MEASURE: SB 402
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CVS CAREMARK

Written Testimony in Opposition to Senate Bill 402

Submitted by:

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To:

The Senate Committee on Health Care and Human Services

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Salem, Oregon

Chair Monnes Anderson, Vice Chair Kruse, honorable members of the Committee on Health Care and Human Services, CVS Caremark is submitting this testimony in opposition to SB402, a bill creating and enacting a new section of the Century Code, relating to maximum allowable cost lists for pharmaceuticals. SB402 is being promoted as an effort to promote transparency in Maximum Allowable Cost (MAC) lists but it, in fact, serves to weaken the ability of Pharmacy Benefit Managers (PBMs) to drive down health care costs for our Oregon clients and consumers. It also interferes with private contracts in an unprecedented way. We respectfully ask for you to reject SB402.

CVS Caremark is the leading pharmacy health care provider in the United States. Through our integrated offerings across the entire spectrum of pharmacy care, we are uniquely positioned to provide greater access to care, engage plan members in behaviors that improve their health, and lower overall health care costs for health plans and their members. CVS Caremark provides multiple points of care to patients through our retail, mail and specialty pharmacies and MinuteClinics. As one of the country's top Pharmacy Benefit Managers (PBM), we also provide access to a network of more than 65,000 pharmacies, including more than 7,400 CVS/Pharmacy stores across the United States. We provide PBM services to over 2,200 clients who provide health coverage through large employers, unions, health plans and state and federal plans. We touch more than 60 million American lives and are one of the largest providers of Medicare Part D coverage.

In Oregon, CVS Caremark performs PBM services for many clients with significant operations and employees in Oregon. To name just a few, these PBM clients include health plans such as HealthNet Oregon, large employers such as Wells Fargo, FedEx, The Home Depot and Georgia Pacific, government clients such as Multnomah County and many more. IN 2012, CVS Caremark managed and/or dispensed nearly 10 million prescriptions in this state. We are a trusted and reliable source of health care for tens of thousands of Oregonians and we do not take this trust lightly and, in fact, take great pride in our employees and the services that they provide to the citizens of the Beaver State.

Introduction to PBMs

Pharmacy Benefit Managers (PBMs) provide a variety of prescription drug benefit design services to health plan clients, large employers, union trust funds and federal, state and local government agencies and public employee benefit plans.. Collectively, PBMs help clients design prescription drug benefit options to fit the sponsor's beneficiary population and needs and then administer the benefit on the sponsor's behalf and specifically tailored to meet the goals of the client initially outlined in their bid/RFP for prescription drug services. PBMs make prescription drugs more affordable for clients with such tools as:

- **Plan Design:** PBMs advise their clients on ways to structure their drug benefit in an innovative and cost-effective manner to ensure appropriate use of resources. A PBM's role is advisory only; the decision to select the features of the benefit rests with the client.
- **Network Optimization:** PBMs negotiate with thousands of pharmacies to create provider networks for beneficiaries to obtain prescription drugs, monitor safety issues across the network and ensure appropriate spending through audits and other efforts that promote network integrity.
- **Formulary Management:** PBMs use panels of independent physicians, pharmacists and other clinical experts to assist in developing a client's formulary or list of drugs approved and/or preferred for reimbursement by the client, and administer cost-sharing and utilization management (e.g., step therapy) as directed by the client. Some clients are large enough and sophisticated enough to have their own in-house expertise in this field and those clients may prefer to develop their own unique formulary. CVS Caremark will work with a client's formulary, we can assist in developing one with them or they can choose to use our formulary. Those are all contractual decisions and are driven by the client.
- **Mail-Service Pharmacy:** PBMs provide highly efficient mail-service pharmacies that offer safe, cost-effective and convenient home delivery of medications. This can be a valuable service for a company that might wish to have the convenience or to leverage savings to provide a richer overall healthcare benefit package for their employees and dependents that otherwise the client may not be able to offer.
- **Manufacturer Rebates and Discounts:** PBMs negotiate substantial discounts from drug manufacturers to lower benefit costs for sponsors and beneficiaries.

