Approved: April 15, 2010
Date

MINUTES OF THE HOUSE GOVERNMENT EFFICIENCY AND FISCAL OVERSIGHT COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 3:34 p.m. on March 29, 2010, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Renae Jefferies, Office of the Revisor of Statutes
Gordon Self, Office of the Revisor of Statutes
Julian Efird, Kansas Legislative Research Department
Artur Bagyants, Kansas Legislative Research Department Intern
Gary Deeter, Committee Secretary

Conferees appearing before the Committee:
Doug Farmer, Director, State Employees Health Benefits Plan
Casey Cabalquinto, Pharmacy Initiatives Coordinator, Change to Win
Allen Horne, Vice President for Governmental Affairs, CVS Caremark

Others attending:
See attached list.

The minutes for the March 18 meeting were approved. (Motion by Representative Sloan and seconded by Representative Ruiz)

Doug Farmer, Director, State Employees Health Benefits Plan, and Deputy Director, Kansas Health Policy Authority, reviewed the contracting process for pharmacy benefits under the State Employee Health Plan (Attachment 1). He explained that the Pharmacy Benefits Manager (PBM) contract is developed under the authority of the Kansas State Employees' Health Care Commission (HCC) and follows all state purchasing rules and regulations. Each new contract begins with a review of the current program, at first in-house and then with the assistance of an outside professional consultant, a review which lays the groundwork for drafting an RFP (Request for Proposal). The RFP process is detailed, in-depth, and extensive, a process that winnows out many prospective vendors. Mr. Farmer noted that the current RFP has reduced the number of bidders to 10 vendors; the final three vendors in the selection process must have an extensive network in Kansas, sufficient financial backing to guarantee serving a large employee population, capacity to handle claims flow, and experience in providing data through the state's payroll system. Meticulous pricing comparisons are a significant factor in awarding a PBM contract, and the final selections are based on face-to-face negotiations. Mr. Farmer stated that the RFP for a new contract closed on February 24 and the agency expects to make a recommendation to the HCC at its May 27, 2010, meeting.

Mr. Farmer answered a variety of questions from members:

- There are three tiers for drugs pricing: generic, preferred name brand, and non-preferred name brand.

- An advisory committee reports on new drugs and recommends which tier to assign a given drug.
- Most pricing is set by contract for each specific drug; a typical example for a given drug would be wholesale minus 17%.
- The big-box stores that advertise $4-per-prescription prices offer a limited selection of drugs. It is difficult to include such a limited pricing structure in a three-year contract.
- Vendors have always been United States companies.
- Bidding is open so that each vendor knows what the other vendors have offered.
- The HCC members are appointed by the Governor and include the Secretary of the Department of Administration, the Insurance Commissioner, an active state employee, a retired state employee, and an at-large citizen.
- The Pharmacy Advisory Council consists of several health-care-related professionals. Mr. Farmer makes the final decision regarding drug categories.
- Rebate amounts are estimated and written into the PBM contract.
- Pricing is balanced with network coverage and a spectrum of other factors.
- The agency attempts to build transparency into the RFP process, but certain financial information is available only to the agency, not to the public.

Casey Cabalquinto, Pharmacy Initiatives Coordinator, Change to Win, explained that he represented a six-million membership of unions dedicated to pharmacy benefit management reform (Attachment 2). He listed several areas where CVS Caremark is deficient in its current PBM contract with the state:

- Caremark failed to provide the lowest prices on many generic drugs.
- An audit of Caremark's rebate program would show inadequate reimbursements to the state.
- Former Caremark clients have saved millions of dollars by using other vendors.
- Caremark's business model is suspect, since it is both a PBM and a retail drugstore.

Mr. Cabalquinto noted a report by Winkelman Management Consulting that supports his claims regarding Caremark's limitations as an appropriate PBM (Attachments 3 and 4).

The Chairman called a recess at 4:30 p.m. to enable members to vote on legislation in the House chambers. The Chairman reconvened the Committee at 5:00 p.m.

Mr. Cabalquinto responded to members' questions:

- A separate audit is needed to show that Caremark rebates are deficient. The fact that Caremark is being investigated by the Federal Trade Commission (FTC) should make members cautious about continuing a relationship with Caremark.
- The questionable business practices of Caremark are documented in Attachment 5.

Mr. Farmer returned to answer further questions:

Minutes of the House Government Efficiency and Fiscal Oversight Committee at 3:34 p.m. on March 29, 2010, in Room 546-S of the Capitol.

- CVS has few pharmacies in Kansas, minimizing the charge of conflict of interest.
- A recent audit of claims returned $120,000 to the state, but the audit cost $80,000. The auditor advised that an audit of rebates would cost more than it would gain. The next audit will be of dependent eligibility, which promises a larger payoff than an audit of rebates. The state employed outside auditor Claims Technologies, Inc.
- The PBM is the first line for complaints, but ultimately the complaints arrive in Mr. Farmer's office.
- Currently Mr. Farmer's office is doing in-depth research on generic pricing.

Allen Horne, Vice President for Governmental Affairs, CVS Caremark, responded to members' questions as follows:

- True, Caremark has lost contracts in several states, but recently has won the PBM contracts for larger states, such as Texas.
- Regarding the FTC investigations, the PBM contracts involve vigorous competition; it is unwise to try to regulate over 2000 different contracts.
- Plan design determines how generic drugs are priced.

A member commented that he had utilized drug purchases through Caremark for years and was happy with the service provided by the company.

Representative Don Hill, speaking as a pharmacist, noted the emergence of various discount programs, such as the $4 prescriptions, most of which have been offered since the PBM contract was written three years ago. He said most contracts are moving toward more transparency.

Mr. Cabalquinto, replying to a question, said that Caremark was a target of Change to Win because it was unique in size and scope, and its combination of retail drug store and PBM raised significant questions regarding its dual status. Mr. Horne responded, saying that other PBM contracts have similar relationships; he cited Walgreen's as an example. He noted that stand-alone companies Medco and Express Script have varied structures evident in their bidding processes.

The meeting was adjourned at 5:58 p.m. No further meeting was scheduled.

HOUSE GOVERNMENT EFFICIENCY AND FISCAL OVERSIGHT COMMITTEE

GUEST LIST

DATE: MARCH 29 2010

NAME	REPRESENTING
RJ Wilson	Change To Win.
Casey Cabalquinto	Change to Win
Jessica Ramirez	Change to Win
Gavin Young	Dept. of Admin.
Rachel Whitten	Kansas Reporter
Steve Ashley	Pharmaceutical Strategies Group
[illegible]	UHG
Austin LaFreniere	Rep. Carl Holmes
Patrick Vogelsberg	Keeney and Assoc.
[illegible]	KBA
Barbara Hollingsworth	Cap-Journal
John C. Bottenberg	Cavanaugh
[illegible]	"
Allen Horne	"
[illegible]	Rep. Ruiz
James A Young	KBA Health
MIKE LARKIN	KS Pharmacists Assoc
LaMeeAnn Brown	MedCo
Jennifer Crow	Sandstone Grp.

HOUSE GOVERNMENT EFFICIENCY AND FISCAL OVERSIGHT COMMITTEE

GUEST LIST

DATE: Page Two March 29 2010

NAME	REPRESENTING
Susie Meyer	Kansas Reporter
Jane Carter	KOSE

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KANSAS HEALTH POLICY AUTHORITY

House Government Efficiency and Fiscal Oversight Committee: State Employee Health Plan Contracting Process

March 29, 2010

Doug Farmer
Director, State Employee Health Benefits Plan
Kansas Health Policy Authority

Mr. Chairman and members of the committee, my name is Doug Farmer and I am the Deputy Director of the Kansas Health Policy Authority and the Director of the State Employee Health Plan (SEHP). I have been asked to provide an overview of the contracting process that his used by the SEHP in contracting for pharmacy benefit management services.

