On behalf of CVS Health, we are submitting a priority list of remaining concerns with the "PBM White Paper" that was accepted by the NAIC Regulatory Framework Task Force during the summer meeting.

- **Remove the Recommendations (pages 35-36)** – this is supposed to be an informational white paper which outlines the issues that should be addressed and provides an overview of the various parties in the prescription drug benefit system. As discussed by the working group, this paper is a snapshot in time of how the system currently works and the issues that are present in the market today. Therefore, it is more appropriate to discuss these recommendations as future charges of the working group, as opposed to including them in an informational white paper.

- **Revise the section on "Steering" (pages 22-23)** – This section provides a reader a good overview of network adequacy. However, the tone of this section and certain sentences are extremely biased and unsupported. At the very least, there are two instances of this extreme bias that we would request be deleted:
  - "*Steering can limit a member's choice, increase costs, and lower quality of care to members*." This is unsupported by any data and in fact, using affiliated pharmacies can lower the cost for the enrollee and the plan sponsor. More importantly, there is absolutely no evidence that use of an affiliated pharmacy lowers the quality of care for a member.
  - "*These types of practices can result in harm, including increasing drug prices, overcharging members, restricting a member's choice of pharmacies, underpaying community pharmacies and other dispensers, and fragmenting and creating barriers to care, particularly in rural areas, and for members battling life-threatening illnesses and chronic diseases*." This closing statement proports that consumers are being harmed by the required or incentivized use of affiliated pharmacies. There is no data to support such a misleading and inflammatory assertion. We strongly request these sentences be deleted.

- **Revise the section on Vertical Integration (pages 20-21)** – Although it is tangentially connected to how various PBMs in the market are structured, this section has been written in a manner that is extremely biased and pejorative. There is a substantial lack of data to support the assertions and most of this section is aligned with one presentation that was made by Dr. Sood, which was cited extensively as the basis of this section. However, Dr. Sood's assertions are only in a working paper that has not been peer-reviewed and no sufficient counter perspective has been included in the paper. For these reasons, the following assertions should be removed as follows:

  "D. VERTICAL INTEGRATION AND CONSOLIDATION

  . . . .

  Consolidation refers to the merger and acquisition of many smaller companies resulting in a few much larger companies. The benefit of consolidation is that a larger firm may be able to realize efficiencies of scale and pass the resulting cost savings to consumers. The downside of consolidation is that costs tend to rise when there are fewer existing firms around to compete on prices and the few remaining firms price their products to maximize profit.[1]

[1] *Id*.

Along with vertical integration, consolidation in the pharmacy benefit supply chain has led to current market conditions, which feature the three largest PBMs covering 79 percent of prescription drug claims.[2] ~~Further, independent pharmacies are put at a competitive disadvantage compared to PBM-affiliated pharmacies when it comes to contracting~~.

~~The proliferation of PBM-health insurer affiliations has resulted in inefficiencies in the market.[3] From the health insurer's perspective, an affiliation with a PBM is incredibly valuable for two reasons: lower costs for pharmacy benefit services and exclusive or priority access to the PBM. From a market perspective, a PBM-health insurer relationship results in lower market competition, dealings within affiliated businesses and possible anti-competitive practices.[4] The three largest PBMs are all affiliated with health insurers, so other large health insurers not affiliated with a PBM are no longer able to find a PBM that operates on their scale that is not affiliated with a competitor.~~

~~A PBM-pharmacy affiliation creates several incentives for PBMs to act against the best interests of the consumer. PBMs have been found inserting language into pharmacy benefit contracts that requires enrollees to use PBM-owned mail pharmacy services for long-term (90 days or longer) "maintenance" medications.[5] This contractual requirement effectively eliminates any competition to fill these prescriptions, allowing the pharmacy to charge higher prices to the consumer. An affiliation with a pharmacy may also incentivize a PBM to do the following, which are all contrary to the best interests of consumers:~~

- ~~Perform fewer generic substitutions;~~
- ~~Switch patients to higher-cost therapeutic alternatives ("therapeutic interchange"); or,~~
- ~~Repackage drugs in a manner that could lead to increased costs to plan sponsors, while maximizing revenue for the PBM ("package size pricing").~~

Please see the appendix for a more detailed explanation regarding our concerns with this language.