There are, essentially, three different types of Pharmacy Benefit Managers. ExpressScripts, is the best example of what can be termed as a "traditional PBM model". The second model is the health-plan carve-in, in which medical and pharmacy plans are offered as an integrated package. A good example of this model is United Healthcare and its in-house management OptumRx business unit. The third is the integrated PBM model. CVS Caremark is the third model and exists in a category of one. What's truly unique about this model is that it has all of the traditional PBM components (e.g. claims adjudication, formulary management, network development, mail-order and specialty) but in 44 states and growing, this model is able to offer clients the a benefit design that canpreserve the economic benefit of mail order while at the same time providing more flexible access to medications through either mail or retail. It also provides members with more ways to access clinical support – they can speak with a pharmacist at their local CVS Pharmacy or on the phone.

Introduction to MAC

MAC (Maximum Allowable Cost) is a common cost management tool specifying the reimbursement limit for a particular strength and dosage of a generic drug that is available from multiple manufacturers, but sold at different prices. It is calculated based on aggregate data that shows what pharmacies on average pay for generic drugs in the marketplace. MACs are used to ensure pharmacies are not overpaid or underpaid and that Payers and their members get the best deal. Likewise all pharmacies, may dispute the accuracy of any MAC claim and be compensated accordingly. For instance, in 2012, of approximately 10 million prescriptions for Oregon residents managed by CVS Caremark, there were less than 800 (or less than 0.0001%) MAC claim disputes/inquires by pharmacies. CVS Caremark reviews each claim and if a pharmacy is correct, we make a price adjustment for the specific generic product in question. That this happens doesn't mean the pharmacy did anything wrong and likewise nor did CVS Caremark. In some cases a pharmacy may be purchasing through a wholesaler who is not selling that generic to them at the price another wholesaler would or they may have purchased the drugs just before a negative price swing and their inventory is then more expensive than the rate that drug is now selling for on the open market. Because generic drugs are a true commodity, inventory management and days of supply on hand are very important business tools for a modern pharmacy to manage. This generic commodity market is not only efficient, but it is one of the key reasons that off-patent prescription drugs (generics) with multiple manufacturers making the same drug and competing for business are so affordable in comparison to brand drugs still on patent. Helping to move beneficiaries to less expensive generic drugs when appropriate is a key role that pharmacies and PBMs play. In fact, while brand drugs have increased in price over the last two years by an average of about 11%, generic drugs have in fact become even less expensive over the same timeframe.

It is important to note that there are currently 46 state Medicaid programs that now use MAC lists.. States adopted MAC lists after Government audits showed that Medicaid reimbursements for generic drugs far exceeded pharmacy's acquisition costs. The fact is that MAC lists are used in both the public and private sectors to help contol costs.

The clients of Pharmacy Benefit Managers are sophisticated purchasers of health care that rely on PBMs to manage their drug benefit. Pharmacy benefit managers consider many factors when establishing MAC lists, including: First Databank/Medispan data, the federal upper limits of CMS, wholesaler information, pharmacy incentive to dispense the generic over the brand, pharmacy feedback, non-MAC discounts and client performance guarantees, to name a few. Contract pricing, including MAC lists, are proprietary information and should not be publicly disclosed or available to other PBMs. Disclosure of proprietary pricing information would have a chilling effect on the generic drug marketplace and would actually drive prices higher. In fact, MAC disclosure has been deemed by the Federal Trade Association as an anti-competitive practice and would only serve to drive up costs in the entire marketplace, the opposite of what we as a nation are trying to accomplish with our infinite medical needs but our quite finite financial resources If MAC information is publicized, competing PBMs could have access to others' pricing information and this would not only be limited to PBMs, but competing pharmacies would have access to each others' reimbursement calculations further complicating and frustrating efforts to save consumers and employers money on their overall healthcare spend. There is no provision in this bill for maintaining the confidentiality of this information and if MAC formulas or reimbursements become subject to disclosure of any kind, even if barriers were put in place, the information will find its way to competitors and the generic prescription drug marketplace in the United States would cease to realize the kinds of savings we have today with generic prescription pharmaceuticals

Why CVS Caremark Opposes Senate Bill 402

Contrary to a rather common misnomer, there is no set MAC list or price. The lists and prices of generic drugs change at any given time based on commodity market forces and it would be impossible for a pharmacist to review all of the changes in lists and prices, even if we were able to make all of them available which is not something we could readily do today. According to the Generic Pharmaceutical Association, "10,072 of the 12,751 drugs listed in the FDA's Orange Book have generic counterparts." In other words, this bill would require us to notify every retail pharmacy in any of our multiple networks in Oregon anytime there is a change in pricing for any one of these 10,000 generic drugs. There are multiple lists because along with our clients and employers, CVS Caremark creates them to keep budgets in check and manage prices. Our clients keep their healthcare costs down by using MAC lists as one of several cost control techniques available to them. Employers and their employees lose if this bill becomes law as it is money out of their pockets and they will be forced to react accordingly. I have included examples of changes in pricing for your review and the necessity of MAC list flexibility.