The SEHP is part of the Kansas Health Policy Authority. However, for purposes of health plan design and contracting, the SEHP reports to the Kansas State Employees' Health Care Commission (HCC). The HCC requires the SEHP to follow all state purchasing rules and regulations when contracting for pharmacy benefit management services.

When a contract is coming to the end of its term, the SEHP begins the Request for Proposal (RFP) process with a review of the current program. With the assistance of outside professional consultation, the SEHP reviews what is working well within the current program, and what areas we would like to change in future years. This process provides the groundwork for drafting an RFP document.

The RFP document asks all vendors to agree to the State's standard purchasing contract provisions and sets performance standards for the vendor's operations. Potential vendors are provided with detailed information about the current plan, specific requirements of the plan such as data file formats, and de-identified plan data for evaluation purposes. We outline our expectations for the plan operation and ask vendors to respond to a series of questions designed to provide us with insight into their: administrative capacity and abilities; experience with public sector plans: customer service operation, and overall operations.

Exhibit worksheets are developed to capture information from the potential vendors in standardized formats. The worksheets are designed to provide us with information about each vendor's pharmacy network and preferred drug list. We then evaluate each vendor's network to determine whether it would provide adequate access for our

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members. We also evaluate the proposed preferred drug list to determine how well it would serve our members in terms of price and disruption of care.

Under separate cover, vendors provide us with their proposed pricing. Standardized worksheets developed by the plan actuaries are used to capture this information. All vendors are asked to bid on the current plan design as well as any alternative plan designs that we would like to review. SEHP staff work in conjunction with the plan actuaries to evaluate the pricing structure information. This evaluation allows us to estimate which vendor offering would provide the best overall pricing for our members. In addition, vendors are required to provide confidential information for review that includes their most current SAS-70 and financial statements.

Following the release of the RFP, vendors are allowed to submit questions for clarification of the plan's request by a date outlined in the released RFP. Following a conference call with potential vendors, an amendment to the RFP is placed on the purchasing website with the plan's official answers to all questions posed by the vendors. Vendors have until the RFP closing date to submit their proposals.

Upon the closing of the RFP, staff and the plan actuaries begin a review of the responses. During the initial review we are examining the completeness of each bid. Bids which do not provide the requested services or are incomplete are disqualified from further consideration.

We then determine which of the remaining vendors have the capacity to provide services to a group the size of the SEHP. This includes a review to determine that the company has successfully completed a SAS-70 review and have staffing and systems in place to be able to accommodate the needs of the SEHP. Experience working with files created under our current payroll system (Peoplesoft) and experience providing data to our data vendor Thompson Reuters are key considerations. Vendors must be able to process our eligibility files correctly and accept implied terminations. We must have vendor's that have the ability to export accurately and securely our claims data to our data analytic interface with Thompson Reuters.

The plan's actuaries review the pricing information presented by each vendor. SEHP staff together with the plan's actuaries review the pricing data, administrative services, and operational capacity of each vendor. Based upon this review, requests for additional information are sent out to the vendors. These requests include questions that must be addressed by a specific vendor in order to continue to be considered as a potential contractor. Any vendor that is unable to satisfactorily respond to these requests is eliminated from further consideration.

Depending upon the number of exceptions that each remaining vendor has to our: mandatory contract provisions; sample contract; and performance guarantees, a phone conference may be held with KHPA staff and attorneys and the potential vendor's staff and attorneys to go over any objections to or modifications to these RFP requirements. As a follow-up to these calls, the vendors are asked to comply with the RFP requests or to provide justification for their requested changes. Any vendor that cannot comply with the standard provisions used in all SEHP contracts is eliminated from further consideration.

The remaining vendors are invited to face to face negotiation sessions. SEHP staff and plan actuaries meet with the vendors and discuss their proposals in-depth to gain a better understanding of each vendor and their operation. Vendors are given a list of follow up items and best and final pricing is requested at this time. Answers are generally due within one week of the face to face meeting.

Upon receipt of any follow-up answers and the best and final pricing, SEHP staff discusses the bids in detail, looking specifically at the: customer service; member disruption due to changes in the preferred drug list; network pharmacy access; pricing, and any other relevant vendor qualifications to determine which vendor will be recommended to the Health Care Commission (HCC) for a three year contract.

The HCC reviews the staff summary, pricing and relevant information at its next meeting. HCC members discuss the options and recommendation and question the SEHP staff about the proposals. The HCC then votes to determine which vendor will receive a contract. Following the HCC meeting, SEHP staff begins working on the final contract for services which is signed by the vendor selected by the HCC.

An RFP for the prescription drug pharmacy benefit manager was released January 15, 2010 and closed on February 24, 2010. SEHP staff and the plan's actuaries are holding weekly conference calls to discuss the bids. We anticipate holding face to face meetings in April and making a recommendation to the HCC for consideration at their May 27, 2010 meeting.

CHANGE to WIN

Testimony of

Casey Cabalquinto
Pharmacy Initiatives Coordinator
Change to Win

Before the

Committee on Government Efficiency and Fiscal Oversight
Kansas House of Representatives

March 29, 2010

Chairman Morrison and Members of the House Committee on Government Efficiency and Fiscal Oversight:

My name is Casey Cabalquinto and I am Pharmacy Initiatives Coordinator at Change to Win, a six million member partnership of unions founded in 2005 committed to restoring the American Dream for a new generation of workers – wages that can support a family, affordable health care, a secure retirement, and opportunity for the future. Change to Win has been supporting pharmacy benefit management reform and contracting best practices for more than two years.

As this Committee is aware, the Kansas State Health Care Commission is currently in the process of bidding out a new contract to provide pharmacy benefits for the Kansas State Employee Health Plan, which is estimated to cost the State approximately $60 million annually.[1] Kansas decision makers should be aware of serious issues about CVS Caremark, the State's current pharmacy benefits manager (PBM), regarding costs, contract transparency, and potential risks from CVS Caremark's business model.

CVS Caremark has failed to offer Kansas the lowest prices on hundreds of generic drugs. Any person who enrolls in CVS pharmacy's generic discount program can purchase hundreds of prescription drugs for significantly lower prices than CVS Caremark charges the State of Kansas and its employees for those same drugs,[2] even though CVS Caremark is paid to reduce drug costs for the Kansas government and its workers. Change to Win research revealed that CVS Caremark charges the State and employees higher prices for 269 generic drugs than CVS charges customers enrolled in the discount program for a 90-day supply; this represents 91% of 296 drugs matched between the Kansas State Employee Health Plan and CVS pharmacy's generic discount program.

An audit of CVS Caremark's rebate arrangements are necessary to ensure the State is receiving contracted pricing guarantees. The contract between the State and CVS Caremark guarantees a *minimum* discount price based on rebate amounts the

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company receives attributable to the State's drug utilization.[3] The State's audit released in May 2009 reviewed claims but not rebate amounts the company received attributable to the State.[4] It is imperative the State audit these rebate amounts to determine if additional rebate offsets were obtained by the company that should have lowered the prices ultimately paid by the State.

An investigation of CVS Caremark should examine limitations of the current contract. CVS Caremark's apparent price gauging on generic drugs and the failure of the recent audit to get to the bottom of drug costs for the State point to a larger problem in the company's conduct. The existing agreement between the State and CVS Caremark appears to be insufficiently clear in a number of important areas, including definitions of drug classifications and rebate reporting. These issues are symptomatic of CVS Caremark's resistance to transparency and should be thoroughly investigated by this Committee and the Health Care Commission.

