THE PROPOSED MERGER BETWEEN EXPRESS SCRIPTS AND MEDCO

HEARING

BEFORE THE

SUBCOMMITTEE ON
INTELLECTUAL PROPERTY,
COMPETITION, AND THE INTERNET

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

SEPTEMBER 20, 2011

Serial No. 112–58

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://judiciary.house.gov

U.S. GOVERNMENT PRINTING OFFICE
68–401 PDF WASHINGTON : 2011

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SEPTEMBER 20, 2011

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THE PROPOSED MERGER BETWEEN EXPRESS SCRIPTS AND MEDCO

TUESDAY, SEPTEMBER 20, 2011

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

The Subcommittee met, pursuant to call, at 3:37 p.m., in room 2141, Rayburn House Office Building, the Honorable Bob Goodlatte (Chairman of the Subcommittee) presiding.

Present: Representatives Goodlatte, Coble, Chabot, Issa, Chaffetz, Marino, Adams, Watt, Conyers, Chu, Deutch and Nadler.

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

Mr. GOODLATTE. Good afternoon. The Subcommittee will come to order. I have an opening statement.

This hearing will examine the proposed $29.1 billion acquisition of Medco Health Solutions by Express Scripts. Express Scripts and Medco are both pharmacy benefit managers, or PBMs. PBMs are probably among the least known and least understood big businesses in America. Essentially PBMs act as middlemen between health insurance plans that offer prescription drug benefits and the pharmaceutical companies and pharmacists who manufacture and dispense prescription drugs to the plan's beneficiaries. But just because most Americans may not have heard of PBMs does not mean that they are anything less than enormous businesses with a significant impact on prices and competition in the market for prescription drugs in America.

When a person with health insurance fills a prescription, it is likely that a PBM was involved in setting the copay, determining the pharmacist's compensation, negotiating rebates and discounts with the drug manufacturer, and billing the health insurance plan for the drugs. For a growing number of prescriptions, the PBM also acts as the pharmacist. PBMs now control a majority of the mail-order pharmacy business.

PBM's position in the center of the American prescription drug market has proven very lucrative. In 2010, Express Scripts and Medco earned a combined profit of about $2.5 billion, with revenue over $100 billion. The proposed merger we examine today would combine two of the three largest PBMs and create a company that would be involved in about a third of all prescription drugs sales in America.

The combined company would control about 60 percent of the mail-order pharmacy market and a majority of the specialty pharmacy market. The combined company would be the incumbent holding the PBM contract for a majority of the companies on the Fortune 50. This consolidation would come in a market that has already come under considerable scrutiny for alleged abuses of market power. Small pharmacists have long complained that PBMs leverage market power to force pharmacies into unfavorable and unfair contracts.

My colleague Mr. Marino of Pennsylvania has led efforts to even bargaining power between PBMs and pharmacies and introduced H.R. 1946, the Preserving Our Own Hometown Pharmacies Act, to empower small pharmacies to negotiate with PBMs on more even terms.

In addition to pharmacies, PBMs enter contracts with essentially every major player in the supply and payment system for prescription drugs. A PBM with too much market power could demand ever larger rebates and discounts from drug companies, capturing more of their profits and perhaps leading to a decrease in competition and innovation to bring new drugs to market.

A PBM exercising unlawful market power could decrease the reimbursement rates for pharmacies filling prescription drugs to levels that make traditional pharmacies unprofitable and push more pharmacy business to the PBMs' own mail-order pharmacy business.

And a PBM unchecked by competition could potentially raise the prices that it charges employers and other health insurance plan sponsors for administering their prescription drug benefits. If this merger leads to a decrease in the supply of prescription drugs and pharmacy services or raises their prices, then America's prescription drug consumers will bear the burden.

It is by no means clear that today's merger will have any of these negative effects. The merging parties argue that far from raising prescription drug prices, PBMs are essential to controlling medical costs by negotiating the best possible deal for health insurance plans and the consumers who are covered by those plans.

There is evidence that PBMs actually do save health care costs, and that PBM mergers can help PBMs realize efficiencies and skills that empower them to save even more money for their clients. One study released just yesterday estimates that PBMs would save their clients almost $2 trillion of health care costs over the next decade.

Another fact to consider is that nearly every major plan sponsor who is responsible for administering a health insurance plan hires a PBM to administer the prescription drug benefit under that plan. If PBMs did not save money for plan sponsors, then presumably plan sponsors would not continue to engage them.

This hearing will examine all of the issues surrounding this merger. I look forward to hearing from our expert witness panel today. But I would like to conclude my opening remarks by raising a larger concern that goes beyond the details of this merger and has to do with our health care economy as a whole.

In the investor call announcing this merger, both Express Scripts CEO George Paz and Medco CEO David Snow, who are here today

as witnesses, mention the President's health care reform as a major factor motivating the merger. Mr. Snow said that, quote, "I believe you are going to see all sorts of combinations across the spectrum of health care as everyone realigns to the new imperatives related to health care reform and the demands the government is making," end quote. I am concerned that Mr. Snow may have been right. In the 18 months since the President's health care bill became law, we have seen a wave of mergers in various levels of the health care economy. I am concerned that this wave of mergers may be a symptom of a deeper dysfunction in our health care economy created by the ill-conceived health care bill.

I hope that today's hearing sheds light on the continuing debate in Congress over whether last year's government takeover of health care will have the effect of favoring regulation over free market, government mandates over competition, and big businesses over small.

At this time it is my pleasure to yield to the Ranking Member of the Subcommittee, the gentleman from North Carolina, Mr. Watt.

Mr. WATT. Thank you, Mr. Chairman. And it will come as no surprise to the Chairman my attitude about hearings about mergers. I have expressed them before, and I want to try to be consistent on this occasion.

To be clear, the Committee on the Judiciary has jurisdiction over all laws related to antitrust. Federal antitrust laws concern the functioning of the marketplace and competition and are enforceable by the Antitrust Division of the Department of Justice, the Federal Trade Commission and private persons.

The proposed merger between pharmacy benefit managers Express Scripts and Medco Health Solutions is currently under examination by the Federal Trade Commission, which recently requested additional information from the companies, signaling that the FTC is paying attention to us knitting, and that the deal has raised antitrust concerns with the regulators.

The FTC's so-called second request demonstrates that the merger will receive close scrutiny, and that the agency stands ready to fulfill its mission to prevent anticompetitive mergers and business practices in the marketplace.

In aid of this investigation, the FTC has the authority to compel detailed, confidential information to which we as legislators simply do not have access, making it far more likely that an appropriate determination will be made based on the facts and not on political pressure.

It should come as no surprise that I believe, as I indicated in prior hearings before the Committee, that our oversight function is best reserved to address legitimate concerns; for example, agency impropriety, incompetence or inexplicable inaction, or if, as is more likely in this budget-cutting fiscal environment, the agency is so understaffed or underfunded that it is ill-equipped to discharge its responsibilities at all. Fortunately no such claims have yet been raised with respect to this merger.

In the area of pharmacy benefit managers, this Committee in prior sessions of Congress has considered whether a limited antitrust exemption is appropriate to permit independent community

pharmacies to collectively negotiate the terms and conditions of insurance contracts in order to produce plans that would arguably protect the patient's choice of pharmacy. To the extent that this hearing sheds light on whether we should revisit that question, I believe it could be helpful to the Committee.

Now, also, other legislative issues, for example, the lack of transparency of the PBM call structures, that the Ways and Means Committee could appropriately consider.

I look forward to hearing from the experts assembled here today. I know that their testimony will provide the public with a fuller understanding of the issues at hand. But let me be clear: The ultimate determination as to whether this merger impermissibly restrains competition or otherwise violates the antitrust laws lies with the FTC and not with the House of Representatives or the Judiciary Committee on which we sit today.

Mr. Chairman, I yield back, and thank you to the Chairman.

Mr. GOODLATTE. I thank the Ranking Member.

The Chair will now recognize the gentleman from Pennsylvania, Mr. Marino, for an opening statement.

Mr. MARINO. I thank the Chairman.

Chairman Goodlatte, Ranking Member Watt, I would like to thank you for holding this hearing today on the proposed merger between Express Scripts and Medco, and particularly for inviting my constituent Mr. Joseph Lech to testify.

I believe that this hearing gives us the unique opportunity not just to discuss the merits of this particular merger, but to discuss the broader challenges that many community pharmacists are facing.

In the 10th Congressional District of Pennsylvania, local pharmacies are the foundation of many communities. People know their pharmacists and have trusted their advice and guidance for years. My daughter takes a great deal of medication on a daily basis. My pharmacist is always there; he knows us on a first-name basis. There have been situations where we have gone away and either forgotten or ran out of a prescription. We just call our pharmacist, and he makes the arrangements, and we are taken care of wherever we are.

It is personal service like this that makes community pharmacies so valuable. In fact, nothing has highlighted the importance of local pharmacies and the role they play in the community more than the recent events that occurred in northeastern Pennsylvania over the past few weeks. It is my understanding that Mr. Lech is prepared to discuss in more detail a personal story about this. But I can tell you that without community pharmacies like Mr. Lech's, a horrible situation for our friends and neighbors could have been much worse.

Community pharmacies are now facing a number of challenges that are threatening their ability to continue to provide personal services to communities and neighborhoods that need them the most. As a result, we have seen the number of community pharmacies decline nearly 50 percent since 1980. This is a disturbing trend, especially because it is small businesses such as Lech's Pharmacy that will lead us out of these difficult economic times.

As policymakers it is our job to focus on laws and policies that empower small businesses to grow and create jobs right here in the United States. I have serious questions and concerns that the merger we are discussing today could worsen the climate for independent pharmacies and could lead to excess access and higher costs for patients.

I am especially concerned about the consolidation this merger would cause in the mail-order and specialty drug markets. According to 2011 Atlantic Information Systems data, the combined mail-order facilities would concentrate 59 percent of the mail-order market, and in 2009 the combined specialty drug market share for Express Scripts and Medco was 52 percent. There have already been a number of reports where patients are being directed away from local specialty pharmacies to ones that may be much farther away and are owned by the PBMs.

While I am concerned about the effects of this merger, it is important to recognize that regardless of the outcome of the Federal Trade Commission review, independent pharmacies will still face substantial difficulties. For this reason I have introduced H.R. 1946, the Preserving Our Hometown Independent Pharmacies Act, that would be one step toward leveling the playing filed for community pharmacies. This legislation would allow independent pharmacies to join together to negotiate the terms and conditions of insurance contracts, to produce plans designed that would better protect the patient's access to their pharmacy of choice and are fair to the pharmacies. This legislation would put an end to the "take it or leave it" tactics that small pharmacies are currently forced to accept. Many of my colleagues from the Committee and Subcommittee have already joined me in these efforts by cosponsoring this legislation.

In conclusion, I would like to enter into the record a letter I received from the Pennsylvania House of Representatives chairman of the Health Committee, Matthew Baker, in opposition to the merger. In the letter he stated, PBMs' record of controlling costs is questionable, and the proposed merger would limit the ability of both the private and public sector to control health care costs, thus resulting in a significant reduction of competition.

Again, I would like to thank the Chairman for holding this important hearing. As the FTC commits its review and continues of this proposed merger, I would ask that they pay special attention to what it would do to patient access to the local pharmacies and the personal care these pharmacies provide. I look forward to working with you, Chairman Goodlatte and Ranking Member Watt, to ensure that we are doing everything we can to give hometown pharmacies the opportunity to grow and create jobs, while providing the best care for our families.

Mr. GOODLATTE. I thank the gentleman, and, without objection, the letter from Mr. Baker will be made a part of the record.

[The information referred to follows:]

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August 9, 2011

Jonathan Leibowitz, Chairman
Federal Trade Commission
600 Pennsylvania Avenue, NW, Room 338
Washington, DC 20580

Dear Chairman Leibowitz:

As Chairman of the Pennsylvania House of Representatives Health Committee, I am writing to express my concerns with the proposed merger of pharmacy benefit management (PBM) firms Express Scripts and Medco. As the Federal Trade Commission reviews this proposal, I would ask that you keep patient care at the forefront.

PBMs' record of controlling costs is questionable, and the proposed merger would limit the ability of both the private and public sector to control health care costs, thus resulting in a significant reduction of competition. Such a substantial decrease in this highly concentrated market would certainly increase costs. I would expect that PBM competition should be a major concern as the nation debates plans for deficit reduction and entitlement reform.

In addition, the standard practices of PBMs require further examination and analysis, such as cost controlling and the use of generic drugs. Lawmakers should have a thorough understanding of whether PBMs are truly benefitting the payors and patients. Similar concerns were recognized during the healthcare reform debate and provisions were included; however, such provisions should be implemented and fully understood before regulators consider this merger.

I respectfully request that the Commission will conduct a comprehensive analysis with all due diligence to address the concerns of diminished competition and PBM practices in an effort to protect the marketplace and, most importantly, the patient. Thank you for reviewing my concerns. Please contact me at any time should you wish to discuss this further.

Sincerely,

Matthew E. Baker

Matthew E. Baker, Chairman
House of Representatives Health Committee

cc: U. S. Senator Pat Toomey
U. S. Congressman Glenn Thompson
U. S. Congressman Tom Marino

Mr. GOODLATTE. We are pleased to be joined by the Ranking Member of the full Judiciary Committee, the gentleman from Michigan, Mr. Conyers, and I am pleased to recognize Mr. Conyers.

Mr. CONYERS. Thank you, Chairman Goodlatte and Mel Watt, our Ranking Member.

I had said before that I have rarely met a merger that I liked, but this is one that I like more than the ones that I don't like. And so the biggest problem I have here is that the small pharmacies and independents are urging me not to support it, and I hope I

hear persuasive discussion that will lead me to go along with this circumstance.

Now, this is a case of a small company taking over a bigger company, isn't it, which is also quite unusual. So here we come with these intermediaries, these folks that work in between the pharmacy benefit managers. How did they get into the picture? Where did they come from? What created them? I understand there are more than 40 floating around, and I think—and I hope I heard my leader Mel Watt say that we determine what is—what violates antitrust, not the FTC. But that is what is in our jurisdiction anyway.

So I come here thinking that in the long run somebody is going to go out of business if they don't merge. I don't want to try to tell you I have looked at the books of anybody, but what I am hearing is if this merger doesn't take place, it is not unlikely that somebody will go out of business, so that from a jobs perspective this is a strong case for the merger.

And so I will introduce into the record my complete statement and ask that all of you expect me to discuss Chairman Goodlatte's observation that the wave of mergers were the result of the ill-conceived health care bill. I hope that you are all prepared to answer that question.

And I thank you, Chairman Goodlatte.

Mr. GOODLATTE. I thank the gentleman.

[The prepared statement of Mr. Conyers follows:]

Statement of the Honorable John Conyers, Jr.
for the Hearing on "The Proposed Merger Between Express Scripts and Medco"
Before the Subcommittee on Intellectual Property, Competition and the Internet

Tuesday, September 20, 2011, at 3:30 p.m.
2141 Rayburn House Office Building

Let me open by thanking Chairman Smith and Chairman Goodlatte for convening this important hearing. When I sent the letter to Chairman Smith in the days following the announcement of the merger, my most immediate concerns were the implications that the proposed acquisition of Medco by Express Scripts, or ESI, would have on American jobs and the price of prescription drugs.

Because the filings and meetings before the Federal Trade Commission are largely closed and secret, today's Subcommittee hearing will provide the American public with one of the only open forums to hear directly from the two companies and experts in the field about jobs, pricing, and competition.

ESI and Medco are Pharmacy Benefit Managers, or PBMs, that contract with employers and health plans to administer prescription drug plans. Besides structuring the drug benefit and negotiating with the drug manufacturers to develop the drug formulary, some of these companies also have networks of retail pharmacies, mail-order pharmacies, and claims processing centers.

Contrary to many mergers, this one appears to have a number of redeeming qualitites. This merger may provide the path to long-term job-security for Medco's thousands of employees and may benefit consumers by keeping prescription drug prices low.

The drug benefit plans administered by PBMs have been shown repeatedly to dramatically reduce the price of medication and the availability of generic alternatives to consumers. As the FTC has testified before this very Committee, PBM's cost control programs have also "been shown to yield significant savings."

There are more than 40 PBMs in the market, and it is not immediately apparent that ESI and Medco are each other's most direct, or "substitutable" in antitrust parlance, competitors.

The market is very convoluted and multifaceted, with frequent segmenting and reportedly low barriers to entry. United Healthcare recently announced, for example, that it would no longer contract with Medco and will instead bring the drug benefit operation in-house with its new OptumRx PBM. More than 20 PBMs serve the Fortune 500, and the business models and revenue sources for PBMs are highly varied. Some operate retail pharmacies, others offer plan administration clearinghouses, while still others run mail-order catalogues. It is my understanding that Medco loses more business to CVS-Caremark than ESI, and ESI loses more business to Aetna than Medco.

For Medco, the past several quarters have proven particularly difficult. The company has lost millions in revenue, and for Medco employees, a merger with ESI may provide the most effective salve to stem long-term job-hemorrhaging.

On the other hand, however, the merger presents several concerns with regard to competition in the PBM market. Along with CVS-Caremark, ESI and Medco constitute the "Big Three" of the PBM market. On its face, this merger would bring that number down to the "Big Two."

Reports indicate that the combined entity could control as much as 52% of the specialty drug market, and as much as 59% of the mail-order market, 64% of the Part D market, and as much as 40% of the overall drug benefit market. The new company would administer the drug benefit for 6 of the 10 largest private American employers, and as many as 30 of the largest 50.

The proposed combination would further concentrate the market and likely result in job losses among the overlapping workforces at ESI and Medco. As opponents to the merger point out, the newly constituted company may use its leverage to outbid competing PBMs and further jeopardize the fiscal solvency of independently owned community pharmacies. These small businesses have been decimated by the increasing size and power of PBMs, and a merger between two of the Big Three should give us all pause for this reason.

Clearly, the two companies and expert witnesses before us today have a number of questions to answer. State Attorneys General have filed numerous antitrust cases against PBMs, the companies clearly play both sides with drug manufacturers and employers, and this merger has the potential to result in job losses among the two companies and community pharmacies.

The merger may, however, provide the only viable long-term future for Medco's employees and increase savings within the hyper-inflating healthcare industry. I look forward to today's testimony, and, once again, thank Chairman Smith, Chairman Goodlatte, and Ranking Member Watt for their attention to these critical issues.

Mr. GOODLATTE. And it is now my pleasure to introduce our witnesses. We have a very distinguished panel of witnesses today. And before I introduce them, I would like them to stand and be sworn.

[Witnesses sworn.]

Mr. GOODLATTE. Thank you, and please be seated.

Each of the witnesses' written statements will be entered into the record in its entirety. I ask that each witness summarize his or her testimony in 5 minutes or less. To help you stay within that

time, there is a timing light on your table. When the light switches from green to yellow, you will have 1 minute to conclude your testimony. When the light turns red, that is it. It signals that the witness' 5 minutes have expired.

Our first witness is George Paz, chairman and CEO of Express Scripts, Incorporated. If the merger is approved, Mr. Paz will be the chairman and CEO of the new merged company.

Our second witness is David Snow, chairman and CEO of Medco Health Solutions.

Our third witness is Joseph Lech, an independent community pharmacist from Tunkhannock, Pennsylvania.

Our fourth witness is Dennis Wiesner, a senior director of the H-E-B grocery chain with responsibilities for privacy, pharmacy and government affairs.

Our fifth witness is Dan Gustafson, a founding member of the Minneapolis law firm Gustafson Gluek.

Our sixth and final witness is Stephanie Kanwit, counsel at the law firm Manatt, Phelps & Phillips.

Mr. Paz, we will begin with you. Welcome.

TESTIMONY OF GEORGE PAZ, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, EXPRESS SCRIPTS, INC.

Mr. PAZ. Thank you, Mr. Chairman and Members of the Subcommittee.

Mr. GOODLATTE. You may want to turn on that microphone and pull it close.

Mr. PAZ. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to explain how the combination of these two innovative companies can benefit the Nation's patients and its public and private purchasers. I believe that today's hearing will demonstrate that this merger is one of the best prospects to secure safer and more affordable prescription drugs for tens of millions of Americans.

I would like to begin by addressing a concern on every American's mind: jobs. Health care costs are a worrisome part of running a business. Yesterday an important new study was released, which I ask to be included in the hearing record. It concludes that for every 1 percentage point reduction in prescription drug costs, 20,000 jobs in the United States can be funded.

PBMs have a proven track record of generating savings for employers and their workers. There are many proven tools available through PBMs like Express Scripts and Medco that reduce drug costs, and this merger will sharpen and expand the availability of these tools.

Four of us on this panel are part of the same noble mission. Patients in need of medicine rely on us for access to affordable care. Each us is committed to the highest ideals of the practice of pharmacy: accuracy, safety, affordable care, and service.

Mr. Lech's pharmacies are a part of our network. We are the PBM for Blue Cross of Northern Pennsylvania, the insurer that covers many of his customers. We work with literally thousands of independent pharmacies like those of Mr. Lech all across the country, and we value those relationships.

Mr. Wiesner's employer, H-E-B, has been our client for many years. His chain of stores are also an important part of our pharmacy network. Let me also acknowledge Mr. Wiesner's service on the Texas Board of Pharmacy, where he is developing the next generation of skilled pharmacists to serve patients.

I am proud to report that one of my company's employees was just named the outstanding young pharmacist of the year by the Texas Pharmacy Association.

Each of us here today should ask ourselves what is in the best interest of a patient when they are trying to fill a prescription? And who is there to ensure that the American family is getting the best value for their money? PBMs help American families and their employers get the best possible deal while improving safety. We make the use of prescription drugs safer and more affordable.

After a patient has been seen by their caregiver and has a prescription that needs to be filled, they are hardly in a position to negotiate with a drug company or a pharmacy. They just know they need the prescription filled as their ticket to getting well. If they are one of our patients, when they walk into a pharmacy, they have all 13,0000 Express Scripts employees standing with them. Before they ever receive their medicine, over 100 safety checks are conducted by our system, one of most advanced high-tech systems in the world. In less than 2 seconds, we determine if there is a clinically appropriate, less costly generic drug available. We also make sure the patient is not subject to adverse drug events. Further, what patients pay is reduced on average by 30 to 40 percent. For Mr. Lech, Mr. Wiesner and other pharmacies, they receive safety information, and they are assured payment, eliminating $7.3 billion in bad debt to pharmacies each year. These are all giant leaps forward for patients and pharmacies that companies like our help create, and we make these benefits available to over 65,000 pharmacies in every corner of the United States.

I believe drug costs are still too high for American families. When the big drug companies' charge for their medicines keeps going up, and large retail drugstore chains want to dictate prices, I want a fair deal for our patients and employers. That mission goes to the core of what our companies are all about. We are fully aligned with our patients and employers. We make money by saving them money. This union of our two companies will strengthen our ability to do just that.

In my formal testimony I go through many of the tools we have developed to drive down drug costs while improving health outcomes. We have a proven track record.

There are other benefits to the health care system by combining our two companies. For example, one, we increase patient adherence and reduce unnecessary medical expenses; two, we help the FDA monitor drug shortages and identify safety concerns quickly; three, we empower Federal and State responders from all public health and respond to natural disasters; and, four, we help law enforcement address fraud, waste and abuse.

In conclusion, the merger of Express Scripts and Medco is the best opportunity to continue to lower drug costs while improving health care today and for the immediate future.

Mr. Chairman and Members of the Subcommittee, I thank you for the opportunity to speak to you today.

Mr. GOODLATTE. Thank you for your testimony, Mr. Paz.

[The prepared statement of Mr. Paz follows:]

Prepared Statement of George Paz, Chairman and Chief Executive Officer, Express Scripts, Inc.

INTRODUCTION

Chairman Goodlatte, Ranking Member Watt, and Members of the Subcommittee, my name is George Paz and I am the Chairman and Chief Executive Officer of Express Scripts, Inc. Express Scripts is headquartered in St. Louis, Missouri and has more than 13,000 employees located in 13 states including Arizona, Florida, Indiana, New York, Ohio, Pennsylvania and Texas.

I wish to thank the subcommittee for the privilege to testify and share my perspective on why and how the proposed merger of Express Scripts and Medco Health Solutions will be a win/win for the nation's patients and its public and private purchasers. It is my hope that today's hearing will also make clear why failure to finalize and approve the merger will eliminate one of the best prospects we know to secure safer, better and more affordable pharmaceutical coverage and care for tens of millions of Americans.

Express Scripts is one of more than 40 pharmacy benefit managers, or PBMs, operating in the United States. Every year, Express Scripts is hired by thousands of small businesses, Fortune 500 employers, Taft-Hartley funds, managed care plans, and state and local governments to manage the pharmacy benefits for more than 50 million patients.

Clients appreciate what we do to help them provide cost-saving, medically appropriate prescription drug coverage for American workers and families. Failure to produce savings and value for our customers means they turn to our competitors or attempt to manage the costs themselves. We are quite proud, however, that our clients "re-elect" us 98% of the time. Several of our more widely known clients such as, Blue Cross Blue Shield of Northeast Pennsylvania, Blue Cross Blue Shield of Massachusetts, MetLife and Lowes have contracted with Express Scripts for more than a decade.

Express Scripts is a genuine American success story. We have grown rapidly over our 25-year history, bringing innovation to the marketplace, driving out unnecessary or expensive spending in the pharmacy benefit and making medicines safer and more affordable. Since being founded in 1986, much has changed in the world. One overriding principle that forms the bedrock of our company never wavered: our goals will always fully align with our clients' needs.

Simply and most accurately put, we and our competitors in the PBM industry are successful when our clients save money through lower employer and employee health premiums and/or reduced out-of-pocket costs while at the same time enhancing safety and more positive medical outcomes. To the extent we fail to deliver on that promise, we fail to retain and sustain our client base and business model.

PBMS LOWER PRESCRIPTION DRUG COSTS FOR CONSUMERS & PAYERS

At Express Scripts, we work hard on behalf of our clients to rein in high drug costs, improve patient outcomes, advance the practice of pharmacy, and assist law enforcement in critical efforts to stop fraud, waste and prescription drug abuse. With nearly four *billion* prescriptions filled in the United States last year alone [1], pharmacy is the most frequently used part of health care and demands the sophisticated tools and expertise only PBMs can bring to bear.

Express Scripts' fundamental mission is to make medicines safer, more affordable and more accessible. PBMs make prescription drugs more affordable for clients by creating old-fashioned American competition among brand-name and generic drug manufacturers as well as among more than 60,000 chain drugstores, mass merchandisers, independent pharmacies, and grocery pharmacies. We "ride the same horse" with our clients, helping them benefit directly from our bargaining know-how and world-class clinical initiatives.

At a time when many Americans struggle to afford their medications, sometimes having to choose between a rent check and the prescription to keep their diabetes

[1] http://www.imshealth.com/deployedfiles/ims/Global/Content/Corporate/Press%20Room/Top-line%20Market%20Data/2010%20Top-line%20Market%20Data/2010__Distribution__Channel__by__RX.pdf

under control, our role has real meaning in the lives of so many. When a patient visits a pharmacy, she leaves with both peace of mind and the right medication to improve her health and well-being. Whether a patient realizes it or not, through our rapid and robust high-tech adjudication process, more than 100 safety checks occurred *before* she left the pharmacy. These safety checks avoid costly drug interactions, contraindications, and other harmful medication errors. PBMs save lives and deliver real value for millions of Americans every day.

PBM–GENERATED COMPETITION LOWERS DRUG PRICES

PBMs have had tremendous success in driving down prescription drug costs for patients and payers. In doing so, PBMs have relied upon a wide range of tools and techniques, including expanded access to less costly, medically appropriate generic drugs, step therapy programs, and home delivery pharmacy. According to our data, Express Scripts members utilizing our full complement of tools enjoy an additional annual average savings of over 11 percent per year. These savings are in addition to the discounts from negotiating with drug makers, which average 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs and 53 percent below the retail cash price for generic drugs.[2]

The decisions we make and the innovations we bring forward are rooted in the best clinical data available anywhere in the world. A key tool PBMs rely upon to increase competition in the prescription drug supply chain begins with a Pharmacy and Therapeutics (P&T) Committee. Comprised of an independent group of highly-trained physicians and pharmacists, these panels review every marketed prescription medication to ensure safety, clinical appropriateness, and establish coverage parameters to guide formulary (the list of covered medications) development. These P&T Committees are focused solely on the clinical benefit of these medicines and are not involved in negotiations with pharmaceutical manufacturers, contracting with network pharmacies, or any other aspect of a PBM's business. The P&T Committee develops independent, science-based clinical parameters consistent with best medical practices, which PBMs use to build innovative programs and negotiate with drug makers to compete at the lowest price.