SB402 mandates by statute a one-size-fits-all approach to the key contract term of MAC pricing without any consideration as to its necessity or consequence. State-mandated terms of private PBM agreements could impede employer and health plans' ability to seek favorable terms during contract negotiations. A PBM may offer its client multiple variations of plan options based on a client's Request for Proposals ("RFP"), culminating into a contract after aggressive negotiations where members' access to prescription

drugs, economic efficiency and quality are key considerations on both sides. Clients choose pricing arrangements that consider impact on their overall costs and cash flow as well as the level of risk they wish to assume. This flexibility affords plans the ability to choose from the most efficient PBM plan options that meet the needs of their members, which ultimately fosters competition among PBMs and allows both sides to preserve incentives that reduce overall health care costs. By dictating the key terms of a contract between health plans and PBMs and by interfering in these contracts, SB402 would handcuff PBMs, employers and health plans from engaging in aggressive negotiations that would otherwise reduce costs while increasing health care quality.

Interference in private PBM contracting as proposed by SB402 is, again, contrary to sound public policy. A March 2007 report from the tax, audit and advisory firm PricewaterhouseCoopers ("PwC") concluded that restricting PBM activities would result in increased costs for prescription drugs, higher insurance premiums and an increase in the number of uninsured individuals. PwC determined that PBMs save consumers and plan sponsors, on average, 29 percent on the cost of prescription drugs compared to retail purchases with no pharmacy benefit management support.[1] The terms of PBM contracts with drug manufacturers, clients and pharmacies are valuable, confidential property protected by federal and state law.

Conclusion

CVS Caremark appreciates the opportunity to provide comments in opposition to SB402. In addition to these comments, it is necessary to highlight the unique nature of this legislation. The legislature, by passing this bill, would be inserting itself, by mandate, into the private pricing contracts that are agreed to between businesses in a competitive and private marketplace. Setting minimum reimbursement rates, that will likely be higher than the current minimums and drive up costs, will only hurt competition and, ultimately, the patients who literally depend on access to these life saving medications. For the aforementioned reasons CVS Caremark respectfully asks that you reject SB402 and vote "NO" on its passage.

Thank you for affording CVS Caremark the opportunity to testify before you today.

[1] PricewaterhouseCoopers, *Pharmacy Benefit Management Savings in Medicare and the Commercial Marketplace & the Cost of Proposed PBM Legislation, 2008-2017* (March, 2007).

ii (PCMA, July 2004)

Addendum

Generic Lipitor Cost Comparison

- Atorvastatin 20mg Tab pricing at launch
  - Average Estimated Acq Cost discount = AWP – 23%
    - ($4.23/tablet)
- Atorvastatin 20mg Tab pricing after exclusivity
  - Average Estimated Acq Cost discount = AWP – 86%
    - ($0.78/tablet)

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Generic Price Range

Drug	Estimated Acquisition Cost Range
Amlodipine 10mg Tab (indication: high blood pressure)	$0.05/tab – $0.32/tab
Fluoxetine 20mg Cap (indication: depression)	$0.05/cap – $0.23/cap
Simvastatin 40mg Tab (indication: high cholesterol)	$0.05/tab – $0.37/tab

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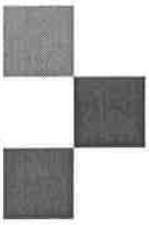

Example of why MAC is needed with only 1 vendor

Drug: Anagrelide Cap 0.5mg
Number of generic vendors: 1
Estimated acquisition cost: $0.20/capsule (translates to AWP-97%)

Approximate current reimbursement (MAC): ~$50/rx

Non-MAC AWP discounts vary : AWP-25% is typical (FEP)

Approximate reimbursement (AWP): ~$680/rx (AWP=7.50 /capsule)

Other Companies that use a MAC with one generic vendor like FEP:
IBM, Wells Fargo, Siemens

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