Former CVS Caremark clients, such as the states of Illinois, New Jersey, and Maryland, have saved or expect to save millions through transparent contracting. For example, in August 2009, New Jersey announced that it would end its relationship with CVS Caremark and enter into a new contract with Medco Health Solutions to provide pharmacy benefits for approximately 670,000 state employees, dependents, and retirees. The new contract is projected to save the State $559 million over five years through a transparent, pass-through pricing model. New Jersey decided on the pass-through option because it "satisfies dual goals of attaining the greatest cost savings while achieving transparency in a time when that keyword is paramount to business operations in the public sector."[5]

Public entities have claimed CVS Caremark overcharged their health plans and sought millions of dollars in recoveries. For example, according to an audit released in February 2009 by the Maryland Department of Legislative Services, while CVS Caremark managed pharmacy benefits for Maryland from 2004 to 2007 it collected more than $10 million in potential overpayments and undisclosed rebates. In 2007, Maryland replaced CVS Caremark with Catalyst, a smaller, transparency-oriented PBM.[6]

CVS Caremark's business model is facing increased scrutiny. The Federal Trade Commission and a multi-state taskforce of state Attorneys General are currently conducting investigations into the company's business practices.[7] According to a March 23rd Fortune article:

> At the heart of the controversy is CVS Caremark's unique business model. Both a drugstore chain and a pharmacy benefits manager, the company sells medicine through its own stores while simultaneously reimbursing rival chains through its PBM. Critics say that arrangement poses a conflict of interest, because PBMs are supposed to be drugstore agnostic -- and Caremark, they say, can't help but favor CVS.[8]

The multi-state taskforce and the FTC probe follow expressions of concern from a host of stakeholders. Federal regulators received communications from health plans, independent pharmacists, consumer groups, five U.S. Senators, and over a dozen members of the House expressing concern about the potential anti-competitive effects of the PBM-drugstore business model and the potential risks for consumers and health

plans when such a large portion of the pharmaceutical supply chain is controlled by one company.[9]

This Committee and the Kansas Health Care Commission should consider whether doing business with a PBM owned by a drugstore, such as CVS Caremark, is in the State's best interest. We believe this Committee and the Health Care Commission should carefully consider the fact that CVS Caremark has failed to offer the State of Kansas the lowest prices on hundreds of generic drugs, that the State may not be receiving contracted pricing guarantees, the potential risks of the CVS Caremark merger and the pending investigations by the FTC and multi-state taskforce of Attorneys General while evaluating any bid submitted by CVS Caremark.

Thank you for this opportunity to provide testimony.

Sincerely,

Casey Cabalquinto
Coordinator, Pharmacy Initiatives
Change to Win

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[1] 2009 Annual Legislative Report, Kansas Health Policy Authority, p20

[2] Under the CVS generics discount program, anyone who enrolls can obtain a 90-day supply of any one of more than 370 generic medications for $9.99, plus an annual enrollment fee.

[3] 2007 – 2009 Pharmacy Benefit Management Services Contract between the Kansas State Employees Health Care Commission and Caremark PCS Health, LP, effective 01 Jan. 2007, at Exhibit E

[4] CVS Caremark Claims Audit, Kansas Health Policy Authority. 15 May 2009, p2.

[5] State of New Jersey, Department of Treasury, Purchasing Bureau, "Award Recommendation, Employee Benefits: Pharmacy Benefit Management, Reference Number: 10-X-20899, T2679," 4 Aug 2009. For savings from transparent contract, see pp 3-4, 46.

[6] Office of Legislative Audits, Department of Legislative Services, Maryland General Assembly, "Audit Report: Department of Budget and Management, Office of Personnel Services and Benefits," Feb 2009, Executive Summary, at p5. Available at: <http://www.ola.state.md.us/reports/Fiscal%20Compliance/OPSB09.pdf>.

[7] Mina Kimes, Fortune, "New troubles for CVS Caremark," 23 March, 2010. Available at: <http://money.cnn.com/2010/03/23/news/companies/cvs_caremark_pharmacy.fortune/index.htm>

[8] Ibid

[9] Letters to the Federal Trade Commission calling for a review of the CVS Caremark merger from: 15 members of Congress; Six health plans and purchasing coalitions – Delaware Valley Health Care Coalition; New York Labor Health Care Alliance; Sergeants Benevolent Association, Police Dept, City of New York; 1199 New England, SEIU; Sheet Metal Workers International Union; Laundry, Dry Cleaning and Allied Workers Joint Board of New York; the National Legislative Association on Prescription Drug Prices (NLARx), Consumer Federation of America, US Public Interest Research Group; and the National Community Pharmacists Association. House members listed in Reuters article along with Jan Schakowsky (IL) and Jim Gerlach (PA); Reuters, "Eight lawmakers ask FTC to reopen CVS merger," 16 Sept 2009. Available at: <http://in.reuters.com/article/rbssConsumerGoodsAndRetailNews/idINN15690882009091 5>; Carol Wolf, Bloomberg News, "Senators Urge CVS Caremark Probe in Letters to FTC," 30 July 2009. Available at: <http://www.bloomberg.com/apps/news?pid=20601087&sid=aCpZ0X2wZxPM>

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Report to the Kansas State Employee Health Care Commission

March 2010

Introduction

The Kansas State Employee Health Plan administrators are involved in an effort to re-bid a $60 million contract for state employees' pharmacy benefits, which is currently managed by CVS Caremark [CM]. I have been asked to offer my critique of the current Agreement between the State and CM, the recent audit that was conducted of CM's performance under this agreement and the RFP that is underway to rebid these services.

My Background and Qualifications

I have been involved in pharmacy for over fifty years. For most of that time I was the senior pharmacy executive for a large chain of retail pharmacies. I also spent several years in the pharmacy computer business and was the senior operations officer for a large Pharmacy Benefits Management firm. For the last seventeen years I have been a consultant, primarily on pharmacy issues. My clients have included several state governments, the Federal HHS Office of Inspector General (HHS OIG), and numerous commercial and non-profit organizations such as Chrysler, Thyssen Krupp Budd, Banco Popular and the Detroit Medical Center (DMC).

In the course of these activities I have been involved in virtually all aspects of pharmacy and pharmacy operations. I have a Bachelor's Degree in Pharmacy from Wayne State

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University in Detroit. Presently I consult in the pharmacy industry. I headed the pharmacy consulting practice for Health Management Associates (HMA) from 1998 through 2001. From March 1996 through June 1997 I was Chief Operating Officer of Cape Medical Inc., an HMO. From 1990 through 1994 I was Senior Vice President, Operations for Value Rx, a large Pharmacy Benefits Manager (PBM). I have had other executive positions in the pharmacy industry as well. A copy of my CV is attached to provide further detail of my experience.

The PBM Industry

To understand the issues involved, it is vital to have a basic understanding of the PBM industry, here are some of the major points:

- About 85% of Americans have a prescription drug benefit.
- This includes Medicaid and Medicare recipients.
- Employer Health Plans – both government and private – use Pharmacy Benefit Managers [PBMs] to manage these benefits.
- The "Big Three" PBMs – Medco, Express Scripts and Caremark – manage 80% of these benefits.
- Although PBMs afford a valuable bundle of services to health plans such as the Commission, they also introduce a **layer of fog** to the market that prevents health plans from fully understanding how to achieve maximum savings for their prescription drug costs.
- Between 2004 and 2008, the "Big Three" have paid over $370 million damages to states, plans and patients in a number of major court cases.
- The large PBMs utilize a variety of opaque tactics to maximize their profits, at the expense of both health plans and recipients.
- Major savings can be obtained by forcing these PBMs to operate on a fully transparent basis and to pass on all of the savings they get through their contracts with providers and drug manufacturers.
- This can best be done through rigorous management of the RFP process and careful execution of the subsequent Agreement with the PBM.

