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Senator Patrick J. Leahy
Chairman, Senate Judiciary Committee
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Leahy:

Thank you for the opportunity to provide testimony at the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy and Consumer Rights on December 6, 2011. I appreciate the subsequent questions submitted from Committee Members on the proposed Express Scripts-Medco merger and the question at hand: "Cost Savings for Consumer or More Profits for the Middlemen?"

Per your request, please find each of the "Questions for the Record," copied verbatim in italics in the attachment, with my responses immediately following. This testimony is my own, and does not represent an official position of The Ohio State University.

Also as requested, I have marked minor changes on the transcript from my December 6, 2011 testimony and returned it to your office in a separate mailing.

Again, thank you for the invitation. Should you have further questions, please do not hesitate to contact me at (614) 292-9277.

Sincerely,

Scott Streator
Associate Vice President, Business Development
The Ohio State University Medical Center

Attachments (3)
Attachment 1: Streator QFR Response to Schumer
Attachment 2: Streator QFR Response to Lee
Attachment 3: Streator QFR Response to Kohl

Questions for the Record from Senator Charles E. Schumer

for witnesses at Senator Judiciary Committee Hearing on

"The Express Scripts/Medco Merger:

Cost Savings for Consumers or More Profits for the Middlemen?"

Respondent: Scott Streator, The Ohio State University Medical Center

- *Question: How would the merger of Express Scripts and Medco affect community pharmacists' ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?*

As established, the Pharmacy Benefit Manager (PBM) acts as a "middleman," or intermediary, between the payers of healthcare and the providers (pharmacists). They also act as an intermediary for the entire pharmaceutical supply chain including the critical pharmaceutical manufacturer component. The PBM mirrors medical insurance functionality that also acts as an intermediary on behalf of payers to contract with physicians and hospitals to form a health plan network. Therefore, it is incumbent the PBM, acting on behalf of payers, strikes a balance between competitive reimbursement rates and a sufficient number of providers in a given geographic area to ensure access to care.

This merger should not negatively affect patients in rural communities, inner cities, or other underserved areas. Furthermore, this merger has the potential of strengthening the business relationships between payers and providers, especially where access is limited. From a payer perspective, it was encouraging to hear the comments from George Paz, CEO of Express Scripts, at the hearing on December 6, 2011. Mr. Paz reiterated the importance and need to strengthen the business relationship with community pharmacy including adequate reimbursement.

Oftentimes payers require PBMs to guarantee specific industry-access standards. For example, PBM contract guarantees may stipulate that 95% of their plan participants (employees and covered dependents) have a network pharmacy within five miles. These standards help in the PBM comparison and contract negotiations phase so that accurate comparisons of various PBM networks can be made to meet payers' specifications. Once a PBM contract is secured, the PBM provides an auditable pharmacy access report, often with financial guarantees to ensure the access standards are routinely met.

Certainly the 2007 merger of CVS and Caremark blurred the traditional payer-provider function. I believe this proposed PBM merger of two entities *not owned* by a retail pharmacy, could strengthen the community pharmacy-PBM relationship. My experience with ESI and Medco has demonstrated the ability for customized networks to be furnished by adding particular community pharmacies to meet specific, local needs in rural, inner-city or underserved populations.

- *Question: How would this merger impact patients and pharmacies in the Medicare Part D program?*

  Medicare Advantage programs have grown to capture approximately 25% of all Medicare patients. These relatively new, privately-administered programs offer expanded choice from traditional Medicare and the integrated Part D pharmacy benefit has provided welcomed economic relief to patients who were "cash-only" in the past.

  Medicare patients are extremely price sensitive. In terms of the impact on patients in the Medicare Part D program, this merger could further expand the competiveness between the current Medicare Part D and Medicare Advantage programs resulting in reduced costs for consumers. The reduced costs may originate from efficiencies in this proposed merger and the growing Medicare Advantage/Part D competition.

