

**PRESERVING OUR HOMETOWN INDEPENDENT
PHARMACIES ACT OF 2011**

HEARING
BEFORE THE
SUBCOMMITTEE ON
INTELLECTUAL PROPERTY,
COMPETITION, AND THE INTERNET
OF THE
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

ON

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PRESERVING OUR HOMETOWN INDEPENDENT PHARMACIES ACT OF 2011

THURSDAY, MARCH 29, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON INTELLECTUAL PROPERTY,
COMPETITION, AND THE INTERNET,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to call, at 9:44 a.m., in room 2141, Rayburn Office Building, the Honorable Tom Marino (acting Chairman of the Subcommittee) presiding.

Present: Representatives Goodlatte, Coble, Chabot, Issa, Griffin, Marino, Watt, Conyers, Chu, Jackson Lee, and Johnson.

Staff present: (Majority) Holt Lackey, Counsel; Olivia Lee, Clerk; and (Minority) Stephanie Moore, Subcommittee Chief Counsel.

Mr. MARINO. Good morning. I would like to call this hearing to order. The Subcommittee will come to order. Without objections, the Chairman is authorized to declare the Subcommittee in recess at any time for votes on the House floor, which will be coming very shortly.

Chairman Goodlatte is stuck in traffic, I understand, behind a traffic accident. So, I would just ask that his statement be entered. Here he is. I have to relinquish this now. [Laughter.]

Mr. GOODLATTE [presiding]. Good morning. Everything that the gentleman from Pennsylvania stated is entirely accurate. And we will begin with an opening statement.

I want to welcome everyone to this hearing of the Intellectual Property, Competition and the Internet Subcommittee. This legislative hearing will consider H.R. 1946, the "Preserving Our Hometown Independent Pharmacies Act of 2011," which was introduced by Representative Marino, and is cosponsored by Representatives Coble and Gohmert of this Committee, as well as 28 other Members of the House.

The bill would create a limited antitrust exemption for small and independent pharmacies to allow them to collectively bargain with health plans and Pharmacy Benefits Managers, or PBMs, to negotiate the contracts under which health insurers reimburse pharmacies for their services. Many pharmacists, particularly small and independent pharmacists, claim that health plans, and particularly PBMs, have significant market power over them, and that collective bargaining rights are necessary to allow them to level the playing field, reduce costs, and stay in business.

Like many Members of this Committee, I am sympathetic to the challenges faced by small pharmacists who want to profitably practice their profession in a healthcare market that is increasingly dominated by a handful of large powerful companies and Washington bureaucracies. The past few decades have seen rapid consolidation and concentration of power in the healthcare market. This trend has accelerated since the passage of Obamacare and can be expected to accelerate even more rapidly if that law becomes fully effective 2 years from now.

I have spoken to pharmacists in my district who tell me that their negotiations with PBMs are too often take-it-or-leave-it affairs in which the PBMs offer them barely enough to stay afloat. When a pharmacist fills a prescription, they are paid for that service by the patient's health plan, which is generally administered by a PBM. In practice, this means that the only way pharmacists can get paid is through an agreement with the PBM that administers the patient's health plan. So, pharmacists are dependent on PBMs for their livelihood and need to enter agreements with them.

But, independent pharmacists are small, disperse, and at the PBM's mercy, while PBMs are large, concentrated, and able to play pharmacies against one another. As a result, these negotiations are often one-sided. Pharmacists tell me that they feel compelled to accept contracts that barely compensate them enough to stay in business.

Independent pharmacies provide an important service and give customers a worthwhile alternative to large chain drugstores or mail-order pharmacies. There is much to be said for the personal pharmacist-patient relationship offered by these small businesses. Like many of my colleagues, I believe that independent community pharmacies should be preserved.

The question presented by this hearing is whether an antitrust exemption is the right solution to the problems faced by independent community pharmacists. In general, antitrust exemptions should be disfavored. The antitrust laws are a cornerstone of our competition-based free-market economy. The antitrust laws guarantee that businesses compete with one another to offer better services, quality, and prices to consumers, rather than conspiring with one another to increase their own profits at consumers' expense.

With few exceptions, every business in America must abide by these laws. As the Antitrust Modernization Commission reported in 2007, vigorous competition protected by the antitrust laws does the best job of promoting consumer welfare and a vibrant growing economy, and exemption from the antitrust laws means firms can avoid tough discipline of competition, at least to some extent.

That commission helpfully recommended procedural steps that Congress should take in considering antitrust exemptions and the standards that Congress should consider in weighing the propriety of a proposed antitrust exemption.

Procedurally, the Commission recommended that Congress should create a full public record on any proposed exemption, should consult with the Federal Trade Commission and Department of Justice about the proposal, and should require proponents of the exemption to submit evidence showing that the immunity is

justified. This public hearing, at which both community pharmacist proponents of H.R. 1946 and the Federal Trade Commission will testify, is intended to fulfill these procedural recommendations. The Commission also helpfully framed the issues that Congress should consider with respect to a proposed antitrust exemption. The Commission recommended that the burden of proving the need for an exemption should rest with the proponents of the exemption.

At a minimum, the Commission suggested that the proponents should have to show that the antitrust laws would prohibit the conduct they want to engage in, that the exemption supports a particular societal need that outweighs consumers' interest in the competitive market protected by the antitrust laws, and that there is no less restrictive way to achieve that societal goal.

I look forward to hearing the testimony of the witnesses today on this important matter.

[The bill, H.R. 1946, follows:]

112TH CONGRESS
1ST SESSION

H. R. 1946

To ensure and foster continued safety and quality of care and a competitive marketplace by exempting independent pharmacies from the antitrust laws in their negotiations with health plans and health insurance insurers.

IN THE HOUSE OF REPRESENTATIVES

MAY 23, 2011

Mr. MARINO (for himself and Mr. GOHMERT) introduced the following bill;
which was referred to the Committee on the Judiciary

A BILL

To ensure and foster continued safety and quality of care and a competitive marketplace by exempting independent pharmacies from the antitrust laws in their negotiations with health plans and health insurance insurers.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Preserving Our Home-
5 town Independent Pharmacies Act of 2011”.

1 **SEC. 2. APPLICATION OF THE ANTITRUST LAWS TO INDE-**
2 **PENDENT PHARMACIES NEGOTIATING WITH**
3 **HEALTH PLANS.**

4 (a) **IN GENERAL.**—Any independent pharmacies who
5 are engaged in negotiations with a health plan regarding
6 the terms of any contract under which the pharmacies pro-
7 vide health care items or services for which benefits are
8 provided under such plan shall, only in connection with
9 such negotiations, be treated under the antitrust laws as
10 an employee engaged in concerted activities and shall not
11 be regarded as having the status of an employer, inde-
12 pendent contractor, managerial employee, or supervisor.

13 (b) **PROTECTION FOR GOOD FAITH ACTIONS.**—Ac-
14 tions taken in good faith reliance on subsection (a) shall
15 not be the subject under the antitrust laws of criminal
16 sanctions nor of any civil damages, fees, or penalties be-
17 yond actual damages incurred.

18 (c) **NO CHANGE IN NATIONAL LABOR RELATIONS**
19 **ACT.**—Nothing in this section shall be construed as chang-
20 ing or amending any provision of the National Labor Rela-
21 tions Act, or as affecting the status of any group of per-
22 sons under that Act.

23 (d) **EFFECTIVE DATE.**—The exemption provided in
24 subsection (a) shall apply to conduct occurring beginning
25 on the date of the enactment of this Act.

1 (e) LIMITATIONS ON EXEMPTION.—Nothing in this
2 section shall exempt from the application of the antitrust
3 laws any agreement or otherwise unlawful conspiracy
4 that—

5 (1) would have the effect of boycotting any
6 independent pharmacy or group of independent
7 pharmacies, or would exclude, limit the participation
8 or reimbursement of, or otherwise limit the scope of
9 services to be provided by, any independent phar-
10 macy or group of independent pharmacies with re-
11 spect to the performance of services that are within
12 the scope of practice as defined or permitted by rel-
13 evant law or regulation;

14 (2) allocates a market among competitors;

15 (3) unlawfully ties the sale or purchase of one
16 product or service to the sale or purchase of another
17 product or service; or

18 (4) monopolizes or attempts to monopolize a
19 market.

20 (f) LIMITATION BASED ON MARKET SHARE OF
21 GROUP.—This section shall not apply with respect to the
22 negotiations of any group of independent pharmacies with
23 a health plan regarding the terms of any contract under
24 which such pharmacies provide health care items or serv-
25 ices for which benefits are provided under such plan in

1 a PDP region (as defined in subsection (j)(4)) if the num-
2 ber of pharmacy licenses of such pharmacies within such
3 group in such region exceeds 25 percent of the total num-
4 ber of pharmacy licenses issued to all retail pharmacies
5 (including both independent and other pharmacies) in
6 such region.

7 (g) NO EFFECT ON TITLE VI OF CIVIL RIGHTS ACT
8 OF 1964.—Nothing in this section shall be construed to
9 affect the application of title VI of the Civil Rights Act
10 of 1964.

11 (h) NO APPLICATION TO SPECIFIED FEDERAL PRO-
12 GRAMS.—Nothing in this section shall apply to negotia-
13 tions between independent pharmacies and health plans
14 pertaining to benefits provided under any of the following:

15 (1) The Medicaid Program under title XIX of
16 the Social Security Act (42 U.S.C. 1396 et seq.).

17 (2) The State Children’s Health Insurance Pro-
18 gram (SHIP) under title XXI of the Social Security
19 Act (42 U.S.C. 1397aa et seq.).

20 (3) Chapter 55 of title 10, United States Code
21 (relating to medical and dental care for members of
22 the uniformed services).

23 (4) Chapter 17 of title 38, United States Code
24 (relating to Veterans’ medical care).

1 (5) Chapter 89 of title 5, United States Code
2 (relating to the Federal employees' health benefits
3 program).

4 (6) The Indian Health Care Improvement Act
5 (25 U.S.C. 1601 et seq.).

6 (7) Part C or D of title XVIII of the Social Se-
7 curity Act.

8 (i) DEFINITIONS.—For purposes of this section:

9 (1) ANTITRUST LAWS.—The term “antitrust
10 laws”—

11 (A) has the meaning given it in subsection
12 (a) of the first section of the Clayton Act (15
13 U.S.C. 12(a)), except that such term includes
14 section 5 of the Federal Trade Commission Act
15 (15 U.S.C. 45) to the extent such section 5 ap-
16 plies to unfair methods of competition; and

17 (B) includes any State law similar to the
18 laws referred to in subparagraph (A).

19 (2) HEALTH PLAN AND RELATED TERMS.—

20 (A) IN GENERAL.—The term “health
21 plan”—

22 (i) means a group health plan or a
23 health insurance issuer that is offering
24 health insurance coverage;

1 (ii) includes any entity that con-
2 tracts with such a plan or issuer for the
3 administering of services under the plan or
4 coverage; and

5 (iii) does not include a Medicare Ad-
6 vantage plan offered under part C of title
7 XVIII of the Social Security Act or a pre-
8 scription drug plan offered under part D of
9 such title.

10 (B) HEALTH INSURANCE COVERAGE;
11 HEALTH INSURANCE ISSUER.—The terms
12 “health insurance coverage” and “health insur-
13 ance issuer” have the meanings given such
14 terms under paragraphs (1) and (2), respec-
15 tively, of section 733(b) of the Employee Retire-
16 ment Income Security Act of 1974 (29 U.S.C.
17 1191b(b)).

18 (C) GROUP HEALTH PLAN.—The term
19 “group health plan” has the meaning given that
20 term in section 733(a)(1) of the Employee Re-
21 tirement Income Security Act of 1974 (29
22 U.S.C. 1191b(a)(1)).

23 (3) INDEPENDENT PHARMACY.—The term
24 “independent pharmacy” means a pharmacy that
25 has a market share of—

1 (A) less than 10 percent in any PDP re-
2 gion; and

3 (B) less than 1 percent in the United
4 States.

5 For purposes of the preceding sentence, all phar-
6 macies that are members of the same controlled
7 group of corporations (within the meaning of section
8 267(f) of the Internal Revenue Code of 1986) and
9 all pharmacies under common control (within the
10 meaning of section 52(b) of such Code but deter-
11 mined by treating an interest of more than 50 per-
12 cent as a controlling interest) shall be treated as 1
13 pharmacy.

14 (4) PDP REGION.—The term “PDP region”
15 has the meaning given such term in section 1860D–
16 11(a)(2) of the Social Security Act (42 U.S.C.
17 1395w–111(a)(2)).

18 (j) 5-YEAR SUNSET.—The exemption provided in
19 subsection (a) shall only apply to conduct occurring during
20 the 5-year period beginning on the date of the enactment
21 of this Act and shall continue to apply for 1 year after
22 the end of such period to contracts entered into before
23 the end of such period.

24 (k) GENERAL ACCOUNTABILITY OFFICE STUDY AND
25 REPORT.—The Comptroller General of the United States

1 shall conduct a study on the impact of enactment of this
2 section during the 6-month period beginning with the 5th
3 year of the 5-year period described in subsection (j). Not
4 later than the end of such 6-month period, the Comptroller
5 General shall submit to Congress a report on such study
6 and shall include in the report such recommendations on
7 the extension of this section (and changes that should be
8 made in making such extension) as the Comptroller Gen-
9 eral deems appropriate.

10 (l) OVERSIGHT.—Nothing in this section shall pre-
11 clude the Federal Trade Commission or the Department
12 of Justice from overseeing the conduct of independent
13 pharmacies covered under this section.

○

Mr. GOODLATTE. And it is now my pleasure to recognize the Ranking Member of the full Committee, the gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Thank you, Chairman Goodlatte. I am happy to be here again today. This is the subject of a bill that I introduced and had reported out of the Judiciary Committee in 2007. And I am so glad that Tom Marino has picked it up and is moving it forward. And like you, Mr. Chairman, I am reluctant to create exemptions in antitrust law, as a rule.

But unlike you, I am going to present evidence that Obamacare, which I happen to like, the buttons that we passed out say, "I Love Obamacare," but I like Obamacare, and I want to prove that it does not further complicate the issue with PBMs that you suggested that it might.

Now, my major concern here today is whether or not the savings created by the exemptions—and by the way, Mr. James was here before. I think you were a witness before in this matter. Maybe you weren't. But, at any rate, I was hoping that there would be some way we could ensure that the savings from the measure that is before us could be passed on to the customer-patient, but I understand that that may not be possible.

But, what I would like to get in today, and I hope we can during the course of the hearing, is the incredible power that the Pharmacy Benefit Manager exerts on the independent pharmacist. It is unfair. As a matter of fact, the pharmacist really isn't even setting the price of the prescription, because that is all being sent back to him as to what the cost should ultimately be. And so, I still support the idea of carving out an antitrust exception for pharmacists, and I am hoping that we can get this measure through the Judiciary Committee and send it on its way.

I will put the rest of my statement in the record. I thank the Chairman.

[The prepared statement of Mr. Conyers follows:]

Prepared Statement of the Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, Ranking Member, Committee on the Judiciary, and Member, Subcommittee on Intellectual Property, Competition, and the Internet

Pharmaceutical care is one of the most important parts of our healthcare system. Pharmacies serve as a direct interface between consumers and their medications, and pharmacists play a critical role in advising and caring for patients all over the country. Pharmacists provide particularly critical and easy-access to health care information in under-served communities, including residents in inner-city and rural areas.

During the past several decades, the cost of medical care in the United States has skyrocketed. And while President Obama and healthcare reform have made progress in reining in these costs to individuals, more clearly needs to be done.

The prescription drug and drug benefits market is one of the least transparent and least competitive in healthcare industry. Some studies estimate that the profits of Pharmaceutical Benefit Managers, or PBMs, increased between 2003 and 2010 by over 600%, and more than 30 states have brought cases against PBMs for fraudulent and deceptive practices since 2007.

And yet, the business model of PBMs pivot around reducing drug costs and negotiating cheaper rates. Large employers and large health plans, the federal government's health plans included, intensely scrutinize which PBMs will keep their premiums low and move between Benefit Managers at will.

Today we discuss a bill authored by Mr. Marino that would grant independent community pharmacies an antitrust exemption that would allow them to band to-

gether to negotiate collectively to obtain more favorable terms from health care plans and Pharmacy Benefit Managers, or PBMs.

In 2000, the House passed the Quality Healthcare Act which contained an amendment I sponsored with similar aims, and in 2007, this Committee reported out a measure similar to Mr. Marino's bill favorably to the House Floor.

I am generally skeptical of antitrust exemptions. The antitrust laws protect our economic freedom against private restraints of trade, and Congress should not take any effort to curtail their reach lightly.

Exemptions may be appropriate, however, when markets have become so dysfunctional that an exemption becomes the only means of restoring effective competition. The independent pharmacists make a compelling case in this regard.

On the other hand, there is no guarantee that if independent pharmacies are granted an antitrust exemption that they will pass these savings on to consumers. Many, and by some accounts most, independent pharmacies already contract with Pharmacy Services Administration Organizations, or PSAOs, to bargain collectively on their behalf for some transactions. There is no guarantee that independent pharmacies, like any business, wouldn't use the savings they gleaned in this area to defray losses in other areas. While they may save money with an exemption, the cost of drugs to consumers may go unchanged.

During the course of today's hearing, I hope that our witnesses will make a clear case on how the proposed antitrust exemption would affect consumers and drug prices for individuals. While the profit margins and business practices of PBMs are certainly relevant, we are here today to discuss those of independent pharmacies, and the burden should be on them to prove how they would use a carve-out from antitrust law to guarantee consumers lower drug prices.

Mr. GOODLATTE. I thank the gentleman. The Chair would note that the Ranking Member of the Subcommittee, Mr. Watt, of North Carolina, is unable to be with us, and his statement will be submitted for the record.*

And the Chair would now recognize the gentleman from Pennsylvania to inquire if he has an opening statement he would like to make.

Mr. MARINO. I do not have an opening statement, Chairman, but thank you.

Mr. GOODLATTE. You do not? Okay. Well then, we will proceed expeditiously. He has made up for almost half of the time that we lost, because of my delay in getting here. We will proceed to introduce our very distinguished panel of witnesses.

Each of the witnesses' written statements will be entered into the record in its entirety. I ask each witness to summarize his testimony in 5 minutes or less. To help you stay within that time, there is a timing light on your table to help. When the light switches from green to yellow, you have 1 minute to conclude your testimony. When the light turns red, it signals that the witness's 5 minutes have expired.

Before I introduce our witnesses, I would like them to stand and be sworn, as is the custom of this Committee.

[Witnesses sworn.]

Mr. GOODLATTE. Thank you very much. And please be seated.

I understand that one of the witnesses today, Renardo Gray, is a constituent of the distinguished Ranking Member of the full Committee, Mr. Conyers. Mr. Conyers has asked for the opportunity to introduce Mr. Gray, and I will now yield to him for that purpose.

*The Subcommittee had not received this material as of September 18, 2012.

Mr. CONYERS. Thank you. We have just met, unfortunately, though, he is a native of Detroit, and so am I, and we live in the same and work in the same part of the city in northwest Detroit. But Renardo Gray is a pharmacist, the owner of his own business, the Westside Pharmacy, a graduate of the University of Michigan College of Pharmacy, and has been in practice on his own since 1985, where he is still working and serving patients today.

He has a thriving small business, and is doing great service to those citizens and patients that have a cause to use his services. And I am glad that this is a great occasion for us to meet today, and I look forward to your testimony. And I thank you, Chairman Goodlatte.

Mr. GOODLATTE. I thank you, Mr. Conyers.

Our first witness today is Mr. Mike James, a community pharmacist and owner of Person Street Pharmacy, in Raleigh, North Carolina. Mr. James served as Vice President and Director of Governmental Affairs for the Association of Community Pharmacies Congressional Network.

Mr. James attended Samford University College of Pharmacy in Birmingham, Alabama, and has worked closely with the State of North Carolina on pharmacy and pharmacy governmental issues for many years. Mr. James was named National Pharmacist of the Year in 2004 and North Carolina Pharmacist of the Year in 2003. I look forward to hearing his perspective on this issue as a hometown independent pharmacist.

Our second witness, Professor Joshua Wright, of George Mason School of Law, focuses his academic work on antitrust law, and holds a J.D. and a Ph.D. in Economics from UCLA. Professor Wright was appointed as the inaugural Scholar in Residence at the Federal Trade Commission Bureau of Competition, where he served until fall of 2008.

Our third witness is Mr. Gray, who was ably introduced by the former Chairman, Mr. Conyers.

And our fourth and final witness is Mr. Richard Feinstein, Director of the Federal Trade Commission's Bureau of Competition. Previous to his appointment—is it Feinstein or steen?

Mr. FEINSTEIN. Fein-steen.

Mr. GOODLATTE. Fein-steen. Mr. Feinstein was partner at Boies, Schiller & Flexner, where he focused on antitrust litigation. Mr. Feinstein is a graduate of Yale University and Boston College Law School.

I welcome all the witnesses, and we will begin with you, Mr. James.

TESTIMONY OF MIKE JAMES, PHARMACIST AND OWNER, PERSON STREET PHARMACY, AND VICE PRESIDENT, ASSOCIATION OF COMMUNITY PHARMACISTS CONGRESSIONAL NETWORK (ACPCN)

Mr. JAMES. Thank you, Mr. Chairman. Chairman Goodlatte, Ranking Member Watt, Members of the Subcommittee, good morning, and thank you for inviting me to testify for the need of the passage of H.R. 1946. My name is Mike James. I am speaking on behalf of the Association of Community Pharmacy Congressional Network, and I am also a pharmacy owner of a practicing phar-

macy and a practicing pharmacist in Raleigh, North Carolina. I have one purpose here today, to help 22,000 independent pharmacies across the country get your attention before they are wiped out. Here is what you need to know.

There are about 50 independent pharmacies in every congressional district. That is 50 small businesses in your districts that are owned, managed, and staffed by the most trusted professionals in your communities. Every one of these small businesses are facing anticompetitive abuses by PBM corporations that are forcing them out of business. They are being forced to lay off employees, close their pharmacy, and turn patients away. Imagine the impact in your congressional district of just one more pharmacy closing. It will mean several lost high-paying jobs, many thousands of dollars in revenues and taxes lost to the community, and redirection of patient care out of your towns into mail-order pharmacies in another State.

The abuses your hometown pharmacies are facing are the result of Congress and the FTC losing sight of what having a competitive market really means. Virtually every single prescription a pharmacist in your district handles is controlled by one of three PBMs. I encourage every Member of Congress to reach out to at least one independent pharmacy at home. You will be told many interesting things.

For example, every pharmacy will tell you that the PBMs use the patient data that they are required to provide to steal their customers by either forcing the patients to drop their local pharmacy or coercing them with discounts. The PBM will not allow the local pharmacies to use these same discounts.

Now, let's look at a real-world fact. Park West Pharmacy, in Little Rock, Arkansas, so far this year has lost money on 218 prescriptions, because PBMs simply refuse to pay them back in full the actual cost of the drugs. In total, they have lost, to this point, about \$3,000.

Here is something else you should know. Park West Pharmacy and every other independent pharmacy in the country are prohibited by contract from telling anyone how much they pay for prescriptions or how much the PBMs pays them back. Why does this matter? Because it prevents planned providers, and Congress, and the FTC from knowing how much these same PBMs charge their customer for the drugs. I don't care what you hear from the PBM industry today, you will not hear them give you this information.

Do you think this is fair? Do Members of Congress think this is anything other than a systematic anti-competitive manipulation of the market? And what about the FTC? Do our Federal regulators, who are supposed to consider the impact of competition and abusive behavior on Main Street think that their so-called analysis of this issue engenders anything but mistrust?

The pharmacists in your district know that the goal of the PBM contract is to undermine the solvency of the independent pharmacies. I challenge the FTC to convince the Committee here today what this will do in showing their outdated studies how it will show any evidence of what they contend. The FTC will tell us that empowering pharmacists to negotiate together will increase drug prices. Based on what facts?

Look closely at the FTC testimony. Do they reference anywhere in their testimony actual drug pricing data? Not that I can find. The agency has opinions, but not facts. Why should Congress bother with these opinions when the agency cannot even comment on how PBMs are manipulating prices right now to destroy competition? How does the FTC explain why PBMs handle 10 percent of prescriptions just a few years ago, and now they handle over 85 percent of all prescriptions?

Is it superior pricing? Certainly not. A survey conducted by “Consumer Reports” in 2011 on popular brand name drugs found that independent pharmacies offered lower prices than traditional and national pharmacies, including those owned by PBMs. And when it comes to lower-cost generic drugs, independent pharmacies are generics to fill over 70 percent of prescriptions compared to less than 60 percent by the PBMs. The FTC offers opinions with that data. The pharmacies in your district can provide you with real data.

Finally, on behalf of the pharmacy owners in your districts who want to compete head to head with the PBMs, we will hope you will ask Mr. Wright to do more in this hearing than simply throw around data that cannot be evaluated. Instead, how about asking him to obtain why they are systematically under paying Park West Pharmacy in Representative Griffin’s district.

Then let’s ask this question: If the FTC and PBM representatives here today see nothing wrong with allowing the largest PBMs to consolidate into a national conglomerate that put a stranglehold on their retail competition, how can they argue that efforts by the independent pharmacies to fight back together will have a worst effect on the marketplace? As long as the FTC fails to grasp the micro-effects of the PBM industry’s clearly anti-competitive practices, there is only one way Congress can address this problem. That is to empower pharmacies to fight back on their own. The PBMs may tell you that a few pharmacies negotiating against them in your districts can manipulate drug prices against your constituents. Do you really believe this?

Mr. GOODLATTE. You need to summarize.

Mr. JAMES. I will. Thank you very much.

Mr. GOODLATTE. Your time has expired.

Mr. JAMES. The reason I am here today is to encourage you to task the independent pharmacists in your district who is manipulating whom.

Mr. Chairman, H.R. 1946 is a key to restoring pharmacy competition. I encourage the Subcommittee to pass it right away.

Mr. GOODLATTE. Thank you, Mr. James.

Mr. JAMES. Thank you. And thank you for your time.

[The prepared statement of Mr. James follows:]

Prepared Statement of Mike James, Vice President, ACP Congressional Network and Pharmacist/Owner, Person Street Pharmacy, Raleigh, NC

Chairman Goodlatte, Ranking Member Watt, and members of the subcommittee, good morning and thank you for inviting me to testify on the need for passage of HR 1946, a bill to let independent pharmacies negotiate together against large, multi-state pharmacy benefit management (PBM) corporations.

My name is Mike James. I am Vice President and Director of Government Affairs for the Association of Community Pharmacies Congressional Network. I am also a

practicing pharmacist and the owner of an independent, community pharmacy in Raleigh, North Carolina.

I have one purpose here today: To help 22,000 independent pharmacies across the country get your attention before they are wiped out. Here is what you need to know:

1. There are on average 50 independent pharmacies in every congressional district—that's 50 small businesses in your districts that are owned, managed, and staffed by (according to annual surveys for the past decade) the most trusted professionals in your communities.
2. Every one of these small business owners is facing anti-competitive abuses by PBM corporations that are forcing them out of business, and every one of them that fails to beat these abuses will be forced to lay off employees, close up shops, and turn patients away. Imagine the impact in your congressional district of just one more pharmacy closure this month: It will mean several lost high-paying jobs, thousands upon thousands of dollars in revenues and taxes lost to the community, and redirection of patient care out of your towns and into mail-order programs that are managed by automated systems in another state.
3. The abuses your home town pharmacies are facing are a result of the erosion of a competitive market that has been enabled by Congress and ignored by the Federal Trade Commission.

Let me explain exactly what I mean.

THE PRESCRIPTION DRUG MARKET IS NOW OWNED BY PBMS

First, let me point out that I testified before the Judiciary Committee on similar legislation that passed the committee in 2007. Since then, the problems the bill was drafted to address have grown worse because PBMs have consolidated their market power.

Specifically, Express Scripts acquired Wellpoint, CVS acquired Caremark, and now Express Scripts is about to acquire Medco. This last deal alone will empower a single PBM to dictate to 150 million consumers what medications they can take, how much they will pay for each prescription, and where they can get their prescriptions filled. In fact, that single PBM will control 40% of the entire prescription drug market in the U.S. The three largest PBMs will control more than 85% of every prescription in America.

Here is what that means: Virtually every single prescription a pharmacist in your district handles is controlled by one of three PBMs. The PBMs tell your pharmacists whether they can fill a prescription at their pharmacies, whether they can use a lower-cost generic or must use a more profitable brand preferred by the PBM, and what profit margin the pharmacy is allowed to keep. Keep in mind that these PBMs are in direct competition with every pharmacy in every one of your districts.

WANT PROOF? ASK YOUR PHARMACY CONSTITUENTS

Let's look closely at the ridiculous system that has been created—I encourage every member of Congress to reach out to at least one independent pharmacy at home. Here is what you will find:

- Every pharmacy will have a contract with one or more PBM. The contract will prohibit any disclosure by the pharmacy—including to patients—of how much the pharmacy paid for the prescriptions they fill, how much the PBM pays the pharmacy for the prescriptions, and how much profit the PBM keeps.
- The contracts will tell every pharmacy they may *not* under any circumstances fill prescriptions for any patient beyond 30 days.
- The contracts will require every pharmacy to turn over all of its data about every patient in a plan, including his or her mailing information.

Here is what else you will find:

- Every pharmacy in your district will be able to provide you with specific examples of how the PBMs reimburse them for prescriptions at less than their actual cost to acquire the drugs.
- Every pharmacy will tell you that the PBMs routinely offer more convenient 60- and 90-day prescriptions to any patient who will agree to leave the pharmacy and register for the PBM's proprietary mail service.

- Every pharmacy will tell you that the PBMs use the patient data they are required to provide to steal their customers by either forcing the patient to drop their local pharmacy or coercing them with discounts the pharmacy is barred by contract from offering.

Now, let's look at real-world data—facts—to see exactly how this works. I have in my hand a copy of a report from Park West Pharmacy in Little Rock, Arkansas, which is located in Representative Griffin's district. They sent me a copy of their letter to you this week, Congressman, in which they requested that this information be entered into the hearing record. It provides a detailed list of every prescription the pharmacy filled from January of this year to Monday of this week in which they lost money because PBMs under-reimbursed them. Here is exactly what the report shows:

- Park West Pharmacy so far this year has lost money on 218 prescriptions because PBMs simply refused to pay them back in full for the actual cost of the drugs.
- Park West Pharmacy spent \$20,716 for the drugs, but received only \$15,489 from the PBMs. When patient co-payments were added, the pharmacy recovered just \$18,886.

That means Park West Pharmacy lost \$1,830, or 9% of their total expenditures. It also means that the PBMs made a profit on these drugs by literally using Park West Pharmacy as a form of lending agent—and then stiffing the lender. Every other independent pharmacy in America faces the same situation on dozens and even hundreds of transactions every day. Here is something else you should know: Park West Pharmacy and every other independent pharmacy in the country are prohibited by contract from telling anyone how much they pay for prescriptions, or how much the PBMs pay them back. Why does this matter? Because it prevents plan providers—and Congress and the FTC—from knowing how much those same PBMs charged their customers for the drugs. I don't care what you hear from the PBM industry today—you will not hear them give you this information.

WHO IS LOOKING OUT FOR PHARMACIES IN YOUR DISTRICTS?

You think this is fair? Do members of Congress think this is anything other than a systematic, anti-competitive manipulation of the market? And what about the FTC? Do our federal regulators—who are supposed to consider the impact of competition and abusive monopolistic behavior on main street Americans—think their so-called “analysis” of this issue engenders anything but mistrust and disgust from 22,000 pharmacy owners and the millions of patients they serve?

Since we have the FTC with us today, let's get real. The pharmacies in your districts know that the goal of PBM contracts is to systematically undermine the solvency of the independent pharmacies that compete with them, and to force patients covered under PBM agreements into their highly profitable proprietary mail-order programs. I challenge the FTC to convince the committee members—and the thousands of small business owners in their districts who are being driven under while you tell us about your outdated studies—otherwise.

THE FTC RELIES ON THEORY, NOT DATA

The FTC will tell us that empowering pharmacies to negotiate together will increase drug prices. Based on what facts? Look closely at the FTC testimony. Do they anywhere reference actual pharmacy pricing data? No. The agency cites 2007 opinions by the Antitrust Modernization Commission, refers to its 2009 study of competition for biologic drugs, two general studies from 2004 and 2005, and staff comments presented to a few state legislatures. The agency has opinions, but not facts.

Why should Congress bother with these opinions when the agency cannot even comment on how PBMs are manipulating prices right now to destroy competition? How does the FTC explain why PBMs handled 10% of prescriptions just a few years ago, and now handle 85% of prescriptions? A significant part of this market expansion is attributed to passage by Congress of provisions in the new Medicare Part D law that handed whole markets over to the PBMs. What attributes for the rest of their aggressive growth?

Is it superior pricing? Certainly not. A survey conducted by Consumer Reports in 2011 of popular brand-name drug prices found independent pharmacies offered lower prices than traditional, national pharmacies, including those owned by the PBMs. And when it comes to lower-cost generic drugs, independent pharmacies use generics to fill over 70% of prescriptions compared to less than 60% by PBMs (since they make more in rebates and secret “spread pricing” from brands). What if we

factor in PBM claims that their mail-order programs can't be beat? Consider this statement from American Health & Drug Benefits, a peer-reviewed forum for pharmacy benefit program designs:

More controversial, however, is the validity of claims by PBMs that mail-order programs offer significant cost savings to plan sponsors. Very limited research has been conducted to definitively establish a significant economic value of mail order pharmacy service. The limited study data published show mixed results, raising questions about the cost impact to the plan sponsor.

The FTC offers opinions without data. The pharmacies in your districts can provide you with data, and it will change your views about the real threat to lower drug prices.

KEY QUESTIONS WE HOPE YOU WILL ASK

Here are questions the FTC and PBM representatives who are with us today should be asked to answer:

1. What other industries are allowed to use confidential patient data that is compelled by contract or federal law to steer consumers into proprietary programs?
2. Why should PBM corporations be allowed to maintain confidentiality provisions in their contracts—even on a supposedly “volunteer” basis—to prevent public disclosure of costs that are borne by state and federal governments?
3. Under what reasonable standard should pharmacies be locked out of the markets for services customers want, like 90-day prescriptions when appropriate?

MISINFORMATION WE KNOW PBMS WILL GIVE YOU

Finally, on behalf of the pharmacy owners in your districts who want to compete head-to-head with PBMs, we hope you will make the PBM industry's representative do more at this hearing than simply throw around aggregate data that cannot be validated, claim that lack of transparency in prescription drug transactions is somehow “good” for keeping prices low, and ask you to look the other way when they steer as many people as possible out of your local pharmacies and into their extremely profitable proprietary programs. Instead, how about asking him to explain why they are systematically under-paying Park West Pharmacy in Representative Griffin's district? Perhaps the PBM representative here today can go through this list of transactions with us to explain what policy guides this behavior. At minimum, let's ask him to tell us how much of the money they took from Park West Pharmacy went to the PBMs' insurance customers, and how much the PBMs simply put in their pockets without telling anyone.

Then let's ask this question: If the FTC and PBM representatives here today see nothing wrong with allowing the largest PBMs to consolidate into national conglomerates that put a stranglehold on their retail competitors, how can they argue that efforts by independent pharmacies to fight back together will have a worse affect on the market?

Finally, as long as the FTC fails to grasp the micro-effects of the PBM industry's clearly anti-competitive practices—micro-effects I might add that sum up to an obvious macro-strategy of restraining trade and manipulating competition—there is only one way Congress can address this problem. That is to empower pharmacies to fight back on their own.

Now let's all sit back and listen to the PBM representative, who will argue that HR 1946 provides a “license to engage in price fixing and boycotts” that will lead to higher drug prices. The FTC may think my small pharmacy in North Carolina has the power to undermine the multi-billion dollar PBM corporations that fight me every day, and the PBMs may tell you that a few pharmacies negotiating against them in your districts can manipulate drug prices against your constituents. But the reason I am here today is to encourage you to go ask the independent pharmacies in your district: “Who is manipulating whom?”

Mr. Chairman, HR 1946 is the key to restoring pharmacy competition. I encourage the subcommittee to pass it right away.

Thank you.

Mr. GOODLATTE. Professor Wright, welcome.

**TESTIMONY OF JOSHUA D. WRIGHT, PROFESSOR,
GEORGE MASON UNIVERSITY SCHOOL OF LAW**

Mr. WRIGHT. Chairman Goodlatte, Members of the Subcommittee, thank you for the opportunity to testify today. My name is Joshua Wright. I am a professor at the George Mason University School of Law, where I teach antitrust law and economics. I also hold a courtesy appointment in the Department of Economics. I was the inaugural Scholar in Residence at the FTC from 2007 to 2008.

I am here today to discuss H.R. 1946, a proposed exemption from the antitrust laws that would allow independent pharmacies to collectively negotiate with health plans on pricing provisions and other contract terms.

It is my view that the proposed legislation is ultimately likely to harm consumers and should be opposed on those grounds. Local pharmacists striving to provide quality care for patients undoubtedly face significant economic pressures from both changes in the healthcare market and from vigorous competition. While identifying ways to reduce costs in complex and dynamic healthcare markets is a critical policy objective, an antitrust exemption for independent pharmacies is likely to undermine that goal.

The purpose of H.R. 1946 is to ensure safety, quality of care, and a competitive marketplace. The overarching goal of the antitrust laws is to foster competition, and thereby maximize consumer welfare. This goal of maximizing consumer welfare is rarely, if ever, served by antitrust exemptions. Indeed, the consensus view is that such exemptions are much more likely to reduce consumer welfare than to enhance it.

The bipartisan Antitrust Modernization Commission has explained that, "A proposed exemption should be recognized as a decision to sacrifice competition and consumer welfare." It is widely recognized that antitrust exemptions benefit small concentrated interest groups while imposing costs broadly upon consumers at large. These costs generally take the form of, to quote the Antitrust Modernization Commission again, "Higher prices, reduced output, lower quality, and reduced innovation."

The Antitrust Modernization Commission concluded that exemptions should rarely be granted and only when proponents have successfully demonstrated that permitting unlawful and anti-competitive conduct is necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy, in general. This burden should not be taken lightly. The Sherman Act has been described as the Magna Carta of free enterprise, precisely because it was designed to enhance economic liberties promoted by competition.

Antitrust exemptions not only pose a risk to consumers, they are also generally unnecessary to achieve legitimate pro-competitive ends. The antitrust laws permit cooperation achieving pro-competitive objectives, rendering an exemption for such activities unnecessary.

The increased incorporation of economic thinking into antitrust analysis over the past several decades has endowed the antitrust laws with sufficient flexibility to permit such pro-competitive collaboration while condemning horizontal arrangements likely to re-

duce competition. Exemptions, in light of existing antitrust law, are simply unnecessary to protect parties from pro-competitive coordination.

Exemptions are equally unnecessary in the healthcare context. There, the antitrust agencies have actively provided guidance to pharmacies and other healthcare providers and folks outside of the healthcare industry, distinguishing lawful from unlawful conduct under the antitrust laws. The FTC issues advisory opinions to market participants seeking to compete more aggressively by means of limited coordination.

Healthcare providers can and do engage in such lawful coordination through the use of pharmacy service administrative organizations and other collaborations. The agencies advise many of those market participants that it will not challenge their coordinated efforts. The antitrust division at the DoJ also actively and in concert with the FTC provides similar guidance to healthcare providers. Most recently, the FTC and DoJ issued a joint policy statement explaining how those agencies would apply existing antitrust laws to accountable care organizations.

The proposed exemption will likely increase healthcare costs. The exemption is designed to allow coordinated activities among pharmacies that both basic economic theory and experience indicate will result in higher prices faced by health plans. Economic theory unequivocally predicts that at least in some of the collective negotiations exempted will raise costs that will in turn be passed on in the form of higher prices paid by consumers.

One obvious implication of the antitrust exemption will be higher reimbursements. One recent study, for example, estimates the increased healthcare costs ranging from \$9 to \$29 billion over a 5-year period. Would such an exemption provide any offsetting benefits for consumers? The answer provided by existing law and economic analysis, I believe, is no. The most critical point is that the current Federal law permits collective activity by pharmacies and other healthcare providers to the extent that it is pro-competitive and benefits consumers.

Thank you.

