Written Testimony of
Scott E. Streator

Associate Vice President Business Development,
The Ohio State University Medical Center
Former CEO of The Ohio State University Health Plan, Inc.

Columbus, Ohio

Before the
United States Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer Rights

December 6, 2011

Introduction

Chairman Kohl, Ranking Member Lee and Members of the Subcommittee, my name is Scott Streator and I am pleased to have been invited by you to testify on the Express Scripts-Medco merger. I will provide a multi-faceted perspective on the issue at hand: "Cost Savings for Consumer or More Profits for the Middlemen"?

My testimony will reflect over twenty years of experience in healthcare and pharmacy benefit management, from each angle: Payer, Provider and Plan. Each of these perspectives of course represents the ultimate customer, our patients. This testimony is my own, and does not represent an official position of The Ohio State University.

By way of background, I began my professional career as a clinical pharmacist at Johns Hopkins Hospital, provided medication management consulting in various health delivery channels and have spent the majority of my career working in health benefit management to innovate, implement and promote cost containment strategies.

My employer, The Ohio State University Medical Center is future-focused and driven by a mission to improve people's lives through innovation in research, education and patient care. The Medical Center, with 17,000 employees, serves more than 1 million patients each year at its main medical campus in Columbus, Ohio and a network of additional sites around Central Ohio. Research funding has surpassed $291 million and over 2,000 research studies are ongoing in virtually every medical specialty. Ohio State's College of Medicine educates more than 800 medical students each year and 1,600 students in the allied medical professions. Today, 13,500 College of Medicine MD and residency program graduates practice in all 50 states and in more than 50 countries around the world.

Recently, I served as the CEO of The Ohio State University Health Plan, managing the medical and pharmacy benefit for our 56,000 health plan members with a focus on health promotion and clinical integration. The OSU Health Plan is also privileged to serve as the administrator of the Rx Ohio Collaborative, a partnership amongst Ohio-based plan sponsors who competitively contract with a single PBM, currently ESI, in a transparent manner. This public-private sector partnership provides services to our member organizations in the areas of benefit consulting, data analysis from our OSU College of Pharmacy and pooled purchasing of benefits to approximately 80 different Ohio-based employers representing 540,000 members and over $1B in pharmaceutical expenditures annually. This business model allows deep

discounts and consultative services to all employer groups so that the financial benefits are realized for any size employer from the small to the large.

Each individual plan sponsor in the Rx Ohio Collaborative is self-insured and therefore has autonomy and financial responsibility for their respective benefit designs. Therefore no provider, nor PBM, mandates how payers in the Collaborative design their benefit structure. Each plan sponsor is responsible for funding and providing benefits to meet their respective organizational requirements. This is an important distinction to make, as community pharmacy providers may assume benefit design decisions rest with the PBM or health plans instead of the individual payer or plan sponsor such as self-insured employers.

Key Position

As one who has been engaged in this industry as a payer, plan administrator and provider, it is clear to me the Express Scripts-Medco merger will further spawn competition from existing pharmacy benefit managers, health plans and emerging business models that can lead to lower overall pharmaceutical therapy costs for payers and consumers. Therefore, I am in favor of this merger.

Greater Competition from Health Plan/Insurers as a result of PPACA

From a payer and health plan perspective, the business context is important before explaining how market forces, competitors and the Patient Protection and Affordable Care Act (PPACA) may alter the PBM industry landscape.

The Pharmacy Benefit Manager (PBM) serves as the claim administrator function in the ERISA self-funded plan sponsor environment. The PBM will administer the plan design according to the rules identified and established by the plan sponsor, or end payer. Areas where the PBM has considerable influence are in the development of the formulary, or list of preferred medications, and in negotiating prices and rebates with pharmaceutical manufacturers. The PBM also negotiates reimbursement rates with the community pharmacy provider network. The PBM can provide these types of services for private sector employers, health plans or governmental agencies.

Historically, self-funded government and private sector purchasers generally contract for pharmacy benefit management services directly from a PBM or a health plan/insurance carrier. Health plan/insurance carriers thus have the option to "carve-in" or "carve-out" the pharmacy benefit. If carved-in, the health plan operates the internal PBM function that allows a plan sponsor to contract for medical and pharmacy benefits. If carved out,

essentially the health plan out-sources a range of functions to a PBM for a given fully insured or self-insured population.

