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United States Senate Committee on Finance
Drug Pricing in America: A Prescription for Change, Part III
April 9, 2019

Chairman Grassley, Ranking Member Wyden, and members of the Committee, thank you for the opportunity to join you today.

My name is Derica Rice, and I am an Executive Vice President at CVS Health and President of CVS Caremark. I joined CVS Health because I believe in the company's vision of helping patients on their path to better health. We want to make health care more accessible, more affordable and improve health outcomes for the communities we serve.

We have long been at the forefront of putting our patients' health first and improving the public health of our communities, through company-wide initiatives such as removing tobacco from our stores and waging a multi-front fight against the opioid epidemic. We provide millions of dollars in charitable support to free clinics and community health centers – the organizations reaching our nation's most vulnerable populations with the care that they need. And it is why, at CVS Health, we decided to stop selling tobacco products more than four years ago – even at the cost of $2 billion in annual sales revenue.

And our purpose – helping people on their path to better health – is what drives us to provide more affordable, accessible and effective health care, and deliver better health outcomes, at a lower cost. Never has our work been more important than today. The rising cost of health care and prescription drugs affects every household in this nation and are critical issues for consumers and policy makers. Our job is to work with the employers, unions, and government programs we serve to ensure that when their members get to the pharmacy counter, they get medicines they need at the lowest possible cost. As drug prices increase and consumers shoulder more of the burden, we believe we can, and we must, do more to ensure affordable care.

In the spirit of our common goal of reducing health care costs for consumers and the overall system, I'm here today to share what we, as CVS Caremark, are doing to directly reduce consumers' out-of-pocket costs at the pharmacy counter, and to discuss polices that would help further advance that agenda. Our goal as a pharmacy benefit manager (PBM) is simple: to reduce costs and improve health outcomes. We do this by negotiating discounts with manufacturers, designing formularies that encourage the use of generics and biosimilars, and creating new tools to help bring escalating drug prices under control.

Our work on behalf of our clients to deliver the lowest cost medicines and the best possible outcomes helps them maintain a healthy workforce at an affordable price. Over the last three years (2016-2018), we have saved our clients $141 billion in drug costs. At the same time, in 2018 alone, 44 percent of our clients saw their net prescription drug prices decline and 85 percent of our members utilizing their prescription benefit spent less than $300 on their prescriptions.

Despite this, we recognize that consumers are often faced with challenging out-of-pocket costs, so we at CVS Health continue to develop solutions to help lower how much they spend on prescription drugs. Manufacturers alone set the price of their medications. What we do is create value for the employers, health plans and government programs we serve in four key ways:

First, we negotiate the lowest cost possible on behalf of our clients and foster competition among drug manufacturers when more than one clinically-equivalent drug is available.

Second, we encourage the use of generics and lower-cost biosimilars because they are proven to improve adherence and outcomes, while also lowering costs. Our research shows that use of generics actually improves outcomes and saves lives, largely because they are more affordable for patients and therefore increase patient adherence to their medicines.

Third, we help reduce drug costs by providing physicians with information that enables them to prescribe the most cost-effective and clinically-appropriate medications for their patients. That means prescribers can see the actual cost of the drug to the member and up to five potentially lower-cost options, and make informed decisions that can help save their patients money. We have also made dramatic strides in reducing the administrative burden for providers and patients by broadening availability of electronic tools to help with prescription management like mobile and online prescription scheduling and reminders on refills.

Fourth, we have developed additional tools to help bring escalating drug prices under control. We recently announced our Guaranteed Net Cost pricing model, a new pricing option that provides our clients with a guaranteed price for retail, mail and specialty drug products, regardless of product or price inflation. This heightens our focus on the lowest actual cost of the drug and under this model 100 percent of the rebates are passed through.

Rebates are not secret or hidden payments to PBMs – our clients have full visibility into the amount of the rebates we secure. Over ninety-eight percent of these discounts are passed directly to plan sponsors, who typically use them to reduce premiums and other costs for their members.

Pharmaceutical manufacturers insist that drug price increases are driven by rebates. This is simply not true. If that was the case, rebates and list prices should be highly correlated. To the contrary, data show that in many cases list prices are increasing faster for drugs with smaller rebates than for medications with substantial rebates.

We believe strongly that our PBM tools bring tremendous savings and value to the clients we serve. We focus every day on delivering the value our clients expect and easing the burden of high drug prices for their members. To help consumers manage their out-of-pocket costs, we were among the first to introduce rebates at the point-of-sale in the commercial market, enabling our clients to pass along the value of negotiated rebates on branded drugs to their members at the pharmacy counter. Currently, almost 10 million of our clients' members are in plans offering these savings.

Two years ago, the Administration raised the idea of point-of-sale rebates in the Medicare Part D program. Given our goal of keeping out-of-pocket costs lower for American seniors, we were the first Medicare Part D plan to offer point-of-sale rebates through our SilverScript Allure plan – which leaves the choice to individual beneficiaries as to what plan best serves their needs.