[The prepared statement of Mr. Wright follows:]

Written Testimony of

Joshua D. Wright
George Mason University School of Law

Before the
United States House of Representatives
Committee on the Judiciary
Subcommittee on Intellectual Property, Competition and the Internet

Hearing on
“H.R. 1946, the Preserving Our Hometown Independent
Pharmacies Act of 2011”

March 29, 2012

Contact information:
jwright@gmu.edu

Mr. Chairman and Members of the Subcommittee – thank you for the opportunity to testify before you today. My name is Joshua D. Wright. I am a Professor of Law at the George Mason University School of Law. I also hold a courtesy appointment in the Department of Economics. I received a J.D. from UCLA in 2002 and a Ph.D. in economics in 2003. I was the inaugural Scholar-in-Residence at the Federal Trade Commission from 2007 to 2008 and have also served as a consultant to the Federal Trade Commission on a number of issues. My research focuses upon antitrust law and analyzing the competitive effects of regulation in a variety of industries, including health care. I represent myself solely at this hearing and I have received no financial support for this testimony.

I am here today to discuss H.R. 1946, a proposed exemption from the antitrust laws that would allow independent pharmacies to collectively negotiate with health plans on pricing provisions and other contract terms. It is my view that the proposed legislation is likely to harm consumers and should be opposed on those grounds. Local pharmacists striving to provide quality care for patients undoubtedly face significant economic pressures from both changes in the health care market and vigorous competition. While identifying ways to reduce costs in complex and dynamic health care markets is a critical policy objective, an antitrust exemption for independent pharmacies is likely to undermine that goal.

I. ANTI-TRUST EXEMPTIONS ARE DISFAVORED

The purpose of H.R. 1946 is to ensure safety, quality care, and a competitive marketplace. The overarching goal of the antitrust laws is to foster competition and thereby maximize consumer welfare.¹ This goal is rarely, if ever, served by antitrust exemptions; indeed, the consensus view is that such exemptions are much more likely to reduce consumer welfare than to enhance it. The Antitrust Modernization Commission has explained, “A proposed exemption should be recognized as a decision to sacrifice competition and consumer welfare”² It is widely recognized that antitrust exemptions benefit small, concentrated interest groups while imposing costs broadly upon consumers at large.³ These costs generally take the form of “higher prices, reduced output, lower quality, and reduced innovation.”⁴

¹ See *NCAA v. Bd. of Regents*, 468 U.S. 85, 107 (1984) (“Congress designed the Sherman Act as a consumer welfare prescription.” (quoting *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979))).

² ANTI-TRUST MODERNIZATION COMM’N, REPORT AND RECOMMENDATIONS 350 (2007), available at http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf; see also Letter from Antitrust Section, Am. Bar Ass’n, to Antitrust Modernization Comm’n 2 (Nov. 30, 2005) [hereinafter Letter from ABA to AMC], available at http://govinfo.library.unt.edu/amc/public_studies_fr28902/immunities_exemptions_pdf/061024_ABA-Shipping-Act.pdf (“Whether justified or not, broad exemptions and immunities from antitrust laws are harmful to consumer welfare almost by their very definition.”). The American Antitrust Institute has also weighed in on the competitive effects of antitrust exemptions, finding they “may be not only unnecessary but harmful to competition and the values that it serves.” Letter from Working Grp. on Immunities & Exemptions, Am. Antitrust Inst., to Antitrust Modernization Comm’n 2 (July 15, 2005) [hereinafter Letter from AAI to AMC], available at <http://www.antitrustinstitute.org/files/433.pdf>.

³ See *The Community Pharmacy Fairness Act of 2007: Hearing on H.R. 971 Before the Antitrust Task Force of the H. Comm. on the Judiciary*, 110th Cong. 3 2007 (statement of David Wales, Deputy Dir., Fed. Trade Comm’n); ANTI-TRUST MODERNIZATION COMM’N, *supra* note 2, at 335; Letter from AAI to AMC, *supra* note 2, at 4; Letter from ABA to AMC, *supra* note 2, at 4.

⁴ ANTI-TRUST MODERNIZATION COMM’N, *supra* note 2, at 335.

Because antitrust exemptions are likely to harm competition and reduce consumer welfare in order to provide benefits to these small, concentrated interest groups, they are disfavored. The Antitrust Modernization Committee, echoing this sentiment, concluded that exemptions should “rarely” be granted and only when proponents have successfully demonstrated that permitting unlawful and anticompetitive conduct is “necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy in general.”⁵ In other words, the burden of justifying the social value of an antitrust exemption lies with the party seeking its protection.⁶ This burden should not be taken lightly; the Sherman Act has been described as “the Magna Carta of free enterprise”⁷ precisely because it was designed to enhance economic liberties promoted by competition.⁸

The danger of antitrust exemptions to consumers is particularly acute when they permit coordination among rivals. Such exemptions are likely to stifle competition by reducing the incentive for competitors to innovate to attract customers. Therefore,

⁵ ANTITRUST MODERNIZATION COMM’N, *supra* note 2, at 335.

⁶ *Id.* at 354 (“Congress should require proponents of an immunity to submit evidence demonstrating that the benefits of competition are less important than the societal value promoted by the immunity under consideration, and that the proposed immunity is the least restrictive means to achieve that value. . . . The burden of justifying any immunity should fall on the proponents of that immunity because they are in an inherently unique position to provide that information as to the relative merits of the immunity.” (internal quotation marks omitted)).

⁷ *United States v. Topco Assoc.*, 405 U.S. 596, 610 (1972) (“Antitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise.”).

⁸ *See also* *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 4 (1956) (“The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade.”); *United States v. Socony Vacuum Oil Co.*, 310 U.S. 150, 221 (1940) (characterizing Sherman Act as a “charter of freedom”); *Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 359 (1933) (same).

claims that an exemption is necessary to protect competition are insufficient to satisfy the burden of proving its necessity.⁹ Similarly, because competition enhances incentives to reduce cost and increase quality, antitrust exemptions are rarely appropriate means to achieve those ends.¹⁰

Antitrust exemptions not only pose a risk to consumers, they also are generally unnecessary to achieve legitimate, procompetitive ends. The antitrust laws permit cooperation achieving procompetitive objectives, rendering an exemption for such activities unnecessary. The increased incorporation of economic thinking into antitrust analysis has endowed the antitrust laws with sufficient flexibility to permit such procompetitive collaboration while condemning horizontal arrangements likely to reduce competition.¹¹ Exemptions are simply unnecessary, as a matter of antitrust law, to protect parties from procompetitive coordination.¹²

⁹ Letter from ABA to AMC, *supra* note 2, at 3.

¹⁰ See Timothy J. Muris, Chairman, Fed. Trade Comm'n, Looking Forward: The Federal Trade Commission and the Future Development of U.S. Competition Policy 4 (Dec. 10, 2002) ("Proponents [of antitrust exemptions] often claim to justify [their] proposals by considerations that, supposedly, cannot be addressed by the market—e.g., 'quality of care' issues in the case of antitrust immunity for doctors. Such claims usually cannot withstand scrutiny."), available at http://www.law.gmu.edu/assets/files/publications/working_papers/04-21.pdf; see also *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 695-96 (rejecting a proffered defense that coordination was necessary to preserve the quality of large-scale engineering projects affecting the public safety).

¹¹ *Health Care Cost Containment Act of 1984: Hearing on S. 2051 Before the S. Comm. on the Judiciary*, 98th Cong. 3 (1984) (statement of Timothy J. Muris, Dir., Bureau of Competition, Fed. Trade Comm'n).

¹² For example, one recent study of antitrust exemptions in the transportation industries found that "[t]he great bulk of agreements and combinations that benefit from antitrust immunity have no absolute need for such an entitlement. . . . [A] majority of the joint venture agreements seem[ed] to present little risk of any antitrust liability." Peter C. Carstensen, *Replacing Antitrust Exemptions for Transportation Industries: The Potential for a "Robust Business Review Clearance"*, 89 OR. L. REV. 1059, 1095-96 (2011).

Antitrust exemptions are equally unnecessary in the health care context. There, the antitrust agencies have actively provided guidance to pharmacies and other health care providers distinguishing lawful from unlawful conduct under antitrust laws. The Federal Trade Commission (FTC) issues advisory opinions to market participants seeking to compete more aggressively by means of limited coordination. The agency has advised many of those market participants that it would not challenge their coordinated efforts. For example, in 2009, TriState Health Partners, Inc., a physician-hospital organization, sought the agency's advice on its proposed joint venture.¹³ The joint venture involved clinical integration of its members and creation of a program to provide medical and other health care services to those covered under certain health benefits programs in TriState's service area.¹⁴ The FTC determined the program was likely to result in significant efficiencies in the provision of health care services and advised TriState that it would not recommend that the Commission challenge the described program.¹⁵ The FTC similarly advised a physicians' association in 2007 that it would not challenge an agreement for the association to "negotiate contracts, including price terms, with payers on behalf of its physician members."¹⁶ The FTC's extensive

¹³ See Letter from Health Care Div., Bureau of Competition, Fed. Trade Comm'n, to Christi J. Braun, Esq. (Apr. 13, 2009) [hereinafter TriState Letter], available at <http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf>.

¹⁴ *Id.* at 7.

¹⁵ *Id.* at 1.

¹⁶ Letter from Health Care Div., Bureau of Competition, Fed. Trade Comm'n, to Christi J. Braun, Esq., & John J. Miles, Esq. (Sept. 17, 2007) [hereinafter GRIPA Letter], available at <http://www.ftc.gov/bc/adops/gripa.pdf>.

experience assessing competition in the health care industry permits it to evaluate proposed coordinated efforts and advise industry participants on the competitive merits of their proposals, thus eliminating the necessity for a broad exemption from the antitrust laws for such conduct. The Antitrust Division also actively – and in concert with the FTC – provides similar guidance to health care providers. Most recently, the FTC and DOJ issued a policy statement explaining how the agencies will apply the antitrust laws to Accountable Care Organizations.¹⁷

II. THE PROPOSED EXEMPTION: H.R. 1946

The stated purpose of the Preserving Our Hometown Independent Pharmacies Act of 2011 (the Act) is “[t]o ensure and foster continued safety and quality of care and a competitive marketplace by exempting independent pharmacies from the antitrust laws” when they negotiate with health plans and health insurers. It applies only to independent pharmacies, which the Act defines as pharmacies with a market share of less than 10 percent in any prescription drug plan (PDP) region (as defined by the Social Security Act) and less than 1 percent in the United States.

The exemption would permit independent pharmacies to collectively negotiate with health plans concerning payment rates. It would operate by requiring that independent pharmacies be “treated under the antitrust laws as employees engaged in concerted activities rather than as employers, independent contractors, managerial

¹⁷ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011).

employees, or supervisor.” The Act limits the exemption two ways. The scope of the exemption is limited to price fixing and does not apply to boycotts, market allocation, unlawful tying arrangements, or monopolization. The exemption also limits the permissible market share for an organization of independent pharmacies at 25 percent share of a given PDP (measured by pharmacy licenses).

III. THE LIKELY EFFECTS OF H.R. 1946

The proposed exemption will likely increase healthcare costs. The exemption is designed to allow coordinated activities among pharmacies that both basic economic theory and experience indicate will likely result in higher prices faced by health plans.¹⁸ H.R. 1946 states that one of its objectives is to foster “a competitive marketplace by exempting independent pharmacies from the antitrust laws.” That purpose ultimately cannot be reconciled with the fact that H.R. 1946 ultimately exempts unambiguously anticompetitive conduct from antitrust scrutiny.

Economic theory unequivocally predicts at least some of the collective negotiations exempted will raise costs that will, in turn, be passed on in the form of higher prices paid by consumers. For example, one obvious implication of the antitrust

¹⁸ The Federal Trade Commission has successfully challenged collective negotiations by health care professionals who have successfully imposed significant price increases. *See, e.g.*, *Advocate Health Care Partners et al.*, No. C-4184, 2007 WL 643035 (F.T.C. Feb. 27, 2007) (consent order); *Health Care Alliance of Laredo*, No. C-4158, 2006 WL 848593 (F.T.C. Mar. 23, 2006) (consent order); *Asociacion de Farmacias Region de Arecibo*, 127 F.T.C. 266 (1999) (consent order).

exemption is higher reimbursements.¹⁹ One recent study estimates the increase health care costs associated with higher reimbursements will range from \$9.2 billion to \$29.6 billion over five years after implementation of an exemption.²⁰ Further, to the extent the exemption interferes with negotiations between pharmacies and pharmacy benefit managers (PBMs), one can expect further increases in costs. There is substantial empirical evidence that PBMs – who enter contracts with plan sponsors such as health insurers, unions, or self-insured employers – significantly reduce costs. For example, PBMs use of selective contracting has been demonstrated to significantly reduce costs.²¹

As discussed, the dangers that antitrust exemptions pose to competition and consumer welfare are well-recognized.²² There is no serious debate that an exemption such as H.R. 1946 will result in a greater incidence of anticompetitive conduct. Would such an exemption provide any offsetting benefits for consumers? The answer provided by existing antitrust law and economic analysis is “no.” The most critical point is that current federal antitrust law already permits collective activity by pharmacies and other health care providers that benefits consumers. The antitrust

¹⁹ See *Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 Before the H. Comm. of the Judiciary*, 106th Cong. (June 22, 1999) (statement of Robert Pitofsky, Chairman, Fed. Trade Comm’n); Peter J. Rankin et al., *The Cost of Independent Pharmacy Antitrust Exemptions* (May 2007), available at http://heartland.org/sites/all/modules/custom/heartland_migration/files/pdfs/22537.pdf.

²⁰ See *id.* at 21.

²¹ See Christine Piette Durrance, *The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures*, 37 ATLANTIC ECON. J. 409 (2009); Kenneth G. Elzinga & David E. Mills, *The Distribution and Pricing of Prescription Drugs*, 4 INT’L J. ECON. BUS. 287 (1997) (explaining the competition-enhancing effects of exclusive provision of prescription drugs); Michael G. Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of “Any Willing Provider” Regulations*, 20 J. HEALTH ECON. 955 (2001).

²² See *supra* Part I.

agencies have consistently provided guidance indicating agreements reducing costs or increasing the quality of health care provided to patients are lawful.²³ Indeed, pharmacies take advantage of many of these opportunities. For example, independent pharmacies employ Pharmacy Service Administrative Organizations (PSAOs), which represent collections of pharmacies in order to take advantage of economies of scale and negotiate with PBMs. To the extent the exemption makes available easier but less consumer-friendly means of coordinated action, pharmacies' incentives to enter into beneficial forms of cooperation will be reduced.

Proponents of the exemption undoubtedly seek to facilitate cost reduction by giving independent pharmacies greater leverage in negotiations with health care providers. This approach is misguided for a number of reasons. As discussed, pharmacies can coordinate for procompetitive purposes without running afoul of the antitrust laws. Further, the much more likely competitive outcome is to dampen the incentives of those providers to encourage providers to reduce the costs of their services. The antitrust laws stand on the proposition that competition – not cartel or

²³ See, e.g., Letter from Richard A. Feinstein, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to Paul E. Levenson (July 27, 2000) (network of independent pharmacies in Massachusetts and Connecticut offering package of medication-related patient care services to physician groups), *available at* <http://www.ftc.gov/bc/adops/neletfi5.htm>; Letter from Richard A. Feinstein, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to John A. Cronin (May 19, 1999) (network of retail pharmacies and pharmacists offering drug product distribution and disease management services), *available at* <http://www.ftc.gov/bc/adops/openadop.htm>; GRIPA Letter, *supra* note 16; TriState Letter, *supra* note 13; Letter from Michael D. McNeely, Assistant Dir., Health Care Div., Fed. Trade Comm'n, to Allen Nichol (Aug. 12, 1997) (pharmacist network offering health education and monitoring services to diabetes and asthma patients), *available at* <http://www.ftc.gov/os/1997/08/newjerad.htm>.

monopoly – is the superior method of achieving H.R. 1946’s goals of quality care and a competitive marketplace.

IV. CONCLUSION

The high costs of health care are a serious concern. Identifying new and effective methods of reducing those costs is among the most important priorities facing the country. Antitrust enforcement in the health care sector continues to play an important role in this marketplace. Granting certain pharmacies a right to engage in anticompetitive price-fixing in the name of extracting greater payments from third-party payers would result in greater costs, less competition, and reduced consumer welfare.

Mr. GOODLATTE. Thank you, Professor Wright. We have enough time, I think, for one more witness to get their testimony in before we have to recess to vote. And so we will now recognize Mr. Gray.

**TESTIMONY OF RENARDO GRAY, OWNER AND PHARMACIST,
WESTSIDE PHARMACY OF DETROIT, INC.**

Mr. GRAY. Thank you.

Chairman Goodlatte, Ranking Member Watt, Mr. John Conyers, we thank you for the opportunity to come represent my views and the views of pharmacists across the United States, we who serve the patients among the most vulnerable in the country. I have been serving my patients for 27 years. I have had to compete with the chains, deal with the healthcare plans. You have CVS as a chain, and you have CVS Caremark, which is a PBM and they have a mail-order outlet. Then you have CVS Caremark Medicare Part D Plan, which is a plan that gets money from the government that then pays everybody else. In a fair market, you would think that CVS Caremark Drug Plan would pay CVS, their stores, you would see them pay their mail-order, and you would see them pay me all the fair price.

I don't get a fee for filling certain prescriptions. If it is a brand-name drug, I get no fee. Just the cost of the medication. Since it is a take-it-or-leave-it contract, I can't even complain. I have to take it or leave it. This bill would allow us to be able to go back and say, "Wait a minute. We need to be treated fairly. We need to have an opportunity, if you pay yourself a fee, you pay the other part of your company a fee, why can't we get a fee?" They will come to us and say they overpaid us and take money back from us, but they don't do anything to address the fact they never paid us a fee in the first place.

We come to the Committee, because we need assistance in getting this bill passed so we can at least compete. We can't even go and complain. It is either you take it or you leave it. There is nothing there.

When the customers, who should be represented here, Medicare Part D is to provide drug care for Medicare D members. The members come to us when the chains or the mail-orders don't get them their prescriptions. They come back to us. We are not paid to handle the service, but we have to make sure that they get the care that they need. If you eliminate us, who is going to be there to buffer or to represent them? It is about their needs. We need this bill to be able to compete. There is not going to be any increase in money. The money is already set. All they have to do is pay us the part that we are supposed to get. If we are allowed to at least compete fairly, there is no problem. But, we at least need a fair chance.

Take the example of a henhouse. If you take a fox, you try to keep the fox out of the henhouse. In this case, we have given the fox charge of the henhouse. He can suck the eggs. He can eat some of the chickens. But, now you tell him you have to share with somebody else. Is he going to do it fairly? He is a fox. But, it has been that way for far too long. It is time now to come back and address the issues. It is about getting the right medicine, at the right time, to the right patient.

Just the other day, a gentleman came to me. He is 83 years old. I have to advocate for him. He is on a medication for Alzheimer's. While he is remembering to take his medication, he comes to me and says, "I have no medicine." So, I go on the computer and find out his prescription was filled by his mail-order plan and mailed

out on the 6th of March. It is the 26th of March. He has no medicine. I called the plan. They say, "Well, we have to call the mail-order side to find out what happened." This man needs medicine while he can remember to take it. He needs his medication.

If you move us from the thing, he would not have any medication. I made sure he had his medication. And I do this on a daily basis. I am not paid to do this, but I cannot let these people, who are "Customers," these are friends and family.

I have had the unique opportunity to perform a wedding in my pharmacy. And when patients die, they sometimes call on me to come and preach the funeral. These are the things we have to do that we are not paid to do. But, the other companies receive the money, and we ask them to give us a fair share that we can compete. How do we compete with somebody when they hold the whole purse, and they can tell us what they will give us? They set a price. We have to take it or leave it. There are no options here. If they underpay us, what do we do? What are we supposed to do?

We come here, looking for redress. We need a methodology to compete, a methodology to go to them and say, "Make it fair." We are there to take care of the patients, and we do this on a daily basis. Without us, there is going to be problems. Because if a patient doesn't get medication, they are going to end up, number one, either in the hospital, in a rehab facility, if they have a stroke, in a nursing home, if they can't go beyond that, or a funeral home. If you take us out of the equation, it is a big problem.

We need this bill passed for this exemption so that we can compete. All we ask for is a fair chance, an opportunity. We are not here asking for more money. We are asking for an opportunity to do what we are supposed to do. We go to them, and they have to pay us fairly.

Right now, they ignore us, because they have the thing. They don't have to talk to us. No PBM has to come and say, "Well, you asked for more money, we can give it to you. We don't have to." They have no desire to talk to us, not even to come to us.

When the patients need service, and mail-order doesn't arrive, what do they do? They have to go the local pharmacist. And we have been there. We have been bearing the brunt of this for now almost 10 years. This program started 2003. It fell on us. All we can do is keep doing it. We have come before and tried to get it addressed, and the ball got dropped. We are here again. We have to get this done.

As healthcare reform goes forth, they need us in the middle to take care of this. We haven't got paid for it so far, but we deserve to be paid for it. A workman is worthy of his hire. If nothing else, we should be allowed to have this bill passed. So, we ask you to consider it and pass it for us.

[The prepared statement of Mr. Gray follows:]

**Prepared Statement of Renardo Gray, Owner and Pharmacist,
Westside Pharmacy of Detroit, Inc., Detroit, MI**

Chairman Goodlatte, ranking member Watt and members of the Subcommittee, thank you for the opportunity to present my views and the views of pharmacists across this country, who serve patients who are among the most vulnerable in this country. I am Renardo Gray, pharmacist and owner of Westside Pharmacy in Detroit, Michigan. In 1979, I graduated from the University Of Michigan College Of

Pharmacy and became a registered pharmacist. In 1985, I realized the American Dream by opening my own independent pharmacy which I still own and from which I have the privilege of serving my patients today.

Unfortunately, successful and well-run local community pharmacies are being forced out of business by the unfair business practices of major Pharmacy Benefits Managers (PBMs) and Medicare Part D Plans. The congressionally-sanctioned PBM-rigged market for prescription drugs must be made more competitive if my small business and thousands of others like it across the nation are to survive.

I would like to commend you for convening this important hearing. As someone who strongly supports parity and justice in medicine and the elimination of disparities in healthcare, I support HR 1946, the Preserving Our Hometown Independent Pharmacies Act of 2011 which was introduced by Congressman Tom Marino (R-PA) and has the support of many members of this Committee including my Congressman, The Honorable John Conyers (D-MI).

Independent pharmacies are often in under-served inner city and rural markets. The local pharmacist is typically the most accessible health care professional in the community. No patient prefers dealing with a pharmacist at a faraway telecenter rather than dealing with the trusted local pharmacist in their community.

Without the backing of a large corporation, my small business and all small independent community pharmacies in today's marketplace have become easy prey for large-corporate Pharmacy Benefit Managers (PBMs) whose primary motivation is to turn a profit in order to impress their board of directors every quarter. That, and the fact that Congress has expanded the market for PBMs through the creation of Medicare Part D, is why their profits have skyrocketed over the past five years. PBMs have been found guilty of switching patients to more expensive and sometimes less safe drugs in order to secure higher rebates. PBMs often manipulate reimbursement policies in order to deny patients access to the drugs they deserve. Independent pharmacies such as Westside Pharmacy spend hours helping patients deal with all of these PBM schemes, making sure they are taking the appropriate drug, helping patients deal with complicated reimbursement issues and assuring the patient is able to get the right drug. Independent pharmacists spend countless hours helping our patients who have become our friends and extended family when problems arise with their mail-order prescriptions. We are not reimbursed for these services. We will not allow our patients (friends and extended family members) to go without the medications.

If we are forced out who will be there the help the patients in their time of need? PBMs coerce patients to use their mail order or limit their access to pharmacies that they own or control. PBMs often force patients to pay full price if they try to use their local independent pharmacy. Patients should and must have the right to choose their pharmacy provider.

The last time the House Judiciary Committee held a hearing on this issue, the PBM market was more competitive with three or four significant competitors. Since 2007, there have been several PBM acquisitions including Express Scripts' acquisition of Wellpoint, CVS' acquisition of Caremark and the proposed Express Scripts' acquisition of Medco. Both the ESI/Wellpoint and CVS/Caremark deals were cleared by the FTC without an extensive investigation. It appears that the FTC is poised to approve the Express Scripts acquisition of Medco which will create a PBM monopoly with over 150 million covered lives that will process over 40% of all prescriptions. Approving this merger would be a big mistake and enable Express Scripts to harm patients by denying access, reducing service and reducing reimbursement rates. But Congress, praise God, has the power to fix this problem and make sure high-quality pharmacy care will continue well into the future by passing HR 1946.

I as an independent pharmacist feel like David going up against Goliath and his brothers at one time. Thank God for this hearing. We need your help. This legislation will allow a limited number of non-publicly traded independent (family owned) pharmacies to work together to negotiate fair, reasonable fees and many other non-payment terms in their contracts with the PBMs. Since local, independent, hometown pharmacies are the only pharmacy entities that are prevented under the anti-trust laws from full participation in the pharmacy market, passage would restore an equal playing field for every drug store in your communities. Our survival is critical to maximizing patient access to affordable healthcare and to the ability of patients to buy their medicines and receive sometimes critical one-on-one advice from the professionally trained and locally-licensed pharmacists.

Independent pharmacists are one of the most trusted professionals in this country and are the only healthcare providers who provide free and trusted care. Pharmacists pride themselves on being able to serve their patients and communities with the highest service. You simply cannot receive that kind of treatment and patient care from a mail-order, automated telephone service.

Without the ability to truly negotiate with the PBMs from a position of parity, independent pharmacies that are otherwise able to compete on price and service will be driven to extinction. This would be acceptable if our demise was a matter of the free market coming to the determination that independent pharmacies add too little value, or that independent pharmacies simply cannot operate as efficiently or effectively as PBMs or other pharmacy innovators. In fact, these factors have nothing to do with why my pharmacy and every pharmacy in your congressional districts require your immediate action.

In this down economy, we hear a lot of talk from Washington, DC about how important it is to create the right environment for small businesses to thrive, and how important it is that we create more small business employment opportunities. There is nothing harder for a small business owner than to terminate an employee. Small independent pharmacy jobs are local jobs, jobs that, in my case, are either lost or created in Detroit. Thanks to “take-it-or-leave-it” PBM contracts, below-cost PBM reimbursement, PBM patient steering and the constant drum-beat of PBMs moving my patients out of my store and into their own PBM mail-order warehouse, I know that it will be extremely difficult to continue to provide local jobs and provide the finest care available to my patients.

I have spent years competing successfully against the PBMs. What has changed is that PBMs are using their massive market power to impose distorted market conditions on my small business: and no one in Washington—not the FTC, not the Justice Department, not Congress—is paying attention!

This country will never be able to replace the value of face-to-face patient counseling that community pharmacists provide on a daily basis to all of their patients. And there will never be the same level of high-quality personal care provided by mail-order companies run by PBMs.

Mr. Chairman, this legislation is the cornerstone for the future of healthcare reform because without the independent pharmacy network, high quality healthcare will be compromised. I ask you and this committee to pass HR 1946 as soon as possible.

Thank you for this opportunity.

Mr. GOODLATTE. Thank you, Mr. Gray. There is approximately 4 minutes remaining in the vote on the Floor.

When we return from the vote—and I ask Members to return promptly, so we can resume and give Mr. Feinstein the floor.

[Recess.]

Mr. GOODLATTE. The Subcommittee will reconvene, and at this time it is my pleasure to recognize Mr. Feinstein.

**TESTIMONY OF RICHARD FEINSTEIN, DIRECTOR OF THE
BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION**

Mr. FEINSTEIN. Thank you, Chairman Goodlatte, and Members of the Subcommittee. I am Richard Feinstein, Director of the Bureau of Competition at the FTC.

Mr. GOODLATTE. Yes. Just pull it closer to you.

Mr. FEINSTEIN. Okay. Sorry. Is that better? All I had gotten through was my name, so I will just continue.

I appreciate the opportunity to testify today regarding H.R. 1946, a bill to grant antitrust immunity to independent pharmacies.

The written statement submitted for this hearing constitutes the view of the Federal Trade Commission. My statement and my answers to any questions represent my own views.

As you know well, healthcare markets continue to change and rapidly. Many small providers, such as independent pharmacists and solo practitioners are struggling to adapt to these changes. As we have seen in other industries, the transition to new business models is not easy. While I am quite sympathetic to the economic challenges faced by independent pharmacies as a result of these

changes, the escalating costs of healthcare products and services demand attention as well.

Competition among healthcare providers is a vital tool to keep costs in check and provide incentives to improve the quality of care, both of which benefit consumers. That is why the FTC devotes significant resources to protect competition and healthcare markets.

Under current law, pharmacies do not need an antitrust exemption in order to provide patients with lower-cost drugs or better service. The antitrust laws already permit pharmacies to work together in ways that benefit patients. For instance, pharmacies can and do take advantage of joint buying programs to obtain volume discounts. They can and do collaborate with one another to provide new products or services to consumers, such as monitoring or education for patients with chronic illnesses.

In short, the antitrust exemption contained in H.R. 1946 would result in higher prices for prescription drugs. The FTC's experience with boycotts among pharmacies demonstrates that collective fee demands can raise fees substantially. The impact of those higher drug costs will be felt by many, by employers and employees in higher healthcare premiums and co-pays, by State and local governments, both in drug benefits for their employees, and in public assistance programs, and by consumers who pay out-of-pocket for some or all of their drug costs. And even with carve-outs for Federal programs, the conduct permitted by this bill will raise direct costs to the Federal Government.

Moreover, once a group of competitors is allowed to band together to collectively demand higher fees, it will be hard to prevent those negotiations from having a much broader impact than intended. After independent pharmacies share competitively sensitive information and come to agreements while negotiating with private drug benefit plans, they will have information they could use to more easily coordinate their prices and competitive behavior outside the scope of the authorized collective action. This spillover effect could further reduce competition among the pharmacies.

Some say that a law to permit price fixing and boycotts is needed so that independent pharmacies can stay in business, that an antitrust exemption will help them cover their costs and continue to provide needed high-quality services to patients, particularly in areas with few options for obtaining prescription drugs. But, an antitrust exemption will not solve these problems. It does not directly address underserved markets or ensure that independent pharmacies will cover their costs. It also does not ensure the survival of independent pharmacies or adequate services in remote or underserved areas of the country. It merely promises that some pharmacies can bargain together to demand higher fees and refuse to deal with health plans that do not accept the group's demands.

In sum, the conduct authorized by this bill will raise healthcare costs and those higher costs will be imposed on others, some of whom are also struggling to make ends meet. For these reasons, I very respectfully submit that H.R. 1946 would not further its intended purposes of promoting quality of care in a more competitive marketplace.

Thank you for the opportunity to share my views on these important issues.

[The prepared statement of Mr. Feinstein follows:]

**Prepared Statement of Richard Feinstein, Director, Bureau of Competition,
Federal Trade Commission**

**Prepared Statement of
the Federal Trade Commission**

**Before the
United States House of Representatives
Committee on the Judiciary
Subcommittee on Intellectual Property, Competition, and the Internet**

**Concerning
H.R. 1946
“Preserving Our Hometown Independent Pharmacies Act of 2011”**

**Washington, D.C.
March 29, 2012**

Introduction

Chairman Goodlatte, Ranking Member Watt, and Members of the Subcommittee, thank you for the opportunity to appear before you today. I am Richard Feinstein, Director of the Bureau of Competition of the Federal Trade Commission, and I appreciate the opportunity to present the Commission's views on H.R. 1946, "Preserving Our Hometown Independent Pharmacies Act of 2011."¹ This bill would create an exemption from the antitrust laws to allow pharmacies to engage in collective bargaining to secure higher fees and more favorable contract terms from health plans.

The Commission is mindful of the challenges and economic pressures faced by local independent pharmacies that serve the needs of patients in their communities, and understands that the bill's proponents are concerned with the quality of patient care. Although the Commission is sympathetic to the difficulties community pharmacies face, the proposed exemption threatens to raise prices to consumers for much-needed medicine, which would have an especially dire impact on seniors. It also threatens to increase costs to employers who provide health care insurance to employees and retirees, which may cause those employers to reduce or eliminate benefits. And there is no assurance that the proposed exemption would produce any offsetting higher quality care. For these reasons, the Commission opposes the legislation.

At various times since the advent of active antitrust enforcement in health care in the 1970s, health care providers have sought antitrust exemptions. The Commission has provided testimony on several such proposals, which would have insulated health care professionals and organizations, including independent pharmacies, from the competitive forces that we count on to help us rein in health care costs and provide incentives to improve the quality of health care

¹ The written statement represents the views of the Federal Trade Commission. My oral presentation and responses to questions are my own and do not necessarily reflect the views of the Commission or of any Commissioner.

throughout the system.² Although these bills have differed in their scope or details, they all have sought some form of antitrust immunity for anticompetitive conduct that would tend to raise the prices, and reduce the availability, of health care products or services. Recognizing that many American consumers already face difficult health care choices in the market, Congress wisely has declined to adopt such exemption proposals.

In 2007, the Antitrust Modernization Commission (AMC)—the bipartisan private body created by Congress to evaluate the application of our nation’s antitrust laws—urged Congress to exercise caution with respect to the creation of exemptions from those laws. The AMC noted that antitrust exemptions typically “create economic benefits that flow to small, concentrated interest groups, while the costs of the exemptions are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation.”³ The Commission agrees with the AMC recommendation that statutory immunities be granted rarely and only where proponents have made a clear case that exempting otherwise unlawful conduct is “necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy in general.”⁴

H.R. 1946 Would Result in Higher Health Care Costs

The Commission’s analysis of H.R. 1946 is informed by a broad range of law enforcement activity, research, and regulatory analysis that it has undertaken as part of its

² See, e.g., Prepared Statement of the Fed. Trade Comm’n Before the H. Comm. on the Judiciary, Subcomm. On Courts and Competition Policy, On “Antitrust Enforcement in the Health Care Industry,” Dec. 1, 2010; Prepared Statement of the Fed. Trade Comm’n Before the Subcomm. On Consumer Protection, Product Safety, and Insurance, Comm. on Commerce, Science & Transportation, On “The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care,” July 16, 2009 (all testimonies available at <http://www.ftc.gov/ocr/testimony/index.shtml>).

³ ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS (April 2007) at 335, available at http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

⁴ *Id.*

mission to protect competition and consumers in the pharmaceutical sector as well as in most other sectors of the economy. The FTC has conducted numerous law enforcement investigations, some resulting in challenges, involving drug manufacturers,⁵ wholesalers, and retailers.⁶ In addition, Commission staff has done empirical studies and economic analyses of the pharmaceutical industry,⁷ and, jointly with Department of Justice, the Commission examined competition in the pharmaceutical sector among other health care sectors in public hearings in 2003 and an ensuing report in 2004. Commission staff has also analyzed competitive issues raised by a wide variety of proposed state and federal regulations affecting the industry including the likely effects of antitrust exemptions for collective negotiations by health care providers.⁸

The collective negotiations authorized by H.R. 1946 can be expected to result in health plans paying more to pharmacies. In prior law enforcement actions involving collective negotiations by competing pharmacies, the Commission found that the pharmacies sought, and ultimately obtained, higher rates.⁹ H.R. 1946 would permit privately-held pharmacies to engage

⁵ For FTC enforcement actions involving pharmaceutical manufacturers, see the Bureau of Competition's Competition Enforcement database at <http://www.ftc.gov/bc/caselist/industry/cases/healthcare/HealthCarePrescriptions.pdf>.

⁶ For FTC enforcement actions involving drug wholesalers and retail pharmacies, see the Bureau of Competition's Competition Enforcement database at <http://www.ftc.gov/bc/caselist/industry/cases/healthcare/HealthCareRetail.pdf>.

⁷ See, e.g., FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (Jun. 2009); FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005); FED. TRADE COMM'N AND DEPT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (Jul. 2004) (all reports available at: <http://www.ftc.gov/reports/index.shtml>).

⁸ See, e.g., FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011); FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009); FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008); FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008) (all advocacies available at: <http://www.ftc.gov/opp/advocacydate.shtml>).

⁹ For example, an association of approximately 125 pharmacies in northern Puerto Rico demanded a 22 percent increase in fees and threatened that its members would collectively refuse to participate in Puerto Rico's indigent care program unless its demands were met, thereby succeeding in securing the higher prices it sought. *Asociacion*

in price-fixing and boycotts to raise fees,¹⁰ without fear of antitrust challenge. If this bill were enacted, some groups of pharmacies likely would seek higher fees in their negotiations with health plans. Absent a sufficient number of alternative pharmacies acceptable to the health plan and its consumer members, a health plan would have no choice but to accede to such fee demands, or it would not have a marketable pharmacy network to offer. This will likely undermine the plans' ability to control drug costs, which could ultimately lead to higher premiums, or changes in coverage such as increased deductibles or higher co-pays, to offset their higher costs.

Higher payments to independent pharmacies would likely increase health care costs for consumers, employers (both public and private), and government benefit programs. It appears that H.R. 1946 seeks to protect the federal government from higher costs, by providing that the antitrust immunity conferred by the bill would not extend to negotiations pertaining to benefits provided under Medicare and various other federal programs. But despite this exclusion, the federal government could still bear significant additional costs from the anticompetitive conduct that the bill would allow. That is because the agreements and sharing of competitively sensitive information the bill would permit in the context of negotiations relating to private drug benefit plans would provide independent pharmacies with information they could use to more easily coordinate their prices and other competitive behavior with respect to federal programs— even

de Farmacias Region de Arecibo, 127 F.T.C. 266 (1999) (consent order). See also *Institutional Pharmacy Network*, 126 F.T.C. 138 (1998) (consent order; conduct targeted state Medicaid program). For other price fixing and boycotts actions involving pharmacies, see FTC Bureau of Competition, Overview of FTC Antitrust Actions in Pharmaceutical Services and Products, 19 – 24, available at <http://www.ftc.gov/bc/healthcare/antitrust/rxupdate.pdf>.

¹⁰ Section 2(e), entitled “Limitations on Exemption,” states that the bill would not immunize any “agreement or otherwise unlawful conspiracy that . . . (1) would have the effect of boycotting any independent pharmacy or group of independent pharmacies, or would exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by, any independent pharmacy or group of pharmacies with respect to the performance of services that are within their scope of practice as defined or permitted by relevant law or regulation.” While it is unclear exactly what this provision is intended to carve out, it does not appear to limit pharmacies’ immunity for boycotts of purchasers or payers in order to force price concessions.

without an actual agreement that could create antitrust liability. Thus, there is reason to expect that the bill would lead to higher spending for Medicare and other federal programs. In 2007, the Congressional Budget Office evaluated a previous bill to immunize collective bargaining by pharmacists and concluded that, despite a carve-out of certain federal programs (not including Medicare), the bill would increase direct federal spending for these programs.¹¹

State and local governments likely would incur higher costs from H.R. 1946 as well, both in drug benefits for their employees and in public assistance programs. Such plans have been victims of coercive boycotts in the past.¹² Finally, if prescription drug coverage becomes more costly, some individuals might have to do without needed drugs. Fewer employers may offer health plans incorporating prescription drug coverage and some presently covered individuals may have to forgo certain prescription purchases, with potentially detrimental effects on their health.

The Market Share Provisions Are Unlikely to Mitigate Harm

H.R. 1946 contains provisions that limit the application of the bill's antitrust exemption, but it is unlikely that these provisions will be effective in protecting health care consumers. First, the "independent pharmacy" to which the bill applies is defined as a pharmacy that has less than a 10 percent "market share" in any Medicare Part D prescription drug plan (PDP) region and less than 1 percent nationally. Second, the bill caps the overall size of the group that may engage in immunized price-fixing or boycotts at 25 percent of the total number of pharmacy

¹¹ Congressional Budget Office Cost Estimate on H.R. 971, "Community Pharmacy Fairness Act of 2007" (Sept. 26, 2008) at 4-5, available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/98xx/doc9824/hr971.pdf>. The Commission also opposed H.R. 971.

¹² See *supra* note 9; see also *Baltimore Pharm. Ass'n, Inc. and Maryland Pharmacists Ass'n*, 117 F.T.C. 95 (1994) (consent order); *Southeast Colorado Pharmacal Ass'n*, 116 F.T.C. 51 (1993); *Peterson Drug Co. of North Chili, New York, Inc.*, 115 F.T.C. 492 (1992) (opinion and order); *Chain Pharmacy Ass'n of NY State, Inc.*, 114 F.T.C. 327 (1991) (consent order); *Empire State Pharm. Soc'y, Inc.*, 114 F.T.C. 152 (1991) (consent order); *Pharmaceutical Soc'y of the State of New York, Inc.*, 113 F.T.C. 661 (1990) (consent order).

licenses issued to all retail pharmacies in a PDP region. However, these market share screens will do little to prevent potentially widespread harm from the collective bargaining contemplated by H.R. 1946.