Perhaps a P&T Committee's role can be best explained through the example of a class of medications that treat high blood cholesterol (hyperlipidemia). Payers, whether health plans, employers or the federal government, spend more on prescription medications in this class than any other group of medications. Within this therapeutic class, there are dozens of available treatments. Looking just at statins, a sub-class that lowers LDL cholesterol, there are seven different medications available. As the P&T Committee reviews this class, clinicians examine all the available data, weed out the "me-too" drugs from truly novel therapies, and determine that a clinically comprehensive formulary should include generic medications and only one high-potency statin. With only one high-potency statin needed on the formulary, the manufacturers of these products blindly bid at the lowest possible price in an effort to ensure placement on the formulary. Price variation in this class is significant, with the monthly treatment costs varying from $11 to more than $200[3].

In 2010, brand drug makers increased prices on statins by an average of 9.3 percent. Yet because of Express Scripts' sophisticated negotiating tools, our clients' exposure to this increase was limited to 6.3 percent—which translates to a 32 percent discount for clients. Our business model is a winning formula for patients, payers, and the entire health care system. Each of our clients makes their own choice about how to use these savings. Some use the savings to offset premium increases. Others offer these savings to patients through reduced copayments, coinsurance, or through copayment waivers altogether. Interestingly, the number of patients receiving treatment for high-blood cholesterol actually increased last year, addressing a public health concern well documented by the Centers for Disease Control and Prevention (CDC)[4].

PBMs are creating competition in the drug supply chain. If a dozen different prescription medications treating the same condition were all covered by a health plan at identical levels, drug makers would be incentivized to maximize prescription drug prices to whatever level the market would bear. Instead, the use of independent

[2] US GAO "Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees and Pharmacies" GAO–03–196

[3] http://www.consumerreports.org/health/resources/pdf/best-buy-drugs/StatinsUpdate-FINAL.pdf

[4] Kuklina EV, Shaw KM, Hong Y. Vital Signs: Prevalence, Treatment, and Control of High Levels of Low-Density Lipoprotein Cholesterol—United States, 1999–2002 and 2005–2008. Morbidity and Mortality Weekly Report. 2011;60(4):109–114. Available at: http://www.cdc.gov/mmwr/pdf/wk/mm6004.pdf Accessed February 4, 2011.

P&T Committees creates a market dynamic where the manufacturers of these products must compete with one another for placement on the plan formulary. The result—patients and plan sponsors save money and have better health outcomes.

PBMS HAVE DRIVEN DRAMATIC DECLINE IN DRUG TREND IN THE PAST DECADE

The emergence of PBMs correlates directly with the reduction in the rate of growth in prescription drug costs. In the late 1990s, the rate of growth in the cost of pharmaceuticals was at an all-time high annual growth rate of 18 percent. This growth rate was simply unsustainable. Employers seeking to rein in costs were desperate for help and began turning to PBMs in earnest for solutions. Throughout the 2000s, the annual rate of growth was reduced gradually to just 5 percent in 2009.[5] This historic decline in drug trend is attributed to a variety of factors, including the expanded use of cost-effective generic alternatives. Trend management tools that promote the use of generic drugs are the single most potent tool to lower drug spending. Largely because of the leadership from companies like mine, the use of generic drugs has saved American patients and payers $824 *billion* in the last decade alone[6].

MEDICARE PART D: WORKING AS CONGRESS INTENDED TO LOWER SENIORS' DRUG COSTS

Medicare and more than 40 million older Americans and people with disabilities have also benefitted from PBMs' tool and techniques. Prior to the advent of Medicare Part D in 2006, about one in three Medicare beneficiaries lacked prescription drug coverage. Without comprehensive drug coverage provided through PBMs, millions of seniors every month faced agonizing choices that either meant forgoing needed medications or diverting scarce resources away from rent or food to pay for their prescriptions. Working together on a bipartisan basis, Congress passed historic legislation in 2003 modernizing Medicare by adding a much-needed prescription drug benefit.

Despite dire predictions by some of high costs and low participation, Medicare Part D has exceeded expectations. Beneficiary satisfaction is very high, with seniors enjoying broad access to a wide range of medicines. Plan participation is robust, with dozens of health plans and PBMs acting as prescription drug plan (PDPs) sponsors or Part D sub-contractors. Premiums are far lower than originally forecast and the program has come in under budget. In fact, the Center for Medicare and Medicaid Services announced in early August that 2012 Medicare Part D premiums will actually *go down* for the first time in the program's six year history. This is due to competition amongst Medicare Part D plans (administered by PBMs) and increased generic utilization.[7] While there are important distinctions between Medicare Part D and how PBMs operate in the commercial marketplace—particularly how Part D's design protects drug makers from competition for certain classes of drugs—Part D nonetheless builds on many of PBMs' core business functions.

IMPROVING PATIENT CARE THROUGH PRESCRIPTION-DRUG ADHERENCE PROGRAMS

While Express Scripts and Medco have built very different capabilities to serve their patients, we have a shared mission to protect working families and small businesses from high prescription drug costs. Express Scripts has advanced this goal by applying behavioral sciences to healthcare to understand the reasons why patients may not always adhere to their medications. More than half of all patients fail to engage in behaviors consistent with their intentions. This disconnect between patient intent and reality results in the wasting of more than $18 million of pharmacy benefits *each and every day.* Imagine if our system could recoup even a modest portion of this waste? These resources could be allocated much more effectively in other parts of the system.

Express Scripts helps close this intent-behavior gap and improve patient outcomes through the application of behavioral sciences. Inherently, we all want to use the least costly medicine, delivered as safely as possible. Any number of barriers can come along that trip us up—leading to non-adherence, financial waste and poor outcomes. We cut through the noise and create simple to execute programs allowing people to act on their best intentions. While Express Scripts has focused on improving compliance, Medco has made a key priority of managing chronic illness through

[5] National Health Expenditure Data from the Centers for Medicare & Medicaid Services. https://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf Accessed September 14, 2011.

[6] http://www.gphaonline.org/about-gpha/about-generics/case/generics-providing-savings-americans

[7] http://www.hhs.gov/news/press/2011pres/08/20110804a.html

Therapeutic Resource Centers (TRCs). TRCs focus on patients diagnosed with different chronic diseases and employ an array of specially trained clinicians to optimize therapy effectiveness, maximize health outcomes by improving adherence, and help patients avoid adverse drug interactions. While our clinical capabilities are very different, we share the same goal and these capabilities will be a powerful complement to one another when the merger receives regulatory approval and is finalized.

Let me leave you with another example of how this combination will improve healthcare. You recall the excitement around the mapping of the human genome. We were promised a golden era of medicines. By and large, that promise has not been fulfilled. By bringing together our companies' complementary expertise in behavioral sciences and pharmacogenomics, we have the potential to truly deliver on the real promise of personalized medicine: ensuring that patients get the right treatment at the right time for the best outcome.

REDUCING PHARMACY FRAUD, WASTE AND ABUSE

Another shared goal of Express Scripts' and Medco's business is driving waste out in the pharmacy benefit, deterring fraud, and reducing prescription drug abuse. In 2010, Americans unnecessarily spent more than $400 billion on their health care, and risked their lives and health, by choosing the wrong medication, pharmacy or through simple but all-too-frequent non-adherence to their doctors' instructions[8]. Beyond wasteful prescription drug spending, these costs include unnecessary hospitalizations, testing and treatment in costly emergency rooms. These are very real problems with costs across the entire health system and PBMs are the most advanced partners to provide common-sense solutions.

As much as 1 percent of prescription drug costs result from fraud, waste, and abuse[9]. With Americans spending $307 billion just on prescription drugs in 2010, this amounts to several billions of dollars in unnecessary costs to our system. Our clients already rely on us to help detect and prevent fraud, waste and abuse. Through advanced high-tech programs and processing systems, we save clients millions of dollars in wasteful pharmacy spending. Beyond saving money for our clients and patients by preventing this wasteful, and in some cases criminal behavior, our merger can bring new resources to bear for law enforcement to address America's other drug problem—prescription drug abuse.

Examples of fraud in the pharmacy marketplace are plentiful. A few years ago, six pharmacists, a doctor, and five drug dealers in Texas were convicted for conspiracy to divert more than 1.7 million tablets of prescription pain killers for illicit sale and use. The $30 million scheme involved pharmacists repeatedly refilling fraudulent prescriptions that were dispensed to drug dealers. These criminal enterprises have become so wide-spread, several states have enacted anti-"pill mill" legislation to detect and end this kind of prescription drug abuse.

The combination of Express Scripts and Medco's systems will create a new tool for law enforcement when investigating potentially criminal prescribing or dispensing patterns. With data from more than 65,000 pharmacies across the country, doctor-shopping, polypharmacy, and other instances of fraud can be stopped like never before.

EXPANDED CLINICAL OFFERINGS

Express Scripts and Medco both have significant clinical capabilities to serve all of our patient groups. By combining these offerings, we can pioneer new drug safety systems, create new resources for public health, and continue to advance evidence-based medicine to better serve our patients.

Express Scripts has been on the cutting edge of improving patient safety. Through a combination of our P&T committee expertise, our vast database of prescription drug utilization, and post-marketing surveillance, Express Scripts identified serious safety concerns with Vioxx® more than six months before the FDA withdrew market approval. By combining with Medco, we will have even more clinical data that can create the largest and best real-time early warning drug safety system in the world.

This combined clinical data is also useful to public health. As various government agencies monitor epidemiology, or track supply chain disruptions in the United States, our resources will provide comprehensive data that have never before existed. The FDA, CDC, DEA and FEMA could all benefit from the comprehensive

[8] Express Scripts. 2010 Drug Trend Report.

[9] Pharmaceutical Care Management Association. White paper on Fraud, Waste and Abuse. July 2011.

warehouse of supply chain data to track, distribute and respond to public health emergencies.

We also intend to continue our focus on evidence-based medicine that improves the safety and cost-effectiveness of prescription drugs. The growing availability of generic alternatives has already created enormous opportunities to better manage prescription drug spending.

ADVANCING SPECIALTY PHARMACY SERVICES

An Express Scripts-Medco merger will facilitate the advancement of specialty pharmacy services for patients facing the challenges of diseases like cancer, MS, leukemia, and hepatitis C among others. Express Scripts is very proud of our specialty pharmacy capabilities. We are committed to providing the best in class specialized care to patients with chronic, complex diseases with medications that can cost tens or even hundreds of thousands of dollars per year. Our specialty pharmacy programs keep patients adherent to injectable and infusible therapies, avoid more costly treatment settings, and improve the livelihood of our patients. Our specialty pharmacies also partner with drug makers, the Food and Drug Administration, and the Drug Enforcement Agency because of the need for post-marketing surveillance. Narrow distribution channels are necessary for drugs that are sometimes schedule III controlled substances. Specialty pharmacy is a complex market with competition both inside and outside of the pharmacy benefit, including retail pharmacies across the nation.

WE WILL PROTECT AMERICAN FAMILIES FROM THE RISING COST OF PRESCRIPTION MEDICINES

A combined Express Scripts and Medco will be well-positioned to protect American families from the rising cost of prescription medicines. The Federal Trade Commission, the country's only regulatory agency tasked with both consumer protection and competition, is reviewing the competitive effects of our merger. After its thorough review, the FTC will make its determination as to whether the proposed transaction passes muster under the antitrust laws.

The PBM marketplace is highly competitive and dozens of PBMs compete for business in various payer streams providing coverage to roughly 260 million Americans. This marketplace consists of large group, small group, and individual insurance markets, Taft-Hartley union plans, and an array of separate public programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, state employee benefit plans, and the federal employees' program (FEP). More than 20 different PBMs service the Fortune 500 employers and the advent of the Medicare Part D program has dramatically increased the number of prescription drug benefit offerors.

While a focus on historical market shares ignores the highly complex and dynamic nature of the marketplace and how PBM business is bid and won, by our estimates, the combined historical shares of the companies would be approximately 30 percent. This range falls well inside the parameters of mergers which have passed antitrust regulatory review.

The benefits of this merger are numerous and will accrue to patients, employers, clinicians, and payers alike by:

- Generating greater cost savings for patients and plan sponsors;
- Closing gaps in care and achieving greater adherence through behavioral approach and clinical strengths;
- Providing leadership and resources required to drive out waste and improve health outcomes;
- Utilizing shared expertise to better manage the cost and care associated with specialty drugs—the biggest driver of costs in the drug supply chain; and
- Responding to the national call for a more affordable and accountable healthcare system.

In conclusion, our health care system is at a crossroads. Consumers want the protection that comes from comprehensive coverage providing high-quality, affordable care, including pharmacy benefits. Employers, already struggling in a difficult economy, are seeking greater value for their health care spending and are looking for a calm port amidst the storm of rising costs and middling outcomes. Policymakers are combing through our nation's accounting ledgers and finding Medicare and Medicaid awash in red ink.

The proposed merger of Express Scripts and Medco will not resolve all of the challenges facing our health care system, but it is an affirmative step in the right direction. The merger of Express Scripts and Medco will help make prescription drugs more affordable for seniors, people with disabilities and working families. It will also help small businesses and large employers better compete in a global economy by helping to rein in their medical costs. Finally, a combined Express Scripts and Medco will help deliver real savings to Medicare and Medicaid beneficiaries and put our nation's fiscal footing on a stronger foundation.

Thank you for the opportunity to testify today and to explain the consumer benefits and enhanced competition that will arise with a merged Express Scripts-Medco.

I look forward to answering any questions you may have.

Mr. GOODLATTE. And, without objection, the study you referenced in your testimony will be made a part of the record.

[The information referred to follows:]

Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers

Prepared for

September 2011

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I. Executive Summary

Pharmacy Benefit Managers (PBMs) implement prescription drug benefits for more than 215 million Americans, who have health insurance from a variety of sponsors: commercial health plans[1], self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, and others. Working under contract to these plan sponsors, PBMs use advanced tools to manage drug benefit programs that give consumers more efficient and affordable access to medications. Visante was commissioned by the Pharmaceutical Care Management Association (PCMA) to estimate the savings that these PBM tools generate for plan sponsors and consumers.

Major Findings:

- **Average PBM Savings:** From 2012 to 2021, PBMs will save plan sponsors and consumers almost $2 trillion, or about 35%, compared with drug expenditures made without pharmacy benefit management. Of the $2 trillion, commercial plan sponsors and their members will save $1.3 trillion; Medicare Part D and its beneficiaries, $700 billion.[2]
- **Range of PBM Savings:** Available PBM savings for individual plan sponsors can range from 20% for those that make limited use of PBM tools to 50% for those that adopt best practices recommended by PBMs.
- **Additional Savings with Best Practices:** If all plan sponsors adopt PBM-recommended best practices, projected prescription drug expenditures could fall by an additional $550 billion over the next decade. Of the $550 billion in additional PBM savings, commercial plan sponsors and their members could save $360 billion; Medicare Part D and its beneficiaries, $190 billion.
- **Lost Savings if PBM Tools are Limited:** Limiting PBM tools could increase projected prescription drug costs by more than $550 billion over the next decade. Drug costs could rise by more than $360 billion in the commercial sector and more than $190 billion in Medicare Part D.
- **PBM Savings and Jobs:** Annual savings generated by PBMs for the commercial sector will cover the cost of more than 700,000 jobs in 2012. By adopting PBM-recommended best practices, commercial plan sponsors could cover the cost of more than 200,000 additional jobs next year. If PBM tools are limited, lost savings to the commercial sector could equal the cost of more than 200,000 jobs. Put another way, each 1% decrease in prescription drug expenditures covers the cost of 20,000 jobs nationwide.

[1] For the purposes of calculating PBM dollar savings, Medicaid managed care plans are included in the commercial sector. For calculations related to jobs, Medicaid managed care plans are excluded.
[2] Average PBM savings represents current practice and is reflected in the government's baseline projections for national health expenditures and Medicare Part D.

II. Discussion

PBM Tools Focus on Five Key Savings Categories

Over the past 20 years, the share of the health care dollar spent on pharmaceuticals has nearly doubled, from roughly 5% to 10%. New medications and broader insurance coverage have increased drug expenditures—now approximately $300 billion annually—and the need for pharmacy benefits management. PBMs have a difficult mission: to increase prescription-drug access while reducing cost growth.

PBM tools focus on five primary categories that reduce drug trend:

1. **Negotiating Rebates from Drug Manufacturers:** PBMs negotiate rebates from manufacturers of brand drugs that compete with therapeutically similar brands and generics. Manufacturers typically provide a rebate if their product is "preferred," which means it is assigned a copay lower than competing products.
2. **Negotiating Discounts from Drugstores:** Retail pharmacies provide discounts to be included in a plan's pharmacy network. The more selective the network, the greater the discount, since each pharmacy will gain business.
3. **Offering More Affordable Pharmacy Channels:** Mail-service and specialty pharmacy channels typically give plan sponsors deeper discounts than do retail pharmacies. These channels also help encourage the use of preferred products for additional savings.
4. **Encouraging Use of Generics and Affordable Brands:** PBMs use several tools to encourage the use of generic drugs and preferred brands. These include: formularies and tiered cost sharing, prior authorization and step therapy protocols, generic incentives, consumer education, and physician outreach. As PBMs and plan sponsors strive for greater savings, drug mix becomes even more important.
5. **Reducing Waste and Improving Adherence:** PBMs use Drug Utilization Review (DUR) to reduce waste such as polypharmacy and implement patient adherence programs to help patients stick to their prescription regimens. Both programs improve clinical outcomes and influence prescription volume and expenditures.

Plan-Sponsor Decisions Determine PBM Savings

Plan sponsors guide how actively pharmacy benefits are managed. They also determine formulary coverage, copayment tiers, utilization management, and pharmacy channel options. In making these choices, plan sponsors weigh many factors, including clinical quality, cost, and member satisfaction.

For example, while nearly 80% of employer-sponsored plans used three, four, or more copay tiers in 2010, 5% were apparently less concerned about managing prescription-drug costs and applied the same copay (an average of $13) for every medication.[3]

[3] Kaiser Family Foundation. HRET Employer Health Benefits Survey, 2010.

Plan sponsors typically wish to balance controlling costs against minimizing change for their members, all while ensuring access to needed care. As sophisticated purchasers, most plan sponsors use a competitive bidding process to specify their requirements and contract with the PBM that can best meet their needs. Independent panels of experts known as Pharmacy and Therapeutics (P&T) Committees ensure that the use of PBM tools is clinically appropriate. Plan-sponsor choices in using PBM tools can produce savings ranging from 20% to 50% over unmanaged expenditures for those adopting best practices.

Figure 1: How Plan Decisions Determine PBM Savings

PBM Savings Relative to Unmanaged Drug Expenditures:	**20%-30%**	**30%-40%**	**40%-50%**
Use of PBM Tools	**Limited**	**Average**	**Best Practice**
Plan Sponsor Decisions	←	—	→
Formulary	Open	Preferred drug list (PDL)	More selective PDL with incentives for generics and preferred brands
Copay Options	Single tier	Two to three tiers with modest copay differentials	Three or more tiers with significant differentials to encourage the use of generics and preferred brands
Utilization Management	None	Pre-approvals for select drugs with safety, efficacy, or cost issues	Pre-approvals plus step therapy to encourage physicians to use first-line treatments
Mail-Service Pharmacy	Minimal copay incentives and usage	Moderate copay incentives and usage	Strong copay and other incentives and high usage
Retail Pharmacy Networks	Open	Network includes vast majority of drugstores in defined geographic areas	Narrower selection of pharmacies able to provide greater discounts
Specialty Pharmacy	None	Specialty pharmacy options available	Use of specialty pharmacy network whenever clinically appropriate

Source: Visante, 2013.

Factors Limiting the Use of PBM Tools

In the commercial sector, large employers, unions, state governments, and other plan sponsors have a range of goals, budgets, and philosophies. PBM savings are limited by benefit design decisions made by individual plans. The wide range of PBM savings observed from plan to plan in the commercial sector reflects this.

PBM savings in Medicare Part D are limited by the need for stand-alone prescription drug plans to attract and retain enrollees and by governmental restrictions placed on the use of certain PBM tools. Because Part D plans have similar goals and limits, PBM savings are fairly consistent across these plans.

Faced with rising health costs, plan sponsors do not typically place limits on PBM tools that have already been integrated into a plan. Looking forward, then, the main factor that could limit the use of PBM tools is restrictive government policy.

If enacted, state and federal proposals that mandate coverage of brand name drugs, increase pharmacy reimbursement levels, restrict the use of mail-service pharmacies, and force the disclosure of proprietary contract information could all serve to limit the use of PBM tools. If such policies decreased the current average PBM savings of approximately 35% to the 25% level typical of plans with limited use of PBM tools, drug costs could rise by hundreds of billions of dollars over the next decade.

PBM Savings Help Employers Preserve and Create Jobs

Employers bear a large portion of health costs in the United States, and studies suggest that rising costs can lead to a decline in employment.[4,5] The savings generated by PBMs provide employers with funds to preserve and create jobs. Based on data produced by the Bureau of Labor Statistics, Visante projects total compensation costs for a full-time equivalent private industry worker at nearly $60,000 in 2012.[6] In economic terms, this represents the approximate opportunity cost of a job. With private-insurance drug expenditures projected at $122 billion in 2012,[7] a 1% increase in that figure equals the opportunity cost of more than 20,000 jobs in the "commercial" sector, defined to include both private-sector workers and government employees receiving health benefits through private insurance. We discuss our calculations in more detail in the methodology.

[4] Baicker, K., et al., "The Labor Market Effects of Rising Health Insurance Premiums," Journal of Labor Economics, 24(3): 609-634, July 2006.
[5] Cutler, D., et al., "Labor Market Responses to Rising Health Insurance Costs: Evidence on Hours Worked," The Rand Journal of Economics, 29(3), 1998.
[6] Bureau of Labor Statistics, "Employer Costs for Employee Compensation," June 2011.
[7] Centers for Medicare and Medicaid Services, National Health Expenditure Data, NHE Historical and Projections, 1965-2020.

III. Methodology

Visante's model for projected PBM savings draws on data from: the Centers for Medicare and Medicaid Services (CMS), Government Accountability Office (GAO), Federal Trade Commission (FTC), Congressional Budget Office (CBO), PBM financial filings with the Securities and Exchange Commission (SEC), PBM drug trend reports, structured interviews with PBM industry experts, peer reviewed studies, and commercial third-party drug claims data.

Deriving Baseline Drug Expenditures Managed by PBMs

To derive baseline drug expenditures managed using PBM tools, Visante began with CMS National Health Expenditure (NHE) projections for outpatient prescription drug expenditures from 2011 to 2020. By these estimates, spending on outpatient prescription drugs will grow from $276 billion in 2011 to $513 billion in 2020, for a total of $3.8 trillion over the 10-year period.[8,9] The projections reflect CMS assumptions concerning the impact of health reform, manufacturer price inflation, patent expirations, new drug introductions, follow-on biologics, and other factors. Our model incorporates these assumptions.

CMS outpatient drug expenditure projections reflect net costs to payers, including plan sponsors and consumers. Manufacturer and pharmacy discounts are reflected in CMS figures. Outpatient prescription drug expenditures account for about 75% of the nation's drug bill, and nearly all PBM management activities focus on outpatient prescription drugs.

CMS segments outpatient prescription drug expenditures by payer, including private insurance, Medicare, Medicaid, and other government programs. Visante assumes that nearly all private-insurer expenditures and nearly all Medicare Part D expenditures are associated with the use of PBM tools. We have excluded the approximately 73% of Medicaid prescription costs that still occur in state fee-for-service programs.[10] Prescription expenditures in the Veterans Administration (VA), Indian Health Service, and DoD/TriCare direct services also were excluded. DoD/TriCare expenditures on prescriptions outside military treatment facilities, however, were included.[11]

Visante next estimated the share of consumer out-of-pocket expenditures arising from copayments/cost sharing for prescriptions associated with PBMs and PBM tools. We started by projecting the average cost sharing per prescription based on survey data for commercial plan sponsors reported by the Kaiser Family Foundation[12] and for Medicare Part D plans as reported by CBO.[13] We then multiplied average cost sharing by the estimated number of prescriptions each year that were managed with PBM tools.

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[8] Centers for Medicare and Medicaid Services, National Health Expenditure Data, NHE Historical and Projections, 1965-2020.
[9] The National Health Accounts do not include projections for 2021. The 2021 value was projected assuming the 2017-20 growth rate held for the following years.
[10] The Lewin Group, Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed, February 2011.
[11] TriCare drug spend under "purchased services" is estimated at $2.8b for 2010, according to The Evaluation of the TRICARE Program: Fiscal Year 2011 Report to Congress, February 2011.
[12] Kaiser Family Foundation, HRET Employer Health Benefits Survey, 2010.
[13] Congressional Budget Office, Effects of Using Generic Drugs on Medicare's Prescription Drug Spending, September 2010.

Visante estimated the prescriptions associated with PBM tools based on data published by IMS Health. In 2010, approximately 3.7 billion prescriptions were filled at chain pharmacies, independent pharmacies, food stores, mail-service pharmacies, and specialty pharmacies. That year, approximately 20% of prescriptions were filled at mail-service pharmacies. The mail figure reflects our estimates of "normalized mail-service prescriptions." That is, one mail-service prescription for a 90-day supply is adjusted to become three "normalized prescriptions" for a 30-day supply.

After these calculations, we estimate that 2012 outpatient prescription drug expenditures associated with PBM tools, including plan sponsor and consumer payments, are approximately $165 billion for the commercial market and $85 billion for Medicare Part D. Over the 2012-2021 period, these figures are $2.3 trillion for the commercial sector and $1.2 trillion for Medicare Part D. Note that more PBMs are playing a management role in physician-administered drugs covered by Medicare Part B and that our baseline or savings estimates don't reflect such activity.

As discussed, CMS's 10-year projections reflect many assumptions regarding marketplace trends. We believe that CMS estimates reasonably capture these trends and reflect the current savings that PBMs achieve in the marketplace. CMS does not publish the detailed factors underlying its model, so we estimated the factor inputs necessary to model PBM savings and then applied them to baseline expenditures derived from CMS data.

We used data from IMS Health[14] to separate drug trend into key sub-components such as the number of prescriptions, the generic dispensing rate (GDR), the mail-service pharmacy penetration rate, and other measures, all detailed below. We also estimated trends in these components based on data published in PBM drug trend reports[15] and other sources.

We assume that over the 10-year projection period:

- Total prescription utilization will grow by 2% to 3% annually
- The generic dispensing rate (GDR) will exceed 80% by 2015
- Brand prices will increase 5% to 10% per year while generic prices will remain relatively flat
- The specialty pharmacy market will grow much more rapidly than the market for traditional prescription drugs, expanding from an estimated $35 billion in 2010 to $160 billion in 2021

Again, we assume that these trends are similarly captured in the CMS projections.

[14] IMS Health, The Use of Medicines in the United States: Review of 2010, April 2011; IMS Health, Channel Distribution by Prescriptions, April 2011.
[15] CVS Caremark, Insights 2011, 2011; Express Scripts, Drug Trend Report, 2011; Medco, Drug Trend Report, 2011.

Developing a Model of PBM Savings

Using the 10-year projections described above, we then developed an economic model to determine ranges of PBM savings relative to unmanaged drug expenditures. We did this by adjusting key variables to reflect potential changes in the level of PBM management. These ranges let us estimate the average savings that PBMs have generated—as well as both limited and best-practice savings estimates depending on the approach of different plan sponsors. For our savings model, we assume that the NHE projections reflect the "average" level of PBM savings.

Our economic model is based on a review of the evidence associated with broad savings categories. These include manufacturer price concessions and pharmacy discounts, use of generics and preferred brands, and utilization management and adherence programs.

Evidence and Estimates of Manufacturer Price Concessions and Pharmacy Discounts

The broad category of price concessions and pharmacy discounts comprises pharmacy network discounts, mail-service pharmacy discounts, specialty pharmacy discounts, and manufacturer rebates.

- **Pharmacy Network Discounts:** In 2003 the GAO reported that the average price PBMs negotiated for retail-pharmacy drugs was about 18% below the average retail-pharmacy cash price for brand drugs and 47% below for generic drugs.[16] Moreover, in 2005 the FTC reported that customers without insurance paid 15% more for brand-name drugs than did customers with insurance.[17] Average Wholesale Price (AWP) discounts for brand drugs were approximately 15% from 2002 to 2004, so the AWP discount correlates well with savings below unmanaged cash prices. Meanwhile, the AWP discounts in pharmacy network contracts have increased to 17% to 18%.[18] But for generic drugs, the discount programs many pharmacies have introduced during the past five years have substantially narrowed the gap between retail cash prices and the network discount prices that PBMs have negotiated.

- **Mail-Service Pharmacy Discounts:** Mail-service pharmacies offer significant discounts over retail pharmacies. According to the GAO, "With deeper discounts and no dispensing fees, mail-order/home-delivery prices are 27% and 53% below the average cash price customers would pay at a retail pharmacy for brand name and generic drugs, respectively."[19] A survey of PBM clients finds mail-service discounts of 23.3% off AWP for brand drugs (6 points better than retail) and 53.5% for generics (7 points better than retail).[20] Another survey of managed care organizations has similar results, with mail-service discounts 6 points better than retail networks.[21] What's more, 79% of surveyed

[16] Government Accountability Office, Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies, January 2003.
[17] Federal Trade Commission, Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies, 2005.
[18] Pharmacy Benefit Management Institute, Prescription Drug Benefit Cost and Plan Design Report, 2010-2011.
[19] Government Accountability Office, op. cit.
[20] Pharmacy Benefit Management Institute, op. cit.
[21] Novartis, "Pharmacy Benefit Report: 2010/2011 Facts, Figures, & Forecasts," 2011.