  Due to an expanded benefit, Medicare Part D has certainly contributed to positive financial gains by community pharmacy. Community pharmacies have a growth opportunity to support this increasing benefit by attracting and retaining new Medicare patients. Medicare Part D requires patients to have choice for their drug distribution. That is, for the 90-day supply, a Medicare Part D member chooses community or a mail pharmacy. The merger will not affect this choice.

  As other retail industries have adapted to "big box" retailers and internet giants such as Amazon, community pharmacy will need to diversify its business model. For example, diversifying reimbursement so pharmacists are not just compensated for "volume" (drug dispensing/distribution), but are paid for "value" (clinical skills in optimizing medication therapy for patients and their physicians). The medical literature is replete with examples of poor outcomes resulting from medication mismanagement, yet pharmacy reimbursement is largely focused on volume.

  Consequently, pharmacies in the Part D program can provide additional value to Medicare Part D patients with aggressive 90-day pricing, medication therapy management and supporting physicians in the emerging patient-centered medical home delivery models. These community pharmacy competitive solutions are independent of the ESI-Medco decision.

- *Question: Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG*

reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?

The influx of the baby boomer generation and the increased attractiveness of alternative private plans versus traditional Medicare will accelerate growth and competition in the Medicare Advantage/Part D market. For example, Aetna's December 15, 2011 Investor Conference report projected a 10-fold membership growth in their Medicare suite of services. The increased competition emanates from large, national or regional health plans, smaller hospital-owned Medicare Advantage plans and, of course, the direct Medicare D plan offerings for Medicare beneficiaries.

Value to payers, patients and taxpayers is a function of reduced costs and/or improved quality for the given health expenditure. Therefore, reducing costs is both the opportunity and challenge for the industry on behalf of these customer entities. With dozens of options for Medicare recipients, price sensitivity is the predominant factor in selecting a particular Part D or Medicare Advantage plan.

The OIG report raised questions related to the PBM's financial value and in particular pharmaceutical manufacturer rebate administration and end-user savings. These would be concerning if there were limited competition offering Medicare PDP services and no regulatory oversight.

Moreover, in response to the OIG report, the Centers for Medicare and Medicaid Services December 16, 2011 memo did not concur with several of the OIG recommendations related to rebate administration and PBM contractual relationships. In particular, CMS emphasized they hold each Part D sponsor accountable for compliance with all Part D requirements, irrespective of delegated responsibility. CMS acknowledges the complexity of rebate allocation and requires Part D sponsors to use appropriate methodologies reflecting various differences in formulary, plan design and utilization patterns that can vary market to market.

As a result, with the increased competition and already existing price sensitivity in the Medicare D and Medicare Advantage market, this proposed merger will accelerate the competitive responses of the industry to provide the best value to patients in both public and private health payer arenas.

Questions for the Record from Senator Mike Lee

"The Express Scripts/Medco Merger:

Cost Savings for Consumers or More Profits for the Middlemen?"

Respondent: Scott Streator, The Ohio State University Medical Center

1. *In your written testimony, you discuss emerging changes in the models for healthcare. In particular, you discussed how an increased emphasis on value over volume, and on outcomes over simply providing services, may affect the PBM market.*

    a. *Question: What role do you see in this new market for a large PBM, such as the merged entity, if the merger is approved?*

In the new health payment-reform market, there are growth opportunities irrespective of the PBM size. One on hand, the smaller PBMs may have competitive advantages over large PBMs with enhanced flexibility to implement customized programs that support "accountable care" types of organizations where the insurance risk shifts from payers to physician/hospital providers.

Payers want increased value for their health investment as evidenced by new payment incentives. For example, if a physician or hospital is financially at risk to prevent a hospital readmission, it will be imperative to have an electronic flow of information from all providers and payers (including the PBM) to ensure medication compliance and medication therapy management is conducted to prevent an avoidable hospital readmission. Thus the size of the PBM is less important as the ability to flexibly integrate, coordinate and manage the care of a given population for improved health outcomes and cost savings.