We have encouraged clients, particularly those who offer a high deductible health plan, to offer benefit plans similar to what we at CVS Health provide our own employees. Our covered employees have point-of-sale rebates while they are in the deductible phase, in addition to zero-dollar co-pays for medications that prevent disease. This includes not only generic medications that may prevent the onset of chronic

conditions but also some key brand drugs like insulin. We believe point-of-sale rebates combined with a zero-dollar co-pay preventive drug list are effective in reducing high out-of-pocket costs for members in high deductible health plans and help increase adherence which improves health outcomes and keeps costs down. At the end of the day, however, we believe in the value of providing choices. A one-size-fits-all approach that limits choice would not be appropriate for every health plan and their beneficiaries.

For patients in a high deductible plans with a health savings account, using a preventive drug list to make medications for common chronic conditions available at a zero-dollar co-pay can lead to better adherence and significant cost savings. As I mentioned, we take this approach with our own employees. CVS Health fully pays for certain drugs, including a number of generic medications, for its covered employees and dependents under the preventive drug list even before they meet their deductible. This has improved our generic dispensing rate, reducing costs for both our employees and CVS Health.

As a health care company, we place a high priority on preventive care, and medication adherence is a key component of achieving better health outcomes for patients. Our metrics for preventive drug regimens for conditions such as hypertension, hyperlipidemia, heart failure, diabetes, asthma/COPD and depression show that health care costs for patients with these conditions are reduced when they take their medications as prescribed. For example, for patients with congestive heart failure, CVS Health found that they spend nearly $8,000 less per year by adhering to their medication.

We continue to develop additional innovations to help bring escalating drug prices and costs under control, especially for chronic conditions.

CVS Health has taken a condition-specific approach through our Transform Care programs to help manage chronic conditions effectively, preventing wherever possible more serious adverse events, and improving clinical outcomes, reducing hospitalizations, emergency care and overall costs. We also have announced an initiative to improve chronic kidney disease and dialysis. Not only are we creating new tools to better identify and manage kidney disease, we are also working to provide more home dialysis, which studies have shown leads to increased satisfaction and better outcomes in appropriate patients.

And most recently, we opened our new HealthHUB locations to help elevate the store into a convenient neighborhood health care destination that brings easier access to better care at a lower cost. With personalized support programs and MinuteClinic services, the HealthHUB teams are focused on improving care for patients managing chronic conditions, with a focus on recommending next best clinical actions and driving medical cost savings. This concept combines the best of today's CVS Pharmacy with the future of accessible, low-cost health services and offers trusted advice.

In addition to developing these unique and innovative delivery system reforms, we have launched patient-centered programs to help consumers save money and increase price transparency across multiple points of care, thus giving our members far greater access to more affordable drugs.

As we've interacted with consumers, they have told us that they want to know whether their drug is covered and what their out-of-pocket costs are going to be. So, we now provide member-specific information in the doctor's office, at the pharmacy counter and directly to consumers on their phones and online. We call this real-time benefits. That means prescribers can see the actual cost of the drug to the member based on their current coverage, and up to five potentially lower-cost options, enabling them to make informed decisions and help patients save money while improving their care.

Real-time prescription benefits information is integrated directly into the pharmacist's existing workflow, making it easy for them to engage CVS Caremark members about potentially lower-cost alternatives, based on the member's specific formulary coverage. Additionally, our approximately 30,000 CVS pharmacists can use our proprietary search tool, Rx Savings Finder, to quickly identify available savings opportunities for customers.

And customers can use our app and online tool, which lets members check and compare prescription drug prices on their computer, phone or other devices. In addition to being able to request refills and view their prescription history, members are able to use the app to see what their out-of-pocket costs for a specific medication will be and find lower-cost alternatives to talk about with their doctor or pharmacist. More than 230,000 searches per month are conducted in this tool.

But as much as we have been able to accomplish, we also understand that more must be done. Because of the rise of high deductible health plans without adequate coverage for preventive drugs, consumers sometimes do not see the benefit of the discounts PBMs negotiate from manufacturers at the pharmacy counter, especially in their deductible phase if they are enrolled in a plan without point-of-sale rebates.

As many of you noted in the last hearing, often there is limited to no competition on drugs because of the myriad manipulative practices in our patent system that prevent competition from coming to market and restrict the FDA from advancing policies that can speed adoption of biosimilars and generics. We support the FDA's focus on bringing more lower-cost alternatives to market faster. We also support many of the policies proposed by members of this Committee, including the Chairman and Ranking Member Wyden, that would bring more competition to the market, create more transparency, and limit out-of-pocket expenses for seniors.

We have identified specific policy solutions that could lower drug costs as Congress and the Administration consider the range of solutions and next steps.

First, we believe Medicare and Medicaid programs should be able to utilize the full breadth of tools that are used in the private marketplace, including for the plans that cover members of Congress and federal employees.