While the market share of health plan-owned PBMs has fluctuated over the years, in today's new PPACA environment, insurance carriers may increasingly decide to carve in, or in-source, this benefit management function as evidenced by United Healthcare's decision to in-source the pharmacy benefit beginning in 2013. In terms of competition, not only has this significantly reduced Medco's market presence, but United's PBM (OptumRx) represents another competitive market entrant with the combined UHC/Optum Rx membership in excess of 20M. Thus insurance carriers can now offer a more competitive alternative to stand alone PBMs by using their own in-house PBM.

As another example, Humana, with approximately 6M members and $12B in drug spend is an "in sourced" PBMs offering. Like other insurance carriers/health plans, Humana competes for Medicare Advantage, PDP members and direct employer contracts. Similarly, Cigna (Cigna Pharmacy Services) and many of the Blue Cross/Blue Shield insurance carriers such as Prime Therapeutics also offer an in-sourced PBM option.

With the likelihood of insurance exchanges emerging for the individual and small group market, the in-sourced PBM offering coupled with the health insurer may be an attractive offering for health plans that do not yet effectively integrate clinical, data and core operational functions across the pharmacy and medical benefit.

<u>Greater Competition from Pharmacy Benefit Managers</u>

I remain optimistic the proposed merger of Express Scripts and Medco will further generate competition with innovative business models that could produce lower costs; some of which will be shared with the payers and consumers of healthcare. More and more, employers are willing to consider innovative solutions to reduce costs and are open to new pharmacy benefit management strategies they may not have considered before.

In terms of PBM organizations competing directly to employers in a "carve out" program, there are a growing number of attractive options to payers, including members of the Rx Ohio Collaborative and other coalitions. While three PBMs have had the majority of market share in the past, there are several companies that have evolved recently with strategic acquisitions to develop a robust infrastructure that can now accommodate large employer needs on all levels. As a result they are gaining market share. For instance Catalyst, SXCI, Navitus, MedImpact, OptumRx, Envision, CVS-Caremark, and Welldyne are several options available in today's PBM marketplace depending on individual or purchasing group needs.

Further, as the barriers to entry in the PBM market have decreased, new PBM entrants will emerge such as retail-only PBM models.

Meanwhile, irrespective of the size of the PBM, end payers can develop innovative partnerships with their PBMs to increase the purchasing value available to them, and to reduce costs. For example, at Ohio State University, we realized savings synergy in our pharmacy benefit when we combined our lives with other large, sophisticated purchasers. We leveraged local public-private expertise, conducted a thorough due diligence bidding process and then selected a PBM that could deliver savings, transparency, service and innovation.

As a result, Ohio State University has saved approximately $10M or 9% for the first three-year term and is on track to continue these savings. Last year, when brand drug makers increased prices by 4.2%, OSU's current per capita ("drug trend") pharmacy benefit expenses have decreased by 0.4%, while our generic dispensing rate increased 3.4%.

For government and private sector employers, these cost containment initiatives are imperative and can help preserve jobs or provide benefit dollars to invest in health promotion and wellness programs for employees. Moreover, other plan sponsors have realized significant savings from clinical programs available from the PBM platform that is not dependent on size of the PBM.

<u>ESI-Medco</u>

The proportion of savings realized to plan sponsors from a PBM is largely dependent on how effectively plan sponsors leverage their purchasing power with competitive, transparent contracting; utilization of clinical programs; and actively manage their benefit. While competition is escalating to provide the best value and lowest costs to payers, current customers of ESI and Medco are also hoping to financially benefit from the combined ESI-Medco platform.

While the Food and Drug Administration works diligently to ensure safety and efficacy, there is no "comparative effectiveness" requirement on prescription drugs as in other developed countries. The merger of ESI and Medco, along with other PBMs, will continue to provide the market pressure on cost containment of pharmaceutical manufacturers. Payers expect the PBM to leverage their book of business to obtain the best value for their expenditures from pharmaceutical manufacturers. Until comparative effectiveness research matures, PBMs and health plans provide drug coverage determination, formulary management and negotiate rebates with pharmaceutical manufacturers on behalf of plan sponsors. Larger PBMs could leverage size in reducing the net cost of various prescription drugs with pharmaceutical

manufacturers; however, the ability to drive market share of the lowest net cost can be done irrespective of the PBM's size.

At the same time, as a result of blockbuster brand drug patent expirations, over 75 of every 100 prescriptions are now filled with generic medications that save over $150 per prescription for our beneficiaries. This wave of patent expirations will limit ESI-Medco, or any PBM's ability to generate increased rebates in a number of therapy classes.

