**Prepared Statement of**

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**Written Testimony of Natalie Pons**
**Senior Vice President, Assistant General Counsel, CVS Health**
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## Opening Statement and Introduction

Good afternoon, Chairman Marino, Ranking Member Johnson, and Members of the Subcommittee. My name is Natalie Pons, and I am Senior Vice President and Assistant General Counsel at CVS Health. We appreciate this opportunity to testify on the critical role that pharmacists and pharmacies play in local communities all across America in providing convenient access to affordable prescription medication and the vibrant marketplace in which we compete.

## CVS Health

From our company's earliest days until now – where we stand at the forefront of a changing health care landscape – CVS Health has been singularly focused on helping people on their path to better health. Every action we take and every decision we make is viewed through this lens. Our values are the same as those of consumers, businesses and communities—we want to make health care more accessible and help improve health outcomes in more affordable, effective ways. Our patient-centric model is organized around how consumers access and use medications. It is a focus and approach that provides multiple points of care and extends across all our business units – our pharmacy benefit management program; our retail, mail, specialty and long-term care pharmacies; our Medicare Part D plan and our MinuteClinics.

Our goal is to more effectively meet the needs of the health plans, employer plans, and the government plans we serve by providing convenient, affordable access to medications and to play a collaborative role in helping them manage chronic diseases. We also provide access to key

preventative care such as vaccinations, smoking cessation and weight loss counseling. Our overriding commitment to improving Americans' health is a main reason we decided to end tobacco sales last year and forgo $2 billion in annual revenue.

We partner with health providers to support the entire continuum of care and have forged clinical collaborations with more than 60 major health systems and health care providers across the country.

CVS Health is proud of its commitment to and success in constraining prescription drug costs through the discounts and savings that are shared directly with our consumer, business, labor, health plan and government partners while helping to improve health outcomes. We are able to help keep premiums affordable and save tens of billions of dollars for patients, employers and taxpayers. Our success is predicated on how effectively we help our partners achieve the best return on their health care dollars. We are able to achieve these results by working every day to ensure that patients receive the right prescription drugs for their condition, at the right time, in the right setting, and at the right price.

**What Pharmacy Benefit Managers Do**

Pharmacy Benefit Managers, commonly referred to as PBMs, manage prescription drug benefits on behalf of a diverse set of purchasing partners that include health plans, employer plans, and government plans – including Medicare Part D – large private employers, state employer plans, state Medicaid programs for managed Medicaid and the Federal Employees Health Benefits Program. Today, more than 215 million Americans nationwide receive prescription drug benefits administered by PBMs.[1] With over 30 different PBMs, the PBM industry is highly competitive with a number of large and mid-sized players that offer businesses, labor, consumers and government a variety of choices when considering options for best managing their pharmacy benefit. With over 60,000 pharmacies in the United States, consumers in all parts of the country have many outlets to fill their prescriptions. In this highly competitive marketplace, PBMs

[1] Pharmacy Benefit Mangers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante prepared for PCMA, Sept. 2011.

contract with every category of pharmacy, including independents, drugstore chains and grocery stores, among others.

Health care purchasers rely on PBMs to extract the lowest possible price from drug manufacturers, assemble pharmacy networks that provide convenient access to affordable medications, and provide a portfolio of clinical programs and services that deliver the best value for our purchasing partners' health care dollars while helping to improve members' health outcomes.

The degree to which drug benefits are managed efficiently has a significant impact on consumers' premiums and cost sharing. According to a 2011 Visante study, PBMs will save plan sponsors and consumers almost $2 trillion, or nearly 35%, between 2012 and 2021 when compared with prescription drug expenditures made without pharmacy benefit management.[2] PBMs are able to do all of this in a health care landscape that has changed profoundly over the last several years – and continues to change as companies respond to market dynamics.

**How We Do It**

Pharmacy Benefit Managers use a variety of strategies and tools to help the health plans, employer plans, and government plans that PBMs serve manage the cost and utilization of prescription drugs, improve patient outcomes and lower overall health care system costs. Each plan determines what tools and strategies work best for them, and the PBM implements this plan design. The role of PBMs is advisory only; the plans always have the final say when creating a drug benefit plan and the plans are free to negotiate the best strategies for their members at the best available price.