Thank you for considering the above concerns and do not hesitate to reach out if you have any questions or would like to further discuss (leanne.gassaway@cvshealth.com or 202-997-9827).

[2] *PBMs ranked by market share: CVS Caremark is No. 1*; Becker's Hospital Review (website); March 8th, 2022.
[3] Sood.
[4] *Id*.
[5] "A Tangled Web," p. 42-43.

APPENDIX

Sentence	Reason for Removal
"Further, independent pharmacies are put at a competitive disadvantage compared to PBM-affiliated pharmacies when it comes to contracting."	There is no data to substantiate this claim and it conflicts with the significant power that PSAOs can levy on behalf of the independent pharmacies they represent as discussed in the white paper.
"The proliferation of PBM-health insurer affiliations has resulted in inefficiencies in the market.[6] From the health insurer's perspective, an affiliation with a PBM is incredibly valuable for two reasons: lower costs for pharmacy benefit services and exclusive or priority access to the PBM. From a market perspective, a PBM-health insurer relationship results in lower market competition, dealings within affiliated businesses and possible anti-competitive practices.[7] The three largest PBMs are all affiliated with health insurers, so other large health insurers not affiliated with a PBM are no longer able to find a PBM that operates on their scale that is not affiliated with a competitor."	This paragraph does not provide any data to support the inefficiencies noted, and in fact, the text could be construed to provide efficiencies for employers and consumers who could realize lower premiums through the integration of care and a more streamlined benefit experience. Again, these perceived "inefficiencies" are not supported by data or studies and should not be included.
"A PBM-pharmacy affiliation creates several incentives for PBMs to act against the best interests of the consumer. PBMs have been found inserting language into pharmacy benefit contracts that requires enrollees to use PBM-owned mail pharmacy services for long-term (90 days or longer) "maintenance" medications.[8]" "This contractual requirement effectively eliminates any competition to fill these prescriptions, allowing the pharmacy to charge higher prices to the consumer." "An affiliation with a pharmacy may also incentivize a PBM to do the following, which are all contrary to the best interests of consumers: • Perform fewer generic substitutions; • Switch patients to higher-cost therapeutic alternatives ("therapeutic interchange"); or,	This paragraph makes many unsubstantiated assertions. There is no data or clinical evidence provided to support anything that is stated here related to PBM-pharmacy affiliation and is intentionally pejorative as opposed to informative as a white paper should be. PBMs are hired to help plan sponsors provide a robust pharmacy benefit while also providing cost savings for the plan and their members. PBMs do not "insert language" into contracts with their clients that they are unaware of and further, it is the client, themselves that selects whether to use the mail order pharmacy. Home delivery programs have been used by plan sponsors for decades as a result of the savings that their enrollees obtain on 90-day supplies of their medications. Several studies have shown that home delivery of 90-day maintenance medications leads to higher adherence and better clinical outcomes. (See JAHA, Dec 21,

[6] Sood.
[7] *Id*.
[8] "A Tangled Web," p. 42-43.

• Repackage drugs in a manner that could lead to increased costs to plan sponsors, while maximizing revenue for the PBM ("package size pricing").””	2020, https://doi.org/10.1161/JAHA.119.016215). Additionally, approximately 91% of all drugs dispensed are generics and PBMs have helped with this through encouraging generic substitution and the use of lower cost options. The assertion that PBM-owned pharmacies perform fewer generic substitutions is not supported by any evidence and not in line with the current high dispensing rates for generics. Lastly, PBMs do not "switch" patients, as their licensed provider is responsible for writing the prescription and it is illegal for a PBM to arbitrarily switch a patient's medication without provider consent. Therefore, such an assertion as made here is not supported by any evidence.