Testimony of Larry McNeely
Health Care Advocate
U.S. Public Interest Research Group

Before the House Committee on Oversight and Government Reform
Subcommittee on the Federal Workforce, Postal Service
and District of Columbia

"A Path to Lower Costs for Federal Employees and Taxpayers: Sunshine for the Pharmacy Benefit Managment Industry"

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Chairman Lynch, Ranking Member Chaffetz and other members of the Subcommittee, I appreciate the opportunity to come before you today and testify about efforts to control the costs of drugs in the Federal Employee Health Benefits Program (FEHBP). My name is Larry McNeely. I am the Health Care Advocate with the United States Public Interest Research Group. U.S. PIRG is a national federation of state-based consumer advocacy organizations. As an organization with a 35 year history of standing up for American consumers, U.S. PIRG is convinced that both strong competition and strong consumer protection are essential to the functioning of any market. Many aspects of the delivery of drug benefits are competitive, especially the retail drug market. Unfortunately, the pathway for prescription pharmaceutical delivery – the market for Pharmacy Benefit Managers (PBMs) – lacks adequate competition or consumer protections. That is why the reforms envisioned in H.R. 4489 are necessary so that federal employees and the federal government receive the greatest benefits at the lowest cost.

My testimony will focus on the importance of transparency to make any market function effectively, and particularly for the market for PBMs. Assistant Attorney General for Antitrust Christine Varney highlighted the importance of transparency when she said, "I am a firm believer in what Justice Brandeis said in another context: 'Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.' Markets work better and attempted harms to competition are more likely to be thwarted when there is increased transparency to consumers and government about what is going on in an industry." Today, I hope to highlight the potential benefits of transparency when it comes to the pharmacy benefits for our federal employees.

Here are the essential points of my testimony:

- **The market for PBMs is inherently flawed as a result of regulatory neglect.** Three essential elements of a competitive market are choice, transparency and a lack of conflicts of interest. The PBM market lacks each of these elements. The market for PBM services is highly concentrated, and the major PBMs routinely

engage in deceptive and fraudulent practices that allow them to maintain their dominant positions in the market, denying their customers additional choices. A lack of transparency and a total lack of federal regulation of PBMs allow this anticompetitive conduct to continue. Moreover, the ownership of PBMs by major pharmacy chains, such as CVS Caremark, raises significant conflicts of interest and harm consumers.

- **Consumer harm is rampant when PBMs improper market behavior is left unchecked** PBMs are the only unregulated segment of the health care market and this permits them to engage in a variety of deceptive and fraudulent practices, including drug switching and self-dealing. A coalition of over 30 states has brought major enforcement actions securing to date over $370 million in damages. It's past time to put an end to these anticompetitive and fraudulent practices.
- **Enacting H.R. 4489 will lead to significant cost savings for taxpayers and protect government workers.** The proposed legislation will lead to a reduction in pharmaceutical costs by requiring pass-through of rebates and prohibiting drug switching and spread pricing. It will protect federal employees and taxpayers by preventing PBM tactics such as drug switching which may force the consumer to pay more. And it will protect the FEHBP and employees by preventing conflicts of interest by prohibiting plans from contracting with PBMs that are owned by retail chains.
- **Public and private plan sponsors have realized significant savings by requiring transparency of their PBMs.** A growing body of evidence demonstrates that transparency allows plan sponsors to monitor and curb their prescription drug spending.
- **OPM should set in place a variety of consumer protections and establish the position of an ombudsman to address complaints.** To take advantage of its increased oversight capabilities, OPM should strengthen the consumer protections in the FEHBP for the pharmacy benefit in particular by establishing an ombudsman and other measures.

Regulating PBMs and strengthening the FEHBP program is more than a matter of dollars and cents. Because of the complexity of PBM operations, they create a tremendous opportunity for fraudulent and deceptive conduct. This is particularly true where PBMs are owned by pharmacy chains, such as CVS Caremark. That merger combining the largest pharmacy chain with one of the largest PBMs pose significant risks for millions of consumers including federal employees. CVS Caremark takes advantage of the closed loop between its PBM and pharmacy operations to exploit plan sponsors, oftentimes putting the ultimate consumer in danger while in pursuit of profits. Below are examples of situations where CVS Caremark sought to drive its own market share at the expense of the health plan it serves and individual patients. By taking on more oversight authority and avoiding the fundamental conflict of interest of a joint PBM-pharmacy like CVS Caremark, the government and other plan sponsors can avoid situations like these documented by the Center for American Progress' Senior Fellow David Balto:

- Susan, a 98-year-old patient in Texas, was released from the emergency room for bleeding ulcers. Her daughter picked her up and immediately stopped at the closest pharmacy to pick up the three prescriptions she needed. Of these three, one critical prescription – and the most expensive – was denied by her CVS Caremark insurance. Susan was told she needed to visit a CVS pharmacy for this particular drug. Her daughter drove the 40-minute round trip to pick up her medication.

- Rebecca, a federal employee, is required to use her plan's mail order specialty pharmacy for a particular high-cost drug she takes. The drug requires special care and must be refrigerated upon delivery. Because she prefers to keep her condition private from her coworkers, she must wait at home for deliveries; when deliveries arrive late, she takes an extra day off work. When the delivery is late, she must go without the medication, sometimes resulting in such extreme pain that she must visit her pain doctor at a high cost to the federal plan.

This is why enactment of H.R. 4489 is vitally necessary.

PBM Markets Lack Choice and Transparency, and are Subject to Anticompetitive and Deceptive Conduct

I have a simple and vital message for this Committee: there is a tremendous need for PBM reform. The fundamental elements for a competitive market are transparency, choice and a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access and securing adequate information may be difficult.

Why are choice, transparency, and a lack of conflicts of interest important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire.

When dealing with intermediaries like PBMs, it is particularly critical that there are no conflicts of interest. . In the PBM market, the service a PBM provides is that of being an "honest broker" bargaining to secure the lowest price for drugs and drug dispensing services. When a PBM has a relationship with either a drug company or a pharmacy, or has its own operations, it is effectively serving two masters.

Only where these three elements – choice, transparency, and lack of conflicts of interest – are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Unfortunately, in all three respects, PBM markets do not function as effectively as they could. **Few markets are as concentrated, opaque and complex and subject to rampant anticompetitive and deceptive conduct as PBM markets. As important, PBMs are the only unregulated segment of the health care market.**

The lack of choice.

First, the PBM market is highly concentrated among three major PBMs (CVS/Caremark, Express Scripts and Medco), which now have over 80% of the national PBM market.[1] The FTC has not undertaken any enforcement activity in the face of this market consolidation. In fact, the past two substantial PBM mergers – Caremark's acquisition of AdvancePCS and CVS's acquisition of Caremark – were approved without a significant investigation, despite leading to a significant increase in market power. **While consumers have faced rapidly increasing costs and inadequate access to pharmaceuticals, from 2003 to 2007, the three largest PBMs—Medco, Caremark and Express Scripts—nearly tripled their annual profits from $966 million to over $2.7 billion.**[2] These rapidly increasing profits are clearly a sign that these three PBMs have market power.

Increasing conflicts of interest.

Today the Committee will hear testimony of the problematic conduct CVS has engaged in after acquiring Caremark. This combination of the largest pharmacy chain with the largest PBM poses significant competitive concerns. The pharmacist testifying today is not alone in expressing these concerns. Consumer groups including the Consumer Federation of American and US PIRG, Change to Win (a coalition of unions), and the National Legislative Alliance on Prescription Drugs (a bipartisan group of state legislators) have called on the FTC to investigate allegations of anticompetitive and deceptive conduct that have increased prices and reduced choices for consumers, and the FTC has responded by opening an investigation.

The concerns raised about the CVS/Caremark alliance bear a striking and disturbing resemblance to the issues raised by last year's scandal surrounding Ingenix and its role in creating exorbitant out of network rates for basic medical services like a physician or an ER visit. In order for the health insurance system to function effectively, there needed to be an honest, independent broker to determine usual and customary rates for out of network service. That was the purpose of Ingenix, which was created to survey those rates. However, Ingenix was owned by United Health, a major health insurer.