PBM clients pay no dispensing fees,[22] which adds 1 percentage point of savings for brands and 4 points for generics. However, mail-service penetration is also a crucial variable in predicting mail-service savings. While IMS data suggest that about 20% of prescriptions are filled at mail[23] (adjusted so that one 90-day prescription is normalized to three 30-day prescriptions), PBM drug trend reports indicate that plan sponsors can achieve mail-service penetration of up to 50% or more.[24]

- **Manufacturer Discounts and Rebates:** PBMs negotiate price concessions with pharmaceutical manufacturers on selected brand-name drugs. A CBO analysis published in 2010 notes that rebates for Medicare Part D are approximately 14%[25]; the investment research firm Sector & Sovereign Research estimates that in 2009, rebates for private plan sponsors averaged 14.3% of brand prescription costs.[26] Since brand costs account for almost 75% of the total, this translates to an overall discount on total drug spend of more than 10%. An OIG report published in March 2011 supports this estimate, with rebates of approximately 10 percent of total gross Part D drug costs.[27] Most recently, the OIG estimated Medicare Part D rebates for just the top 100 brands at 19%.[28] However, other sources estimate slightly lower rebates. A 2005 Federal Trade Commission report estimated rebates of 7.5% on average brand prescription costs for 2003.[29]

- **Specialty Pharmacy:** PBMI reports that specialty pharmacy discounts are approximately 1 percentage point higher than those for retail, with an average 18.7% discount off AWP.[30]

Since the average PBM savings is included in the base economic model projections, the savings compared to unmanaged drug expenditures are easily calculated. We simply remove all discounts associated with pharmacy network contracts, mail-service pharmacies, and specialty pharmacies—and remove all manufacturer rebates—to determine drug expenditures based on undiscounted prices.

We base assumptions for retail/mail/specialty discounts on PBMI reported values for limited, average, and best-practice in each channel.[31] Mail-service penetration is estimated at a minimum of 0% in plans with no mail-service benefit, 20% (measured as normalized prescriptions) for average plans, and up to 50% for plans with high mail-service-pharmacy use. Rebates for average plans were estimated at 11% of expenditures on brand drugs.

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[22] Pharmacy Benefit Management Institute, op. cit.
[23] IMS Health, Channel Distribution by Prescriptions, April 2011
[24] CVS Caremark, op. cit.
[25] Congressional Budget Office, op. cit.
[26] "Drug Prices Rise Despite Calls for Cuts," *The Wall Street Journal*, March 17, 2011.
[27] Department of Health and Human Services, Office of Inspector General, "Concerns With Rebates in the Medicare Part D Program," March, 2011.
[28] Department of Health and Human Services, Office of Inspector General, "Higher Rebates For Brand-Name Drugs Result In Lower Costs for Medicaid Compared to Medicare Part D," August 2011.
[29] Federal Trade Commission, op. cit.
[30] Pharmacy Benefit Management Institute, op. cit.
[31] Ibid.

The September 2009 change in published AWP has altered the technical calculations of contract discounts and pharmacy prices. We assume, however, that the fundamental market dynamics remain unchanged, with approximately the same net discounts off pharmacy cash price.

Based on this evidence and methodology, Visante calculates the following savings from price concessions and discounts:

Figure 2: Range of Possible PBM Savings vs. Unmanaged Expenditures Through Manufacturer Price Concessions and Pharmacy Discounts

Limited	Average	Best-practice
16% to 22%	22% to 28%	28% to 32%

Source: Visante, 2011

Evidence and Estimates of PBM Impact on Use of Generics and Preferred Brands

PBMs implement a variety of tools and techniques to promote generics and more-affordable brands. These tools include formularies, tiered copays, prior authorization, step therapy programs, generic incentives, and consumer education. GAO reported that plan savings for these PBM intervention techniques ranged from 1% to 9% of total spending on prescription drug benefits.[32]

According to IMS Health, approximately 75% of all drug prescriptions in 2010 were filled with generics, but brands still accounted for almost 75% of drug expenditures.[33] Generic dispensing rates (GDR) have increased significantly during the past few years, due to patent expirations for blockbuster brands and PBM strategies to maximize the new generics. Indeed, while most plans report GDRs of 70% to 75%, some have reported close to 80%[34] or above.[35] Key data on how PBM tools can shift drug mix toward more affordable products includes the following:

- **Generic Substitution:** Most plans now require generic substitution whenever possible. A survey of health plans indicates that generic substitution rates (i.e., how often a generic product is dispensed when available as a brand alternative) are more than 96% for commercial plans.[36] PBM research has suggested that plans can save from 6% to 10% when requiring clinically appropriate generic substitution.[37] A peer-reviewed study showed that mandatory generic substitution in a two-tier plan cut drug spending by 8%.[38] Other data suggest that mail-service pharmacies increase generic substitution. Within the first week of the introduction of generic zolpidem, one mail-service pharmacy achieved a

[32] Government Accountability Office, op. cit.
[33] IMS Health, op. cit.
[34] CVS Caremark, op. cit.
[35] Pharmacy Benefit Management Institute, op. cit.
[36] Novartis, "Pharmacy Benefit Report: 2010/2011 Facts, Figures, & Forecasts," 2011.
[37] Kaiser Family Foundation, "Cost Containment Strategies for Prescription Drugs: Assessing the Evidence in the Literature," March 2005.
[38] Joyce, et al., "Employer Drug Benefit Plans and Spending on Prescription Drugs," *JAMA*, 288:1733-1739, 2002.

generic substitution rate of 97%, compared with a 77% substitution rate over the same period at retail pharmacies.[39]

- **Formularies and Therapeutic Interchange:** CBO examined potential substitution for seven therapeutic classes identified by Medicare. It concluded that if generics rather than single-source brand-name prescriptions had been used, prescription drug costs in 2007 would have fallen by $4 billion—or 7% of total payments to plans and pharmacies that year.[40] PBM research suggests savings of 1% to 5% through therapeutic substitution.[41]

- **Step Therapy:** These programs apply clinical guidelines to encourage use of a preferred, first-line drug before a more expensive, second-line drug. Many plans report using step-therapy programs in 2009-10, and more plans—91% of commercial (up from 86% in 2009) and 83% of stand-alone PDPs (up from 75% in 2009)—forecast using such programs in 2011.[42] One study examined step-therapy for three classes: proton pump inhibitors (for ulcers), selective serotonin reuptake inhibitors (for depression), and nonsteroidal anti-inflammatory drugs (for pain). The plan sponsor experienced a decrease in net cost after implementing step therapy, while the comparison group had an increase. This translated to a savings of approximately 2.3% of total drug spend.[43] Another study evaluated step therapy for antihypertensive drugs, and found that drug costs were 13% lower for the patients in the step therapy intervention group.[44]

- **Copay Tiers:** During the past 5 to 10 years, plan sponsors have dramatically increased the use of 3-tier copay structures to encourage greater use of generics and preferred brands. The implementation of tiered copays has created more aligned incentives for consumers. One study examined the addition of a three-tier copay, with relatively modest copays of $8/$15/$25. Payer costs dropped 17%, with 10% attributed to the absolute increase in copayments and 7% to the utilization and lower cost of substituted drugs.[45] Another peer-reviewed study demonstrated that adding a third copayment of $30 for non-preferred brand drugs to a two-tier plan ($10 generics, $20 brand) lowered overall drug spending by 4%.[46]

- **Consumer Education:** PBMs deliver various educational materials to increase consumer understanding of their pharmacy benefit. PBMs may include additional incentives in their pharmacy network contracts to achieve improved formulary compliance and use of generic alternatives. A PBM study estimated that it can save up to 4% from generic incentives and education.[47]

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[39] Medco, op. cit.
[40] Congressional Budget Office, op. cit.
[41] Kaiser Family Foundation, op. cit.
[42] Novartis Pharmacy Benefit Report: 2010/2011 Facts, Figures, & Forecasts
[43] Motheral, et al., "Plan-Sponsor Savings and Member Experience With Point-of-Service Prescription Step Therapy," *AJMC*, July 2004.
[44] Yokoyama, et al., "Effects of a step therapy program for angiotensin receptor blockers on antihypertensive medication utilization patterns and cost of drug therapy," *J Manag Care Pharm* 2007 Apr;13(3):235-44.
[45] Motheral, et al., "Effect of Three-Tier Prescription Copay on Pharmaceutical and Other Medical Utilization," *Medical Care*, 39(12): 1293-1304, December 2001.
[46] Joyce, et al., op. cit.
[47] Medco, op. cit.

- **Specialty Pharmacy:** While this segment currently offers limited opportunities to promote generics, managing specialty drug mix is still important. Specialty drug categories in which formulary-preferred brands are most often selected include: growth hormone, multiple sclerosis, rheumatoid arthritis, blood modifiers, and hepatitis C. In one plan, a specialty pharmacy increased market share of the formulary-preferred human growth hormone from 27% to 82% within 12 months, generating savings of 20% in this expensive category.[48]

In our model, we adjusted drug mix to reflect a higher or lower dispensing of cheaper alternative drugs, primarily generics and preferred brands.

To calculate the additional cost associated with unmanaged drug mix, we reduced the generic dispensing rate (GDR) in the current projections by 8 points (based on lower GDRs observed in plans with limited management, as well as fee-for-service Medicaid). We also assumed greater use of higher-cost brands in an unmanaged environment. The net result indicates that drug mix delivers 11% to 16% of savings for the average PBM-managed plan vs. unmanaged drug expenditures.

To model a best-practice-savings scenario, we estimate that lower-cost drug alternatives could be used in place of 30% of brand prescriptions in an average savings environment. Of these lower cost alternatives, approximately two-thirds could be generics and one-third formulary-preferred brands. A high-performing plan could increase GDR by 5 percentage points, which correlates to best practice GDRs reported by PBMs.[49] Similarly, limited PBM management will reduce GDR by approximately 5 percentage points.

Based on this evidence and methodology, Visante calculates the following savings from managing drug mix to encourage the use of generics and preferred brands:

Figure 3: Range of Possible PBM Savings vs. Unmanaged Expenditures Through the Use of Generics and Preferred Brands

Limited	Average	Best-practice
7% to 11%	11% to 16%	16% to 20%

Source: Visante, 2011.

Evidence and Estimates of Utilization Management and Adherence Programs

PBMs provide tools that tend to reduce utilization by eliminating waste and polypharmacy. They also use tools that may increase utilization through improved adherence to drug therapy for chronic disease.

[48] "Specialty Pharmacy: Historical Evolution and Current Market Needs," presented at PCMA Specialty Pharmacy Symposium, May 5, 2008.
[49] CVS Caremark, op. cit.

- **Utilization Management:** Drug utilization review (DUR) programs improve quality and safety by preventing drug duplication, drug interactions, and polypharmacy. Such programs also reduce dangerous over-utilization of prescription drugs. Numerous studies have documented drug cost savings associated with DUR programs. One peer-reviewed study examined DUR programs and found average savings of 6.9% on total drug spend.[50] Other PBM tools that help reduce excess utilization include:

  - ✓ *Refill Too Soon:* According to one survey, the most common plan-sponsor tool—used by 89%[51]—is a "refill too soon supply edit." Such an edit triggers if, say, a pharmacy dispenses a 30-day supply of medication and the patient tries to refill it 10 days later.

  - ✓ *Quantity Limits:* Managed care organizations report using quantity limits more than 50% of the time for the top 19 drug categories.[52] PBM research notes that plan exclusions, including specific drug limits and general limitations, can save up to 1% of drug spend.[53]

  - ✓ *Prior Authorization:* Prior authorization (PA) ensures that a prescription drug meets clinical guidelines before it is dispensed. One study looked at 22 states that implemented prior authorization programs for Cox-2 inhibitors, non-steroidal anti-inflammatory drugs (NSAID). With nearly 18 million NSAID prescriptions covered by Medicaid in 2003, PA reduced the annual cost of these prescriptions by $185 million, lowering total drug spend by 0.6% in this drug category alone.[54]

- **Patient Adherence:** PBM tools for increasing clinical quality and patient health may increase the numbers of prescriptions. This can occur in the PBM programs focused on ensuring that patients adhere to prescribed drug therapies for such chronic diseases as diabetes, hypertension, and heart failure. Numerous studies have demonstrated that improved patient adherence delivers improved clinical outcomes and greater value. A recent study quantified savings for adherent patients with congestive heart failure, high blood pressure, diabetes, and high cholesterol, indicating that they may save the health care system as much as $7,800 per patient annually.[55] (Note that modeling non-drug medical savings was beyond the scope of this study.) Research has shown that 90-day supplies filled via mail-service, with lower copays—combined with refill reminders, auto-refills, patient education, and other adherence strategies—can improve adherence by approximately 8 percentage points.[56,57] Adherence programs have historically focused on mail-service pharmacy, however some evidence suggests that adherence can also be

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[50] Moore, et al., "Systemwide Effects of Medicaid Retrospective Drug Utilization Review Programs," *Journal of Health Politics, Policy and Law*, Volume 25, Number 4, August 2000, pp. 653–688.
[51] Pharmacy Benefit Management Institute, op. cit.
[52] Novartis Pharmacy Benefit Report: 2010/2011 Facts, Figures, & Forecasts.
[53] Medco, op. cit.
[54] Fischer, et al., "Medicaid Prior-Authorization Programs and the Use of Cyclooxygenase-2 Inhibitors," *New England Journal of Medicine*, 2004; 351:2187-2194, November 18, 2004.
[55] Roebuck, et al., "Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending," *Health Affairs*, 30(1), 2011.
[56] Express Scripts, "Is Compliance Really Better in Home Delivery? Evidence Across Three Chronic Therapy Classes," 2008.
[57] Duru, et al., "Mail-Order Pharmacy Use and Adherence to Diabetes-Related Medications," *Am J Managed Care*,16(1):33-40, 2010.

improved using similar strategies at retail pharmacies,[58] particularly with 90-day-at-retail prescriptions increasingly being incorporated into pharmacy benefit designs. The fulfillment of a 90-day supply of drugs from network retail pharmacies was offered in 2009 by 58% of commercial plans and by more than 90% of stand-alone Medicare PDPs. An additional 9% of surveyed plans intended to introduce it in 2010 or 2011.[59]

- **Specialty Pharmacy:** Utilization management and patient adherence programs play an important role in specialty pharmacy. One specialty pharmacy, for instance, identified inappropriate utilization according to nationally recognized clinical guidelines for six therapy categories. Applying these clinical guidelines with 52 clients cut costs by 24% in these categories.[60] Specialty pharmacies can also reduce product waste by eliminating excessive quantities of expensive pharmaceuticals. One specialty pharmacy demonstrated that hemophilia assay management and waste reduction reduce expenditures 7.7%, that Revlimid dose optimization saves 6.6%, and that a Synagis waste reduction program saves 1%.[61] Patient adherence is often crucial to successful therapy in diseases related to specialty pharmacy (e.g., multiple sclerosis, hepatitis C). Patients taking hepatitis C medications delivered through a specialty pharmacy were significantly more adherent (90%) to therapy than were patients receiving medications through a retail pharmacy (49%), as measured by their prescription refill rate.[62]

Visante estimates that for a plan with average use of PBM tools, utilization management programs reduce prescription volume by approximately 1% to 2%, while typical adherence programs increase prescription volume by 1% to 2%. The programs each offset the other in drug costs but improve clinical quality and potentially cut non-drug medical costs.

Because pharmacies and pharmaceutical manufacturers have an economic incentive to promote patient adherence in order to increase prescription volume, we assume that half the adherence impact would be present for an unmanaged benefit, yielding a potential net 2% to 3% increase in utilization for adherence programs in a managed environment.

The use of PBM drug-utilization tools depends on plan-sponsor goals. Plan sponsors that focus primarily on prescription cost management may choose utilization management programs without adherence programs, thereby cutting utilization by up to 2%. Other plan sponsors may be more interested in improving patient adherence. We know of no plan sponsors that have implemented maximum adherence with no utilization management, so the lower range is defined by maximum adherence (an approximately 2% to 3% increase) combined with maximum utilization management (an approximately 1% to 2% decrease). Based on this evidence and methodology, Visante calculates the following savings from utilization management:

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[58] Cutrona, et al., "Modes of Delivery for Interventions to Improve Cardiovascular Medication Adherence," *Am J Managed Care*, 2010; 16(12):929-94, 2010.
[59] Novartis, "Pharmacy Benefit Report: 2010/2011 Facts, Figures, & Forecasts," 2011.
[60] Specialty Pharmacy.... Needs," op. cit.
[61] Ibid
[62] McDermott, et al., "Adherence to Hepatitis Treatment Based on Refill Rates, A Comparison between Curascript and Retail Pharmacy," Poster Presentation AMCP Spring 2005 Annual Meeting, 2005.

Figure 4: Range of PBM Savings vs. Unmanaged Expenditures Through Utilization Management and Adherence Programs

Limited	Average	Best-practice
0% to 1%	-1% to 1%	-1% to 2%

Source: Visante, 2011

Evidence and Estimates of Administrative Efficiencies

PBMs have created the most efficient claims processing system in the health care industry. No other health care segment (physicians, hospitals, long-term care, home care, etc.) can yet duplicate the PBM system's speed and low cost. In the 1980s, PBMs essentially wired the country to connect online with every pharmacy in the nation. This connectivity and online claims processing system allows each prescription claim to be adjudicated in seconds with great cost efficiency.

PBM-pioneered systems also speed vital information and data to pharmacists. For example, if a patient uses multiple pharmacies, the PBM system can compare the new prescription with the patient's entire claims history across all pharmacies, identify a potentially dangerous drug-drug interaction, and alert the pharmacist before the new prescription is filled. No other U.S. health care segment has been able to replicate this innovation.

PBMs also use advanced computer algorithms and auditing techniques to efficiently detect and combat fraud, waste, and abuse. Most PBMs screen for fraud, waste, and abuse both before and after a claim is paid and problem claims can often be detected automatically.

PBM fees are low compared with the value of PBM services. GAO reported PBM fees from Federal Employee Health Benefit Program (FEHBP) plans for various administrative and clinical services, including processing claims and drug utilization reviews. These administrative fees, which varied by plan depending on contracted services, accounted for an average of about 1.5% of each plan's total drug benefit spending.[63] However, the FEHBP represents an extremely large PBM client, likely to pay relatively low fees compared with other clients. Therefore, fees for average PBM clients are assumed to be higher. According to financial reports from the three largest PBMs, Earnings Before Interest, Depreciation, Taxes and Amortization (EBIDTA) accounts for 3% to 5% of total revenue (i.e., drug spend).[64] Visante assumes that administrative costs account for approximately 3% to 5% of managed drug spend.

[63] Government Accountability Office, op. cit.
[64] Securities and Exchange Commission, Forms 10-Q, CVS Caremark, Express Scripts, Medco Health Solutions, 2011.

Projecting Limited/Average/Best-Practice PBM Savings

To project average PBM savings relative to unmanaged expenditures, we must first project potential drug expenditures with no pharmacy benefit management (unmanaged expenditures). We combined estimated percentage savings for average PBM management with our estimation of baseline expenditures managed by PBMs, derived from CMS data (which already reflect this level of savings). We then subtracted current drug expenditures from unmanaged drug expenditures to derive average PBM savings.

Based on the sources and methodology above, Visante estimates savings of approximately 20% with limited use of PBM tools and up to 50% with high use of PBM tools (i.e., best practices).

Figure 5: Estimated Ranges of PBM Savings vs. Unmanaged Expenditures By Level of PBM Management and Savings Category

Savings Category	Level of Pharmacy Benefits Management		
	Limited	Average	Best-practice
Manufacturer Price Concessions and Pharmacy Discounts	16% to 22%	22% to 28%	28% to 32%
Encouraging Generics and Preferred Brands	7% to 11%	11% to 16%	16% to 20%
Utilization Management and Adherence Programs	0% to 1%	-1% to 1%	-2% to 2%
TOTAL*	**20% to 30%**	**30% to 40%**	**40% to 50%**

* Reflects combined savings ranges less 3%-5% administrative costs

Source: Visante, 2011.

Using the midpoints for the estimated ranges of limited, average, and best-practice use of PBM tools, we calculate the 10-year projected savings for each of these three scenarios:

Figure 6: Projected Ten-Year Drug Expenditures Under Various Scenarios (Dollar figures in trillions)

Category of Drug Expenditures	Level of Pharmacy Benefits Management			
	None	Limited	Average	Best Practice
Private Insurance	$3.6	$2.7	$2.3	$2.0
Medicare	$1.9	$1.4	$1.2	$1.1
All PBM-Administered Drug Expenditures	**$5.5**	**$4.1**	**$3.6**	**$3.0**

Source: Visante, 2011

Estimating the Cost of Jobs Covered by PBM Savings

The Bureau of Labor Statistics (BLS) estimates that total compensation costs per hour for private industry workers was $28.13 in June 2011.[65] This figure was multiplied by 2,080 hours (40 hours per week, 52 weeks per year) to derive 2011 total compensation costs of $58,510 per full time equivalent (FTE) job. This figure was inflated by 2.3%, the most recent 12-month change in the Employment Cost Index (ECI) for private industry workers (June 2010 to June 2011), to project 2012 compensation costs of $59,872 per FTE job. This figure was used as the cost of a job in the in 2012.

Savings generated by PBMs for the commercial sector were derived by multiplying the midpoint of our estimated average PBM savings (35%) by 2012 private-insurance drug expenditures of $122.8 billion estimated by CMS. This figure was divided by the cost of a FTE job in 2012 to derive that 717,691 jobs could be covered by savings generated by PBMs in 2012. We then similarly calculated how jobs could be paid for at best-practice and limited PBM savings levels.

If all commercial plan sponsors choose best practices recommended by PBMs in 2012, the resulting savings would cover the cost of 922,476 jobs, an increase of more than 200,000 jobs from those covered if plan sponsors continued at an average-level of PBM savings. Similarly, if plan-sponsor choices or government policies limit the use of PBM tools, lost savings would equal the cost of 200,000 jobs.

[65] Bureau of Labor Statistics, op. cit.

IV. Conclusion

PBM tools provide substantial savings to plan sponsors and consumers. Plan sponsors balance controlling costs against minimizing change for their members, all while ensuring access to needed care. Savings can range from 20% with limited use of PBM tools to 50% with best practices. At current use, PBM tools will save almost $2 trillion over the next decade. In addition to these expected savings, an additional $550 billion could be saved if all plan sponsors adopted best practices. Likewise, $550 billion could be lost if PBM tools are limited by government policies or other factors. Much is at stake, as PBM savings could help employers to preserve hundreds of thousands of jobs over the next 10 years.

Mr. GOODLATTE. Mr. Snow, welcome. We are pleased to have your testimony.

TESTIMONY OF DAVID B. SNOW, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, MEDCO HEALTH SOLUTIONS, INC.

Mr. SNOW. Chairman Goodlatte, Ranking Member Watt, Members of the Committee, thank you for this opportunity to discuss the proposed merger of Medco Health Solutions and Express Scripts. My name David Snow, and I am the chairman and CEO of Medco Health Solutions. Medco is an industry leader in pharmacy that employs over 3,000 skilled pharmacists. We develop innovative solutions that deliver unique value to private and public employers, health plans, labor unions, and government agencies of all sizes, as well as individuals served by Medicare Part D drug plans.

Everyone recognizes that the ever-rising cost of health care in America is unsustainable. As the health care industry necessarily focuses on reducing costs without compromising patient care, we all face the irrefutable fact that we must do more with less.

The services that PBMs provide are very much part of the solution. By merging Medco with Express Scripts, we will significantly accelerate our efforts to reduce overall costs in the health care system and improve the quality and efficiency of care delivery.

To understand the value of the combination of our two companies, it is critical to recognize the dynamic marketplace in which we operate. Our competitors include some 40 PBMs, household names like Aetna, and Cigna, and CVS Caremark, and others who may not be so well known but continue to make major investments, like Prime Therapeutics, Catalyst, SXC, and perhaps most significantly UnitedHealth Group, who has announced its plans to take in house the 14 million lives previously served by Medco in order to increase its investment in its own PBM, Optum Rx.

As these few quick examples demonstrate, competition for PBM services is intense and diverse, and new entry remains a very real prospect. That competition will only be enhanced by the Express Scripts-Medco merger.

It was within the context of this competitive marketplace that the merger of our two companies was conceived. The essence of the PBM business is to bring lower drug prices and higher-quality care to patients, employers and taxpayers. The combination of Medco and Express Scripts will accelerate our efforts to achieve that goal in a number of ways. I will just mention two: volume and improved clinical practices.

First, our combined entity will be able to lower drug and patient-user costs by achieving even greater discounts from drug manufacturers, thereby lowering costs to consumers and employers. In fact, under the terms of our existing employer contracts, the ones that we have in place today, $1 billion in savings will be passed back to our clients, guaranteed.

And second, the merger will create synergies by combining the best of our complementary patient-centered clinical care programs. We are particularly proud of Medco's specially trained pharmacists who use clinical protocols and in-depth counseling to help chronically ill Americans to most appropriately and safely manage their highly complex conditions. The result? An estimated $900 million in savings from reduced hospitalizations and associated costs last year. But we have only scratched the surface. We as a Nation could

save a total of over $350 billion a year by addressing medications that are underprescribed, misprescribed or simply not taken as directed by their physician.

Taken together, the merger will help government, businesses and the economy as they jointly confront the necessity to decrease the cost of entitlement programs, thus reducing the overall deficit and increasing job growth. As is the case with the private sector, better management of costs within the Medicare and Medicaid programs can achieve savings without the need to reduce benefits. And at 12 percent of payroll, health care is the most costly benefit expense for employers. Improving outcomes while reducing costs is the definition of doing more with less, and it will make our Nation's businesses more competitive and successful.

We recognize that many have voiced concern about the impact of an Express Scripts-Medco merger on retail pharmacies, particularly on independent pharmacies. More than 85 percent of Medco customer prescriptions are filled through our network of over 60,000 retail pharmacies nationwide. There is nothing we plan to do that will change this. As our written testimony details, we are proud that our partnership with the community pharmacist has provided technology and information that have helped independent pharmacies protect and grow their business in an environment that favors national chains and big box retailers.

The examples I have provided today clearly demonstrate that our health care system does best when many different companies and different models are all working to improve patient health. This diversity of approaches breeds innovation and collaboration. It is a catalyst for experimentation and progress, often leading to breakthrough solutions.

We all know the future belongs to those who deliver more for less. Together Express Scripts and Medco will build a strong, competitive company that helps millions of people to live longer, healthier lives, while supporting the Nation's goal of a sustainable, affordable health care system.

Mr. Chairman, Ranking Member Watt and Members of the Committee, thank you for listening to my testimony, and I would be happy to answer any questions you may have.

Mr. GOODLATTE. Thank you, Mr. Snow.

[The prepared statement of Mr. Snow follows:]

Prepared Statement of David B. Snow, Jr., Chairman and Chief Executive Officer, Medco Health Solutions, Inc.

I. INTRODUCTION

Chairman Goodlatte, Ranking Member Watt and Members of the Committee, thank you for this opportunity to discuss the proposed merger of Medco Health Solutions and Express Scripts. My name is David Snow, and I am the Chairman and CEO of Medco Health Solutions. Medco is a leading health care company that has pioneered the world's most advanced pharmacy. When we originally became a public company, our goal was to leverage the power of pharmacy to redefine the way that health care is delivered—to improve patient outcomes and lower costs. Today, we define that mission in three words, "making medicine smarter."

We are an industry leader in developing innovative solutions that deliver unique value to our clients and their members. We provide clinically driven pharmacy services designed to improve the quality of care and lower total health care costs for private and public employers, health plans, labor unions and government agencies of all sizes, as well as for individuals serviced by Medicare Part D Prescription Drug Plans.

Everyone has recognized that the ever-rising costs of the health care system in America are unsustainable. In 2010, U.S. spending for prescription drugs alone was more than $300 billion and is expected to reach more than $450 billion by 2019.[1,2] As the health care industry necessarily focuses on reducing costs; as the "Super Committee" seeks to find health care savings without compromising patient care; and as all participants in the system are faced with the prospect of doing more with less, we believe that the services that Medco provides are part of the solution. And now, by joining with Express Scripts and combining the complementary expertise of the two companies, we will be able to significantly accelerate efforts to reduce overall costs in the health care system and improve the quality and efficiency of care delivery.

II. MEDCO BACKGROUND

Our mission to make medicine smarter truly defines our company and guides our business strategy. In 2011, Medco captured the number one position in the Health Care: Pharmacy and Other Services sector on Fortune's World's Most Admired Companies List for the fourth consecutive year. In this sector, Medco ranked number one in all nine attributes: innovation, use of corporate assets, social responsibility, quality of management, financial soundness, quality of products and services, people management, long-term investment and global competitiveness.