First, these market share provisions do not reflect antitrust markets from either a legal or economic perspective. PDP regions are established by the Centers for Medicare and Medicaid Services to determine a health plan's or pharmacy benefits manager's eligibility to offer Medicare Part D prescription drug plans. Each PDP is at least as large as an entire state and some are as large as three.¹³ Competition among retail pharmacies, however, is frequently local in nature, with consumers using pharmacies within a few miles of their homes.¹⁴ As a result, the bill would permit price-fixing by pharmacies that, although constituting less than 25 percent of a PDP, have a much larger share of economically meaningful markets. Second, it is unclear what products or services provided by pharmacies should be used to calculate the market share limits contained in the bill.¹⁵ Due to this uncertainty, the bill would be difficult to implement in practice.

¹³ Of the 34 PDP regions established by the Centers for Medicare and Medicaid services, 25 encompass one state, while six cover two states and the other three cover three or more states. See *2012 Medicare Part D Prescription Drug Plans: Overview by CMS Region*, available at <http://www.g11medicare.com/PartD-Medicare-PartD-Overview-byRegion.php>.

¹⁴ See, e.g., *Rite Aid Corp. and The Jean Coutu Group (PJC) Inc.*, Dkt. C-4191 ¶16,015 (CCH) (Sept. 17, 2007) (consent order) (order requiring divestiture of retail pharmacies in 23 local markets to prevent anticompetitive effects of proposed merger); *J.C. Penney and Thrift Drug, Inc.*, 123 F.T.C. 778 (Feb. 28, 1997) (geographic markets were state of North Carolina and four Metropolitan Statistical Areas within North Carolina).

¹⁵ In reviewing proposed mergers among pharmacies, the Commission has considered the likely competitive effects in different product markets. See, e.g., *Rite Aid*, *supra* note 14 (retail sale of pharmacy services to cash customers); *CVS Corp. and Revco, Inc.*, 124 F.T.C. 161 (Aug. 1997) (consent order) (retail sale of pharmacy services to third-party payors); *J.C. Penney and Thrift Drug, Inc.*, *supra* note 14 (same); FTC News Release, *FTC Will Seek to Block Rite Aid/Revco Merger*, (Apr. 17, 1996), available at <http://www.ftc.gov/opa/1996/04/ritercvc.shtml> (sales of prescription drugs sold in retail pharmacy outlets) (merger abandoned).

No Compelling Need Has Been Shown for the Proposed Exemption

Although the purpose of H.R. 1946 is “[t]o ensure and foster continued safety and quality of care and a competitive marketplace,” the Commission is concerned that the proposed exemption would not further those goals. Nothing in the bill requires that the collective bargaining it authorizes, or the higher reimbursement rates that it will likely cause, be directed at improving patient safety or quality. On the contrary, antitrust immunity not only would grant competing sellers a powerful weapon to obstruct innovative arrangements for the delivery and financing of pharmaceuticals, but also would dull competitive pressures that drive pharmacies to improve quality and efficiency in order to compete more effectively.

Some joint conduct by health care providers can benefit consumers, create efficiencies, and be pro-competitive, without running afoul of the antitrust laws. In their joint *Statements of Antitrust Enforcement Policy in Health Care*, the antitrust agencies have expressly recognized that there are a variety of lawful ways – short of price fixing and coercive boycotts – that health care providers can collectively express to health plans their concerns about both price and quality issues.¹⁶ In addition, joint ventures among pharmacists to provide medication counseling and disease management programs for patients with chronic illnesses such as asthma, diabetes, and heart disease have the potential to improve care and reduce overall costs. Commission staff has issued advisory opinions to groups of pharmacies that planned to develop such programs and jointly negotiate the fees for such services with third-party payers, finding that the antitrust laws presented no barrier to their proposed arrangements.¹⁷ Similarly, independent pharmacies often

¹⁶ See U.S. Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (August 1996) at Statements 4 and 5, available at <http://www.ftc.gov/reports/hlth3s.pdf>.

¹⁷ Letter to Paul E. Levenson regarding *Northeast Pharmacy Service Corporation* (July 27, 2000) (network of independent pharmacies in Massachusetts and Connecticut offering package of medication-related patient care services to physician groups) available at <http://www.ftc.gov/bc/adops/neletfi5.htm>; Letter to John A. Cronin, Pharm. D., J.D. regarding *Orange Pharmacy Equitable Network* (May 19, 1999) (network of retail pharmacies and

participate in joint purchasing groups that allow them to lower costs and compete more effectively.¹⁸ The proposed exemption would reduce incentives for pharmacies to undertake such lawful, pro-competitive, but perhaps more difficult, collaborations to improve service and compete more effectively in the marketplace.

Those who seek antitrust immunity for collective negotiations by pharmacies argue that health plans and pharmacy benefits managers (PBMs) have superior bargaining power when contracting with independent pharmacies. Thus, some suggest an antitrust exemption will “level the playing field” by enabling pharmacies to exercise countervailing power. According to proponents, allowing pharmacies to exercise leverage to obtain more favorable contracts will help ensure the survival of small pharmacies, and thereby promote high quality and accessible health care.

This type of rationale has been used to request special treatment for a host of situations and participants throughout our economy, both within and outside the health care sector. Antitrust law, and the enforcement agencies, recognize the risks of undue power on the part of buyers. Excessive buying power, known as “monopsony,” enables buyers to depress prices below competitive levels. In response, sellers may reduce sales or stop selling altogether, ultimately leading to higher consumer prices, lower quality, or substitution of less efficient alternative products. If there were evidence of this type of consumer harm, antitrust enforcement

pharmacists offering drug product distribution and disease management services) available at <http://www.ftc.gov/bc/adops/openadop.htm>; Letter to Allen Nichol, Pharm. D. regarding *New Jersey Pharmacists Association* (Aug. 12, 1997) (pharmacist network offering health education and monitoring services to diabetes and asthma patients) available at <http://www.ftc.gov/os/1997/08/newjerad.htm>.

¹⁸ For example, the Independent Pharmacy Cooperative (IPC), which describes itself as “the nation’s largest group purchasing organization for independent pharmacies,” is a member-owned cooperative that has been in operation since 1984. IPC claims to represent 4500 pharmacy members. See http://www.ipcrx.com/public/About_IPC/MOC.aspx. Another independent pharmacy purchasing cooperative, EPIC Pharmacies, Inc., was formed in 1982, and describes itself as “a not-for-profit buying group of hundreds of independently owned pharmacies across the country.” See <http://www.epicrx.com/about/index.aspx>.

might be necessary to combat an exercise of monopsony power. It is important, however, to distinguish between this type of buyer power, which can harm competition and consumers, and disparities in bargaining power, which are common throughout the economy and can result in lower input costs and lower prices for consumers.

Lawmakers are understandably concerned that some independent pharmacies may be unable to survive in the current environment, and especially about the prospect that some rural communities might be left without a local pharmacy. But these concerns do not justify a broad antitrust exemption that would apply to diverse businesses in markets throughout the country. To the extent that certain local concerns may warrant attention, targeted efforts to address particular issues in the distribution of pharmaceuticals and pharmacy services (perhaps looking to strategies used for medically under-served areas) may be a better way to address problems of access to prescription drugs, while avoiding the concerns that are raised by an antitrust exemption.

The Commission's opposition to this particular antitrust exemption proposal is not based on any policy preference for any particular type of pharmacy, or disregard for the strong sense of responsibility that individual pharmacists feel for the welfare of their patients. Rather, our opposition is based on the Commission's experience investigating the harm to consumers of numerous instances of collective bargaining by independent health care providers, including pharmacies.

Conclusion

Antitrust enforcement in the health care sector has helped ensure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. It has helped to restrain the upward-spiral of health care costs. Although health care markets have changed dramatically over time, and continue to

evolve, collective action by health care providers to obstruct new models for providing or paying for care, or to interfere with cost-conscious purchasing, remains a significant threat to consumers. Policymakers have been exploring ways to address widespread concerns about our health care system, including ways to stem spiraling costs and improve quality. Giving health care providers – whether pharmacies, physicians, or others – a license to engage in price fixing and group boycotts aimed at extracting higher payments from third-party payers would be a costly step backward, not forward, on the path to a better health care system.

Thank you for this opportunity to share the Commission's views on this proposed legislation. The Commission looks forward to continuing to work with the Subcommittee to ensure that our antitrust laws and policies are sound and that they benefit consumers without unduly burdening businesses.

Mr. GOODLATTE. Thank you, Mr. Feinstein. I will start the questions, and start with you.

Professor Wright testifies that the antitrust agencies are willing to offer guidance to pharmacies that want to enter into pre-competitive collaborative arrangements, without running afoul of the antitrust law. Is there any realistic chance that the FTC applying

current law would consider requests by a group of independent pharmacies to collectively bargain reimbursement rates with a health plan or a PBM?

Mr. FEINSTEIN. I think it would depend entirely upon the reason that the collective bargaining was necessary. There certainly have been many instances where otherwise competing healthcare providers have been permitted to form networks where they collaborate to improve the quality of the service or deliver their products and services more efficiently, and where joint selling of their service is necessary or reasonably necessary for them to achieve the benefit to consumers, then those kinds of arrangements can be approved.

Mr. GOODLATTE. Have any been submitted for approval?

Mr. FEINSTEIN. None have been submitted for approval by pharmacies on that specific question. We have produced, or we have in the last decade issued letters authorizing collaborations among pharmacies. They have not requested authorization for joint pricing. They have involved other things.

Mr. GOODLATTE. Do you agree that the PBM market is significantly more concentrated now than it was 5 years ago when this Committee last held a hearing on this issue?

Mr. FEINSTEIN. I would agree that there has been additional consolidation in the PBM market. The term "significantly" is one that is ambiguous, and it would be difficult to, you know, necessarily agree with that, but certainly there has been more concentration in the PBM market over the last 5 years.

Mr. GOODLATTE. Let me direct a similar question to Mr. Gray and Mr. James.

Independent pharmacies can currently collect collective bargaining through Pharmacy Service Administration Organizations, or PSAOs. What does H.R. 1946 give to independent pharmacies that they did not already have the ability to do through PSAOs?

Mr. JAMES. Mr. Chairman, I think there is a misconception about PSAOs. I think that PBMs will try to convince you that these PSAOs sit down with my pharmacies and sit down with pharmacies across this country and negotiate contracts and prices with PBMs. That is not true.

The PSAO's prime purpose is to review a contract and make a recommendation to a pharmacy that is a member of that PSAO whether or not that should be taken or not. Economically, from a business standpoint should it be taken. I don't think you are going to find anybody that would say to you from a PSAO's side that they sit down and negotiate contractual dollars and cents for reimbursement purposes. As a matter of fact, I know some of the bigger PBMs who will refuse to talk to some of the PSAOs where they attempt to work out those details.

So, I think that is probably what needs to be understood, is what the real purpose of a PSAO is, as opposed to being a negotiating entity from the standpoint of pricing.

Mr. GOODLATTE. Professor Wright, do you have a view on that?

Mr. WRIGHT. The only thing I would like to add with respect to the advisory letter process that Mr. Feinstein raised is that there is something that should be understood about existing antitrust law with respect to distinguishing pro-competitive from anti-com-

petitive collaboration. That is, indeed, the existing law that runs through the agency guidelines. And the FTC faces a challenge, as do courts and the DoJ, in distinguishing pro-competitive forms of collaboration that help competition from those that harm consumers. This is the job of those agencies. It is the job of those courts. They have developed significant expertise in making that distinction over time, and I would imagine well-suited if such a request comes in to be able to distinguish between the two.

Mr. GOODLATTE. You testified that basic economic theory and experience indicate that coordinated activity among pharmacies will likely result in higher prices faced by health plans. But, to the extent that health plans currently contract out the administration of their prescription drug benefits to PBMs and PBMs compete with each other for each health plan's contract, is it possible that any additional prescription reimbursement costs will come only out of PBM's margins without the health plans incurring additional costs?

Mr. WRIGHT. As a matter of economic principles, no.

Mr. GOODLATTE. That would depend, wouldn't it, on how competitive the PBM market is for dealing with those—

Mr. WRIGHT. How much pass-through you get will depend on the demand, the elasticity of demand in the market. It will depend on the intensity of competition. But, you will not get zero pass-through, essentially, under any economic assumptions you would like to make about any of those pertinent variables. But, certainly, the amount of pass-through to consumers will depend upon a variety of factors. That number is going to be positive.

Mr. GOODLATTE. I think Mr. James wanted to respond as well.

Mr. JAMES. I would just like to comment on the fact that what we see in the marketplace today is just as you stated, it is competition between PBMs for the plan's sponsor's business. What we see in the pharmacy, when that patient comes in, we adjudicate that claim, and that PBM does, in fact, tell us directly what to charge the consumer. We do not set the price, nor does anyone in that pharmacy have anything to do with the price. It is charged to the consumer. That is dictated to us by the PBM.

Now, if, in fact, there are negotiations allowable, and the PBM feels like they are going to have to wind up paying more money to the pharmacy, the question is: What do they do? It is their decision, and it is their plan's sponsor's decision. Instead of making \$6 billion this year, do they make \$5.8 billion and pay the pharmacy a little bit more money, or do they charge the plan's sponsor more, which entail causes them to charge more. That is not in our habitat. We don't have anything to do with that.

As you see today, when that patient is charged, it is a charge that is dictated to by the PBM.

Mr. GOODLATTE. Thank you. My time is expired. The gentleman from North Carolina, Mr. Watt, is recognized.

Mr. WATT. Thank you, Mr. Chairman. And let me start by apologizing to the Chairman, and the Committee Members, and our witnesses for being late. My community pharmacist will be happy to know that I was out doing something that was to their benefit, which was going to my allergist to get another prescription, so that I could go to my community pharmacy to get it filled. So, you are the beneficiaries of my not being here.

I am not sure as you are as much the beneficiaries of my being here, because I have some reservations about the bill that has been introduced. It is obviously a very difficult question. So difficult, in fact, that I am told that I was a sponsor of a similar bill in a prior term of Congress, and so, obviously, it continues to be a difficult issue. So, let me ask a few questions that might help me clarify or refine my own position, if we consider this bill.

There has obviously been an attrition of independent community pharmacies. I am looking for evidence that that is as a result of what this bill addresses. I am not sure I have seen that evidence. Perhaps somebody can provide it to me after this hearing. Or whether it is a function of larger conglomerates like the CVSs of the world, I presume they don't call themselves independent pharmacies, providing more and more competition to community pharmacies.

Just this morning, or this afternoon, or tomorrow, when I go home, I will have to make a choice between whether I go to a community pharmacy or to the CVS that happens to be right down the street from my house. I am not sure that that choice will be made based on whether it was a community pharmacy or, you know, a chain, or whether it was a PBM involved in it, or not involved in it. There are some other things that are driving this.

So, at some point, if somebody has evidence that this attrition that is taking place is as a result of what this bill deals with, I would dearly like to have that in writing.

Second, there seems to be an ongoing consolidation of PBMs, obviously. One is under consideration right now. One potential consolidation about to be ruled on. And if there are antitrust implications, one would think that those implications would be thoroughly evaluated and considered, and that application would be denied. From everything I am hearing the application is likely to be granted. I am not involved in that process, and have tried to keep the Committee out of it, to some extent. But, we had a hearing on the question, and it is not our decision to make, but the criteria involve whether there are antitrust implications of that merger. And while independent pharmacies may not be at the table making that decision, there is a set of rules by which that decision gets made. So, that is troubling me.

I guess the basic thing that is troubling me, and I guess I haven't asked a question yet, but I am putting some issues on the table, I guess the basic thing that is troubling me is the thing that I have said in some other context about providing antitrust exemptions to anybody. My mama, who always gave me good advice when I was growing up, one of the pieces of advice she gave me was that two wrongs don't make a right. And if somebody is violating the antitrust laws over here, and antitrust laws are good, I think there are remedies to deal with that. I am not sure that I think the appropriate remedy to deal with that is to give somebody else the right to violate the antitrust laws.

So, I put all these things on the table, my concerns. Professor Wright, maybe you could, if you would just give me 1 minute to ask one question.

Mr. GOODLATTE. Without objection.

Mr. WATT. Is there some evidence to demonstrate that anti-competitive practices of PBMs is the cause of the attrition of independent pharmacies nationwide? Or what is your take on that?

Mr. WRIGHT. If there is, not that I am aware of. There is significant evidence, on the other hand, that as, I think your intuition suggested, and also with respect to your skepticism about antitrust exemptions, there is ample evidence that one might expect, if one gives an antitrust exemption, to violate the antitrust laws, folks take advantage of that exemption in order to engage in anti-competitive activity. In other words, there is ample evidence that where exemptions lie, losses to consumers follow.

Mr. WATT. Well, I won't get you into speculating about that.

Mr. WRIGHT. That is not speculating. That is a body of evidence.

Mr. WATT. A body of evidence. Okay. All right. Well, you are not speculating then. Okay. All right.

Well, I guess I am beyond my time, so in fairness to the other Members of the Committee, if we have a second round, I will go into some of these issues more thoroughly. I have kind of put my cards on the table. They say I have been on all sides of this issue at some point or another, but, you know, that is the way politicians are. We try to be on all sides of an issue. But, at some point we have to vote on these things, and that is why we have these hearings, so that we can inform ourselves and make an educated good vote, not just a political decision about it. So, I will yield back for the time being.

Mr. GOODLATTE. Thank you, gentlemen. And the Chair recognizes the gentleman from Pennsylvania, Mr. Marino, for 5 minutes.

Mr. MARINO. Thank you, Chairman.

Gentlemen, thank you for being here. And I first want to thank Chairman Conyers, because a great portion of why I am doing what I am doing was when I read his legislation. So Chairman, thank you for the guidance.

Mr. Feinstein, I think it is publically time that we state that the emperor has no clothes on, and I think the emperor right now is the PBMs and the large chains. And you stated that pharmacies are requesting special treatment, at least in your testimony and your written testimony, by being allowed to negotiate with much larger PBMs.

I find it deeply concerning that this is called special treatment for the independent pharmacists, but there seems to be no limits for PBMs to continue to combine and merge together with no action by the FTC. Why is the FTC so aggressively opposed to small independent pharmacies getting on a level playing field, decentralized groups of independent pharmacies joining together, while permitting massive consolidation in the PBM market, particularly when it comes to mail-order and no negotiation of the prices?

Mr. FEINSTEIN. Microphone on?

Mr. MARINO. Yes.

Mr. FEINSTEIN. First, let me make very clear that the FTC is not aggressively opposed to independent pharmacies. That was how you began your question. We are not aggressively opposed to independent pharmacies.

Mr. MARINO. Well, that is my take.

Mr. FEINSTEIN. I understand, but I want to make it clear, speaking for myself, at least, that is not my view, that is not the FTC's view.

What we are concerned about, and I also, as I indicated in my opening statement, we recognize that times are tough for some independent pharmacies. We recognize that. I think the question that was raised about whether this is the primary cause of that is an important question.

Also, it is not my understanding that there has, in fact, been substantial attrition among independent pharmacies. It is my understanding that the number of independent pharmacies has remained relatively flat over the last decade. And I am sure others will correct me if that is incorrect. But, leaving that aside, I take it, as a given, that times are tough for some independent pharmacies.

The problem that we have is that this solution is a very blunt instrument that will have a lot of problematic effects throughout our healthcare system in the form of increased costs. And that is true often with antitrust exemptions, regardless of the industry, and it is true in this setting as well.

It is also our perception that, you know, while it is certainly the case that there are some circumstances, maybe many circumstances, when a PBM or a health plan that is negotiating with a single pharmacy has much more leverage in that negotiation. No one disputes that.

There is also great variation. This is not sort of a one-size-fits-all problem. For example, when PBMs are putting together networks of pharmacies, which they do to make sure that they are serving the needs of the employees of the sponsors of the health plans, in other words, the corporations that provide the healthcare benefits for their employees, and they contract with the PBM to administer the pharmacy.

Mr. MARINO. Sir, I only have a couple of minutes.

Mr. FEINSTEIN. Sure. I just want to make the point that there are places in those networks where they have to deal with independent pharmacies, because there are rural locations, for example, where the independent pharmacies may be the only one in a town.

Mr. MARINO. I understand that, sir, but if you look behind you there are pharmacy students from the prestigious Howard University. I don't know if they have any plans on going independently or where they may be going to work. But, they are sitting here listening to a very unlevel playing field, particularly when you are dealing with PBMs, when the PBMs aren't even telling people who need their prescription drugs that there are various ways of getting that. So, they are cornering the market on there. And I think it is the responsibility of the FTC to look into those matters, not wait till we bring it to your attention. That is my basic problem with the bureaucracy. But, we will leave that for another day.

Professor Wright, you made a statement that there will be no benefits to consumers. And I am hearing from my colleagues, my constituents in my district, pharmacists, and around the country that the PBMs are just basically killing them, as far as no negotiation on the prices. Yet, independent pharmacists across my district today are repeatedly struggling, and I think we can produce some numbers as to how many pharmacists, Mr. Feinstein, have gone

out of business, because they can't compete any more with the PBMs, and that some pharmacies have closed their doors as a result.

How could you say that giving pharmacies the limited ability to better compete and keep their doors open would not benefit consumers? Doesn't competition breed good pricing, especially given that nothing in the world beats a face-to-face interaction with pharmacists and patients? And I know, because I have a daughter who has cystic fibrosis, and I am dealing with my independent pharmacist on a weekly basis, three or four times a week.

Mr. WRIGHT. There are in the antitrust laws an economics. Collaborative efforts that enhance the competition make it more intense and have benefits for consumers. And there are types of collaboration that do not. The bill would, by exempting independent pharmacies from the antitrust laws, allow all forms of collaboration, but in particular would allow independent pharmacies to avail themselves of anti-competitive forms of coordination.

The basis for my statement that I suspect the likely effects will be to reduce consumer welfare is a body of evidence that suggests that when competitors are allowed to collude on price, consumer welfare goes down.

Mr. MARINO. Thank you. But, you know, we are talking about, and your credentials—

Mr. GOODLATTE. Without objection, the gentleman is recognized for one additional minute.

Mr. MARINO. Thank you. Thank you. But, we are talking in theory here. You say "likely." You say "theory." Mr. Feinstein says "probably," "could have." I talked to the pharmacists. I know what they are going through. So, I would like to ask quickly, gentlemen, Mr. James and Mr. Gray, can you briefly describe your interaction with PBMs and how they treat your pharmacy during negotiations, if there are negotiations.

Mr. JAMES. Well, I think the problem is that the word "negotiation" is used incorrectly. There are no negotiations. There is a contract that comes to your pharmacy. It states the terms. It states the conditions. And it gives you one or two choices. You sign that contract, or all your patients are moved to another pharmacy, because they will not allow them to come to your pharmacy to get their prescriptions filled.

Mr. MARINO. Mr. Gray, quickly, please.

Mr. GRAY. There is no negotiation. You either take it or leave it. We don't go to the table and say, "Well, this is what we want, and this is what we need. This is what we have got to have." It is either you take this or leave it. There is no negotiation.

Mr. MARINO. But, there is with the large chains.

Mr. GRAY. With the large chains, they do well.

Mr. MARINO. Thank you, Chairman. Thank you so much.

Mr. GOODLATTE. Thank you, gentlemen.

The gentleman from Michigan is recognized.

Mr. CONYERS. Thank you, Chairman Goodlatte. Well, I think we are beginning to reveal several things here that are important. One, the need for the legislation is based on the expectation that the pharmacist will be able to bargain collectively, which they can't do now, and that is why the antitrust exemption is being sought.

And so, I feel that that is one of the rare reasons to exempt any company from antitrust control. As a matter of fact, this is the only instance that I think that there is some possibility for this being salutary.

Now, what is being asserted here is that there is no choice when you are dealing with a PBM, and now it turns out that CVS owns one of the largest PBMs itself. Caremark. So, the concentration, and the power, and the less negotiating ability on the part of the independent pharmacies, let's face it, this is a classic capitalist case of the little guys versus the big guys. And it seems to me that fairness dictates that this exemption be given very good consideration.

Mr. James, do you think that I am putting this in a fair description?

Mr. JAMES. I think that is a very good interpretation of what is going on, and I would say in addition to that, that what we have to look at here is, if you look at the world of pharmacy, I submit to you that independent pharmacies are the only people that are being hammered by this antitrust law. If you think about the bigger pharmacies, you think about the CVSs you mentioned, the Rite-Aids, all the major pharmacies, for example, CVS has about 7,000 pharmacies across the country. You have to understand that that pharmacy, CVS, is, in fact, negotiating with a PBM. But, they are able to negotiate, because all of their stores are in one corporation. So, they can sit down with them and say, "You want us in or you want us out. Take your choice. If so, here is the deal."

What the PBMs realize, which has been stated here earlier, is that independent pharmacies are separate corporations unto themselves, which are now falling under this antitrust law, so there is no way to negotiate. That is why you get take-it-or-leave-it contracts.

So, as I said earlier, I submit to you that independent pharmacies are the only pharmacies being affected by this antitrust law.

Mr. CONYERS. Thank you.

Could I ask that the second-year pharmacy students from Howard University just stand for one moment, please? There is only one man in this seven-person group. Is there some explanation for this imbalance? I won't ask Professor Stolp to explain that, but look ladies, we want to bring more fellows into this. Normally, we are arguing just the reverse, so we have to get more women into a situation.

Mr. WATT. Mr. Ranking Member, we might ask the Chair to have a hearing about that. [Laughter.]

Mr. CONYERS. That is right. Look, we have a long list of possible hearings, and this will go on the list, but at the bottom.

Anyway, welcome, and don't be discouraged by the power plays that are going on in your future profession. I congratulate you all.

Mr. MARINO. Mr. Conyers, would you yield for 1 second? I am going to argue on behalf of the gentleman. He is in an ideal situation. All right? [Laughter.]

I am with you.

Mr. WATT. All he needs to do is move to the middle there, it would be great. [Laughter.]

Mr. WATT. He is not quite ideal yet, but he is getting there.

Mr. JOHNSON. Well, I am going to tell you, if any of the young ladies has a dad like Tom Marino, then you are in trouble, young man. [Laughter.]

Mr. CONYERS. All right. You may sit down, please. And we are very proud of all of you in your work. And we hope that we can continue to get the issue of fairness in this matter. But, it seems a little bit one-sided. Not only does PBM control, but some of the biggest pharmacies create their own PBM. So, look, the more we dig into this, the deeper the problem becomes.

I thank the Chairman for his generosity with the time, and yield back.

Mr. GOODLATTE. I thank the gentleman. The Chair recognizes the gentlewoman from California, Ms. Chu, for 5 minutes.

Oh. I'm sorry. He slipped in on me. I am glad to be joined by another one on my side of the aisle.

Mr. GRIFFIN. I am glad I am making it.

Mr. GOODLATTE. And we will recognize Mr. Griffin for 5 minutes.

Mr. GRIFFIN. Mr. Chair, I am glad I am making such an impact on you. [Laughter.]

Mr. Chairman, I am concerned about Park West Pharmacy in my district, in Little Rock, and you referred to in your testimony. And at the request of Park West Pharmacy, which is a community pharmacy in Little Rock, I ask unanimous consent to submit for the record some documents that they gave to me, indicating marginal losses on prescriptions associated with transactions between the pharmacies and the PBMs. And I have those documents here.

Mr. GOODLATTE. Without objection, so ordered.

[The information referred to follows:]

Park West Pharmacy

904 Autumn Road
Suite 273
Little Rock AR 72211
Phone (501) 224-3499
Fax (501) 224-2140
parkwest@aristotle.net

March 27, 2012

Dear Representative Griffin,

Please make sure this information is entered into the Hearing Record for the March 29, 2012 hearing on HR 1946.

Sincerely,



Bill Bloodworth, R.Ph., P.D.

Example of PBM Under-Payments

This form provides an example of how PBMs are under-paying pharmacies in our state to unlawfully destroy competition and force residents into their proprietary programs.

Identification

- 1. My U.S. Representative is: Tim Griffin
- 2. The name of my pharmacy is: Park West Pharmacy
- 3. My pharmacy location: 904 Autumn Road Little Rock
Address City
AR 72211 (501)224-3499 parkwest@aristotle.net
State Zip + 4 Digits Phone Email (please write clearly)

* Please see the following pages *

Case Study

- 4. Does this example relate to payments under a federal or state program? (indicate program on this line): _____
- 5. What was the drug product? _____ To treat what condition? _____
- 6. My cost to acquire drug _____ Reimbursement paid by PBM _____
 Co-Pay Paid by Patient _____ Dispensing fee paid by PBM _____

Anti-Competitive Effect on Pharmacy Operations

- 7. Amount I lost by filling this prescription (amount of PBM "spread") _____
- 8. Did the PBM require you to sign a contract to prevent you from disclosing how much it pays your pharmacy for this drug? Yes _____ No _____
- 9. Does the PBM prevent you from competing for this patient's business by offering the same services (e.g., 90-day prescriptions) that it offers? Yes _____ No _____
- 10. Do you believe this case demonstrates that the PBM is engaging in potentially unlawful anti-competitive behavior against your pharmacy? Yes _____ No _____

Impact on Consumer / Local Resident

- 11. Please tell us about your customer/patient (excluding name and other private information). What impact does this case have on him/her?

Fax to Association of Community Pharmacists at 202-966-3336

PARK WEST PHARMACY, INC.
 904 AUTUMN ROAD SUITE 273, LITTLE ROCK, AR
 (501) 224-3499

PAGE NO: 1
 DATE: 03/27/2012

List of Rx - Paid less than Acq Cost
 (01/01/2012 To 03/27/2012)

Rx#	DispDate	Pay type	Ref#	Ins Paid	Copay	Revenue	AcqCost	Gross Margin
486782	01/02/2012	I	0	4.29	2.60	6.89	7.22	-0.33
486805	01/03/2012	I	0	35.57	10.00	45.57	46.53	-1.06
486610	01/04/2012	I	0	121.46	6.00	127.46	141.24	-13.78
486974	01/05/2012	I	0	202.54	0.00	202.54	203.76	-1.22
487048	01/05/2012	I	C	155.16	0.00	155.16	157.40	-2.24
487116	01/06/2012	I	0	7.64	1.35	8.99	10.20	-1.21
487119	01/06/2012	I	0	18.13	10.00	28.13	29.07	-0.94
487156	01/09/2012	I	0	168.35	0.00	168.35	171.26	-2.91
487171	01/09/2012	I	0	124.71	15.00	139.71	146.42	-6.71
487209	01/09/2012	I	0	165.35	3.00	168.35	171.26	-2.91
487178	01/09/2012	I	0	169.35	0.00	169.35	171.26	-2.91
487274	01/10/2012	I	0	0.00	18.58	18.58	20.38	-11.80
487339	01/11/2012	I	0	375.81	30.00	405.81	411.75	-5.94
487324	01/11/2012	I	0	0.37	18.91	19.28	21.22	-1.94
487359	01/11/2012	I	0	110.47	15.00	125.47	137.25	-11.78
487367	01/11/2012	I	0	66.35	10.00	76.35	76.60	-0.25
487369	01/11/2012	I	0	0.00	9.30	9.30	11.50	-2.20
487387	01/12/2012	I	0	2.67	15.00	17.67	21.66	-3.99
487396	01/12/2012	I	0	66.25	10.00	76.25	88.64	-12.39
487466	01/12/2012	I	0	109.63	10.00	119.63	127.17	-7.54
487489	01/13/2012	I	0	64.21	4.00	68.21	83.70	-15.49
487643	01/16/2012	I	0	2.22	0.56	2.78	6.82	-4.04
487764	01/18/2012	I	0	60.82	10.00	70.82	76.60	-5.78
487959	01/20/2012	I	0	20.29	3.58	23.87	26.98	-3.11
487978	01/21/2012	I	0	112.45	10.00	122.45	133.20	-10.75
487999	01/23/2012	I	0	163.35	5.00	168.35	171.26	-2.91
487915	01/23/2012	I	0	399.61	2.60	402.21	444.99	-42.78
488023	01/23/2012	I	0	0.00	6.49	6.49	8.63	-2.14
488042	01/23/2012	I	0	35.68	10.00	45.68	46.15	-0.47
488043	01/23/2012	I	0	50.33	10.00	60.33	61.93	-1.20
488086	01/24/2012	I	0	52.50	30.00	82.50	87.41	-4.81
488103	01/24/2012	I	0	4.79	2.58	7.37	10.05	-2.68
488107	01/24/2012	I	0	0.00	6.49	6.49	8.63	-2.14
488147	01/24/2012	I	0	13.44	4.22	17.66	18.33	-0.67
488148	01/23/2012	I	0	3.38	7.00	10.38	11.32	-0.94
485969	01/25/2012	I	C	0.00	17.36	17.36	29.70	-12.34
488265	01/26/2012	I	0	137.37	5.00	142.37	152.59	-10.22
488271	01/26/2012	I	0	0.00	10.00	10.00	12.92	-2.92
488273	01/27/2012	I	0	168.35	0.00	168.35	171.26	-2.91
486539	01/27/2012	I	0	15.27	7.00	22.27	22.61	-0.34
488204	01/27/2012	I	0	13.75	10.00	23.75	25.00	-1.25
488337	01/28/2012	I	0	54.63	5.00	59.63	61.53	-1.90
488488	01/31/2012	I	0	261.84	20.00	281.84	314.79	-32.95

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PARK WEST PHARMACY, INC.
 904 AUTUMN ROAD SUITE 275, LITTLE ROCK, AR
 (501) 224-3489

PAGE NO: 2
 DATE: 03/27/2012

List of Rx - Paid less than Acq Cost
 (01/01/2012 To 03/27/2012)

Rx#	DispDate	Pay type	Ref#	Ino Paid	Copay	Revenue	ACQCost	Gross Margin
488445	02/01/2012	I	0	116.69	30.12	146.81	157.40	-10.59
488497	02/01/2012	I	0	111.21	27.80	139.01	146.42	-7.41
488600	02/02/2012	I	0	21.63	3.82	25.45	25.64	-0.19
488643	02/02/2012	I	0	12.39	6.00	18.39	18.73	-0.34
488686	02/03/2012	I	0	50.98	4.00	54.98	64.46	-9.48
488684	02/03/2012	I	0	165.35	3.00	168.35	171.26	-2.91
488719	02/03/2012	I	0	8.90	6.00	14.90	20.66	-5.76
488756	02/04/2012	I	0	231.38	60.74	292.12	314.79	-22.67
488714	02/06/2012	I	0	121.46	6.00	127.46	141.24	-13.78
488828	02/07/2012	I	0	124.71	15.00	139.71	146.42	-6.71
487883	02/07/2012	I	0	22.71	6.00	28.71	28.85	-0.14
488925	02/07/2012	I	0	119.97	10.00	129.97	130.41	-0.44
488931	02/07/2012	I	0	0.00	8.30	8.30	9.21	-0.91
488944	02/07/2012	I	0	35.57	10.00	45.57	46.63	-1.06
489011	02/08/2012	I	0	45.33	15.00	60.33	61.53	-1.20
489072	02/08/2012	I	0	128.93	10.00	138.93	148.86	-9.93
489074	02/09/2012	I	0	168.35	0.00	168.35	171.26	-2.91
489035	02/09/2012	I	0	155.16	0.00	155.16	157.40	-2.24
489567	02/11/2012	I	0	73.95	7.00	80.95	113.59	-32.64
489163	02/11/2012	I	0	168.35	0.00	168.35	171.26	-2.91
489162	02/11/2012	I	0	168.35	0.00	168.35	171.26	-2.91
489171	02/11/2012	I	0	258.54	24.39	282.93	338.10	-55.17
489172	02/11/2012	I	0	13.72	4.00	17.72	21.67	-4.15
489208	02/13/2012	I	0	26.59	4.69	31.28	33.31	-2.03
489226	02/13/2012	I	0	5.92	6.00	11.92	12.12	-0.20
489437	02/15/2012	I	0	0.00	9.30	9.30	11.50	-2.20
489512	02/16/2012	I	0	104.28	60.00	164.28	171.26	-7.08
489508	02/17/2012	I	0	56.07	17.48	73.55	76.25	-2.70
489697	02/20/2012	I	0	252.12	40.00	292.12	314.79	-22.67
489786	02/21/2012	I	0	2.02	10.00	12.02	12.98	-0.96
489948	02/23/2012	I	0	0.00	23.21	23.21	23.62	-0.42
489959	02/24/2012	I	0	8.58	1.51	10.09	21.99	-11.90
489993	02/24/2012	I	0	54.72	10.00	64.72	76.68	-11.96
490104	02/27/2012	I	0	39.72	10.00	49.72	81.39	-31.87
490170	02/28/2012	I	0	50.98	4.00	54.98	64.46	-9.48
490227	02/28/2012	I	0	168.35	0.00	168.35	171.26	-2.91
490259	02/29/2012	I	0	6.70	8.00	14.70	18.33	-3.63
490280	02/29/2012	I	0	165.35	3.00	168.35	171.26	-2.91
490306	03/01/2012	I	0	0.00	22.64	22.64	25.19	-2.34
490082	03/01/2012	I	0	121.46	6.00	127.46	141.24	-13.78
490348	03/01/2012	I	0	29.88	7.47	37.35	40.84	-3.49
490370	03/01/2012	I	0	10.54	20.00	30.54	30.77	-0.23
490471	03/02/2012	I	0	0.00	46.34	46.34	49.36	-2.02

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PARK WEST PHARMACY, INC.
904 AUTUMN ROAD SUITE 275, LITTLE ROCK, AR
(501) 224-3499

PAGE No: 3
DATE: 03/27/2012

List of Rx - Paid less than Acq Cost
(01/01/2012 To 03/27/2012)

Rx#	DispDate	Fay type	Ref#	Ins Paid	Copay	Revenue	AcqCost	Gross Margin
490495	03/02/2012	I	0	39.65	16.98	56.61	56.68	-0.27
490577	03/05/2012	I	0	0.00	9.65	9.65	10.05	-0.40
490591	03/05/2012	I	0	2.42	12.00	14.42	16.00	-1.58
490709	03/07/2012	I	0	67.76	0.00	67.76	70.04	-2.28
490710	03/07/2012	I	0	251.05	0.00	251.05	281.15	-30.10
490701	03/08/2012	I	0	66.10	10.00	76.10	86.75	-10.65
490744	03/08/2012	I	0	0.00	15.51	15.51	15.92	-0.01
490959	03/09/2012	I	0	43.26	40.00	83.26	122.76	-39.50
490833	03/09/2012	I	0	46.14	10.00	56.14	59.16	-3.02
490863	03/09/2012	I	0	129.93	10.00	139.93	148.86	-9.93
490874	03/09/2012	I	0	124.71	15.00	139.71	146.42	-6.71
490886	03/10/2012	I	0	19.21	4.00	23.21	29.16	-5.95
490888	03/10/2012	I	0	278.93	4.00	282.93	338.10	-55.17
490895	03/10/2012	I	0	168.35	0.00	168.35	171.26	-2.91
490903	03/10/2012	I	0	0.61	5.00	5.61	5.75	-0.14
490969	03/12/2012	I	0	168.35	0.00	168.35	171.26	-2.91
490935	03/14/2012	I	0	0.00	29.25	29.25	51.76	-22.51
491090	03/14/2012	I	0	0.00	149.77	149.77	157.40	-7.63
491126	03/14/2012	I	0	20.04	5.01	25.05	33.97	-8.92
491188	03/15/2012	I	0	252.12	40.00	292.12	314.79	-22.67
488628	03/15/2012	I	0	124.02	36.00	160.02	161.00	-0.98
491271	03/16/2012	I	0	0.00	21.50	21.50	24.45	-2.95
491292	03/16/2012	I	0	42.39	18.16	60.55	60.94	-0.39
491290	03/16/2012	I	0	0.00	340.00	340.00	348.66	-8.66
488681	03/16/2012	I	0	73.95	7.00	80.95	81.45	-0.50
491325	03/17/2012	I	0	35.57	10.00	45.57	46.63	-1.06
491335	03/19/2012	I	0	47.94	5.00	52.94	59.23	-6.29
491069	03/19/2012	I	0	110.33	70.00	180.33	310.32	-129.99
491300	03/19/2012	I	0	5.00	4.00	9.00	10.20	-1.20
491447	03/20/2012	I	0	178.85	30.00	208.85	216.99	-8.14
491454	03/20/2012	I	0	252.12	40.00	292.12	348.66	-56.54
491464	03/20/2012	I	0	64.74	6.00	70.74	77.58	-6.84
491431	03/20/2012	I	0	41.73	10.00	51.73	57.43	-5.70
491552	03/21/2012	I	0	0.20	4.18	4.38	5.76	-1.38
491563	03/21/2012	I	0	277.29	20.00	297.29	348.66	-51.37
491596	03/22/2012	I	0	14.68	10.00	24.68	25.00	-1.20
491699	03/24/2012	I	0	42.31	8.00	50.31	50.05	-7.74
491714	03/26/2012	I	0	54.21	6.00	60.21	64.59	-4.38
491733	03/26/2012	I	0	7.70	47.28	54.98	71.77	-16.79
TOTALS: 125				10014.93	2007.92	12022.85	13158.23	-1135.38
479518	01/02/2012	I	4	118.72	6.00	124.72	137.25	-12.53
482043	01/02/2012	I	4	8.90	6.00	14.90	20.66	-5.76