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1 American Antitrust Institute. "The Next Antitrust Agenda: The American Antitrust Institute's Transition Report on Competition Policy to the 44th President of the United States." See Chapter Nine: Competition in the Unhealthy Health Sector. See page 324.
http://www.antitrustinstitute.org/archives/files/Health%20Chapter%20from%20%20AAI%20Transition%20Report_100520082050.pdf

2 See Medco, Express Scripts and CVS Caremark annual 10-K filings for 2003 to 2008.

United's ownership of Ingenix, however, distorted that relationship and created a conflict of interest. Under the ownership of United, Ingenix deflated those usual and customary rates, forcing consumers to pay more for out of network services. That is why the New York Attorney General required United to divest its holdings in IngenixIngenix and mandated the creation of a non-profit entity to perform its function.[3]

Similarly, CVS' ownership of Caremark distorts Caremark's incentive and ability to be an honest broker. There is a clear conflict of interest and an ability to manipulate the relationship to harm CVS' rivals (other pharmacies) and consumers. Moreover, controlling health care costs and health care reform is dependent on PBMs being honest brokers. Caremark, because it is a CVS subsidiary, is unlikely to function as an honest broker.

Ongoing fraudulent and deceptive conduct.

More generally, PBM consumer protection issues have an important impact on the potential for the government to control health care costs while protecting employees. Chairman Lynch's legislation appropriately addresses the practices that allow PBMs to exploit plan sponsors. For example, PBMs are able to "play the spread" between pharmaceutical manufacturers, pharmacies and the health care plans. As the union coalition Change to Win noted, "A lack of transparency is one of the key problems in the pharmacy benefit management industry. For example, PBMs often charge the health plans they serve significantly more for the drugs than they pay the pharmacies that distribute the drugs to patients. PBMs also may switch patients to a drug other than the one their doctor prescribed sometimes a drug more expensive for the health plan and patient to take advantage of rebates the PBM receives from drug manufacturers, which are often hidden from the PBM's customers."[4] Thus, PBMs can artificially decrease the level of reimbursement to pharmacies. This conduct is clearly similar to the types of fraudulent and deceptive conduct that United Healthcare engaged in with its Ingenix subsidiary. H.R. 4489 bans this practice outright.

A number of other secretive practices by PBMs make it difficult for a plan sponsor to enjoy the reduced costs competition between PBMs would otherwise product. Some PBMs secure rebates and kickbacks in exchange for exclusivity arrangements that may keep lower priced drugs off the market. More recently, there have been a series of acquisitions by PBMs to acquire specialty pharmaceutical companies. These specialty pharmaceuticals are higher-priced drugs that need special handling. After these acquisitions, many of these PBMs rapidly increased the price of these specialty pharmaceuticals.[5] With transparency, a plan sponsor can monitor their PBM's activities and ensure that they will not be subject to deceptive practices like these.

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3 Cook, Bob. "Final health plan reaches settlement over Ingenix database." American Medical News. July 6, 2009. Accessed at http://www.ama-assn.org/amednews/2009/06/29/bisc0629.htm.

4 Change to Win, Letter to Chairman Lynch and the members of the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia, Committee on Oversight and Government Reform. June 24, 2009. Available at http://federalworkforce.oversight.house.gov/documents/20090625153554.pdf.

5 Freudenheim, Milt. "The Middleman's Markup." The New York Times. April 19, 2008. http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63

No other segment of the health care market has such an egregious record of consumer protection violations. In the past several years, a coalition of over 30 state attorneys general have brought several cases attacking unfair, fraudulent and deceptive conduct by PBMs. Between 2004 and 2008, the three major PBMs have been the subject of six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. **These cases listed below, resulted in over $371.9 million in damages to states, plans, and patients so far.**

- United States v. Merck & Co., Inc., et.al – $184.1 million in damages for government fraud, secret rebates, drug switching, and failure to meet state quality of care standards.
- United States v. AdvancePCS (now part of CVS/Caremark) – $137.5 million in damages for kickbacks, submission of false claims, and other rebate issues.
- United States v. Caremark, Inc. – pending suit alleging submission of reverse false claims to government-funded programs.
- State Attorneys General v. Caremark, Inc. – $41 million in damages for deceptive trade practices, drug switching, and repacking.
- State Attorneys General v. Express Scripts – $9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans.

A group of state attorneys general and the DOJ are continuing to conduct several investigations of the three major PBMs, and several private actions challenging their conduct have been brought by unions and other customers. The current concentration of the national full-service PBM market only exacerbates these problems, increasing the need for government enforcement and potential regulation of the industry.