Our services are designed not only to reduce drug costs, but also to close gaps in pharmacy care. We reduce drug costs for our clients and their members in a variety of ways including: maximizing the substitution rate from expensive brand-name drugs to lower-cost clinically equivalent generic drugs; driving competitive discounts and rebates from brand-name and generic drug pharmaceutical manufacturers; minimizing the cost and improving the accuracy of filling prescriptions; and applying our sophisticated service innovations to efficiently administer prescription dispensing through our mail order pharmacies. By utilizing advanced clinical tools to encourage adherence and drawing on real-time prescription drug and medical databases in a truly wired fashion, we improve patient health and reduce total medical spending levels.

Our business model requires collaboration with payors, retail pharmacies, including independent pharmacies nationwide, physicians, pharmaceutical manufacturers and CMS for Medicare and state Medicaid agencies. We provide our services through our national networks of retail pharmacies and our own mail order pharmacies, as well as through our specialty pharmacies.

Our unique Medco Therapeutic Resource Centers conduct therapy management programs using Medco Specialist Pharmacists who have expertise in the medications used to treat the most prevalent and costly chronic conditions. Our personalized medicine capabilities through our Medco Research Institute™ and genomics counseling services foster the integration of genetic information into everyday health care decision making. These services represent innovative and successful models for the care of patients with chronic and complex conditions.

III. DYNAMIC MARKETPLACE

The business of pharmacy benefit managers (PBMs) is defined by robust competition, with more than 40 PBMs working hard to provide differentiated value propositions for public and private payors. These firms are a diverse group with very different business models and varying degrees of vertical integration, some integrated with pharmacies, others integrated with managed care organizations and others entirely independent. Nine Fortune 500 companies operate their own PBMs. Non-PBM participants like Wal-Mart and Target also contribute meaningfully to the competitive landscape by offering low-price generic prescriptions, as do other retail pharmacies that are providing steep discounts on 90-day prescriptions.

Whatever customer group you might define, there are numerous PBMs currently serving accounts and many more with the capability to do so. This is because the core services offered by PBMs are similar regardless of the size and nature of a client's business. For example, in the context of the largest accounts, more than 10 PBMs currently serve state accounts; at least 10 PBMs serve Fortune 50 companies.

Our competitors often are major industry participants with household names like Aetna, Cigna and CVS Caremark. Other competitors may not be so well-known but

[1] IMS Institute for Healthcare Informatics' study, "The Use of Medicines in the United States: Review of 2010," April 2011.

[2] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2010.

continue to make major investments to grow and to better serve current and potential customers.

For example, Catalyst acquired Walgreens' PBM in June, more than doubling its number of members and prescriptions. In a recent earnings call, Catalyst's COO highlighted the company's recent success in winning large, national employers during this selling season—and this was even before the acquisition. Several of Catalyst's recent wins came against Medco and Express Scripts for Fortune 500 firms. These wins have allowed them to add big name companies like Ford Motor Company, MGM Mirage International, Whirlpool and Waste Management to their growing roster of Fortune 500 customers—a list that already included companies like Nike, Sprint, Southwest Airlines and Lear Corporation.

Prime Therapeutics recently won from Medco the Blue Cross and Blue Shield of North Carolina account with more than a billion dollars in drug spending. Prime was originally formed by Blue Cross entities and has expanded from the PBM inside the private label offering of the Blues to becoming a major independent customer.

And just last month, another notable merger was announced: SXC Health Solutions agreed to acquire PBM PTRx and mail order pharmacy provider SaveDirectRx, again illustrating the constantly evolving nature of the market. At one time SXC was thought of as more of a data processor for PBMs and other health organizations. They have evolved with the marketplace and now offer a full service PBM capable of competing effectively. The company, which this year jumped to number one on Fortune's 100 Fastest-Growing Companies list, has also captured more than a billion dollars in drug spend with its Bravo Health victory.

Perhaps nothing more clearly demonstrates the dynamic character of the PBM business than the evolution of our soon-to-be former customer UnitedHealth Group, now the largest single health carrier in the U.S. UnitedHealth used to have its own PBM business but sold it in the early 1990's. They became a Medco customer in 2000, and over the years Medco facilitated a private label PBM offering by UnitedHealth that had Medco "inside" running the PBM operation while UnitedHealth was the "outside" face to the customers. In 2005, as part of the PacifiCare acquisition, United acquired Prescription Solutions, a stand-alone PBM. United has steadily built up Prescription Solutions and rebranded it as Optum Rx. This summer it was announced that they would not renew their contract with Medco and would take in-house the 14 million lives previously served by Medco. At the same time, UnitedHealth has publicly highlighted its increased investment in Optum Rx and its intention to serve accounts of all sizes. We now have another major competitor in the marketplace, one that is widely regarded to be a significant force in the market going forward. And, as noted by Optum Rx CEO Jacqueline Kosecoff in a recent interview, the company is "very interested in the employer market and [is] getting very aggressive on bidding some very large accounts."

As you can tell from just these examples, Medco itself is all too familiar with the intensity and diversity of competition for PBM services. We compete against a wide variety of firms, generating a number of wins, as well as some significant losses. New entry remains a very real prospect in this business, one that ensures competition remains strong. Against this backdrop, PBM clients will have plenty of competitive choices post-merger, and the combined Express Scripts and Medco will be fully subject to the competitive pressures that will ensure value-based pricing and service. Taken together, these recent activities demonstrate the dynamic, competitive nature of the PBM marketplace and belie the notion that the combination of Medco and Express Scripts represents a threat to client choice. The reality is that the PBM business is extremely competitive and that competition will only be enhanced rather than diminished by the Express Scripts-Medco merger.

IV. BENEFITS OF THE COMBINATION

It is within the context of this competitive marketplace that the merger of our two companies was conceived and ultimately approved by our management and respective boards of directors. The essence of the PBM's business is to bring lower drug prices and higher quality care to its clients. We compete with one another to provide that value, and as competition becomes more intense in our industry, it drives innovation aimed at doing even more to serve our patients. In the health care industry today, we all share the same goal of reducing costs by improving the quality and efficiency of care delivery.

The combination of Medco and Express Scripts makes strategic sense for our clients and patients. Each company uses a fundamentally different business model to address the needs of customers. Combining the best attributes of those business models will give us an enhanced capability to lower prices and improve quality care for our clients. We will accomplish this in a number of ways.

First, our combined entity will be able to lower drug acquisition costs by improving efficiency across the system and encouraging the most appropriate channels of distribution based on patient needs. Our clients and the consumers we mutually serve will benefit from these savings. For example, Medco negotiates the terms of its agreements with its clients in a fully transparent manner which, at the client's discretion, directs us to pass through discounts and rebates that we negotiate with pharmaceutical manufacturers. Under the terms of our existing contracts alone, $1 billion in savings from the merger will be passed back to our clients.

Second, the combined entity will allow us to further innovate our robust technology platform so we can fully leverage the cost and quality benefits of our fully wired system that seamlessly integrates prescription management at both mail order and retail with our client and member services. This will result in substantial cost savings passed on directly to government, businesses and, ultimately, consumers.

Third, our combined company will bring together advanced capabilities to integrate prescription management, including technological platforms to communicate with pharmacists and physicians in real time, allowing not only efficient claims processing, but also secure access to patient information and drug utilization reviews. Both Medco and Express Scripts complement and enhance physicians' care using advanced clinical services to deliver tailored treatments with the highest levels of efficacy, value and speed. For instance, the Medco Research Institute integrates genetic information into everyday health care decision making—offering patients and providers actionable information to drive more precise health care decisions. One Medco Research Institute study conducted with the Mayo Clinic showed that a simple genetic test reduces hospitalization rates by nearly one-third for patients on warfarin, a widely-prescribed blood thinner. The combined entity will deliver even greater value to the companies' clients and their members by applying the best practices of both companies.

Fourth, the merger will allow the companies to benefit from economies of scale as the firms merge operations and implement each other's best practices. Many aspects of core PBM operations can benefit from economies of scale, including contracting, mail order pharmacy operations, and designing and operating specialized clinical programs. At a high level, our ability to put more volume through a combined network will drive efficiencies that will reduce the unit cost of medications for our patients and customers. Increased scale will also allow the merged company to develop and apply new programs and practices more broadly. And the expanded scale and expertise of the combined firm will allow us to accelerate the research, development and deployment of new and innovative solutions for improving adherence and safety that have the potential go well beyond what each company could accomplish on its own.

Finally, and perhaps most significantly, the Express Scripts–Medco combination will allow the two companies to use their collective and complementary expertise and capabilities, creating unique synergies to close gaps in care, particularly for chronically ill patients. Even the most effective treatments cannot help patients if they are not used properly. Gaps in care related to medication non-adherence affect millions of Americans; they cost dollars and lives. More than 75 percent of all health care costs in the United States are associated with chronic and complex conditions, such as cancer, heart disease, and asthma.[3] In nearly 90 percent of these cases, prescription drugs are considered a first line of defense.[4] However, gaps in care, largely caused by under-prescribed and mis-prescribed medications, as well as patient non-adherence, result in substantial waste each year in the form of unnecessary hospitalizations, emergency room visits, and extended illnesses. Poor management of chronic and complex conditions has lead to an estimated $350 billion in unnecessary health care costs annually.[5]

To address the needs of patients with chronic and complex conditions, Medco's Therapeutic Resource Centers (TRCs) engage members and model behaviors to improve clinical outcomes and reduce costs. In the Medco TRCs, more than 1,000 Medco specialist pharmacists—who have additional training and certification in the medications used to treat the most prevalent and serious chronic conditions and comorbidities—use clinical protocols to assess patients' prescription orders along with barriers to adherence; they provide in-depth counseling to patients as well as reminders to take their prescribed medications. Through use of TRCs, Medco members have achieved significantly higher adherence rates than patients receiving tradi-

[3] Medco Research Data, 2010.
[4] Ibid.
[5] RAND Corporation Study, 2005; Institute for Health and Productivity Management; Medical Care. 2004 Mar; 42(3); 200–209.

tional pharmacy care for a broad range of medication categories. We estimate that in 2010 alone, TRCs closed more than 2.3 million clinical gaps in care with a projected savings of approximately $900 million from reduced hospitalizations, ER visits, and other medical expenses across a range of chronic and complex conditions.[6]

At the same time, through its Consumerology initiative, Express Scripts has applied advanced behavioral science to identify and change common behaviors that prevent patients from adhering to their prescription medications. Their research has also helped to increase generic substitution and increase use of the most efficient and safest delivery channels. Through this initiative, Express Scripts has also increased adherence and achieved significant cost savings.[7]

Combining Medco's expertise in advanced clinical pharmacy with Express Scripts' expertise in behavioral science will create a new entity that is uniquely able to provide significant progress toward closing gaps in care, saving dollars and saving lives. By joining together, millions of members served by both of our companies will reap the benefits of these unique and complementary programs: increased prescription adherence and reduced gaps in care, resulting in better health outcomes and lower costs. And these benefits will help businesses and the economy more broadly. At 12% of payroll, health care is the most costly benefit expense for employers. Reducing the cost of quality patient care will make all American business more competitive—creating a healthier, more productive workforce, preserving existing jobs and creating new jobs in the future.

V. INDEPENDENT PHARMACIES

We recognize that many have expressed concern about the impact of an Express Scripts-Medco merger on retail pharmacies, particularly on independents. The facts are that more than 85% of prescriptions filled for Medco customers are filled through our networks of more than 60,000 retail pharmacies representing over 95% of all retail pharmacies nationwide. In short, either as a stand-alone company or combined with Express Scripts, Medco is dependent on the continued existence of strong independent retail pharmacies. Even as our companies seek to drive efficiency in the health care system, retail pharmacies will always play a crucial, complementary role to PBMs.

Moreover, the services that PBMs provide have helped independent pharmacies better care for their patients, including by helping to close gaps in care, increase patient adherence and reduce adverse drug interactions. The Express Scripts-Medco combination will combine both companies' capabilities aimed at improving patient adherence, which means that the millions of patients who use independent pharmacies will be more likely to complete their full course of prescription treatment, improving their overall health. The combination will also create additional partnership opportunities that can help independent pharmacies improve their customers' adherence while creating new sources of value.

A program implemented by Medco is an example of the type of mutually beneficial collaboration that could be expanded under the merger. Medco's Cognitive Care Initiative, a twenty-six-week collaboration with community pharmacies in Illinois, significantly improved adherence and increased the value offered by participating independent pharmacies. Community pharmacists were trained to provide expert patient counseling on the importance of adherence and techniques to improve it. The initiative identified 2,400 adherence gaps; pharmacists in the program filled 48% more prescriptions after patient counseling and closed 27% more adherence gaps.[8] The success of the pilot led to additional partnerships between Medco and community pharmacists in New Mexico, North Carolina and Florida. We look forward to continued collaboration on initiatives such as this in the days ahead.

In recent years, even as PBMs have become increasingly important participants in the health care system, independent pharmacies have thrived. Between 2009 and 2010, the number of independent community pharmacies grew by almost 400, to more than 23,000, representing a $93 billion industry. Last year, they filled nearly three times more prescriptions than were filled through mail order delivery services such as those offered by Express Scripts and Medco. And pharmacy profits have doubled since 1999, with average profits per pharmacy of close to $1 million.[9] These data points confirm what our experience tells us to be true: PBMs and independent pharmacies are complementary businesses whose success can be mutually beneficial. It is our expectation that a successful Express Scripts-Medco—far from being

[6] Medco 2010 Annual Report.
[7] ESI 2010 Drug Trend Report.
[8] Medco Health Solutions Illinois Pilot Project.
[9] Drug Channels, "Owning a Pharmacy: Still Pretty Profitable," January 25, 2011 (Analysis of 2010 NCPA Digest Data).

a threat to independent pharmacies—will actually be a driver of improved care for our mutual customers and improved economics for their businesses.

VI. CONCLUSION

The data points I have discussed confirm what our market experience has long told us: our health care system does best when many different companies and different models are all working to improve patient health. This diversity of approaches breeds innovation and collaboration. It is a catalyst for experimentation and progress, leading to incremental improvements and often to breakthrough solutions.

Today, there is a sense of urgency among all these many participants in our health care system. We all know the future belongs to those who deliver more for less. The merger of Express Scripts and Medco is part of that transformative process. Together, our companies will focus on lowering the prices customers pay for their medicines and improving their quality of care. And by delivering on that promise we will build a strong, competitive company that helps millions of people to live longer, healthier lives, while supporting the nation's goal of a sustainable, affordable health care system.

Mr. GOODLATTE. Mr. Lech, welcome. We are pleased to have you here today.

TESTIMONY OF JOSEPH LECH, R.Ph., OWNER, LECH'S PHARMACY, AND MEMBER, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Mr. LECH. Thank you.

Good afternoon, Chairman Goodlatte, Ranking Member Watt and Members of the Subcommittee. Thank for conducting this hearing and for the opportunity to share my view regarding the proposed Express Scripts-Medco merger. My name is Joe Lech of Tunkhannock, Pennsylvania. I am the owner of five independent retail community pharmacies in rural northeast Pennsylvania, and have been a practicing pharmacist for 30 years. I am a member of the National Community Pharmacists Association, which represents the pharmacists, owners, managers and employees of more than 23,000 independent community pharmacies across the United States. These pharmacies dispense nearly half of the Nation's retail prescriptions.

I would also like to thank Congressman Marino, my Congressman, for the active role he has taken in trying to level the playing field between community pharmacies and pharmacy benefit managers. In particular we thank him for introducing the Save Our Independent Hometown Pharmacies Act, which has been endorsed both by NCPA and NACDS, the group representing chain pharmacies. Thank you.

As a health care provider, my primary concern is the health and well-being of my patients, and access to prescription medications is essential in maintaining the health of those patients.

As you are aware, Pennsylvania, like many other States, was recently devastated by flooding. Many people in the area where I am from were evacuated from their homes with nothing more than the clothes on their back. The morning after the rain started, the road conditions were so bad that my usual 30-minute commute to the pharmacy took almost 2 hours. As I approached the pharmacy, I saw Mr. Slater, a longtime patron of our pharmacy, standing in front. He and his wife had been plucked from an upstairs window of their home and taken by boat to safety. They were unable to re-

trieve his 16 medications and her 8 that they need on a daily basis. I assured them I would provide them with their prescriptions. But what would happen in cases such as this if pharmacies like mine disappeared from the community that they rely on? The fact is community pharmacies are closing.

This is just one story. There are thousands just like mine of community pharmacies stepping up to assist patients and getting their much-needed prescription medications.

During the recent flooding, Congressman Marino's district office staff got their feet wet, so to say, as they participated with Lech's Pharmacy and Red Cross in prescription and supply deliveries from our pharmacy. Our three pharmacies were the only pharmacies open in the county for 2 days, and they assisted in the delivery of prescriptions and supplies by boat. The reason I am telling you this is because PBMs, or middlemen, already have so much control over the marketplace that it greatly concerns me about what will happen should this merger occur.

Over my 30 years in pharmacy, I have seen the large pharmacy benefit managers gobble up smaller PBMs to reduce competition. The result is a highly concentrated, consolidated marketplace. Currently there are three PBMs that overwhelmingly dominate the national marketplace: Express Scripts, Medco and CVS Caremark. As a health care provider, I am aware of the consolidation within the health care industry, specifically consolidation within the PBM industry, which I believe has and will continue to negatively impact not only community pharmacies, but, more importantly, the patients that we serve.

The recently announced proposal of a merger of Medco and Express Scripts will exacerbate the problems pharmacies and patients face with respect to PBMs. The merger of these two PBMs would create a mega PBM with overwhelming power in markets that are critical to controlling health care costs. I believe the resulting merger will harm patients by reducing choice, by decreasing access, and ultimately leading to higher prescription drug costs paid by plan sponsors and consumers. In fact, the proposed merger a tipping point in terms of PBM market concentration. The merger will cause a substantial reduction in both price and nonprice competition among PBMs. If approved, this mega PBM will control over 40 percent of the national prescription drug market.

The size of this consolidation is enhanced by the fact that large and national health plans, insurance companies and government-sponsored health plans are already largely limited in their PBM choice. Postmerger, these large national customers will have fewer drug benefit administration alternatives, which will allow the merged PBM entity to dictate plan design and benefit structures at the expense of purchasers.

The merger will force more into mail order. The merger will create the largest mail-order operation, accounting for over 60 percent of all mail-order directed business in the U.S. The merged firm will have the increased ability and incentive to force consumers to utilize the mail-order portion of their business.

A misconception put forth by the merging parties is that this switch to mail order will lower drug costs for consumers. Evidence demonstrates the opposite. Mail-order operations push out more

brand-name drugs and fewer generics than the retail pharmacies, thereby lowering generic dispensing rates.

A dramatic consequence of more and more switch to mail is in too many cases a pharmacy is unable to stay in business. Pharmacy closures are felt particularly hard in rural areas, where these community pharmacies function as health care providers on the front lines when a disaster such as a hurricane, a tornado, or, in my case, excessive flooding strikes.

ESI and Medco neglect to tell you that this merger, if approved, will cost our local economies jobs and tax revenues due to the number of pharmacies that will likely be out of business due to the shift of prescriptions to out-of-State mail-order production. This merger will harm small business and cost jobs, something our economy can least afford at this time.

In conclusion, I would add that I enjoy being a pharmacist, I love what I do, and I believe I am making a difference to all the patients who depend on my pharmacies. However, I am concerned that this merger will reduce patient access, ultimately leading to higher drug costs due to the reduction in competition.

I thank you for the invitation, I welcome any questions, and as part of the proceedings, I would like to enter this document, which I believe all the Members have received in a packet—but I would like to introduce this document called Waste Not, Want Not, dealing with waste in prescriptions.

Mr. GOODLATTE. Without objection, the report will be made a part of the record, and thank you, Mr. Lech.

[The prepared statement of Mr. Lech follows:]

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United States 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

Testimony of Joseph Lech, Independent Pharmacist and Member of the National Community Pharmacists Association
September 20, 2011

Chairman Goodlatte, Ranking Member Watt, and Members of the Subcommittee:

Thank you for conducting this hearing and for providing me the opportunity to share my views regarding the Express Scripts-Medco merger. My name is Joe Lech of Tunkhannock, PA. I am the owner of 5 independent pharmacies in northeast Pennsylvania and have been a practicing pharmacist for 30 years. I am a member of the National Community Pharmacists Association, which represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. These pharmacies dispense nearly half of the nation's retail prescription medicines.

I would also like to thank Congressman Tom Marino, my Congressman, for the active role he has taken in trying to level the playing field between community pharmacies and pharmacy benefit managers or PBMs. In particular, we thank him for introducing the "Preserving Our Hometown Independent Pharmacies Act of 2011" (H.R. 1946), which has been endorsed by NCPA.

As a healthcare provider, my primary concern is the health and well-being of my patients and access to prescription medications is essential in maintaining the health of those patients. As you are aware, Pennsylvania, like many other states, was recently devastated by flooding. Many people in the area where I am from were evacuated from their homes with nothing but the clothes on their backs. The morning after the rain started the weather was so bad that my usual 30-minute commute to the pharmacy took almost 2 hours. As soon as I drove up to the pharmacy, I saw a gentleman standing out in front. He had been evacuated from his house by boat and was unable to retrieve the 16 prescription medications he took on a daily basis. Thankfully, I was able to refill his medications. But what would happen in cases such as this if pharmacies like mine disappeared from the communities that rely on them? Unfortunately, pharmacy closings are happening on a regular basis.

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This is just one story. There are thousands of stories just like mine of community pharmacies stepping up and assisting patients in getting their much-needed prescription medications. The reason I am telling you this story is because these PBMs or "middlemen" already have so much control over the marketplace that it greatly concerns me about what could happen should this merger take place.

Over my 25 years in pharmacy, I have seen the large pharmacy benefit managers relentlessly gobble up smaller and medium sized PBMs to reduce competition. The result is a highly-concentrated, consolidated marketplace. Yet, drug spending continues to go up, not down. Currently, there are three PBMs that overwhelmingly dominate the national marketplace– Express Scripts, Medco and CVS-Caremark. As a health care provider, I am keenly aware of recent efforts toward consolidation within the health care marketplace; specifically consolidation within the PBM industry. I believe this will continue to negatively impact not only community pharmacies but more importantly the patients we serve. The recently announced proposed merger of Medco and Express Scripts will likely exacerbate the problems pharmacies face with respect to PBMs.

The merger of these two PBMs would create a "mega PBM", specialty pharmacy provider and mail-order pharmacy with overwhelming power in markets that are critical to controlling health care costs. I believe the resulting merger will harm patients by reducing choice, decreasing access to pharmacy services and ultimately leading to higher prescription drug costs paid by plan sponsors and consumers. In fact, the proposed merger is a tipping point in terms of PBM market concentration. The merger will cause a substantial reduction in both price and non-price competition among PBMs, especially in certain defined customer segments. If approved, the "mega PBM" would control over 40% of the national prescription drug volume.[1]

The overwhelming size of this consolidation is enhanced by the fact that large national employers, unions, large health plans, insurance companies and government-sponsored health plans are already largely limited in their PBM choices. Moreover, smaller regional, captive, and niche PBMs are simply not viable alternatives when it comes to the size and scope necessary to manage and administer the complex prescription drug benefits for these large national customers. Post-merger, these large national customers will have even fewer drug benefit administration alternatives, which will allow the merged PBM entity to dictate plan design and benefit structures at the expense of purchasers.

Beyond the impact of the merger on the overall pharmacy marketplace, the merger would also create a dominant PBM with substantial market power in two specific submarkets: specialty pharmacy and mail-order services. The merger will combine two of the three largest suppliers of specialty pharmacy services, creating an entity with more than a 50% share of all specialty pharmaceutical sales.[2] This entity will have both the incentive and ability to reduce competition and prevent new competition in specialty pharmacy, an increasingly lucrative market.

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[1] Atlantic Information Services ("AIS"), 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill's Guide to Rx Channel – An Investor Handbook, May 10, 2011.

[2] Based on 2009 reported market shares of CuraScript and Accredo to AIS and estimates from Pembroke Consulting.

Also, the merger would likely force more customers into mail-order. The merger will create the largest mail-order pharmacy accounting for close to 60% of all mail-order prescriptions processed in the U.S.[3] The merged firm will have an increased incentive to force consumers to utilize their mail order business. One misconception perpetuated by the merging parties is that this switch to mail order will lower drug costs for consumers. Evidence demonstrates that mail order pharmacies consistently dispense more costly brand-name drugs and fewer generics than retail pharmacies. Mail order firms also play games with pricing benchmarks that are designed to deceive payers into thinking they get a better price by moving to mail order.

At the end of the day, the shift to more mail order will lower the rate of generic dispensing, ultimately raising drug costs. Another consequence of patients being switched to mail order from their local pharmacy is that in many cases that pharmacy will be unable to stay in business. Pharmacy closures are felt particularly hard in rural areas, where these community pharmacies also are the health care providers on the frontline when a natural disaster, such as a hurricane, tornado or in my case, excessive flooding, strikes.

Myths vs. Truth of the Proposed Merger

- ESI and Medco will say that this merger will drive out so-called "waste" in the health care system. Frankly, these are just code words for squeezing my pharmacy reimbursement as far down as they can and trying to shift as many of my patients as they can to their own mail order facilities. My pharmacy has no leverage with these PBMs which are able to exploit their vertical power over community pharmacies to the benefit of their own competitor mail order pharmacies. Imagine what this will mean for the 23,000 independent pharmacies when there are only two PBMs and one of them pays for 40 percent of all prescriptions. In my pharmacy, this merged company will pay for more than half of the prescriptions filled!

  Fewer pharmacies mean less competition. For your constituents in rural and urban areas where most independents operate, fewer pharmacies will result in poorer quality health care and higher costs to consumers. ESI and Medco have not said that they will pass on these alleged savings, and I'm skeptical given the enormous profits both companies have seen in recent years.

- ESI Medco will tell you that this will lead to greater efficiencies in the supply chain. Yet, past consolidation in the industry has not borne this out. These are empty promises that do not match reality once these mergers are approved. PBMs routinely deny patients the choice of where they fill their prescriptions by aggressively pushing them to their own mail order facilities. This merger is likely to make these types of anticompetitive actions and unfair business practices worse, particularly since a combined ESI Medco will be able to exert even more power over pharmacies.

- ESI and Medco will tell you that this merger will lead to patients more often taking their medications as prescribed – often referred to as "adherence." To the contrary, the evidence tells us that face-to-face interaction with their community pharmacist is the best way to modify patient behavior and increase medication adherence, not putting large quantities of drugs through the mail, hoping that they get to the patient, and then hoping that the patient takes them properly. Time and again our patients turn to us when their medications don't come on time through the mail, and they need our help in managing their medications.

[3] AIS 2011 data.

- ESI and Medco will tell you that this will be good for lowering costs, but there's reason to doubt them here, too. Everyone knows the fastest way to reduce drug costs is to maximize the proper utilization less-expensive generic drugs. Yet, community pharmacies dispense generics at a much higher rate than the PBM-owned mail order outlets because we do not have incentives, such as kickbacks from manufacturers, to dispense brand name drugs. For example, the generic dispensing rate at the ESI mail facility is 60%. It is 62% at the Medco facility. By contrast, community pharmacies dispense generics on average 72% of the time.

- ESI and Medco neglects to tell you that this merger, if approved, will cost our economy jobs and tax revenues due to the number of pharmacies that will likely be out of business because of the shift of prescriptions to out of state mail order operations. For each pharmacy clerk laid off, there is $3,000 in reduced tax revenue. For each pharmacy technician laid off, there is $4,041 in reduced tax revenue. For each pharmacist laid off, there is $15,900 in reduced tax revenue. This merger will harm small businesses, cost jobs, and hurt local economies, something our economy can least afford at this time.

In conclusion, I would add that I enjoy being a pharmacist and I believe I am making a difference for all the patients who come in to my pharmacy. However, I am very concerned that this merger could reduce patient access while ultimately leading to higher drugs costs due to the reduction in competition.

Thank you again for inviting me to testify before you today. I would be happy to answer any questions from the Subcommittee.

[The information referred to follows:]

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THE VOICE OF COMMUNITY PHARMACY

Waste Not, Want Not

Examples of mail order pharmacy waste

*These are actual images sent by participating pharmacies in the Dispose My Meds Program. Patient information has been removed or obscured to comply with all applicable laws protecting personal health information.

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Mail Order Waste – ESI

"Just one example of Express Scripts overutilization of the healthcare system. The patient has since deceased and his spouse opened up about how many times that she tried to get Express Scripts to stop sending items. That is over $6,000 that Express Scripts charged the patients plan."

*These are actual images sent by participating pharmacies in the Dispose My Meds Program. Patient information has been removed or obscured to comply with all applicable laws protecting personal health information.