Meanwhile, larger PBMs can leverage scale and national coordination efforts for employers dispersed across large geographical areas. Also, larger PBMs may have additional capacity to leverage important policy considerations on behalf of plan sponsors. For example, large PBMs acting as "middlemen," can advocate for increased competition in the biotech industry with "bio-generics." Finally, large PBMs can create national partnerships with community pharmacy for integrated medication therapy management programs that reward improved health and medication outcomes versus simple drug distribution reimbursement only.

2. *I have heard concerns expressed about the effect of the merger on consumer access to specialty drugs.*

    a. *Question: What effect do you see the merger having on the market for specialty drugs?*

The proliferating "specialty" drug classes, known as biologics, have been managed by the PBMs due to unique distribution requirements, monitoring and patient education requirements. The Express Scripts-Medco merger will provide a sizeable purchasing platform that payers can benefit. While some believe the combined specialty market share will approach 50% with this proposed merger, it is important to note that half of specialty drugs and many new biologics can only be distributed and administered at physician offices or outpatient settings that will effectively reduce this market share. Regardless, the PBM industry provides the market response on behalf of plan sponsors and consumers to help manage and mitigate these costly mediations that average more than $2,000 per month, but can exceed more than $10,000 per month. Furthermore, the combined purchasing power of larger PBMs should underscore the need for an accelerated bio-generics pathway approval.

Another important consideration is the narrow distribution channels for complex biologic products required by the biotech/pharmaceutical manufacturers. Below are three examples where the manufacturer has established clinical quality standards that have narrowed distribution away from both community pharmacy and the large PBM specialty pharmacies.

Example 1
Product: Cayston
Manufacturer: Gilead
Disease State: Cystic Fibrosis Infection.

Specialty pharmacy providers: CF Services Inc., Foundation Care, IV Solutions, Pharmaceutical Spec. Inc.

Notes: The manufacturer, Gilead, requires clinical pharmacists to be specialized in Cystic Fibrosis; the product is administered via inhalation necessitating the pharmacy to have specialized compounding capabilities.

Example 2
Product: Prolastin-C
Manufacturer: Talecris

Disease state: A1A deficiency
Specialty pharmacy provider: Centric Exclusive
Notes: Alpha 1 deficiency is undertreated disease; the manufacturer requires a specialty

pharmacy with capabilities in genetic testing for the disease.

Example 3
Product: Caprelsa
Manufacturer: Astrazeneca
Disease state: Thyroid cancer

Specialty pharmacy provider: Biologics Exclusive
Notes: The market is estimated at 2000 patients nationwide; therefore, the manufacturer required a focused pharmacy for the small patient base.

Finally, with new product entrants and health payment reform models emerging where the financial risk shifts to physicians/hospitals, biotech/specialty manufacturers may direct their distribution to outpatient units directly, thereby by-passing the PBM or specialty pharmacy distribution channel altogether.

3. *I have heard concerns expressed about the merged entity's share of mail-order prescriptions filled in the United States.*

    a. *Question: What role does mail-order play for your organization with respect to how it evaluates contracting with one PBM as opposed to another?*

As one of Ohio's largest employers, The Ohio State University values both the community and mail pharmacy options and provides choice at the individual member level. With over 55,000 employees and dependents living across all 88 counties in Ohio, access to prescription medication is imperative for population health and cost containment. Similarly, employers in our 540,000-member Rx Ohio Collaborative value both mail-order pharmacy, as a home delivery service, and the face-to-face interaction provided by local community pharmacists.

At Ohio State University, approximately 90% of our prescriptions are filled at community pharmacies while 10% are filled by mail order. For both formulary brand and non-formulary brands, there is a 30% co-insurance at both mail and community pharmacies while generics have lower copayments.