Executive Summary

1. Current Agreement Between the Commission and Caremark:

- The "Reimbursement Formula" defined in EXHIBIT E is not competitive. A detailed review is provided below.
- This Agreement is too costly to the State, as compared with the net costs our firm achieves, by requiring:
    - Full pass through of the rates paid by the PBM to network providers (no 'Spread' allowed);
    - Full pass through of all of the revenue that the PBM gets from drug manufacturers that is attributable to the Client's book of business;
    - Competitive pricing from the Mail Order Pharmacy owned by the PBM;
    - Assuring that the PBM's only source of profit is the negotiated administrative fee.
- The Agreement lacks proper definitions of such things as:
    - Brand Vs Generic drugs
    - Transparency
    - Rebates
    - Use of Participant Information
    - "Approved Information"
    - "Standard Policies"
    - And more
- The Agreement does not mandate pass-through pricing.

2. Claims Audit

- It appears that only one year's experience was audited;
- It does not appear that 100% of the claims were reviewed;

- We found no record of an audit of the rebate reconciliation as described in the Agreement, in Exhibit E, item (10);
- We found no audit of the "Generic Minimum Discount Guarantee" as described in the Guaranteed Overall Cost Formula in Exhibit E;
- There was no Eligibility Audit.

3. Current RFP for PBM Services

While it is clear that the RFP document is quite comprehensive and carefully prepared, it is not adequately specific in requiring Bidders to propose fully transparent and pass-through pricing. This omission increases the likelihood that full economies will not be obtained.

It is also lacking with respect to definitions that would prevent the PBM from extending its profits through the 'cute' opaque tricks that are all too often used by these PBMs to extend their profits in ways that the Client cannot readily catch.

One example deals with the issue of 'Lower-of Pricing'. It is customary that providers agree to accept the lower of the negotiated reimbursement or their Usual and Customary (U&C) pricing. In the RFPs that we manage, we have expanded the definition of U & C to include the lower of the store-sponsored generic discount programs. Doing so assures that both the Plan and the recipients get the economic benefit of the generic discount programs offered to uninsured patients by such drug retailers as Wal-Mart, CVS and Walgreens.

Limited Critique of the Agreement between the Kansas State Employee Health Care Commission (Commission) and Caremark (CM)

This agreement, executed in March of 2007, is too voluminous and too complicated to allow for a detailed, line-by-line analysis in the limited time we have been allotted.

Accordingly, we have limited our critique to the "Prescription Reimbursement Formula and Credits," as defined in EXHIBT E of the Agreement. It is our conclusion that it enables CM to achieve very high – and undisclosed – profits at the expense of the Commission and its recipients.

Nowhere in the Agreement is there a statement or an acknowledgement that CM will provide transparent, pass-through pricing. Rather, it is clear that CM is operating as a Principal, which means that they can charge the Commission more than they pay Network Providers and can sequester and keep much of the money they get from Drug Manufacturers (Pharma) that is attributable to the Commission's Book of Business.

Here are the specifics:

1. CM has agreed to accept an Administrative Fee of $0.95 per claim. This is well below the revenue required to manage the benefit profitably. Accordingly, it is immediately evident that they are making up the shortfall with opaque practices, as described below.

2. It is critical to understand that Caremark is owned by CVS. As such, it is not only the benefit manager, but a major provider as well. This is akin to the manager of a team also being the referee. In the RFPs we manage, we require that, when such a conflict exists, the PBM must provide mechanisms to assure that the health plan is not disadvantaged by this duality. In this case we suggest that Caremark be obliged to adhere to a "Favored Nations" requirement, under which they would reimburse their own stores at the lowest rates they have negotiated with any other provider.

3. Single Source Brand Drugs

    - The discount rates at retail are 'constant' per year and drop off slightly over the three year period, but the rates in the network

agreements are not renegotiated in tandem with the quoted schedule. Accordingly, it is evident that CM is paying these providers at rates that differ from the charges to the Commission. Rest assured that the advantage goes to CM and not to the Commission.

- As an expert in network negotiations, I can assure the reader that PBMs contract with network providers at different rates. (See #8 in this exhibit). Accordingly if the charges were truly pass-through, they would be quoted in a range, so as to take into account variability based on the provider mix.

4. Rebates

- CM guarantees that rebates will be between 6% and 6.3% of the AWP for Retail Brand claims. Assuming that an average AWP will be $125.00 for retail brand claims, this guarantee equates to about $9.65 per claim. But the going rate – for PBMs that are fully transparent and pass-through -- is in the range of $12 to $14 per retail brand claim.[1]

- CM includes a description of a rebate reconciliation in item 10 of the exhibit, but:

- The language in that section is quite murky. As an example, while CM avers, in item 7, that rebates will be will applied at the NDC level, this is contradicted in #10: "*Rebates paid at the point of sales will be reported on an aggregate level*".
- This aggregate reporting makes true-up and auditing virtually impossible. We note, parenthetically, that the Commission's Auditor did not attempt to reconcile the rebate reconciliation

[1] Based on the rates that our firm is able to negotiate with these PBMs for groups that are smaller than the Kansas program.

- We further note that the explanation in #10 is not clear as to whether the recipient or the Plan garners the economic benefit of this downstream reconciliation.
- We further note that the Agreement is silent on the exact definition of what the term 'rebate' includes. It has been our experience that PBMs are adept at hiding and sequestering much of the money that they receive from the Pharma firms. In our RFPs we demand that all of the funds that flow from the Pharma firms that are attributable to the Plan must be passed through by the PBM.
- We also note that the concept of a rebate discount offset, followed by a true up, gives the PBM a very substantial cash-flow advantage, to the detriment of the Commission.

5. Pricing of Generics

- Note that CM has a class of drugs, called Multi-Source Brands, with much higher reimbursement levels than generics. This is a cute trick to increase their profits, since these drugs can be obtained most of the time at nearly the same costs as the generic equivalents. CM garners undisclosed profits thereby in two ways. First, they often reimburse their provider pharmacies at the much lower MAC prices, but charge the Commission at the higher Multi-source brand costs. In addition, their Mail Order pharmacy buys these drugs at substantially lower prices – in the range of AWP-60%, but gets reimbursed by the Commission at the 32.5% rate.

- Note the reference to MAC pricing, and the definition in #6. This must be read carefully; what is not written is that the large PBMs such as Caremark have multiple MAC prices for the same item. In the trade these are called 'Pay-MAC' and 'Bill-MAC.' Simply put, they pay providers a lower unit cost than they charge to the Plan. Note that CM agrees to provide a copy of the list to the plan, but not the prices.

- The 'Minimum Discounts' off AWP for generics offered by CM are between 60% and 63% over the three agreement period. Pharmacies actually buy these drugs at

discounts in the range of 80 to 85% off AWP. Accordingly, our firm expects the PBM to guarantee discounts in the range of 70 to 75% off AWP. Generics now account for about two-thirds of all prescriptions, so these unduly high rates result in *much higher* costs to the Commission.

6. 'Usual and Customary Pricing' (#1)

Please refer to the comments above on Usual and Customary Pricing.

7. 11 digit NDC (#2)

Note that CM indicates that all discounts are based on the costs for the actual package size from which the prescription is filled, but contradict this notion as to their captive mail order pharmacy in #5. *".....The standard package size applicable to a mail service pharmacy shall mean 100 units (i.e. pills, tablets, capsules, etc), unless a smaller package size is available...."*

This cute trick, in this writer's opinion, increases the profitability of their mail order services by between 1 and 2%.

8. Credits

Please see Section C of Exhibit E, which describes a set of Credits that CM will pay to the Commission. If fully funded, the Commission would receive about $500,000 over the life of the agreement. On the surface, this is quite compelling and it is typical for the authors of RFPs for PBM services to solicit such considerations. But such payments beg the question of how they are funded, for if the PBM was truly providing transparent, pass-through pricing, it would have no logical war-chest from which to fund these Credits. The conclusion is unmistakable: These credits are being funded by the opaque practices described herein.

CONCLUSION

We trust that these comments will be helpful to the Commission, will enable a better understanding of this complex subject and will lead to cost savings. We do need to point out that the information we have provided herein is based on our present understanding of the materials with which we were provided and is subject to change should other inputs be made available.

