To: RI House Corporations Committee

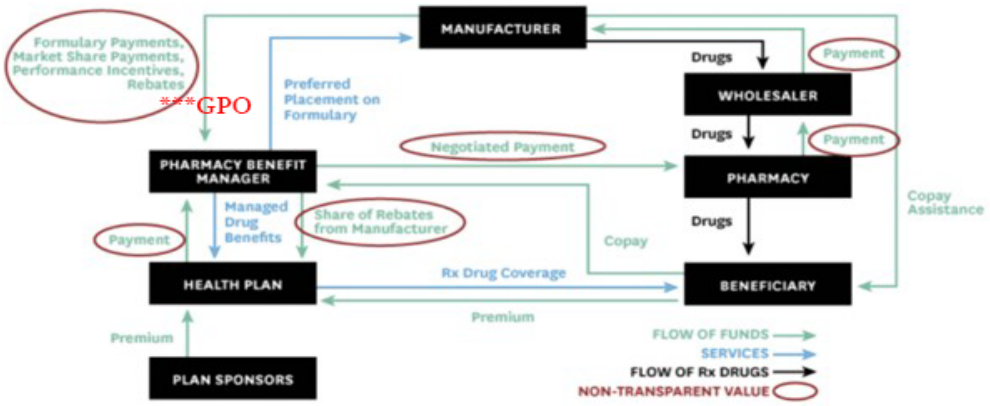
From: J. Mark Ryan, MD, FACP, Physicians for a National Health Program – RI Chapter, Chair

Date: 1/30/24

Re: In support of 2024 – H. 7139 – better oversight of PBMs

In a health care system that functions properly, as in Canada, the insurance company, Canadian Medicare, is large enough to negotiate lower prices from pharmaceutical companies to minimize cost to the insured. The United States unfortunately has a dysfunctional system in which individual insurance companies are too small to effectively negotiate lower prices. They therefore hire another middleman, pharmacy benefit managers (PBMs) to deal with this. PBM's do not negotiate lower prices. Instead, PBM's make deals with pharmaceutical companies to put their drugs on formularies and exclude their competitors, from which they receive kickbacks. These deals, not the efficacy of the pharmaceuticals in question, determine which drugs are available to patients. The judgement of treating physicians does not enter into this process at all. In addition, the current system of getting drugs from manufacturers to patients is so complex and opaque, middlemen are able to syphon off huge revenues without evidence of actually helping consumers.

Figure 1: Unknown Flows of Funds in Drug Distribution System



***Group Purchasing Organizations (GPOs) - New since 2020 layer

Source adapted from, Sood, N., et al., "Flow of Money Through the Pharmaceutical Distribution System," USC Schaeffer Center for Health Policy white paper. https://healthpolicy.usc.edu/research/flow-of-money-through-the-pharmaceutical-distribution-system/

This complicates and compromises the care I can provide my patients. I spend hours every week trying to figure out which medicines are covered by each patient's insurance and which are not. I get forms from PBMs every week telling me that medicines my patients need or have been successfully treated with for years are no longer covered and the patient will need to be prescribed a different medicine. The forms usually do not bother to tell me which alternatives are covered. Frequently, patients do worse when they are forced to change drugs or use covered alternatives. In addition, many cannot even afford to take drugs that are "covered" because they are in a higher "tier."

For example, COVID has caused many people with latent asthma to become full-blown asthmatics. The guidelines from professional societies now recommend a combination steroid/bronchodilator inhaler be used as first-line therapy. In our current system, these are very expensive. For example, Advair costs about $180 per inhaler even if you have insurance). In Canada, you can get Advair for about $35 per inhaler. Many of my patients now routinely get their medicine by mail order from Canada. Of course, their insurance will not cover the cost of medicines from an "out of network" pharmacy, so they pay out of pocket.

Periodically I am contacted by area hospitals and emergency rooms about my patients who have been admitted for complications of chronic conditions such as hypertension, diabetes and COPD. Frequently a major cause of the problem is that the patients were not taking the medicines to control these because they could not afford them but they were too embarrassed or ashamed to tell me.

PBMs are causing problems, not helping solve them. I urge you to pass S. 106 to better monitor and control the damage they are inflicting on patients.

J. Mark Ryan, MD, FACP