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PARK WEST PHARMACY, INC.
 904 AUTUMN ROAD SUITE 275, LITTLE ROCK, AR
 (501) 224-3499

PAGE NO: 4
 DATE: 03/27/2012

List of Rx - Paid less than Acq Cost
 (01/01/2012 To 03/27/2012)

Rx#	DispDate	Pay Type	Ref#	End Paid	Copay	Revenue	AcqCost	Gross Margin
476202	01/02/2012	I	3	176.06	2.60	178.66	183.34	-4.98
483076	01/03/2012	I	1	2.52	5.00	7.52	13.11	-5.59
469366	01/03/2012	I	10	39.63	16.98	56.61	56.88	-0.27
478702	01/04/2012	I	2	52.60	30.00	82.60	87.41	-4.81
483878	01/05/2012	I	2	118.72	6.00	124.72	137.25	-12.53
470691	01/06/2012	I	8	35.91	22.01	57.92	64.04	-6.12
485829	01/09/2012	I	1	20.64	6.00	26.64	30.02	-3.38
482079	01/11/2012	I	3	74.10	13.08	87.18	96.22	-9.04
478422	01/11/2012	I	2	31.66	0.00	31.66	31.94	-0.28
484310	01/11/2012	I	1	0.00	8.90	8.90	19.56	-10.66
475499	01/12/2012	I	6	0.00	9.27	9.27	14.40	-5.13
485803	01/12/2012	I	1	84.83	2.60	87.43	96.22	-8.79
474525	01/12/2012	I	7	32.20	10.00	42.20	43.38	-1.18
479515	01/13/2012	I	4	72.83	7.00	79.83	81.45	-1.62
481722	01/13/2012	I	3	366.43	5.00	371.43	432.00	-60.57
478154	01/14/2012	I	3	12.10	5.00	17.10	19.50	-2.40
474166	01/17/2012	I	3	0.00	18.82	18.82	20.07	-1.25
484422	01/18/2012	I	2	90.33	25.00	115.33	115.92	-0.59
480272	01/18/2012	I	2	18.27	8.00	26.27	26.98	-0.71
478432	01/19/2012	I	6	0.00	12.80	12.80	15.61	-2.81
486653	01/20/2012	I	1	1.30	29.44	30.74	30.84	-0.10
482037	01/20/2012	I	1	43.01	12.00	55.01	57.38	-2.37
471123	01/21/2012	I	2	54.21	6.00	60.21	64.59	-4.38
474428	01/22/2012	I	1	248.27	79.01	327.28	352.94	-25.66
479599	01/23/2012	I	3	130.86	10.00	140.86	140.62	-0.16
478886	01/23/2012	I	1	118.72	6.00	124.72	137.25	-12.53
482332	01/23/2012	I	3	30.84	40.00	70.84	70.85	-0.01
473159	01/23/2012	I	4	82.23	5.00	87.23	96.22	-8.99
472755	01/27/2012	P	1	0.00	11.20	11.20	19.95	-8.75
483560	01/27/2012	I	3	31.11	10.00	41.11	46.28	-5.17
483878	01/28/2012	I	3	118.72	6.00	124.72	137.25	-12.53
485283	01/30/2012	I	1	30.03	6.00	36.03	42.00	-5.97
481997	01/30/2012	I	3	180.40	0.00	180.40	182.95	-2.55
479559	01/30/2012	I	2	17.10	5.00	22.10	22.41	-0.31
485829	01/31/2012	I	2	20.64	6.00	26.64	29.95	-3.31
484782	01/31/2012	I	2	72.47	18.12	90.59	109.82	-19.23
483076	02/01/2012	I	2	2.52	5.00	7.52	13.11	-5.59
469366	02/03/2012	I	11	39.63	16.98	56.61	56.88	-0.27
484234	02/06/2012	I	2	95.78	23.95	119.73	140.94	-21.21
480232	02/06/2012	I	4	0.00	15.51	15.51	15.52	-0.01
487110	02/08/2012	I	1	9.51	35.00	44.51	46.47	-1.96
482078	02/09/2012	I	4	74.15	13.08	87.23	96.22	-8.99
481722	02/10/2012	I	4	366.43	5.00	371.43	432.00	-60.57

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PARK WEST PHARMACY, INC.
904 AUTUMN ROAD SUITE 275, LITTLE ROCK, AR
(501) 224-3498

PAGE NO: 5
DATE: 03/27/2012

List of Rx - Paid less than Acq Cost
(01/01/2012 To 03/27/2012)

Rx#	DispDate	Pay type	Ref#	Ino	Paid	Copay	Revenue	ACQCoat	Cross Margin
478944	02/11/2012	I	2		16.64	0.86	17.50	19.00	-1.50
478306	02/14/2012	I	6		76.80	0.00	76.80	103.23	-26.43
474166	02/15/2012	I	4		0.00	18.92	18.92	20.07	-1.25
478154	02/15/2012	I	4		12.10	5.00	17.10	19.50	-2.40
484422	02/18/2012	I	3		90.33	25.00	115.33	115.92	-0.59
486053	02/21/2012	I	2		13.43	12.31	30.74	30.84	-0.10
482932	02/21/2012	I	4		30.84	40.00	70.84	70.95	-0.01
485929	02/22/2012	I	3		23.12	6.00	29.12	29.95	-0.82
480882	02/22/2012	I	2		149.68	71.31	220.99	221.00	-0.01
481071	02/24/2012	I	2		139.97	59.95	199.92	208.56	-8.74
488082	02/24/2012	I	1		17.64	10.00	27.64	28.85	-1.21
485188	02/24/2012	I	2		0.00	87.74	87.74	96.22	-8.48
470891	02/28/2012	I	10		35.10	21.51	56.61	56.88	-0.27
479559	02/28/2012	I	3		17.10	5.00	22.10	22.41	-0.31
479097	02/29/2012	I	5		46.14	10.00	56.14	59.16	-3.02
486539	03/01/2012	I	1		15.27	7.00	22.27	22.61	-0.34
481997	03/01/2012	I	4		175.40	5.00	180.40	182.95	-2.55
486844	03/02/2012	I	1		40.69	10.00	50.69	66.82	-16.13
488841	03/05/2012	I	1		0.00	4.38	4.38	7.01	-2.63
489437	03/05/2012	I	1		0.00	9.30	9.30	11.50	-2.20
475982	03/06/2012	I	9		46.14	10.00	56.14	59.16	-3.02
488639	03/06/2012	I	1		18.97	3.35	22.32	23.16	-0.84
483603	03/06/2012	I	4		15.41	8.00	23.41	23.68	-0.27
482333	03/07/2012	I	2		84.83	2.60	87.43	96.22	-8.79
478231	03/07/2012	I	10		10.81	44.38	55.19	59.16	-3.97
488719	03/08/2012	I	1		8.90	6.00	14.90	16.53	-1.63
487110	03/09/2012	I	2		7.71	35.00	42.71	46.47	-3.76
487260	03/10/2012	I	2		50.70	5.00	55.70	56.33	-0.63
475913	03/10/2012	I	8		122.03	10.00	132.03	168.91	-36.88
487343	03/12/2012	I	2		0.00	54.85	54.85	57.76	-2.91
479422	03/13/2012	I	3		31.66	0.00	31.66	31.94	-0.20
472258	03/14/2012	I	3		154.75	36.00	190.75	192.04	-1.29
486113	03/15/2012	I	2		8.82	2.60	11.42	13.12	-1.70
487246	03/15/2012	I	2		261.02	2.60	263.62	386.79	-123.17
473159	03/15/2012	I	5		82.23	5.00	87.23	96.22	-8.99
478306	03/15/2012	I	7		102.43	0.00	102.43	103.23	-0.80
479507	03/15/2012	I	8		46.14	10.00	56.14	59.16	-3.02
474166	03/16/2012	I	5		0.00	18.82	18.82	20.07	-1.25
485929	03/16/2012	I	4		24.24	6.00	30.24	35.93	-5.69
489795	03/19/2012	I	2		12.32	6.00	18.32	18.71	-0.39
484422	03/19/2012	I	4		39.73	25.00	114.73	115.92	-1.19
478154	03/21/2012	I	5		12.10	5.00	17.10	19.50	-2.40
482932	03/22/2012	I	5		30.84	40.00	70.84	70.85	-0.01

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PARKWEST

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PARK WEST PHARMACY, INC.
804 AUTUMN ROAD SUITE 275, LITTLE ROCK, AR
(501) 224-3489

PAGE NO: 6
DATE: 03/27/2012

List of Rx - Paid less than Acq Cost
(01/01/2012 To 03/27/2012)

Rx#	DispDate	Pay type	Ref#	Ins Paid	Copy	Revenue	AcqCost	Gross Margin
479559	03/22/2012	I	4	17.10	5.00	22.10	22.97	-0.87
479097	03/22/2012	I	6	46.14	10.00	56.14	59.76	-3.62
479662	03/22/2012	I	2	80.89	10.00	90.89	96.43	-5.54
481697	03/26/2012	I	1	7.12	10.00	17.12	17.25	-0.13
484782	03/26/2012	I	4	72.47	18.12	90.59	109.82	-19.23
TOTALS: 93				5474.83	1388.85	6863.68	7558.47	-694.79
TOTALSUMMARY: 218				15489.76	3396.77	18886.53	20716.70	-1830.17

January 2012

Park West Pharmacy-List of RX -Paid Less Than ACQ

Revised or State Program	Medication and Indication	ACQ Cost to Administer (per Qty Pharmacy)	Total Amount Paid for Pharm	Reimbursement Paid by PSM	Co-Pay Paid by Patient	Dispensing Fee Paid by PSM (Included in Reimbursement)	Loss on RX	RX #
605947	Phenazolin Chlorhydrate Cough	46.15	4.68	32.68	10.00	1.75	.47	488042
605947	Hydrocortisone Chlorhydrate Cough	61.55	60.33	50.33	10.00	1.75	1.30	488045
605947	Tetracyclin Chlorhydrate Cough	87.41	82.00	52.60	30.00	0	4.81	488046
604336 (Retail)	Methylene Blue Solution	10.05	7.27	4.75	2.58	1.05	2.68	108103
604336	Hydrocodone/APAP	8.03	6.19	0	6.00	1.00	2.14	488197
610016	Cyclosporin/AFA P	13.33	17.66	13.44	4.22	1.50	.87	488197
610097 (Retail)	Tobramycin 3% Ocular Solution	11.22	10.38	3.38	7.00	1.50	3.	488108
610097 (Retail)	Nicotinamide UTP/Infectin	29.70	17.06	0	17.06	1.10	12.34	483969
610014	Methylphenidate ER 27mg ADD/ADHD	132.59	142.37	172.37	5.00	1.50	10.22	488262
601377	Tricyclic Antidepressants	12.92	10.00	0	10.00	1.50	2.92	488271
610094 (State)	Methylphenidate ER 36mg ADD/ADHD	171.36	168.35	168.35	0	3.41	2.91	488273

January 2012

Park West Pharmacy-List of RX -Paid Less Than ACQ

Item/State or State Program	Manufacturer and Indication	ACQ (Cost to Pharmacy)	Total Amount Paid for Client	Reimbursement Paid by PBM	Co-Pay Paid by Patient	Dispensing Fee (Included in Reimbursement)	Loss on RX	RX #
610336	1-Methylcysteine 750mg Supplement	70.83	70.84	30.84	40.00	2.00	.01	485972
610415	Aluvostin 10mg Citrusflavor	87.23	87.23	87.23	5.00	1.05	8.59	479159
610014	Dipeptide/tyrosine 200mg/ml Diphenhydramine	41.11	41.11	31.11	10.00	1.25	8.17	483660
604336 (Federal)	Amoxicillin Cholesterol 20mg	136.72	136.72	118.72	6.00	1.00	12.53	323878
610438 (Federal)	Lidocaine 2% Viscous Solution Anesthetic	36.03	36.03	36.03	6.00	1.00	3.97	485283
610575	Venlafaxine ER 225mg Depression (SSRI)	186.40	186.40	186.40	0	1.25	2.55	481997
610415	Public Supplement (NSAID)	22.10	22.10	17.10	5.00	1.05	.31	496539
605855 (Federal)	Theophylline 1% Inhaler	26.64	26.64	26.64	6.00	1.50	3.31	485829
610415	Cefaclor 250mg Capsules (Cephalosporin)	109.22	90.39	72.47	18.12	1.05	19.23	487382

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Park West Pharmacy-List of RX - Paid Less Than ACQ

Refill/End of State Payment	Medication and Indication	ACQ (Cost to Acquire Drug by Pharmacy)	Total Amount Paid for Claim	Reimbursement Paid by PBM	Co-pay Paid by Patient	Dispensing Fee Paid by PBM (Included in Reimbursement)	Loss to RX	RX #
00388	Trasoprazole 30mg GARDOL	43.38	42.29	32.20	10.00	1.25	1.18	479583
00388	Triamcinolone Acetate Allergic Rhinitis	81.45	79.83	72.83	7.00	1.25	1.82	479615
610020	Backscaple Acetamin Aspirin	437.30	371.45	366.40	5.00	1.75	60.57	481722
610014	Zellamamide Resomand Athlete (DMARSD)	19.50	17.10	12.10	5.00	1.50	2.40	478154
003316	Penicillins 5mg Cefazolin (cephalosporins)	20.07	18.52	0	18.82	1.00	1.25	474166
00388	Nortrin LA 30mg Amitriptyline/ HTP/ Adu.	115.32	115.30	90.33	25.00	1.25	.29	484422
610057 (Event)	Polyethylene Glycol Laxative	26.58	26.27	18.27	8.00	1.50	.71	480272
012320 (Event)	Pteroylglutamic Acid	15.61	12.80	0	12.80	1.25	2.81	478432
610014	Microbial Succinylcholine Chloride	30.84	30.44	1.36	29.14	1.50	.10	480053

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Park West Pharmacy-List of RX -Paid Less Than ACQ

State or State Program	Medication and Indication	ACQ (Cost to Acquire Drug by Pharmacy)	Total Amount Paid for Chain	Reimbursement Paid by PBM	Co-Pay Paid by Patient	Dispensing Fee Paid by PBM (Included in Reimbursement)	Loss on RX	N.N.#
00455	Atorvastatin 80mg Calcium Salt	137.25	124.72	118.72	6.00	1.00	12.53	479515
00436	Phenytoin 100 mg Suspension	20.56	14.99	8.90	6.00	1.00	5.76	482043
00136	Calcium Acetate 650mg Calcium Supplement	183.54	178.65	178.06	2.60	1.00	4.88	476202
01152	Lorazepam 1mg Hydrochloride	13.11	7.72	2.32	5.00	1.43	5.59	483076
01015	Amoxicillin 500mg Capsules	56.88	36.61	39.63	16.98	1.50	37	469566
60047	Tadalafil 20mg Tablets	37.41	32.60	32.60	30.00	0	4.81	172902
00136 (Federal)	Atorvastatin 20mg Cholesterol	137.25	124.72	118.72	6.00	1.00	12.53	481878
61004 (Federal)	Penicillin V Potassium 250mg Oral	64.04	37.52	35.91	22.01	1.50	6.12	470091
00385 (Federal)	Placebo 1% Glucerna Milk	30.02	26.54	30.64	6.00	1.50	3.38	485879
01020 (Federal)	Amoxicillin 500mg Cholesterol	96.22	37.18	34.10	13.08	1.60	9.04	822078

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Park West Pharmacy-List of RX -Paid Less Than ACQ

Benefit/Member State Program?	Medication and Indication	ACQ (Cost to Pharmacy)	Total Amount Paid for Claim	Reimbursement Paid by PBM	Co-Pay Paid by Patient	Dispensing Fee Paid by PBM (Included in Reimbursement)	Loss vs. RX	RX #
004336	Glibenclamide ER 2.5mg Diabetes	7.22	6.89	4.29	2.60	1.00	.35	488782
005847	Contraceptive Patch Side Patch ADR0A0HD	46.63	45.57	35.57	10.00	1.75	1.06	486805
004336 (Federal)	Sertraline 50mg Patch	141.24	127.45	121.46	6.00	1.00	13.78	484610
610415 (Federal)	Phenacetol 3% Amphetamine	202.76	202.31	202.34	0	1.00	1.22	486891
61085 (State)	Methylphenidate ER 5mg ADR0A0HD	157.10	155.06	153.16	0	5.51	2.24	457048
610239 (Federal)	Albuterol 2mg/ml Inhaler	10.20	8.99	7.54	1.35	1.00	1.21	487116
610502 (Federal)	Fluoxetine 20mg New Formulation	29.07	28.13	18.13	10.00	1.00	.94	487119
610593 (State)	Methylphenidate ER 5mg ADR0A0HD	171.26	168.35	165.35	0	5.51	3.29	487156
000847	Demoxolone 30mg ADR0A0HD	146.42	139.71	124.71	15.00	1.75	6.71	487771
610293 (State)	Methylphenidate ER 5mg ADR0A0HD	171.26	168.35	165.35	3.00	5.51	2.01	487809
610693 (State)	Methylphenidate ER 5mg ADR0A0HD	171.26	168.35	165.35	0	5.51	2.31	487778

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Park West Pharmacy-List of RX -Paid Less Than ACQ

Identical or Same Program	Medicine and Dosage	ACQ (Cost to Acquire Drug by Pharmacy)	Total Amount Paid for Claim	Reimbursement Paid by PBM	Co-Pay Paid by Patient	Dispensing Fee Paid by PBM (included in)	Loss on RX	RX#
005847	Amoxicillin 20mg Chewable	437.25	125.47	110.47	15.00	1.75	11.78	487359
008848	Clarithromycin ER 500mg Antibiotic (Macrolide)	76.65	76.35	66.35	10.00	1.25	.25	487467
012320 (Fiscal)	Hydrocodone/AP AP 5/325 Pain	11.40	9.30	0	9.30	1.25	2.20	487569
004335	Clonidine ER 2.5mg Diabetic	21.66	17.67	2.67	15.00	0	2.96	487387
610014	Atenolol tablets ER 30mg ADJVALEHD	88.84	76.25	66.25	10.00	2.00	12.39	487395
008847	Clarithromycin 500mg Antibiotic (Macrolide)	127.17	119.63	105.63	10.00	1.75	7.54	487466
004336 (Fiscal)	Oxycodone 30mg Pain	83.70	64.21	61.21	4.00	1.75	15.49	487489
610219 (Fiscal)	Metformin ER 250mg Anti-diabetic	6.82	2.78	2.22	.56	1.00	4.04	487643
003384 (Fiscal)	Clindamycin ER 300mg Antibiotic (Lincosamide)	76.66	70.82	60.82	10.00	2.00	5.78	487761
610239 (Fiscal)	Propofolone Oral Osmol. Lactulose	26.08	23.87	20.89	3.53	1.00	3.11	487959

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Park West Pharmacy-List of RX -Paid Less Than ACQ

610014	Nitroglycerin Sublingual Tablets	22.61	22.27	13.27	7.09	1.30	.34	486139
610614	Metformin HCL Extended Release Tablets	25.00	33.75	13.75	10.00	1.25	1.25	483294
610471	Diclofenac 50mg Tablets	57.38	53.01	45.01	12.00	1.50	2.27	482017
606336	Colistipol 100mg Capsules	64.59	60.21	54.21	6.00	1.00	4.38	471123
610415	Levamisole 100mg Tablets	352.94	327.98	248.27	79.01	0	33.55	474468
606028	Omeprazole Delayed Release Tablets	140.82	140.56	130.66	10.00	1.25	1.5	475599
606336	Atorvastatin Tablets	137.23	124.72	118.72	6.00	1.00	12.33	47086
610014	Valiuron Tablets	133.20	122.45	112.45	10.00	1.25	10.75	457798
610014	Morphine Sulfate Tablets	171.26	168.35	163.35	5.00	5.31	2.91	457999
610014 (Federal)	Penicillin V Tablets	441.99	402.21	398.51	2.00	1.50	4.78	487915
606336	Hydrocodone/APC Tablets	8.63	5.40	0	6.45	1.00	2.14	488023

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Park West Pharmacy-List of RX -Paid Less Than ACQ

Manufacturer State (Patient)	Medication and Indication	ACQ (Cost to Acquire Drug by Pharmacy)	Total Amount Paid for Claim	Reimbursement Paid by PBM	Co-Pay Paid by Patient	Dispensing Fee Paid by PBM (Included in Reimbursement)	Loss on RX	RX #
004336 (Patient)	Carbidopa/Levodopa Syrup Parkwest Syrup	31.24	31.66	31.66	0	2.50	.38	479422
004336	Symond 1.2mg hydrocodone	19.56	8.80	0	8.80	2.00	10.66	489110
004336 (Patient)	Domnamide 20mg (HRE)	44.40	9.27	0	9.27	2.90	5.13	475490
012320 (Patient)	Axerumatin 10mg Cholesterol	65.22	87.43	84.83	2.60	1.23	8.79	483803
010074	Cefixim 300mg granule for oral suspension (Cephalosporin)	30.38	18.38	0	18.38	1.30	11.80	487274
005947	Acromentin 200 Cholesterol	411.75	406.81	379.81	30.00	0	5.94	487239
003286	Methimazole 10mg Hypothyroidism	31.22	19.28	.27	18.91	0	1.94	487264
005947	Methylprednisolone 50.00mg ADJUDICAP	314.79	201.84	204.84	20.00	1.23	32.95	488188
004336	Hydrocodone Chlorpheniramine Cough	61.53	59.60	54.60	5.00	1.05	1.99	488337

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Mr. GRIFFIN. Thank you, Mr. Chairman, I appreciate that. I have not decided what I am going to do on H.R. 1946 at this point, but I am concerned about our community pharmacies, and I have expressed those concerns about the merger that is being considered right now. I know we are expecting a decision on that soon, but I registered my concerns about that, and the implications of that on community pharmacies.

I wanted to ask you, Mr. James, a couple of questions. First of all, can you talk a little bit about the limitations of PSAOs and their ability to negotiate and bargain with the PBMs? What hinders that organization that independent pharmacies are members of from doing that sort of negotiating?

Mr. JAMES. I think it boils down to the fundamental fact that each pharmacy is its own corporation, its own entity. It is a private entity. They can represent them in advice, when we all come together, because I belong to one. It is 500 or 600 stores. And they can come together, look at contracts, which that normal pharmacist usually is not an attorney. He doesn't have all the expertise he needs to have to address that contract and what it says. He knows what they are saying they are going pay him. He knows what they are going to do about audits, things of that nature, but he doesn't know all the other legalities of the contract.

So PSAOs formed several years ago to bring stores together and say, "We could advise you on this program." They can talk to the PBM about things they don't like in that contract, things that are onerous type things, things that have to do with audit processing, and things of that nature. They can turn to me, as a member of that PSAO and say, "We don't think this is a good contract for you. We would advise you not to take this, or we would advise you to take this."

The difference here is that once they give me that advice, I am still my own entity, and I have the right to join that contract, if I choose, no matter what they say. So, they can be as strong as possible, recommended you to turn it around, and then anybody that chooses to can go ahead and join the program. But, they don't have any legal standing to negotiate for my pharmacy.

Mr. GRIFFIN. Do you have anything to add to that, Mr. Gray?

Mr. GRAY. No. He told it just like it is. They are there, but they don't negotiate. They just give us advice.

Mr. GRIFFIN. I want to ask you, Mr. James, since you referenced the Park West Pharmacy in my district, can you give me a little background on these documents that you discussed in your testimony? Well, at least your prepared testimony. You might have changed it for today after talking with my staff and learning that I was going to introduce these into the record. But, can you tell us a little bit about what these documents that I have put into the record, what they represent, what they tell us, and why the folks at Park West Pharmacy in Little Rock were so keen on having these entered into the record?

Mr. JAMES. What you have is a listing from Park West Pharmacy that shows the actual prescription medication they used in filling a prescription, the actual amount that was billed, and the actual amount the PBM paid them for that product.

So, for example, if you had a prescription you were filling, your actual acquisition cost for the product was \$100. You transmit that to the PBM. They trans back to you what they are paying you for that product, what your fee is on that product, and how much you should charge the patient as a co-pay.

What this document shows are 218 prescriptions, if I remember correctly, that they were paid just for the product, less than the product actually cost.

Mr. GRIFFIN. Just to clarify. I see the yellow light is on. I am running out of time. What Park West receives for that prescription is not a surprise to them. They are not saying that they are owed money that they can't get. They are just saying that the price they

have to agree to is less than they would prefer. It is not a surprise to them. I am just trying to—

Mr. JAMES. The interesting part of this is that they do not know what that PBM is going to pay them today or tomorrow for the same drug. It may change.

Mr. GRIFFIN. Gotcha.

Mr. JAMES. So what we are looking at in your examples there is maybe that \$100 came back to them at \$95.

Mr. GRIFFIN. Gotcha.

Mr. JAMES. So they were down \$5 as soon as they fill the prescription from the acquisition costs.

Mr. GRIFFIN. Gotcha. I see I am out of time. Thank you, Mr. Chairman.

Mr. GOODLATTE. I thank the gentleman. And the Chair recognizes the gentlewoman from California, Ms. Chu, for 5 minutes.

Ms. CHU. Thank you, Mr. Chair. I am concerned about the proposed merger of Express Scripts and Medco, which would then cover more than 135 million lives. Should this merger be approved, there would be even more of a limit in the ability of community pharmacists to be able to negotiate in a manner that enables them to continue to serve their patients. And one of those examples of the growing power of the PBMs is the mail-order business, and I would like to ask Mr. Gray and Mr. James about this.

I have heard from constituents and from pharmacies about how PBMs use data from the community pharmacists' patients to try to push these patients to use the PBM's own mail-order business. And the PBMs are in a position to force the plan beneficiaries to use the PBM-owned mail-order pharmacy, and that they even are allowed to use the pharmacy's patient data.

Is this your experience, and how do the PBMs pressure the customers to use their mail-order services?

Mr. JAMES. Yes, it is my experience, and it happens everyday. I mean we have had instances in which a patient would fill a prescription under a new plan they have just gone on and literally had a call from the PBM mail-order house that afternoon saying, "I see that you received such-and-such drug. We can save you a lot of money if you will buy this through the mail-order program. We will give you a discount on your co-pay."

So, what we are seeing happen is, we are seeing the data that we transmit, which consists of all their information, including the medication, going to the PBM, and immediately be transferred to their marketing department, so that they can call and write letters.

We see people on a regular basis get two or three letters a month from a PBM trying to coerce them. And these letters are written in such a way that it almost convinces that patient that if you don't do this, you are going to lose your benefit. And so then they come to the pharmacy saying, "I have got to go mail-order, because here is what they are saying." Bring me your letter and when you read the letter, that is not exactly what they said. They insinuated that, but obviously, the patient thinks that is the case.

The major fear among patients in cases like this is losing their benefit. They are afraid they are going to lose their healthcare coverage, and because of that, they are going to do anything that they think they have to do to retain that.

Mr. CHU. Mr. Gray.

Mr. GRAY. Many times, the letter comes and says that they don't have a choice now. They are forced to go mandatory mail-order. And that is the ones we see the most, where they actually have no choice. They have to get it mail-order or pay cash. And there should be a choice in this. The patient should be able to choose their own doctor, their own pharmacy, where they get their car fixed. They should be able to have choices, but now they are not given a choice. And the PBM doesn't allow us to do anything about it. They even tell us that we have to advertise for them. "Oh. I am sorry. I can no longer fill your prescription, Ms. Chu. You have to get yours through mail-order." So I am actually forced to tell them where they have to go, who they have to call. And that is really not fair.

Ms. CHU. Mr. Wright, if pharmacies are not allowed an antitrust exemption, even as limited as the one as in H.R. 1946, why should PBMs be allowed to engage in these kind of practices?

Mr. WRIGHT. To begin with, I am not sure that the exemption in the existing bill is limited. It depends what you mean by "limited." From my perspective, part of what would clearly be allowed as conduct that would be prescribed under Section 1 of the Sherman Act, and always has been on the grounds that it will result in higher prices and reduced welfare for consumers. And in that sense, I would not describe the exemption as particularly limited from an antitrust perspective.

With respect to antitrust analysis of what the PBMs have done with respect to mail-order, that is not a question that I have studied or have any particular view, based on analysis.

Ms. CHU. Okay. I would like to ask a question to Mr. Feinstein about special treatment. You stated that pharmacies are requesting special treatment by allowing them to negotiate with the much larger PBMs, especially given the limits that would be placed under H.R. 1946. I find it of great concern that this is called "special treatment" for pharmacies, but there seems to be little concern given to the special treatment that is given to the PBMs and their ability to conceal information regarding pricing and audit standards.

If we were to oppose special treatment for any party, why are PBMs allowed to withhold this information from pharmacies during contract negotiations? Because, in effect, that sounds like special treatment for the PBMs.

Mr. FEINSTEIN. Just to make sure that my position is clear, the "special treatment" that I was referring to was special treatment under the antitrust laws. And antitrust exemptions, whoever may be seeking them, it is an exception from the antitrust laws that otherwise apply generally.

With respect to the provisions that you are speaking of, which are not provisions that really are sound in antitrust law, my understanding is that that arises primarily from the relationship between the PBM and the sponsor of the health plan, which very often is an employer, as I mentioned earlier. And the employers want the PBMs to deliver the services that they are delivering under competitive conditions, in terms of both price and quality.

I mentioned in my earlier statement that there are a lot of new business models that are emerging in healthcare generally. Certainly, this is no exception. And certainly, the phenomenon of mail-order is an example of that. And I am not pro or con mail-order, but it has emerged, and it is one of the features that is offered as a way of helping to contain costs in some circumstances. It doesn't do that in every circumstance, necessarily. But, what is happening is that the provisions that I think are being described here are part of the financial arrangement and the contractual arrangement between the PBM and the provider of the health benefit, and it is intended to help control healthcare costs.

So, I think we have to be careful in how we approach them. But, again, these are not fundamentally contractual provisions that tee-up antitrust issues, unlike the antitrust exemption.

Ms. CHU. I yield back.

Mr. GOODLATTE. I thank the gentlewoman. The gentleman from California, Mr. Issa, is recognized for 5 minutes.

Mr. ISSA. Thank you. I guess I will start with Professor Wright.

As far as I know, the PBMs are not on trial here. We only have one narrow question, which is: Do we grant additional antitrust to a retail entity so they can work with other retail entities to do more than just have a buyers group? Is that really what we are talking about here today? I just want to make sure it is in simple language for the American people.

Mr. WRIGHT. That is how I understand the issue.

Mr. ISSA. I used to be a manufacturer. They already have an ability to form buyers groups, and buy in greater numbers, so they can compete with Wal-Mart or anybody else that has larger buying power. That is not a question here today, right?

Mr. WRIGHT. My understanding is that under current antitrust laws, the independent pharmacies have the ability to engage in pro-competitive coordination.

Mr. ISSA. Okay. So, I am kind of going through and saying, okay, it is not about price, because, essentially, all the independents could form a group that all by itself would essentially be as large as the top five or six, you know, non-small. So, the further cooperation antitrust is not necessitated based on something to do with the other side of the coin.

Mr. Feinstein, I guess I will go to you, because you are sort of the regulator in the room. Where is the compelling need to do this that favors action toward these private businesses? And the reason I ask, before I go further, because you have a portfolio far greater than pharmacy. If we are looking at all of the buying, and I was in consumer electronics, the same could be said of trying to deal with my old company, or Sony, or Panasonic, any of these things, everybody would like to have the ability to get together and to compare not just prices for, you know, group buying, but they would like to be able to compare who got how much co-op, what the salesmen did for them for lunch, everything else. If we were to expand it here, wouldn't we essentially open the floodgates for all small businesses to say they have a similar situation in which they would get a competitive advantage, if they were allowed to operate, if you will, as a cartel of storefronts?

Mr. FEINSTEIN. I think that is a legitimate concern, Congressman, and I think that is one of the reasons that the Antitrust Modernization Commission issued its views that these sorts of exemptions should occur very rarely and be thoroughly considered by Congress before they are authorized.

Mr. ISSA. Now, it is not within this Committee's jurisdiction, but if we looked at the other side of the coin probably over at Ways and Means or Energy and Commerce, the fact is you can reform the actions of the middle parties, you know, in other words, you can reform insurance law, you can reform any part of it, certainly, what now is probably called by the Administration, "Obamacare." For a while, I was told not to say it. Now, they are using it. So, the healthcare reform law. The fact is it reforms a lot of that, doesn't it? Aren't there a lot of changes in the air in the case of, if you will, healthcare delivery and insurance?

Mr. FEINSTEIN. Yes, there are. And I think that is an example of the point that shouldn't be lost, which is that because this is such a blunt instrument, that is, authorization of price fixing, to put it bluntly, antitrust exemptions have widespread unintended consequences, although, they are foreseeable.

If this concern needs to be addressed, I believe it should be addressed more directly and more surgically in a way that does not have all of those ripples throughout the economy.

Mr. ISSA. Now, Professor Wright, I am going to—and I would like to open it up to the others quickly. We have a lack of transparency, generally, in this relationship. The pricing, and distribution, and sales of pharmaceuticals, it is pretty much voodoo magic. You can't figure out what somebody's really paying till you look at a series of discounts, and so on. Is that your understanding? And then I would like to go to the pharmacists.

Mr. WRIGHT. Like many industries, I think they analyze price.

Mr. ISSA. Okay. So, now I would like to go to, if you will, to the other side of the coin. Mr. Gray, Mr. James, if we cannot grant you antitrust, isn't one of the alternatives a dramatic increase in the transparency of the actual pricing, purchase price, sales price, profit margins, which we could do? We could demand that there be effectively a fair price for a fair volume, and that that be transparent.

And in the case of government-funded programs, Medicare, and the like, where we work off of a series of discounts, because everything is based on some hypothetical retail price, isn't that reform the alternative that you might seek from Congress in order to get a fairer, easier to understand relationship?

Mr. JAMES. I think that where we are at this moment in time, there are a couple of answers to that. Number one, we have to remember in this bill the Federal Government is not involved in this bill. This is strictly about a private situation.

Number two, we have to remember in your example of electronics that when cost of electronics goes up from the manufacturer, that individual dealer has a right to raise his price, if he chooses to, to try to compensate for that. In our industry, that doesn't exist. With PBMs, they set both ends of the equation. So, if the drug goes up, they don't give us any additional—

Mr. ISSA. Right. And for both of your answers, and my time is expired, I just wanted you to sort of say, if we fix that part of the equation, if you will, the bizarre pricing situations in which there really is not an honest, and fair, and open, and transparent delivery. I mean pharmaceuticals are the only things worse to try to figure out what they really cost, they're the only things worst than a hotel room on Priceline.

Mr. JAMES. I think what you have is a situation in which once you have transparency, you may know more about what is going on. I don't think that is going to force the PBMs to do anything with us.

Mr. GOODLATTE. The time for the gentleman has expired.

We have 11 minutes remaining in a vote. I think that is sufficient time to be able to recognize the gentleman from Georgia, Mr. Johnson, for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. I remember Andy, of Mayberry, the Andy Griffin Show, and there was Floyd, the barber. I don't know if you-all remember Floyd or not. But then, right next door to Floyd may have been John, the pharmacist. But, the landscape has changed since then, and we don't have many John the pharmacists in business market- share.

And I know you, Mr. Gray, and you, Mr. James, you are a little bigger than John, the pharmacist back then. You are a little bigger, but still the same community-minded pharmacists. But, you are kind of a vanishing breed. And I suppose a lot of folks are going to work for the PBMs and the drugstores, the major drugstore chains, and that kind of thing, and then the PBMs are even purchasing the drugstore chains now, to where they can be the retailer. They can be the retailer on the street, brick-and-mortar retailer, and control the mail-order market. And it is three, basically, PBMs that control about 60 percent, I am told, of the drug dispensation market in America. Anybody disagree so far?

Mr. FEINSTEIN. I don't necessarily disagree. I just need to know a little more about it specifically.

Mr. JOHNSON. Okay. I am kind of spoon feeding now.

Mr. FEINSTEIN. Understood.

Mr. JOHNSON. The first bite was good. First spoonful was good.

Now, it is the PBMs that negotiate the drug prices with the pharmaceutical manufacturers. And the pharmaceutical manufacturers don't hear from John, the pharmacy type guys, because of the antitrust law, which is a relic from the past. Even though the business model has changed, we are still depending on those old traditions in the law insofar as antitrust exemptions are concerned. But, John, the pharmacist, has been losing market-share probably since Andy Griffin, since that time, and the trend continues to go down. And I think that you, Mr. Gray, and you, Mr. James, have made a good case for why we should have the option of either going to the small pharmacist, or going to the major drugstore chains, you know, to get our mail. Oh, we do it the modern way, through the mail, you know, that kind of thing.

Choice is real important. Choice, by the way, is not a part of this bill, is it, in terms of PBMs having to tell folks that you have the right to go through your drugstore or through mail. They don't have to do that, and you are not asking for that with this legisla-

tion. But, you just want a seat at the table when it comes to negotiating the price or the reimbursement for the drug. Is that correct?

Mr. GRAY. That is correct.

Mr. JOHNSON. Okay. Now, given the fact that the market has changed, and John, the Barber, is threatened now with extinction, due to the larger entities that have control over the drug dispensation market, what would be so wrong with allowing them for the limited purpose of coming together to negotiate price? How could they drive up prices being only 40 percent of the dispensation market and still declining? That is what I would like to know, Mr. Feinstein.

Mr. FEINSTEIN. I think the simple answer, at least—

Mr. GOODLATTE. Given the shortness of time, without objection, the gentleman is recognized for an additional 30 seconds, and then you will have to recess.

Mr. FEINSTEIN. I think that the price increases of some magnitude are inevitable, because that is whole purpose of the legislation. And I don't mean to be pejorative about that. I am just trying to give you a direct answer. The idea is to immunize conduct which is intended to increase the reimbursement to the community pharmacist, and that will increase the costs to the system.

Mr. JOHNSON. Well, now if the community pharmacist doesn't know how much the PBMs are getting for reimbursement and the PBMs can just dictate to the independent pharmacist how much they will be able to receive.

Mr. GOODLATTE. The time of the gentleman has expired.

We have less than 5 minutes remaining in this vote. We are going to return, and when we return the gentleman from Pennsylvania will be in the Chair, and he will first recognize the gentleman from Texas, Ms. Jackson Lee. I, unfortunately, will not be able to return, but the gentleman from North Carolina and the gentleman from Pennsylvania may have some additional questions that they may wish to ask of the panel, too.

So, we appreciate your forbearance, and the Committee will stand in recess.

[Recess.]

Mr. MARINO [presiding]. The Judiciary hearing will come to order again. I want to thank the witnesses for giving us their valuable time and waiting, and the people out there as well.

Now, I am going to ask the distinguished Congresswoman from Texas. She has 5 minutes.

Ms. JACKSON LEE. Mr. Chairman, thank you for your courtesies, and thank the witnesses for their patience for our schedule.

Mr. Marino, I am delighted that you have revived this legislation. We had a vote on it in Committee in the last session under the gentleman from New York, Mr. Weiner, and I think that Members, I would like to see some further life in the bill. I think this was at the end of the term, and I think as you have listened to the questions in a Committee that is the protector of competition, it raises a concern on the issue of harm, when we give an exemption, who are we harming. So, I believe this is an important hearing that allows us to deal with this issue and be thoughtful, and see how we can come to a reasoned response.