We would also welcome an opportunity to discuss all of this directly with appropriate State Officials.

MYRON WINKELMAN, R.Ph.

EXPERIENCE SUMMARY

Distinguished career in the pharmaceutical industry includes leadership and management for some the country's leading pharmacy and managed care organizations. Wide range of experience includes:

- Executive leadership in country's major PBMs, drug chains, and government entities
- Industry leader in pharmaceutical care and delivery
- Innovator of unique pharmacy management programs
- Repeatedly proven results in pharmacy benefit cost savings and audits

SELECTED INVOLVEMENTS AND APPOINTMENTS

- National Association of Chain Drug Stores [NACDS] Task Force on National Health Insurance, Former Chairman
- Pharmaceutical Care Management Association [PCMA], Former Member, Board of Trustees. This is the trade association for Pharmacy Benefit Management firms and Mail Order Pharmacy.
- Founding Member, National Council for Prescription Drug Programs [NCPDP], which is the Industry's standards organization.
- Board of Directors, Lannett Corporation (LCI)

EXPERIENCE DETAILS

CONSULTING AND AUDITING
2002 - Present

- Provides consulting and management services with a primary focus on pharmacy and pharmacy benefit management issues.
- Unique expertise with PHS (340B) drug pricing.
- Performs and directs pharmacy benefit analyses for health plan sponsors including full claim audits.
- Recent and current clients include the State of Michigan, Oakland County Michigan, Chrysler Corporation, the Federal HHS-Office of Inspector General and The Michigan Public School Employee Retirement System (MPSERS)
- Also manages the recruitment of Pharmacy Benefit Managers [PBMs] for health plan sponsors.
- Mr. Winkelman also provides expert testimony and research for litigation on pharmacy benefit management issues

HEALTH MANAGEMENT ASSOCIATES, INC. (HMA)
Principal 1998 - 2001

- Headed HMA's pharmacy consulting area.
- Activities were done on behalf of state Medicaid drug programs, where he has expertise in drug cost containment.
- Facilitated an RFP for a coalition of New England States, helping them recruit a single Pharmacy Benefit Manager (PBM) for Medicaid, state employees and the uninsured.
- Subsequently aided the Northeast Coalition on Prescription Drug Prices in their efforts to unify an eight state group to pool their dug purchasing

Attachment 4
GEFO 3-29-10

- Led the effort by the Rx Work Group, centered in West Virginia, to recruit a single PBM for this multi-state group resulting in savings of over $20 million per year.
- Served as the pharmacist for the Vermont Medicaid program and was responsible for establishing a State MAC program.
- Leveraged his expertise in PHS (340B) drug pricing helping a number of HMA clients achieve significant savings through this process.
- Helped facilitate the start up of the first e-commerce pharmacy, SOMA.com.

CAPE MEDICAL, INC. 1996-1997
Chief Operating Officer

- Guided the development of this Medicaid plan in transition into an effective, capable managed care organization.
- Led the recruitment of new staff, development of new facilities, and implementation of a new computer system.
- Helped Cape clear several regulatory hurdles to become a licensed HMO.
- Drove the process to help Cape become a successful bidder for the State of Michigan's Medicaid RFP.
- The provider network was dramatically expanded - both for primary and specialty providers.
- Cape received approval for expansion into Oakland and Macomb Counties.
- Census grew by over 40%.
- The internal infrastructure was rebuilt and a marketing and advertising program was initiated.

WINKELMAN MANAGEMENT CONSULTING, INC. 1994-1996
President

Provided consulting services including basic business planning, systems support, product development, government and regulatory affairs, and sales and marketing to various managed care programs.

VALUE Rx, INC. 1990-1994
Senior Vice President, Operations

- Part of a senior management team that took this Pharmacy Benefits Management (PBM) firm from a local third party plan to a major, national company. Along the way, the parent, Value Health was able to complete a public stock offering, completely based on the growth of ValueRx, its largest division.
- Duties included: network development, operations, product development, provider relations, and mail order pharmacy.

RITE AID, INC. 1989-1990
Vice President, Managed Care Programs

Restructured department, reducing staff by half, installed on-line claims adjudication system, designed and implemented review system for payment adjustments, reduced outstanding receivables by more than 50%, and initiated review of all contracts and relationships with third party agencies, resulting in more than two million additional potential Rite Aid prescription customers.

PERRY DRUG STORES, INC. 1986-1989
Vice President, Pharmacy Operations

- Planned and implemented pharmacy technician program

- Redeveloped prescription pricing strategy, which resulted in a gross margin increase of 3% - while increasing volume,
- Rebid major suppliers of pharmaceuticals, saving almost $1 million per year
- Developed new computer system for pharmacies (Perry Link)
- Restructured institutional pharmacy operation, correcting billing and inventory problems and planning and implementing move to proper quarters.

McKesson (3PM Division) 1979-1986
Vice President

- Sold hundreds of pharmacy systems to chain and independent pharmacies
- Developed nursing home pharmacy computer system
- Developed and managed sophisticated customer service operation.

FW KERR WHOLESALE DRUG COMPANY 1978
Vice President, Professional Services

- Facilitated implementation of automated order entry system and complete renovation of order fulfillment systems, resulting in improved inventory turns and reduced out of stocks.

REVCO DRUG STORES, INC. 1962-1978
Vice President, Pharmacy Services

Responsibilities at Revco included:

- Pharmaceutical buying,
- Warehousing and distribution;
- Pharmacy repackaging;
- Rx marketing and advertising;
- Government affairs;
- Professional staffing, recruitment and retention
- Professional relations.

EDUCATION

Bachelor of Sciences, Wayne State University College of Pharmacy, 1959

CVS CAREMARK'S
GENERIC RIP OFF

How CVS Caremark Gouges Kansas Taxpayers and State Employees on Generic Drugs

March 2010

Attachment 5
GBFO 3-29-10

Introduction

The Kansas State Health Care Commission (HCC) is currently in the process of selecting a vendor to provide pharmacy benefit management services for state employees and their families. In advance of HCC's decision, this report reveals the failure of the State's current pharmacy benefit manager, CVS Caremark, to offer its lowest price on hundreds of generic drugs to state employees and the state government.

Broken Promises?

In 2007, retail pharmacy chain CVS merged with pharmacy benefit manager Caremark to form the largest pharmacy services company in the country. The combined company filled or managed 1.3 billion prescriptions in 2009.[1] After its merger, CVS Caremark promised that it would "help manage costs for employers and improve access and choice for consumers."[2] A corporate spokesperson recently reiterated that promise to the *Wichita Eagle*: "Our integrated pharmacy and PBM operations provide greater choice and more convenience for customers and patients, improve health outcomes, and lower overall health care costs for plan sponsors and participants."[3]

The research detailed in this report calls into question some of these promises and should raise alarms for Kansas taxpayers, state employees and legislators. As this report shows, CVS Caremark has failed to offer its lowest price on hundreds of generic drugs to the State of Kansas and tens of thousands of state employees enrolled in the Kansas State Employee Health Plan, for which CVS Caremark provides prescription drug benefits. Any person who enrolls in the generic discount program offered at CVS' retail pharmacies can purchase hundreds of prescription drugs for significantly lower prices than CVS Caremark charges the State and its employees for those same drugs, even though CVS Caremark is paid by the State to reduce drug costs. Remarkably, for 91 percent of the 296 drugs matched with the generic discount program drug list, a person with no insurance who belongs to CVS' generics discount program would pay less than a Kansas state employee and the government under the state health plan. Indeed, if CVS Caremark offered the State its publicly available $9.99 generic discount program price, taxpayers could save millions of dollars.

Given that CVS charges the State more for hundreds of drugs than it charges to people off the street, what service is the company really providing? Why is the State paying the company to reduce drug costs when CVS Caremark is failing to provide its lowest price on generics at the retail pharmacies it owns?

