PSSNY
Pharmacists Society of the State of New York, Inc.

ASSEMBLY COMMITTEES ON INSURANCE AND HEALTH
PUBLIC HEARING
Monday, June 4, 2018

CVS Health's Acquisition of Aetna, Inc.

To evaluate the proposed plan by CVS Health to acquire Aetna Inc. and the potential impacts on the delivery of health care and the health insurance market in New York State.

Chairman Gottfried and Chairman Cahill and esteemed members of the Senate and Assembly Health and Insurance committees, thank you for conducting this hearing on the potential impacts on the delivery of health care and the health insurance market in New York State due to the pending merger of CVS Health and Aetna Inc. that is currently under review at the Antitrust Division of the Department of Justice.

The Pharmacists Society of the State of New York (PSSNY) represents licensed pharmacists in the State of New York. The vast majority of our members work in community pharmacy and a significant number of them are independent pharmacy owners.

New York State has 2,325 independent pharmacies, representing over 10% of the total independent pharmacies in the country and just over half of the pharmacies in New York State. New York is ranked first in the nation for number of independent pharmacies. These local New York businesses generate more than $7.7 billion in pharmacy sales and create more than 21,000 full-time jobs. They fill nearly 139 million prescriptions each year and generate an additional $7.5 billion in economic activity and create 8,742 jobs outside the pharmacy in their local communities. They are major players in their local communities and economies.

See Addenedum A for more information on the economic impact of independent pharmacies.

PSSNY is very concerned that increased vertical integration in the healthcare industry will contribute to higher costs, negatively impact patient choice, and drive independent pharmacies out of business. PSSNY recommends that the proposed merger between CVS Health and Aetna Inc. be closely examined to ensure a decision is made that puts the patient's healthcare access and choice first and foremost. **ALL** patients have the right to local, personal relationships with healthcare providers. If this integration moves forward local pharmacies will no longer be able to compete with these large, integrated PBM/insurer systems who will dominate the market.

Pharmacy Choice for Patients

The proposed CVS Health/Aetna Inc. merger raises several questions regarding its impact on pharmacy choice for patients. A recent Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad,* found that just three pharmacy benefit managers (PBMs) account for 85% of the market.[1] CVS/Caremark, the PBM business for CVS Health, is the second largest PBM in the U.S., covering approximately 34% of covered lives.[2] This significant market share allows CVS/Caremark (as well as the other largest PBMs) to exercise undue market leverage and generate outsized profits for themselves. Community pharmacies have very little negotiating power when contracting with PBMs like CVS/Caremark, and routinely must agree to take-it-or-leave-it contracts to be a part of the PBM's pharmacy network. In some cases, even if a pharmacy is willing to accept onerous contract terms, the PBM will exclude certain pharmacies from their networks altogether, limiting patient choice. Aetna, for which CVS/Caremark administers the pharmacy benefit, has already engaged in this practice as the 2018 plan year marks the second consecutive year that many independent pharmacies were excluded from the opportunity to bid for preferred status in Aetna's Part D pharmacy networks. Having the opportunity to be a part of a plan's preferred network is critical, as nearly all Part D plans in 2018 include preferred networks that offer lower co-pays to beneficiaries in exchange for lower reimbursement to the pharmacy. Additionally, the opportunity to be in preferred networks allows pharmacies to evaluate a potential benefit of increased volume of consumers from those preferred network patients.

Indeed, Aetna has already engaged in problematic practices with respect to its pharmacy networks. CMS sanctioned the company in 2010[3] and again in 2015[4] for misleading seniors about which pharmacies were in-network. According to CMS:

Aetna reported that a total of 6,887 non-network retail pharmacies were erroneously identified by Aetna as "retail in-network" for 2015 on its website and through its call center customer service representatives during the calendar year 2015 Annual Election Period. Beneficiaries that selected a plan based on its in-network pharmacies may have been misled by this incorrect information.

The confusion created by errors in Aetna's pharmacy network directory on their website led to disruption in the marketplace. After January 1, 2015, many Aetna enrollees presented with a prescription at their usual pharmacy only to discover that the pharmacy was not in their plan's network. These enrollees complained because they either had to pay cash at the point of sale for their prescription (and seek subsequent repayment from Aetna) or to leave the pharmacy without their drug. Aetna's complaint rates for Part D issues were five times greater than the complaint rate for all Medicare Advantage Part D Plans and Prescription Drug Plan parent organizations.

