Written Testimony on Hearing:

The Role of Pharmacy Benefit Managers in Prescription Drug Markets
Part I: Self-Interest or Health Care?

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Miriam Atkins, MD, FACP

AO Multispecialty Clinic (Augusta, Georgia)

President, Community Oncology Alliance

COMMUNITY ONCOLOGY ALLIANCE
Innovating and Advocating for Community Cancer Care

1225 New York Avenue, NW, Suite 600
Washington, D.C. 20005
(202) 729-8147 | communityoncology.org

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Chairman Comer, Ranking Member Raskin, and members of the House Committee on Oversight and Accountability, thank you for the opportunity to submit this written testimony. I appreciate appearing before the Committee to talk about my experiences on the frontlines of medical care dealing with pharmacy benefit managers (PBMs) almost daily and their policies that hinder patient care.

I am a medical oncologist with AO Multispecialty Clinic, which is located in Augusta, Georgia. I have been with my current group for 23 years, which is a medical practice with physicians specializing in medical oncology, hematology, gynecological oncology, rheumatology, and urogynecology. We treat patients in the greater Augusta area at four clinic locations. Prior to that, I worked for Texas Oncology after serving eight years in the United States Army Medical Corps.

I currently serve as President of the Community Oncology Alliance (COA), an organization dedicated to advocating for the complex care and access needs of patients with cancer and the community oncology practices that serve them. COA is the only non-profit organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving treatment for cancer. Since its grassroots founding 20 years ago, COA's mission has been to ensure that patients with cancer receive quality, affordable, and accessible cancer care in their own communities where they live and work, regardless of their racial, ethnic, demographic, or socioeconomic status.

In my 33 years of taking care of patients, with 30 of those years treating patients with cancer, I have seen many advancements in the treatment of cancer. Cancer is no longer a death sentence. Many Americans with cancer are now cured or are at least living normal, productive lives with cancer. These positive changes are due in large part to research and innovations in how cancer is treated, as well as improvements in how cancer is screened and diagnosed.

While there has been remarkable progress in treating cancer, there are many notable obstacles that we oncologists now face that hinder patient care. When I first started treating cancer patients, I was able to be their physician and focus on caring for them while relying on the knowledge and skills I honed during my extensive oncology training. I didn't have to spend countless hours fighting with faceless corporations to justify the treatment plans I developed in concert with my patients. That has changed dramatically as I now have to struggle daily to be a physician because I am forced to deal with faceless, corporate middlemen who practice medicine, without a medical degree or years of expertise.

Every day, my partners and I literally have to fight with insurance companies and their pharmacy benefit (mis)managers to overcome their objections and hurdles to the nationally recognized life-saving treatment and care that my patients deserve and expect. The consolidation among health insurers and among the top PBMs, and now between each other, has created an oligopoly of sorts controlling what treatments I give and how and where they are given. More and more, they are practicing medicine without a license or regard for my patients.

It is very important for Congress to understand that many of the new oncology drugs are in oral formulations. While oral medications offer patients the convenience of not having to come to the clinic for treatment, they often create more obstacles for patients when it comes to insurance coverage at the hands of PBMs, and how and where they are able to obtain their often life-saving drugs. Due to the fact that upwards of 35 percent of drugs we use to treat cancer are orals, and very expensive at that, PBMs have found a very lucrative and profitable market in these oral medications.

Our medical practice has a drug dispensary on-site where most of these oral cancer medications are available. As such, we are able to integrate drug treatment with these agents with the overall care of our patients. Our medical team is able to make sure patients understand the importance of taking these drugs as indicated and how to deal with any side effects produced by the medications. However, the PBMs and their corporate insurers more often are mandating that patients get their medications not from our clinic integrated at the site-of-care but from their remote mail order pharmacies that the top PBMs own. They essentially rip a critical component of the patient's treatment out of our hands simply so they can profit.

Not only do PBMs mandate that patients get their medications from their mail order pharmacies, which causes delays and even denials of treatments, but PBMs often dictate use of their "preferred" drug, which can greatly hinder my patients' care. After all, who knows best how to treat my patients – me or some faceless, profit-seeking corporation?

Let me give you some real-world stories of how PBMs and their corporate insurers hinder and even are a detriment to patient care.