PBMs' promise of controlling pharmaceutical costs has been undercut by a pattern of conflicts of interest, self-dealing, deception, and anticompetitive conduct. As a bipartisan group of state legislators noted:

> We know of no other market in which there have been such a significant number of prominent enforcement actions and investigations, especially in a market with such a significant impact on taxpayers. Simply put, throughout the United States, numerous states are devoting considerable enforcement resources to combating fraudulent and anticompetitive conduct by PBMs. This is because those activities are taking millions of taxpayer dollars and denying government buyers the opportunity to drive the best bargain for the state.[6]

6 Letter from Mass. State Senator Mark Montigny to FTC Chairman Deborah Platt Majoras. May 11, 2005.

In an important decision upholding state regulation of PBMs, one federal court observed "[w]hether and how a PBM actually saves an individual benefits provider money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider." The court elaborated:

> This lack of transparency also has a tendency to undermine a benefits provider's ability to determine which is the best among competing proposals from PBMs. For example, if a benefits provider had proposals from three different PBMs for pharmacy benefits management services, each guaranteeing a particular dollar amount of rebate per prescription, the PBM proposal offering the highest rebate for each prescription filled could actually be the worst proposal as far as net savings are concerned, because that PBM might have a deal with the manufacturer that gives it an incentive to sell, or restrict its formulary, to the most expensive drugs. **In other words, although PBMs afford a valuable bundle of services to benefits providers, they also introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs.**[7]

The Demonstrated Savings from PBM Transparency

The information provided by transparency allows a plan sponsor to curb both fraud and waste. In addition to revealing and eliminating the deceptive and fraudulent practices the major PBMs routinely engage in, transparency gives plan sponsors the tools to monitor their prescription drug spending and reduce it.

A number of public and private plan sponsors have required transparency of their PBMs and realized significant savings as a result. Richard Beck has testified today on the savings Texas expects since they have consolidated their various state, employee and retiree prescription benefit plans and enacted transparency. The State of New Jersey recently opted for a transparent, pass-through contract with Medco, one which bans spread pricing much like H.R. 4489 does. The state anticipates savings of over $550 million.[8] Similarly, the University of Michigan has saved nearly $55 million by managing its own pharmacy benefit for the past six years, managed by a single PBM which gives the university more control over the plan.[9]

The Provisions of H.R. 4489 are Necessary to Make PBM Markets Work for the FEHBP

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7 Pharm. Care Mgmt. Ass'n v. Rowe, 2005 U.S. Dist. LEXIS 2339, at *7-8 (D. Me. Feb. 2, 2005), aff'd, 429 F.3d 294 (1st Cir. 2005).

8 State of New Jersey. Department of the Treasury. Purchase Bureau. Award Recommendation. Reference Number 10-X-20899, T2679. August 4, 2009.

9 See Appendix A of this document for more examples of the savings from transparency.

The major PBMs have paid hundreds of millions of dollars in damages for a variety of anticompetitive and anti-consumer conduct, including failure to meet ethical and safety standards. In these instances, state attorneys general exposed the problematic conduct and addressed it directly. For the most part, however, PBMs conduct business with plan sponsors behind a veil of secrecy. Transparency requirements remove this veil: they give plan sponsors greater control over their plan members' experiences, and provide an essential intermediary between individual patients and the PBMs' policies and practices that might put them in danger.

Each of the provisions of H.R. 4489 are necessary to protect federal employees and give FEHB plans and OPM the tools necessary to reduce drug costs and prevent anticonsumer conduct.

Section 2A of the bill prevents a pharmaceutical manufacturer or a retail pharmacy from owning a PBM used by a FEHB plan. The purpose of the restriction is straightforward – to prevent the conflict of interest from these types of cross-ownership. OPM regulations already prohibit PBMs from being owned by pharmaceutical manufacturers; this extends the restrictions to retail pharmacies.