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Mail Order Waste – ESI

Tricare patient

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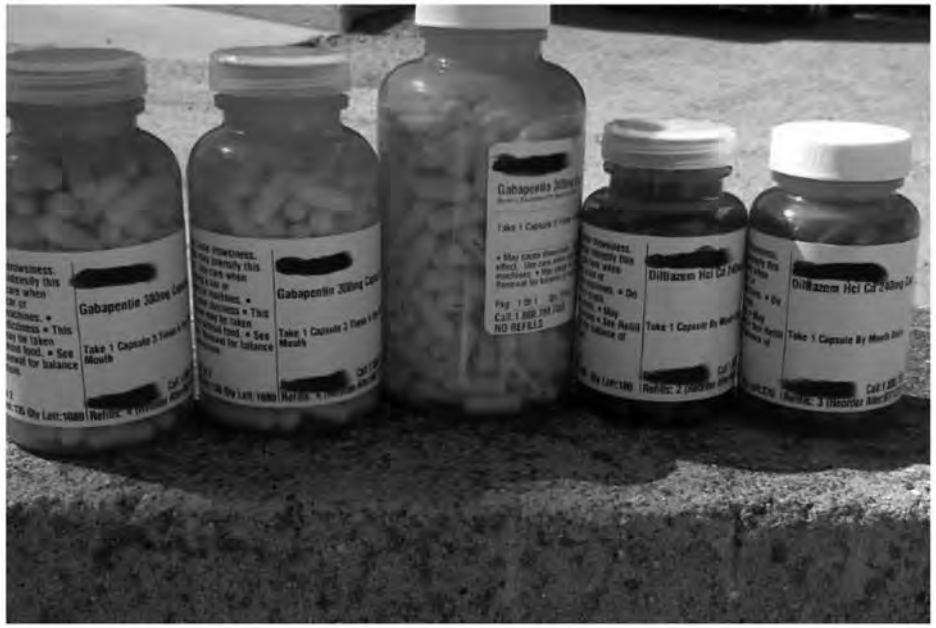
Mail Order Waste – ESI



*These are actual images sent by participating pharmacies in the Dispose My Meds Program. Patient information has been removed or obscured to comply with all applicable laws protecting personal health information.

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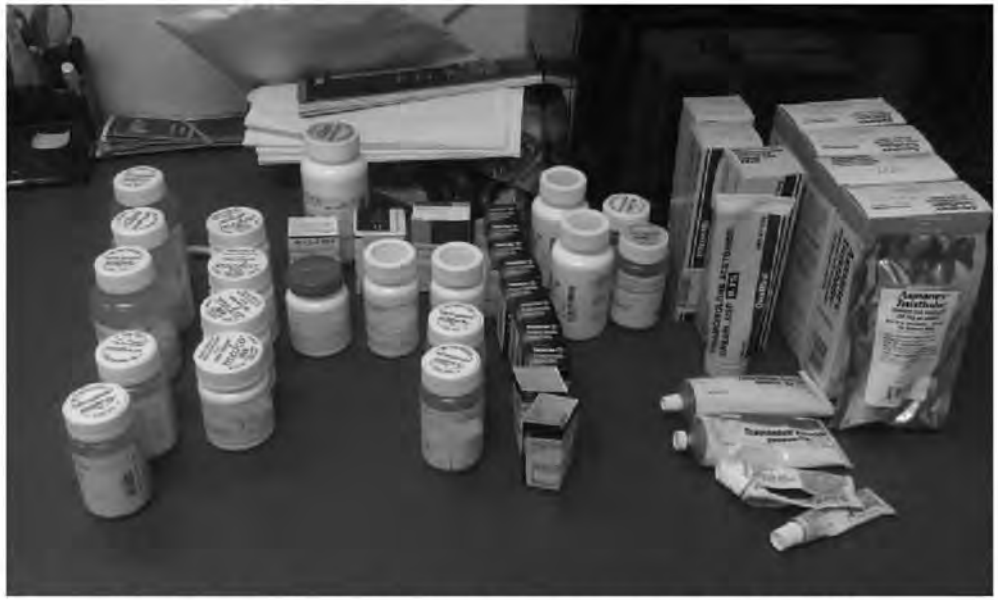
Mail Order Waste – Medco



"Almost all were returned unopened" ~ $2,300

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Mail Order Waste – Medco

"Just over $17,000 worth of meds from Medco Mail order. I hate to see what this persons company paid for these meds and what it did to his company's health premiums. Mail order facilities can shout from the rooftops about compliance all they want but just because you mail a person his/her meds, that doesn't mean they are taking them."

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Mail Order Waste – Medco

"One patient. Six months over supply due to 90-day rx filling and therapy changes." Approximately $4,000

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Mail Order Waste – Caremark

$61,000

"This is all for ONE patient that passed away and the family brought it into us to see if we could dispose of it for them. The patient was a Cystic Fibrosis patient that was dealing with Caremark Specialty mail order."

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Mail Order Waste – Caremark

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Mail Order Waste – Caremark

$17,000

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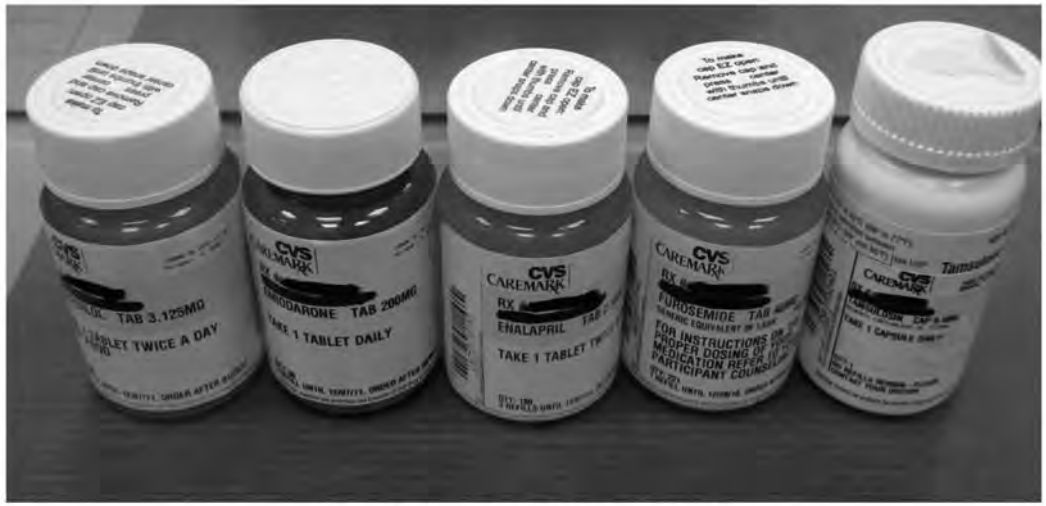
Mail Order Waste – Caremark



Medicare Part D Patient

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Mail Order Waste – Caremark

Medicare Part D Patient

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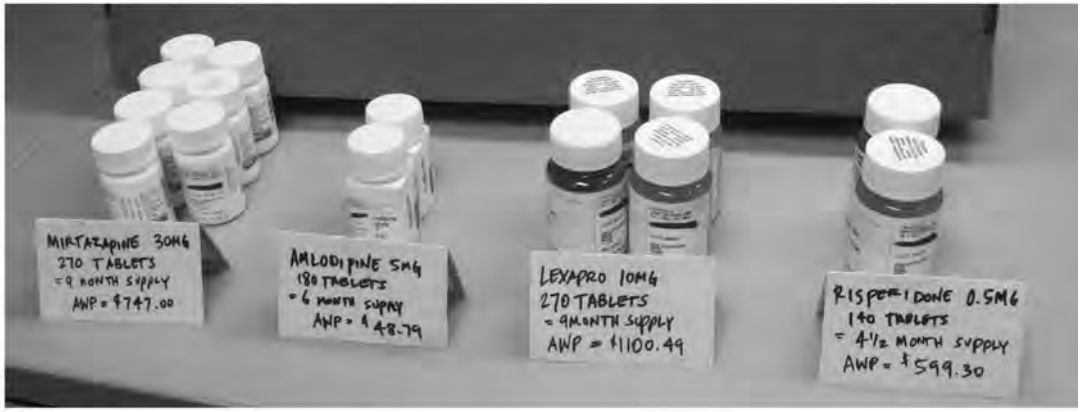
Mail Order Waste – Caremark



"This patient is cared for in a dementia unit so these are not missed doses, it is overfilling by mail order."

$2,500

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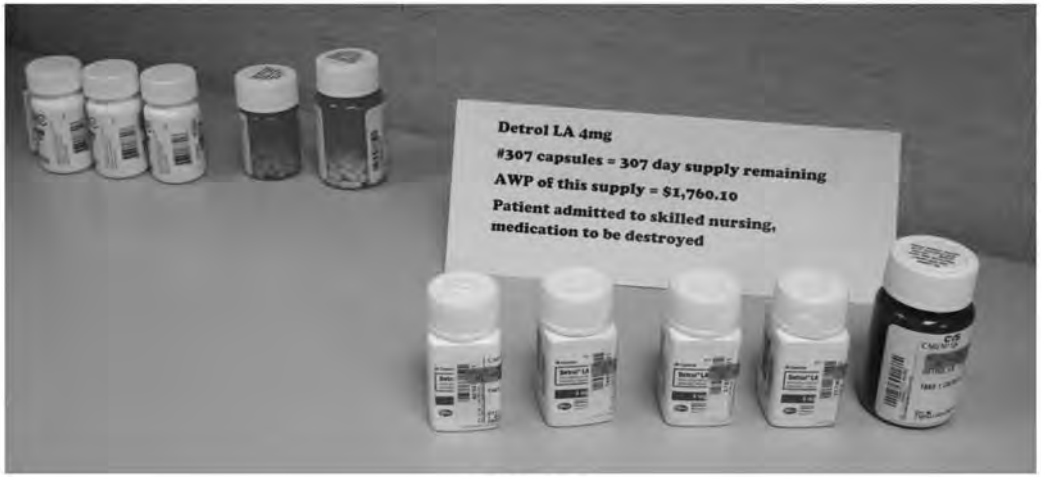
Mail Order Waste – Caremark



$1,760

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Mail Order Waste – Veteran's Affairs

$6,800

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Mail Order Waste – Veteran's Affairs

$3,500

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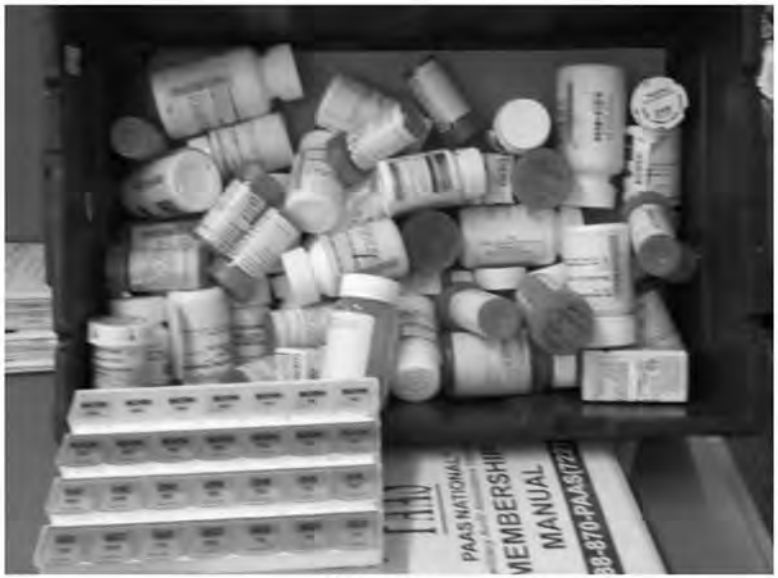
Mail Order Waste – Veteran's Affairs



$1,000

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Mail Order Waste – Veteran's Affairs

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Mail Order Waste – Cigna

"A patient of ours was 'forced' to use mail order for her insulin. Cigna mail order signed her up for an auto ship program. She told us that she called them to alert them that she would be on vacation and to hold her insulin until she returned. They shipped about $2,000 worth of insulin which sat on her front porch in the summer heat for over a week."

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Mail Order Waste – Prescription Solutions

$2,500

"Photos of insulin that one of our regular customers got from mail order - the patient has not been in good health for some time and passed away. The family brought in this unused insulin to see what to do with it. Unfortunately the only option was to tell them to dispose of it."

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Mail Order Waste

$7,000

$2,700

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Mail Order Waste

$2,800

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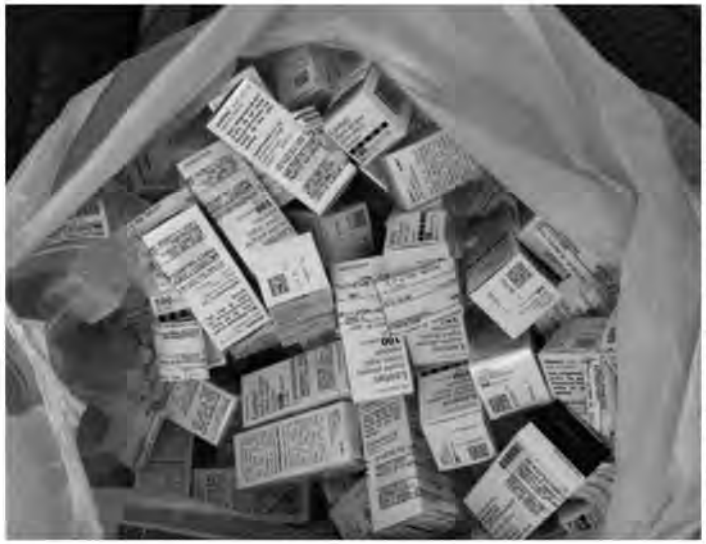
Mail Order Waste



$11,096

"26 vials of Novolog and 84 vials of Lantus. About $11,096 worth of waste in the mail order pharmacy system. Auto Shipped from Liberty Medical to patient who accumulated beyond belief and now wants them wasted, since they are changing to the Insulin Pen. Adherence was not great for this patient. Do you think that Liberty Medical every checked to see of the patient was compliant. Or do you think they just kept auto shipping, and auto shipping, and auto shipping. "

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Mr. GOODLATTE. Mr. Wiesner, we are pleased to have you with us today.

TESTIMONY OF DENNIS WIESNER, R.Ph., SENIOR DIRECTOR OF PRIVACY, PHARMACY, AND GOVERNMENTAL AFFAIRS, H-E-B GROCERY COMPANY, LP

Mr. WIESNER. Thank you. Mr. Chairman, and Members of the Subcommittee. Thank you for the opportunity to testify. My name is Dennis Wiesner. I am a pharmacist, and I have worked in com-

munity pharmacies for over 40 years. I have grave concerns about this proposed merger. It would be a tipping point in PBM market consolidation, harming patients as well as government and private health plans and employers.

Mr. NADLER. Mr. Chairman, can you ask the witness to speak into the mic more?

Mr. GOODLATTE. Is it turned on? Make sure the green light is on. Is that better?

Mr. WIESNER. There is only one stakeholder that would benefit: the new mega PBM. Since the merger was announced, many Members of Congress, consumer groups, State insurance commissioners, State attorneys general and State legislators have expressed concerns to the Federal Trade Commission. This would be a merger of two of the big three PBMs. If approved, nearly 135 million Americans would rely on this single PBM to manage their prescription benefits. It would control over 40 percent of the national prescription volume, 60 percent of the mail-order pharmacy market, and more than 50 percent of specialty pharmacy sales.

Patients in particular will be harmed through reduced or no choice of their pharmacy providers; decreased or limited access to essential pharmacies services; a separation of their prescription medication records that could result in potential adverse patient health outcomes, disruption to normal timely prescription service, and potentially decreased medication adherence. Reducing patient choice and access will lead to higher prescription costs, potential adverse patient outcomes, and higher downstream health costs.

Do PBMs actually reduce health care costs? There is no proof that they pass along the purported savings to health plans, employers or consumers. In fact, the PBM industry has been fraught with allegations of extensive deceptive and fraudulent practices. In recent years cases brought by a coalition of over 30 State attorneys general have resulted in over $370 million in penalties. It has been found that PBMs have accepted rebates from manufacturers in return for placing higher-priced medications on prescription drug plan formularies, switched customers to the higher-priced drugs, and then benefited from both the rebate received and the higher-priced drug payment without passing along the enrichment to the health plan or employer.

PBMs already operate in an opaque manner. They are middlemen in a unique position to dictate contract terms to health plans and pharmacy providers. The new mega PBM would have even greater ability to dictate one-sided, unfavorable contract terms to pharmacies, health plans and employers, ultimately harming consumers. This is one reason we oppose the merger and we seek legislative relief on PBM practices.

Pharmacies that refuse their contract terms would be shut out of the networks that provide pharmacy services to their neighbors and huge portions of American consumers. In addition, more consumers would be forced into using PBMs' own mail-order facility as opposed to choosing their local pharmacy, depriving consumer access to vital health care services and valuable face-to-face counseling.

The Butt family founded H-E-B 106 years ago with a firm commitment to serve all the citizens in all our communities. That com-

mitment is stronger today than ever. However, being able to continue servicing the prescription and health care needs of our customers and neighbors has been threatened by the one-sided nature of pharmacy agreements with PBMs. We have seen firsthand the unilateral nature of these contracts. They are allowed to establish the basis of costs for the prescription medications; they are allowed to change that basis of cost with limited or no notice, especially for generic medication; and they are allowed to second-guess or override a physician's prescription order. Claims submitted to the PBM and approved are routinely reviewed retroactively and payment recouped due to inadequacies in the PBM claims adjudication system. My company experiences these and other examples each and every day.

Our internal health benefits team provides health care services to over 140,000 individuals. They feel strongly that this merger would limit competitive options and result in total costs, especially administrative fees, increasing.

Pharmacists helped ensure that patients understand their medications and take them as directed. Pharmacists collaborate with doctors and other local health care providers to assist in medication decisions. Community pharmacies also provide critical, cost-effective services like immunizations, disease state management and monitoring, health education, and screening programs. Together all these services improve patients' health and reduce out costs.

As I said, the situation with PBMs has worsened through consolidation. Because of this, we support legislation to rein in their more egregious actions, including H.R. 1971 and H.R. 1946.

In conclusion, PBMs already use a lack of transparency, failing to pass through rebates from drug manufacturers to consumers and other payers, inflating drug costs for health plans and employers, and lowering payments to pharmacies for their own personal financial gain. Patients appear to be an afterthought. A mega PBM would have an increased ability to engage in similar conduct to the detriment of consumers, payers and pharmacy providers.

Thank you for your time.

Mr. GOODLATTE. Thank you, Mr. Wiesner.

[The prepared statement of Mr. Wiesner follows:]

Prepared Statement of Dennis Wiesner, R.Ph., Senior Director of Privacy, Pharmacy, and Governmental Affairs, H-E-B Grocery Company, LP

On behalf of the National Association of Chain Drug Stores (NACDS), I am pleased to submit a statement for the hearing on "The Proposed Merger between Express Scripts and Medco." My name is Dennis Wiesner. I am a pharmacist and have worked in numerous roles in community pharmacy for over forty years. I am currently a Senior Director for H-E-B with responsibilities for privacy, pharmacy and government affairs. H-E-B is a private family owned regional food-drug retailer with over 300 stores in Texas, 222 of which have pharmacies. In addition, H-E-B has extensive warehousing and manufacturing facilities and over 80,000 employees. Our stores provide services to over 20 million Texans each year.

I am also Chairman of the NACDS Policy Council. 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 full-time 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.

This proposed merger poses significant anti-competitive threats to numerous U.S. industries and markets. If allowed, this merger would have grave consequences for consumers and the nation's community pharmacies that serve them, as well as for health plans and employers that utilize PBM services, specialty pharmacy services, and mail order pharmacy services. NACDS opposes this merger and has urged FTC to block it. Earlier this month, the FTC issued a "Second Request" to Express Scripts and Medco to gather more data on the merger. According to media reports, only 4% of similar proposed deals in 2010 were issued a Second Request by the FTC. This merger has received the attention of not only FTC and this Committee, but also numerous other Members of Congress, numerous state Insurance Commissioners, state Attorneys General, and state legislators, who have all asked FTC to give this proposed merger a high level of scrutiny.

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 the community pharmacies. In addition, Express Scripts and Medco each separately own two of the largest specialty pharmacy companies in the U.S.

As an industry, PBMs are virtually unregulated. They may have tangential regulatory compliance for insurance related processes through their relationships with health plans and employers. A handful of states directly regulate some PBM functions, such as how they conduct audits of pharmacies, and some state boards of pharmacy regulate them to 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.

OVERVIEW OF CONCERNS

The proposed merger of Express Scripts and Medco would result in unparalleled market concentration in an already extremely limited marketplace. Because of several mergers and acquisitions over the past decade, the number of PBMs has declined significantly since 2000 and the concentration among the largest PBM providers has increased during that time. The market for national prescription drug plans is currently concentrated in just three PBMs. If the merger proceeds, there will be a reduction in competition in already highly-concentrated markets, including those involving PBM services, as well as mail order distribution services and specialty pharmaceutical services.

The proposed merger would be a tipping point in terms of PBM concentration that would have a considerable anti-competitive impact on employers, health plans, federal employee benefit plans, and TRICARE, along with their beneficiaries. The post-merger PBM marketplace would have markedly reduced choice for all patients and consumers, as well as governmental, employer and third-party payors.

REDUCED PBM COMPETITION

Express Scripts and Medco are two of the "Big Three" PBMs that control 50–60% of the national overall prescription drug volume.[1] If approved, approximately 1/3 of all Americans (roughly 135 million people) would rely on the new "mega PBM" to manage their prescription benefits.[2] This "mega PBM" alone would control over 40% of the national prescription drug volume.[3] Certain classes of customers such as large, complex health plans would be left with only two choices for PBM services, the merged entity and the one remaining large PBM. Smaller regional PBMs would be unable to constrain anticompetitive conduct because of their smaller size, geographic limitations, and lack of ability to secure rebates.

This substantial reduction in competition will harm purchasers of PBM services and the purchasers' beneficiaries by limiting consumer choice, reducing transparency, reducing access to pharmacy services, and increasing costs to the beneficiaries.

ANTI-COMPETITIVE CONCENTRATION IN THE PBM MARKET

The proposed merger will lead to anticompetitive concentration in the PBM market, resulting in market foreclosure practices that harm purchasers of PBM services and consequently, consumers of pharmacy services. Specifically, the merged PBM will have an incentive to use its increased market power as both a seller and a purchaser of pharmacy services to impose unfavorable contract terms on community pharmacies. Consequently, this "mega PBM" would have the ability to raise prices for health plans and patients, limit access to pharmacy patient care and force patients to use the PBM's mail order pharmacies rather than their trusted community pharmacies, driving up costs for employers, health plans and other federal and state programs.

PBMs operate unregulated and in an opaque manner. They claim that they save money by negotiating rebates and discounts from drug manufacturers and negotiating lower reimbursement rates from pharmacies. However, there is no proof that they pass along any of this purported savings to health plans, employers or consumers. In fact, the PBM industry has been fraught with allegations of extensive deceptive and fraudulent practices. In recent years, cases brought by a coalition of over 30 State Attorneys General have resulted in over $370 million in penalties for deceptive and fraudulent conduct.[4] It was found that PBMs accepted rebates from manufacturers in return for placing higher priced medications on prescription drug plans' formularies, switched customers to the higher priced drugs that were paid for by the health plan/employer, and benefitted from both the rebate received and the higher priced drug payment without passing along the enrichment to the health plan/employer. In essence, PBMs use lack of transparency to negotiate higher rebates from drug manufacturers, higher drug prices for health plans/employers, and lower payments to pharmacies, while keeping the gains for themselves. We can expect a "mega PBM" to have freer reign to engage in similar egregious conduct.

As middlemen, PBMs claim that their ability to negotiate with drug manufacturers and pharmacies reduces overall prescription drug costs. However, despite their claims, overall prescription drug spending continues to steadily increase. Moreover, recent studies show that PBMs' mail order pharmacies have lower generic dispensing rates than retail community pharmacies.[5] A "mega PBM" would be even more likely to increase drug costs by shifting more patients to mail order, which utilizes more expensive, brand name drugs. This increased cost would be borne by health plans, employers, and ultimately consumers.

CONCERNS ABOUT SPECIALTY PHARMACY AND MAIL ORDER SERVICES

Specialty pharmaceuticals are high cost drugs required by patients undergoing intensive therapies for chronic, complex, relatively rare and/or potentially life-threatening illnesses. Industry experts anticipate that sales of specialty pharmaceuticals

[1] Atlantic Information Services ("AIS"), 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill's Guide to Rx Channel—An Investor Handbook, May 10, 2011.

[2] Bloomberg, Express Scripts-Medco Deal May Spur Purchases by Rivals, July 22, 2011.

[3] Atlantic Information Services ("AIS"), 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill's Guide to Rx Channel—An Investor Handbook, May 10, 2011.

[4] The American Antitrust Institute; "Commentary: The FTC Should Issue a Second Request on Express Scripts' Proposed Acquisition of Wellpoint's PBM Business," May 11, 2009.

[5] See 2010–2011 Prescription Drug Cost and Plan Benefit Design Report at 28, available at http://www.benefitdesignreport.com/Portals/0/2010–2011__BDR__R1.pdf.

will account for an increasing dollar share of all drugs consumed, estimated to be 27% of all drug sales by 2015.[6]

The merger would combine two of the three largest suppliers of specialty pharmacy services, creating an entity with more than 50% share of all specialty pharmacy sales. CuraScript (owned by Express Scripts) and Accredo (owned by Medco) are the two largest specialty pharmacies in the U.S. Combined, these two entities account for an estimated 52% of all specialty pharmaceuticals in the U.S.; this would be enough power to stifle competition in the specialty pharmacy market and command even higher prices. Both PBMs have attempted to significantly increase prices of specialty pharmaceuticals in recent years. We can expect an even greater effort to do this should the merger be approved.

The merger will also create the largest mail-order pharmacy accounting for close to 60% of all mail-order scripts processed in the U.S.[7] The merged company will have even more market power to reduce patient access to community pharmacies and force consumers and employers to use its own captive mail order operation. Although the merging firms may claim that shifting prescriptions to mail order prescriptions from retail community pharmacies will drive down drug costs to consumers, their increased market power is likely to result in an artificially high reduction in prescriptions filled through community pharmacies, and increased costs for payors and beneficiaries.

The ability of PBMs to drive prescriptions to their own mail order facilities is inherently anticompetitive. Congress has recognized the potential for this type of abuse, and in Medicare, this type of "self dealing" in the case of physicians is illegal. Moreover, PBMs determine the income received by pharmacies (by setting pharmacies' reimbursement rates) and then directly compete with pharmacies by driving prescriptions to their own mail order facilities. Further consolidation of PBMs and mail order pharmacies, in addition to the lack of transparency in PBM operations, will further exacerbate these conflicts. The result will be increased costs for public programs such as Medicare, beneficiaries, private health plans and employers, and the American taxpayer.

In addition, the merged entity's ability to shift patients to its mail-order operations will have a direct and harmful impact on patient care. It will allow the mega PBM to limit consumers' access to their local pharmacies and the vital healthcare services and one-on-one counseling they provide. In addition to dispensing prescriptions, pharmacists counsel patients on a daily basis to ensure that they take their medications as directed by their doctors. They also provide a broad range of critical, cost-effective services such as immunizations, counseling for diseases such as diabetes, and other health education and screening programs. These high quality services increase the therapeutic benefits of prescription drugs, which improve health outcomes and lowers costs. There is simply no substitute for the in-store, face-to-face services provided by pharmacists.

CONCLUSION

NACDS thanks the Committee for consideration of our comments on the proposed merger of Express Scripts and Medco. We are deeply concerned about the anti-competitive impact the merger would have and are extremely skeptical that the American public can trust a "mega PBM" to look out for the best interests of patients and payors, or to pass any purported "savings" along to beneficiaries and other consumers. These concerns are compounded by the fact that the PBM industry as a whole is virtually unregulated.

Mr. GOODLATTE. And now we will hear from Mr. Gustafson. Welcome.

TESTIMONY OF DAN E. GUSTAFSON, PARTNER, GUSTAFSON GLUEK PLLC

Mr. GUSTAFSON. Chairman Goodlatte, thank you for providing me the opportunity to testify today. My name is Dan Gustafson, and I practice antitrust law at Gustafson Gluek in Minneapolis. I

[6] See CVS Caremark Corp., 2010 Annual Report at http://www.annualreports.com/HostedData/AnnualReports/PDFArchive/cvs2010.pdf (citing ModernHealthcare.com).

[7] AIS 2011 data.

am also working with a group at the American Antitrust Institute to evaluate the proposed merger.

Although our work is preliminary, we have identified several potential concerns with regard to this merger, but before I identify these concerns, let me emphasize first that the time for careful evaluation of this merger is now. Although antitrust enforcement can sometimes undo the effects of already concentrated markets or anticompetitive conduct, preventing such conduct before it occurs is far more effective antitrust and public policy. For that reason we applaud the FTC's second request for information as it continues to evaluate this merger proposal.

PBMs play an important and ever-expanding role in our health care system. They touch most American lives in their role as managers of prescription drug benefits through their pharmacy claims processing, formulary management and home-delivery pharmacy services. They also negotiate discounts and rebates on purchases from pharmaceutical companies.