And I think there is an enormous amount of right on the side of community and small pharmacies. It is a mountain of rightness on that. But as the protectors of the antitrust law, that it works so that the Federal Trade Commission and the Department of Justice Antitrust Division have the tools that they need to protect the consumer, we have to have a respectful balance.

So, I am not asking you, Mr. Feinstein—should I say stine? I didn't hear the pronunciation before.

Mr. FEINSTEIN. Fein-steen. Yes.

Ms. JACKSON LEE. Fein-steen. Thank you—to go overboard because you are a government regulator. You adhere to the law.

So, my question to you, I am putting this word in front of it, what is the devastating harm of the potential of a bill like the one that we are addressing here today, 1946—and I heard Mr. Issa's comments about if one gets it, the other gets it. But, let's move past that. I have already heard that. Just give me what else. And I need to talk to other witnesses. So, if you could be precise, what would be the expanse of the harm? And, frankly, I would like you to just focus on this industry and this concept, which is an exemption for our smaller guys, giving some sort of equal playing field. But, go ahead, sir.

Mr. FEINSTEIN. Thank you. In short, the harm that we are most concerned about is increases in costs to the healthcare system. Unambiguously, the purpose of this proposal, and they have been very direct about it, is a perceived need on the part of the community pharmacist to be paid more for the services they provide. And I understand that perception on their part. I totally understand how that would help them. Antitrust exemptions always help the people that are seeking them, and I don't mean to be pejorative in saying that. It is just a fact.

Ms. JACKSON LEE. That is all right.

Mr. FEINSTEIN. But, our constituents, our consumers, as a whole, when I say "our," I mean the FTC, the enforcement agencies, and our concern is that this will introduce additional costs, and Professor Wright has explained how, you know, it is an economic certainty that at least some of them will be pass-through.

Ms. JACKSON LEE. And the costs will be on the ultimate product that the consumer is coming to the pharmacy for.

Mr. FEINSTEIN. Yes. I mean one way to think about it is, you know, the PBMs contract with employers, employers are paying the PBMs to provide these services. Those costs, if they get passed through to the sponsors of the health plans, that is going to show up in some fashion. It is going to show up in reduced benefits in the health plans. It is going to show up in higher co-pays. There are lots of different ways. And it is just fact.

And I guess I would also point out, you know, if it were clear that that wasn't the case, and there weren't going to be cost increases, why would the bill exempt the Federal Government from its provisions. I mean for other reasons, we think some of those costs will nonetheless be imposed on the government. I think that is a genuine question that hasn't been answered.

Ms. JACKSON LEE. Yes. Mr. Marino, I am already going to ask for additional time just to finish my line of reasoning. Because, Mr. James, I wanted to ask, the regulator, he has to follow the law.

How do you answer the question of higher costs? My concept of it is, allowing you-all to negotiate with the PBMs for lower costs, or to give you the ability to go out and get lower-cost prescription, now you are saying that your costs are higher, and, therefore, you need to be paid higher?

Mr. JAMES. No. What we are saying is that what we are doing, as we talked about earlier, is that in some cases in these programs that we are contracting with PBMs, we are actually being paid lower than the cost of the drug not to address fees to fill the prescriptions. Things of that nature. But what we are trying to do is, everybody has focused here today on cost. They talked about getting more dollars.

If you look at one of these contracts, what you realize very quickly is there is a tremendous amount of onerous things in these contracts that affect pharmacy beyond the figure of cost. For example, their ability to go into a pharmacy 2 years after the fact and do an audit, and retrieve those dollars that were used to fill those prescriptions, even though the prescription was filled properly, the patient got the medication, and has taken the medication, but yet, they come in, because in their contract it gives them the right to handle that anyway they choose.

So, this debate about negotiation is not just about dollars. It is about other things, also.

Ms. JACKSON LEE. That burden you from surviving. Is that what you are saying?

Mr. JAMES. I am sorry? Say it again.

Ms. JACKSON LEE. That burden the small pharmacies from surviving.

Mr. JAMES. Yes.

Ms. JACKSON LEE. And you are giving quality care. Do you think you are giving quality care to individuals who, you may be in places where they don't have access to the big guys or you may have a special relationship that is necessary, particularly the senior population? Do you believe that you have sort of a unique service as well?

Mr. JAMES. Absolutely. Patient care is about face to face. It is not about the mailman. Once you leave, and what I believe as a pharmacist is, there should not be anyone between you and your physician. You go to the physician, they diagnose your problem, they select a drug of choice, and you should be able to get that drug. What we are finding with PBMs is, we fill a prescription, and they refuse to fill it. They refuse to pay for it.

Ms. JACKSON LEE. Let me ask the Chairman, can I have an additional minute to inquire of Mr. Gray.

Mr. MARINO. Without objection.

Ms. JACKSON LEE. I appreciate it. I thank the Ranking Member for coming back, and the Chairman for coming back.

There are a lot of people praying on the steps of the Supreme Court. I guess they were praying in the last 3 days. Today is Thursday. I am praying, too, for victory, because I believe that what we tried to do in the Affordable Care Act, close the doughnut hole, keep people alive who have preexisting diseases is a good thing. So, I am really interested in giving access to healthcare.

So, let me just try to probe. I understand the issue now, and I am called toward the fairness question, which I guess balances the competition. So, I think all of us are sort of grappling with that. I hope there is some life that we can deal with this issue.

But, Mr. Gray, tell us a little bit about your business, because I understand you had an 83-year-old that had a problem. And so, talk about the service. And I want to acknowledge as well the Howard University pharmaceutical students, thank them for their presence here. But, tell us a little bit about that service, and when you deal with the PBMs, that you are the underdog. So, go ahead and tell us a little bit about that.

Mr. GRAY. Well, a gentleman came in. Like I say, he was an 83-year-old gentleman, and he is suffering with Alzheimer's. He remembers he needs his medicine. The mail-order plan said they mailed his prescription to him on March 6. On March 26, he came to me for medication. After making several phone calls, I was able to generate a 30-day supply of medication for him, so he can get his medication. We do these things every day, because they can't call the PBMs. The PBMs have already ignored them. The mail-order plant said, "We mailed it out." But, our objective is to get the medication into the people's hands.

Medicare Part D is to provide medications for Medicare Part D recipients, provide their medications. It has certain limitations. But, we talk about increasing costs. We are not asking for you to increase the costs. We just want the PBM to pay us as they are paying themselves. They pay themselves a fee when they fill the prescription for CVS, CVS Caremark, CVS Caremark Medicare Part D plan. They pay CVS a fee when they fill a brand-name drug.

Ms. JACKSON LEE. So, the PBMs include these large companies.

Mr. GRAY. Right. They own each other.

Ms. JACKSON LEE. And you get no fee?

Mr. GRAY. We get no fee for a brand-name drug. You get the cost only. But, they get a fee. They get one. In their mail-order option and in their stores, they get a fee. We don't get a fee. Why can't we have a fee if they get one?

Ms. JACKSON LEE. All right.

Mr. GRAY. We are looking for fairness.

Ms. JACKSON LEE. Mr. Chairman, I thank you for your indulgence. I think I have sort of pierced the veil here, and I hear a cry for help. I am hoping the Judiciary Committee can help Mr. Feinstein on his regulator responsibilities, but I hope that we can find a way to help these small pharmacies, because I don't want them to die. I think they have a valuable role, even as a small business, but as a familiar face to the community.

This gentleman may not have known where the mail was coming from, but he could make his way over to this gentleman's pharmacy. So, I really believe we should try and find some common ground.

I thank the gentleman for yielding and extending the time.

And I yield back my time.

Mr. MARINO. Thank you. Ranking Member Watt has some additional questions.

Mr. WATT. I just have one additional question. I think we have heard a lot of talk about the abusive relationship between PBMs and pharmacies. And I am wondering why an antitrust case against the PBMs wouldn't be a viable solution. I mean the pharmacies could band together without an antitrust exemption to bring such an action. Why would that not be viable? Maybe there is some reason that I am missing here. And if each one of you can just give me your spin on that, that would be my only question.

Mr. JAMES. If I understood your question correctly, it is my understanding from the antitrust law that individual corporations are prevented from banding together to negotiate.

Mr. WATT. To negotiate, but not to file a lawsuit.

Mr. JAMES. Yes. We can do that. We can band together to not negotiate. If we file a lawsuit, the question is, how do independent pharmacies, with the source of revenue that we have, actually fight a lawsuit with companies that are making \$60 billion a year?

Mr. WATT. That is why I was suggesting you band together, because I assume that one response would be we are too small as individuals to fight the PBMs. But, if you banded together, and filed a lawsuit, if there were abusive practices taking place, why would that not be a viable option? I guess that is the question I am asking.

Maybe there are some reasons. Maybe the professor can tell us whether there are some reasons why that would not be a viable option.

Mr. WRIGHT. I certainly can't speak to viability in terms of what the pharmacies would like to spend to fund such a lawsuit or not, but with respect to the antitrust law question, of course, there are exemptions, petitioning exemptions under the First Amendment that would allow groups to band together for the purpose of petitioning activity, including lawsuits. There would be no bar from the antitrust laws to such a suit.

Mr. WATT. And there is nothing in the antitrust laws themselves that prevent such a suit.

Mr. WRIGHT. No. The question of such a suit would be proof that the——

Mr. WATT. Mr. Gray?

Mr. GRAY. My question is: Why haven't the antitrust laws been applied to stop this in the first place? We have to go file a lawsuit?

Mr. WATT. Well, that is a good question. I mean I have raised that question, too. If mergers are taking place, for example, that are abusive, then those get reviewed by the relevant government agencies, but it is kind of like this, I mean we pass laws that prevent things from happening, that prohibit things from happening. That does not prevent them from happening.

When I was practicing law, clients, and now as a politician, constituents, who come to me all the time saying, "I have been discriminated against." And I said, "There is a law on the books that prohibits discrimination based on race, or gender, or sex." But, you have to go and file a personal action to enforce that law.

And I guess the question I am asking here is: Why has somebody not filed a lawsuit to enforce the law that says you can't collude and take abusive positions in the marketplace against us? Is there

some reason that that is not a viable option, as opposed to amending the antitrust laws and saying that that is the solution here?

Maybe Mr. Feinstein can tell me.

Mr. FEINSTEIN. I would—

Mr. WATT. Even got triple damages if you win, I think.

Mr. FEINSTEIN. The only thing I would say, Congressman, is that I agree with Professor Wright that the antitrust laws absolutely would permit community pharmacists to come together to file an antitrust case. I don't have a view on what the antitrust theory would be.

Mr. WATT. Okay.

Mr. FEINSTEIN. But, they certainly wouldn't be precluded from doing that.

Mr. WATT. And I mean this is not unlike, I made the analogy to employment discrimination. We have an EEOC, an Equal Employment Opportunity Commission, whose responsibility it is to investigate, but the ultimate remedy, we have the FTC and the Department of Justice in the antitrust arena that is there, but the ultimate remedy still is for individuals to enforce the law.

And unless there is some reason that, and maybe there is, I don't know. Okay. I have asked my question, and you-all have done the best you can. If you come up with any additional answers, please submit them. I will be happy to look at them.

I yield back, Mr. Chairman.

Mr. MARINO. Thank you. I believe the Congresswoman from Texas may have an additional question.

Ms. JACKSON LEE. Mr. Chairman, thank you so very much.

It may have been that I didn't hear Mr. Watt clearly, so I am going to just quickly ask Mr. Feinstein, you are at FTC, and there are many levels of consumers. The pharmacies, these small ones, are consumers as well, as consumers of a product. They happen to be a business. And many times, you look at whether, you know, big bell, Ma Bell infringed upon little bells, and obviously, little bells now become gigantic bells, in the telephone industry.

But, in terms of your actual evaluation of Express Scripts-Medco merger, but other actions by these companies, many of them we know their names, who are PBMs, can't you initiate a review or an evaluation as to whether there is any antitrust ramifications in terms of the impact on smaller pharmacies?

Mr. FEINSTEIN. Let me begin my answer by just making it clear that I can't speak to the Express Scripts-Medco.

Ms. JACKSON LEE. Go right ahead. Pass right on by that, and just generally speaking, can you make evaluation on the impact that the actions, what the PBMs, Mr. Watt said a lawsuit, and then I am saying can you initiate an evaluation, administrative review of this impact?

Mr. FEINSTEIN. That is certainly something that the FTC has the authority to do. Yes.

Ms. JACKSON LEE. What would move you to do it?

Mr. FEINSTEIN. Pardon me?

Ms. JACKSON LEE. Then what would we need to move you to do it?

Mr. FEINSTEIN. Well, I think we would need, I think, to reach the preliminary view that the problem that is being described is the re-

sult of antitrust violations by someone else in the system. And that may or may not be the case. But that would be the threshold question. If there is reason to believe that this is a problem that reflects the absence of competition, as opposed to the presence of competition.

Ms. JACKSON LEE. Well, let me just say that I would like to see an initiation of some review. I think as a Judiciary Committee, Mr. Marino, we need to see what role that we would be playing in that issue.

And to Mr. Wright, just a quick question here. I am trying to see Mr. Wright. Where are you? Right here. Okay. Sorry.

How does the proposed Express Scripts-Medco merger advance the notion of free enterprise, et cetera?

Mr. WRIGHT. I don't have any particular view of the Express Scripts-Medco merger. I don't have access to the data and documents that the Federal Trade Commission has.

Ms. JACKSON LEE. Just another element in the whole structure of antitrust review. That is okay if you don't have one.

I will just close, Mr. Marino, by just saying to Mr. James, if, for example, there was an evaluation of your situation, could your small pharmacies provide data to the Federal Trade Commission to indicate a bias or unfair practice, unfair competition practice? If we tried to glean all of the information, would you be able to provide data?

Mr. JAMES. We could do that.

Ms. JACKSON LEE. All right. Mr. Chairman, with that, I yield back my questions. I yield back my time. I am sorry.

Mr. MARINO. Thank you. In closing, this is a rhetorical statement, but if anyone has any information pursuant to this, please let me know. The FTC has not moved in any way, whatsoever, on reviewing whether there is evidence to pursue an investigation in this, has it? So, with that little housekeeping, I need to enter into the record some testimony that was written and sent, and the individuals were not able to testify.

I have testimony for the record from National Community Pharmacists Association, in support of the legislation, the National Association of Chain Drug Stores. A letter in support from antitrust Attorney David Balto, a former FTC official. And the Ranking Member Watt is giving me a document that he would like to put into the record from the Pharmaceutical Care Management Association, and the testimony of that association.

[The material submitted by Mr. Marino follows:]


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House of Representatives Committee on the Judiciary
 Subcommittee on Intellectual Property, Competition, and the Internet
 Hearing on
 H.R. 1946, the “Preserving Our Hometown Independent Pharmacies Act of 2011”
 Thursday, March 29, 2012
 Statement for the Record

Chairman Goodlatte, Ranking Member Watt, and members of the Subcommittee, the National Community Pharmacists Association appreciates the opportunity to submit the following statement for the record for this hearing regarding the “Preserving Our Hometown Independent Pharmacies Act of 2011” (H.R. 1946). NCPA would like to thank Congressman Tom Marino, a member of the subcommittee, and a strong supporter of independent community pharmacy issues, for the active role he has taken in trying to level the playing field between community pharmacies and pharmacy benefit managers (PBMs) by introducing this legislation.

The National Community Pharmacist Association (NCPA) represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. The nation’s independent pharmacies, independent pharmacy franchises and independent chains dispense approximately 40 percent of the nation’s retail prescription medicines.

Community Pharmacists’ Role in Health Care Delivery

Independent community pharmacists are a critical component of our nation’s health care delivery system, and they play a vital role in not only providing medications but in providing individual face-to-face service, counseling and care to their patients. Because of the personal relationships that local independent community pharmacists have with their patients, their patients are more likely to take their medicines properly, to refill medications when needed, and to avoid harmful drug interactions. By ensuring proper medication adherence and preventing complications and harmful drug interactions, trusted independent community pharmacists not only help to improve patient outcomes but they can also

100 Daingerfield Road
 Alexandria, VA 22314-2888
 (703) 683-8200 PHONE
 (703) 683-3619 FAX

THE VOICE OF THE COMMUNITY PHARMACIST

help to lower health care costs by preventing complications that can often require hospitalization and more significant interventions.

In addition, because independent pharmacies are often located in rural and underserved areas, including our inner cities, our members ensure the delivery of important health care products, services and counseling to patients who might otherwise not be reached. Simply put, our pharmacists often go where the chains will not, and they often serve in communities where the closest physician might be miles away. In spite of the important role that community pharmacists play in delivering quality health care products and services to their patients in their own communities, the ability of community pharmacists to serve their patients and their communities is being increasingly threatened by the PBMs.

Today, Congress is taking an important step toward correcting the problem by examining legislation that would enable independent pharmacies to collaborate and negotiate third-party contracts with the PBMs. H.R. 1946, the “Preserving Our Hometown Independent Pharmacies Act of 2011,” would be an important step in the right direction and an appropriate response to a severe imbalance in the prescription drug marketplace. While PBMs make record profits, independent pharmacies are being driven out of business, and patients and communities suffer. Ultimately, the cost of the imbalance of negotiating power is borne by us all—by patients, by employers, by health plans—both public and private, and by taxpayers. This legislation would be a response, among others, to this significant market imbalance and its enactment will benefit both consumers and competition.

The Preserving Our Hometown Independent Pharmacies Act—A Brief Summary

The purpose of our antitrust laws is to help consumers by encouraging competition in the marketplace. Ironically, however, in the pharmacy segment of the economy, the antitrust laws are having the opposite effect by enabling PBMs to exert unchecked market power. At present, independent pharmacies are barred from joining together to negotiate binding contracts with PBMs in the way large chains can. H.R. 1946 would help address this inequity by allowing independent pharmacies (defined in the legislation as pharmacies representing less than 10% of a Part D prescription drug plan region) that represent no more than 25% of all retail pharmacies in a Medicare Part D prescription drug plan to aggregate to negotiate their third-party contracts. While, in most cases, the size of the new negotiating entities allowed under H.R. 1946 would still pale in comparison to the large chains, independent

pharmacies would be able to come together to the negotiating table with the much larger PBMs and advocate to secure the best possible plan design for the patients and communities they serve.

Why Legislation Is Needed—Lack of Transparency and Egregious Audit Practices

Two of the key reasons for this legislation are (1) the lack of transparency in the contracts that PBMs offer to pharmacies and (2) the overly-aggressive and egregious audit practices employed by PBMs. First of all, there is often a lack of transparency in contracts that PBMs negotiate with pharmacies. For example, PBMs generally provide little, if any, insight into how they determine reimbursement for generic drugs. PBMs use a calculation known as maximum allowable cost (MAC), which serves as a reimbursement cap for many common generic medications, but when pharmacies ask for the MAC pricing list or any insight as to how the PBM calculated the MAC, pharmacies are repeatedly denied that information and, in turn, the ability to make determinations about a plan's reimbursement policies. As a result, independent pharmacies are increasingly—and without warning—reimbursed at rates that fluctuate and fail to cover either the pharmacy's cost of dispensing or its cost of acquiring that particular drug. Instead of being able to study the implications of possible contracts, independent pharmacies regularly find themselves with limited information as they attempt to evaluate what is effectively a take-it-or-leave-it contract offer from the PBM. While independent pharmacies are largely powerless in their attempts to secure such important information in the contract negotiation process, H.R. 1946 would enable independent pharmacies to use their collaborative efforts to bring transparency to the contract negotiation process—better enabling pharmacies to make informed decisions to ensure that they will continue to be able to serve their patients and communities.

While NCPA believes that fair auditing is a necessary activity in order to detect and prevent fraud, waste and abuse, such auditing must be a clearly defined process that is consistent with standards already existing in state and federal law. Unfortunately, PBMs often engage in overly aggressive auditing tactics that go well beyond requirements included in state and federal law. In a November 2011 survey, NCPA found that PBM practices negatively affect pharmacies' ability to care for patients and their viability as a business. The survey found that PBMs generate significant waste within Medicare and Medicaid, and it also found that PBMs abuse their role as auditors of pharmacies.

One of the ways that many PBMs practically ensure that auditing discrepancies will be found is to establish elaborate record keeping requirements well in excess of what is required under state or federal law. Pharmacies typically maintain contracts with multiple PBMs; the result is a myriad of conflicting documentation requirements that can make operating a busy pharmacy and responding to patient concerns an even greater challenge. When audits do occur, PBMs require auditors to sign confidentially agreements that prohibit auditors from disclosing key information to their own clients—the very health plans that requested the audit and contracted with the PBM to manage their drug benefit. PBMs similarly limit information based on proprietary claims. Again, pharmacies find themselves with little, if any, power to address these unfair standards when they consider a contract, but H.R. 1946 would give pharmacies at the least the opportunity to come together to negotiate to bring some transparency, consistency and fairness to PBMs’ auditing practices.

Why Current Models Do Not Address the Problem

While opponents will claim that there are already opportunities for pharmacies to join together and consolidate their market presence, these arrangements are extremely limited in their ability to represent the needs of community pharmacies and their patients. Unfortunately, the current structure of delivering drug benefits and administering reimbursement between plan sponsors and pharmacies is not conducive to an optimal aligned pharmacy benefit management-payor relationship. Independent pharmacies often belong to pharmacy services administration organizations (PSAOs) which handle accounting functions and provide advice and counsel on contracts for pharmacies. PSAOs follow the “messenger model” approach, which is a way to facilitate the flow of information between pharmacies and PBMs. However, they are limited in their ability and scope to negotiate more equitable contracts between pharmacies and PBMs. Additionally, PBMs generally contract with large chains first on behalf of plan sponsors leaving independents out. When PBMs then contract with independents and PSAOs who are undercut by the unbinding nature of the messenger model, PBMs are able to make only take-it-or-leave-it offers. In addition, if the PSAO cannot reach an agreement on behalf of its member pharmacies, PBMs have the ability to selectively choose independents with whom to negotiate.

An Added Challenge—Growing Consolidation in the PBM Market

An added challenge to pharmacies and an added reason in support of H.R. 1946 is significant and growing imbalance in the market between large insurers and healthcare providers. This is a similar

challenge we have seen in the PBM marketplace where the top three PBMs—Express Scripts, Medco, and CVS-Caremark—have become industry giants with almost \$2 billion in annual revenue. More significantly, these three PBMs account for more than half of all prescriptions processed each year. In order to balance against growing consolidation, we believe that collective negotiation would help to level the playing field and bring a competitive balance that will ultimately enhance patient care. Today, these concerns about competitive imbalance have never been greater. Both the health insurance and PBM markets have become significantly more concentrated as continual consolidation has gone unabated. At the same time independent pharmacies have average sales below \$4 million annually, which is so low as compared to costs that it is increasingly driving these entrepreneurs out of the market.

Our members are keenly aware of recent efforts toward further consolidation within the health care marketplace; specifically consolidation within the PBM industry will continue to negatively impact not only community pharmacies but more importantly the patients our members serve. The proposed merger of Medco and Express Scripts would likely lead to decreased patient choice and decreased access to care, decreased competition in the prescription drug marketplace, and a potential increase in drug prices to patients, employers, health plans—both public and private—and, ultimately, to taxpayers. Over the past 10 years, there has been considerable consolidation within the PBM market that has led to the current three firms dominating. Further consolidation with the proposed merger of Express Scripts and Medco, which would create a PBM with more than 135 million covered lives, would result in higher costs for the buyers of PBM services and would only further reduce the ability of independent pharmacies to negotiate with PBMs regarding these challenging issues. As a result, we believe it is of the utmost importance that our member pharmacies have the ability to join together when attempting to negotiate with these large companies so that they can achieve the best possible deal for their patients and the communities they serve.

Conclusion

Thank you again for holding this hearing and providing NCPA with this opportunity to highlight the challenges that are facing community pharmacies and their patients in the current marketplace. Patients highly value the work of their community pharmacists when it comes to their own health care, and pharmacists routinely rank as one of the most trusted and respected professions. Unfortunately, PBMs are attempting to use their growing power to try to limit and undermine this relationship in the name of

lower costs without any evidence that their largesse results in savings to consumers. If the power of PBMs grows unfettered without any check or balance, community pharmacists will become increasingly limited in their ability to advocate on behalf of their patients. Through the threat of antitrust litigation, PBMs can effectively limit pharmacies from advocating on behalf of their patients. H.R. 1946 is a step in the right direction to eliminate this antitrust uncertainty and allow independent pharmacies to fully participate in the marketplace.

Statement

Of

The National Association
of Chain Drug Stores

For

U.S. House of Representatives
Committee on the Judiciary

Subcommittee on Intellectual Property,
Competition and the Internet

Hearing on:

H.R. 1946, the “Preserving our Hometown
Independent Pharmacies Act of 2011”

March 29, 2012

9:30 a.m.

2141 Rayburn House Office Building

National Association of Chain Drug Stores (NACDS)
413 North Lee Street
Alexandria, VA 22314
703-549-3001
www.nacds.org

Introduction

Chairman Goodlatte, Vice Chairman Quayle, Ranking Member Watt, and Members of the Subcommittee on Intellectual Property, Competition, and the Internet, the National Association of Chain Drug Stores (NACDS) thanks you for the opportunity to submit a statement for the hearing on H.R. 1946, the “Preserving our Hometown Independent Pharmacies Act of 2011.”

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. The total economic impact of all retail stores with pharmacies transcends their \$900 billion in annual sales. Every \$1 spent in these stores creates a ripple effect of \$1.81 in other industries, for a total economic impact of \$1.76 trillion, equal to 12 percent of GDP. For more information about NACDS, visit www.NACDS.org.

We are pleased to offer our support for H.R. 1946, which will allow independent pharmacies to join together to negotiate fairer contracts with pharmacy benefit managers (PBMs). Since H.R. 1946 applies to “independent pharmacies,” we want to be clear about our support for this legislation. We thank Congressman Marino for recognizing that small chain pharmacies encounter many of the same obstacles as single location pharmacies. Pursuant to this recognition, the legislation’s definition of “independent pharmacy” includes a pharmacy that has a market share of less than 10% in any Medicare Part D Prescription Drug Plan (PDP) region, and less than 1% in the United States. Many of our smaller chain pharmacy member companies fall under this definition and would be positively impacted by H.R. 1946.

Background on PBMs

PBMs manage and administer the prescription drug benefits of more than 210 million Americans. Employers and health plans contract with PBMs to manage and administer prescription drug benefits (as opposed to medical benefits) as part of overall health benefits. PBMs construct and manage drug formularies and use these formularies to negotiate discounts with pharmaceutical drug manufacturers. Manufacturers want to include their drugs on a PBM's formulary, and in order to do so, they provide discounts and rebates to the PBM, which are not always disclosed or passed on to purchasers of PBM services (e.g., employers and health plans). If the PBM can increase a manufacturer's market share for certain drugs, the rebates and discounts are typically adjusted accordingly to incentivize the PBM to increase the dispensing of the manufacturer's drugs, even if the incentives increase the costs to plans. The PBM consults with employers and health plans as to what drugs they should place on their formulary, but often without full transparency of the financial incentives. In other words, the PBM acts as a "double agent" negotiating with drug manufacturers as well as employers and health plans to create consumers' prescription drug plans that benefit the PBM's profitability.

The PBM then contracts with community pharmacies to provide prescription drugs and pharmacy services to the plans' beneficiaries. The payment from a PBM to a pharmacy for dispensing a prescription drug differs from the amount a PBM charges a plan for the same prescription drug, to the benefit of the PBM. Plans sponsors are typically unaware of this difference, commonly referred to as the "spread." PBMs profit not only from the spread, but also from additional administrative fees charged to the plan for processing the claim. Many PBMs also own mail order pharmacies that they encourage consumers to use instead of community pharmacies.

As an industry, PBMs are virtually unregulated. They may have tangential regulatory compliance for insurance related processes through their relationships with health plans

the extent that their activities can be construed as practicing pharmacy. The vast majority of their remaining functions and activities are unregulated, as there are no state or federal authorities with direct jurisdiction over them. Consequently, PBMs frequently exert their power to impose unilateral contract provisions on pharmacies that pharmacies must accept in order to continue providing service to their patients.

Community Pharmacy's Critical Role

Pharmacists are our health system's medication experts. Professional services provided by community-based pharmacists, both chain and independent, help ensure the safety and effectiveness of patients' health and medication therapy. According to a recent Gallup survey, pharmacists are seen as one of the most highly trusted, highly accessible, neighborhood healthcare experts.

As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to actively engage patients in their own healthcare and medication self-management through a variety of pharmacist-delivered services, such as medication therapy management (MTM) and immunizations. Services provided by community pharmacists are an essential part of improving patient medication adherence, improving the delivery of healthcare services, improving quality and outcomes, and are a cost effective and convenient way to prevent illness and reduce overall healthcare costs.

Poor patient medication adherence costs the U.S. healthcare system \$290 billion annually, equal to 13% of total health expenditures (New England Healthcare Institute, 2009). An estimated one-third to one-half of all patients in the United States do not take their medication as prescribed. There are many reasons. Many simply fail to pick up their medications from their pharmacy. Others fail to take their medication correctly, stop taking it altogether or never take it in the first place. These circumstances seriously undermine quality of life and quality of care, patient outcomes and the value of healthcare dollars spent. This lack of compliance with prescription drug regimens results

is also estimated that there are 4.5 million medical setting visits per year related to adverse drug events, a figure which could be reduced through increased medication counseling and management.¹ Clearly, steps need to be taken to address the issue of lack of adherence with medication therapy. This is one reason we are so devoted to ensuring that patients adhere to their prescription drug treatment regimens.

Not only can pharmacists be utilized to increase medication adherence among patients, but also pharmacists also can provide other life saving services. Community pharmacies have played an integral role in recent years in providing vaccinations and immunizations against such illnesses such as H1N1 flu. Despite the availability of effective immunizations, many Americans remain unvaccinated and susceptible to vaccine-preventable diseases. An Institute of Medicine Report estimates that more than 50,000 adults and 300 children in the United States die each year from vaccine-preventable diseases or their complications.² However, the United States Department of Health and Human Services has found that immunizations, including those administered by pharmacists, help prevent 14 million cases of disease and 33,000 deaths yearly.³ We are pleased that now all 50 states allow pharmacists to provide immunizations.

Community Pharmacy Increases the Utilization of Generic Drugs

Pharmacists are also leaders in promoting cost savings, helping educate consumers and providers about affordable alternatives like generic drugs and over-the-counter remedies. Community pharmacies have long promoted generic drugs as safe, cost-effective alternatives for many patients. We are leading the way to maximize the appropriate use of generic drugs. Community pharmacy has a higher rate of generic dispensing than any other practice setting. For example, according to Wolters Kluwer Health, in 2010,

¹ Sarkar, Urmimala, et al. Adverse Drug Events in U.S. Adult Ambulatory Medical Care. *Health Services Research*, May 9, 2011

² Institute of Medicine Report. Shaping the Future For Health – Calling the Shots – Immunization Finance Policies and Practice. http://books.nap.edu/html/calling_the_shots/reportbrief.pdf

Conclusion

As medication use experts, community pharmacists assist patients in achieving positive outcomes from their medication therapy. They help patients every day by counseling on proper use of medications, checking for possible side effects, drug interactions or allergies, and helping to coordinate insurance benefits. All these activities help ensure patients receive maximum therapeutic benefit from their medication therapy. Community pharmacists provide life-saving immunizations, and help reduce healthcare costs by encouraging the use of generic medications. We are pleased that H.R. 1946 will provide relief to community pharmacies from the overbearing actions of PBMs.

³Department of Health and Human Services, Fiscal Year 2008. Centers for Disease Control and Prevention. *Justification of Estimates for Appropriation Committees*. Available: http://www.317coalition.org/documents/cdc_fy2008budget_immunization.pdf

DAVID A. BALTO
ATTORNEY AT LAW
1350 I STREET, NW
SUITE 850
WASHINGTON, DC 20005

PHONE: (202) 789-5424
Email: david.balto@yahoo.com

March 26, 2012

Honorable Tom Marino
United States House of Representatives
410 Cannon House Office Building
Washington, DC 20540

Re: H.R. 1946, Preserving Our Hometown Independent Pharmacies Act

Dear Congressman Marino:

I applaud your introduction of H.R. 1946 Preserving Our Hometown Independent Pharmacies Act, a measure that is critical for consumers to provide an antitrust exemption for community pharmacies to collectively negotiate with Pharmacy Benefit Managers ("PBMs"). I strongly believe this legislation will benefit consumers and the marketplace by enabling community pharmacies to negotiate for better reimbursement which will provide greater access and service for consumers.¹

As you know I am the former Policy Director of the Federal Trade Commission ("FTC") and was a government antitrust enforcer for almost 20 years. My practice focuses on representing consumers and public interest groups. In 2007 I testified in favor of H.R. 971², the Community Pharmacy Fairness Act, which sought to provide an antitrust exemption for pharmacies. For all of the reasons outlined in my 2007 testimony (attached), I strongly believe in the merits of H.R. 1946 providing an antitrust exemption for pharmacies today.

In 2007 I explained that from a consumer perspective an antitrust exemption for pharmacies is necessary and beneficial because:

- The PBM market is broken. The market is plagued by anticompetitive and anticonsumer conduct and pharmacies are left highly vulnerable because of the substantial market power of the dominant PBMs;
- Collective negotiation by pharmacies is a necessary response to this disparity and ultimately, consumers would benefit;

¹ I represent many of the major consumer groups including AARP, Consumers Union, Consumer Federation of America, US PIRG, National Consumers League, Community Catalyst and the National Legislative Alliance on Prescription Drug Prices on health care competition issues.

² See Testimony of David Balto before the House Judiciary Committee on "The Impact of our Antitrust Laws on Community Pharmacies and their Patients" October 18, 2007.

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- The threat of antitrust liability prevents collective negotiation;
- An antitrust exemption is appropriate and consistent with past exemptions enacted by Congress; and
- Anticompetitive effects from an antitrust exemption are highly unlikely because independent pharmacies are too small to have market power.

All of these reasons are equally true today. In fact, an exemption is even more necessary than it was five years ago. I am certain that the pharmacy associations can present compelling evidence how the conditions for community pharmacies have deteriorated considerably since 2007. Increasingly dominant PBMs have forced unreasonable reimbursement on pharmacies, often compelling pharmacies to dispense vital drugs at a loss or just barely over cost. Dominant PBMs have forced consumers into using mail order that is less convenient, more wasteful, and harmful to medication adherence and generic dispensing rates (typically mail order has a generic rate of about 60% and community pharmacies have a generic dispensing rate of around 70%).³

Plain and simple, PBMs want pharmacies to participate in a serf-like status, with ever diminishing reimbursement keeping them minimally viable.

As an advocate for consumers and public interest groups, I know that consumers care a tremendous amount about having access to their community pharmacy. I recently testified on behalf of the major consumer groups, including Consumers Union and Consumer Federation of America detailing why pharmacy access is critical to consumers.⁴ Community pharmacies provide a wide variety of valuable services including health care consulting and advice and treatment management and monitoring. The community pharmacist is typically the most accessible member of the healthcare delivery team. They provide a particularly critical level of healthcare access for underserved populations, including the residents of inner-city and rural areas. No consumer prefers dealing with a pharmacist at a distant telecenter to speaking face-to-face with the trusted pharmacist serving their local community.

The PBM's interest is in their own bottom-line-- not in providing the best service to the consumer. Often this means putting profits before patients. PBMs are the least regulated segment of the healthcare market, and exploit the lack of competition, regulation, and lack of transparency.⁵ The three major PBMs – Medco, Express Scripts (ES) and Caremark -- have each been found guilty of switching consumers to more expensive (and sometimes less safe) drugs, in order to secure higher rebates. PBMs force consumers to use mail order or limit their access to community pharmacies. PBMs often manipulate reimbursement policies in order to deny consumers access to the drugs they deserve, refusing to accept requests for reimbursement.

³ See National Community Pharmacists Association. "Community Pharmacists Leading the Way on Generic Drug Utilization, While PBMs Addicted to Brand Name Rebates," November 12, 2010, *available at* <http://ncpanet.wordpress.com/2010/11/12/community-pharmacists-leading-the-way-on-generic-drug-utilization-while-pbms-addicted-to-brand-name-rebates>.

⁴ See Testimony of David Balto before the Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights, on behalf of Consumers Union, Community Catalyst, Consumer Federation of America, National Consumers League and others, December 6, 2011.

⁵ Until the enactment of the Affordable Care Act there was no federal regulation of PBMs. State regulation is modest with only a handful of states regulating PBM conduct.

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Community pharmacies spend hours helping consumers navigate issues with their prescription benefit including making sure they are taking the appropriate drugs, moving patients to more affordable generic versions if available and appropriate, and helping consumers deal with complicated reimbursement procedures.

Plain and simple, who speaks for the consumer when there is a problem with the PBM or the insurance company? The community pharmacy.

I would expect the opponents of the legislation to rehash the arguments they made in 2007. But a lot has changed in the past five years and the changes to the marketplace actually strengthen the case to provide pharmacies an antitrust exemption.

1. The PBM market is far more concentrated.

In 2007 the PBM market was marginally competitive with three or four significant national competitors. Since 2007, there have been several PBM acquisitions including ESI's acquisition of Wellpoint and CVS' acquisition of Caremark. Now another mega-merger is pending before the FTC -- the proposed ESI's acquisition of Medco. Both the ESI/Wellpoint and CVS/Caremark deals were cleared by the FTC without an extensive investigation. It is very possible that the FTC will approve ESI's acquisition of Medco, thus creating a PBM giant with more than 150 million covered lives.⁶ Approving this merger would be a tremendous mistake and will enable ESI to harm consumers by denying access, diminishing service and reducing reimbursement rates to community pharmacies to a level that will be unsustainable. **That is why all of the major consumer groups including Consumers Union, Consumer Federation of America, US PIRG, and National Consumers League have vigorously opposed the merger.⁷ (Not a single consumer group supports the merger).**

2. There is no evidence that consolidation has benefitted consumers.

What has been the result of all that consolidation? There is simply no evidence that the mergers over the past five years have led to greater benefits for consumers or lower prices. The increased power the major PBMs have secured through past mergers has not improved consumer welfare, but rather, diminished competition and lined the pockets of the major PBMs with skyrocketing profits.

Over the past seven years, the combined profits of the three largest PBMs – Express Script, Medco and Caremark, have increased by over 600% from about \$900 million to over \$6 billion annually.⁸

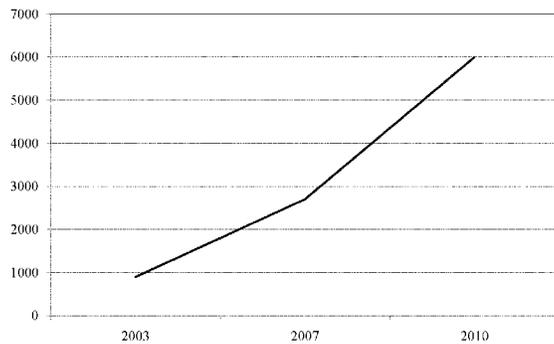
⁶ See Letter from Senator Herb Kohl to FTC Chairman Jon Leibowitz, February 2, 2012.

⁷ See Letter from Consumers Union, Consumer Federation of America, US PIRG, National Consumers League and the National Legislative Association on Prescription Drug Prices to FTC Chairman Jon Leibowitz opposing the ESI-Medco merger, September 20, 2011.

⁸ See Testimony of David Balto before the Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights, December 6, 2011 at 4.

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**Profits of the "Big Three" (in millions)
from \$900 million to over \$6 billion**



These skyrocketing profits could not exist in a market if it was competitive, transparent and free of conflicts of interest. Rather than leading to improved welfare of plan sponsors and ultimately, beneficiaries, the expanding PBMs secure skyrocketing profits by increasingly cutting reimbursement, forcing pharmacies to dispense below cost, forcing consumers to use mail order, and not passing on accrued savings to consumers.

3. **PBMs Continue to Engage in Deceptive and Egregious Practices Harming Consumers.**

Facing nearly nonexistent transparency regulations, PBMs frequently engage in a wide range of deceptive and anticompetitive conduct that ultimately harms and denies benefits to consumers. Some PBMs secure rebates and kickbacks from manufacturers in exchange for exclusivity arrangements that may keep lower priced drugs off the market. PBMs may switch patients from prescribed drugs to an often more expensive brand drug to take advantage of rebates that the PBM receives from drug manufacturers. In addition, PBMs derive their enormous profits from the ability to collect the difference in the rates they pay pharmaceutical manufacturers, reimburse pharmacies, and charge health care plans (this is known as "playing the spread").

