CVSHealth

CVS Health Comments

Sub. HB 64

Mike Ayotte, RPh

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Chairman Smith, Vice-Chairman Schuring, Ranking Minority Member Driehaus and members of the House Finance Committee:

My name is Mike Ayotte and I lead State Government Affairs for CVS Health and I thank you for the opportunity to talk with you today. By way of background, my company is a proud member of the Ohio business community employing almost 7,000 people in our 320 CVS/pharmacy stores and 52 Minute Clinic locations throughout the state.

In 2014, CVS Health filled over 30 million prescriptions at our CVS/pharmacy retail locations, processed 23.5 million prescriptions through our PBM Mail Pharmacies, CVS/caremark, and paid nearly 63 million dollars in state and municipal taxes in Ohio.

Today, I am here to address one very specific issue contained within Sub HB 64. It is my understanding that the *as introduced* version of HB 127 (Brown) regarding PBM regulation was inserted into the bill as merely a placeholder while interested parties continue to work through outstanding issues. It is our hope that the legislation ultimately becomes reflective of the agreements reached with the proponents as discussions have progressed over the last year. We at CVS Health are willing to continue to work with other interested parties to achieve a favorable resolution. I think that, to date, we've made great progress.

We have expressed our concerns with HB 127 to the bill sponsor, and members of the House Insurance Committee, to where the bill was referred.

Let me provide a brief overview of the role of pharmacy benefit managers (PBMs) as some members may not be familiar. The CVS/caremark division of CVS Health works for payers or what is also referred to as a "plan sponsor." A plan sponsor can be an employer, a consortium, a public pension system, a public health payer, Medicaid, unions, local governments, a health insurer, etc. Plan sponsors have benefits consultants both in-house and retained as well as lawyers who help them determine their drug benefit needs. They have expertise that makes them sophisticated purchasers of healthcare and designers of benefits that they choose to offer to their members. The sponsor will put out an RFP, and then there's a competitive bidding process under which we compete with other PBMs to win the business.

The RFP process involves the potential client asking every possible question that could be asked including ones pertaining to full disclosure and transparency. The last word, transparency, will be thrown

around a lot in discussions today and moving forward but it must be noted that the very entity the bill is trying to protect, the plan sponsors, haven't, to our knowledge, asked for this language. By being completely transparent to our client through the RFP process as well as after the awarding of the contract, the contracting process between two private sector entities satisfactorily addresses all concerns of the payer and the PBM. Additionally, contractual terms between the plan sponsor, including the state of Ohio, and the PBM give the plan sponsor the ability to come in and audit the PBM to ensure that they're getting everything to which they are entitled.

Mandating by statute a disclosure of proprietary costs and pricing information between two sophisticated entities that entered into a contract after a rigorous competitive bidding process is, quite simply, legislative overreach into the marketplace. The Federal Trade Commission has repeatedly weighed in on this topic by stating, "Vigorous competition in the marketplace for PBMs is more likely to arrive at an economically efficient level of transparency than regulation of those terms. Just as competitive forces encourage PBMs to offer their best price and service combinations to health plan sponsors in order to gain access to subscribers, competition also encourages disclosure of the information group health plan sponsors require to decide which PBM to contract with."

In conclusion, the language that we are asking to be removed in lines 46910-46917 isn't being asked for by the people paying the bills and it implies that we as a PBM are not fully transparent to our clients, the payers. Additionally, it also implies that we pay pharmacies in our network one amount and that we turn around and bill our client another amount and that simply is not true. The latter implication is actually offensive as it alleges that a traditional, or "spread pricing" model, chosen by nearly half of our clients, is a deceptive business practice. Every for-profit entity in the private sector, including retail pharmacies, sell, or try to sell, their goods and services at a higher price than for what they buy them. It's a markup and is how we make a profit under the traditional model. Profit, I hope, is not something frowned upon and it should be noted that net margin in the PBM industry is between 2-5%, depending on the company, and what is not reflected in that net margin number are the services provided to the client including, but certainly not limited to, claim adjudication, formulary and network management and adherence programs that help to keep their members healthy. To put the margin number in perspective, net margins for drug manufacturers are around 13% and for biotech companies, roughly 12% and to imply that our clients are not getting the most bang for their buck or are being misled, is wrong.

Again, and on behalf of CVS Health, thank you for the opportunity to talk with you today and please know that we will continue to work on this and any other issue that the Committee deems important.