The market for national PBM services is already concentrated. CVS Caremark, Express Scripts and Medco control more than 50 percent of the market when measured in terms of prescriptions, and over 80 percent of the market when measured in terms of large plan-sponsored contracts. A merged Express Scripts-Medco company will overwhelmingly dominate the PBM services market, covering nearly 150 million prescription drug consumers and over 50 percent of the large plan sponsors. In terms of covered lives, no other PBM would remotely approach Express Scripts-Medco.

As a result of our evaluation of this merger, we raise several concerns. First, will the merger reduce competition for the provision of PBM services to large plan sponsors? Although there are numerous smaller PBMs, many of these smaller entities operate only in regions, some serve only a special niche markets such as government services, and other offer a limited menu of services in areas such as specialty drugs, mail order or claims processing. The smaller PBMs lack the ability to negotiate the same discounts and rebates from drug manufacturers that large PBMs can obtain. As a result, regional PBMs may be unable to constrain potential anticompetitive conduct.

Second, will the proposed merger lead to increased prices or reduced services in the distribution of specialty pharmaceuticals? Significant concerns exist in the market for the distribution of specialty drugs where Express Scripts and Medco will own the two largest specialty pharmacy businesses. The proposed merger will result in a company holding more than a 50 percent share of the specialty pharmacy market segment. Specialty pharmacies provide important service and treatments to consumers with complex, chronic and often life-threatening illnesses. They often help administer complex treatments, work with physicians to monitor patient therapy, and play a role in the medication compliance issues. Reduced competition in this market segment could lead to increased costs and reduced services to the consumers who depend on those treatments the most.

Third, will the proposed merger increase the exercise of buyer power to reduce the delivery of traditional pharmaceutical services? We are concerned that the major PBMs already possess the ability

and incentive to exercise market power over retail independent and chain pharmacies. Reimbursements from the PBMs is a major source of their revenue, and the proposed merger could enable the two remaining large PBMs to push compensation to the retail pharmacies below competitive levels, eliminating jobs and leading to reduced and important services for their consumers.

This proposed merger would also create the largest mail-order pharmacy in the United States, accounting for nearly 60 percent of all mail-order scripts, because large PBMs could divert prescriptions to their own mail-order facilities instead of to their retail traditional pharmacies. They could maximize their own gains if they then select drugs on which they receive superior rebates from manufacturers. The opportunity for potentially anticompetitive self-dealing which harms consumers may be enhanced by the creation of a dominant PBM in the mail-order pharmacy market space and elimination of one of its only two competitors.

Finally, we need to be careful to examine the claim deficiencies to determine if the savings that are proposed are specific to this merger and cannot otherwise be obtained by means unrelated to the merger. A careful analysis made as to whether and to what degree these claimed efficiencies will actually be passed on to plans, and therefore consumers, is important as well.

Past consolidation in this industry provides sufficient data to evaluate the previous efficiency promises that have been made. The recent spike in the profits of the largest PBMs suggest less and not more competition and, as a result, higher prices for plans and for consumers.

Thank you for providing me the opportunity to testify today. I am happy to answer any questions that you may have.

Mr. GOODLATTE. Thank you, Mr. Gustafson.

[The prepared statement of Mr. Gustafson follows:]

Prepared Statement of Dan E. Gustafson, Partner, Gustafson Gluek PLLC

I. INTRODUCTION

Chairman Goodlatte, Ranking Member Watt, and members of the Committee. Thank you for providing me the opportunity to testify before you today regarding the proposed Express Scripts-Medco merger, two of the largest pharmacy benefit managers (PBMs) in the United States. My name is Dan Gustafson from Gustafson Gluek in Minneapolis, Minnesota. I am an advisory board member of the American Antitrust Institute (AAI)[1] and part of an ad hoc working group of the AAI that is investigating and analyzing the impact of this proposed merger.

II. AAI'S ROLE AND ANTITRUST ENFORCEMENT

Our analysis has just begun and has been limited to considering publicly available materials. At the conclusion of our evaluation, we expect to author an antitrust white paper to recommend actions that the AAI believes the FTC should take with respect to this proposed merger.

Although the working group has not yet reached any conclusions and the AAI Board of Directors has not taken any position on the merger, I appear before you today at their request to identify some areas of concern that suggest further careful investigation and analysis is warranted. We hope that this information will assist the Committee as it considers this proposed merger.

[1] The AAI is an independent Washington-based non-profit organization addressing antitrust issues from a perspective of increasing competition and ensuring that competition works to benefit consumers through vigorous public and private antitrust enforcement. AAI Website, About Us, http://www.antitrustinstitute.org/content/about-us

It is important to note that now is the time to evaluate and analyze this proposed merger. Although some post-merger antitrust enforcement successfully corrects excessive market concentration or other anticompetitive conduct, antitrust policy in this area should focus on preventing anticompetitive conduct by foreclosing combinations that incentivize or further anticompetitive conduct. Effective merger review requires that regulatory agencies take appropriate steps at this stage—before the merger happens—to ensure that competition and consumer interests are protected.

With respect to this proposed merger, the FTC has already issued a Second Request, and the AAI applauds its continuing investigation of this matter. Although the FTC cleared the CVS Caremark merger without a Second Request, previous decisions of the Commission indicate that it believed the PBM industry to be competitive. Although the Commission has issued some broad statements about the competitiveness of the industry, we believe those statements should be reexamined in light of recent enforcement actions by state attorneys general, increased consolidation and the escalating profits of the major PBMs.

III. INDUSTRY BACKGROUND

PBMs play several roles in our healthcare system. They touch most American lives in their role as managers of prescription drug benefits for third-party payors. In this role, they integrate retail pharmacy claims processing, formulary management, and home delivery pharmacy services.[2]

In addition to adopting a pre-approved list of commonly prescribed prescription medications, formulary management includes managing the utilization of covered medications by balancing clinical effectiveness with costs, traditionally through clinical programs developed and maintained by plan doctors and pharmacists.[3] Litigation by state attorneys general in recent years has raised concerns that the decisions made by large PBMs on these formulary issues may be improperly influenced by discounts and rebates received from manufacturers in exchange for placing higher priced medications on the formulary, and exclusive contractual arrangements that may lead to favorable treatment for higher priced drugs, irrespective of their relative utility.[4]

In recent years, many PBMs, including both Express Scripts and Medco, have acquired major specialty pharmacy businesses and, as a result, now also serve as distributors of specialty drugs. Although there is no universally accepted definition for a "specialty drug," it usually refers to medications for the treatment of serious, chronic ailments that are expensive and often require special handling and control, complex administration and careful monitoring.[5]

The large PBMs have also increasingly expanded into mail order pharmacy businesses. These mail order pharmacies further the vertical integration of large PBMs and compete directly with national, regional and traditional local pharmacies.[6] The PBMs with large mail order operations often limit distribution of certain drugs solely through the mail.[7]

IV. PROPOSED MERGER BETWEEN EXPRESS SCRIPTS AND MEDCO

A. Market Concentration

Although it is premature to reach conclusions about the relevant market definitions in an antitrust context, the AAI working group is considering some market concentration issues that may raise potential concerns. The market space for PBM services is already concentrated. The top three PBMs, CVS Caremark, Express Scripts and Medco, control approximately 50% of the market when measuring pre-

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[2] Mark Meador, *Squeezing the Middleman,* 20 Annals of Health Law 77, 78–79 (2011).

[3] Blue Cross Blue Shield of Massachusetts, Glossary, http://www.bluecrossma.com/bluelinks-for-employers/glossary.html

[4] AAI White Paper, *The FTC Should Issue a Second Request on Express Scripts' Proposed Acquisition of Wellpoint's PBM Business,* May 11, 2009 ("AAI 5/11/09 White Paper"), at 4.

[5] Testimony of David Balto on Health Industry Consolidation, September 9, 2011 ("Balto 9/9/11 Testimony"), at 6; Change to Win, *CVS Caremark: An Alarming Merger, Two Years Later,* November 2009, at 6; AAI 5/11/09 White Paper, *supra,* at 9.

[6] Allison Dabbs Garrett & Robert Garis, *Leveling the Playing Field in the Pharmacy Benefit Management Industry,* 42 Val. U. L. Rev. 33, 37, 66–68 (2007); AAI White Paper, Express Scripts' Proposed Acquisition of Caremark: An Antitrust White Paper, February 14, 2007 ("AAI 2/14/07 White Paper"), at 2, 4, 7–8.

[7] PBMs also offer additional services such as compliance programs outcome research, drug therapy management programs, data analysis, and distribution services. Garrett & Garis, *supra,* at 34–38; AAI 5/11/09 White Paper, *supra,* at 7.

scriptions filled or controlled.[8] If the market concentration is measured in terms of contractual arrangements with large plan sponsors,[9] the market is even more concentrated, with the big three PBMs controlling over 80%.[10]

Concentration in this market already has occurred through mergers. CVS Caremark is a result of a $21 billion merger of CVS and Caremark in 2007 that was cleared without a Second Request from the FTC.[11] If Express Scripts and Medco merge, three will become two. A merged Express Scripts-Medco company will dominate the PBM services market space covering more than 150 million prescription drug consumers and 50% of the large employer market.[12] Combined with the next largest PBM, CVS Caremark, the two would cover approximately 240 million prescription drug consumers.[13] In terms of covered lives, no other PBM, post-merger, would remotely approach Express Scripts-Medco. Even CVS Caremark would be a distant second.[14]

The post-merger Express Scripts-Medco company may lessen the competition between the top PBMs and smaller, regional PBMs and as a direct result, may harm consumers, plans, employers, unions, and pharmacies.

In the past, the FTC has defined this market as the provision of PBM services to large plan sponsors.[15] Although that market definition is clearly relevant to the discussion of the proposed merger today, it is not the only market segment that should be examined. We also plan to consider the impact of PBM concentration on at least the specialty, mail order, and retail independent and chain pharmacy market segments.

There may be substantial concerns in the market space for distribution of specialty drugs where Express Scripts and Medco own, respectively, Curascript and Accredo, the two largest specialty pharmacy businesses.[16] Specialty pharmacies provide service and treatments to consumers with complex, chronic, and often potentially life-threatening illnesses, including HIV/AIDS, Crohn's Disease, and some forms of cancer.

Specialty pharmacies also often provide the most cost-effective use of these expensive treatments, and reduced competition in this market segment could lead to reduced service and increased costs to the consumers who depend on specialty treatments and the broad counseling services provided by independent specialty pharmacies. This market segment has become increasingly concentrated and poses its own special concerns. This proposed merger would leave the post-merger company with more than a 50% share of the specialty pharmacy market segment, and may threaten competition in this area.

The largest PBMs also own businesses that provide mail order pharmacy operations. These mail order pharmacy operations provide a significant source of revenue because the PBM controls both the claims adjudication function and prescription dispensing function.[17] Some sources suggest that a merged Express Scripts-Medco company would control almost 60% of the mail order market space.[18] Although the proposed merger parties may claim that shifting prescriptions to mail order prescriptions from retail community pharmacies will lessen drug costs for consumers, their increased market power in the mail order segment may actually reduce pharmacy prescriptions and increase costs.[19]

Concerns also have been raised over the past several years on the lack of competition in the PBM market and deceptive conduct that harms consumers. In the past six years, a coalition of over 30 state attorneys general have brought cases against

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[8] Guggenheim, ESRX/MHS Still Faces Tough Review—We Think This Could Benefit WAG and CVS at 3, Sept. 6, 2011.

[9] A plan sponsor is the employer insurance company, union or other entity which purchases PBM services on behalf of its employees or members.

[10] AAI 5/11/09 White Paper, *supra,* at 1.

[11] AAI 5/11/09 White Paper *supra,* at 2.

[12] Balto 9/9/11 Testimony, *supra,* at 6.

[13] Balto 9/9/11 Testimony, *supra,* at 6.

[14] Numbers based on http://pbmi.com/PBMmarketshare1.asp.

[15] *In re Merck & Co.,* 127 F.T.C. 156 (1999); *In re Eli Lilly & Co.,* 120 F.T.C. 243 (1995).

[16] Balto 9/9/11 Testimony, *supra,* at 6.

[17] Garrett & Garis, *supra,* at 67.

[18] Zachary French, *Express Scripts and Medco Merge Mail Order, Specialty Pharmacies, and of Less Importance, PBM Operations,* July 22, 2011.

[19] PBMs determine the income received by pharmacies (by setting pharmacies' reimbursement rates) and then directly compete with pharmacies by driving prescriptions to their own mail order facilities. See Statement of the National Association of Chain Drug Stores for U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, Hearing on "Health Care Industry Consolidation," September 9, 2011.

each of the big three PBMs securing over $370 million in penalties and fines.[20] Over the past few years, the profits of the big three have soared over 400%.[21]

B. The Antitrust Concerns

There are several issues that the AAI working group will continue to investigate and evaluate.

First, could the merger reduce competition for the provision of PBM services to large plan sponsors?

Currently, CVS Caremark, Express Scripts, and Medco are, by far, the three largest PBMs serving large plan sponsors. Over 40 of the "Fortune 50" largest corporations rely on these three PBMs for PBM services.[22] Because of their size and potential to offer exclusive contracts, these big three PBMs have significantly greater purchasing power than smaller PBMs for both brand and generic drugs. Their mail order and specialty operations similarly enable them to provide a wider range of services, and they have broader technological capability and better claims processing. Not surprisingly when one of the big three loses a large plan sponsor it is almost inevitably to another one of the big three.[23]

Although there are numerous smaller PBMs in the market space for PBM services, smaller PBMs often face regional limitations, others serve a special niche market, such as government entities, and others do not have a full menu of services such as mail order, specialty pharmacy and the lack of claims processing capabilities to service national accounts. These smaller PBMs also face a limited ability to secure discounts or rebates from PBM suppliers.[24]

The Express Scripts-Medco merger reduces the number of viable providers of PBM services to large plan sponsors from three to two and may result in higher prices, less innovation, and increased barriers to entry. As noted above, the three national PBMs have significant advantages in national scope, drug purchasing, discounts and rebates, mail order distribution, specialty pharmaceuticals and administrative services. As a result, the remaining smaller, regional PBMs may be unable to constrain potential anticompetitive conduct of the large PBMs.[25] A key consideration in that respect is how markets are ultimately defined.

Because PBMs enter contracts with large plan sponsors that typically span several years, the ability to compete for such contracts lessens as the bigger PBMs increase their base. These contracts are renewed at a high rate.[26] PBMs also enter contracts with government entities—such as Medicare Part D, Tricare, and the Federal Employee Health Benefit Plan—through a competitive bidding process. PBM contracts with large plan and government plan sponsors are exclusive.[27]

Second, would the merger pose a threat of coordinated interaction by eliminating a major competitive firm from the market?

As the PBM services segment loses major participants, the risk of coordinated interaction increases. The market is already dominated by a small number of large firms and there are substantial barriers to entry. Transparency issues make it difficult for plan sponsors to determine whether they are receiving the full benefits from their arrangement with the PBM. The lack of transparency and the length and exclusivity of contracts hamper plan sponsors' ability to negotiate meaningfully with PBMs.[28]

As one federal court has observed, "Whether and how a PBM actually saves an individual benefits provider [plan sponsor] customer money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider."[29] Even when a benefits provider receives a shared rebate from the PBM, it

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[20] AAI 5/11/09 White Paper, *supra,* at 4.

[21] National Community Pharmacists Association, *Pharmacists Can Help States Reduce Medicaid Costs, While Preserving Patient Choice,* June 16, 2011, http://www.ncpanet.org/index.php/news-releases/1016-community-pharmacists-can-help-states-reduce-medicaid-costs-while-preserving-patient-choice.

[22] Morgan Stanley Research, *Healthcare Services & Distribution: Fortune 50 and Respective PBMs,* July 28, 2011.

[23] AAI 5/11/09 White Paper, *supra,* at 5–7.

[24] AAI 5/11/09 White Paper, *supra,* at 7.

[25] AAI 5/11/09 White Paper, *supra,* at 5–7.

[26] AAI 5/11/09 White Paper, *supra,* at 7.

[27] Medscape News, The Medicare Prescription Drug Benefit: PBMs and Supporting Institutions, http://www.medscape.com/viewarticle/409818_3.

[28] Garrett & Garis, *supra,* at 61–72; AAI 5/11/09 White Paper, *supra,* at 5–7; Statement of National Association of Chain Drug Stores for Hearing on "Health Care Industry Consolidation," September 9, 2011 ("NACDS Statement"), at 4–6.

[29] *Pharm. Care Mgmt. Ass'n v. Rowe,* Civ. No. 03–153, 2005 WL 757608, *2 (D. Me. Feb. 2, 2005), *aff'd* 429 F.3d 294 (1st Cir. 2005).

may not make up for the higher base price of the more expensive drugs that the PBM selects based on manufacturer rebates or exclusive supply arrangement, resulting in a net economic loss to the benefits provider. In the current climate, PBMs "introduce a layer of fog to the market that prevents benefits providers from fully understanding how best to minimize their net prescription drug costs."[30] Further consolidation could threaten to make this problem worse.

Third, could the proposed merger lead to increased prices in the distribution of certain specialty pharmaceuticals?

Specialty pharmaceuticals, which are generally more costly than traditional pharmaceuticals, are an increasingly important area of concern for cost-conscious plan sponsors and a major source of revenue for PBMs. The cost of specialty drugs in the aggregate is rising rapidly—increasing by nearly 20 percent in 2010 and the cost of all specialty drugs is expected to reach as high as 27.5 percent of the cost of all medications covered by pharmacy benefits by 2013.[31] By 2016, 8 of the top 10 prescription drugs are expected to be considered specialty drugs.[32]

Specialty pharmacies manage the highly expensive treatments of the most dynamic, complex, and serious illnesses and the service they provide is both distinct and significant. Specialty pharmacies traditionally educate patients on effective treatment utilization, monitor side effects and partner with physicians to identify ineffective medications and recommend treatment changes. Specialty pharmacies also play an active role in providing continuity of patient care to ensure that costs are minimized and health outcomes improve.[33]

This proposed merger needs to be investigated to see whether it poses a threat to competition in this important area of primary care because each of the major PBMs has acquired specialty pharmaceutical companies in the recent years. Some critics have suggested that it is a common business practice for these PBMs to prevent other pharmacies from dispensing specialty drugs and to force patients to use the PBM's mail order facility.[34] These restricted networks disrupt the continuity of care and degrade health outcomes by forcing patients to switch away from their pharmacy of choice. The major PBMs also regularly mandate that patients purchase large supplies of expensive medication. Not uncommon in the treatment of these complex conditions, many patients may find after purchasing that they are not responsive to the drug, their treatment regimen needs to be adjusted or that they cannot tolerate the drug. Having already purchased a large prescription of non-refundable medication, even minor adjustments to improve the effectiveness of treatment may result in thousands of dollars in wasted medication in addition to the cost of the replacement drug that they need.[35]

Because the proposed merger would give Express Scripts-Medco a much larger role as a PBM, it will expand its control of patient data and realize an increased ability to use this data to move patients to its own pharmacy operations. This concern is real in light of CVS Caremark's demonstrated ability to use data received in its PBM capacity to boost sales of its CVS pharmacies.[36] Because the relationship with a clinical pharmacist has been repeatedly shown to improve medication compliance and health outcomes, a market free of anticompetitive conduct by PBMs to steer patients in-house would support the services that most effectively promote the health of the patient. This proposed merger, however, will likely limit patient choice and lessen clinical service because of the favoritism that the benefit manager exhibit towards its own mail-order operations.[37]

The proposed merger would create the largest mail order pharmacy in the United States, accounting for nearly 60% of all mail order scripts processed.[38] PBMs can direct prescriptions to their own mail order facilities instead of to competitors.[39] PBMs channeling prescriptions through their own mail order operations may maximize their own gains—at increased price to the plan sponsor—by selecting drugs on

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[30] *Pharm. Care Mgmt. Ass'n v. Rowe,* Civ. No. 03–153, 2005 WL 757608, *2 (D. Me. Feb. 2, 2005), *aff'd* 429 F.3d 294 (1st Cir. 2005).

[31] Express Scripts, *2010 Drug Trend Report: A Market and Behavioral Analysis* (April 2011), at 91.

[32] Medco Health Solutions, *2011 Drug Trend Report* (2011), at 35.

[33] Change to Win, *supra,* at 6; Balto 9/9/11 Testimony, *supra,* at 6; NACDS Statement, *supra,* at 6–7.

[34] NACDS Statement, *supra,* at 6–7; Balto 9/9/11 Testimony, *supra,* at 6.

[35] Lehigh Valley Women's Journal, Administrators of Pharmaceutical Industry "Steering" Profits to Themselves, and Refusing to Give Patients a Choice, Sept. 14, 2011.

[36] Change to Win, *supra,* at 6; Balto 9/9/11 Testimony, *supra,* at 6; NACDS Statement, *supra,* at 6–7.

[37] Change to Win, *CVS Caremark: An Alarming Merger, Two Years Later* (Nov. 2009).

[38] NACDS Statement, *supra,* at 7.

[39] Meador, *supra,* at 84.

which they receive superior rebates from manufacturers.[40] The opportunity for this kind of potentially anticompetitive, self-dealing, which harms consumers, will be enhanced by the creation of a dominant PBM in the mail order pharmacy market and the elimination of one of its only two real competitors.

In addition to expanding its ownership of specialty pharmacies and mail order operations, the major PBMs continue to expand exclusive distribution arrangements with pharmaceutical manufacturers. Further analysis is required to determine whether these acquisitions and distribution alliances have led to decreased service and consumer choice in providers, as well as substantial increases in the prices of several specialty drugs.[41] In the past, Express Scripts has imposed substantial price increases after becoming the sole distributor of certain drugs. For example, the price of H.P. Acthar Gel, a drug for treating children with a rare form of epilepsy, jumped from $1,600 a vial to $23,000 a vial after Express Scripts was given sole distributorship rights.[42]

By securing sole access to over 50 percent of the specialty market, Express Scripts-Medco could have increased leverage to restrict network access and enter into exclusivity arrangements with drug manufacturers.[43] The proposed merger thereby could increase the potential for Express Scripts-Medco to engage in anticompetitive conduct and threatens to increase specialty drug prices and limit access to critical medications.

Fourth, will the proposed merger increase the exercise of monopsony power to reduce the local delivery of pharmaceutical services?

We should be concerned that the major PBMs may already possess the ability and incentive to exercise market power over retail independent and chain pharmacies because reimbursement from PBMs is a major source of revenue for retail pharmacies.[44] The proposed merger could enable these major PBMs to push compensation to the retail pharmacies below competitive levels, ultimately leading to lost jobs and diminished service for their consumers.

An adverse impact on the delivery of pharmaceutical services at the retail level should be sufficient by itself to raise serious concerns and motivate the government regulators to closely scrutinize the proposed merger. In recent years, federal and state regulatory agencies have become more sensitive to the exercise of buyer power as raising a potential antitrust concern. The Antitrust Division has brought cases against both health insurers and agricultural processors based on the impact on doctors and farmers respectively. In the recent *George's Foods* enforcement action, the DOJ sued to enjoin a merger of two of the three largest chicken processors in the Shenandoah Valley area, which were "the only competitive buyers for grower services" in the area, solely based on the impact on chicken farmers.[45] Thus, the exercise of such buyer power should be a primary focus of any further review.

C. Potential Efficiencies Must Also Be Investigated

There should also be careful consideration about whether the proposed merger will lead to increased efficiencies that are specific to this proposed merger and that cannot be achieved by means not related to a merger. In the context of this proposed merger, any efficiency claims should be supported by existing business documents and demonstrable outcomes.

Cognizable efficiencies should not be associated with anticompetitive reductions in output or service. For example, if reducing excess capacity of mail order pharmacy services as the result of the merger is a potential efficiency, the companies should demonstrate that the existing mail order capacity has not historically contributed to lower health care costs for plan sponsors and that reduction in capacity would not also entail substantial job losses.[46] Competition also has the ability to create efficiency, and the merging entities must show that the same efficiencies cannot be realized through existing, continued competition.[47]

The FTC and this Committee should also work to make sure that any suggested cost savings will result from scale efficiencies and not the exercise of monopsony power and focus on whether, and to what extent, these claimed cost savings will actually be passed on to the PBMs' customers and, therefore, consumers. A fruitful area of investigation may be to determine why profits of the PBMs have increased

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[40] Garrett & Garis, *supra,* at 67.
[41] Meador, *supra,* at 77–84.
[42] AAI 5/11/09 White Paper, *supra,* at 9.
[43] Balto 9/9/11 Testimony, *supra,* at 6; Milt Freudenheim, *The Middleman's Markup,* New York Times, April 19, 2008.
[44] NACDS Statement, *supra,* at 3–7; Garrett & Garis, *supra,* at 46.
[45] *United States v. George's Foods, LLC,* No. 5:11-cv-00043 (W.D. Va.)
[46] Barclays Capital, Medco-Express Scripts Antitrust: Part II, Sept. 12, 2011, at 9.
[47] FTC v. Cardinal Health, Inc., 12 F. Supp. 2d 34, 61–63 (D.D.C. July 31, 1998).

at such a substantial rate during a time of industry consolidation which promised increased efficiencies. Does this suggest that the merged firms will retain a good portion of any future cost savings? Such profit retention (as opposed to passing on such savings) is consistent with a market place that exhibits less, not more, competition.

V. CONCLUSION

Thank you for providing me the opportunity to present my views of the proposed merger of Express Scripts and Medco. The proposed merger raises serious concerns that call for further careful study and evaluation, including the risks to competition in the PBM services to large plan sponsors, specialty pharmacy operations, mail order pharmacy operations and retail pharmacy markets, as well as to consumers and patient health care. The AAI looks forward to providing you its white paper once it has been completed.

Mr. GOODLATTE. Ms. Kanwit.

TESTIMONY OF STEPHANIE KANWIT, COUNSEL, MANATT, PHELPS & PHILLIPS, LLP

Ms. KANWIT. Thank you, Mr. Chairman and Members of the Subcommittee. I am honored to be asked to testify here today. I am Stephanie Kanwit, and I want to note that I am not testifying on behalf of either party to this merger, but, given my antitrust and Federal Trade Commission backgrounds, have been asked to testify about how the agency is likely to view this merger based on both Federal merger law as well as its previous and very extensive studies and letters relating to PBMs.

I have great respect for the FTC's expertise here. And they are very knowledgeable, the agency is very knowledgeable, about what PBMs do for a living, all the entities they interface with, and how competitive the market is. As Mr. Watt rightly noted in his introduction, the FTC is going to subject this merger to very close scrutiny.

And here is the ultimate question that the agency has to answer in antitrust lingo: Will it substantially lessen competition? And what that means is will there still be aggressive competition in the PBM marketplace that will promote lower prescription drugs prices for consumers and result in higher quality and more access to prescription drugs? As.

The Federal merger guidelines make clear—they were just enacted by the FTC and the Department of Justice last year—antitrust merger law is about the impact of the merger on the cost and quality for consumers. It is not concerned with the impact on individual competitors in that particular market.

So here is how the FTC will be looking at this merger. It is going to be looking at both hats that the PBMs wear. They wear many hats, but it is these particular hats they will look at.

First question: What is the impact on PBM customers? In a nutshell my testimony outlines in detail multiple reports and FTC investigations which have found the market competitive and found that PBM customers out there have choices. The FTC has repeatedly, in letters and studies, et cetera, talked about all the multiple PBMs out there, how they are varied, how they sell in a variety of geographic and product markets. And, in fact, some are even buying groups of independent pharmacies.

It is a fluid market where entries and exits are frequent. And, for example, I will just give you one example, recently the large retailer, Walmart, has entered the PBM space. So the bottom line is that the FTC has found, in a very extensive 2005 study where it subpoenaed PBMs for information, that customers both large and small have multiple choices and frequently can and do switch PBMs if they are unhappy with service or pricing, and that they can negotiate contracts that benefit their members and themselves at both prices and quality, whatever they want in terms of price and quality.

The number second question in addition to customers the FTC is going to ask is what is the impact on retail pharmacies? Now, the representative retail pharmacies here today have been very eloquent in condemning this merger, but I just want to make two points, one practical and one legal. As you have heard from some of the previous testimony, PBMs need retail pharmacies and pharmacists. They need them. They have to assure that their customers can fill prescriptions at various locations. And I would just note access standards in programs like TRICARE for the military and Part D Medicare, they are very, very strict what they call network adequacy standards, where, for example, in urban areas 90 percent of the beneficiaries have to live within 2 miles of a retail pharmacy. So it is important, as the FTC has found, for PBMs to have extensive pharmacy, retail pharmacy, networks.

Legally you have also heard some discussion about whether this is going to adversely affect retail pharmacists, but that is not the test under antitrust law. Antitrust law, as I mentioned, is concerned with competition in general, not individual competitors. So the FTC is going to look, and this is a long section of the merger guidelines, at whether it brings efficiencies to the market and what are those efficiencies.