As discussed earlier, the key to PBM services is for the PBM to be an honest broker – securing the best price for the plan, from both pharmaceutical manufacturers and retail pharmacy chains. But there is increasing evidence of significant harm from pharmacy chain ownership of PBMs, primarily CVS' ownership of Caremark. When the deal was announced CVS Caremark CEO Tom Ryan stated that the company would be "agnostic" about what pharmacy would be used and would treat CVS and non-CVS pharmacies alike.[10] The company also has stated they would have a firewall separating CVS and Caremark operations.[11] But both of these promises seem to be regularly violated. There have been dozens of allegations that CVS is using Caremark to drive consumers away from other pharmacies to CVS stores by increasing co-pays, misusing confidential information, or through deceptive marketing practices.[12]

Moreover, a plan sponsor cannot expect Caremark to aggressively with negotiate or audit CVS stores when they are owned by the same parent. CVS Caremark has no incentive to bargain down CVS' reimbursement rate when higher rates are paid entirely by the plan sponsor and enjoyed entirely by CVS. Nor will Caremark be a very effective "cop on the beat" when policing harmful practices by CVS. That is why the prohibition on cross-ownership is necessary.

Section 2B of the bill prevents PBMs from engaging in certain types of drug switching without the physician's approval or to a higher-cost drug. Without

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10 Day, Kathleen. "CVS, Drug Benefit Manager to Merge." The Washington Post. November 2, 2006. http://www.washingtonpost.com/wp-dyn/content/article/2006/11/01/AR2006110100881.html

11 Davidson, Joe. "FTC propping CVS Caremark's prescription drug practices." The Washington Post. February 9, 2010. http://www.washingtonpost.com/wp-dyn/content/article/2010/02/08/AR2010020803379.html

12 Bartz, Diane. "Pharmacies ask U.S. to reassess CVS, Caremark Merger." Reuters. May 13, 2009. http://www.reuters.com/article/idUSTRE54C7AK20090513

transparency, the major PBMs routinely engage in drug switching, encouraging or requiring a patient to switch from one drug to an equivalent simply so the PBM can earn greater rebates.[13] This takes away from the patient's autonomy to choose, with their physician, an appropriate medication, and introduces a new variable into their drug regimen, increasing the likelihood of lack of adherence. Ultimately this may threaten their health. When the switch to a higher-cost drug affects a patient's co-pay, this practice can affect patient's out-of-pocket costs. And when Medicare Part D plans engage in drug switching at a higher cost to the plan, a patient's access to drugs is threatened if the patient hits their "donut hole" gap in coverage as a direct result of the PBM's decision to switch their drug.

Plans cannot anticipate the way their costs will go up due to PBMs' secretive drug switching strategies. By prohibiting drug switching unless it results in a net benefit to the plan, and by making all rebates pass through to the plan, the plan sponsor can better anticipate their overall drug spend. This allows for more consistent premiums in the long term.

Section 2C of the bill requires full pass-through of any rebates received by the PBM. A major source of cost savings that PBMs receive are rebates drug manufacturers give to be placed on the PBM drug formulary.[14] In effect, the PBM is able to leverage the "lives" it represents into higher rebates and lower drug costs. Since the PBM is basically leveraging the bargaining power of the FEHBP, the government should receive the full benefit of that bargaining power.

Section 2E of the bill eliminates "spread pricing" – the practice of charging the plan sponsor more for a prescription than what the PBM pays the pharmacy. Such spread pricing does not benefit plan sponsors in any fashion. As an honest broker, the PBM should pass on the benefits of its negotiating power to the plan.

Section 2H of the bill gives OPM full audit rights and access to data, ensuring that there will be adequate oversight. OPM has previously testified about its concerns over the lack of transparency and it is important for OPM to have all the tools necessary to audit PBMs and make sure that the federal government can effectively control costs.

I strongly recommend that H.R. 4489 be enacted to protect both the federal government and federal employees. To supplement that action I suggest two additional reforms.

- **OPM should appoint an ombudsman to field complaints from various plan members and address their concerns.** This ombudsman should have direct authority to override policies or restrictions in the federal employee's plan which might be inappropriate to that plan member's needs.

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13 See State Attorney General v. Caremark, Inc. and State Attorney General v. Express Scripts.
14 Freudenheim, Milt. "The Middleman's Markup." The New York Times. April 19, 2008. http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63

- **OPM should require plans to establish protocols to ensure that patients get their drugs when needed.** Should the plan have restrictions on the pharmacies a customer can use on particular drugs, the plan should take certain measures to notify the patient of these restrictions well in advance of the time they might need those drugs. Should a patient use mail order for a particular drug, they should have access to a local pharmacy for emergency refills when a delivery is delayed or damaged. Moreover, patients should be granted exceptions to mail order policies.