[1] Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad*, Feb. 2018, *available at* https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf.

[2] According to CVS Health, it has 90 million PBM plan members. *See* CVS Health, *available at* https://cvshealth.com/about/facts-and-company-information. The Pharmaceutical Care Management Association testified that PBMs administer drug plans for more than 266 million Americans. *See* Testimony of Mark Merritt, Pharmaceutical Care Management Association, before the United States House of Representatives Energy and Commerce Committee Subcommittee on Health, "Examining the Drug Supply Chain," Dec.13, 2017.

[3],[4] Manos, Diana, Healthcare Finance, *CMS issues sanctions against Aetna*, Apr. 12, 2010, *available at* http://www.healthcarefinancenews.com/news/cms-issues-sanctions-against-aetna.

Aetna's 3,767 complaints accounted for 33 percent of all complaints received by CMS. Of those complaints, 2,750 (73 percent) were marketing complaints that beneficiaries were misled about in-network pharmacy coverage.

In New York, our members have had patients receive letters from CVS/Caremark indicating that a recently used pharmacy is no longer part of the network without identifying the name of the pharmacy. Many patients assume it is the pharmacy they use most frequently and make plans to use one of the pharmacies suggested in the letter. Our members have had to scramble to determine if they are in fact removed from the network, and then communicate the fact that they have not been removed to their patients. By the time this has been completed, the damage is done—a patient has moved to a new pharmacy when there was no need to do so.

See Addendum B for CVS patient letter.

Merging a pharmacy/PBM with a health plan will only solidify problems with respect to pharmacy access issues especially in underserved areas. PBMs like CVS/Caremark already direct or incentivize patients into certain pharmacies based on prescription benefit design. For example, the PBM can create a design that offers patients a lower co-pay at their own mail order pharmacy or retail stores than at the other community pharmacies with which it contracts. An entity that controls the healthcare benefit as well as the prescription drug benefit will give consumers even less control over their choice of healthcare providers.

An example we have already seen is the integration of Prime Therapeutic (a health plan-owned PBM) with Walgreens forming the AllianceRx Walgreens Prime network driving patients to a Walgreens for specialty and mail order pharmacy. These integrations/mergers align mail service, specialty pharmacy, PBMs, health plans and a huge retail giant. It has NOT resulted in increased patient access.

CVS Health operates the largest pharmacy chain in the United States with approximately 9,700 retail locations and has significant share in many markets. Will the merged entity be able to use their dominant position to increase payments to CVS pharmacies? Conversely, will health plan competitors foreclose CVS pharmacies from their plans?

For example, will Aetna adopt a plan design that only allows Aetna customers to access CVS' Minute Clinics (or raise costs to competitors who want access to the clinics for their beneficiaries)? Will Aetna direct patients into CVS Minute Clinics rather than the healthcare provider of their choice? Will those patients also be incented to use the CVS pharmacy where the Minute Clinic is located, leaving the patient with little choice in where they receive their healthcare and prescriptions?

The Department of Justice should also examine whether Aetna will require or strongly incentivize patients to use CVS Health's mail order and/or specialty pharmacies. Forcing patients, particularly those that have more complex conditions that require specialty drugs, to get their prescriptions from a pharmacy with which it has no personal relationship severely limits patients' choice and may impact the quality of care and adherence. Will this transaction force more patients to use CVS retail or mail order pharmacies despite a preference by consumers to use their pharmacies of choice?

Recently, several HIV/AIDS patients sued CVS Health, alleging the pharmacy leveraged insurance laws to force patients to fill their prescriptions at CVS pharmacies or CVS Health's mail order company.[5] If the patient chose to obtain their prescription drugs from a different pharmacy, the patient faced thousands of dollars in costs to obtain the drugs. Patients reported a number of other issues with being forced into using one pharmacy provider, including a patient who received drugs from CVS' mail order program, that had his drugs left outside his home, "baking in the afternoon sun."[6] The National Community Pharmacists Association (NCPA) has received over a hundred photographs of mail order waste from CVS and other mail order pharmacies in which millions of dollars of unwanted prescription drugs have been sent to consumers. These consumers seek out their local pharmacists' help in disposing these unnecessary and often costly drugs.[7]

Thus, there are serious questions as to whether patients will continue to have access to their preferred pharmacies and other healthcare providers and whether quality and service will be impacted to the detriment of patients.

