Written Testimony in Opposition to House Bill 2123-1

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On Behalf of CVS Caremark Corporation

To: The House Committee on Health Care

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Salem, Oregon

Chairman Greenlick, Vice Chair Keny-Guyer, honorable members of the Committee on Health Care, CVS Caremark is submitting this testimony in opposition to HB2123-1, a bill that would add four new sections to ORS chapter 689, which primarily governs the Board of Pharmacy, the practice of pharmacy and the regulation of drug outlets. Among other reasons, we oppose the bill because (1) Section 2 would inappropriately require that pharmacy benefit managers (PBMs) be licensed by the State Board of Pharmacy, (2) Section 3 would place unreasonable and arbitrary restrictions on PBMs' ability to audit pharmacies to recover for our clients payments that were inappropriately made to pharmacies, and (3) Section 4 would inappropriately insert the state itself into the private pricing contracts that are agreed to between businesses, governments and other entities in a competitive and private marketplace. We respectfully ask that you reject HB2123-1.

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 and PacifiCare, 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 unique prescription drug needs and then we administer the benefit on the sponsor's behalf. We specifically tailor our offering to meet the specified goals of the client as initially outlined in their bid/RFP for prescription drug services. In aggregate 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 always rests with the client.
- **Network Optimization:** PBMs negotiate with thousands of pharmacies and PSAOs or Pharmacy Services Administration Organization (a PSAO is, among other things a group purchasing organization utilized by independent pharmacies to increase their buying power and reimbursement leverage) when creating provider networks for beneficiaries to obtain prescription drugs, to 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, government agency, health plan or union 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 might not have been able to offer.
- **Manufacturer Rebates and Discounts:** PBMs negotiate substantial discounts from drug manufacturers to lower benefit costs for sponsors and beneficiaries.

Also, for background purposes, when we talk about "PBMs", in practice there are, essentially, three different types of PBMs or Pharmacy Benefit Managers doing business in the United States today. ExpressScripts, is the

best example of what can be termed as a "traditional PBM model". ExpressScripts is a stand-alone PBM business with mail-order and specialty pharmacy capability, but is not a part of nor does the company own a health insurance arm or have traditional brick-and-mortar retail pharmacies or health clinics. The second PBM model is the health-plan carve-in model. This is a model owned or integrated with a health insurer and where both medical and pharmacy benefit plans are typically offered as an integrated package. A good example of this model is United Healthcare and its in-house PBM business unit, OptumRx. The third PBM model 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 can preserve the economic benefit of mail order while at the same time providing more flexible access to medications through either mail or retail at one price point for the client. 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. This model also offers clients access to retail health clinics staffed by nurse practitioners or physician assistants, who can treat minor illnesses, injuries and routine care such as sports physicals at rates more affordable than a traditional primary care physician or urgent care center. These clinics accept walk-in patients with no appointment and are generally open during hours when a traditional physician's office may not.

Why CVS Caremark Opposes House Bill 2123-1

1. It would be inappropriate to place PBMs under the jurisdiction of the Board of Pharmacy

Section 2 of the bill would require PBMs to obtain a license from the State Board of Pharmacy in order to act as a PBM in the state. We oppose this proposed requirement for several reasons. First, by law, five of the seven members of the Board must be licensed pharmacists, appointed by the Governor from a list of names submitted by the Oregon State Pharmacy Association.[1] Such a licensure requirement for PBMs presents a clear conflict of interest for the Board members from retail pharmacies because of their business relationships with PBMs, as they not only have contracts with PBMs to provide pharmacy services in PBMs' pharmacy networks, but are also direct competitors of PBMs' mail service pharmacies.

The Federal Trade Commission (FTC) stated their concerns with a similar piece of legislation in Mississippi as follows:

> Because pharmacists and PBMs have a competitive, and at times, adversarial relationship, we are concerned that giving the pharmacy board regulatory power over PBMs may create tensions and conflicts of interest for the pharmacy board. Indeed, the antitrust laws recognize that there is a real danger that regulatory boards composed of market participants may pursue their own interests rather than that of the state.[2]

[1] ORS 689.115

[2] FTC letter to Representative Mark Formby, Mississippi House of Representatives (March 22, 2011). The FTC cited a U.S. Supreme Court case (*Patrick v. Burgett*, 486 94 (1988), an antitrust case involving the oversight of peer review decisions by

Second, such a licensure requirement for PBMs – which are *not* pharmacies – is not consistent with the stated purpose of Chapter 689:

> It is the purpose of this chapter to promote, preserve and protect the public health, safety and welfare by and *through the effective control and regulation of the practice of pharmacy and of the registration of drug outlets* engaged in the manufacture, production, sale and distribution of drugs, medications, devices and such other materials as may be used in the diagnosis and treatment of injury, illness and disease.[3] (emphasis added)

While the Board may have the expertise and resources necessary to fulfill that statutory charge, we do not believe that the Board has the expertise and resources necessary to oversee PBMs and the diverse set of non-pharmacy services that they provide, as described above.