Conclusion

Throughout the debate on health care reform, it has become clear that transparency is a critical tool for reducing waste and fraud. A variety of plan sponsors have learned that requiring transparency of their PBMs is a vital step in curbing prescription drug spending. Today, the FEHB spends more on prescription drugs than any other federal program; by enacting transparency, the federal government has the opportunity to achieve significant savings.

Strengthening OPM's oversight will also benefit the federal employees who would otherwise subject to the major PBMs' fraudulent, deceptive and otherwise problematic practices. Drug switching or mail order requirements, for example, might benefit the PBM while harming the ultimate consumer.

Attachment A
The Demonstrated Savings from Transparency

Below is just a sample of the many examples of the cost savings that transparent PBMs offer plan sponsors, from small employers to large corporations, state governments and TRICARE.

- **TRICARE anticipates savings of $1.67 billion by negotiating its own drug prices, including rebates, rather than going through a PBM.** Following the National Defense Authorization Act of 2008, TRICARE, which provides health care coverage to over 9 million Uniformed Services members, dependents and retirees, will administer its own pharmacy benefit through the Department of Defense. This process began in 2004 by negotiating a contract over which TRICARE had greater administrative power, even though they did not have access to federal discounts. In 2007 alone, TRICARE saved $976 million by using one uniform formulary and centralized management to negotiate drug prices and rebates with manufacturers.
- **Texas estimates savings of $265 million by switching to a transparent PBM contract.** Texas decided to enact transparency legislation after an audit of all the state's PBM plans found huge discrepancies between spending on enrollees. While the state's Teacher Retirement System plan administered by Medco cost only $994 per member in 2007, the same plan administered by Caremark cost fully $2737 per member, nearly three times the cost under Medco's plan.[15] The Employee Retirement System anticipated savings of $265 million by enacting transparency in their contract with CVS/Caremark.[16] These savings would come from lower reimbursement rates to mail order and retail pharmacies and from additional rebates awarded to the ERS rather than CVS/Caremark. Based on these findings, Texas enacted legislation in 2009 to make all state PBM contracts transparent.
- **The University of Michigan has saved nearly $55 million by administering its own plan for the past six years.** The University of Michigan chose to cancel its five contracts with major PBMs in 2005, citing the lack of transparency in their plans. The University has since hired a single new PBM, InformedRx, which offers transparency and allows the University administrative control over the plan and spending.[17] In the program's Annual Report, the University announces that their per member per year total drug costs are decreasing at a rate of 2.22% annually, and program initiatives have saved nearly $1.5 million in plan costs. Overall, by comparing their spending with national drug trend surveys, the

15 State Auditor's Office. "Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions." August 2008.
16 Letter from Ann S. Feulberg, Executive Director, Employees Retirement System of Texas, to Representative Hopson, Texas House of Representatives. April 8, 2008.
17 http://www.reuters.com/article/pressRelease/idUS213844+03-Mar-2009+BW20090303

University estimates it has saved nearly $55 million through its self-administered drug plan in just six years.[18]

- **The State of New Jersey projects savings of $558.9 million over six years when it switches to a transparent contract for its 600,000 covered employees, dependents and retirees.** The state ended its contract with CVS/Caremark and recently chose a transparent, pass-through pricing contract with Medco. The state will save this money by receiving rebates in full from the manufacturer and by not paying Medco more for a prescription than the amount Medco reimburses the pharmacy which handles that claim.[19]
- **DC-37, New York City's largest public employee union, signed a contract in 2006 with Innoviant, a transparent PBM, and saved $50 million.** Their new contract, which allowed patients to use whichever pharmacy they choose and is transparent, saved this amount on their 274,000 enrollees.
- **The State of Wisconsin saved over $30 million by switching to Navitus, a transparent PBM.** For nearly a decade, Wisconsin had experienced annual increases of 15% on its prescription drug spending. After switching to Navitus, they actually saved money, despite rising drug costs across the country. Navitus charges a flat free for its management services and is transparent to plan sponsors.[20]
- **Successful transparency legislation saved over $800,000 in a single year in South Dakota.** South Dakota passed PBM transparency legislation in 2004. In a single year, the state saved over $800,000.[21]
- **Maryland switched to a transparent PBM after finding it had overpaid $10 million to CVS/Caremark.** The State of Maryland conducted an audit and discovered that it had paid Caremark over $10 million in potential rebates and other savings. In 2007, Maryland canceled its contract with CVS/Caremark and started a transparent plan with Catalyst Rx.[22]
- **The California Health Care Coalition found that Catalyst Rx, a transparent PBM, could save members between $3 and $6 *per prescription*, and chose Catalyst Rx as its recommended PBM.** [23] These savings come from the fact that Catalyst's revenues are based solely on customer service fees, not from "undisclosed deals with drug companies." In addition, 'Catalyst passes 100 percent of the price discounts and rebates it negotiates with suppliers... on to clients."