PBMs design plan features that encourage the use of cost effective generics over more expensive branded products, which helps consumers and plans save money on prescription drugs without compromising clinical efficacy. PBMs also offer the plans clinically based programs that help improve patient adherence to medications, which helps lower costly hospital readmissions and reduce aggregate health care system costs. For example, PBMs check for drug interactions and

[2] Pharmacy Benefit Mangers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante prepared for PCMA, Sept. 2011.

inappropriate or duplicate prescription and monitor prescription safety across all our network pharmacies, alerting pharmacists to potential drug interactions even if a consumer uses multiple pharmacies – something an individual pharmacy cannot do.

**Pharmaceutical Manufacturer Rebates and Discounts:** PBMs negotiate with pharmaceutical manufacturers to obtain discounts called rebates to help achieve the lowest drug prices for the plans to help keep patient premiums and cost-sharing manageable. PBMs are able to negotiate lower prices from pharmaceutical manufacturers because they have multiple clients, and therefore are able to negotiate larger volume discounts than individual plans.

**Formularies:** PBMs use panels of independent physicians, pharmacists, and other clinical experts to develop lists of drugs that plans can adopt as part of their plan design. One of the key ways PBMs do this is by driving higher utilization of generics, which now account for more than 86 percent of prescriptions in the US. According to a August 2015 Generic Pharmaceutical Association (GPhA) report, generic utilization has saved patients and purchasers more than $1 trillion dollars over the last decade.[3]

**Network Management:** PBMs provide plans with options for pharmacy networks that provide consumers with convenient access to affordable medications. When establishing networks, PBMs negotiate contracts with pharmacies throughout the country that are willing to provide discounted rates in exchange for access to a plan's members, prompting competition among many different types of pharmacies to offer the best prices and services in order to be included in the network. PBM network management helps plans reduce their healthcare costs.

According to industry reports, 80 percent of independent pharmacies use Pharmacy Services Administration Organizations (PSAOs), which are group purchasing organizations, to collectively negotiate on behalf of independent pharmacies with pharmaceutical manufacturers

[3] GPhA. "Generic Drug Savings in the U.S." Generic Pharmaceutical Association, 15 Aug. 2015. <http://www.gphaonline.org/media/wysiwyg/PDF/GPhA_Savings_Report_2015.pdf>

and PBMs.[4] Many independent pharmacies participate in one or more of the three leading PSAOs to lower their drug purchasing costs and better manage their network arrangements.

Plans select PBMs based on their ability to provide their members with convenient access to affordable medications. To provide the type of coverage clients expect, independent community pharmacies play a particularly important role in PBM network management because they allow PBMs to fill in gaps in network coverage in many parts of the country.

With approximately 23,000 independent community pharmacies – over a third of all retail pharmacies nationwide – independents are a healthy and profitable industry segment, representing an $88.8 billion in revenue annually. The number of independent pharmacies has grown more than 15% since 2002 as overall profit margins for the average independent pharmacy grew to 23% of revenues.[5] On average, our independent pharmacies generally receive higher reimbursement than other network participants.

**Selective Networks:** PBMs also offer a choice of more selective networks as a way to help health plans, employer plans and government plans further reduce costs while still providing their members with convenient access to affordable medications. Typically, health plans will offer their members a lower copay at certain pharmacies as a way to encourage them to fill prescriptions at those pharmacies. Pharmacies that are part of these networks can benefit from greater prescription volume in return for a lower reimbursement rate. PBMs therefore stimulate competition between pharmacies for positions in these networks, which lowers costs in the healthcare system.