Thanks For Hiring Us, Now We'll Charge You More

CVS Caremark manages all prescriptions filled at retail drugstores for the Kansas State Employee Health Plan (the "Kansas Plan"), which covers 93,000 state workers, retirees and

their dependents, including public sector employees at non-state entities such as school districts and townships.[4]

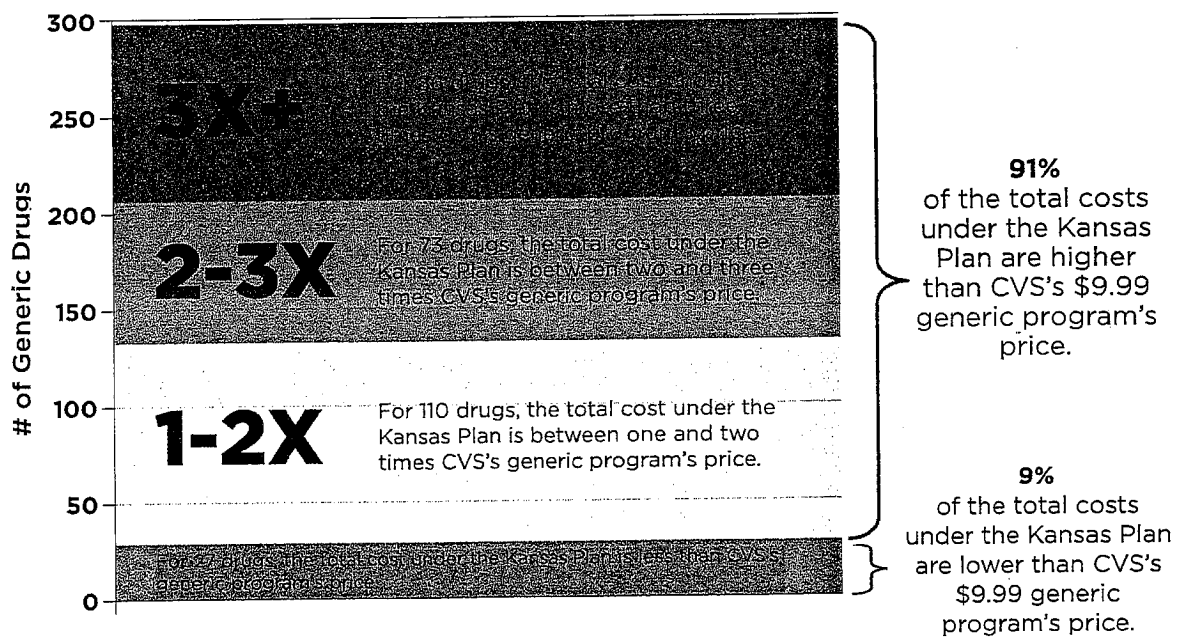
The Kansas Plan provides three health insurance coverage options for plan participants – Options A, B or C – which differ in both deductibles and co-payment structure. Nearly all Kansas plan participants select Option A.[5] Plan participants' prescription drug coverage for all three options is administered by CVS Caremark.[6]

Under both Options A and B, which cover more than 99% of the plan population, plan participants pay 20 percent of the total cost of the prescription when purchased at retail, and the employer pays the remaining 80 percent.[7] Under Plan C, after reaching a deductible, plan participants pay a flat co-payment of $10 and the plan pays the remainder of the drug cost, if any.[8]

Meanwhile, CVS pharmacy's discount program for generic drugs, the Health Savings Pass (HSP), is open to any customer who signs up and pays a $10 annual fee. These customers are then eligible to fill prescriptions for 90-day supplies of hundreds of generic drugs for $9.99. Open to all, the CVS HSP program offers easy online or in-store enrollment.[9]

Figure 1

Under the Kansas State Employee Health Plan, the total cost for hundreds of generic drugs are significantly higher than CVS's $9.99 generics program price.



5-3

The analysis in this report compares the $9.99 price for generic drugs under the CVS HSP program with the total price for the 296 generic drugs that were matched to generics available under the Kansas Plan.[10] This comparison shows that for a vast majority of drugs, Kansas Plan participants as well as the underwriters of the health plan – Kansas taxpayers – are not getting the best deal available from CVS Caremark (Figure 1). Specifically, under the Kansas Plan, CVS Caremark charges higher prices for 269 drugs, 91% of the 296 drugs priced, than CVS charges walk-in customers through its generics discount program. The total costs – defined as the plan participant co-payment plus the plan's contribution – for hundreds of generic drugs are higher than the costs incurred by a person who simply walks in off the street and signs up for the CVS discount generics program. A list of the generic drugs available through the discount program and their costs under the Kansas Plan is provided in Appendix B.

The differentials between the total costs under the Kansas Plan and the CVS generic $9.99 price are large in many cases. For example, a majority of the drugs (159 drugs, or 54% of the total priced) are at least twice as expensive under the Kansas Plan as under the CVS generics discount program. There is a particularly large price gap for 86 generic drugs where the Kansas Plan's total cost is at least triple the price available under the CVS generics discount program.

While switching from a brand-name drug to a generic drug can be a good cost saving measure, the state government does not reap the maximum benefit from generics when CVS Caremark fails to provide its best price to the State of Kansas and its employees. This drives up the costs that are ultimately borne by plan participants and Kansas taxpayers. Given the co-payment structure of the Kansas State Employee Health Plan drug benefit, the State of Kansas and therefore, Kansas taxpayers, bear the greatest burden.

Significant Potential Impact on Drug Costs: An Example

Without data on how many prescriptions are filled for each generic drug under the Kansas Plan, it is not possible to measure exactly how much more the state government pays under its CVS Caremark-managed drug plan than it would if CVS Caremark charged Kansas Plan participants the lowest generic drug prices it offers. However, a portion of these cost differences can be estimated by assuming Kansas Plan members use generics at the same rate as national utilization rates and making cost comparisons for specific generic drugs on this basis.

Using data on the two most commonly utilized drugs in the country and assuming national utilization rates, it is possible to calculate the difference in estimated costs between the employer-sponsored Kansas Plan and the CVS discount generics program. These two drugs are Levothyroxine, a thyroid medication, and Lisinopril, a medicine for high blood pressure.

For Levothyroxine, the most commonly-taken generic drug in the United States,[11] plan participants and the state government together pay up to an estimated $424,000 annually. But if CVS Caremark charged Kansas Plan participants the same price it offers through its generics discount program, the total drug cost for Levothyroxine would likely be closer to $164,000

annually. Hence, switching from filling Levothyroxine prescriptions using the Kansas Plan to the CVS generics discount program could result in an estimated annual savings of $260,000 for this single generic drug. Similarly, the state government and plan participants could save an estimated $200,000 annually if CVS Caremark charged the Kansas Plan the $9.99 generic discount price for Lisinopril, the second-most commonly utilized drug in the United States, than under the CVS Caremark-managed Kansas Plan. Imagine, then, how much the government could save if CVS Caremark offered the government the same $9.99 price for all the generic drugs available through the discount program. While it is impossible to say for certain, the savings would likely be in the millions of dollars.

Table 1

Annual prescription drug costs for the two most commonly prescribed generic drugs extrapolated to the Kansas State Employee Health Plan population[1]

	Levothyroxine[a]	Lisinopril[b]
Kansas State Employee Health Plan		
Patient cost[2]	$84,796	$72,019
Employer cost[2]	$339,679	$288,075
Total cost	**$424,475**	**$360,094**
CVS discount generics program		
Patient cost[3]	$164,170	$159,882
Employer cost	$0	$0
Total cost	**$164,170**	**$159,882**
Difference between Kansas State Employee Health Plan Cost and CVS generics discount program total cost	**$260,305**	**$200,212**

Note: For a detailed discusion of these extrapolations, refer to Appendix A.

