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M E M O R A N D U M

TO: Members of the House Health Care Committee

FROM: Charles ("Chuck") Storrow, KSE Partners, LLP, on behalf of Express Scripts, Inc.

DATE: April 14, 2015

SUBJECT: S.139/Pharmacy Benefit Managers

The purpose of this memorandum is to provide a general overview of the role our client, Express Scripts, Inc. ("ESI"), a pharmacy benefit manager ("PBM"), plays in the health care system and its position concerning the pharmacy benefit management provisions in S.139 (bill sections 1 and 2).

ESI is a national company that helps health insurers, self-insured employers, union sponsored health plans, and public health plans manage their prescription benefits. ESI helps manage the prescription drug benefits provided to over 100 million Americans. In Vermont ESI helps the State Employees Health Plan and Blue Cross/Blue Shield of VT manage their respective prescription drug benefits.

It should be noted that while ESI is a large company, in 2013 its profit margin was 1.76%.

PBMs help health plans reduce the cost of providing prescription drug benefits. To do that they utilize strategies that are designed to eliminate unnecessary costs. MAC pricing, the use of mail order pharmacies and provider networks are examples of such strategies.

GENERAL OVERVIEW OF PBMs

Selection of Pharmacy Benefit Managers by Health Plans

- Health plans generally select pharmacy benefit managers via a competitive RFP process. The health plans are typically advised by knowledgeable consultants in structuring their RFPs and evaluating proposals.

- There are a number of ways in which the contracts can be structured. For instance, the issue of who gets the benefit of manufacturer rebates (discussed below) and whether there will be "spread pricing," i.e., the PBM is paid more by the health plan than what it reimburses a pharmacy for the price of a given prescription drug, are issues that are

subject to negotiation.

- Under 18 V.S.A. § 9472(c)(1) a PBM must provide a health plan with all financial and utilization information relating to the services the PBM provides to the health plan. This gives health plans the ability to audit their PBM to make sure that it is getting the benefit of the terms of its contract with the PBM.

Development of Formularies

- Using panels of independent physicians, pharmacist and other clinical experts PBMs work with their clients to develop "formularies," i.e., lists of drugs approved for reimbursement. Clinical effectiveness is the primary consideration in the development of formularies. If two drugs are equally clinically effective then cost effectiveness will generally be the next consideration as to which of the two drugs are included on a formulary.

- Formularies typically have "tiers," with tier one being generic drugs, tier two being "preferred" brand drugs, and tier three being non-preferred brand drugs.

- Generally speaking, preferred brand drugs are those for which the drug manufacturer has agreed to provide a discount and/or rebate. Health plan beneficiaries are typically encouraged to use preferred brand drugs by way of having a lower out of pocket cost than would be the case if they use a non-preferred brand drug. The manufacturer of the preferred brand drug benefits because its drug will be utilized more than otherwise would be the case if it were not included in a favorable position on the formulary.

- A good example of how this system helps control prescription drug prices is illustrated by the accompanying December 22, 2014 *New York Times* article about an agreement ESI reached with a manufacturer of a new hepatitis treatment drug.

Manufacturer Rebates

- In addition or in lieu of providing discounts sometimes drug manufacturers will offer rebates in exchange for their drug being included on the lower tiers of a formulary. The total amount of the rebates for a given drug is tied to the volume of utilization of that drug. In entering into contracts with a PBM the question of which party is to receive the benefit of the rebates is a subject of negotiation. There are pros and cons to the health plan in either approach.

Pharmacy networks

- PBMs build networks of retail pharmacies to provide consumers convenient access to prescriptions at discounted rates. Health insurers and PBMs will enter into agreements with pharmacies whereby the pharmacy will agree to provide a discount on their dispensing fee in exchange for the volume of business they receive from being in the health insurer's/PBM's "network."

- Federal and state law requires health insurers to have adequate networks of health care providers i.e., enough approved providers so that people have adequate access to health care providers. As a result, in order to create a legally adequate network of pharmacies a health insurer/PBM has to do what is needed in terms of financial agreements to entice an adequate number of pharmacies to be in its network.

- PBMs need pharmacies. PBMs help health plans manage prescription drug benefits. Retail pharmacies are obviously a necessary component in a system involving the provision of prescription drug benefits. Accordingly, it is in the interests of PBMs that their financial arrangements with pharmacies are such that an adequate number of pharmacies have the ability to be in business.

Mail Order Pharmacies

- PBMs provide highly efficient mail-service pharmacies that supply home-delivered prescriptions, typically for "maintenance drugs," with great accuracy and safety and at a substantial savings.
- Health plans/PBMs often provide an incentive for plan beneficiaries to obtain a 90 day supply of drugs from a cost effective mail order pharmacy by reducing the co-pay or co-insurance amount the plan beneficiary has to pay if they do so.
- Importantly, under existing law (8 V.S.A. § 4089j) a health insurer and/or PBM must allow a retail pharmacy to fill a prescription that would otherwise be filled by a mail order pharmacy if the retail pharmacy is willing to do so on the same terms and conditions as the mail order pharmacy. In other words, a plan beneficiary already has the ability to have a retail pharmacy fill a prescription that would otherwise be filled by a mail order pharmacy if the retail pharmacy can match the terms and conditions of a mail order pharmacy.

S.139

MAC Pricing

- As passed by the Senate S.139 would require PBMs to provide pharmacies with a list of drugs subject to "maximum allowable cost" ("MAC"), update that list at least every seven days, and provide a "reasonable" appeals process for a dispensing pharmacy to contest a listed MAC. ESI does not generally oppose these requirements. It does, however, have some suggested revisions to the bill's language which will be presented to the committee in connection with my testimony.

- The MAC pricing tool was developed by state Medicaid agencies and relates to the fact that there can be widely differing wholesale prices for any given generic drug depending on the particular wholesaler.

- PBMs like ESI analyze the wholesale market on a continuous basis and determine the prices available to pharmacies (or groups of pharmacies acting together in purchasing

drugs) in purchasing, at wholesale, various generic drugs.

- In reimbursing pharmacies for the generic drugs they purchase and dispense PBMs like ESI pay the pharmacy an amount—"maximum allowable cost"-- that is based on the reasonable wholesale cost of a given generic drug.

- The amount the PBM pays the pharmacy may or may not reflect the pharmacy's actual cost. In some cases the amount paid to the pharmacy is more than the pharmacy's actual cost and in some cases it may be less than the pharmacy's actual cost.

- PBMs use the MAC pricing tool in reimbursing pharmacies in order to normalize the widely differing wholesale prices for many generic drugs.