Patients' Healthcare Costs

The merging parties have stated that the proposed transaction will create efficiencies and save hundreds of millions of dollars for consumers. They have not, however, explained whether those purported savings will be passed on to consumers. The largest PBMs already claim their size enables them to achieve significant efficiencies and cost savings. As patients' out-of-pocket costs and premiums continue to rise, there is evidence to suggest that these savings are not, in fact, being passed on to consumers. Will savings from this merger be passed along? Did the 2012 merger of PBMs Express Scripts and Medco result in consumer savings?

As discussed above, many patients that visit CVS Minute Clinics are likely to pick up their drugs at the CVS pharmacy. We question whether picking prescription drugs up at a CVS will result in lower costs? Will CVS use the proximity of its store locations within its Minute Clinics to extract higher payments from healthcare plan sponsors?

The federal employee health plan whose pharmacy benefit is managed by Caremark provides a public website where plan members can analyze their out-of-pocket costs for various medications at different pharmacy locations. We analyzed five different medications in eight different geographic areas of New York State comparing patient out-of-pocket costs at a local independent with regional and national chains.

[5] Herman, Bob, Axios, *HIV patients sue CVS over pharmacy networks*, Feb. 21, 2018, *available at* https://www.axios.com/cvs-pharmacy-lawsuit-hiv-1519160365-c6f5527a-f5f2-429d-b817-6a9ea321335d.html; *see also John Doe One et al. v. CVS Health Corporation,* Case No. 3:18-cv-1031, N.D. Cal. (filed Feb. 16, 2018).

[6] Id.

[7] NCPA, *Waste Not, Want Not*, *available at* https://www.ncpanet.org/pdf/leg/sep11/mail_order_waste.pdf.

Medication	Regional Chain	NYS Independent	CVS	Walmart	Walgreens	Mail service (90 supply)	Medication Purpose
Aripiprazole 10mg Tablet, 30 day supply	$4.13	$4.22	$5.61	$38.62	$46.16	$15.00	Treat Mental/Mood disorder Example: Bi-polar disorder/schizophrenia
Duloxetine Hcl 60mg Capsule Dr, 30-day supply	$2.23	$1.45	$14.48	$15.38	$7.44	$15.00*	Treat depression and anxiety
Esomeprazole Magnesium 40mg Capsule Dr	$3.27	$3.36	$30.34	$30.96	$29.80	$15.00	Treat stomach and esophagus problems Example: acid reflux
Tamsulosin Hcl 0.4mg Capsule Er 24h, 30-day supply	$0.54	$0.63	$2.95	$2.68	$3.16	$15.00	Treat the symptoms of an enlarged prostate
Temozolomide 100mg Capsule	$204.73	$204.75	$818.47	$818.47	$818.50	n/a	Treat certain types of brain cancer

Standard Option without Medicare Part B- Cost of Prescriptions on CVS Prescription Website: https://www.fepblue.org/benefit-plans/coverage/pharmacy

NYS Independent figures were determined by taking the average of eight different stores throughout the state;
Albany, Binghamton, Buffalo, Hudson Valley, Long Island, Northern New York, New York City, and Rochester.

** 30-day supply*

Some highlights:

- The patient's out-of-pocket cost is consistently and significantly higher at national chains than it is at regional chains and local independents.
- At regional chains and local independents, the retail cost of a 90-day supply is lower than the mail order 90-day supply.
- These numbers **DO NOT** reflect the wholesale cost of the medication for any of these parties. Independent pharmacists have confirmed that some of these patient out-of-pocket costs are below their wholesale cost and would be dispensed at a loss.