1 Drug utilization rates for the Kansas Plan assume the plan participants use the indicated drugs at the same rate as the national population. Extrapolation made to a full-calendar year, consisting of four 90-day prescription fills.

2 The patient co-payment and employer payment are assumed to be 20% and 80% of the total cost of the drugs, respectively. This co-payment structure is consistant with Options A and B in the Kansas State Employee Health Plan, which covers 99.5% of Kansas Plan participants.

3 The price of a 90-day supply at retail in the CVS generics program is $9.99.

a Levothyroxine's national utilization rate is 4.4%; extrapolating to Kansas Plan participants translates to 4,108 Levothyroxine takers.

b Lisinopril's national utilization rate is 4.3%; extrapolating to the Kansas Plan participants translates to 4,001 Lisinopril takers.

Kansas Leaders Raise Concerns as CVS Caremark Faces Federal Scrutiny

As this report demonstrates, CVS Caremark charges the State of Kansas and its employees significantly higher prices for many generic drugs than it charges retail customers who simply

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join its discount generics program, even though the State pays CVS Caremark to reduce its drug costs. Moreover, the State of Kansas paid CVS Caremark $1.6 million last year in administrative fees[12] yet CVS makes lower generic prices available to anyone for only a nominal $10 annual fee.

CVS Caremark's practice of charging higher prices to the State and its employees for hundreds of generic drugs calls into question whether the company is really acting in the financial interests of its clients, and whether the PBM-drugstore model is in the best interest of plan participants. The higher prices also point to broader issues with the company's lack of transparency and accountability. CVS Caremark has a track record of resisting oversight, as detailed in Change to Win's reports: *CVS Caremark: An Alarming Prescription* and *CVS Caremark: An Alarming Merger*.

Elected leaders in Kansas are taking up concerns about CVS Caremark's generic pricing practices. State Representative Jim Morrison, Chairman of the Government Efficiency & Fiscal Oversight Committee, expressed apprehension that the relationship between CVS and Caremark could allow the company to "kind of pick and choose their own products" and said the findings documented in this report could mean that "we are getting charged a bunch more than we should be."[13] Representative Melody McCray Miller voiced concerns that generic drugs "are priced in a way that's good for the big pharmacy, but not for the consumer."[14]

Questions about CVS Caremark's conduct towards the State of Kansas are emerging as the company faces increasing scrutiny at the federal level. CVS Caremark acknowledged recently that it is being investigated by the Federal Trade Commission (FTC).[15] The FTC has received communications from health plans, independent pharmacists, consumer groups, and members of Congress expressing concerns about the potential anti-competitive effects of the merged retail-PBM business model and the potential risks for consumers and health plans when such a large portion of the pharmaceutical supply chain is controlled by one company.[16] Additionally, proposed federal legislation would bar PBM-retailer combinations like CVS Caremark from doing business with the Federal Employees Health Benefit Program, the largest employer-sponsored health program in the country.

Our findings suggest the Kansas State Health Care Commission should carefully consider the fact that CVS Caremark has failed to offer the State of Kansas the lowest prices on hundreds of generic drugs, the potential risks of the CVS Caremark merger and the pending investigation by the FTC while evaluating any bid submitted by CVS Caremark.

For more information on transparent pharmacy benefit contracting and CVS Caremark's troubled track record, visit www.AlarmedAboutCVSCaremark.org.

Appendix A

Methodology

In March 2010, Change to Win research staff compared the $9.99 discount price under the CVS HSP program to the prices charged under the CVS Caremark-managed Kansas State Employee Health Plan (hereafter referred to as the Kansas Plan) using the drug price check tool on the CVS Caremark website for each option. We relied solely on the data provided by CVS Caremark's website. We only examined prices for generics purchased at CVS retail locations; mail order prices are not examined in this report.

Of the 374 drugs listed on the $9.99 CVS HSP list, 296 were matched in terms of drug, dose, form, and quantity; the analyses herein are limited to the matched set of drugs. Excluded from the analysis were drugs on the CVS HSP list for which the CVS Caremark website either: (1) did not have the particular form and/or strength of the drug, (2) did not provide the same quantity of the drug in a 90-day supply (3) did not make the drug available at all and/or (4) where the website produced a plan participant price that was not 20 percent of the overall (total) cost. The latter exclusion criteria are based on Kansas State Employee Plan documents that state that for drug coverage Options A and B – which cover 99.5% of plan participants – the plan participant price is 20 percent of the total cost. Hence, drugs for which the information provided by the website did not conform to this co-payment structure were excluded.[17]

Kansas Health Plan Drug Cost Extrapolations from National Utilization Data

The top nationally prescribed generic drugs in terms of volume were identified using the Medical Expenditure Panel survey administered by the US Department of Health and Human Services. The top two drugs were Levothyroxine and Lisinopril; both are generic drugs. The top drugs and their usage rates can be found at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/drugs/2007/hcdrugest_totpur2007.shtml. The drug usage data employed in this analysis are national in scale and are for the most recent year for which data is available, 2007.

The utilization rate for each drug was calculated by dividing each drug's "total number of persons with purchases [of the drug]" by the 2007 US population figure. The US Census Bureau estimated the US population at 301,621,157 on July 1, 2007. The US population figure can be found at: http://www.census.gov/popest/states/NST-ann-est2007.html.

The Kansas Plan drug cost figures used in the extrapolations were derived from the website look-ups described above. For each drug, several versions are available on the CVS HSP list; these versions differ in terms of form (i.e. tablet or caplet) or strength (i.e.10mg or 20mg) or both. To determine the Kansas Plan drug costs used in the extrapolations, the median cost was taken from the various versions of each drug that matched the versions that appear on the CVS generics discount list.

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In order to extrapolate the cost figures from a per drug cost to the Kansas Plan's population, it was assumed that the utilization rate for each drug among the Kansas Plan population was identical to the national utilization rate. Hence, the number of Kansas Plan members taking each drug was defined as equal to the national drug utilization rate multiplied by 93,000, the number of covered lives in the Kansas Plan.

The cost of each drug among the Kansas Plan population – disaggregated into the employer and patient components – was calculated by multiplying the estimated number of plan participants taking each drug by the 90-day cost of each drug. The 360-day fill costs were calculated by multiplying the 90-day fill costs by 4.

Appendix B

Appendix B, which includes a full list of drugs available through the Kansas State Employee Health Plan and examined as part of our research, is included in the digital version of this report, available online at www.AlarmedAboutCVSCaremark.org

Endnotes

1 Ted Nesi, *Providence Business Journal*, "CVS filled 1.3 billion prescriptions in '09," 15 Mar. 2010. Available at: http://www.pbn.com/detail/48559.html

2 CVS Caremark Press Release, 22 Mar. 2007. Available at: http://info.cvscaremark.com/newsroom/press-releases/cvscaremark-merger-closes-creating-nations-leading-pharmacyservices-company. (last visited 28 Jan. 2010)

3 Dion Lefler, *Wichita Eagle*, "Is State Overcharged in Employees' Prescription Plan?" 21 Mar. 2010. Available at: http://www.kansas.com/2010/03/21/1234960/is-state-overcharged-in-employees.html

4 2009 Annual Legislative Report, Kansas Health Policy Authority, p 19.

5 *Ibid.*, p20; In 2008, the most recent year for which data are available, 98.3% of active participants selected Option A, 1.2% selected Option B, and 0.5% selected Option C.