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18 University of Michigan Benefits Office. 2008 Prescription Drug Plan Annual Report. Executive Summary. January 16, 2009. Accessed at http://benefits.umich.edu/forms/2008drug_plan_annual_report.pdf.

19 State of New Jersey. Department of the Treasury. Purchase Bureau. Award Recommendation. Reference Number 10-X-20899, T2679. August 4, 2009.

20 Guy Boulton. "State gets prescription for savings." Milawukee Journal Sentinel. June 7, 2005.

21 Prescription Policy Choices. "PBM Fiduciary Duty and Transparency." Accessed at http://policychoices.org/documents/PBMTransparency_FastFacts.pdf

22 Reuters. "State of Maryland's CVS Caremark Contract Audit Reveals More than $10 Million in Potential Overpayments, Undisclosed Rebates, Improper Drug Switching, According to CtW." March 6, 2009. Accessed at http://www.reuters.com/article/pressRelease/idUS179408+06-Mar-2009+BW20090306

23 California Health Care Coalition. "CHCC Develops New Pharmacy Program." Accessed at http://www.chccnet.org/files/CHCC_Pharmacy_Program_1018.pdf

- **Privately-run Medicare Part D plans do not save as much on prescription drug costs as do Medicaid or VA plans.** A July 2008 report to the House Committee on Oversight and Government Reform compared the prescription drug spending on dual eligible beneficiaries, each of whom transferred their drug coverage from Medicaid to Medicare Part D when the program started in 2006. On average, Medicare Part D plans received rebates and discounts that reduced these enrollees' drug costs by 14% in 2006 and 2007. Had they remained under Medicaid coverage, however, Medicaid would have cut their drug costs for those same drugs another 30%. Those PBMs which manage Medicare Part D plans clearly do not pass all their potential savings on to consumers or plan sponsors.[24]
- **The Lear Corporation saved over $1.1 million on a $3.6 million budget by switching to a transparent PBM.** The Lear Corporation's switch to CatalystRx, a transparent PBM, led to a 4% increase in generic utilization paired with a drop in average price for generics, from over $36 each to under $30. Together, these led to savings of $1.1 million dollars per year on a $3.6 million budget.
- **Local Funds of the Sheet Metal Workers' International Association saved up to 30% in their first year after switching to a transparent PBM.** Local affiliates of the union who chose to switch their contracts experienced savings in a year when prescription drug prices were going up 12% across the country.[25]
- **The HR Policy Association estimates that use of a transparent PBM contract saves employers up to 9% annually.** The HR Policy Association Pharmaceutical Purchasing Coalition has laid out guidelines for PBM transparency. Manufacturer rebates must be passed on to the plan sponsor in full, and the PBM cannot charge a plan sponsor more than the amount they are reimbursing a pharmacist for a given claim. The coalition, which is made up of some of the country's largest companies, announced that using PBMs certified as transparent under these guidelines could save plan sponsors up to nine percent of their prescription drug costs annually.[26]

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24 U.S. House of Representatives Committee on Oversight and Government Reform. Majority Staff. "Medicare Part D: Drug Pricing and Manufacturer Windfalls." July 2008. Accessed at http://oversight.house.gov/documents/20080724101850.pdf

25 Business Wire. "Envision Pharmaceutical Services 'Lives Up to the Promise' at Sheet Metal Workers' International Association 2006 Business Managers Conference." August 31, 2006.

26 redOrbit. "Aetna Pharmacy Management Selected by the HR Policy Association for Meeting Transparency Guidelines." August 10, 2005. Accessed athttp://www.redorbit.com/news/health/203682/aetna_pharmacy_management_selected_by_the_hr_policy_association_for/