We also believe Congress should require the adoption of real-time benefits to give doctors and patients transparency and information on lower-cost options when the prescription is written.

We support transparency proposals, such as the one recently introduced by a bipartisan group of Senators on this Committee to make the amount of rebates collected and passed through that is now shared with CMS available to MedPAC and MACPAC, as well.

We think Medicare should also encourage Part D providers to include a point-of-sale rebate option in their plan bids. Point-of-sale rebate plans do not make sense for everyone, which is why we oppose mandating it for all plans. But it should be an available option for the seniors who are facing higher drug costs, so they have the opportunity to choose a point-of-sale rebate plan if it works for them.

We believe Congress should enact an out-of-pocket spending cap for Medicare beneficiaries and change the reinsurance component of Medicare Part D in keeping with what MedPAC has recommended.

Changing the rules governing health savings accounts, or HSAs, by giving plans the ability to offer more coverage prior to the deductible being met would make a big difference for consumers. Currently, plans paired with HSAs are unable to offer first-dollar coverage of services such as chronic condition management. Medications may only be covered prior to the deductible being met if they are preventive, and the government has taken a very limited position on what is considered preventive.

We support policies, including legislation led by members of this Committee, to allow first-dollar coverage of all preventive medications, as well as treatment for chronic disease. This one change could immediately lower out-of-pocket costs for millions of Americans, while saving the health care system billions of dollars by improving medication adherence and preventing future costs.

We support increased access to generics and biosimilars. Biosimilars have the potential to save the health system $54 billion over ten years, but we need more of them on the market. In the European Union, 53 biosimilars have been approved, while only 17 have been approved in the United States and most of them are not on the market. We encourage the Administration to finalize interchangeability guidance to improve competition in the biologic market.

Additionally, we support efforts to address anti-competitive behavior. CVS Health is a longstanding supporter of the CREATES Act, and we thank Chairman Grassley for his leadership on this issue. The CREATES Act would address cases where brand manufacturers abuse safety protocols to keep generic and biosimilar competitors off the market.

We also support ending “pay-for-delay,” a tactic that allows brand manufacturers to pay generic competitors to keep products off the market and extend market exclusivity.

As you know, the Office of Inspector General at HHS recently proposed a rule that would require any discount we negotiate for Medicare Part D plans and Medicaid Managed Care Organizations to be applied at the pharmacy counter, in effect, providing 100 percent point-of-sale rebates. We fully support the Administration's objectives to lower drug prices and out-of-pocket costs for consumers. However, we found that under the proposed rule, if finalized, approximately 15 percent of beneficiaries would benefit, approximately another 15 percent may benefit, and approximately 70 percent of beneficiaries would have higher costs in increased premiums—increases that would be higher than any savings they see at the pharmacy counter.

At a time when consumers want more choices, this rule mandates 100 percent point-of-sale rebates as the only option. It might be right for some patients, but it will raise health care costs across the board while only benefiting a small minority of patients. The question for policymakers is whether the positives of such a system outweigh the negatives. From our perspective, they do not.

Today, we pass along effectively 100 percent of the rebates to Medicare Part D plans, which use them, in general, to lower plan premiums, reducing costs for both beneficiaries and the government. This is a tremendously successful program in not only providing a needed benefit to seniors but keeping premium costs to beneficiaries stable. The CMS actuaries indicate that the proposed rule would upend this stability by increasing premiums by 19 percent initially and by 25 percent after the impacts have been fully incorporated into the plans’ costs. If these changes are implemented some seniors will either decide to drop current Part D coverage or sign up for coverage only when they are faced with high costs, thereby incurring a penalty.

If rebates are forced at point-of-sale only, it could also undercut the negotiating power of PBMs to advocate for lower prices from the drug manufacturers by making competitively sensitive discount information widely available, therefore reducing manufacturer willingness to provide deep, differentiated discounts. This will likely lead to higher net drug prices.

Unfortunately, nothing in this proposal would require drug manufacturers to lower drug prices by the rebate amounts that exist today. In fact, the proposed rule provides drug manufacturers with two windfalls. The CMS actuaries' analysis estimates that manufacturers will keep 15 percent of the rebates they currently pass along as higher net drug prices, and second, that manufacturers will pay as much as $39.8 billion less over ten years in lower discount payments in the coverage gap of Part D.

While we oppose the proposed rule, CVS Health is proactively working with pharmaceutical manufacturers to ensure that the potential effects of this rule would not have a negative financial impact on Part D plans and beneficiaries. In March 2019, we sent a letter to leading drug companies asking them not to increase their net prices for prescription drugs as a result of the rule, which could cause increases in premiums and out-of-pockets costs for Part D beneficiaries.

We appreciate this Committee's attention and work on the challenging issue of drug pricing. And, Mr. Chairman, aligned with your leadership, we continue to advocate for policies that foster competition, lower consumer costs and restrain anti-competitive behavior. We look forward to continuing to work with you and every member of this Committee.

Thank you again for the opportunity to testify, and I am happy to answer any questions.