6 *Ibid.*

7 State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Active Employees, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/active/comparison_chart_active/prescription_drug_benefits_a_b and;
State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Non State Groups, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/non-state/comparison_chart_non_state/prescription-drug-benefits-plan-a-and-b-non-state; and
State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Retiree/Direct Bill, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/retiree_direct_bill/comparison-chart-retiree-health-plan/prescription-drug-benefits-plan-a-and-plan-b-retiree

8 State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Active Employees, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/active/comparison_chart_active/prescription_drug_benefits_c-1 and;
State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Non State Groups, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/non-state/comparison_chart_non_state/prescription-drug-benefits-c-non-state

9 A full CVS discount generics program description. Available at: http://www.cvs.com/CVSApp/promoContent/promoLandingTemplate.jsp?promoLandingId=1046. While the HSP program boasts over 400 generic drugs available at $9.99 for a 90-day supply at retail, there are actually only 374 unique generic drugs on the list for that price.

10 This analysis is based on the co-payment structure of Options A and B, which apply to 99.5% of the plan participants. In this co-payment structure, plan participants pay 20% of the drug cost and the plan pays 80%.

11 U.S. Department of Health & Human Services, Medical Expenditure Panel Survey, "Top Prescribed Drugs by Total Purchases, 2007." Available at: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/drugs/2007/hcdrugest_totpur2007.shtml

12 John Hanna, *Associated Press*, "Union criticizes company managing drug plan for Kansas state workers; lawmakers plan hearings," 19 Mar. 2010. Available at: http://www.startribune.com/business/88692262.html?elr=KArks:DCiU1OiP:DiiUiD3aPc:_Yyc:aUU

13 Dion Lefler, *Wichita Eagle*, "Is State Overcharged in Employees' Prescription Plan?" 21 Mar. 2010.

14 *Ibid.*

15 Carol Wolf, *Bloomberg News.* "CVS Caremark under FTC investigation, company says." 5 Nov. 2009. Available at: http://www.bloomberg.com/apps/news?pid=20601087&sid=azghXGZgKcCw&pos=6

5-9

16 Letters to the Federal Trade Commission calling for a review of the CVS Caremark merger from: 15 members of Congress; Six health plans and purchasing coalitions – Delaware Valley Health Care Coalition; New York Labor Health Care Alliance; Sergeants Benevolent Association, Police Dept, City of New York; 1199 New England, SEIU; Sheet Metal Workers International Union; Laundry, Dry Cleaning and Allied Workers Joint Board of New York; the National Legislative Association on Prescription Drug Prices (NLARx), Consumer Federation of America, US Public Interest Research Group; and the National Community Pharmacists Association. House members listed in *Reuters* article along with Jan Schakowsky (IL) and Jim Gerlach (PA); *Reuters*, "Eight lawmakers ask FTC to reopen CVS merger," 16 Sept. 2009. Available at: http://in.reuters.com/article/rbssConsumerGoodsAndRetailNews/idINN156908820090915; Carol Wolf, *Bloomberg News,* "Senators Urge CVS Caremark Probe in Letters to FTC," 30 July 2009. Available at: http://www.bloomberg.com/apps/news?pid=20601087&sid=aCpZ0X2wZxPM

17 State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Active Employees, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/active/comparison_chart_active/prescription_drug_benefits_a_b; and
State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Non State Groups, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/non-state/comparison_chart_non_state/prescription-drug-benefits-plan-a-and-b-non-state; and
State Employee Health Plan, *Health Plan Comparison Chart and Other Information: For Retiree/Direct Bill, Open Enrollment 2010*, Kansas Health Policy Authority. Available at: http://www.sehp2010ks.org/covered_groups/retiree_direct_bill/comparison-chart-retiree-health-plan/prescription-drug-benefits-plan-a-and-plan-b-retiree

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www.ChangeToWin.org

ALARMED ABOUT CVS CAREMARK

Alarmed About CVS Caremark is a Change to Win initiative to educate consumers, health plan managers and trustees about CVS Caremark, the country's largest pharmacy services company, operating both a pharmacy benefits manager (PBM) and retail pharmacy chain. Our reports, *CVS Caremark: An Alarming Prescription* and *CVS Caremark: An Alarming Merger*, detail the troubling patterns exhibited by both CVS and Caremark prior to their merger, and explores the new risks presented by the merged entity CVS Caremark.

www.AlarmedAboutCVSCaremark.org

info@alarmedaboutcvscaremark.org

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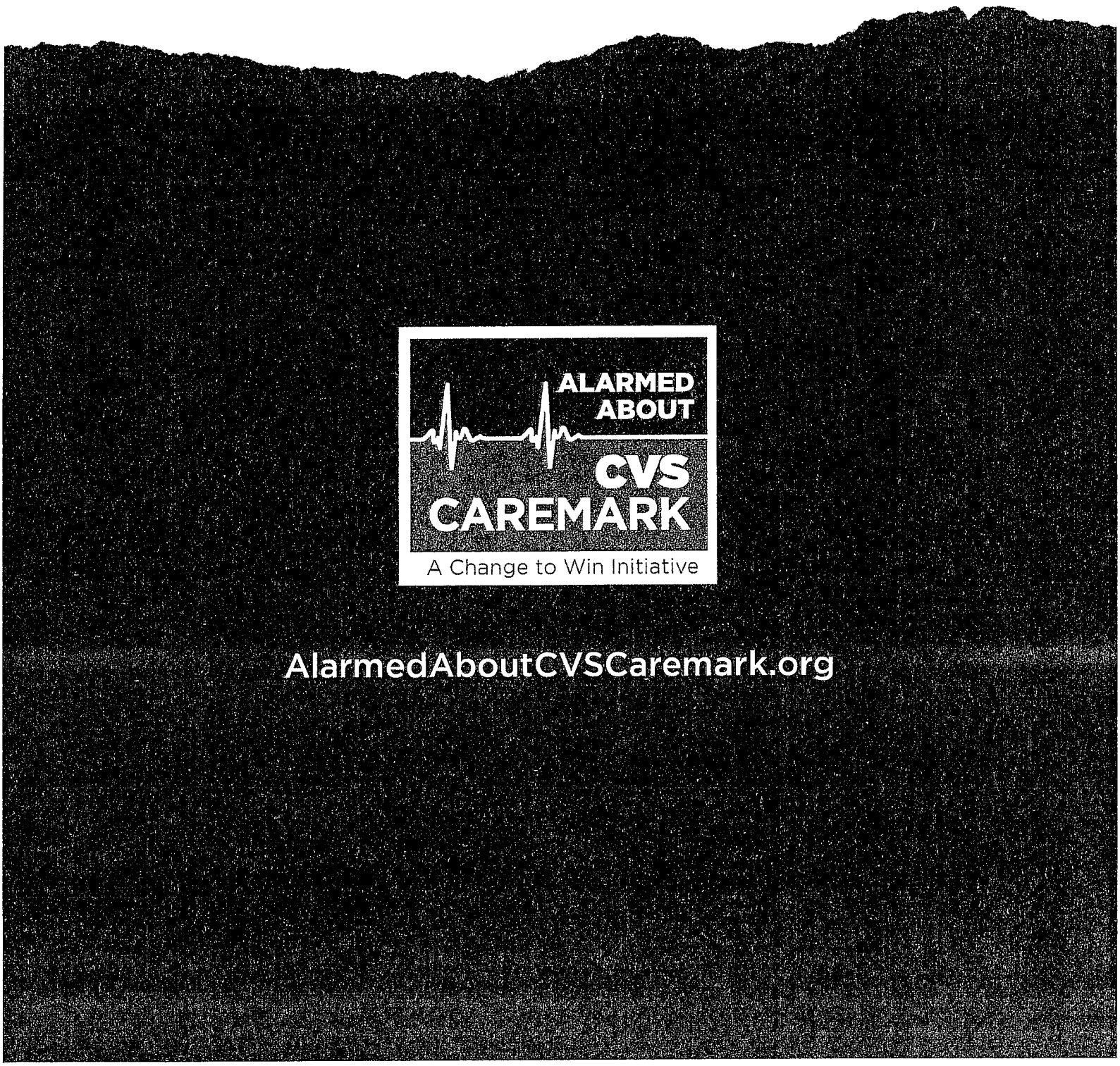
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