I just cite in my testimony in detail a past PBM merger case talking about how a merger is pro-competitive if it results simply in a shift in purchases from an existing source to a lower-cost, more efficient source rather than a reduction in purchases. So, in other words, that is important. If you are taking costs out of a system, a merger can be very pro-competitive.

In conclusion, I just want to say the merger guidelines make very clear that the FTC is supposed to look and see whether a proposed merger is competitively harmful, but it is also supposed to avoid interference with what the guidelines call competitively beneficial mergers. That is right out of the guidelines. So the FTC is going to look at this merger in light of the prism of its previous conclusions in this area, and it has found in many different studies that the market is competitive.

Thank you for your time.

[The prepared statement of Ms. Kanwit follows:]

Prepared Statement of Stephanie Kanwit, Counsel, Manatt, Phelps & Phillips

Thank you for inviting me to speak today. I am counsel to the law firm of Manatt, Phelps & Phillips. I was formerly a Regional Director of the Federal Trade Commission (FTC), and have written a textbook on that agency. I have forty years of antitrust background as a litigator, have served as head of litigation for a large health

insurer as well as general counsel of a health plan trade association, and teach a course in health care competition at George Washington University graduate school.

I would like to note that while my firm is an outside counsel, as am I, for the trade association of pharmaceutical benefit managers (PBMs), and occasionally provides legal services for Medco Health Solutions, neither the firm nor I represent Express Scripts or Medco in regard to this proposed merger. Nor have I spoken to or consulted with any of the companies' personnel or their attorneys, or with any of the government personnel involved in the evaluation of the proposed merger in connection with the proposed transaction.

As a result, I am acting here as a witness at the invitation of the Committee, am not appearing on behalf of any party, and have purposefully avoided gaining specifics of the proposed merger except through public sources. My testimony outlines generally what the FTC has found in its extensive recent analyses of the competitiveness of the PBM industry, as well as my sense of how the agency is likely to view this proposed merger based on its previous rulings and studies.

More specifically, this testimony outlines:

(1) The role of the FTC in preventing unfair methods of competition.

(2) The FTC's extensive analyses of the nature of the PBM industry, including its multiple findings that the market is highly competitive.

(3) How the FTC has characterized the functions of the PBM industry and the characteristics of its participants, customers and contractual partners.

(4) How the agency could be expected to evaluate the proposed merger to determine if it "substantially lessens competition."

(5) The precedent of the FTC's opinion finding no anticompetitive effects of the 2004 AdvancePCS/Caremark merger, and how the agency evaluates merger efficiencies.

I. INTRODUCTION: THE FTC'S ROLE IN ENSURING COMPETITIVENESS IN HEALTH CARE MARKETS:

Health care markets have always been a high priority for the Commission. The agency's goal has been to ensure that these markets operate competitively, and its reports, advocacy letters, and investigations aim to carry out the mandate Congress gave it almost a hundred years ago, in 1914: to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[1]

The FTC's role, in a nutshell, is to protect the market from anticompetitive conduct that prevents it from responding freely to the demands of consumers. That is the key to antitrust law initiatives—determining the impact on consumers, in terms of possible higher prices and reduction in quality and choices. As former chair Timothy Muris of the FTC has succinctly stated, "Aggressive competition promotes lower prices, higher quality, greater innovation, and enhanced access."[2] The FTC and its sister enforcement agency, the Department of Justice (DOJ), step in when they view private markets as operating improperly, such as when competitors collude on prices, or divide customers and markets, or when monopolists charge higher than competitive prices for goods or services. Indeed, the Agencies have collaborated in issuing reports such as the massive 2004 Healthcare Report examining the role of health care competition in addressing the cost and quality challenges facing our health care system.[3]

The result of what Prof. Muris calls "aggressive competition," however, may not always be desirable for the particular competitors involved.[4] That's because competition law focuses on protecting competition and the competitive process, rather than individual competitors.[5] Indeed, in their 2004 Report the enforcement agencies pointed out that while "competition can be ruthless," in the long run the fact that

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[1] FTC Act, 15 U.S.C. § 45.

[2] Timothy J. Muris, "Everything Old is New Again: Health Care and Competition in the 21st Century," Competition in Health Care Forum, Nov. 7, 2002, at 6.

[3] FTC and DOJ, "Improving Health Care: A Dose of Competition" (2004) (hereafter "FTC/DOJ Report")

[4] Sage, W., Hyman, D., and Greenberg, W., "Why Competition Law Matters to Health Care Quality," 22 Health Affairs No. 2 at 31. (March/April 2003).

[5] See *Brown Shoe v. United States,* 370 U.S. 294, 320 (1962) (Clayton Act illustrates "congressional concern with the protection of competition, not competitors, and its desire to restrain mergers only to the extent that such combinations may tend to lessen competition.")

it "creates winners and losers can inspire health care providers to do a better job for consumers." [6]

Most pertinent here today is the FTC's merger work, including its issuance last year in conjunction with the DOJ of new revised Horizontal Merger Guidelines for the first time in more than 18 years. Those Guidelines, discussed below, provide what the FTC calls "more transparency so that businesses and their counsel may better understand the merger review process." [7] The FTC uses the principles in those Guidelines to review a wide variety of mergers in the health care arena, not just PBM mergers, but also drug company mergers, as well as mergers involving hospitals, insurers, and ancillary services like dialysis clinics.

II. THE FTC'S EXTENSIVE ANALYSES OF PBMS:

The proposed merger the Committee is focused on today involves pharmacy benefit managers, or PBMs, and the FTC considers itself as an expert in the area—and rightfully so. It has been extensively involved in reports and advocacy letters regarding PBMs, including:

- Its ground-breaking report on health care competition issued in 2004 (in conjunction with the DOJ) contains an extensive discussion of why the growth of PBMs constitutes "an important development in providing consumer access to prescription drugs." [8] The report devotes an entire chapter to how PBMs operate, and covers such topics as drug formularies, payment terms, industry overview, as well as data on PBM cost savings.[9]
- Its 2005 comprehensive "Conflict of Interest" PBM Study, written at the behest of Congress under the 2003 legislation that instituted the Medicare prescription drug program, which examined possible conflicts of interest that might arise when PBMs owned mail-order pharmacies. The Commission obtained extensive data, including agreements between PBMs and their plan sponsors as well as between PBMs and pharmaceutical manufacturers. The PBM Study found strong evidence that such ownership of mail order pharmacies generally did not disadvantage plan sponsors and that competition in the industry afforded health benefit plans sufficient tools with which to safeguard their interests.
- Multiple advocacy letters, where the FTC comments on the anticompetitive implications for consumers of proposed state legislation that interferes with PBMS' flexibility to work with their customers to design drug benefits that lower costs and expand access. For one example, it recently recommended against enactment of a New York bill that would limit a health plan's ability to steer beneficiaries to a lower cost mail order vendor of drugs.[10] For another example, it has been in the forefront in opposing state attempts to pass so-called "transparency" statutes (which mandate exhaustive disclosures of proprietary information to PBM clients) as counterproductive, because (1) PBM customers do not need the mandated information to make purchasing decisions, and (2) having that information publically available furthers possible tacit collusion among pharmaceutical manufacturers with which PBMs must bargain for lower drug prices.

The Commission's general concern in all these studies and reports, again, is how well the market is working competitively for consumers to keep drug prices low. The FTC has repeatedly cautioned against enacting legislation resulting in higher prices for PBM services and pharmaceuticals that can "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford." [11]

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[6] FTC/DOJ Report, Executive Summary, at 4.

[7] Id. at Sec. 1.

[8] "Improving Health Care," ch. 7 at 9. See Kanwit, S, "FTC 'Conflict of Interest Report': Implications for the Competitive Marketplace in Prescription Drugs," American Bar Ass'n *Antitrust Bulletin* (2005).

[9] There is extensive literature on PBM cost savings, including from the U.S. General Accountability Office (PBMs produced savings for health plans participating in FEHBP from retail pharmacies averaging about 18% lower than cash customers paid):"Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies," Jan. 2003.

[10] FTC Letter to Hon. James L. Seward, New York, Aug. 8, 2011.

[11] Letter to Assembly member Greg Aghazarian, California, Sept. 2, 2004, at 9; *see also* letter to Rep. Patrick T. McHenry, North Carolina, July 15, 2004; letter to Delegate Terry Kilgore, Virginia House of Delegates, Oct. 2, 2006.

III. HOW THE FTC WILL LOOK AT THE PBM MARKET:

The FTC will view the potential merger at issue here against the backdrop of this extensive history of analyzing the PBM marketplace, and hence some of its previous analyses and findings are instructive here in terms of (1) what the industry does, and (2) how competitive the industry is.

What PBMs do: More than 215 million Americans (nearly 90% of all of those with prescription drug coverage) get their benefits through PBMs, according to the research firm Visante. Those benefits can be provided through Federal programs (like Medicare, Medicaid, and the Federal Employees Health Benefits Program, or FEHBP), and also through the commercial market. The functions PBMs perform are many-faceted, as they interface both "up" and "down" with all the myriad entities in the drug distribution chain. In the words of the FTC, PBMs do the following:

- they interface with their clients, namely the health plans, private and public employers, insurers, unions and other entities that provide prescription drug benefits to their employees or members;
- they interface with retail pharmacies as they assemble networks to allow consumers to fill prescriptions at many locations;
- they may set up mail-order operations for health plan enrollees, often for maintenance medications;
- they interface with pharmaceutical manufacturers as they negotiate pricing, including preferred placement rebates and administration fees.[12]

In addition, PBMs often provide "quality-related" services to their customers, including the following, again in the FTC's words:

- they provide drug utilization reviews that include analysis of physician prescribing patterns to identify physicians prescribing high cost drugs when lower cost, therapeutically equivalent alternatives are available.
- they provide disease management services by offering treatment information to and monitoring of patients with certain chronic diseases.[13]

How competitive the market is: The FTC has consistently found that the PBM industry is *vigorously competitive,* in that multiple PBMs compete for contracts with plan sponsors.[14] The agency's 2005 PBM Study estimated that about 40–50 PBMs operate in the country.[15] Another source, Atlantic Information Services, indicates that today that number has risen to nearly 60 PBMs in the marketplace.[16]

No single PBM or PBM model dominates the marketplace. The Commission's former Chairman in the agency's FTC Study specifically noted "the variety of PBM services" available to PBM customers, including the wide variations in ownership structure.[17] Some PBMs are stand-alone independent PBMs (like Express Scripts), some are affiliated with health insurers or health plans (like Aetna, CIGNA, and Kaiser), and some consist of buying groups of independent pharmacies, such as EPIC. CVS Caremark is a combination of a PBM and a retail drug chain. Until recently, in fact, the large drug retailer Walgreens owned a PBM business, which it sold to another PBM.

PBMs also vary greatly when it comes to the market they specialize in—e.g., larger vs. smaller employers, or regional vs. national markets. Significantly, although some PBMs operate only locally or regionally, the FTC in the past has found them capable of competing with the big national PBMs.[18] Moreover, while some PBMs operate their own mail order facilities, others contract that service out. Some PBMs participate in the Federal Medicare prescription drug program known as Part D as PDPs, including the two companies at issue here, while some do not.

To add more heterogeneity to the competitors operating in the market, only some PBMs manage the important and fast-growing category of specialty drugs, i.e., those used to treat serious and chronic conditions like cancer, multiple sclerosis, hemophilia, and rheumatoid arthritis; the drugs in this category are not only costly (tens of thousands or even hundreds of thousands of dollars a year) but often require spe-

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[12] FTC PBM Study, Executive Summary, at i through vi.
[13] FTC Letter to Terry Kilgore, VA House of Delegates, Oct. 2, 2006 at 4.
[14] FTC Statement, *In the Matter of Caremark Rx, Inc./AdvancePCS,* at 6.
[15] FTC PBM Study, Exec. Summary, at v.
[16] Atlantic Information Services, "2000–2009 Survey Results: Pharmacy Benefit Trends and Data," 2009.
[17] FTC PBM Study, Press Statement of Chairman Deborah Platt Majoras, Sept. 6, 2006.
[18] FTC Letter to Rep. Patrick McHenry, regarding No. Carolina HB 1374 (July 15, 2005), at 8.

cial handling and administration.[19] Competing with PBMs in this market segment are entities such as health plans and stand-alone specialty providers.

IV. HOW WILL THE FTC DETERMINE IF THE PROPOSED MERGER WILL "SUBSTANTIALLY LESSEN COMPETITION"?

Under the Federal premerger notification program established by the Hart-Scott-Rodino Act, larger mergers are subject to the regulatory approval process run by the FTC as well as the DOJ.

The starting point in determining how the FTC is likely to look at this (or other) proposed mergers is the antitrust agencies' new joint Horizontal Merger Guidelines, released in April, 2010.[20] The Guidelines emphasize that they are just that –guides –to assist the analytical process. Their goal is to help answer the key question: *will the merger substantially lessen competition*? That accords with the underlying statute, Section 7 of the Clayton Act, which condemns mergers and acquisitions where the effect "may be substantially to lessen competition, or to tend to create a monopoly."[21] The Clayton Act is enforced by both the DOJ and FTC.

The Guidelines note that the Agencies wisely attempt "to identify and challenge competitively harmful mergers while avoiding unnecessary interference with mergers that are either competitively beneficial or neutral." How is that determination made? The process is always steered by the facts particular to a given merger. Like antitrust law in general, merger analysis is (in the words of the Guidelines) "a fact-specific process through which the Agencies, guided by their extensive experience, apply a range of analytical tools to the reasonably available and reliable evidence to evaluate competitive concerns . . ."

The most important theme of the Guidelines is that "mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise." Reams have been written about what constitutes "market power," but the definition in the Guidelines is relatively straightforward: *"A merger enhances market power if it is likely to encourage one or more firms to raise prices, reduce output, diminish innovation, or otherwise harm customers as a result of diminished competitive constraints or incentives."*

While the Guidelines generally cover merger analysis in terms of impact on pricing, they caution that enhanced market power "can also be manifested in non-price terms and conditions that adversely affect customers . . . " So the Agencies would look at a proposed merger through the prism of whether it would be likely to (for example) reduce the quality of the product, or the variety of product available, or reduce product quality, or diminish innovation—all key to assessing competitive impact.

What sources of evidence does the FTC look at? The Guidelines note that information can come from (1) the merging parties in the form of documents, testimony, or data "describing industry conditions," (2) customers, who can be asked about the likely impact of the merger, and (3) other industry participants and observers, such as suppliers, analysts, and rival firms in the market. All perspectives are considered, whether evidence that the "merger is likely to result in efficiencies" will be reviewed, as well as any evidence of possible anticompetitive results, such as "that the merging parties intend to raise prices, reduce output or capacity, reduce product quality or variety . . ."[22]

What kinds of evidence is the FTC assessing? Broadly, "*any* reasonably available and reliable evidence" may be reviewed to see if a merger "may substantially lessen competition." For example, the Guidelines call for looking at evidence regarding "direct comparisons based on experience," i.e., the *economic history and structure* of the PBM industry, such as "recent mergers, entry, expansion, or exits in the relevant market."[23] The second type of evidence would include "the merging parties' market shares in a relevant markets, the level of concentration, and the change caused by the merger." In addition, the Guidelines note that the Agencies will consider "whether the merging firms have been, or likely will become absent the merger, substantial head-to-head competitors."

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[19] "Slowing the Impact: The Role of Specialty Pharmacy in Managing Progressive and Chronic Diseases," UnitedHealth Group White Paper, April 2011.

[20] Horizontal Merger Guidelines, released April 20, 2010, replacing the Guidelines issues in 1992, revised in 1997. The FTC's Bureau of Competition has also issued a Statement on Negotiating Merger Remedies, at www.ftc.gov./bc/bestpractices030401.shtm.

[21] 15 U.S.C. § 18.

[22] 2010 Guidelines at 4.

[23] 2010 Guidelines at 3.

Applying the Merger Guidelines to PBMs:

Market share analysis generally:

When sellers exercise market power, it is called "monopoly," and when buyers exercise it, it is called "monopsony." Both decrease consumer welfare. PBMs can be viewed in a broad sense as both buyers (of services and discounts from retail pharmacies to be included in a plan's pharmacy network, for example) as well as sellers (of administrative services to health plans and their other customers). That dual role makes the analysis more complicated, but the same principles apply to both.

Media accounts of mergers or proposed mergers often focus on the concept of "market share," implying that this measure is a certain way to determine anticompetitive effects. What the antitrust agencies care about is *market power: do sellers (or buyers) in the market have the ability to profitably maintain prices above (or below) competitive levels for a significant period of time*? Measuring market power is a fact-intensive job. Absent *direct evidence* of anticompetitive effects (higher prices, lower outputs, and lower quality), the analysis begins with (1) identification of the relevant product and geographic markets, and then (2) calculation of the shares of the market participants and the concentration ratios. To identify concentration levels that might require further regulatory scrutiny, the antitrust agencies traditionally use the Herfindahl-Hirschman Index (HHI), calculated as the sum of squared market shares.[24] The antitrust agencies consider both the post-merger level, as well as the increase resulting from the merger, and regard a market in which the HHI is below 1500 as unconcentrated, while above 2500 is deemed highly concentrated.

But it is a mistake to place too much weight on market concentration in a highly fluid market like PBMs, where market shares are not "stable over time" (in the words of the Guidelines.)[25] As the Agencies note, "even a highly concentrated market can be very competitive if market shares fluctuate substantially over short periods of time in response to changes in competitive offerings." Conclusions regarding "concentration" depend enormously on how market is defined, whether broadly or narrowly. In addition, once the particular market is determined the real issue becomes whether the firm has obtained or maintained that power through improper means.

Applying the Market Share Analysis to PBMs:

It is likely that the FTC will find the PBM market to be unconcentrated, assuming it regards the product market as the national provision of pharmacy benefit manager services. As outlined below, (1) no single PBM's market share exceeds 12% based on 2009 data, and customers have multiple choices; (2) the market is dynamic, meaning that there are multiple entries and exits of market participants; and (3) it appears that the market has become more competitive and more heterogeneous over time.

To analyze competitive effects, the agency, in accord with classic merger analysis, will first likely define the various markets in which PBMs operate (e.g., small vs. large employer, government customers vs. commercial business, mail-order vs. non-mail order, among others) and analyze those customers' "ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service."[26]

While it is difficult to know definitively what market (or markets) the FTC will choose to evaluate here, it may be multiple markets. In a past (1999) evaluation involving a PBM, it found the market to be "the provision of [PBM] services by national full-service PBM firms."[27] Because both the merging parties operate nationally, that is likely to be designed as the geographic market. But in terms of product market, the FTC may decide to look not just at the commercial market as a whole, but also at the merging parties' shares of retail scripts vs. mail scripts; or shares of the Medicare Part D market, where numerous PDPs including UnitedHealth Group, CVS Caremark, Humana, Coventry, CIGNA and others compete.[28] Then the FTC must judge if the large employer market is separate from the small employer market, and if so, what the impact on those customers might be if the parties merged.

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[24] 2010 Merger Guidelines at 18.
[25] 2010 Merger Guidelines at 18.
[26] 2010 Guidelines at 7.
[27] *Merck & Co., Inc.,* 127 F.T.C. 156 (1999). That case involved the acquisition by a pharmaceutical manufacturer of a PBM.
[28] Note that Express Scripts partners with health plans in the Part D program, while Medco is a PDP itself, and has a broad portfolio of Part D products.

There are numerous sources of respected data for the FTC to peruse regarding PBM market share, and it is likely the FTC will look at both (1) the number of covered lives (i.e., members) each company has, as well as (2) the total annual prescription volume of each PBM. Using either measure, Atlantic Information Services (AIS) reports that no single PBM dominates the market: under the "covered lives" measure, the largest PBM in 2009 (CVS Caremark) had an 11.85% market share, while Medco Health Solutions was assigned a 8.67% and Express Scripts a 7.95% share.[29] Thus, no individual PBM's share exceeded 12% during that time period.

That 2009 data, however, must be tweaked in light of the fluidity of the PBM marketplace. Players (and their market shares) have changed since then, and are likely to continue to morph, a fact that the FTC will undoubtedly take notice of. The FTC and its economists in the Bureau of Economics will have up-to-the-minute data presenting a complete picture of that market in all its complexity. For an important example, the 2009 AIS data cited above will soon be outdated as to Medco, since UnitedHealth announced this summer that it will take back the PBM business it outsourced to Medco at the end of the year for its own PBM, OptumRx. Two more examples: the AIS 2009 survey lists Walgreens-OptionCare as having 10.85% of the PBM market, but Walgreens has since sold that business,[30] and it also lists WellPoint's NextRx as having 5.07% of the market, but WellPoint sold that business in the second half of 2009.

The possibility of new entrants is also critical: whether it is relatively easy to enter into the market and compete with the merged entity is also a factor for the FTC.[31] Again demonstrating the fluidity of the market, the large retailer Wal-Mart has recently entered the PBM space, and introduced a preferred network model that includes 400 employers and 20 PBMs and managed care organizations; it also has a Part D network in conjunction with the health insurer Humana.[32] Moreover, "Drug Benefit News" and other industry sources report continually on new initiatives and novel business models undertaken by large PBMs as well as small PBMs, some affiliated with health plans and some stand-alone, as well as retail pharmacies.

Impact of a merger on PBM customers:

The Merger Guidelines stress that what counts in assessing a proposed merger is whether customers have alternatives both in terms of price and/or quality.[33] The FTC will look at the impact on both (1) PBM clients, which include the health plans, private and public employers, insurers, unions, and (2) the ultimate consumers of those drugs, who will ultimately benefit if the merger brings efficiencies to the marketplace.

It is likely, given what the FTC has previously found to be the competitive nature of the market, that customers will have sufficient alternatives to which they can turn should they find that the merger has resulted in a price increase or a reduction in quality of service. Plan sponsors can and regularly do change PBMs if they are dissatisfied with performance and/or pricing.[34] The FTC has found that PBM customers are sophisticated purchasers, who often submit Requests for Proposal (RFPs) to suppliers of PBM services to assure they have options and an objective assessment of multiple alternatives. Often clients rely on expert consultants to assist them throughout the RFP process to assure their needs are met and their interests are protected, including agreed-upon pricing based on the customer's unique requirements, plan designs to encourage plan enrollees to use more affordable medications, specific performance guarantees, and extensive audit rights. Moreover, most PBM contracts are only for relatively short periods (one, two or three years is common) so that plan sponsors have the opportunity to switch PBMs if they are dissatisfied with performance or pricing.

As a result of the RFP process, the PBM customer can almost always leverage its negotiating ability and have multiple PBMs competing for its business. Sometimes those customers increase competition among PBMs by bidding out separate aspects of PBM services (such as claims processing or network access), instead of

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[29] Atlantic Information Services, Inc., 2000–2009 Survey Results, Pharmacy Benefit Trends & Data: Costs, Benefit Design, Utilization and PBM Market Share, at 53.

[30] Walgreens sold its PBM business to Catalyst Health Systems, and WellPoint sold its PBM to Express Scripts.

[31] "A merger is not likely to enhance market power if entry into the market is so easy that the merged firm and its remaining rivals . . . could not profitability raise prices or otherwise reduce competition . . . " 2010 Guidelines at 27.

[32] AISHealth.com, "Drug Benefit News," Sept. 9, 2011.

[33] Id.

[34] For example, CalPERS (the California Public Employees' Retirement System) announced in May, 2011 that it would not renew its contract with Medco beyond 2011.

retaining a single PBM to provide a comprehensive group of services. Moreover, critically for competitive purposes, these PBMs have to compete for the business on non-price dimensions as well, including benefit design, the extent of the retail network, and the quality of mail-order service.

The FTC has historically been very confident of plan sponsors' ability to negotiate flexible yet transparent contracts with PBMs that suit the customers' particular needs. As the FTC noted in its PBM Conflict of Interest study, "health plans already are able to negotiate contract terms –including diverse disclosure and audit rights— that protect them from conflicts of interest." The agency has emphasized the wide range of pricing models available to customers in PBM contracts.[35]

V. EVALUATING A PBM MERGER FOR POSSIBLE EFFICIENCIES: THE 2004 CAREMARK/ADVANCEPCS EXAMPLE:

In 2004, the FTC investigated a proposed merger of two large PBMs and found there was not likely to be anticompetitive impact either for plan sponsors or for retail pharmacies. In fact, the merger was found likely to generate *efficiencies* that helped the merged entity's ability to compete and might result in lower drug prices for consumers.

The then-proposed acquisition of AdvancePCS by Caremark Rx., Inc. involved (in the FTC's words) "two of the largest providers of prescription benefit management services in the United States." After analysis, it found the following:

- No anticompetitive impact for either small or large employer customers, because they could turn to other alternatives. The FTC concluded that (a) "dozens of small, often regionally-oriented PBMs provide sufficient service offering to smaller employers (and will continue to do so post-acquisition)," and (b) "large employers are not likely to encounter anticompetitive effects" given adequate competition from full-service PBMs with national scope as well as "significant additional competition from several health plans and several retail pharmacy chains offering PBM services . . ."[36]
- No anticompetitive impact on retail pharmacies: Focusing on the merged entity's future negotiation of dispensing fees with retail pharmacies, the FTC concluded that the impact was not likely to be anticompetitive. While those dispensing fees might be reduced as a result of the increased bargaining power of the merged PBM, such increased bargaining power can be "procompetitive when it allows the buyer to reduce its costs and decrease prices to its customers."

This second finding in the *AdvancePCS* investigation is important here, because the FTC addressed the fact that PBMs in effect wear "two hats" in the prescription drug marketplace. Viewed vis-à-vis retail pharmacies, PBMs are "buyers" of their services. What the FTC found is that it is procompetitive if a PBM merger results simply in a shift in purchases from an existing source "to *a lower-cost, more efficient* source," rather than a reduction in purchases.[37] And who are the ultimate beneficiaries? The consumers of prescription drugs, since the agency found it "likely that some of the PBM's increased shares would be passed through to PBM clients," given the highly competitive nature of the industry.

Thus when PBMs contract with retail pharmacies, it does not constitute an indicia of anticompetitive behavior if a merger results in lower payments to pharmacies. As the FTC commented: "Nor do competition and consumers suffer when the increased bargaining power of large buyers allows them to obtain lower input prices without decreasing overall input purchases."[38] The *AdvancePCS* merger analysis highlights a second important point: as noted in the Merger Guidelines, mergers can bring about efficiencies and enhance the merged firm's ability and incentive to compete. The result may be "lower prices, improved quality, enhanced service, or new products."[39]

While the Guidelines caution that these types of efficiency claims cannot be "vague" or "speculative," it is likely that the Agency will find efficiencies here, when the merger is viewed in light of the following:

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[35] FTC Letter to Hon. James L. Seward, N.Y. Senate, March 31, 2009; FTC PBM Study at 57–58.

[36] Statement of the Federal Trade Comm. "In the Matter of Caremark Rx, Inc./AdvancePCS File No. 031 0239" at 2, available at http://www.ftc.gov/os/caselist/0310239/040211ftc statement310239.pdf.

[37] FTC Statement at 2, emphasis in original.

[38] FTC Statement at 2.

[39] 2010 Guidelines at 29.

- the demand in the marketplace for PBM services,
- the highly competitive nature of marketplace, and
- the record of PBMs in driving down prescription drug prices.

The evidence on the last point, the record of PBMs in driving down drug prices, is impressive. Prescription drug spending (according to government figures) grew only 3.5% in 2010, down from 5.3% in 2009.[40] Much of the credit for that goes to PBMs as well as their customers, who are seeking to control total health care costs, and adopting measures such as promoting the cost-savings of generic medications as well as other options such as larger copayment spreads and narrower pharmacy networks.[41]

VI. CONCLUSION

The mission of the Federal Trade Commission in evaluating this proposed merger is to decide if the merger will be competitively harmful while at the same time "avoiding unnecessary interference with mergers that are either competitively beneficial or neutral."[42] The FTC is uniquely qualified to perform that evaluation –and in a relatively short time—given its past extensive studies and reports on the PBM marketplace.

Thank you for the opportunity to testify, and I am available to answer any questions on my statement.

Mr. GOODLATTE. Thank you, Ms. Kanwit. We will now proceed with questions for the witnesses. I will start with you, Mr. Paz.

Isn't there a great benefit to patients in having a personal relationship with a community pharmacist rather than a detached relationship with a mail order pharmacy? For example, how can Express Scripts' mail order drug adherence programs be as effective in promoting proper use of prescription drugs as a live, in person consultation with a pharmacist?

Mr. PAZ. Thank you, Chairman. First of all, to follow on with what Ms. Kanwit said, it is very important that we have all levels of access to pharmaceuticals, both at the retail level and at the mail order. If you think about somebody with a severe health condition and they are in a local community, they need to be able to get to that local pharmacist, and we do support local retail pharmacies. The independents are very important to us, as that is again part of the negotiation between the large drugstore chains and the small drugstores. It is very important to have them and to keep all the prices competitive. So we don't selectively choose one versus the other. Most of our clients, who are very sophisticated, want access. We supply access.

With respect to the actual pharmacist—I am sorry?