I have a patient, a 69-year-old man with multiple myeloma, who had stage 3 disease when he was diagnosed. He had his initial rounds of chemotherapy followed by a stem-cell transplant. The standard of care for most multiple myeloma patients is to start taking the oral medication lenolidamide once the patient has recovered from the transplant. I wrote a prescription for this medication for my patient on October 14, 2022. When I saw him for a follow-up three weeks later, he told me he had not received the medication. I spoke with my pharmacist about this and was informed that his PBM required the medication to be filled by the specialty pharmacy Biologics. We contacted Biologics and were told the insurance company had redirected the prescription to their PBM, CVS Caremark. My pharmacist contacted CVS Caremark and was told they were waiting for the patient to call them. My patient called his insurance company and was told they were waiting for authorization from my office. My patient finally received his medication on December 5, 2022. His care was delayed by almost eight weeks.

Another patient I have is a 61-year-old woman with hormone +/HER negative metastatic breast cancer. The standard of care for this type of patient is a hormone blocker and what is known as a CDK 4/6 inhibitor. I wanted to treat my patient with ribociclib along with a hormone blocker. Her insurance denied the ribociclib and stated they would only approve the drug after my patient had failed palbociclib (another CDK 4/6 inhibitor). This insurer and PBM tactic is referred to as “fail first” step therapy. However, with CDK 4/6 inhibitors, it is not standard of care to use another drug in the same class after failure on the initial drug. This is how PBMs and their insurers practice medicine without a license and do not understand what standard of care is, thus endangering the lives of cancer patients.

A 63-year-old woman with a history of breast cancer and colon cancer has now developed a metastatic gastrointestinal stromal cancer (GIST). The standard of care for her cancer is imatinib, which is a drug that has been around for almost 30 years. When my pharmacist billed it through her insurance company, my patient’s copay would have been $1,500 per month. Because the patient could not afford that amount, my pharmacist decided to check the price of the drug. Amazingly, my practice was able to provide my patient the drug at a cost of $128 per month. This is a difference of $1,372 that the middleman is pocketing as profit.

Any oncologist can provide the committee with many more examples, like the ones I have documented in this testimony, where PBMs and their insurers hinder and delay patient care. This is especially true in the cases where the PBMs mandate use of their own mail order pharmacies. As I have previously related in this testimony, when I write a prescription for an oral cancer drug and it is filled at our clinic, the medical staff and I know that the patient walks out of the clinic with their medication and understands how and when to take it. Additionally, I am able to closely monitor my patients’ progress. I control the treatment, not the corporation.

The use of PBM mail order pharmacies for potentially life-saving cancer drugs is unreliable, unsafe, and wasteful. For example, many oral cancer medications require refrigeration, yet patients have had medications that were shipped by a PBM pharmacy left on their front porch or mailbox during the heat of summer. Additionally, PBM mail order pharmacies often send 90 days of medication. However, if I need to change the dose of the drug because of side effects – which I often do – medication is wasted. Worse yet, the PBM will not fill that same drug until after 90 days. This also leads to more expense for patients. Most of our patients keep their appointments as scheduled, but if a patient has 90 days of medication, they might not keep their follow-up appointment for monitoring and the un-monitored medication could cause harm to the patient.

PBMs say they save money for those paying the bills, including patients. However, the reality is that PBMs hinder care and cost everyone involved, including patients, more money. The top PBMs, integrated with the largest insurers, have such leverage that they do what they want. And what they want is to profit at the well-being and expense of my patients. They are not only driving independent pharmacies out of business but physicians as well, weary from the day-in, day-out fight with PBMs.

Finally, as I am writing this testimony, I am just learning from my colleagues in Washington State and Oregon how Prime, the PBM for some of the largest Blue Cross plans in the country, has a convoluted mandate to switch infusable drugs like chemotherapy from the medical benefit to the pharmacy benefit. Aside from being an unsafe operational mess, this will simply expose all patients receiving infusable cancer treatment, like chemotherapy, to the dangerous prior authorizations, "fail first" step therapy, and overall delays and denials of treatment. As I have stated, the top PBMs, often under the same corporation as the top insurers, do what they want and how they want. They are taking the practice of medicine out of the hands of doctors.

Congress needs to pass legislation that will rein in the abuses that PBMs inflict on patients and their providers and how they ratchet up drug costs.

In addition to what I have written above, I submit for the record seven volumes of PBM "horror" stories that COA has compiled. Here are the links to those documents:

PBM Horror Stories Volume I

PBM Horror Stories Volume II

PBM Horror Stories Volume III

PBM Horror Stories Volume IV

PBM Horror Stories Volume V

PBM Horror Stories Volume VI

PBM Horror Stories Volume VII

I appreciate the opportunity to provide this testimony and answer any questions during the hearing or after.

Miriam Atkins, MD, FACP
AO Multispecialty Clinic
President
Community Oncology Alliance