



# RECAP

Multi-Disease Coalition  
Capitol Hill Briefing on

# PHARMACY BENEFIT MANAGERS



PARTNERSHIP TO ADVANCE  
**Cardiovascular  
Health**



**DCAN**  
DERMA CARE ACCESS NETWORK

# INTRODUCTION



On June 21, 2023, the Partnership to Advance Cardiovascular Health, The Headache & Migraine Policy Forum and the Derma Care Access Network co-hosted a briefing at the United States Capitol. The event briefed legislators' staff on the burdens that pharmacy benefit managers and prior authorization can place on patients and health care providers.

Senator Marsha Blackburn (R-Tenn.) offered opening remarks, calling for accountability and transparency in the opaque pharmacy benefits manager industry. Other speakers included migraine specialists, dermatologists, cardiologists and patient advocates.

Several key themes resonated throughout the event:

- Prior authorization places a heavy administrative burden on medical practices.
- Prior authorization can create significant delays for patients, hindering care and heightening the risk of adverse reactions to medications.
- Pharmacy benefit managers, or PBMs, can make medication less affordable and harder for patients to access.
- The current coverage system allows insurers to dictate medical decisions without medical expertise, leading to burnout for providers and suboptimal care for patients.

# PRESENTERS

Speakers' full remarks have been provided below. They have been edited for clarity and brevity.



## Courtney Lamar

The process of getting prescribed medications approved by insurance companies can be frustrating and time-consuming. It often involves long wait times on hold, being transferred multiple times, and speaking to representatives who lack knowledge about a patient's health condition.

These interferences are often the result of utilization management.

Utilization management is a set of tactics insurers use to control access to medications, more often for cost-saving reasons than anything to do with health care delivery.

One utilization management practice is prior authorization. Prior authorization requirements cause significant delays, taking up to seven-10 days to process. Dealing with certain insurance companies can be particularly difficult, especially when handling complex cases. Patients living with chronic diseases may also not have the capacity nor expert knowledge to navigate an often-onerous denial and appeals process. PBMs add an additional layer of complexity to these challenges, as they vary in size and accessibility.

This situation has been worsening over time, leading to unnecessary denials of medications that patients have relied on for years and in some cases, dangerous outcomes for patients. The process needs improvement to ensure that patients receive the medications they need to live their lives.



## Dharmesh Patel, MD

Providers frequently say they feel frustrated by insurance restrictions, as it often stands in the way of providing the best care to their patients.

Prior authorizations cause heavy administrative burdens for providers and significant care delays for patients. The typical clinic can deal with more than 40 prior authorizations per week, and they significantly raise the likelihood that a patient experiences an adverse reaction.

Insurers sometimes switch patients for financial reasons. This practice is known as non-medical switching, and it has nothing to do with what is best for a patient. Many clinicians perceive non-medical switching as having a negative impact on quality of care, with some patients abandoning necessary medications as a result.

PBMs are third party companies that function as intermediaries between insurance providers and pharmaceutical manufacturers. PBMs create formularies, negotiate rebates (discounts paid by a drug manufacturer to a PBM) with manufacturers, process claims, create pharmacy networks, review drug utilization, and occasionally manage mail-order specialty pharmacies.

In light of rising [health care](#) costs, Congress is examining the role of PBMs with a particular focus on transparency to consumers regarding rebates and reimbursements.

Doctors have seen first-hand the resulting medication affordability issues caused by PBMs, whose financial interests often take precedence over patient needs.

Moreover, this entire ecosystem- where insurers with no medical expertise are dictating medical decisions - is leading to burnout among doctors.



## Sara Sacco, MD

Migraine is the second most disabling condition in the United States, costing employers and the economy billions of dollars in lost productivity. It affects one in six adults, women most commonly, and it can make it difficult for patients to do daily tasks – with family, work or school. Beyond the patient, migraines also negatively impact families and come with high costs to the healthcare system.

Clinicians aim to treat migraines effectively to prevent their escalation from episodic to chronic. Chronic headaches are defined as those occurring fifteen days a month. Proper treatment is vital to prevent an increasing likelihood the disease will lead to disability.

Getting patients on the most suitable medication is complicated by health plans, however. Insurance policies often require step therapy, where patients must try and potentially fail certain medications before they can access newer, potentially better treatments. This can delay effective treatment by months, even as the disease worsens. Some required medications might even be harmful to persons living with migraine disease given significant comorbidities in cardiovascular disease, for example.

Insurance policies... can delay effective treatment by months, even as the disease worsens.

The costs of not providing patients with prescribed medications are high, too. There is a notable increase in emergency room visits for migraines when treatments are not accessed, especially among Black and Hispanic Americans. They face higher rejection rates for treatments and coincidentally visit the emergency 20% to 24% more than white patients.

The Safe Step Act, if passed, would give providers greater latitude to treat individual patients.



## Lawrence Green, MD

Both prior authorization and re-authorization present significant challenges to my practice and patients. Even if a patient is stable and responding well to a medication, 25% of them will still be required by insurers to be reauthorized. Furthermore, 36% of patients report that the alternative medications they're switched to aren't as effective, and 27% end up abandoning the medication altogether.

The administrative and financial burdens that prior authorization and reauthorization place on medical practices are immense.

On average, staff spend 3.5 hours per day, and providers one hour per day, handling prior authorizations. Given a nationwide shortage of dermatologists, freeing up additional time could mean that potentially five to eight more patients could be seen per day.

Legislation like the Pharmacy Benefit Manager Reform Act and the Pharmacy Benefit Manager Accountability Act are a step in the right direction, especially with respect to Medicare. Being proactive at the federal level may pave the way for similar actions at the state level across the country.



# WRAP UP

## PBM Prescribing: The Doctor's Perspective

Noon - 1:00 PM



The Headache  
& Migraine  
POLICY FORUM



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Attendees were asked to support the following legislation in the 118th Congress:



The Pharmacy Benefit  
Manager Reform Act



The Patient Before  
Middleman Act



The Safe Step Act



The HELP Copays Act



The Improving Seniors  
Timely Access to Care Act,  
*if reintroduced*



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