Selective networks have proven successful in negotiating competitive reimbursement rates and contributing to improved prescription drug adherence, which leads to better medical outcomes. For example, a CMS analysis of Medicare Part D 2015 enrollment data showed that 81% of

[4] GAO. PRESCRIPTION DRUGS: The Number, Role, and Ownership of Pharmacy Services Administrative Organizations. Published: Jan 29, 2013. Publicly Released: Feb 28, 2013

[5] 2002 independent pharmacy data from IMS Health showing 19,700 independent pharmacies. 2013 pharmacy data from 2014 NCPA Digest showing 22,814 independent pharmacies. (22,814-19,700)/19700=.158, a 15.8% increase; Fein, Adam, Ph.D. "Profits Up Again for Independent Pharmacy Owners." Drug Channels. Pembroke Consulting, 2 Dec. 2014. Web. 03 Sept. 2015

Medicare beneficiaries chose plans with preferred pharmacy networks.[6] A 2013 CMS study analyzing prescription drug data for Part D plans concluded that on average, branded drugs cost 3.3 percent less, and generic drugs cost 11 percent less at preferred pharmacies.[7] Over the next ten years, preferred pharmacy network plans are estimated to reduce federal Medicare spending by $7.9 to $9.3 billion.[8]

**Mail-Service Pharmacy:** PBMs allow plans to choose to provide efficient mail-service pharmacies to members that supply home-delivered prescriptions with great accuracy and safety and at a substantial savings. This can be a valuable service for a company, government agency, health plan or union that might wish to have this convenience.

In a 2005 report, the FTC determined that there is no conflict of interest in a PBM owning a mail-order pharmacy and that PBM-owned mail-order pharmacies offer lower prices on prescription drugs than retail and non-PBM owned mail pharmacies. The FTC also determined that PBM-owned mail-order pharmacies are very effective at capitalizing on opportunities to dispense cost-effective and generic alternatives, and have incentives closely aligned with their customers.[9] It is also important to note that mail order utilization has remained steady over the last decade.[10]

**A Highly Competitive Marketplace**

Competition in the PBM industry has been aptly described as "vigorous" by the Federal Trade Commission (FTC).[11] After a thorough investigation in which the FTC "interviewed over 200 market participants, including customers, other PBMs, retail and specialty pharmacies, pharmacy

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[6] PCMA, "New Analysis: 81 Percent of Medicare Part D Seniors Choose "Preferred Pharmacy" Plans in 2015," <www.pcmanet.org/newsroom/new-analysis-81-percent-of-medicare-part-d-seniors-choose-preferred-pharmacy-plans-in-2015>

[7] FTC Letter to CMS, March 7, 2014. https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf

[8] Milliman, prepared for PCMA. "The Impact of Preferred Pharmacy Networks on Federal Medicare Part D Costs, 2014-2023." Oct. 2013. Web. 9 Nov. 2015. <http://www.pcmanet.org/images/stories/uploads/2013/milliman%20preferred%20pharmacy%20networks.pdf>.

[9] Federal Trade Commission, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," August 2005

[10] Drug Channels, "Profits Up Again for Independent Pharmacy Owners", 2 December 2014

[11] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004

trade groups, pharmaceutical manufactuerers, and healthcare benefit consulting firms" and reviewed "millions of documents," the FTC concluded that "competition for accounts is intense, has driven down prices, and has resulted in declining PBM profit margins."[12]

Competition for the right to manage health plan members' and employers' drug benefits involves intense negotiation and competitive bidding ability – in fact, the efficient functioning of the PBM industry relies on competition. And, as Professor Gerard Anderson, the Director of Johns Hopkins' Center for Hospital Finance and Management has said, "without competition, there would be no market forces to limit prescription drug price increases."[13]

At our PBM, CVS/caremark, we welcome competition; indeed, our success is predicated on thriving competition in the health care marketplace. After all, it is healthy competition that drives innovation and allows us to effectively help the consumer, business, labor, health plan and government partners we serve achieve the best returns on their health care investments. As costs continue to rise, our purchasing partners will expect us to demonstrate value for their health care dollars. If we are unable to do so, they will look elsewhere.

We look forward to working with the Members of this Committee and others to continue promoting a competitive health care landscape that provides access to affordable medications while helping control health care costs.

I ask that the full text of my written testimony be submitted for the record along with supporting documents.

Thank you for this opportunity to testify.

[12] Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., FTC File No. 111-0210, April 2, 2012.
[13] Surowiecki, James. "Taking on the Drug Profiteers." *The New Yorker*. 12 Oct. 2015. <http://www.newyorker.com/magazine/2015/10/12/taking-on-the-drug-profiteers>.