Since 2007, a coalition of over 30 state attorneys general have brought several cases attacking unfair, fraudulent and deceptive conduct by the three major PBMs securing over \$370 million in penalties and fines. These cases found fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback

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schemes; and failure to meet ethical and safety standards.⁹ Although the PBMs may claim they have “cleaned up their act,” the facts don’t support that allegation. For example, just last week Medco agreed to pay the state of California \$2.8 million to resolve allegations that they had secured a contract through a \$4 million consultant contract paid to fund improper payments, gifts and campaign contributions to board members of the California Public Employees’ Retirement System.

4. **The FTC has failed to Protect Consumers or Pharmacies against Anticompetitive Conduct by PBMs.**

Often when enforcement officials are faced with a potential antitrust exemption, they engage in straightforward soul-searching of their enforcement policies. They ask whether they are using all of their enforcement tools appropriately. And they ask whether the current interpretation of the law may result in unintended consequences.

For example, in 2000 when the House passed the Campbell-Conyers amendment, the Quality Health Care Act of 2000, which would have provided an antitrust exemption for all health care professionals, the FTC and DOJ responded by trying to show that an exemption was unnecessary. The DOJ brought an important challenge to a health insurance merger to protect the interests of physicians.¹⁰ And the DOJ provided greater guidance permitting a broader range of physician collaborations. The enforcers were basically saying to Congress “give us a chance to solve the problems without legislation.”

But since 2007, the FTC has simply not stepped up to the plate. Unlike the cases by state attorneys generals, the FTC has failed to bring any enforcement actions against PBMs for anticompetitive, deceptive or egregious conduct.¹¹ As noted earlier it cleared the ESI/Wellpoint and CVS/Caremark mergers without a significant investigation. **If it chooses to clear the anticompetitive ESI /Medco merger it would be difficult to fathom what type of case the FTC would ever bring against a PBM.**

Moreover, when states have attempted to regulate to protect consumers from deceptive or egregious practices by PBMs, the FTC has consistently weighed in on

⁹ For examples of cases since the 2007 hearing see, e.g., *State Attorneys General v. Caremark, Inc.* (Feb. 14, 2008)(\$41 million in damages for deceptive trade practices, drug switching, and repackaging); *State Attorneys General v. Express Scripts* (May 27, 2008)(\$9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans).

¹⁰ *United States v. Aetna, Inc. and Prudential Insurance Co.*, No. 99-cv-1397 (Dec. 7, 1999).

¹¹ As noted earlier the FTC did not conduct an extensive investigation of In CVS’ acquisition of Caremark. After the acquisition was consummated the FTC conducted an extensive two-year investigation of the acquisition and a variety of competition, consumer protection and privacy violations. The FTC resolved the investigation with a minor action addressing CVS misleading consumers about prices for certain drugs under Medicare. It took no action to address the allegations that consumers were harmed from competition, consumer protection and privacy violations.

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the side of the PBMs and opposed regulation.¹² The American Antitrust Institute has questioned the FTC's pro-PBM advocacy noting

Considering the substantial number of enforcement actions and the severity of the PBM conduct, we believe these efforts at regulating PBMs are well founded and that the FTC's advocacy has been ill-advised.¹³

Simply, the lack of FTC enforcement and their opposition to state regulation have given the PBMs a de facto antitrust exemption. Not one ever approved by Congress.

5. The FTC Stance Toward Pharmacy Collaboration Continues to Prevent Pharmacies from Meaningful Collaboration.

I would expect the FTC to proclaim that pharmacies can effectively collaborate under the DOJ/FTC Healthcare Guidelines. They may recite three "advice letters" they gave over a decade ago as examples of the ability of pharmacies to form collaborations.¹⁴ They have not approved any pharmacy collaborations since those advice letters.

The reality is that the FTC standards are so stringent almost no pharmacy group can effectively form a meaningful collaboration. For example, in 2008 13 community-based specialty pharmacies in 13 different states sought to form a network to negotiate with national buyers. They asked the FTC for an opinion letter approving the venture. The FTC staff declined to approve the collaboration. It is difficult to comprehend why the FTC would decline to approve a proposed collaboration among 13 pharmacies that clearly did not compete with each other.¹⁵

As a general matter, the standards for collaboration for healthcare providers have received significant criticism. A recent study by the Center for American Progress found that the number of healthcare collaborations approved by the FTC has

¹² Mississippi S.B. 2445 (signed into law April 29, 2011 by Governor Barbour) and New York S.B. 3510-B (signed into law December 13, 2011 by Governor Cuomo) represent recent successes by states to increase regulation of PBMs despite FTC opposition. The Mississippi legislation provides that PBMs are regulated by the Board of Pharmacy. The New York legislation provides greater pharmacy access by permitting pharmacies to participate in mail order oriented networks.

¹³ See American Antitrust Institute, *The Next Antitrust Agenda, Transition Report on Competition Policy*, "Chapter Nine Competition in the Unhealthy Health Sector," October 2008, available at http://www.antitrustinstitute.org/files/Health%20Chapter%20from%20%20AAI%20Transition%20Report_100520082050.pdf.

¹⁴ None of these examples are very meaningful. The FTC permitted extremely limited collaborations that permitted collective negotiations over extremely limited services. With such narrow limitations on services, it is not surprising that each of these ventures failed soon after they were formed.

¹⁵ It is difficult to determine what could have been the competitive concerns from the proposed collaboration. It is extremely unlikely they would have had any market power. Indeed, the FTC has permitted several retailer pharmacy mergers, such as Rite Aid-Eckerdts, even though it would have resulted in the firm having over a 40% market share in several metropolitan markets.

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plummeted over the past several years.¹⁶ Indeed, the study found that time to secure approval of one of these ventures takes 436 days, or just a month less than it took Congress to consider and enact the Affordable Care Act.¹⁷ In addition, the cost of securing one of these approval letters from the FTC exceeds \$100,000, a daunting sum for almost any group of healthcare providers.

Simply, one cannot expect pharmacies to be able to engage in meaningful collaboration under the current FTC standards.

6. Recent Experience Shows that Antitrust Exemptions Can Benefit Consumers, Providers and Payors.

The FTC and opponents of the legislation will proclaim that antitrust exemptions raise prices and therefore harm consumers. But what evidence do they have? There are several state healthcare antitrust exemptions that exist, but the evidence that the exemptions lead to higher prices and consumer harm are extremely limited. There are antitrust exemptions for healthcare providers in several states but there are no studies that suggest these exemptions lead to higher prices, less access, or lower quality.

Indeed, the opposite may be true. In 2008, the Minnesota state legislature considered a law to provide an antitrust exemption for rural healthcare cooperatives. The FTC vigorously opposed the legislation, claiming it would lead to higher prices and lower quality service.¹⁸ The arguments were remarkably similar to those posed in its opposition to H.R. 971. The legislature held several hearings on the subject and carefully considered the FTC's views and the views of insurance companies that opposed the legislation. Ultimately the legislation was enacted and Governor Pawlenty signed it into law.¹⁹

Have the FTC's predictions of consumer Armageddon in Minnesota been borne out? Not in the least. Almost all of the insurance companies in the market signed up with the health care cooperative acting under the statute. Costs have not increased. And numerous rural Critical Access Care hospitals and physician groups are able to stay in business and serve underserved rural communities because the cooperative can collectively negotiate on their behalf for fair reimbursement rates.

¹⁶ David A. Balto, "Making Health Reform Work, Accountable Care Organizations and Competition," Center for American Progress, February 2011, available at http://www.americanprogress.org/issues/2011/02/pdf/aco_competition.pdf.

¹⁷ *Id.* at 9.

¹⁸ See Letter to Minnesota State Senator Tom Emmer from David Wales, Director of the Bureau of Competition, FTC, March 18, 2009.

¹⁹ See Minn. Leg. §62R.09 (2009). One cooperative entered into a consent decree with the FTC resolving concerns about alleged anticompetitive conduct. *Minnesota Rural Health Cooperative* (2010). See *FTC v. Lake Wobegon, Hospital and Health News*, Apr. 1, 2011 available at http://hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/04APR2011/0411HHN_Outbox&domain=HHNMAG

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There is no evidence that antitrust exemptions for healthcare providers such as pharmacies harm consumers.

The FTC may claim that an antitrust exemption will lead to higher prices for consumers, but it is critical to recognize that the entire focus of their argument is on the *impact on PBMs, not consumers*. The FTC will argue that if community pharmacies can collectively negotiate, *PBMs will have to pay more for pharmacy access*. But the fact that PBMs may be paying higher reimbursement does not mean that consumers will pay more. Indeed, increased reimbursement may simply result in a reduction of the PBMs' skyrocketing profits and more of those profits will be shared with the community pharmacies, ultimately benefitting consumers.

President John Adams once said "facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passions, they cannot alter the state of facts and evidence." For consumers who every day must struggle with the problems of receiving sound healthcare advice and affordable drugs, which need to be protected against the egregious conduct of PBMs, the facts are simple – they need their community pharmacy, and that's why Congress should enact H.R. 1946.

Sincerely,



David A. Balto

[The material submitted by Mr. Watt follows:]



Testimony of

Pharmaceutical Care Management Association

Submitted to the

**UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY**

**SUBCOMMITTEE ON INTELLECTUAL PROPERTY, COMPETITION, AND
THE INTERNET**

*Hearing on: H.R. 1946, the "Preserving Our Hometown Independent Pharmacies
Act of 2011"*

March 29, 2012

The Pharmaceutical Care Management Association (PCMA) is the national association that represents America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 216 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, and the Medicare Part D program. PCMA strongly opposes H.R. 1946, "Preserving Our Hometown Independent Pharmacies Act", which would exempt independent pharmacies from the federal antitrust laws and permit them to bargain collectively with health plans and insurers on prices and non-price related contract terms.

The U.S. economy is based on the twin principles of competition and fair play. The antitrust laws were enacted by Congress to assure that competition flourishes and not to bestow an advantage or assist particular competitors in the marketplace. An antitrust exemption for a specific industry group, whose members compete for business against each other, not only diminishes competition, but undermines the basis for our economy, as every other industry group will want similar a similar competitive advantage. These exemptions are not without victims – they represent an income transfer from consumers to an industry subgroup, in this case, independent pharmacies.

Indeed, the congressionally mandated Antitrust Modernization Commission concluded in its 2007 report that antitrust exemptions "create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, and reduced innovation." H.R. 1946 claims to "ensure and foster continued safety and quality of care", but not one provision in the bill is specifically focused on advancing such goals. Under current antitrust law, health care professionals already may collaborate to improve quality of health care.

Antitrust Immunity is not needed to Encourage Legitimate Professional Collaboration

Independent pharmacies claim that an antitrust exemption is necessary to "level the playing field" in their negotiations with health plans or PBMs, and for them to legitimately band together to create joint ventures or engage in other collaborative arrangements. PCMA respectfully submits that legitimate integration of common business interests among independent pharmacies already can be achieved under existing laws, regulations, and antitrust enforcement agency guidance, without seeking the radical step of antitrust immunity. Numerous advisory opinions and judicial rulings have explicitly set forth what the antitrust enforcement agencies view as the criteria for successful financial and clinical integration among health professionals. Pharmacy groups are well aware of these opportunities. For example, over 80 percent of independent pharmacies today participate in group purchasing organizations, such as the independent pharmacy cooperative (IPC), which has more than 4500 member stores. Further, independent pharmacies routinely employ pharmacy service administrative organizations (PSAOs) which allow them to work together to reduce administrative costs of contracting and achieve economies of scale. Belying claims that individual pharmacies have no bargaining power, PSAOs negotiate

with PBMs on behalf of groups of independent pharmacies. In addition, the Affordable Care Act includes additional incentives for pharmacists to integrate in order to improve quality of care and promote innovation in service delivery, through the Shared Savings Program under Medicare.

Antitrust Immunity will increase Health Care Costs, in both Commercial and Government Markets

Antitrust immunity for independent pharmacies will raise prices for prescription drugs. The Federal Trade Commission (FTC) has settled charges with pharmacies for conspiring to boycott a state government's employee drug plan, and found that the collective fee demands of the pharmacists cost the state \$7 million. The FTC also settled charges with an association of 125 pharmacies in Puerto Rico which was charged with fixing prices and demanding a 22 percent increase for participation by its members in an indigent care program. The Congressional Budget Office (CBO) scored a 2010 version of H.R. 1946 as costing \$727 million to the Federal government over 10 years, and this estimate only considered the impact on the Federal government's share of the market.

While H.R. 1946 specifically excludes several government programs—such as Medicaid, Medicare Part D, TRICARE, and the Veterans' Administration—from the antitrust immunity granted to independent pharmacies, the CBO found that such exclusions cannot limit the spending effects for federal programs. First, higher compensation rates in commercial markets inevitably spill-over into government programs and affect the rates that plans working with federal programs must pay in order to assure provider coverage in pharmacy networks. Second, private plans and PBMs administer many of the excluded government programs, including Medicare Part D drug benefits, and use the same, or very similar, pharmacy provider networks. Finally, the exclusion of federal programs suggests that the bill's sponsors understand that the bill would drive up pharmacy costs and sought to avoid imposing those costs on the taxpayers. Still, taxpayers will have to pay for the higher costs through subsidies for the Exchange plans, at least under the new health care law enacted in 2010.

In a 2012 study on the impact of H.R. 1946 on pharmacy costs and access, Charles River Associates (CRA) found that the bill would increase direct costs to commercial and government payers by \$7.6–\$15.6 billion over five years, an average increase of approximately 4–8% percent of total prescription sales across all independent pharmacies. Citing DOJ and FTC evidence that pharmacists and other providers who collude on prices often seek fee increases of 20% or more, CRA's study goes beyond CBO's to assess the impact on taxpayers and premium payers alike were pharmacists to be given an antitrust exemption that allowed competitors collectively to negotiate prices with employers and health plans. CRA concludes that there is no compelling economic reason to confer antitrust exemptions to independent pharmacies, since these institutions are profitable, expanding, and use existing market mechanisms such as PSAOs to gain leverage in bargaining with health plans and PBMs.

Antitrust Immunity does not improve Patient Safety or Quality of Care

H.R. 1946 states that it will “ensure and foster continued safety and quality of care and a competitive marketplace by exempting independent pharmacies from the antitrust laws.” Nothing in the bill, however, requires the collective bargaining it authorizes, in fact, to be directed toward improving patient safety or the quality of pharmaceutical care, such as the innovative use of electronic health information, patient counseling, medication therapy management, or prevention of fraud and abuse. The absence of any such requirements is telling.

The FTC has consistently argued that antitrust immunity “dulls competitive pressures that drive pharmacies to improve quality and efficiency in order to compete more effectively.” And, the FTC has taken numerous steps to reach out to professional groups, through the publication of the Antitrust Guidelines for Collaboration Among Competitors (issued jointly with the Department of Justice, Antitrust Division in April 2000) and the issuance of numerous advisory opinions, to encourage joint activities that improve quality and foster competition. One example of this outreach is the FTC’s July 27, 2000 Advisory Opinion approving the Northeast Pharmacy Service Corporation’s proposal to establish a network of independent pharmacies in Massachusetts and Connecticut to provide medication management services and improve the quality of care for the patients of health plans and other third-party payers. The services provided by Northeast were designed to decrease the overall cost of treating patients by reducing their use of physician office visits, emergency room treatments, and hospital inpatient stays. The Northeast Pharmacy Service Corporation’s proposal clearly demonstrates that patient safety and quality of care can be improved through collaborative arrangements that fall well within existing antitrust law enforcement guidelines.

Antitrust Immunity for Independent Pharmacies is Not Consistent with the Organized Labor Exemption

The antitrust exemption for labor organizations under the National Labor Relations Act (NLRA) applies only in the employee/employer context and does not protect combinations of independent individuals engaged in competing businesses. The object was to allow workers or their union representatives to negotiate regarding *wages* or other *terms and conditions of employment* without being charged with conspiracies in restraint of trade. The exemption is bounded by an elaborate array of federal safeguards to ensure true employee collective bargaining supervised by the National Labor Relations Board. H.R. 1946 has none of these safeguards.

Antitrust laws were enacted to achieve lower prices and more consumer choices by encouraging more competition. The inevitable result of allowing independent pharmacies to be treated like a bargaining unit of a labor union to achieve an exemption from the antitrust laws will be exactly the opposite. Even for egregious antitrust violations like boycotts, that normally would be *per se* illegal, H.R. 1946 assures that independent pharmacies will not be subject to criminal

sanctions nor civil damages, fees, or penalties beyond actual damages. H.R. 1946 only excludes boycotts from the exemption that are directed at an independent pharmacy or a group of independent pharmacies. It does not exclude boycotts by independent pharmacies of PBMs and insurers, for example, which could leave consumers without any access to prescription drugs.

Conclusion

PCMA urges the Committee to consider H.R. 1946 with great skepticism. At a time of continuing increases in the prices for health care goods and services, it is inappropriate for Congress to carve-out independent pharmacies from the rigor of the competitive marketplace and enable them to demand higher fees from consumers, employers, and other payers for filling prescriptions. PCMA believes that such an exemption would substantially harm consumers and stifle innovation in the delivery of pharmaceutical care. Granting an exemption from the antitrust laws to independent pharmacies would create a dangerous precedent, encouraging similar demands from other health professionals and driving up health care costs at a time when the nation can ill afford it.

Mr. MARINO. Is there any other documentation?

Ms. JACKSON LEE. Mr. Chairman, just an inquiry to the Chair and the proponent of the legislation, Mr. Marino. In the legislation, forgive me for not knowing the precise, do we define small pharmacies in that legislation? I mean the criteria.

Mr. MARINO. Yes. It is very well defined in there. If anyone has any suggestions on how to further define it or even have sugges-

tions on, if I may use the simple word, tweaking this, I am certainly open to hear that.

Ms. JACKSON LEE. That will be welcome. The only reason, I am continuing to speaking to the Chair, and there is some undercurrent that this will open it up to the world, and I think the more precise, if anyone is interested, those of us who are looking at this, are interested in being fair to the PBMs, being fair to these gentlemen, who are out in the community, to be able to look at and to make sure that it is not underlying open to the world.

Mr. MARINO. All right. Thank you.

I want to thank our witnesses for their testimony today and for your indulgence. Without objection, all Members will have 5 legislative days to submit to the Chair additional written questions for the witnesses, which we will forward and ask the witnesses to respond to as promptly as they can so do, that their answers may be part of the record.

Without objection, all Members have 5 legislative days to submit any additional materials for inclusion in the record.

Thank you again. The meeting is adjourned.

[Whereupon, at 12:29 p.m., the Subcommittee was adjourned.]

A P P E N D I X

MATERIAL SUBMITTED FOR THE HEARING RECORD

Questions for the Record for Mike James

Hearing on:

H. R. 1946, the "Preserving Our Hometown Independent Pharmacies Act of 2011"

Thursday, March 29, 2012

9:30 a.m.

2141 Rayburn House Office Building

Question Offered by Vice Chairman Ben Quayle:

- 1) How many independent community pharmacies were there in 2007, 2008, 2009, 2010 and 2011?
- A) The number of independent pharmacies in the US in 2006 was 24,500 and the number has fluctuated each year, 2007—23,348; 2008—22,728; 2009—23,117; 2010—23,064. While the number appears to be a relatively small percentage fluctuation, it must be taken into account that any pharmacy opening and receiving a pharmacy permit is considered retail pharmacy with some exceptions such as Health Departments, clinics and others of this type. It should also be acknowledged that the new pharmacy permit that is counted in California does not care for the patients that lost their pharmacy in rural Texas. The new permit may compensate in numbers for the lost one in Texas but the Texas patients still do not have a pharmacy.
- 2) What is the delta between what an insured patient with a PBM card versus a cash-paying patient pays?
- A) A patient who has a PBM plan is at the mercy of the PBM. The patient could pay a \$10.00 co pay for a generic or could pay a standard \$40 or \$50 co pay for a brand drug. Some patients pay a percentage of the total cost of the prescription as defined by the PBM. There is no limit by the PBM for what this patient's co pay could total as defined by the plan. A cash paying customer will pay the market value for the medication—they will shop for the best price— just like they would for any other item they might purchase in any retail business. Hence, the market dictates retail cash prescription prices in the marketplace. As PBMs raise prescription prices to the plan, the cost to the patient goes up both at the prescription co pay level but also with increase in premiums for the plan.

It is also important to note that the 2011 NCPA Digest reported that the generic dispensing rate for independents in 2010 was 72%, for Medco it was 62.8%, for Caremark it was 62.4% and for Express Scripts it was 60.55%. The PBM numbers are from the third quarter earnings reports from 2010. Without question, patients

are much more likely to receive a generic prescription from their independent pharmacies than from PBM mail order. Also very important to note is that the average price of a generic prescription in 2010 was \$72 and the average price of a brand prescription was \$198 (July 25, 2011 Associated Press article citing Wolters Kluwer Pharma Solutions). If the independent pharmacies are dispensing generics at a rate of 72% and PBM mail order dispenses at a rate of 62%, the patient on average pays \$107.28 for medication purchased through their independent pharmacy and on average pays \$119.88 for medication dispensed through PBM mail order. Patients/consumers pay on average between \$12 and \$13 LESS for their prescriptions from independent pharmacies. So when PBMs and those who advocate for them claim that costs will go up if HR 1946 passes, they are wrong.

- 3) The antitrust carve-out under this legislation applies only to prescription drugs reimbursed by employers and health plans. Do you also perceive a need for an antitrust carve-out for non-prescription items such as durable medical equipment and diabetic supplies?
 - A) No. DME and diabetic products for example are currently negotiated items and fall into the normal market place. Prices are determined by competition. These prices are not dedicated by a PBM and can be sold as dictated by competition.
- 4) Why are federal health programs excluded from this proposed antitrust carve-out legislation?
 - A) These programs have federal guidelines related to how the PBM must operate and how the PBM patient is treated. Patient co pays are set and reimbursement fee are established for each program and the PBM must abide by these guidelines. Therefore, they do not need to be included in this legislation. H. R. 1946 was drawn to focus on the private sector.

Questions Offered by Representative Mike Pence:

- 1) What is the approximate growth rate of independent community pharmacies over the last five years? How would a limited antitrust exemption affect this are of growth?
 - A) Independent pharmacy permits have actually dropped in number since 2006 by about net 6%. While this does not seem to be a large drop, it should be acknowledged that this number is from permit counts. The long established pharmacy that closed in Texas was not physically replaced by the new permit that was issued in California. Hence, the patients who lost their Texas pharmacy still do not have a pharmacy in their town just because a permit was issued in California.

- 2) The limited antitrust exemption under H. R. 1946 would apply only to prescription drugs reimbursed by employers and health plans. Do you anticipate any future need to expand this exemption to include non-prescription items?
- A) No. All other items are sold in the open market and the PBMs do have a lock on dictating prices to the pharmacy or the public. The cost of these items are determined by the marketplace and the patients can shop for the best price at any pharmacy.



Questions for the Record for Renardo Gray

Hearing on:

H. R. 1946, the “Preserving Our Hometown Independent Pharmacies Act of 2011”

Thursday, March 29, 2012

9:30 a.m.

2141 Rayburn House Office Building

Question Offered by Vice Chairman Ben Quayle:

- 1) How many independent community pharmacies were there in 2007, 2008, 2009, 2010 and 2011?**

Answer: The number of independent pharmacies in the US in 2006 was 24,500 and the number has fluctuated each year, 2007—23,348; 2008—22,728; 2009—23,117; 2010—23,064. While the number appears to be a relatively small percentage fluctuation, it must be taken into account that any pharmacy opening and receiving a pharmacy permit is considered retail pharmacy with some exceptions such as Health Departments, clinics and others of this type. It should also be acknowledged that the new pharmacy permit that is counted in California does not care for the patients that lost their pharmacy in rural Texas. The new permit may compensate in numbers for the lost one in Texas but the Texas patients still do not have a pharmacy.

- 2) What is the delta between what an insured patient with a PBM card versus a cash-paying patient pays?**

Answer: A patient who has a PBM plan is at the mercy of the PBM. The patient could pay a 10.00 co pay for a generic or could pay a standard \$40 or \$50 co pay for a brand drug. Some patients pay a percentage of the total cost of the prescription as defined by the PBM. There is no limit by the PBM for what this patient’s co pay could total as defined by the plan. A cash paying customer will pay the market value for the medication—they will shop for the best price—just like they would for any other item they might purchase in any retail business. Hence, the market dictates retail cash prescriptions prices in the marketplace. As PBMs raise prescription prices to the plan, the cost to the patient goes both at the prescription co pay level but also with increase in premiums for the plan.

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Statement of:

Adam J. Fein, President, Pembroke Consulting, Inc.

To:

U.S. House of Representatives

Committee on the Judiciary

Subcommittee on Intellectual Property, Competition, and the Internet

Concerning:

H.R. 1946

“Preserving Our Hometown Independent Pharmacies Act of 2011”

April 10, 2012

Thank you, Chairman Goodlatte, Ranking Member Wyatt and members of the subcommittee. My name is Adam Fein. I appreciate the opportunity to present my views about the pharmacy industry relevant to H.R. 1946, "Preserving Our Hometown Independent Pharmacies Act of 2011." In testimony to the subcommittee, proponents of H.R. 1946 made many statements about the economic structure and functioning of the U.S. retail pharmacy. As I will explain, certain key claims are false and at odds with third-party industry data. As a result, there is no compelling need for this legislation.

First, a few words about my industry experience and knowledge of these issues. I am an expert on the complex economic interactions within the U.S. pharmacy distribution and reimbursement system. I earned my Ph.D. in Managerial Science and Applied Economics from the Wharton School of Business at the University of Pennsylvania. A significant portion of my doctoral dissertation was devoted to analyzing the history and evolution of the pharmaceutical distribution industry. As president of Pembroke Consulting, Inc., a management consulting and research firm based in Philadelphia, I help executives at the country's leading pharmaceutical manufacturers improve their commercial strategies and publish detailed industry reports on the economics of pharmacies, wholesalers, and PBMs. I also write the influential website Drug Channels (www.DrugChannels.net). There, I analyze news and research related to pharmaceutical economics and the drug distribution system.

Independent pharmacy owners claim that Pharmacy Benefit Managers (PBMs) are (1) forcing independent pharmacies out of business, and (2) shifting patients from independent pharmacies to mail-order pharmacies owned by the PBMs. These business owners ask for antitrust exemptions to negotiate collectively with PBMs.

I will explain the flawed premises behind these arguments. I will show that the pharmacies' positions are not supported by objective industry data, including financial information collected and published by the community pharmacies themselves. I will also explain how smaller pharmacies can and do organize for collective action under current antitrust laws using large, well-established Pharmacy Services Administrative Organizations (PSAOs.)

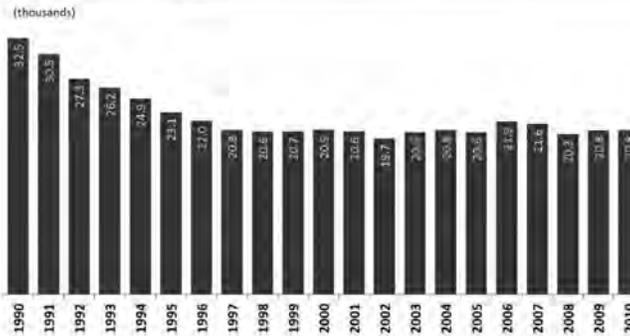
I will now discuss four specific observations based upon my knowledge of this industry:

1. Smaller, pharmacist-owned independent pharmacies are not vanishing and remain an important segment of the industry.
2. The financial position of independent pharmacies has not deteriorated.
3. Independent pharmacies are losing business to competing retail chains, not to mail-order pharmacies.
4. Smaller pharmacies already have the ability to negotiate collectively with PBMs.

1) Smaller, pharmacist-owned independent pharmacies are not vanishing and remain an important segment of the industry.

Contrary to claims made in testimony to the subcommittee, the number of independent pharmacies has been stable since the late 1990s. Over the past 10 years, the number of independent pharmacy locations has remained almost the same—20,896 in 2000 vs. 20,835 in 2010.¹ (See Exhibit 1.) For 2010, the National Community Pharmacists Association (NCPA) states the even-higher figure of 23,064 independent pharmacies.²

Exhibit 1: Number of Independent Pharmacies, 1990-2010



Number of pharmacies in thousands.
Source: 2011-12 NACDS Chain Pharmacy Industry Profile; IMS Health.

2) The financial position of independent pharmacies has not deteriorated.

Independent pharmacies have claimed widespread economic harm from “unfair” PBM contracts. However, the facts show few negative economic effects on independent pharmacies during recent years.

Total revenues at independent pharmacies increased by \$1.1 billion (+2.5%) in 2010, and grew by \$11.2 billion from 2000 to 2010.³ Average revenue at an independent pharmacy outlet has also grown. Average revenues grew by 34% from 2000 to 2010. In 2010, average revenues were the highest they have been since 2006.

In contrast to testimony, independent pharmacy profit margins on prescriptions have been increasing, not declining. According to survey data from the NCPA, gross profit margins on prescription sales were 23.3% in 2010 vs. 21.5% in 2006.⁴ Prescription profit margins have increased consistently since the launch of Medicare Part D, although there was a slight decline of 10 basis points, from 23.4% in 2009 to 23.3% in 2010.

Overall profit margins have also remained stable. NCPA member surveys document that overall gross profit margins (including both prescription and non-prescription products) for independent drugstores have remained stable—ranging from 22% to 24% over the past 10 years.⁵ These surveys are consistent with the U.S. Census Bureau’s latest retail data, which show 2010 gross margins for Pharmacies and Drug Stores (NAICS 44611) to have been 23.9%—identical to the 2007 gross margin figure.⁶

The continued growth of pharmacist salaries also refutes pharmacy owners’ claims of economic harm. In 2011, average annual salary of a pharmacist working in a retail drug store was \$114,040, an increase of \$6,230 (+5.8%) vs. 2009.⁷ It is especially notable that this salary growth occurred during a time of widespread economic weakness and declining household incomes. Pharmacy owner salaries are more than twice as large. According to my analysis of NCPA survey data, the average pharmacist owning a single pharmacy earned over \$250,000 in 2010 (the most recent year available).⁸

3) Independent pharmacies are losing business to competing chain stores, not to mail-order pharmacies.

The true competitive threat for independent pharmacies is other retail pharmacies, not mail order. Despite claims about “unfair competition” from PBMs, it is chain stores—chain drugstores and mass merchants with pharmacies—that continue to gain market share at the expense of all other dispensing formats.

In 2011, total retail prescriptions grew by only 0.3%, while chain stores grew at six times the industry’s overall growth rate. (See Exhibit 2.) Chain drugstores such as CVS and Walgreen are prevailing with new store openings, organic growth from larger and busier pharmacies, and acquisitions of regional chains. Walmart, which is now the third-largest chain in the pharmacy industry, has used its \$4 generic drug discount and other strategies to increase pharmacy traffic in its stores.

Exhibit 2: Number of Prescriptions by Dispensing Format, 2010 vs. 2011

Dispensing Format	Prescriptions (millions)			Share of Prescriptions		
	2010	2011	% Change	2010	2011	Change
Chain stores	2,173	2,212	1.8%	51.7%	52.5%	77 b.p.
Independent drugstores	748	740	-1.1%	17.8%	17.6%	-24 b.p.
Supermarkets with pharmacies	489	483	-1.2%	11.6%	11.5%	-18 b.p.
Mail-order pharmacies*	792	780	-1.5%	18.8%	18.5%	-34 b.p.
Total	4,202	4,215	0.3%	100.0%	100.0%	

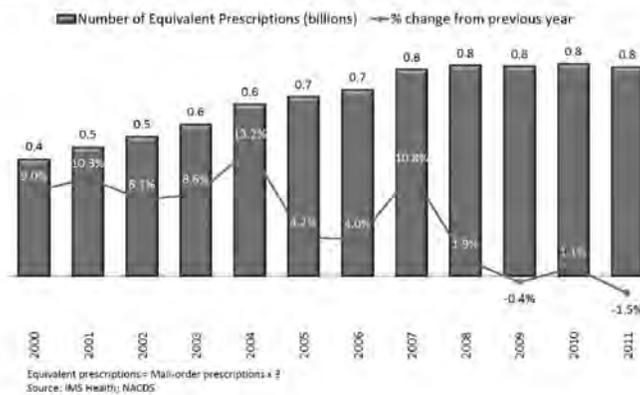
* Prescription data for mail-order pharmacies show Equivalent Scripts (Actual Scripts x 3)
 Totals may not sum due to rounding.
 b.p. = Basis Point (one hundredth of one percent, 0.01%)
 Source: “Channel Distribution by U.S. Dispensed Prescriptions” IMS Health, April 2012.

As Exhibit 2 shows, independent pharmacy owners’ statements about mail order are simply not true. In contrast to testimony made to the subcommittee, mail order growth has lagged the overall market. In 2011, every non-chain format declined. Prescriptions filled by

mail order pharmacies dropped by 1.5%, while prescriptions filled by independents dropped by only 1.1%. In other words, mail pharmacies lost more market share than did independent pharmacies.

The 2011 data are consistent with a long-term slowdown in the growth of prescriptions dispensed via mail-order pharmacy. (See Exhibit 3.) From 2007 to 2011, total U.S. retail prescriptions (excluding mail pharmacies) grew by 162 million, a gain of 4.9%. During the same five-year period, total mail prescriptions grew by 9 million, a gain of only 1.2%. What's more, the total number of prescriptions dispensed from mail pharmacies has declined in two of the past four years.

Exhibit 3: Equivalent Mail Prescriptions, Annual Total and Growth, 2000-2010



My research identifies three key factors behind this decline in mail pharmacies' performance:

- Mail's economic advantage is diminishing: 6 out of 10 employers allow community pharmacies to fill 90-day prescriptions for maintenance medications.⁹ These

programs reduce the cost gap between mail and community pharmacy for both consumers and third-party payers.

- Retail community pharmacies are competing more aggressively with the discounts offered by mail pharmacies. Pharmacies have either pursued cash-pay consumers with discount generic programs, or reduced their reimbursement rates to providers to participate in more limited networks.
- Since 2006, the Medicare Part D benefit has favored retail prescription growth over mail growth. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) contains a “level playing field” requirement, which prohibits mandatory use of mail order pharmacies. If a Medicare Part D plan offers a 90-day supply at mail, then it must offer a 90-day supply option at retail.

4) Smaller pharmacies already have the ability to negotiate collectively with PBMs.

Nearly all independent pharmacy owners participate in Pharmacy Services Administration Organizations, or PSAOs, to leverage their influence in contract negotiations with PBMs. The prevalence and size of these organizations undermines the need for H.R. 1946, or any similar legislative action.

The largest 9 PSAOs represent nearly 22,000 pharmacies.¹⁰ (See Exhibit 4, on the next page.) According to my research,¹¹ three of the country’s largest PSAOs are owned and operated by drug wholesalers that rank among the 30 largest U.S. corporations in the Fortune 500. These wholesalers have revenues of more than \$275 billion and distribute more than 85% of all prescription drugs in the United States. About 10,000 independent-drugstore owners rely on the three largest wholesalers’ PSAOs to negotiate and administer contracts between PBMs and independent pharmacies. This corporate ownership provides a further negotiating advantage for smaller drugstores.

The other PSAOs shown in Exhibit 4 are owned not by a wholesaler but by the member pharmacies. The services provided by a member-owned PSAO are similar to those provided by a wholesaler-owned PSAO. The presence of pharmacy-owned PSAOs illustrates the ability of smaller pharmacies to organize for collective action under current antitrust laws.

Exhibit 4: Largest Pharmacy Services Administration Organizations, 2011

Pharmacy Services Administration Organization (PSAO)	Participating Pharmacies	Ownership
GNP Provider Network	5,000	AmerisourceBergen
Rx Pr1de	3,300	Member owned
Access Health	3,000	McKesson
Third Party Station	2,500	Wholesale LLC*
LeaderNET	2,000	Cardinal Health
United Drugs/AAAP	2,000	Member owned
EPIC Pharmacy Network, Inc.	1,900	Member owned
TriNet Third Party Network	1,200	PBA Health
Major Value Third Party Network	1,000	HD Smith
Total	21,900	

Sources: Company reports; Pembroke Consulting estimates.

* Wholesale Alliance LLC is jointly owned by the following regional drug wholesalers: Burlington Drug, Dakota Drug, Dik Drug, King Drug, Kinray, NC Mutual, Rochester Drug Co, Smith Drug, and Value Drug.

The typical PSAO gives a group of independent pharmacies access to benefits normally associated with large, multi-location chain pharmacy corporations. These benefits include:

- **Negotiation**—PSAOs represent independent pharmacies in contractual negotiations with third parties such as PBMs and managed care organizations. Contract terms include pharmacy reimbursement rates and payment timing. Many PSAOs tout their ability to increase reimbursement relative to contracts between a single pharmacy and a PBM.
- **Contracting**—Small-business owners often lack the legal background and time to evaluate third-party contracts. A PSAO reduces the pharmacy's contracting workload by providing a centralized and efficient means of reviewing contracts with PBMs and other third-party payers.

- Claims Payment—PSAOs act as intermediaries between PBMs and pharmacies. Through the “central pay” process, a PSAO collects the money from the claims filed with PBMs. The PSAO then resends the money from the PBM to individual pharmacies.
- Reconciliation—Most PSAOs will generate customized, store-level reports for pharmacies that summarize claims activity and identify outstanding claims.
- Business Support—PSAOs provide other services to independent pharmacies, such as publishing a listing in a provider directory, legislative updates, or profitability analyses.

Consider Good Neighbor Pharmacy Provider Network (GNPPN), the PSAO owned by \$80 billion wholesaler AmerisourceBergen (NYSE: ABC). A GNPPN webpage includes the following testimonial from an independent pharmacy owner:¹²

“Good Neighbor Pharmacy Provider Network has good negotiators who bring forth the fairness of reimbursement. My reliance on them is total.”

Mike Douglas, RPh, Owner

Mike’s Medical Pharmacy, Oregon

Other PSAOs communicate similar messages. Consider these sample statements from the publicly-available websites of three major PSAOs:

- AccessHealth: *“As an AccessHealth member, you have the contracting strength of 3,000 pharmacies, and the superior reimbursement rates, terms, and contract conditions that come with it.”*¹³
- EPIC Pharmacy Network: *“...operates as the exclusive contracting agent on behalf of more than 1,900 members in 26 states, aggressively promoting the network as one*

entity to provide independent pharmacies with the tools they need to better manage managed care.”¹⁴

- United Drugs: *“Using current claim data, we analyze the profitability of contracts at the current and proposed reimbursement rates. The goal: turning a one-sided agreement in favor of the PBMs and health plans into a mutually-beneficial agreement for both parties.”¹⁵*

As these statements illustrate, the presence and activities of PSAOs undermine the need for H.R. 1946 or similar legislation.

Conclusion

Based on the economic facts and current pharmacy industry structure, there is little need for independent pharmacies to receive special treatment under antitrust laws via H.R. 1946 or similar legislation. I thank the Committee for considering my analysis and am available to answer any questions concerning it.