Finally, contrary to what some of the bill's proponents might say, this licensure requirement entails more than simply completing an application and paying a small fee. It also requires a surety bond, with no cap placed on the amount that could be required. (p. 2, line 9; compare the statutory requirements for Third Party Administrators in ORS Chapter 744.700 *et seq.*, for example, with no surety bond requirement) In addition, it gives the Board the authority to "establish by rule the procedure and qualifications for obtaining and renewing a license under this section" (p. 2, lines 3-5). Although the bill specifies what the procedure "must" include, there is no limit in the language for what additional requirements the Board could impose on PBMs to obtain the necessary license beyond those mandated in the bill. (p. 2, lines 5-9) There is nothing, for example, that would restrict the Board from requiring PBMs to submit proprietary financial information as part of the application. This is in addition to the Board's existing statutory grant of "duties, powers and authority as may be necessary to the enforcement of this chapter and to the enforcement of board rules made pursuant thereto."[4]

2. The bill would place unreasonable and arbitrary restrictions on PBMs' ability to audit pharmacies to recover for our clients payments that were inappropriately made to pharmacies

This legislation, although it appears to help pharmacies, will actually have the unintended consequence of opening the door to fraud, abuse, and wasteful spending in health care. Health plans and employers with pharmacy benefit plans rely on audits of their network pharmacies to recoup monies incorrectly paid for claims with improper quantity, improper days supply, improper coding, duplicative claims, and other irregularities. Health plans and employers should have the right to ensure that the pharmacy claims that they are paying for are legitimate. In a time of rising health care costs, preventing fraudulent activity is an important tool to keeping health care costs down. This legislation severely restricts the ability of health plans and employers to make sure they are getting what they pay for. Auditing is part of the cost of doing business. That goes for any type of business – pharmacies should not be an exception to the rule.

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the Oregon Board of Medical Examiners, which in turn cited *Hallie v. Eau Claire*, 471 U.S. 34, 47 (1985); see id., at 45 ("A private party . . . may be presumed to be acting primarily on his or its own behalf")

[3] ORS 689.025(b)

[4] ORS 689.135

For example, the bill requires PBMs to provide pharmacies/pharmacists with a written advanced notice 10 days before an audit. This would give individuals ample time to hide evidence of fraudulent activities or evade authorities altogether. Similarly, this legislation limits the number of prescriptions available to audit to 200, and limits entities to only one on-site audit in any 12-month period, even though PBMs may have multiple clients in the state for which the PBM is obliged to conduct an audit, which could also impede the ability of auditors to detect fraudulent prescriptions. (p. 3, line 30 to p.4, line 5)

Pharmacy Benefit Managers look for errors, irregularities, and suspicious patterns over time. Claims are compared with historical information as well as claims submitted by similarly situated pharmacies. Substantial changes in the volume of claims or the dollar amount of claims from particular pharmacies can indicate fraudulent activity. The bill puts the proverbial cart before the horse with respect to audits that involve fraud and other inappropriate conduct, by saying that the restrictions imposed by this section do not apply to any audit or investigation that *follows* a finding of fraud or other specified activity. (p. 6, lines 22 to p. 7, line 21) Audits are conducted in order to uncover evidence of fraudulent or other improper activity; to lift the restrictions only *after* there's been a "finding" of fraud severely limits PBMs' ability to uncover fraudulent activity in the first place and recover payments that were inappropriately made to pharmacies.

Finally, the bill defines "audit" very broadly to include not only on-site audits, but also a "remote review of the records of a pharmacy." (p. 2, lines 24-5) With respect to a remote review of a pharmacy's records, why should a PBM not be able to conduct such a review during the first five days of the month, or have to give the pharmacy 15 days advance written notice, for example? Application of the bill's restrictions to remote reviews makes no sense.

3. The bill inappropriately intrudes on contract pricing in the private marketplace through its proposed requirements on MAC pricing

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, and to encourage pharmacies to be efficient and prudent purchasers of generic drugs by seeking the best available pricing in the marketplace. All pharmacies in our networks may dispute the accuracy of any MAC claim and be compensated accordingly if they can demonstrate they are being underpaid for a particular claim. For instance, in 2012, of an approximate 10 million prescriptions for Oregon residents managed by CVS Caremark, there were fewer than 800 individual generic drug MAC claim disputes/inquires by pharmacies (or less than 0.0001%). CVS Caremark reviews each disputed claim and if a pharmacy is correct, we make a price adjustment for the specific generic product in question. These extremely rare occasions simply reflect the fact that while CVS Caremark knows the price that generics are available for in the marketplace at any given time, we have no visibility into what a specific pharmacy pays for their prescription drugs, what wholesaler they may be using or when they may have purchased prescriptions—nor should we.