The proliferating "specialty" drug classes, or biologics, have been managed by the PBMs due to unique distribution requirements, monitoring, and patient education requirements in this small subset of the pharmaceutical marketplace. The Express Scripts-Medco merger will provide a sizeable purchasing and clinical platform to benefit payers. While some believe the combined specialty market share approach 50% with this proposed merger; it is important to note that half of specialty drugs and many new biologics anticipated to receive approval by the FDA in coming years, can only be distributed and administered at physician offices or outpatient settings. This shift to infused or physician administered products will effectively reduce this perceived market share. Regardless, at costs that can exceed more than $10,000 per month, the combined purchasing power of larger PBMs should underscore the need for an accelerated bio-generics or bio-similar approval pathway as there is *little if any competition for various biologics* or specialty products.

While there are certain scale advantages of large PBMs, it is important to note flexibility can be a tradeoff. It is well established clinical programs can yield tremendous savings that far exceed simple drug discounts for plan sponsors. For example, when Prilosec OTC was introduced several years ago, PBMs that swiftly changed formularies, distribution strategies and implemented customized plan design changes produced tangible savings far exceeding discounts of leading brand-name prescription products for their payer customers. Smaller PBMs and health plans can be more agile in implementing customized programs to meet local health market characteristics and plan sponsor requirements.

An important competitive consideration with this proposed merger is the affect on community pharmacists and their role as network providers. Plan sponsors and consumers should be given choice of their preferred drug distribution channel. With the growing Medicare Advantage/PDP, the 90 day retail supply provides competition to the ESI-Medco mail pharmacy distribution channel. For the Rx Ohio Collaborative there is no "preferred channel" of distribution as each employer plan sponsor is responsible for their own unique plan design.

While reimbursement to community pharmacy needs to be competitive; true savings sought by pension systems, government, and private sector employers will be a result of

coordinating care, improving compliance, safety, and quality of health care. Thus, PBMs and health plans need to integrate with community physicians and pharmacists to ensure patients are on the proper medications, and medications therapies are appropriately managed as part of a coordinated care process for improved outcomes.

Emerging Models

This leads me to my final point; there is an over-emphasis in the payer and provider community by equating value with "discounts," whether the discount is in the form of physician's "fee for service" charge or a discount off the pharmaceutical's ingredient cost and dispensing fee. Regardless of what ultimately happens with PPACA, it is clear the current fee for service reimbursement model in physician and hospital sectors is evolving from "payment for volume" to "payment for value." In the future, due to the passage of the PPACA and payer financial pressures, the insurance risk will increasingly shift from payers to the physician/hospital delivery channel as evidenced by greater financial risk for hospital re-admissions and bundling of payments for episodes of care. These may indeed replace the current discounted fee for service reimbursement schedules.

How will new financial models alter the PBM and community pharmacy industry? Since reimbursement of pharmaceuticals is also largely based on discounts off the ingredient cost, it is unclear how new health financing models will modify the current reimbursement model. As the Patient Centered Medical Home and Accountable Care type of organizations emerge, coordination of care and outcomes will be valued versus the current "compartmentalization" of pharmaceutical expenses. In these emerging reimbursement models where the risk shifts to the health delivery system; managing costs of pharmaceuticals in a "silo" while important, will be de-emphasized versus improving the overall effectiveness of managing medication therapies across the entire care continuum.

For example, in the November 24, 2011 New England Journal of Medicine article "Emergency Hospitalizations for Adverse Drug Events in Older Americans" an estimated 37% of emergency department visits required hospitalization for adverse drug events. With economic risk shifting from insurers/payers to providers, integrating the management of pharmaceuticals to prevent hospital admissions (and readmissions) by both physicians and pharmacists will be necessary and financially incentivized to prevent these needless occurrences.

Thus both community pharmacy and PBMs can play a vital role supporting the physician by reviewing and recommending therapies in a given population.

Conclusion

Greater competition from PBMs and health plans is emerging, and will continue to advance as a result of the proposed ESI-Medco merger. Lower costs can be generated with greater competition and thus I support the proposed merger. Moreover, the impact of the Patient Protection and Affordable Care Act and health exchanges will provide new opportunities for current and emerging business models. New reimbursement models will be shifting greater financial risk from insurers to the physician and hospital level. Thus the PBM landscape will be altered so that the size of the PBM may be less important as the ability to manage and coordinate care at the individual and population level.