ENDNOTES

- ¹ *2011-12 Chain Pharmacy Industry Profile*, National Association of Chain Drug Stores, August 2011, 12.
- ² *2011 NCPA Digest*, National Community Pharmacists Association, October 2011, 5.
- ³ *2011-12 Chain Pharmacy Industry Profile*, 52.
- ⁴ *2011 NCPA Digest*, October 2011, 10.
- ⁵ *2010 NCPA Digest*, National Community Pharmacy Association, October 2010, 6.
- ⁶ *2010 Annual Retail Trade Report*, U.S. Census Bureau, March 2012. Available at <http://www.census.gov/retail/index.html#arts>.
- ⁷ Occupational Employment Statistics, U.S. Bureau of Labor Statistics, May 2011 (<http://www.bls.gov/oes/current/oes291051.htm>) and May 2009 (<http://www.bls.gov/oes/2009/may/oes291051.htm>). Accessed April 6, 2012. Figures show Annual Mean Wage for pharmacists employed by Health and Personal Care Stores (NAICS 446100).
- ⁸ "The True Economics of Pharmacy Ownership," Drug Channels, October 18, 2011. Available at <http://www.drugchannels.net/2011/10/true-economics-of-pharmacy-ownership.html>.
- ⁹ *The 2011-12 Prescription Drug Benefit Cost and Plan Design Report*, Pharmacy Benefit Management Institute, 9.
- ¹⁰ This total represents slightly more than the total number of independent drugstores. This occurs because an independent pharmacy can simultaneously belong to more than one PSAO. For instance, a pharmacy could work with both a regional PSAO and a national PSAO. Thus, the number of unique pharmacies represented may be less than the computed total shown in Exhibit 4. However, a pharmacy typically must interact with any given PBM through only one PSAO.
- ¹¹ *The 2011-12 Economic Report on Retail and Specialty Pharmacies*, Pembroke Consulting, Inc., January 2012, 42-43. Available at <http://www.pembrokeconsulting.com/pharmacy.html>.
- ¹² Source: http://www.amerisourcebergen.com/abcdrug/retail_pharmacies/independent_pharmacies/good_neighbor_pharmacy/index.jsp. Accessed April 9, 2012.
- ¹³ Source: http://www.mckesson.com/en_us/McKesson.com/For%2BPharmacies/Retail%2BNational%2BChains/Managed%2BCare/AccessHealth%2BServices/Third-Party%2BContracting.html. Accessed April 9, 2012.
- ¹⁴ Source: <http://www.epicrx.com/members/whyjoin.aspx>. Accessed April 9, 2012.
- ¹⁵ Source: <http://www.rxaap.com/reimbursement-template.php>. Accessed April 9, 2012.



Prepared For:

Pharmaceutical Care Management Association
601 Pennsylvania Avenue, Suite 740
Washington, DC 20004

The Cost of Independent Pharmacy Antitrust Exemptions, 2013-2017

Prepared By:

Peter J. Rankin, Archan H. Ruparel, Remy
Agamy, and Andrew Smith
Charles River Associates
1201 F Street NW Suite 700
Washington, DC 2004

Date: March 28, 2012

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1. Executive Summary

In 2011, the latest in a series of pharmacy antitrust exemption bills, H.R. 1946, was introduced. The bill would create a five-year antitrust exemption to allow independent pharmacies to negotiate collectively with health plans and pharmacy benefit managers ("PBMs") over payment rates and other contract terms. Under current antitrust law, regulators would consider such collective negotiations to be collusion.

Regulators generally reject the need for antitrust exemptions and the Federal Trade Commission ("FTC") has testified against a similar pharmacy antitrust exemption bill. According to the FTC, a pharmacy antitrust exemption "threatens to raise prices to consumers" and "threatens to increase costs to private employers who provide health care insurance to employees, potentially reducing those benefits" all "without any assurance of higher quality care."¹ Likewise, in scoring previous pharmacy antitrust exemption legislation, the Congressional Budget Office ("CBO") noted that pharmacy antitrust exemptions would "increase premiums for group health insurance" and lead employers to respond with "reductions in the scope or generosity of health insurance benefits."²

Charles River Associates ("CRA") has been commissioned to estimate the potential impact of pharmacy antitrust exemptions proposed in H.R. 1946. We find that:

- H.R. 1946 could increase direct costs to commercial payers by \$7.6-\$15.6 billion over five years, an average increase of approximately 4-8 percent of total prescription sales across all independent pharmacies;
- Increased costs from antitrust exemptions to independent pharmacies would likely be passed on to health insurers, employers, and consumers and could result in employers reducing health insurance benefits;
- While antitrust exemptions under H.R. 1946 do not apply to most federal programs, they would allow pharmacies to collectively bargain with plans in the new state-based health insurance exchanges, which could increase federal costs;
- There is no compelling economic reason to confer antitrust exemptions to independent pharmacies, since these institutions are profitable and protected by existing competition laws; and
- Existing market mechanisms give independent pharmacies leverage to bargain with health plans and PBMs. Both government and private payers require health plans and PBMs to meet pharmacy access standards for their plan members, which gives

¹ Prepared Statement of the FTC before the Antitrust Task Force of the H. Comm. on the Judiciary, Concerning H.R. 971, "The Community Pharmacy Fairness Act of 2007," 110th Cong., Oct. 18, 2007, (<http://www.ftc.gov/os/testimony/P859910pharm.pdf>).

² CBO, "H.R. 971: Community Pharmacy Fairness Act of 2007," Congressional Budget Office Cost Estimate, January 11, 2008 and September 26, 2008.

pharmacies in unique locations added bargaining leverage. Likewise, nearly 80 percent of independent pharmacies rely on intermediaries known as Pharmacy Services Administration Organizations ("PSAOs") that pool the bargaining power of many independents to collectively negotiate reimbursement and contract terms with health plans and PBMs.

2. Introduction

Following several years of significant reform and structural change, health care continues to command significant political, regulatory, and judicial attention. Recent attention culminated in the 2010 signing of the Patient Protection and Affordable Care Act ("PPACA"), the health care reform law that will introduce significant structural changes to health care access over a staggered implementation from 2010 through 2018. Under PPACA, sophisticated payers, including employers, unions, government programs, commercial health insurers, and pharmacy benefit managers ("PBMs") will continue to provide pharmacy benefits using networks of independent and retail pharmacies. Through insurance plans available on state health insurance exchanges and individual and employer coverage mandates, PPACA is anticipated to ensure insurance coverage for 90 percent of non-elderly U.S. residents.³

In providing health care coverage, payers (health insurers and PBMs) often build networks of health care providers from which their covered patients are encouraged or required to seek treatment or therapy. Competition among potential members of a network is one way in which payers reduce costs: payers accept those pharmacies that provide the most efficient services. In return, those pharmacies that are part of payer networks gain access to the number of potential patients whose benefits are managed by that payer.

2.1. Current legislation proposing independent pharmacy antitrust waivers: H.R. 1946

Independent pharmacy representatives contend that the current economic circumstances have placed independent pharmacies at a competitive disadvantage to payers and PBMs. The suggested remedy, antitrust exemptions, would allow independent pharmacies to bargain collectively with health plans and PBMs. In particular, antitrust exemptions would allow independent pharmacies to collude to determine the reimbursement required to dispense prescriptions to patients. In May 2011, Representative Thomas Marino (R-PA) introduced H.R. 1946, the "Preserving Our Hometown Pharmacy Act."⁴ Notably, among other provisions H.R. 1946 would:

³ Congressional Budget Office ("CBO"), "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 13, 2012, Table 3. Judicial challenges to PPACA are pending, with oral arguments before the Supreme Court scheduled for March 27-29, 2012. As noted below, changes to PPACA or the expected sources and mix of insurance types will affect the potential cost of independent pharmacy antitrust waivers.

⁴ U.S. House of Representatives, 112th Congress, "H.R. 1946," May 23, 2011 ("H.R. 1946").

- Define "independent pharmacy" by "market share" rather than ownership status or chain affiliation;⁵
- Convey an antitrust exemption to independent pharmacies for a period of five years (with an additional year for contracts entered into during the five-year period);
- Limit such antitrust waiver to exclude boycotts, market allocation, unlawful tying, and monopolization or attempts to monopolize;⁶ and
- Prevent application of the antitrust exemption to certain government programs, including Medicaid and Medicare Parts C and D.⁷

This study evaluates the direct commercial cost increases that would likely result from granting antitrust exemptions to independent pharmacies under H.R. 1946. The cost estimates are based on price increases resulting from collective negotiation by independent pharmacies on reimbursement terms. This report does not include all aspects of direct commercial costs (e.g., reduced tax revenues, increased health insurance exchange subsidies), nor does it quantify indirect expenses (e.g., cost increases to payers passed through to patients). As described in the following sections, this analysis concludes that:

- There is no compelling economic reason to confer antitrust exemptions to independent pharmacies, as these institutions are profitable, are protected by enforcement of existing competition laws, and have at their disposal existing means through which legitimate competitive concerns can be addressed;
- Despite the exemptions introduced in H.R. 1946, direct costs to payers could increase by \$7.6 to \$15.6 billion over 5 years, an increase of 3.8 to 7.9 percent of total prescription sales across all independent pharmacies; and
- There are reasons to believe that direct and indirect costs would also be borne by the government, despite exclusion of governmental programs in the scope of permissible collective activity under H.R. 1946.

⁵ Under H.R. 1946, an independent pharmacy is defined as a pharmacy that has a "market share" of less than 10 percent in any PDP region and less than 1 percent in the United States. In earlier legislation (H.R. 971, introduced in 2007), independent pharmacy was defined as a pharmacy not owned or operated by a publicly traded company.

⁶ This provision would seem to be potentially contradictory, as collective negotiation will not lead to change if the colluding independent pharmacies lack the market power necessary to extract higher reimbursements. As any change under the legislation is predicated on this strengthened market position, the analysis and cost estimate that follow assume that independent pharmacies operating with an antitrust exemption would be able to affect reimbursements despite the exclusion of monopoly or attempted monopolization.

⁷ Other provisions include a full list of the specified government programs for which the waivers are to have no application, definitions, and a requirement for a General Accountability Office study of the impact of the legislation to during the fifth year of enactment. For full details, see H.R. 1946.

2.2. Previous legislation proposing independent pharmacy antitrust waivers: H.R. 971

The call for independent pharmacy antitrust waivers is not new. In October 2007, the U.S. House of Representatives Judiciary Committee's Antitrust Task Force held a hearing at which the Federal Trade Commission ("FTC"), a government regulatory agency that protects competition, provided testimony in which it concluded that:

"Simply put, although the Commission is sympathetic to the difficulties independent and family pharmacies face, the exemption threatens to raise prices to consumers, especially seniors, for much-needed medicine. It also threatens to increase costs to private employers who provide health care insurance to employees, potentially reducing those benefits, and to the federal government, which was projected to have paid over 30 percent of the costs of prescription drugs in 2006, all without any assurance of higher quality care. For these reasons, the Commission opposes the legislation."⁸

The support for the cost estimates of H.R. 1946 is provided below. Section 3 considers whether the conditions faced by independent pharmacies support the grant of antitrust waivers. Section 4 summarizes the literature and opinions regarding price increases expected to result from antitrust waivers. Section 5 estimates the costs of providing antitrust exemptions under H.R. 1946 and provides details of the calculation.

3. Antitrust exemptions are unnecessary for independent pharmacies

3.1. There is no economic justification for antitrust waivers for independent pharmacies

Analysis of previous legislation that would grant antitrust waivers noted that the economic circumstances of independent pharmacies did not support the notion of a competitive imbalance with payers and PBMs. Using data collected and disseminated by the National Community Pharmacy Association ("NCPA"), a trade association for independent pharmacies, review of the financial circumstances of independent pharmacies showed that the average gross profit margin for independent pharmacies was near 20 percent and increasing in 2005 and that the volume of prescriptions was increasing concurrent with increases in gross profit margin.⁹

⁸ Prepared Statement of the Federal Trade Commission before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, "The Community Pharmacy Fairness Act of 2007," 110th Cong., Oct. 18, 2007, (<http://www.ftc.gov/os/testimony/P859910pharm.pdf>).

⁹ A 2007 CRA report on the same topic relied on data provided in the NCPA Digest, which was then publicly available. (Peter J. Rankin, Monica G. Noether, and Emily Telleen-Lawton, "The Cost of Independent Pharmacy Antitrust Exemptions," May 2007 ("CRA 2007").) Since 2007, distribution of the NCPA Digest has been restricted to NCPA membership. Where possible, this updated cost study uses data from NCPA to maintain consistency.

Recent data indicate that independent pharmacies remain profitable. Figures from the NCPA suggest that pharmacy profit margins are not declining and that gross profits have nearly doubled over the past ten years. NCPA figures also suggest that independent pharmacy profit margins are at their highest levels since 2003, while the NCPA Digest points out that the total gross margin has "remained in the 22 to 24 percent range seen over the past 10 years." Average revenues per pharmacy location, which were \$1.967 million on average in 1999, were at \$4.026 million in 2009. Correspondingly, gross profits, which were at \$472,000 per pharmacy location in 1999, reached \$958,000 in 2009. Owner's compensation, defined as the sum of compensation paid to a working pharmacy owner and a pharmacy's net operating income, averaged \$274,000 per pharmacy location.¹⁰

3.2. Current regulations safeguard competition and allow legitimate coordinated activity

The FTC, along with the Antitrust Division of the U.S. Department of Justice ("DOJ") and State Attorneys General, monitors competition and enforces laws and regulations intended to protect consumers from inappropriate corporate behavior. Central to that responsibility is the monitoring of "market power," which describes the ability to affect prices, relative to competitive levels, for a significant period of time. The regulatory agencies and State Attorneys General monitor both areas where sellers appear to be increasing prices above competitive levels (e.g., monopoly) as well as circumstances where purchasers appear to be decreasing prices below competitive levels (e.g., monopsony).

The FTC and DOJ have established a series of general and health care-specific guidelines to distinguish appropriate and problematic corporate behavior. For example, the FTC and DOJ jointly issued and regularly update the Horizontal Merger Guidelines guidance, which identify the types of behaviors and market conditions likely to violate competition laws.¹¹ The agencies have also articulated the conditions under which collective agreements are ancillary

¹⁰ Adam Fein, Ph.D., "Owning a Pharmacy: Still Pretty Profitable," January 25, 2011, available at <http://www.drugchannels.net/2011/01/owning-pharmacy-still-pretty-profitable.html>.

¹¹ DOJ and FTC, "Horizontal Merger Guidelines," August 19, 2010, available at <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>.

and subordinate to achieving some significant procompetitive end, such as quality improvement or cost reduction.¹²

In addition, mechanisms exist to allow independent pharmacies to reduce administrative costs and increase volumes without antitrust exemptions. Pharmacy Service Administrative Organizations ("PSAOs") provide a range of services to pharmacies, including PBM contract management and negotiation.¹³ Nearly 80 percent of independent pharmacies rely on PSAOs that pool the bargaining power of many independents to collectively negotiate reimbursement and contract terms with health plans and PBMs.¹⁴ The typical PSAO represents thousands of pharmacies. It gives a group of independent pharmacies access to benefits normally associated with large, multi-location chain pharmacy corporations such as pooled contractual negotiating power, centralized claims payment, and reconciliation of prescription payment activity.¹⁵

3.3. Antitrust exemptions are a flawed response to perceived competitive imbalance

The grant of antitrust exemptions tends to be a particularly problematic response to perceived competitive imbalances. The search for antitrust exemptions can be a rent-seeking activity that provides no economic efficiency and may be unjustified. It can increase the problems of market power and substantially increase prices without providing any gain to consumers. Former FTC chairman Robert Pitofsky noted, "From a policy and enforcement perspective, the most effective response to the emergence of excessive buyer power is not to permit the

¹² This is a topical consideration, as the FTC and DOJ recently released a joint policy statement on Accountable Care Organizations ("ACOs"), another facet of health care reform. Under this reform model, groups of providers and suppliers "may work together to manage and coordinate care for Medicare fee-for-service beneficiaries..." (FTC and DOJ, Antitrust Division, "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," Federal Register, Vol. 76, No. 209, October 28, 2011 ("FTC and DOJ ACO Statement 2011," pp. 67026-67032.)) Despite the program specifically calling for coordinated activities, the FTC and DOJ note "The Agencies [FTC and DOJ] recognize that not all such ACOs are likely to benefit consumers, and under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality of care." (FTC and DOJ ACO Statement, p. 67026.) In their discussion, the FTC and DOJ reiterate a position previously articulated in "various policy statements, speeches, business reviews, and advisory opinions" that "Joint price agreements among competing health care providers are evaluated under the rule of reason, however, if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration." For the full discussion, see FTC and DOJ ACO Statement, p. 67027.

¹³ Medicare: Sponsors' Management of the Prescription Drug Discount Card and Transitional Assistance Benefit. United States Government Accountability Office, January 13, 2006, fn. 24. For an example of such a PSAO, see: http://progressivepharmacy.com/PBM_contract_management.php.

¹⁴ NCPA, 2006 NCPA-Pfizer *Digest*, 2006 p. 53, Table 14. Department of Health and Human Services, Office of the Inspector General, "Review of Medicare Part D Contracting for Contract Year 2006," A-06-07-00082, July 2006, pp. 5-6.

¹⁵ Statement of Adam J. Fein before the U.S. House of Representatives Committee on the Judiciary, Subcommittee on Intellectual Property, Competition, and the Internet Hearing on "The Proposed Merger between Express Scripts and Medco," Tuesday, September 20, 2011.

aggregation of some form of countervailing power. Rather, the appropriate response is to try to prevent the aggregation of excessive buying power in the first place.¹⁶ A similar sentiment was expressed in the FTC and DOJ's "Dose of Competition" Report.¹⁷ The FTC contends that the argument for antitrust waivers "presupposes that providers are at the mercy of monopsony health plans," which has not been demonstrated to be true.¹⁸ Additionally, the FTC states that even if the premise of the argument were true, the establishment of an opposing "provider cartel" could doubly harm consumers, who could be forced to pay elevated fees to the provider cartel in addition to any inflated fee imposed by the monopsony health plan.¹⁹ The Antitrust Modernization Commission, a body created by Congress "to evaluate the application" of antitrust laws, states that an antitrust exemption creates "economic benefits that flow to small, concentrated interest groups, while the cost of the exemption are widely dispersed, usually passed on to a large group of consumers through higher prices, reduced output, lower quality, and reduced innovation."²⁰

Since 2007, the FTC has issued several complaints against organizations suspected of such conduct; it has also released a number staff comments from its Bureau of Economics and Competition detailing the potential anticompetitive effects of exemptions from collective bargaining regulations.²¹ It has recently advised against antitrust waiver legislation for health care providers in Puerto Rico and Ohio.²² It has pursued enforcement actions against

¹⁶ FTC Chairman Robert Pitofsky, *Thoughts on "Leveling the Playing Field" in Health Care Markets*, speech delivered to the National Health Lawyers Association, February 13, 1997.

¹⁷ "The Agencies believe that antitrust enforcement to prevent the unlawful acquisition or exercise of monopsony power by insurers is a better solution than allowing providers to exercise countervailing power. Joel Klein, the Assistant Attorney General in 1999, noted that a 'better approach [than allowing countervailing market power] is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health care insurance plans) and sellers (health care professionals) of provider services.'" ("Improving Health Care: A Dose of Competition, A Report by the FTC and the DOJ," July 2004, Chapter 2, p. 21. Parenthetical material included in source material.)

¹⁸ FTC Staff Comment to the Puerto Rico House of Representatives Regarding Senate Bill 2190 Concerning Health Care Collective Bargaining, January 30, 2008 ("FTC Comment on SB 2190"), <http://www.ftc.gov/os/2008/02/v080003puerto.pdf>, p. 6.

¹⁹ *Ibid.*

²⁰ Antitrust Modernization Commission, Report and Recommendations, Apr. 2007 ("AMC Report"), p. 335. http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf; see in FTC Comment on SB 2190, p. 6 and FTC Staff Comment to the Honorable William J. Seitz, Senator, State of Ohio Senate, Regarding Ohio Executive Order 2007-23S, Establishing Collective Bargaining for Home Health Care Workers, February 14, 2008 ("FTC Comment on Ohio Executive Order 2007-23S"), p.5.

²¹ See, for example: FTC Comment on SB 2190; FTC Comment on Ohio Executive Order 2007-23S; FTC Press Release, "U.S. Court of Appeals Affirms FTC Decision That Texas Doctors' Group Engaged in Illegal, Anticompetitive Price-Fixing," May 16, 2008. <http://www.ftc.gov/opa/2008/05/ntsp.shtm>; FTC Press Release, "FTC Settles Price Fixing Charges Against San Francisco bay Area Doctors' Group," June 4, 2009, <http://www.ftc.gov/opa/2009/06/altabates.shtm>.

²² FTC Comment on SB 2190; FTC Comment on Ohio Executive Order 2007-23S.

North Texas Specialty Physicians Group,²³ Alta Bates Medical Group,²⁴ and Minnesota Rural Health Cooperative.²⁵ While enforcement actions have generally pertained to physician groups, the FTC states, "the competition analysis is consistent across different types of health care providers."²⁶

4. Antitrust waivers are expected to increase costs

4.1. Geographic access requirements tend to convey market power

Health plan sponsors, both public and private, typically require that their network of pharmacies be sufficiently broad to provide in-network pharmacies close to members' homes.²⁷ For example, the Centers for Medicare & Medicaid Services ("CMS") require that health plans seeking to participate in Medicare Part D create pharmacy networks that meet the following geographic access requirements:

- At least 90 percent of Medicare beneficiaries, on average, in urban areas served by the Part D plan sponsor live within 2 miles of a network pharmacy that is a retail pharmacy;
- At least 90 percent of Medicare beneficiaries, on average, in suburban areas served by the Part D plan sponsor live within 5 miles of a network pharmacy that is a retail pharmacy; and
- At least 70 percent of Medicare beneficiaries, on average, in rural areas served by the Part D plan sponsor live within 15 miles of a network pharmacy that is a retail pharmacy.²⁸

Facing specific geographic requirements for pharmacy networks, PBMs and health insurers must choose among a limited set of pharmacies in local geographic areas. As a result,

²³ FTC Press Release, "U.S. Court of Appeals Affirms FTC Decision That Texas Doctors' Group Engaged in Illegal, Anticompetitive Price-Fixing," May 16, 2008. <http://www.ftc.gov/opa/2008/05/ntsp.shtm>.

²⁴ FTC Press Release, "FTC Settles price Fixing Charges Against San Francisco bay Area Doctors' Group," June 4, 2009. <http://www.ftc.gov/opa/2009/06/altabates.shtm>.

²⁵ FTC Press Release, "Minnesota Health Care Provider Group Settles FTC Price Fixing Charges," June 18, 2010. <http://www.ftc.gov/opa/2010/06/ruralhealth.shtm>.

²⁶ FTC Comment on SB 2190, p. 6.

²⁷ CRA 2007, p. 16.

²⁸ 42 CFR 423.120.

pharmacies need mainly compete on quality and price within the set of local alternatives.²⁹ To the extent the limited choice of alternatives permits pharmacies to increase prices or reduce quality above the competitive level, there is what the antitrust literature refers to as market power.³⁰ By virtue of their being a limited set of alternatives in a geographic area, PBMs and payers could not turn to other pharmacies should the pharmacies in an area collectively reduce their quality or increase their prices. For example, if there is only one pharmacy in a rural area near a mass of plan members, the pharmacy would have market power as it would have to be included in pharmacy networks and would face little competitive constraint relative to a multi-pharmacy situation.³¹ However, when there is a limited set of pharmacies that currently competes on quality, price, and other metrics, through collective negotiation that antitrust waivers would allow, independent pharmacies would be allowed to coordinate activities and reduce such competition. Having a limited set of local competitors, pharmacies acting in concert can have market power where individually they do not.

4.2. Collective bargaining leads to increased reimbursements

When collectively bargaining, independent pharmacies act as one and are thus able to demand network inclusion at higher reimbursement rates (on a quality-adjusted basis) or ensure that none of them contracts with the PBM or insurer. When independent pharmacies effectively coordinate,³² areas containing multiple and mainly independent pharmacies will become like those containing only one pharmacy. In its enforcement actions against health care providers that have collectively bargained, the FTC has found that “groups have often sought fee increases of 20 percent or more.”³³ Additionally, for other types of health care

²⁹ Note that the requirement that only 70 percent of members in rural areas and 90 percent otherwise be within the specified geographic proximity creates incentives for a limited second-order of competition among pharmacies across geographies not to fall outside of the 70th or 90th percentiles, respectively. The degree of competition is substantially reduced, however, relative to one in which local pharmacies compete directly to be the preferred in-network provider.

³⁰ Market power is defined in the economics literature as pricing above marginal cost (Jean Tirole, *The Theory of Industrial Organization*, 4th Ed., 1990, Cambridge: MIT Press, p. 284). Economists tend to use it on a quality-adjusted basis, where lower quality without appropriate reductions in cost would also be viewed as having market power.

³¹ It is well documented that this situation arises in rural areas. For example, there are only about 230 retail pharmacies in Montana, where 10 counties have no retail pharmacies and 17 counties have a single retail pharmacy (Ronald A. Wirtz, “Special Delivery? Innovations are Changing How, Where and When People Receive Pharmacy Services – Not Everyone Is Thrilled,” *FedGazette*, Federal Reserve Bank of Minneapolis, January 2006).

³² Note that the economics literature on coordination strategies among firms that cannot explicitly collude often finds instability among cartels due to their inability to impede defections (for an overview, see Jean Tirole, *The Theory of Industrial Organization*, 4th Ed., p. 241, 1990, Cambridge: MIT Press). If activities under the waivers can be enforced, however, pharmacies may be able to impede defections through the force of justiciable agreements and act as more perfect monopolists than a typical cartel.

³³ FTC, Prepared Statement Before the Antitrust Task Force of the H. Comm. the Judiciary, Concerning H.R. 971, “The Community Pharmacy Fairness Act of 2007,” 110th Cong., footnote 18, Oct. 18, 2007, (<http://www.ftc.gov/os/testimony/P859910pharm.pdf>). The cited groups sought increases in fees of 20 percent to 90 percent.

providers, the health economics literature has shown both theoretically and empirically that as providers with multiple locations merge or otherwise collectively negotiate rates with payers they are able to obtain higher prices.³⁴ One antitrust remedy used for mergers raising concerns regarding market power is to require separate negotiation.³⁵

4.3. Increased reimbursements will increase costs to plans and increase national health expenditures

The impact of increased reimbursement rates will pass through into higher plan premiums and increases in national health expenditures. As noted above, the FTC has stated that the PBM industry is highly competitive. Additionally, state insurance regulators ensure that health insurers set prices sufficiently to break even, and profit margins among health plans are lower than the median industry.³⁶ The competitiveness of PBMs and payers has a critical economic consequence for who bears cost increases: any cost absorption by PBMs or insurers would likely be only transitory.³⁷ Increased costs from antitrust exemptions to independent pharmacies would likely be passed on to health insurers, employers, and consumers and could result in employers reducing health insurance benefits. The net result is that cost increases would pass into higher costs borne by beneficiaries and plan sponsors, which would in turn raise U.S. health expenditures and the rate of medical inflation.³⁸ This increase in costs will also increase government spending through:

³⁴ See theoretical models and their application in Katherine Ho, "Insurer-Provider Networks in the Medical Care Market," *The American Economic Review*, Volume 99, Number 1, March 2009, pp. 393-430(38); Cory Capps, David Dranove, and Mark Satterthwaite, "Competition and Market Power in Option Demand Markets," *The RAND Journal of Economics*, Vol. 34, No. 4 (Winter, 2003), pp. 737-763; Robert Town and Gregory Vistnes, "Hospital competition in HMO networks," *Journal of Health Economics*, 2001, vol. 20(5), pages 733-753, September. See empirical estimates of the effects of hospital consolidation in Cory Capps and David Dranove, "Hospital Consolidation And Negotiated PPO Prices," *Health Affairs*, 23, no. 2, 2004, pp. 175-181; Leemore Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," *Journal of Law and Economics*, Vol. 52, No. 3, August 2009, pp. 523-550; W. B. Vogt, and Robert J. Town, "How has hospital consolidation affected the price and quality of hospital care?" *Research Synthesis Report 9*, 2006, Robert Wood Johnson Foundation, Princeton, NJ.

³⁵ For example, see FTC Press Release, "FTC Issues Final Opinion and Order to Restore the Competition Lost in Evanston Northwestern Healthcare Corporation's Acquisition of Highland Park Hospital," April 28, 2008, <http://www.ftc.gov/opa/2008/04/evanston.shtm>.

³⁶ Yahoo! Finance Industry Summary, http://biz.yahoo.com/p/sum_qpmd.html, comparing Net profit margin for health plans relative to other industries, as viewed on March 22, 2012.

³⁷ Regulators have described the PBM industry as highly competitive, and economics argues that in competitive industries cost increases pass through directly to customers (i.e. health insurers and employers in the case of PBMs). (CRA 2007, p. 19.) Additionally, there is evidence that in health insurance, little in the way of premium increases comes from recent insurer concentration whereas the vast majority appears to be related to cost increases (Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," NBER Working Paper No. 15434, October 2009.)

³⁸ Current National Health Expenditures are estimated at nearly 18 percent of GDP (CMS, "NHE Fact Sheet" https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp). The CBO projects that National Health Expenditures will reach 49 percent of GDP by 2082 (CBO, "The Long-Term Outlook for Health Care Spending," November 2007, p. 13).

- 1) Increases in the health insurance tax subsidy. Through increasing the amount of employees' earnings paying for untaxed items such as employer sponsored health care or flexible spending accounts for health insurance, the amount of employees' earnings subject to taxation will decline. The net effect is an increase in the tax subsidy provided to health insurance and a decline in tax revenues.
- 2) Increased costs for health insurance exchange subsidies under PPACA. Due to the subsidies being indexed to the cost of the second lowest cost silver plan on a state-based health insurance exchange, an increase in plan costs will translate directly into increased subsidies.³⁹
- 3) Spillover onto Medicare and other Federal Programs. As noted by the CBO, the effects of antitrust waivers that do not apply to federal programs can nonetheless raise costs to federal programs.⁴⁰ Though H.R. 1946 prevents application of the antitrust exemptions to government programs like Medicaid and Medicare Parts C and D, the same pharmacies will negotiate with the same payers or PBMs to determine participation in those government programs. While they will not be permitted to actively coordinate for negotiations with government programs, they will have learned information from other independent pharmacies (e.g. cost structures, valuations) and the negotiating positions of payers and PBMs that could inform their negotiations and willingness to participate in these government programs.

4.4. CBO score of similar legislation

In 2008, the CBO scored similar provisions in H.R. 971.⁴¹ The CBO estimated that independent pharmacy payments would increase one percent upon renegotiation, and that it would increase the costs to group health insurance by less than 0.1 percent, before accounting for responses to the cost increase. Responses to the cost increase, including "reductions in the scope or generosity of health insurance benefits," were expected to offset 60 percent of the cost of the bill.

The CBO's approach to H.R. 971 may not be appropriate generally or in the current context. First, it is not clear how the CBO reached the conclusion of a one percent increase in drug costs for independent pharmacies. Other health care providers that have colluded or merged have obtained reimbursement increases of 20 percent or higher.⁴² Areas served mainly by independent pharmacies, such as rural areas, would see a marked reduction in competition. Second, it is not clear that reductions in coverage should be ignored as costs of the legislation, as economists have found that the cost of health insurance plans comes directly

³⁹ See Patient Protection and Affordable Care Act, Part A, Title I, Subtitle E, Sec. 1401.

⁴⁰ CBO, "H.R. 971: Community Pharmacy Fairness Act of 2007," January 11, 2008 and September 26, 2008.

⁴¹ *Ibid.*

⁴² See *supra* note 333. The cited groups sought increases in fees of 20 percent to 90 percent.

out of employees' earnings.⁴³ To the extent health care becomes more expensive, either employees get less in earnings or they lose a benefit.

5. Estimated cost increases from H.R. 1946

This study estimates the cost increases that would likely result from provision of antitrust exemptions under two main scenarios, namely allowing independent pharmacies to increase their commercial reimbursements to levels that:

- Result in reimbursement increases of 20 percent on commercially insured prescriptions, consistent with FTC determinations of increases due to collective action, representing a 66.7 percent increase in the commercial gross profit rate;⁴⁴ or
- Equal those that North Dakota pharmacists demanded, through apparent collective efforts but in the absence of collective negotiation legislation, to participate in Medicare Part D pharmacy networks, representing a 32.4 percent increase in the commercial gross profit rate.⁴⁵

The result is that in the first scenario, costs would increase by an estimated \$15.6 billion or 7.9 percent of current total prescription sales across all independent pharmacies. In the second scenario, costs would increase by \$7.6 billion or 3.8 percent of current total prescription sales across all independent pharmacies.

A complete description of the cost model methodology and sources are provided in the notes to Exhibits A and B. Significant aspects of the cost estimate model include:

- *Price elasticity of demand for prescriptions:* The impact that these two scenarios have on total pharmacy costs to payers, PBMs, and their customers depends in part on how sensitive pharmacy customers are to price increases. The "price elasticity of demand" reflects how much patients reduce their consumption when the cost of prescription pharmaceuticals increases. As a result of the proposed legislation, if patients are sensitive to the price of their pharmaceuticals, they may forego beneficial pharmaceutical care, just as increases in the cost of health insurance increase the

⁴³ For a review of the literature, see Ezekiel Emmanuel and Victor Fuchs, "Who Really Pays for Health Care? The Myth of 'Shared Responsibility,'" *Journal of the American Medical Association*, March 5, 2008, Vol. 299, No. 9, pp. 1057-1059.

⁴⁴ See *supra* note 33. Note that the commercially insured group excludes the Federal Employee Health Benefit Program as well as government programs including Medicare Part D, consistent with H.R. 1971.

⁴⁵ For details, see CRA 2007, p. 20. While there have been other health care examples of cost increases following collective behavior since 2007, as noted above, this scenario is consistent with those more recent developments and specific to independent pharmacies. This cost report includes a third scenario in which independent pharmacy gross margins for commercially-insured prescriptions approaches the gross margins for cash transactions. In this scenario, costs could increase up to \$39.7 billion or 20.1 percent of total prescriptions across all independent pharmacies.

numbers of uninsured. The cost model adopts price elasticity of demand for pharmaceutical prescriptions of -0.27 based on a summary of economic research.⁴⁶

- *Assumed percent of lives covered with inflexible geographic access requirements:* Geographic access requirements force PBMs to include independent pharmacies in their provider networks. If costs of broad networks increase and PBMs negotiate new contracts with plan sponsors, a shrinking portion of the lives covered by PBMs may be subject to access requirements, either because plan sponsors will relax the requirements in the face of increased costs or because PBMs will be less willing to actively manage lives covered by geographic requirements necessitating negotiations with independent pharmacies. As a result, the cost model includes a parameter to account for the possibility that some commercial accounts could avoid the cost increases associated with antitrust exemptions.⁴⁷
- *The extent of coordinated behavior among independent pharmacies:* The extent of participation of independent pharmacies in collective negotiation is uncertain. If rural pharmacies enjoy greater competitive advantage in negotiations with health insurers or PBMs due to the small number of pharmacies in rural areas and the presence of geographic access requirements, they may have different incentives to participate than independent pharmacies located in more competitive areas, where chain, supermarket, and mass merchandiser pharmacies are more prevalent. The model calculates costs separately for rural independent pharmacies to account for this possibility.
- *Effects of health insurance exchanges on the mix of prescriptions per payer type filled at independent pharmacies:* The cost model incorporates evidence-based assumptions regarding the Part D share of prescriptions, but H.R. 1946 notes that antitrust waivers are not to apply to Medicare Parts C or D. More prospective assumptions must be made regarding payer mix following the creation of health insurance exchanges and changes in Medicaid eligibility under the Patient Protection and Affordable Care Act.

As described in the technical notes of Exhibits A-1 and A-2, the cost model adopts CBO estimates of change in payer mix among the non-elderly population over the next five years, starting in 2013.⁴⁸ Revisions to the CBO analysis, particularly if they reflect any structural changes resulting from Congressional amendments or judicial

⁴⁶ Dana Goldman, Geoffrey Joyce, and Jesse Malkin, "The Cost of a Medicare Prescription Drug Benefit: A Comparison of Alternatives," RAND, January 2002, pp. 7-8. In addition to assessing other literature, this article estimated a price elasticity of demand of -0.27 (that is, a 10 percent increase in price is expected to decrease the volume of prescriptions purchased by 2.7 percent).

⁴⁷ The cost model assumes that the percentage of covered lives with inflexible geographic access requirements decreases from 100 percent starting in Year 1 by the same amount, 10 percent, each year.

⁴⁸ CBO, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 13, 2012, Table 3.

review of PPACA, will require updates to this aspect of the cost model, if relevant. The cost model also adopts CMS statistics on payer mix for the elderly population and holds those constant over the next five years, starting in 2013.

The cost model assumes that each payer type will retain its relative drug utilization per beneficiary even as the number of beneficiaries in each segment changes. As there is no established drug utilization estimate for the health insurance exchanges, they are assigned an average utilization. The cost model demonstrates that health insurance exchanges will cover an increasing share of prescriptions, consistent with CBO projections, starting in 2014. Medicare utilization is expected to decline slightly, while Medicaid utilization is expected to increase. Decreases in share are also expected to occur for the third-party payer and cash segment shares.