In terms of evaluating PBM's mail pharmacy program there are many factors to be considered as each employer, or coalition of employers, determines the best "weighting" based on plan sponsors needs. Following are some examples:

Generic Medications--What is the overall discount for generic medications and does it apply to all generics or only to those medications with two or more generic manufacturers? Is it a guaranteed overall discount and how it this reported to the plan sponsor? How long will the guarantee be in place, one year or longer? Will the pricing improve over the contract's lifespan? How are members notified if there is a shortage or a substitution? What is the generic dispensing rate and successful conversion from appropriate brand drugs by the PBM's mail pharmacy? What is the dispensing error rate?

Branded Medications-- Many of the same questions also pertain to brand and specialty brand products. In addition, what is the PBM's rebate guarantee? Is it for all brand mediations or just "formulary" brand products? What is the success rate in converting to generics? How often can audits and rebate audits be performed?

Compliance--How is compliance measured? How is drug safety monitored, improved and communicated with patient and the prescriber?

Systems-How flexible are the systems to make plan-sponsor specific request such as a customized formulary? How well do they integrate data and how can plan sponsors access data?

Clinical Programs--What clinical programs are implemented at the mail order pharmacy (and community pharmacy) for enhanced value? How effective are they with patients, community pharmacists and prescribers? How is the effectiveness measured?

Customer Service- Like any service industry, plan sponsor account services and member services determine the overall customer experience. The PBM's customer service function generally supports the mail distribution service. Therefore the effectiveness of the PBM's customer service operations is crucial in the overall evaluation.

Oftentimes site visits to both the mail and customer's service operations are conducted before a final PBM section is made. The use of industry consultants, whether retained as employees or outsourced, is often used in the RFP/bidding process. The Ohio State University has leveraged in-house industry expertise with academia to form a best-in-class purchasing model to carefully select, monitor and augment the PBM functionality for supporting self-insured employers in Ohio.

b. Question: What effect do you see the merger having on competition among PBMs with respect to mail-order offerings?

The combined entity will leverage existing scale, purchasing power and "best in class" services between both organizations that current plan sponsors may not be presently

receiving from either of the organizations. Competitor PBMs will need to offer other distinctive services to effectively compete. As listed above, there are numerous services, beyond discounts, that could be leveraged across the competitive landscape to improve the value equation.

There is one additional point for consideration. This potential merger should not prohibit community pharmacy from creating and launching their own innovative market solutions for plan sponsors. For example, if retail pharmacy can leverage its purchasing power, integrate clinical functions with physicians and offer greater value versus mail pharmacy, plan sponsors would welcome new delivery models that reflect health payment reform trajectory.

Questions for the Record from Senator Herb Kohl

"The Express Scripts/Medco Merger:

Cost Savings for Consumers or More Profits for the Middlemen?"

Respondent: Scott Streator, The Ohio State University Medical Center

- *Question: In your written testimony, you contend that it is the health plan sponsors that instruct the PBMs how to design pharmaceutical benefit plans, and the PBMs are merely acting at the direction of the plan sponsors. But will this merger reduce the leverage of plan sponsors to insist on specific aspects of plan design, leaving plan sponsors more in a "take it or leave it" position?*

  Plan sponsors fiduciary responsibilities include thorough due diligence in the selection and ongoing management of benefit provider organizations including PBMs. When expertise or resources are lacking, many choose qualified industry experts such as national consultants or coalition consultation services. The advantage of plan sponsors banding together increases their purchasing power that spawns new service requirements and new models all together from the chosen PBM.

  There are competitive advantages and unique value offerings across the horizon of large and small PBMs, health plan-owned PBMs and fully-integrated health care delivery systems. Without the PBM function, pharmaceutical manufacturers would offer a "take it or leave it" pricing position.

  Plan sponsors are seeking value from their provider network, from physicians, hospitals and pharmacists. The retained benefit provider, whether a health plan and/or PBM, should respond to plan sponsor requirements and offer creative solutions. Regardless, the plan sponsor makes the final decision. With this proposed merger, the fiduciary decision and responsibility will not change.