Moreover, when CVS Caremark "overpays" for a MAC'd generic, we don't come back and seek recoupment from the pharmacy for having paid them significantly more than their costs. That is simply the nature of generic pharmaceuticals. Because they are no longer patent-protected they are simply a commodity, and like any other commodity, consumer demand, volume purchased, shortages and other factors determine price on the open market. That this happens doesn't mean a pharmacy has done anything wrong, likewise nor has 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 and operating under an effective monopoly. Helping to move beneficiaries to less expensive generic drugs when appropriate is a key role that pharmacies and PBMs alike play in today's healthcare landscape. 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.

MAC is a common and well established pricing methodology for generic prescription drugs. MAC has been in existence for over 20 years and is one of the primary reasons why generic pharmaceuticals in the United States are the envy of the western world from a pricing and competition standpoint. Moreover, MAC is not just a tool used by PBMs, it is important to note that there are currently 46 state Medicaid programs that now use MAC lists to set their reimbursement levels for generic drugs. 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 control costs and there is no more efficient and equitable tool available.

Contrary to a rather common misnomer, there is no set MAC list or generic drug price. The lists and prices of generic drugs change at a given time based on commodity market forces. The sheer volume of generics and frequency of changes in price make it 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 of changes in pricing for the thousands of generic drugs available on our MAC lists (most of which are available in various different quantities and strengths). There are multiple lists because along with our clients and employers, CVS Caremark and other PBMS create them to meet specific client needs and to help manage prescription drug expenditures based on the demand and needs of each unique client. PBMs like CVS Caremark help keep our clients healthcare costs under control by effectively using MAC pricing as one of several cost control measures.. Employers and their employees ultimately lose when a bill like this becomes law..

Why we oppose the MAC provisions

House Bill 2123-1 would mandate 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") or bid requirements, culminating into a contract only after aggressive negotiations and competition among multiple PBMs 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 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, HB 2123-1 would handcuff PBMs, employers and health plans from engaging in aggressive negotiations that would otherwise reduce costs while increasing health care quality.

The clients of Pharmacy Benefit Managers are sophisticated purchasers of health care that rely on PBMs to help them 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 absolutely 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 by eliminating the ability to compete in this area. In fact, MAC disclosure 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, yet quite finite financial resources. 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 inevitably find its way into competitors hands and the generic prescription drug marketplace in the United States would cease to realize the kinds of savings and efficiencies we enjoy today.

Interference in private PBM contracting as proposed by HB 2123-1 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.[5] The terms of PBM contracts with drug manufacturers, clients and pharmacies are valuable, confidential property protected by law.

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

We also have some specific objections. For example, the bill would prohibit a PBM from creating a MAC for a particular generic drug if there are fewer than three drug substitutes available. (p. 4, lines 19-22) At the beginning and the end of the life cycle of a particular generic molecule, there will typically not be three or more generic versions available, and there can still be significant differences in the prices at which the drugs are sold. By prohibiting PBMs from creating a MAC for those drugs, a higher reimbursement rate similar to brand reimbursement will likely be the result, which means that payers and patients lose the cost savings that generic drugs should provide.

Second, if a PBM changes the MAC reimbursement rate following an appeal, the change must be made retroactive to the date the pharmacy initiated the appeal proceedings **and** apply to all pharmacies in the PBM's network. (p.4, line 41 to p. 5, line 1) Retroactive adjustment is problematic, even for one claim by one pharmacy. The transaction could have occurred months ago - the patient has paid the co-pay or co-insurance, the pharmacy's claim has been adjudicated, and the PBM has in all likelihood billed the client and been paid for that claim, all of which would be disrupted. If a patient is obligated to pay 20% co-insurance, for example, and the MAC rate is raised from $20 to $25, then the patient's share of the cost would rise from $4 to $5 for that claim. How does the pharmacy collect that additional amount from the member? Application of the adjusted rate to all pharmacies in the network is also problematic, for two reasons. First, if applied retroactively across the network for all transactions for that particular drug, the disruption among patients, pharmacies, PBMs and clients is multiplied. Second, it would represent a windfall to some pharmacies, as not all pharmacies in the network receive the same reimbursement rate. With their greater purchasing power and economies of scale, for example, chains may receive a lower reimbursement rate than independents. Under those circumstances, giving those chains an adjustment based on the result of an appeal by one independent pharmacy makes no sense.

Finally, we question why the bill would create a new pharmacy entity ("retail community pharmacy") with its own definition (p. 7, lines 24-7). Is there a difference between that newly defined entity and the established definition of a "retail drug outlet" in the pharmacy practice act? See ORS 689.005(33) ("'Retail drug outlet' means a place used for the conduct of the retail sale, administering or dispensing or compounding of drugs or chemicals or for the administering or dispensing of prescriptions and licensed by the board as a place wherein the practice of pharmacy may lawfully occur.")

Conclusion

CVS Caremark appreciates the opportunity to provide comments in opposition to HB 2123-1. For the aforementioned reasons CVS Caremark respectfully asks that you reject HB 2123-1 and vote "NO" on its passage.

Thank you for affording CVS Caremark the opportunity to testify before you today. I am happy to address any questions the Committee members may have at this time.