Exhibit A. Cost Projections for Antitrust Waivers to Independent Pharmacies

	Year 1 (2013)		Year 2 (2014)		Year 3 (2015)		Year 4 (2016)		Year 5 (2017)	
	All pharmacies	Rural pharmacies								
Base Cost Projections for Independent Pharmacies										
(1) Geographic distribution of independent pharmacies, 2010	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
(2) Total independent pharmacy sales (\$MM)	23,024	11,923	23,024	11,923	23,024	11,923	23,024	11,923	23,024	11,923
(3) Prescription sales per independent pharmacy location (\$000)	4,754	4,754	5,050	5,050	5,356	5,356	5,733	5,733	6,102	6,102
(4) Total independent pharmacy prescription sales (\$M)	109,647	57,018	118,707	60,888	124,222	64,386	132,270	69,754	140,734	73,181
(5) Gross margin (GM) percentage for prescriptions at independent pharmacies, 2010	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%	23.3%
(6) Total independent GM per independent pharmacy location (\$000)	1,106	1,106	1,175	1,175	1,255	1,255	1,336	1,336	1,422	1,422
Player Mix for Independent Pharmacies										
(7) Third-party payer (TPP)	46.7%	20.0%	44.6%	20.0%	44.0%	20.0%	43.2%	20.0%	43.1%	20.0%
(8) Cash	11.9%	54.0%	8.1%	54.0%	6.7%	54.0%	5.4%	54.0%	5.4%	54.0%
(9) Medicaid	17.6%	18.7%	17.6%	18.7%	17.6%	18.7%	17.6%	18.7%	17.6%	18.7%
(10) Medicare Part D	20.0%	18.6%	27.3%	18.6%	27.4%	18.6%	27.4%	18.6%	27.3%	18.6%
(11) Health insurance exchanges	0.0%	0.0%	2.6%	20.0%	3.8%	20.0%	6.3%	20.0%	6.8%	20.0%
(12) Share of Prescriptions Covered by TPPs, Excluding Federal Employees	45%		42%		42%		41%		41%	
(13) Percent of Covered Lives with Inflexible Geographic Access Requirements	100%		90%		80%		70%		60%	
Base Revenues for Cost Simulation										
(14) Independent pharmacy TPP prescription sales (\$M)	48,873	25,414	49,355	25,670	52,860	27,037	54,394	28,265	57,732	30,021
Cost Simulation Scenarios										
(15) Increase prices such that gross margins on TPP equal those on cash transactions	170.0%	34.0%	170.0%	34.0%	170.0%	34.0%	170.0%	34.0%	170.0%	34.0%
(16) Increase prices on TPP transactions by 20%	96.7%	13.3%	86.7%	13.3%	66.7%	13.3%	66.7%	13.3%	66.7%	13.3%
(17) Increase prices such that gross margins on TPP increase to North Dakota requested rate	32.4%	6.5%	32.4%	6.5%	32.4%	6.5%	32.4%	6.5%	32.4%	6.5%
Effect of 0.27 Price Elasticity of Demand for TPP Prescriptions										
(18) Increase prices such that gross margins on TPP equal those on cash transactions	124.1%	24.8%	124.1%	24.8%	124.1%	24.8%	124.1%	24.8%	124.1%	24.8%
(19) Increase prices on TPP transactions by 20%	46.7%	9.7%	46.7%	9.7%	46.7%	9.7%	46.7%	9.7%	46.7%	9.7%
(20) Increase prices such that gross margins on TPP increase to North Dakota requested rate	23.7%	4.7%	23.7%	4.7%	23.7%	4.7%	23.7%	4.7%	23.7%	4.7%
Increase to Gross Margins for TPP Prescriptions										
(21) Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	12,130	6,308	11,027	5,724	10,343	5,379	9,450	4,914	8,566	4,471
(22) Increase prices on TPP transactions by 20% (\$M)	4,757	2,474	4,324	2,249	4,055	2,109	3,708	1,927	3,322	1,753
(23) Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	2,512	1,263	2,102	1,063	1,671	1,023	1,651	857	1,053	652
Resulting Total Prescription Sales										
(24) Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	61,003	31,722	60,382	31,404	62,433	32,403	63,644	33,199	64,930	34,452
(25) Increase prices on TPP transactions by 20% (\$M)	26,515	13,748	24,628	12,498	22,113	11,302	20,112	10,147	18,112	9,021
(26) Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	51,185	26,816	50,467	26,703	54,061	28,112	55,190	29,221	56,371	30,673
(27) Increase prices such that gross margins on TPP equal those on cash transactions	24.6%	24.6%	22.8%	22.8%	19.9%	19.9%	17.4%	17.4%	14.9%	14.9%
(28) Increase prices on TPP transactions by 20%	11.6%	11.6%	10.6%	10.6%	8.6%	8.6%	7.4%	7.4%	6.2%	6.2%
(29) Increase prices such that gross margins on TPP increase to North Dakota requested rate	4.7%	4.7%	4.3%	4.3%	3.8%	3.8%	3.3%	3.3%	2.8%	2.8%

Exhibit A. Cost Projections for Antitrust Waivers to Independent Pharmacies

Sources:

- [1] 52% is the estimated share of independent pharmacies serving 20,000 people or less in 2010. "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPAweb.org, October 10, 2011, <http://www.ncpa.net/cgi/index.php/news-releases/1165-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling>. The NCPA notes that this percentage has remained constant recently.
- [2] "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPAweb.org, October 10, 2011, <http://www.ncpa.net/cgi/index.php/news-releases/1165-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling>. The number of independent pharmacies has remained fairly constant in recent years. Adam J. Fein, "2010 A Good Year for Independent Pharmacies," DrugCharmak.net, September 6, 2011, <http://www.drugcharmak.net/2011/09/2010-good-year-for-independent.html>
- [3] "2010 NCPA Digest Executive Summary," <http://www.ncpa.net/cgi/index.php/news-releases/1165-ncpa-digest-executive-summary>, Figure 1. Sales are projected from 2008 according to the 2008-2009 CAGR of 4.4%, such that Year 1 represents 2013. Additionally, 92% of total independent pharmacy revenue is assumed to derive from sales of prescription drugs. "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPAweb.org, October 10, 2011, <http://www.ncpa.net/cgi/index.php/news-releases/1165-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling>.
- [4] Adam Fein, "The True Economics of Pharmacy Ownership," DrugCharmak.net, October 18, 2011, <http://www.drugcharmak.net/2011/10/the-true-economics-of-pharmacy-ownership.html>. This number remained fairly constant, mainly increasing over the 5 years from 2008 to 2010.
- [5] See Exhibit A.
- [6] "The True Economics of Pharmacy Ownership," DrugCharmak.net, October 18, 2011, <http://www.drugcharmak.net/2011/10/the-true-economics-of-pharmacy-ownership.html>
- [7] Health insurance exchanges QM is assumed to equal TPP QM.
- [8] $= [7] \times 0.8 = 2.0 \text{ / } 7.46 = 0.268$. In 2008, 8 million people were federal employees, retirees, and dependents. USDOA, "Prescription Drugs: Overview of Approaches to Control Prescription Drug Spending in Federal Programs," June 24, 2009, http://www.gao.gov/assets/GAO-09-333/P_2. According to Exhibit A, the average number of prescriptions per TPP enrollee is 2.6, and that is divided by 7.46 million total prescriptions.
- [9] $= [8] \times 0.268 = 0.0718$. To maintain comparability with CRA 2007 analysis, the cost model also assumed a decrease of 10% in each year model.
- [10] $= [9] \times 1.1 = 0.079$.
- [11] $= [10] \times 1.1 = 0.087$.
- [12] $= [11] \times 1.1 = 0.096$.
- [13] $= [12] \times 1.1 = 0.105$.
- [14] $= [13] \times 1.1 = 0.116$.
- [15] $= [14] \times 1.1 = 0.127$.
- [16] $= [15] \times 1.1 = 0.140$.
- [17] $= [16] \times 1.1 = 0.154$.
- [18] $= [17] \times 1.1 = 0.169$.
- [19] $= [18] \times 1.1 = 0.186$.
- [20] $= [19] \times 1.1 = 0.205$.
- [21] $= [20] \times 1.1 = 0.225$.
- [22] $= [21] \times 1.1 = 0.248$.
- [23] $= [22] \times 1.1 = 0.273$.
- [24] $= [23] \times 1.1 = 0.300$.
- [25] $= [24] \times 1.1 = 0.329$.
- [26] $= [25] \times 1.1 = 0.361$.
- [27] $= [26] \times 1.1 = 0.396$.
- [28] $= [27] \times 1.1 = 0.434$.
- [29] $= [28] \times 1.1 = 0.475$.
- [30] $= [29] \times 1.1 = 0.520$.
- [31] $= [30] \times 1.1 = 0.569$.
- [32] $= [31] \times 1.1 = 0.622$.
- [33] $= [32] \times 1.1 = 0.679$.
- [34] $= [33] \times 1.1 = 0.740$.
- [35] $= [34] \times 1.1 = 0.815$.
- [36] $= [35] \times 1.1 = 0.895$.
- [37] $= [36] \times 1.1 = 0.980$.
- [38] $= [37] \times 1.1 = 1.071$.
- [39] $= [38] \times 1.1 = 1.169$.
- [40] $= [39] \times 1.1 = 1.274$.
- [41] $= [40] \times 1.1 = 1.386$.
- [42] $= [41] \times 1.1 = 1.506$.
- [43] $= [42] \times 1.1 = 1.634$.
- [44] $= [43] \times 1.1 = 1.770$.
- [45] $= [44] \times 1.1 = 1.914$.
- [46] $= [45] \times 1.1 = 2.066$.
- [47] $= [46] \times 1.1 = 2.227$.
- [48] $= [47] \times 1.1 = 2.396$.
- [49] $= [48] \times 1.1 = 2.573$.
- [50] $= [49] \times 1.1 = 2.759$.
- [51] $= [50] \times 1.1 = 2.954$.
- [52] $= [51] \times 1.1 = 3.158$.
- [53] $= [52] \times 1.1 = 3.371$.
- [54] $= [53] \times 1.1 = 3.594$.
- [55] $= [54] \times 1.1 = 3.826$.
- [56] $= [55] \times 1.1 = 4.067$.
- [57] $= [56] \times 1.1 = 4.318$.
- [58] $= [57] \times 1.1 = 4.578$.
- [59] $= [58] \times 1.1 = 4.838$.
- [60] $= [59] \times 1.1 = 5.107$.
- [61] $= [60] \times 1.1 = 5.366$.
- [62] $= [61] \times 1.1 = 5.634$.
- [63] $= [62] \times 1.1 = 5.902$.
- [64] $= [63] \times 1.1 = 6.179$.
- [65] $= [64] \times 1.1 = 6.456$.
- [66] $= [65] \times 1.1 = 6.733$.
- [67] $= [66] \times 1.1 = 7.010$.
- [68] $= [67] \times 1.1 = 7.287$.
- [69] $= [68] \times 1.1 = 7.564$.
- [70] $= [69] \times 1.1 = 7.841$.
- [71] $= [70] \times 1.1 = 8.118$.
- [72] $= [71] \times 1.1 = 8.395$.
- [73] $= [72] \times 1.1 = 8.672$.
- [74] $= [73] \times 1.1 = 8.949$.
- [75] $= [74] \times 1.1 = 9.226$.
- [76] $= [75] \times 1.1 = 9.503$.
- [77] $= [76] \times 1.1 = 9.780$.
- [78] $= [77] \times 1.1 = 10.057$.
- [79] $= [78] \times 1.1 = 10.334$.
- [80] $= [79] \times 1.1 = 10.611$.
- [81] $= [80] \times 1.1 = 10.888$.
- [82] $= [81] \times 1.1 = 11.165$.
- [83] $= [82] \times 1.1 = 11.442$.
- [84] $= [83] \times 1.1 = 11.719$.
- [85] $= [84] \times 1.1 = 11.996$.
- [86] $= [85] \times 1.1 = 12.273$.
- [87] $= [86] \times 1.1 = 12.550$.
- [88] $= [87] \times 1.1 = 12.827$.
- [89] $= [88] \times 1.1 = 13.104$.
- [90] $= [89] \times 1.1 = 13.381$.
- [91] $= [90] \times 1.1 = 13.658$.
- [92] $= [91] \times 1.1 = 13.935$.
- [93] $= [92] \times 1.1 = 14.212$.
- [94] $= [93] \times 1.1 = 14.489$.
- [95] $= [94] \times 1.1 = 14.766$.
- [96] $= [95] \times 1.1 = 15.043$.
- [97] $= [96] \times 1.1 = 15.320$.
- [98] $= [97] \times 1.1 = 15.597$.
- [99] $= [98] \times 1.1 = 15.874$.
- [100] $= [99] \times 1.1 = 16.151$.
- [101] $= [100] \times 1.1 = 16.428$.
- [102] $= [101] \times 1.1 = 16.705$.
- [103] $= [102] \times 1.1 = 16.982$.
- [104] $= [103] \times 1.1 = 17.259$.
- [105] $= [104] \times 1.1 = 17.536$.
- [106] $= [105] \times 1.1 = 17.813$.
- [107] $= [106] \times 1.1 = 18.090$.
- [108] $= [107] \times 1.1 = 18.367$.
- [109] $= [108] \times 1.1 = 18.644$.
- [110] $= [109] \times 1.1 = 18.921$.
- [111] $= [110] \times 1.1 = 19.198$.
- [112] $= [111] \times 1.1 = 19.475$.
- [113] $= [112] \times 1.1 = 19.752$.
- [114] $= [113] \times 1.1 = 20.029$.
- [115] $= [114] \times 1.1 = 20.306$.
- [116] $= [115] \times 1.1 = 20.583$.
- [117] $= [116] \times 1.1 = 20.860$.
- [118] $= [117] \times 1.1 = 21.137$.
- [119] $= [118] \times 1.1 = 21.414$.
- [120] $= [119] \times 1.1 = 21.691$.
- [121] $= [120] \times 1.1 = 21.968$.
- [122] $= [121] \times 1.1 = 22.245$.
- [123] $= [122] \times 1.1 = 22.522$.
- [124] $= [123] \times 1.1 = 22.799$.
- [125] $= [124] \times 1.1 = 23.076$.
- [126] $= [125] \times 1.1 = 23.353$.
- [127] $= [126] \times 1.1 = 23.630$.
- [128] $= [127] \times 1.1 = 23.907$.
- [129] $= [128] \times 1.1 = 24.184$.
- [130] $= [129] \times 1.1 = 24.461$.
- [131] $= [130] \times 1.1 = 24.738$.
- [132] $= [131] \times 1.1 = 25.015$.
- [133] $= [132] \times 1.1 = 25.292$.
- [134] $= [133] \times 1.1 = 25.569$.
- [135] $= [134] \times 1.1 = 25.846$.
- [136] $= [135] \times 1.1 = 26.123$.
- [137] $= [136] \times 1.1 = 26.400$.
- [138] $= [137] \times 1.1 = 26.677$.
- [139] $= [138] \times 1.1 = 26.954$.
- [140] $= [139] \times 1.1 = 27.231$.
- [141] $= [140] \times 1.1 = 27.508$.
- [142] $= [141] \times 1.1 = 27.785$.
- [143] $= [142] \times 1.1 = 28.062$.
- [144] $= [143] \times 1.1 = 28.339$.
- [145] $= [144] \times 1.1 = 28.616$.
- [146] $= [145] \times 1.1 = 28.893$.
- [147] $= [146] \times 1.1 = 29.170$.
- [148] $= [147] \times 1.1 = 29.447$.
- [149] $= [148] \times 1.1 = 29.724$.
- [150] $= [149] \times 1.1 = 30.001$.
- [151] $= [150] \times 1.1 = 30.278$.
- [152] $= [151] \times 1.1 = 30.555$.
- [153] $= [152] \times 1.1 = 30.832$.
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- [155] $= [154] \times 1.1 = 31.386$.
- [156] $= [155] \times 1.1 = 31.663$.
- [157] $= [156] \times 1.1 = 31.940$.
- [158] $= [157] \times 1.1 = 32.217$.
- [159] $= [158] \times 1.1 = 32.494$.
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- [161] $= [160] \times 1.1 = 33.048$.
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- [168] $= [167] \times 1.1 = 34.987$.
- [169] $= [168] \times 1.1 = 35.264$.
- [170] $= [169] \times 1.1 = 35.541$.
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- [172] $= [171] \times 1.1 = 36.095$.
- [173] $= [172] \times 1.1 = 36.372$.
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- [175] $= [174] \times 1.1 = 36.926$.
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- [181] $= [180] \times 1.1 = 38.588$.
- [182] $= [181] \times 1.1 = 38.865$.
- [183] $= [182] \times 1.1 = 39.142$.
- [184] $= [183] \times 1.1 = 39.419$.
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- [186] $= [185] \times 1.1 = 39.973$.
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- [188] $= [187] \times 1.1 = 40.527$.
- [189] $= [188] \times 1.1 = 40.804$.
- [190] $= [189] \times 1.1 = 41.081$.
- [191] $= [190] \times 1.1 = 41.358$.
- [192] $= [191] \times 1.1 = 41.635$.
- [193] $= [192] \times 1.1 = 41.912$.
- [194] $= [193] \times 1.1 = 42.189$.
- [195] $= [194] \times 1.1 = 42.466$.
- [196] $= [195] \times 1.1 = 42.743$.
- [197] $= [196] \times 1.1 = 43.020$.
- [198] $= [197] \times 1.1 = 43.297$.
- [199] $= [198] \times 1.1 = 43.574$.
- [200] $= [199] \times 1.1 = 43.851$.
- [201] $= [200] \times 1.1 = 44.128$.
- [202] $= [201] \times 1.1 = 44.405$.
- [203] $= [202] \times 1.1 = 44.682$.
- [204] $= [203] \times 1.1 = 44.959$.
- [205] $= [204] \times 1.1 = 45.236$.
- [206] $= [205] \times 1.1 = 45.513$.
- [207] $= [206] \times 1.1 = 45.790$.
- [208] $= [207] \times 1.1 = 46.067$.
- [209] $= [208] \times 1.1 = 46.344$.
- [210] $= [209] \times 1.1 = 46.621$.
- [211] $= [210] \times 1.1 = 46.898$.
- [212] $= [211] \times 1.1 = 47.175$.
- [213] $= [212] \times 1.1 = 47.452$.
- [214] $= [213] \times 1.1 = 47.729$.
- [215] $= [214] \times 1.1 = 48.006$.
- [216] $= [215] \times 1.1 = 48.283$.
- [217] $= [216] \times 1.1 = 48.560$.
- [218] $= [217] \times 1.1 = 48.837$.
- [219] $= [218] \times 1.1 = 49.114$.
- [220] $= [219] \times 1.1 = 49.391$.
- [221] $= [220] \times 1.1 = 49.668$.
- [222] $= [221] \times 1.1 = 49.945$.
- [223] $= [222] \times 1.1 = 50.222$.
- [224] $= [223] \times 1.1 = 50.499$.
- [225] $= [224] \times 1.1 = 50.776$.
- [226] $= [225] \times 1.1 = 51.053$.
- [227] $= [226] \times 1.1 = 51.330$.
- [228] $= [227] \times 1.1 = 51.607$.
- [229] $= [228] \times 1.1 = 51.884$.
- [230] $= [229] \times 1.1 = 52.161$.
- [231] $= [230] \times 1.1 = 52.438$.
- [232] $= [231] \times 1.1 = 52.715$.
- [233] $= [232] \times 1.1 = 52.992$.
- [234] $= [233] \times 1.1 = 53.269$.
- [235] $= [234] \times 1.1 = 53.546$.
- [236] $= [235] \times 1.1 = 53.823$.
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- [239] $= [238] \times 1.1 = 54.654$.
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- [241] $= [240] \times 1.1 = 55.208$.
- [242] $= [241] \times 1.1 = 55.485$.
- [243] $= [242] \times 1.1 = 55.762$.
- [244] $= [243] \times 1.1 = 56.039$.
- [245] $= [244] \times 1.1 = 56.316$.
- [246] $= [245] \times 1.1 = 56.593$.
- [247] $= [246] \times 1.1 = 56.870$.
- [248] $= [247] \times 1.1 = 57.147$.
- [249] $= [248] \times 1.1 = 57.424$.
- [250] $= [249] \times 1.1 = 57.701$.
- [251] $= [250] \times 1.1 = 57.978$.
- [252] $= [251] \times 1.1 = 58.255$.
- [253] $= [252] \times 1.1 = 58.532$.
- [254] $= [253] \times 1.1 = 58.809$.
- [255] $= [254] \times 1.1 = 59.086$.
- [256] $= [255] \times 1.1 = 59.363$.
- [257] $= [256] \times 1.1 = 59.640$.
- [258] $= [257] \times 1.1 = 59.917$.
- [259] $= [258] \times 1.1 = 60.194$.
- [260] $= [259] \times 1.1 = 60.471$.
- [261] $= [260] \times 1.1 = 60.748$.
- [262] $= [261] \times 1.1 = 61.025$.
- [263] $= [262] \times 1.1 = 61.302$.
- [264] $= [263] \times 1.1 = 61.579$.
- [265] $= [264] \times 1.1 = 61.856$.
- [266] $= [265] \times 1.1 = 62.133$.
- [267] $= [266] \times 1.1 = 62.410$.
- [268] $= [267] \times 1.1 = 62.687$.
- [269] $= [268] \times 1.1 = 62.964$.
- [270] $= [269] \times 1.1 = 63.241$.
- [271] $= [270] \times 1.1 = 63.518$.
- [272] $= [271] \times 1.1 = 63.795$.
- [273] $= [272] \times 1.1 = 64.072$.
- [274] $= [273] \times 1.1 = 64.349$.
- [275] $= [274] \times 1.1 = 64.626$.
- [276] $= [275] \times 1.1 = 64.903$.
- [277] $= [276] \times 1.1 = 65.180$.
- [278] $= [277] \times 1.1 = 65.457$.
- [279] $= [278] \times 1.1 = 65.734$.
- [280] $= [279] \times 1.1 = 66.011$.
- [281] $= [280] \times 1.1 = 66.288$.
- [282] $= [281] \times 1.1 = 66.565$.
- [283] $= [282] \times 1.1 = 66.842$.
- [284] $= [283] \times 1.1 = 67.119$.
- [285] $= [284] \times 1.1 = 67.396$.
- [286] $= [285] \times 1.1 = 67.673$.
- [287] $= [286] \times 1.1 = 67.950$.
- [288] $= [287] \times 1.1 = 68.227$.
- [289] $= [288] \times 1.1 = 68.504$.
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- [291] $= [290] \times 1.1 = 69.058$.
- [292] $= [291] \times 1.1 = 69.335$.
- [293] $= [292] \times 1.1 = 69.612$.
- [294] $= [293] \times 1.1 = 69.889$.
- [295] $= [294] \times 1.1 = 70.166$.
- [296] $= [295] \times 1.1 = 70.443$.
- [297] $= [296] \times 1.1 = 70.720$.
- [298] $= [297] \times 1.1 = 70.997$.
- [299] $= [298] \times 1.1 = 71.274$.
- [300] $= [299] \times 1.1 = 71.551$.
- [301] $= [300] \times 1.1 = 71.828$.
- [302] $= [301] \times 1.1 = 72.105$.
- [303] $= [302] \times 1.1 = 72.382$.
- [304] $= [303] \times 1.1 = 72.659$.
- [305] $= [304] \times 1.1 = 72.936$.
- [306] $= [305] \times 1.1 = 73.213$.
- [307] $= [306] \times 1.1 = 73.490$.
- [308] $= [307] \times 1.1 = 73.767$.
- [309] $= [308] \times 1.1 = 74.044$.
- [310] $= [309] \times 1.1 = 74.321$.
- [311] $= [310] \times 1.1 = 74.598$.
- [312] $= [311] \times 1.1 = 74.875$.
- [313] $= [312] \times 1.1 = 75.152$.
- [314] $= [313] \times 1.1 = 75.429$.
- [315] $= [314] \times 1.1 = 75.706$.
- [316] $= [315] \times 1.1 = 75.983$.
- [317] $= [316] \times 1.1 = 76.260$.
- [318] $= [317] \times 1.1 = 76.537$.
- [319] $= [318] \times 1.1 = 76.814$.
- [320] $= [319] \times 1.1 = 77.091$.
- [321] $= [320] \times 1.1 = 77.368$.
- [322] $= [321] \times 1.1 = 77.645$.
- [323] $= [322] \times 1.1 = 77.922$.
- [324] $= [323] \times 1.1 = 78.199$.
- [325] $= [324] \times 1.1 = 78.476$.
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- [333] $= [332] \times 1.1 = 80.692$.
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- [335] $= [334] \times 1.1 = 81.246$.
- [336] $= [335] \times 1.1 = 81.523$.
- [337] $= [336] \times 1.1 = 81.800$.
- [338] $= [33$

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 March 28, 2012

Exhibit A-1: Payer Mix for Independent Pharmacies

	Year 0 (2012) (b)	Year 1 (2013) (b)	Year 2 (2014) (c)	Year 3 (2015) (d)	Year 4 (2016) (e)	Year 5 (2017) (f)
Estimated Effects of the Patient Protection and Affordable Care Act (PPACA)						
<i>Coverage under current law (millions of non-elderly people by calendar year)</i>						
[1]	167	169	170	171	173	174
[2]	55	56	56	56	56	57
[3]	34	34	34	34	32	32
[4]	13	13	13	14	14	14
[5]	-	-	-	-	-	-
[6]	268	271	273	274	275	277
Expected change due to implementation of PPACA						
[7]	2	1	(3)	(3)	(6)	(7)
[8]	(2)	(2)	(18)	(24)	(30)	(31)
[9]	-	1	13	15	17	16
[10]	-	-	-	-	-	-
[11]	-	-	8	12	20	22
[12]	-	-	-	-	1	-
Coverage under PPACA (millions of non-elderly people)						
[13]	169	170	167	168	167	167
[14]	53	54	38	32	26	26
[15]	34	35	48	48	48	48
[16]	13	13	13	14	14	14
[17]	-	-	8	12	20	22
[18]	268	271	273	274	276	277
Total Population by Payer Type						
<i>Elderly, Medicare-eligible population with drug coverage</i>						
[19]	9	9				
[20]	0	0				
[21]	23	23				
[22]	32	32				
[23]						
Total population by payer type under PPACA						
[24]	177	178	175	176	176	176
[25]	53	54	38	32	26	26
[26]	34	35	48	48	48	48
[27]	36	36	36	37	37	37
[28]	-	-	8	12	20	22
[29]	300	303	305	306	308	309

Exhibit A-1: Payer Mix for Independent Pharmacies

Independent Pharmacy Prescriptions by Payer Type		Average number of prescriptions filled at independent pharmacies per beneficiary	
[30]	TPP	2.0	
[31]	Cash	1.7	
[32]	Medicaid	2.9	
[33]	Medicare Part D	5.9	
[34]	Health Insurance Exchanges	2.5	
[35]	Average	2.5	
Number of prescriptions by payer type (millions)			
[36]	TPP	349	351
[37]	Cash	88	80
[38]	Medicaid	98	101
[39]	Medicare Part D	210	210
[40]	Health Insurance Exchanges	-	-
[41]	Total	746	752
Percentage distribution of prescriptions by payer type			
[42]	TPP	47%	44%
[43]	Cash	12%	7%
[44]	Medicaid	13%	18%
[45]	Medicare Part D	28%	27%
[46]	Health Insurance Exchanges	0%	3%
[47]	Total	100%	100%

Sources:

- [1-5, 7-11] CBO, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012, [http://cbo.gov/publication/43076](http://.cbo.gov/publication/43076). "Medicaid & CHIP" is assigned to Medicaid. "Employer" is assigned to TPP. "Nongroup & Other" is divided based on notes. Half is assigned to TPP, and all "Nongroup & Other" change is assigned to TPP. The remainder of "Nongroup & Other" is assigned to Medicare. "Uninsured" is assigned to Cash.
- [6] = sum of [1-5].
- [12] = sum of [7-11].
- [13-17] = corresponding [1-6] + [7-12].
- [18] = sum of [13-17].
- [19-22] See Exhibit A. 2.
- [23] = sum of [19-22].
- [24-28] = corresponding [13-17] + [19-22][e].
- [29] = sum of [24-28].
- [30-35] See Exhibit A. 2. "Health Insurance Exchanges" is assumed to have an average number of prescriptions per enrollee.
- [36-40] = corresponding [24-28] × [30-34][e].
- [41] = sum of [36-40].
- [42-47] = corresponding [36-41] / [41].

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Exhibit A-2: Independent Pharmacy Prescriptions by Payer Type

	<u>Independent Pharmacy Mix of Prescriptions by Payer Type, 2009</u>		
[1]	Third-party payer (TPP)		45.0%
[2]	Cash		11.0%
[3]	Medicaid		15.3%
[4]	Medicare Part D		28.7%
[5]	<u>Independent Pharmacy Prescriptions (millions), 2009</u>		754
	<u>Number of Non-Elderly Individuals by Payer Type (millions), 2010</u>		
[6]	TPP		164
[7]	Cash		50
[8]	Medicaid		40
[9]	Medicare Part D		14
[10]	Total		267
	<u>Number of Elderly Individuals by Payer Type (millions), 2010</u>		
[11]	TPP		9
[12]	Cash		-
[13]	Medicaid		-
[14]	Medicare Part D		23
[15]	Total		32
	<u>Total Number of Individuals by Payer Type (millions), 2010</u>		
[16]	TPP		172
[17]	Cash		50
[18]	Medicaid		40
[19]	Medicare Part D		37
[20]	Total		299
	<u>Average Number of Independent Pharmacy Prescriptions Filled per Beneficiary</u>		
[21]	TPP		1.97
[22]	Cash		1.66
[23]	Medicaid		2.88
[24]	Medicare Part D		5.93

Cost of Independent Pharmacy Antitrust Exemptions, 2013-2017
 March 28, 2012

Exhibit A-2: Independent Pharmacy Prescriptions by Payer Type

Average 2.52

Sources:

- [1-2] "2010 NCPA Digest Executive Summary," <http://www.ncpanet.org/pdf/digest/2010/2010digestexecsum.pdf>, Table 1. Cash is assumed to be the remainder after government programs and other third-party programs are accounted for.
- [3-4] NCPA's 2010 Digest notes that 44% of independent pharmacy prescriptions are covered by government programs. NCPA, "2010 NCPA Digest Executive Summary," <http://www.ncpanet.org/pdf/digest/2010/2010digestexecsum.pdf>, Table 1. NCPA's 2011 Digest summary notes that the 2010 ratio of Medicaid to Medicare prescriptions at independent pharmacies is 16 to 30, respectively, and that ratio has been used to split the 44% between the programs. "NCPA Digest Finds Independent Community Pharmacies Reducing Health Costs Through Generic Use, Patient Counseling," NCPANet.org, October 10, 2011, <http://www.ncpanet.org/index.php/news-releases/1166-ncpa-digest-finds-independent-community-pharmacies-reducing-health-costs-through-generic-drug-use-patient-counseling>.
- [5] Adam J. Fein, "Chains Win Big in 2009," DrugChannels.net, April 15, 2010, <http://www.drugchannels.net/2010/04/chains-win-big-in-2009.html>.
- [6-10] Letter from the CBO to Majority Leader Harry Reid, November 18, 2009, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10731/reid_letter_11_18_09.pdf, Table 3. "Medicaid & CHIP" is assigned to Medicaid. "Employee" is assigned to TPP. "Nongroup & Other" is divided based on note c. Half is assigned to TPP, and all "Nongroup & Other" change is assigned to TPP. The remainder of "Nongroup & Other" is assigned to Medicare. "Uninsured" is assigned to Cash.
- [11-14] Centers for Medicare and Medicaid Services, "Total Medicare Beneficiaries with Prescription Drug Coverage," as of February 16, 2010, <http://www.cms.gov/prescriptiondrugcoventn/>. "Medicare Part D" is assigned to Medicare Part D. "Retiree Drug Subsidy," "FEHBP Retiree Coverage," "Active Workers with Medicare Secondary Coverage," "Other Group Coverage," and "Medigap and other sources" are assigned to TPP. Figures are multiplied by the share of Medicare enrollees that have met the age criteria for Medicare enrollment in 2010. CMS, "Medicare Enrollment: National Trends: 1966-2010," <http://www.cms.gov/MedicareEnrpts>.
- [15] = sum of [11-14].
- [16-20] = corresponding [6-10] + [11-15].
- [21-24] = corresponding [1-4] * [5] / [16-19].
- [25] = corresponding [5] / [20].

Exhibit B: Present Value of Cost Projections for Antitrust Waivers to Independent Pharmacies

	Nominal [a]		Net Present Value Given 10% Discount Rate [b]	
	All	Rural pharmacies	All	Rural pharmacies
[1] Base Revenues for Cost Simulation	262,454	136,476	197,362	102,628
Expected Cost Increases as a Result of H.R. 1946				
[2] Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	51,548	26,805	39,705	20,646
[3] Increase prices on TPP transactions by 20% (\$M)	20,215	10,512	15,701	8,087
[4] Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	9,824	5,109	7,557	3,935
[5] Increase prices such that gross margins on TPP equal those on cash transactions	19.6%	19.6%	20.1%	20.1%
[6] Increase prices on TPP transactions by 20%	7.7%	7.7%	7.9%	7.9%
[7] Increase prices such that gross margins on TPP increase to North Dakota requested rate	3.7%	3.7%	3.8%	3.8%
Resulting Total Independent Pharmacy Prescription Sales				
[8] Increase prices such that gross margins on TPP equal those on cash transactions (\$M)	314,002	163,281	237,067	123,275
[9] Increase prices on TPP transactions by 20% (\$M)	282,669	146,988	212,933	110,725
[10] Increase prices such that gross margins on TPP increase to North Dakota requested rate (\$M)	272,278	141,585	204,930	106,563

Sources:

- [1-4, 8-10][a] Exhibit A. Nominal amounts are sums of Years 1-5.
- [1-4, 8-10][b] Exhibit A. Present values are found by summing $\frac{Nominal}{(1+10\%)^t}$ for Years 1-5, where $n = \text{Year}$.
- [5] = [2] / [1]
- [6] = [3] / [1]
- [7] = [4] / [1]



April 9, 2012

The Honorable Bob Goodlatte
Chairman, U.S. House Judiciary Committee Subcommittee on Intellectual
Property, Competition and the Internet
B-352 Rayburn House Office Building
Washington, DC 20515

The Honorable Mel Watt
Ranking Member, U.S. House Judiciary Committee Subcommittee on
Intellectual Property, Competition and the Internet
B-351 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Goodlatte and Ranking Member Watt:

The Academy of Managed Care Pharmacy (AMCP) has serious concerns with H.R. 1946, the "Preserving Our Hometown Independent Pharmacies Act of 2011." The legislation would provide an exemption from antitrust law that would allow certain independent pharmacists to collectively bargain reimbursement rates and other contract terms with health plans and pharmacy benefit managers (PBMs). AMCP believes that this legislation would raise costs for payers and patients and reduce access to care without ensuring higher quality care as a countervailing benefit.

AMCP is a national association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's 6,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit.

AMCP agrees with the conclusion drawn by the Federal Trade Commission (FTC) that passage of H.R. 1946 would almost certainly raise costs to health plans and PBMs and even the federal government.¹ Rarely, if ever, has a group lobbied to secure an anti-trust exemption in order to collectively bargain wages downward. It would be expected that independent pharmacists

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Regeneron
Phoenix, AZ

Director
H. Eric Cannoci, PharmD, FAMCP
SelectHealth
Salt Lake City, UT

Director
Sabote S. Edgar, PharmD, MBA
CatalyRx
Rockville, MD

Director
William H. Francis, RPh, MBA
The University of Arizona, Health Plans
Tucson, AZ

Director
Roulo S. Ficat, PharmD
Regeneron
Bozoe, ID

Chief Executive Officer
Edith A. Rosato, RPh, IOM
AMCP
Alexandria, VA

¹ Prepared statement of the Fed. Trade Comm'n before the H. Comm. on the Judiciary, Subcomm. on Intellectual Property, Competition and the Internet, on "H.R. 1946, Preserving Our Hometown Independent Pharmacies Act of 2011," March 29, 2012.

working within the exemption would seek to negotiate higher reimbursement rates. Higher costs to health plans and PBMs would result in higher premiums for members. Despite an attempt to shield taxpayers from increased costs by exempting negotiations pertaining to federal government programs, it is also questionable whether an independent pharmacist would not use information gathered during collective bargaining when negotiating contracts for Medicare Part D, Medicaid, the Federal Employees' Health Benefit Program or other federal programs. Those increased costs would then be absorbed by the federal government.

Additionally, AMCP shares the concerns of the FTC regarding the impact H.R. 1946 would have on a health plan or PBMs' ability to design a quality, efficient pharmacy network that meets the needs of all members. While the legislation would prohibit independent pharmacists from organizing boycotts of other independent pharmacies, there would be nothing to prevent a boycott of a retail or mail-order pharmacy. Independent pharmacies are vital members of health plan and PBM networks, however, retail and mail-order pharmacies also provide unique benefits to patients and their access should not be curtailed. Health plans and PBMs may also have no recourse to exclude a pharmacy from their network that does not meet the plan's quality standards.

Like many members of Congress, AMCP is concerned about the future of independent pharmacy. Independent pharmacists are important members of health plan and PBM networks, and are frequently the only option for patients who live in rural areas of the country. However, legislation that would grant independent pharmacists the ability to collectively negotiate higher reimbursement rates and other contract terms would be a misguided attempt at help that would only lead to higher costs for payers, patients and the federal government.

The Academy respectfully requests that this letter be included in the record of the March 29th hearing. Please do not hesitate to contact me if I may be of further assistance.

Sincerely,



Edith A. Rosato, RPh, IOM
Chief Executive Officer





AMERICAN BENEFITS
COUNCIL

March 29, 2012

Representative Bob Goodlatte
Chair
House Committee on the Judiciary
Subcommittee on Intellectual Property,
Competition and the Internet
House of Representatives
Washington, DC 20515

Representative Mel Watt
Ranking Member
House Committee on the Judiciary
Subcommittee on Intellectual Property,
Competition and the Internet
House of Representatives
Washington, DC 20515

Re: Opposition to H.R. 1946, Preserving Our Hometown Independent Pharmacies Act of 2011

Dear Chairman Goodlatte and Ranking Member Watt:

The American Benefits Council (the "Council") appreciates the opportunity to provide comments to the House Judiciary Committee's Subcommittee on Intellectual Property, Competition and the Internet in opposition to H.R. 1946, denominated the Preserving Our Hometown Independent Pharmacies Act of 2011, ("H.R. 1946" or "the Act"). The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly, or provide services to, retirement and health plans that cover more than 100 million Americans. Our members bear the bulk of the costs of health care coverage for these covered individuals, the majority of enrollment in private health plans in the country.

We oppose H.R. 1946 because its principal impact is likely to be to increase costs to our employer members and their employees for prescription drug benefits. Indeed, permitting price fixing by pharmacies in their dealings with health plans appears to be the primary aim of H.R. 1946.

H.R. 1946 would create a broad antitrust exemption from both state and federal antitrust law for price fixing and other anticompetitive agreements by otherwise

competing pharmacies in their dealings with America's employee health benefit plans and the insurance carriers and administrators who serve those plans. The proposed legislation would do this by treating pharmacies as if they were fellow employees negotiating with a common employer, when they are in fact neither fellow employees and they do not have a common employer. H.R. 1946 would give pharmacies' joint price negotiation activities with health plans the full protections that labor unions enjoy with regard to collective actions of their employee members with regard to employers. This would apparently include the right to jointly withhold services, to pressure health plans with threats of boycotts and refusals to participate in health plans, and would do so without imposing any of the responsibilities or obligations that labor unions must bear.

While subsection 2(e) of H.R. 1946 contains certain purported limitations on the Act's scope, these limitations do not alter the fundamental thrust of the Act—which is to immunize price fixing by competing pharmacies in their negotiations with health plans. The Act excludes from the new antitrust immunity: (a) boycotts of independent pharmacies; (b) imposition of limits on the scope of services provided by pharmacies; (c) allocation of markets among competitors; (d) unlawful tying arrangements; and (e) monopolization or attempts to monopolize.

Thus, price fixing, effected through joint negotiations on price among competing pharmacies, would be immunized from both state and federal antitrust challenge. Subsection 2(h) of H.R. 1946 excludes from its scope price-fixing directed at Medicare, Medicaid and certain other government programs, but the Act remains squarely intended to immunize price fixing in connection with the employer sponsored health plans serving American citizens, including both private employer plans and government employee plans serving school districts and city and state governments across the country.

Subsection (f) of H.R. 1946 also puts a purported "market share" cap on the joint negotiations by independent pharmacies with a health plan that would receive the new antitrust exemption. The cap is 25 percent of the independent pharmacies operating within a "region". While this sounds as if it might provide protection against abuse and the exercise of market power to raise prices, the term "region" is defined in Section 2(i)(4) of the Act by cross reference to use of the term "region" in the Medicare Part D prescription drug program law. See §1860DD-11(a)(2) of the Social Security Act, 42 U.S.C. § 1395w-111(a)(2). Under Medicare Part D, the Centers for Medicare & Medicaid Services has established 34 "regions" covering the entire United States, and five more covering the U.S. territories. See <http://www.g1medicare.com/PartD-Medicare-PartD-Overview-byRegion.php>. Every region includes at least an entire state, and some contain as many as two, four or seven states.¹

¹ Region 25 includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming.

Since pharmacy services are typically provided at a local or community level, and the joint price negotiations protected by the Act could be undertaken on exactly such a local or community basis, a market share cap based on the number of pharmacies participating across a region that is the size of a whole state, or even larger, would not constrain the exercise of market power by these price-fixing combinations of pharmacies in communities across the country. For example, if all the independent pharmacies in Winchester, Virginia were to jointly negotiate prices with health plans, employers would have no other alternative than to pay higher prices, notwithstanding that the pharmacies in the scheme would be far fewer, of course, than 25 percent of the licensed pharmacies in the entire Commonwealth of Virginia. Tinkering with the Act's phrasing would not solve the problem – if the joint price setting would not alter the dynamics of the price negotiations so as to permit the pharmacies to achieve higher pricing that they would consider more desirable, it is not evident what purpose the legislation would serve in the first place.

Finally, the Act permits any “independent” pharmacy company to participate in the immunized price fixing, with independent status depending under section 2(i)(3) of the Act on whether the retail pharmacy company had less than 10 percent of the pharmacies in the entire region and less than 1 percent of the pharmacies in the whole country. This constraint would not, obviously, protect competition in local market areas throughout the country where a particular pharmacy could have a very high share, while being less than 10 percent statewide. And, of course, as noted above, multiple pharmacies that each have less than 10 percent of a region's pharmacies could freely engage in price fixing under the bill's terms so long as these combinations were separately organized around a state, so that the statewide caps on “region” market share were avoided.

Congress has consistently rejected similar efforts to provide antitrust immunity to price fixing by health care providers going back to the 1970s. Comments by the Federal Trade Commission in opposition to the very similar proposed Community Pharmacy Fairness Act of 2007 remain applicable today.¹ The Commission explained:

The bill would immunize price-fixing and boycotts to enforce fee and other contract demands, conduct that would otherwise amount to blatant antitrust violations. Experience teaches that such conduct can be expected to increase health care costs, both directly through higher fees paid to pharmacies, and less directly by collective obstruction of cost containment strategies of purchasers. These higher costs would fall on consumers, employers – both public and private – who purchase pharmaceuticals and other products on behalf of their employees

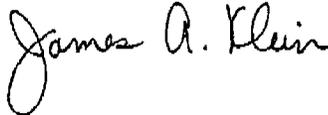
¹ See Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the Committee on the Judiciary United States House of Representatives Concerning H.R. 971 “The Community Pharmacy Fairness Act of 2007,” October 18, 2007.

Giving health care providers – whether pharmacies, physicians, or others – a license to engage in price fixing and boycotts in order to extract higher payments from third-party payers would be a costly step backward, not forward. . . .³

Rising health care costs are a key public policy challenge for our country, and, in particular, for employer-sponsored health plans. Federal legislation providing an antitrust exemption for pharmacies to negotiate higher rates of payment with health plans would drive up health costs for employers and their employees and retirees, and limit, rather than enhance, choice for American consumers. We appreciate that community pharmacies face challenges in today's marketplace, just as employers sponsoring health plans do. Creating an antitrust exemption for price fixing is not a fix for anything that ails us.

Thank you for this opportunity to share our views.

Sincerely,



James A. Klein
President
American Benefits Council

³ Id. at pp. 4, 21.

