy benefit managers, see ROBIN FELDMAN, DRUGS, MONEY, AND SECRET HANDSHAKES: THE UNSTOPPABLE GROWTH OF PRESCRIPTION DRUG PRICES (2019) (discussing the role of PBMs in the pharmaceutical market); Robin Feldman, [Perverse Incentives: Why Everyone Prefers High Drug Prices—Except for Those Who Pay the Bills](#), 57 HARV. J. ON LEG. 303 (2020) (describing the incentive structures that lead PBMs to contribute to rising drug prices); Robin Feldman, [The Devil in the Tiers](#), 8 J.L. &

Historically, PBMs operated as claims processors, just handling the paperwork.³ But 15 years ago, when Medicare coverage expanded to include prescription drugs, PBMs offered to help health plans negotiate with drug companies for better prices.

But instead of prices coming down, prices of many drugs dramatically increased. For example, the prices of 65 common medicines have almost tripled, just during those 15 years.⁴ There are many contributing factors, but PBMs have been in the middle of it.

So how did this happen? How did PBMs—which were supposed to help negotiate lower prices—end up helping to inflate drug prices instead? Rather than act as honest brokers for the health plans, PBMs have acted in their own self-interest. And as it turns out, their own interests are not aligned with low prices.

Quite simply, higher prices put more dollars into a PBM's pockets. When the starting price of a drug rises, and the PBM negotiates a rebate, the PBM appears successful. It's like a store that raises the price of a coat before putting it on sale. The markdown looks like a great bargain; but it's not. In addition, the PBM often keeps a percentage of the rebate, so it gets to pocket more.

All of this might not be so bad if no one actually paid that high list price. But people do. Many consumers have what are called high-deductible plans, in which they pay that high list price out of their pockets until they reach a certain threshold;⁵ other plans require that patients pay a percentage of the high list price for what is known as co-insurance.⁶ And many Americans don't have coverage for prescription drugs, even if they have health insurance.

I mentioned raising the price of a coat before you put it on sale. It gets worse. Imagine if the price jump is higher than the sale discount. That's what's happening with medicine. Medicine prices are rising faster than rebates. Between 2010 and 2017 in Medicare, prices for particular drugs *after* rebate still rose 313% on average.⁷ We are buying the same coat, but it is costing us more and more. And a significant portion of that price increase is going to PBMs.

BIOSCI. 1 (2021) (analyzing the role PBMs play in distorting the organization of drug formularies); Robin Feldman, Why Prescription Drug Prices Have Skyrocketed, WASH. POST (Nov. 26, 2018), <https://www.washingtonpost.com/outlook/2018/11/26/why-prescription-drug-prices-have-skyrocketed/> (discussing the role PBMs play in the pharmaceutical market). For a discussion of potential solutions, see Feldman, Devil, at 31–41 (suggesting that drugs should be located on formulary tiers based on list, rather than net, price to remove the incentive for anticompetitive formulary manipulation); FELDMAN, SECRET HANDSHAKES, at 95–102 (describing the significance of transparency and potential state and federal level responses).

³ Feldman, WASH. POST, *supra* note 1.

⁴ STEPHEN W. SCHONDELMAYER & LEIGH PURVIS, AARP PUBLIC POLICY INSTITUTE, TRENDS IN RETAIL PRICES OF BRAND NAME PRESCRIPTION DRUGS WIDELY USED BY OLDER AMERICANS, 2006 TO 2020 1–2 (2021).

⁵ For an example of a plan requiring that the patient pay 100 percent of the costs of drugs up to a certain limit, see the Anthem insurance plan described at First Am. Consolidated Class Action Compl., at para. 13, In re Express Scripts/Anthem ERISA Litigation, 2018 U.S. Dist. LEXIS 3081 (S.D.N.Y. 2016) (No. 16–3399).

⁶ See Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy 408–09 (2017).

⁷ Feldman, Devil, *supra* note 1, at 19, 21–22.