In addition, will the combined company force more mail order on patients who often pay more for costlier drugs in the mail order program? It is a common misconception that steering patients into mail order will lower drug costs for consumers.[8] Evidence demonstrates that mail order pharmacies consistently dispense costlier brand-name drugs and fewer generics than retail pharmacies. As a "price giver" and a "price taker," mail order firms can manipulate pricing schemes. Plan Sponsors (employers, the federal government, individual purchasers) are often misled into thinking their overall prescription drug costs will be lowered by moving to mail order. At the end of the day, a shift to more mail order will lower the rate of generic dispensing, ultimately raising drug costs. In comparison, community pharmacies dispense generics 88% of the time.

[8] *A Comparison of the Costs of Dispensing Prescriptions through Retail and Mail Order Pharmacies, available at* http://www.ncpanet.org/pdf/leg/feb13/comparison_costs_dispensing_prescriptions_retail_mail_order.pdf.

Viability of Healthcare Providers

PSSNY has serious concerns that independent pharmacies will be able to survive the integration of CVS/Caremark and Aetna. A recent Wall Street Journal editorial, titled *Why CVS Loves Obamacare*, agrees. Many of the points made in this editorial hit home in New York State.

See Addendum C for Wall Street Journal editorial.

On October 26, 2017, pharmacists noticed a sudden, drastic drop in reimbursement as they dispensed generic medications and submitted claims for Medicaid Managed Care patients in the seven health plans managed by CVS/Caremark. How low were the new reimbursement rates? Many pharmacies saw reimbursements of 40% or more **BELOW COST**. At that reimbursement rate, pharmacies were personally funding the Medicaid program. Many could not replace inventory and predicted they would be forced to close their doors because CVS/Caremark controlled 70% to 80% of prescriptions dispensed at these pharmacies.

New York State law provides pharmacies a process to appeal below cost reimbursements for generic medications. This law was blatantly ignored. One single pharmacy has record of over 700 appeals that went unanswered.

New York's unenforced law created an opening for a brazen move by CVS/Caremark. The sudden, drastic drop in reimbursement brought many independent pharmacies to the breaking point. *Unbelievably, on November 9, pharmacies in this weakened state received store purchase offers from CVS/Caremark.*

See Addendum D for CVS pharmacy sale letter.

If it weren't for the actions of the New York legislature, the Governor's office, the Office of the Medicaid Inspector General, and the New York State Department of Health, PSSNY believes hundreds of pharmacies would have shut down. It was only through pressure from all sides that on November 19 CVS/Caremark eased up on the aggressive reimbursement cuts. Be aware that not all New York pharmacies experienced this improvement at that time. Some suffered until February with these unheard of reimbursement rates. It is also worth noting that New York was the anomaly. Pharmacies in other states did not see improvements to the October reimbursement rates until February.

When pharmacies are reimbursed 40% below wholesale cost, they cannot afford to maintain inventory and certain medications inevitably become unavailable. Patients such as those who have been stabilized on medications were at risk of losing access to necessary medications and at risk of needing treatment in emergency rooms or in hospitals. Just as suddenly hospitals were at risk of losing thousands of dollars in incentive payments they would otherwise earn under the Medicaid Redesign initiative.

There are still unanswered questions from this scenario which the *Wall Street Journal* editorial answers for the state of Ohio, but not New York.

- If the pharmacies were being reimbursed at below cost rates, was the State of New York paying the PBM a reduced rate for those medications?
- What was the difference between what New York's taxpayers paid vs. what the pharmacy was paid? Where did that money, referred to as the spread, go?
- Why doesn't the payor have access to that data?
- What did this whole debacle cost New York taxpayers?

What happened during these few weeks demonstrates the wide-ranging impact one PBM can have over pharmacies and healthcare as a whole. In our view, the experience makes a convincing case for federal and state regulation of pharmacy benefit managers and serious concerns with vertical integration within the system. NO state or federal law is currently in place to protect consumers, pharmacies or entire health delivery systems from the destabilizing actions of one, two or all three of the large pharmacy benefit managers.

Conclusion

As the healthcare system continues to consolidate, healthcare costs continue to increase, and patients have fewer choices. Members of the Assembly should be concerned with this trend and encourage close examination of the CVS Health/Aetna merger to determine whether the transaction will result in significant anticompetitive effects. PSSNY believes it will.