A PBM may be brokering deals for a health plan, but it is a strange relationship. PBMs refuse to tell the health plans—their own clients—the details of the deals they are making. Neither health plans, nor the government, nor the market has any disclosure.⁸ Given their monopoly over pricing information, and the fact that just three PBMs control most of the market,⁹ PBMs are setting the terms of almost every arrangement. It is not a free or fair market.

And despite the fact that PBMs should be serving as honest brokers for the health plans, PBMs also ask drug companies for side payments—again, payments that rise when the price of the drug rises. And they vigorously deny having a fiduciary or any other type of duty to act in the best interests of the health plan and its patients.

So, what so PBMs do to protect their income stream of rebates and side payments? PBMs stand at the center. As well as negotiating prices, PBMs help decide if patients will be reimbursed and how much they will be reimbursed. So, when dealing with drug companies, PBMs can offer to exclude a drug company’s competitor or make it harder for patients to get the competitor’s medicine.¹⁰ As a result, less-expensive medicines are disadvantaged, and patients are channeled into higher-priced drugs.

Although the pharmaceutical supply chain is complex, the overview of these aspects of the problem can be summarized fairly simply: PBMs are able to exploit their role at the center to extract dollars and channel the system towards higher-priced drugs. Patients and taxpayers must pick up the bill.

⁸ PBMs refuse to disclose net prices, the precise size of rebates, or the details of the rebate terms, asserting that the information is a trade secret. Even auditors and regulators are not given full access. For an explanation of why prices and price terms negotiated between PBMs and drug companies do not constitute trade secrets, see Robin Feldman & Charles Tait Graves, [Naked Price & Pharmaceutical Trade Secret Overreach](#), 22 Yale J.L. & Tech 61 (2020).

⁹ Neeraj Sood, Dana P. Goldman, & Karen Van Nuys, Follow the Money to Understand How Drug Profits Flow, STAT (Dec. 15, 2017), <https://www.statnews.com/2017/12/15/prescription-drug-profits-pbm/> (“The top three pharmacy benefit managers, which negotiate drug prices on behalf of insurers and self-insured employers, dominate 85 percent of their market.”). See also Neeraj Sood, Transcript of Understanding Competition in Prescription Drug Markets: Entry & Supply Chain Dynamics Workshop (Nov. 8, 2017), https://www.ftc.gov/system/files/documents/videos/understanding-competition-prescription-drug-markets-panel-2/ftc_understanding_competition_in_prescription_drug_markets_-_transcript_segment_3.pdf.

¹⁰ See generally ROBIN FELDMAN, DRUGS, MONEY, AND SECRET HANDSHAKES: THE UNSTOPPABLE GROWTH OF PRESCRIPTION DRUG PRICES (2019). For press reports and case allegations describing formulary exclusion as a result of rebate deals, see, e.g., Charles Ornstein & Katie Thomas, *Take the Generic, Patients Are Told. Until They Are Not.*, N.Y. TIMES (Aug. 6, 2017) (describing health plans forcing patients to pay more for the generic version of a drug or declining to reimburse for the generic at all; <https://www.nytimes.com/2017/08/06/health/prescription-drugs-brand-name-generic.html?mtrref=undefined> [<https://perma.cc/U4JU-4P3X>]; see also Complaint, Regeneron Pharmaceuticals Inc. v. Amgen Inc., No. 1:22-cv-00697 (D.Del 2022) (alleging bundled rebates for cholesterol medication induced health plans to exclude competitor medication from formularies in order to obtain rebates) case number [1:22-cv-00697](#), in the U.S. District Court for the District of Delaware; Complaint, Shire U.S., Inc. v. Allergan, Inc., No. 17-7716 (D.N.J. 2017) (alleging bundled rebates for the eye medication Restasis deterred health plan formularies from including competitors); Complaint, Pfizer, Inc., v. Johnson & Johnson and Janssen Biotech, Inc., 2018 U.S. Dist. LEXIS 31690 (E.D. Pa. 2018) (No. 17-4180) (bundled rebates for the rheumatoid arthritis drug Remicade resulted in hospitals and health plan formularies essentially excluding the lower-priced biosimilar).