Mr. GOODLATTE. I just want to interrupt and ask you if your resistance to Walgreens' promoting 90-day prescriptions to its retail customers, is that at least partly motivated by your desire to fill these prescriptions through your own mail order pharmacy?

Mr. PAZ. No, sir. The 90-day prescriptions are set by plan design. We do not govern the client's plan design. We show them the cost. Mail order is much cheaper. It makes sense. We can fill over 100,000 prescriptions a day with Six Sigma quality; in other words, less than two defects per million error rates, which is very, very,

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[40] Keehan, S. et al., "National Health Spending Projections Through 2020," 30:8 *Health Affairs* (Aug. 2011), citing figures from CMS's Office of the Actuary.

[41] "Step therapy, generics, smart technology are among top 2012 benefit design tactics," "Drug Benefit News," Aug. 15, 2011.

[42] 2010 Guidelines at 1.

very low. The cost of producing an error in prescription is very high.

So what ends up happening is the plan ultimately decides what their cost structure wants to be. A company that is in economic trouble will be much more confined and want higher levels of mail order. Those clients that don't have economic issues, they may be less forceful in these areas.

For example, setting copay levels. The more the company has to save on its drug costs, the higher the copays. Express Scripts nor Medco nor CVS Caremark set those levels. The plan sets those levels. We administer those on behalf of our plans. Ninety day retail at Walgreens——

Mr. GOODLATTE. Mr. Paz, I am going to have to interrupt because I have got a bunch of questions to ask a bunch of people and only have 5 minutes to do it in.

Mr. PAZ. Well, let me just finish by just telling you that we do not want to stand in front of the community pharmacist serving their member. Many, many pharmacists——

Mr. GOODLATTE. Let me direct that question to Mr. Snow. You testified that PBMs are dependent on the continued existence of strong independent retail pharmacies and that PBMs engage in "mutually beneficial collaboration with independent pharmacies."

If the PBM-pharmacy relationship is mutually beneficial, why is there so much tension, criticism and distrust of PBMs among pharmacists?

Mr. SNOW. That is a very good question, and there are a number of factors that go into that, and I understand the plight of the independent pharmacists. If you look at the competitive landscape today, new retail pharmacies continue to open each and every year. They are independent pharmacies, they are chain pharmacies, they are grocery store pharmacies. The numbers of pharmacies in this country continue to grow. When I walked down the street in my hometown 10 years ago, there was one pharmacy that served my community.

Mr. GOODLATTE. But why is the tension there? Why when I visit one of these community pharmacies do I hear an earful about you?

Mr. SNOW. Here is why, because now there are two chain stores within 100 yards of that independent pharmacy. So you have intense—and every grocery store since 10 years ago has opened their own pharmacies as well. So you have enormous competition for that foot traffic. Patients are making choices. There is this competition for foot traffic. It is a very competitive environment, and it does put stress on the economics of an independent pharmacy.

Mr. GOODLATTE. Let me ask you a question about competition at the PBM level. What is the largest contract that Medco has bid for and lost in recent years that went to anyone other than Express Scripts or CVS Caremark?

Mr. SNOW. Let me think. I won't name the account, but it is a well-known account that was about $1.5 billion, and it went to one of those companies I mentioned in the second tier in terms of Catalyst Rx.

Mr. GOODLATTE. How long ago was that?

Mr. SNOW. That was I think 18 months ago, 2 years ago, approximately.

Mr. GOODLATTE. Thank you. Well, my time has expired. I will now recognize the gentleman from North Carolina, Mr. Watt.

Mr. WATT. Thank you, Mr. Chairman. I think Ms. Kanwit's testimony demonstrates how technical and precise this analysis will have to be and illustrates the point that I made in my opening statement. But we are here, and let me see if I can ask a few questions to try to clarify my own thinking.

Mr. Snow, I understand that Medco, the special niche that Medco has in North Carolina is in the specialty drug area, is that correct?

Mr. SNOW. We are in North Carolina. We have many, many clients in North Carolina, but we are a full service PBM. We don't have a special niche.

Mr. WATT. You said—you are denying what some people have told us?

Mr. SNOW. I do not have a special niche in specialty pharmacy in North Carolina.

Mr. WATT. If you do and Mr. Gustafson's testimony is correct that this combination will give more than 50 percent control over the specialty market, would that be a relevant consideration as far as you are concerned?

Mr. SNOW. Yeah, it would be. But the facts on this are in the PBM space broadly there are 40 competitors today. In the specialty space there are hundreds of competitors. And honestly, if you look at the specialty space, you need to look at the disease level.

Mr. WATT. I am not looking for a treatise on the way the industry works.

Ms. Kanwit, let me just pull out the specialty drug area here. Assume that the combination of these two companies ends up with more than 50 percent of the specialty drug market. How is that likely to play itself out before the FTC?

Ms. KANWIT. Well, number one, we have to decide—the FTC has to look at it, Mr. Watt, as the submarket, in other words, if that is an actual market for antitrust purposes there and that 50 percent is relevant.

Secondly, as I caution in my testimony, market shares per se don't really mean very much. What really is interesting is how much market power the companies can exercise.

Mr. WATT. You are saying a company that has 50 percent of the market doesn't have more market power than somebody that has 5 percent of the market?

Ms. KANWIT. Well, here is my point. Specialty drugs are a whole different kettle of fish and as I understand it, manufacturers of specialty drugs drive the distribution process. It is a different process than it is, say, with Lipitor or just a regular brand name drug.

Mr. WATT. Is that more a mail order——

Ms. KANWIT. Well, it can be, if they are maintenance drugs. There are very specific administration issues related to speciality drugs which as you know are for cancer and multiple sclerosis and hemophilia, et cetera.

Mr. WATT. So the bottom line is the FTC may segment this whole analysis on specialty drugs and analyze that as a separate impact situation?

Ms. KANWIT. It may. It may choose to do so.

Mr. WATT. Okay. All right. Efficiency, Mr. Paz and Mr. Snow, you have made some claims about it. How do we know that the results of those efficiencies are being passed along to customers?

Mr. PAZ. Well, I will start, and, David, you can certainly chime in. If you look back at Express Scripts' history, it is one of acquisitions. We have done many transactions. If you also look at our contract with the Department of Defense, we are proud to serve our men and women in uniform and their families. Over the course of those acquisitions, if you look at the pricing, the pricing has stepped down through every one of our acquisitions. We have saved the Department of Defense over half a billion dollars over our contract term.

Mr. WATT. That is fair. Let me just ask this question, Mr. Snow and Mr. Paz. You all have been competitors for a number of years. What benefits have there been from your being competitors that will go away as a result of the merger?

Mr. PAZ. Well, I don't——

Mr. WATT. I am just being honest now. This is not a trick question.

Mr. PAZ. I don't see the benefits going away. Actually, Mr. Snow's company, Medco, has a different approach to the administration of the drug benefit than my company. I think they are both very good. But together, combining the best of both companies I believe takes us to a whole new level of clinical expertise and the ability to drive more costs and improve health outcomes——

Mr. WATT. What do you say on that, Mr. Snow? My time is up, but I would like to get your view on it.

Mr. SNOW. The reason the companies hire us, Mr. Watt, is they——

Mr. WATT. That is not what I asked you, but if you want to answer a different question than the one I asked. I am asking what benefits were there from the competition between the two companies that will go away as a result of the merger?

Mr. SNOW. As Mr. Paz said, we honestly see no benefits going away. We only see benefits added.

Mr. WATT. Okay. My time has expired. Thank you. I yield back, Mr. Chairman.

Mr. GOODLATTE. The Chair now recognizes the gentlewoman from Florida, Mrs. Adams, for 5 minutes.

Mrs. ADAMS. Thank you, Mr. Chair.

Mr. Paz, we all know that health care costs are on the rise and a lot of us here and my constituents back home want to know what can be done to further lower the costs of prescriptions, both in the commercial market and Medicare and Medicaid markets?

Mr. PAZ. One of the most important things we can do, Congresswoman, is to eliminate fraud, waste and abuse. It is the biggest issue we face. Everything from, and Florida is a great example, we have helped the law enforcement agencies by turning over pharmacies that were pill-mills, if you will, where we could see undue uses of C2—of, you know, of controlled substances, I am sorry, I am used to the industry jargon, but controlled substances. And getting people to stay on their medication and getting them on the right medication and looking for gaps in care are incredibly important for eliminating costs in the equation.

Mrs. ADAMS. So what we are here to talk about is competition today, so I am curious as to how many PBMs typically compete with Express Scripts when you bid on a contract and how often do you win, how often do you lose on those contracts?

Mr. PAZ. Right. From a competitive perspective, most clients enter into 3-year contracts. When they go out for bid, they usually invite anywhere from seven to eight to nine different companies to bid that contract. They usually take it down to two or three, which become the finalists.

When you look at the purchasers of our product, these are very sophisticated buyers. They understand—the big, big Fortune 500, the big health plans, they hire people who know prescription drugs and have been in our industry, are pharmacists by education or have a medical background. They also hire consultants, and the consultants are the ones that also help them. They often come out of our industry as well. It is an incredibly competitive process bought by very sophisticated buyers.

Mr. SNOW. Congresswoman, can I add something please?

Mrs. ADAMS. Sure.

Mr. SNOW. It is an important fact that for the Fortune 50, there are 10 different PBMs right now serving the Fortune 50, to give you a sense of how competitive our market is.

Mrs. ADAMS. So would you agree that health care costs, it is waste, fraud and abuse, or would you believe that it is competition that could add to the lowering of the cost?

Mr. SNOW. I actually would focus on something else. George said our companies are different, and I think when you pull them together, you get more. But I honestly believe, and it involves all pharmacists, is we as a country need to focus on the better management of patients with diabetes and other chronic diseases, because they spend 96 percent of the drug money, 75 percent of the medical money in this country.

It is estimated we waste $350 billion a year each and every year because of the poor management of chronic and complex disease. Using a wired health care system, seeing gaps in care, helping pharmacists when they are seeing a patient know there is a gap in care, closing those gaps in care, get in enormous amounts of money that help our system.

We in fact in your State are doing a project with retail pharmacies where we push information about the patient and all the drugs they are taking from all the pharmacies they go to so that they can see up against national-based, evidence-based protocols what that patient's gaps in care are so they have an opportunity to close those gaps in care. And we have worked with States to help the retail pharmacies get reimbursed for that cognitive time and patient, because that is where—it isn't what retail pharmacies cost. They are an important part of our system. It is really how we are wasteful in the way we deliver total health care, and we need better systems to support the patient in that care. That is what Medco has been all about, and that is really what we want to continue to do.

Mrs. ADAMS. Did you want to add something to that? You looked like you were thinking about what he was saying.

Mr. LECH. Oh, yes. I have been chomping at the bit.

Mrs. ADAMS. I could tell.

Mr. LECH. I think we are confusing matters here. It is the pharmacies—the pharmacists who have gone to school to become pharmacists. It is not a PBM. It is not all this technology they talk about that makes that difference. Yes, we need the things that PBMs do. We need that data integration. We need those reports about those DEA kind of situations. But we have got it twisted by the way these gentleman to my right are describing it.

Somewhere in their testimony they mentioned that a pharmacy is complementary to the PBM industry. Well, I will tell you what. As a professional, as a pharmacist, they have got that totally backward. They are the complement to us. It is our profession, it is our art, it is our science, that in a sense they are getting in the way of. They have become burdensome and they have become fat, to use that word. And I believe the reason why they are fat is because of the profits that they are extracting by the eloquent way they have been able to self-aggrandize themselves and do this great marketing thing and release a study the day of the hearing that is funded by them.

So, rather than go on and on and on about that, I think we need to put things into perspective and put the power into the pharmacist's hands. We have that technology now. We might not have everything he is talking about, but we have computer systems that bring up interactions. And they say there is 100. The only ones I seem to get are the ones refilled too soon. We don't get these clinical edits, we can get them from our software. I get them from the online that I subscribe to for my clinical use, and my pharmacy and every pharmacist does that.

And we also—we need one—it would be ideal if a person had one pharmacy and one pharmacist. To have all this data, yeah, people travel and all that kind of stuff. But I think we need to get a health care system that directs persons to a pharmacy home, just as they do a medical home. When a doctor writes a prescription, that is the beginning of my job. You go to a doctor and you get a diagnosis and you get an examination and you get some lab tests that you want, his job is done in that sense. My job starts. And these guys are there to complement me in doing that and not get in my way.

Mrs. ADAMS. Thank you. My time has expired. I yield back.

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

Mr. CONYERS. Thanks, Chairman.

Mr. Snow, how has the health care bill complicated or made more convenient your life as a pharmacist?

Mr. SNOW. I would tell you that the health care bill has not necessarily complicated my life, other than the fact that underneath the policy Congress passed the rules are not yet written. So it is very difficult to manage my company and my 23,000 employees and set direction for that company when I don't know what the administrative rules are underneath the policy, because many of the things that were promulgated are not effective until 2014 and 2015. That is hard.

But I will say, I am a big believer that the things we are trying to do as part of health care reform are important. Chairman Good-

latte mentioned a comment I made on the announcement that in fact health care reform is driving many mergers. It is happening with physicians and hospitals. Hospitals are being bought by health plans. Health plans are buying physician practices. I am not saying these are bad things. I am saying that what is happening in our environment is people know that this combination in scale drives enormous efficiency that drives costs out of the system, which is really at the root of what health care reform is all about.

Mr. CONYERS. Who wants to add their view to this discussion? Okay, then I will call on somebody.

Mr. LECH. Driving inefficiencies out of the system is very important and we need to work together in doing that.

Mr. CONYERS. Well, Mr. Snow, you support the bill and its objectives?

Mr. SNOW. I support many elements of the bill, and I would also say that the bill is a first step along an evolutionary path. We are going to need to do an awful lot more to finish the reform effort.

Mr. CONYERS. Mr. Lech, have you ever heard of universal health coverage?

Mr. LECH. Certainly, Congressman.

Mr. CONYERS. Okay. How does that figure into your plans for health care for all Americans as an independent pharmacist?

Mr. LECH. If universal health care coverage means that every American has health care, then I am 100 percent in favor of it.

Mr. CONYERS. Does everybody agree with that?

You know, I don't get many volunteers for my questions. I am wondering, are you trying to—see, we have a fundamental philosophy here in the lawmaking process. My good friend the Chairman thinks that this was an ill-conceived effort in health care.

Do you, Ms. Kanwit?

Ms. KANWIT. Yes, Mr. Conyers. I think portions of the bill are very, very beneficial. For example, I am watching closely the portion on accountable care organizations, the Medicare demonstration project, to see if that can drive costs out of the system and get more value into the health care system.

Mr. CONYERS. Do you think the bill is unconstitutional, Mr. Paz?

Mr. PAZ. Sir, I am not a lawyer. I will tell you that I think part of the bill, again, is good. I think we are one of the richest countries in the Nation and people should have access to health care. I think that we did not do enough to address the cost side. I see it in my business every day, a lot of waste and spend. The $300 billion that Mr. Snow was discussing, we see it every day. We didn't address that, sir.

Mr. CONYERS. Boy. Did you guys meet before this hearing? No, I know you didn't. But what I am trying to find out—that is right, you are under oath, too, so you have got to tell me the truth.

Where does this issue of pharmacy practice—we have got three people for this bill, we have got three people against the bill. How does the ObamaCare health care plan affect your business?

Mr. SNOW. May I volunteer?

Mr. CONYERS. Yes.

Mr. SNOW. The way I think about the President's health plan bill and Congress' bill is that health care reform is a three-legged stool; it is access, cost and quality. We have done a good job beginning

the process of trying to get universal access. It is fundamentally important. However, we as a nation need to finance that access.

To Mr. Paz's point, I agree with him, we need to do more on the cost-quality equation side to pay for the access. So I think that is where more evolution will occur, and I think that is where the public-private partnership between health care providers and government is going to bring the best result. I think it is underway. It is just going to continue to evolve. You are already seeing some of the policies evolving as we work with them and we learn that there is even a better way. That is expected.

Mr. CONYERS. Can I get a half a minute more, Chairman Goodlatte?

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

Mr. CONYERS. How does all this saving from fraud, waste and abuse, how will that be affected by whether or not this merger is approved?

Mr. PAZ. Under this merger, one of—our continuing focus is to bring the best of both of our tools together to look for those gaps in care, to find out where prescriptions aren't being properly written, and contact the doctors, work with the pharmacists, work with the local pharmacies to make sure that in fact we can take that waste out of the system.

Many diabetics today are not getting drugs for hypertension and lowering their cholesterol. It is a proven fact those are better for them. We are not doing it today. Identifying that——

Mr. CONYERS. You know, you are the first—if somebody else agrees with you on the panel, I have never heard a pharmacist to call up doctors to tell them that they prescribe the wrong thing.

Mr. LECH. Oh, it happens all the time, practically daily.

Mr. CONYERS. Oh, really?

Mr. WIESNER. That is a daily occurrence, sir.

Mr. CONYERS. All right, let me recognize my friend over here.

Mr. GUSTAFSON. Congressman, I wanted to answer the question about fraud and abuse. I would suggest that the best thing that will combat the fraud, waste and abuse would be more vigorous competition. If these companies are forced to fine tune their operations in order to lower their costs so they can lower their bids to the customers that they seek to obtain contracts from, that alone will generate the best cost savings through saving fraud, waste and abuse.

And I was going to respond to Congressman Watt when he asked what would be missing if these two companies combined. What we will be missing is a national bidder in each of these accounts. When they have national accounts that they put out to bid every 3 years, what will be missing from the competitive landscape is a company that is capable of making a bid on those contracts.

Mr. LECH. In regard to fraud, waste and abuse, if I could reference the document I mention, Waste Not-Want Not, it goes on to show at least the waste part of it. I think we need to differentiate between fraud, waste and abuse. They are oftentimes lumped together.

Fraud is fraud. If it is criminal, it is criminal. That is pretty black and white. That has got to be dealt with in that way. Waste

can be underuse, overuse, excessive prescribing. Abuse could be narcotics that are taken too much, the dosages that are right for the patient or wrong for the patient. But if you look at those pictures, these are things that I see, these are things that every pharmacist sees, where patients bring in bags of things that they have automatically been shipped from the drug mail order firms.

Long ago when I first started testifying when I was a young buck, I testified in Pennsylvania in Erie with then State Senator Peterson, and the mail order companies at that time considered a drug called Accutane which now is in a REMS program, a program that you really need to be careful who gets it and how they take it and what happens to it after they get it.

They regarded, and it was Express Scripts, they regarded Accutane as a maintenance medicine. 180 doses were being dispensed and a teenager was taking these for maybe a week. All this extra medicine with a medicine that could cause—was known to cause fatal birth defects. So this is pretty telling I believe as far as the waste that happens. I think they could do a better job of fine tuning that.

Maybe a way they can do that is allow the pharmacist which knows which patient maybe can use a 90-day supply because of their ability to manage their own medicine; which medicines because of cost or danger might be drugs that shouldn't be 90-day supplied, to me a pretty commonsense thing. Let's take it a patient at a time and a drug at a time, and not lump it all into maintenance drugs. I think there is a problem with that because it is profit driven.

Mr. GOODLATTE. The time of the gentleman has expired. The gentleman from Pennsylvania, Mr. Marino, is recognized for 5 minutes.

Mr. MARINO. Thank you, Chairman.

Mr. Lech, how would my legislation be a positive impact on independent pharmacies, if it would be?

Mr. LECH. I believe it would be because the ability for—an independent pharmacy with one or two or not many locations is at a disadvantage when compared to other folks that may be able to negotiate certain prices, may or may not be able to negotiate prices. It would give us the ability to have access provided for the patients, which I think the Federal Trade Commission needs to consider. I understand from the testimony they are. I would suggest that a way that that could be done is to get out of the office and into the pharmacy and actually go see face-to-face what happens in those pharmacies.

But it would give us the ability to have a fair, level playing field. We are not asking to be paid more money, paid more money. We just want to be able to compete. And there are non-price issues also that can be addressed.

Mr. MARINO. I want to get a couple more questions in here. Mr. Paz, Mr. Snow, respectively, do you agree that that statement that Mr. Lech just made?

Mr. PAZ. Again, Congressman, I am not a lawyer, but I don't believe that allowing anybody in our—in American business to collude makes sense. Effectively it allows a whole bunch of people to come together and negotiate price against——

Mr. MARINO. Well, isn't that what you are doing? Isn't that what you do with a group of large chains who have more stores, they get a cheaper price?

Mr. PAZ. Well, first of all, they don't necessarily get a cheaper price.

Mr. MARINO. Okay. Now, are you telling me that the volume business that you do, I am an independent individual owning a pharmacy, and let's just say X, Y and Z owns 100 stores. You are telling me that I am going to get drugs generally speaking at the same price as X, Y and Z pharmacy?

Mr. PAZ. What I am telling you, Congressman, is that what determines price is the amount of competition in a given area. We have stores in Alaska, North Dakota and other areas that get paid much, much more than any other pharmacy. Where there is a lot of competition, competition sets price, as it should, in our country.

Mr. MARINO. Okay, I understand that. You are dodging my question.

Mr. PAZ. I am not, sir.

Mr. MARINO. Are you telling me that as an independent, I am going to get the same price as somebody owning 100 stores in my region?

Mr. PAZ. What I am telling you is that if you have 100 stores in a given region and there is a lot of competition, the plan design ultimately determines how many pharmacies——

Mr. MARINO. Okay, what if there are 100 stores with one company and there are three independent pharmacies. Are the independent pharmacies going to get the same price as the 100 stores?

Mr. PAZ. I can't answer the question blanket because it is not the same answer across the board.

Mr. MARINO. You know something else? As an 18-year prosecutor, you are dodging my question and you do not want to answer it.

Mr. Snow, do you want to answer it?

Mr. SNOW. Sure, I would like to. Thank you. At Medco, we recognize the plight of the retail pharmacist who is an independent, does not have the scale, does not have the purchasing power of some of the bigger chains. It is not uncommon for our independent retailers to have higher reimbursement rates in our network than the larger companies who have the ability to negotiate a cheaper price, number one.

Number two, one of the things that is in place today, and you may be aware of it but I just want to say it for the records, there are group purchasing organizations that many individual retailers join so that they can get purchasing scale relative to buying their drugs, buying the things that they put into their store, so that they can at least begin to create critical mass to drive the kind of price that their competitors do.

Mr. MARINO. Okay, sir. I understand your answer. Thank you. Do either of you, Mr. Paz or Mr. Snow, do you disagree with my legislation?

Mr. SNOW. I would say, sir, that as Mr. Paz said, I am not a lawyer. I would——

Mr. MARINO. Gentleman, stop with "I am not a lawyer."

Mr. SNOW. I would like the independent retailers to survive. I would like them to have the right footing in a way that doesn't violate antitrust. So whatever the lawyers and the FTC and Congress decides, I think what you are trying to do for the retail pharmacist is the right thing to do. How to do it, I am not as sure, but that is not my job. I agree with what you are trying to do.

Mr. MARINO. Thank you. Do either of you own—your companies own retail pharmacies? Mr. Paz?

Mr. PAZ. No, we do not.

Mr. MARINO. Mr. Snow?

Mr. SNOW. No, we do not.

Mr. MARINO. Do you own mail order businesses related to pharmaceuticals?

Mr. PAZ. Yes, we do.

Mr. SNOW. We are a mail order pharmacy.

Mr. MARINO. And am I correct in assuming that you do direct your customers to purchase from your mail ordering, as opposed to independent pharmacies?

Mr. PAZ. If the client wants it. Again, I am not trying to dodge your questions, Congressman, but let me fully answer that question.

Mr. MARINO. Thank you.

Mr. PAZ. Some clients do not allow mail order. Some clients want mail order. It is a plan design decision that we administer for our clients. Mail order costs less than retail pharmacies. There is better economics of scale. We can deliver cheaper. So if a client directs us to, then we use mail order. If they don't, we don't.

Mr. MARINO. Chairman, could I have 30 seconds, please?

Mr. WATT. I ask unanimous consent that he have 2 additional minutes.

Mr. GOODLATTE. Without objection, the very generous motion of the gentleman from North Carolina is agreed to.

Mr. MARINO. Thank you, sir.

Gentleman, you are saying that this merger—and my legislation, I think you are aware of this, has nothing to do really with the merger or no merger. Do you understand that? My legislation is to give the independents—be able to form a group to purchase stronger in a power situation where several individuals as opposed to one is purchasing drugs from any company.

But are you saying that with this merger, and I am going to put you both on the spot right now, that you are guaranteeing that you are going to be selling drugs to the consumer at a cheaper price than you are selling it now?

Mr. SNOW. Total drug costs with our book, not drug by drug, total drug costs will go down. It absolutely will go down. And that really depends on our customer's design, what patient gets and what the payer retains. So we have Fortune 500 companies. As George said, they all specify plan design.

Mr. MARINO. Okay, let me back up here a moment. I get your answer. I get your answer. I do, sir. I understand it. I have limited time here. But you said total cost. Now, coming from the business sector, I know what total cost means. It can mean anything from it is going to be cheaper to maintain the building, I am going to be able to hire somebody at less of a cost.

If I purchase drugs from you, if you are merged tomorrow, am I going to get them cheaper tomorrow than I will today from you independently?

Mr. SNOW. Yes, you will. And can I just explain my answer?

Mr. MARINO. Please. Go ahead.

Mr. SNOW. Okay. The reason I said it the way I said it is that there are certain drugs where there is no other drug competing against it. It is a single type of drug in the class, meaning you have no leverage to gets the price down. Many of the biotech drugs are that way. But where there is competition and you have leverage, you can get better drug pricing, you can get better procurement prices for drugs. Absolutely.

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

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

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

Ms. CHU. Thank you, Mr. Chair.

I am hearing from my community pharmacists who are very concerned about this merger creating even more buying power for PBMs. They are expressing concern that the large PBMs will leverage their market share to force pharmacies into even more unfavorable contract terms and that they will have to make the decision to choose between inefficient reimbursement rates or exclusion from the PBM networks, and that they don't have the bargaining power to negotiate better contract terms so they oftentimes find themselves agreeing to more unfavorable terms.

Mr. Lech, could you comment on that?

Mr. LECH. Well, I didn't get into the practice of pharmacy to eventually think that I would be forced out, whether it would be by a decision of myself or someone else that made that decision. The last thing I want to do is stop providing what I do to my patients and my customers and my consumers. And when the time comes, I would like to transfer that perhaps to my sons, who are both—one is a pharmacist and one is about to become a pharmacist, or to someone else if my sons don't want to do that.

But if there came a time when because of onerous restrictions, whether it be price or non-price, and when I say non-price, there are many dozens of things that could be included in that, I can't deny that there may come a time when the decision to say I can't do it anymore happens. And it would be certainly not what I wanted to do, but what I had to do from a business perspective.

Ms. CHU. How much business does your pharmacy do with PBMs?

Mr. LECH. With PBMs. Third party we call that, probably 90. These particular PBMs, if the merger were to happen, it would be over 50. That counts Medicare part D and all the different components of the claims process.

Ms. CHU. Mr. Wiesner, would you want to comment on this issue about the contract terms?

Mr. WIESNER. Sure. Just to go to your last question, currently about 90 percent of our prescription volume is paid for by a third party. The two gentlemen, their particular group combined together, would be one-third of our entire volume.

From the standpoint when we are talking about unilateral contracts and things of that nature, it puts us in a very precarious position. We are in that position because that is one-third of my customer base. So if I am presented with what I would deem to be an onerous contract, I don't have much wiggle room. And we are reaching very quickly a tipping point as it relates to our cost to dispense products, which hasn't really been discussed today but there have been quite a few studies, and the ability for us to at least receive that much as an equitable reimbursement for our activities.

So I think not only my company, but many companies have kind of reached a point in the entire process where we are having to take a step back and understand, is this a viable activity we can continue to engage in? We want to take care of our neighbors and our community, but we have some real concerns along that regard.

One last comment. There is a little bit of a difference in my world. There is a lot of talk about rebates from manufacturers and getting greater discounts with rebates from manufacturers. And what we are talking about are brand products for which there is not a generic. In my world, because these gentlemen may get a rebate, that does not mean my cost to obtain that product is going down. So there is two different scenarios when you are talking about product cost.

Ms. CHU. I see. I would also like to ask about the transparency. The merger of Express Scripts and Medco would result in one PBM controlling one-third or 135 million of all American prescriptions, and so transparency will be a major concern for a company that will be handling such a large amount. And a concern for PBM transparency was recently raised in a March 2011 Office of the Inspector General report which cited concerns about the lack of transparency with regard to PBM rebates in the Medicare part D program.

So Mr. Gustafson, I would like to know about wouldn't the natural assumption be that this concern would grow if this merger is approved and won't the level of transparency decrease post-merger because employers and health plans would have fewer options and thus not be in a position to demand greater transparency?

Mr. GUSTAFSON. I think that is right, Congresswoman. I think one of the things that competition does in this marketplace, in any marketplace, is it forces the seller to be more transparent because the consumer has more choices, or in this case the plan sponsor or whoever the customer is in that instance. So I think that concentration in this market will allow the participants who remain to be less transparent, and I think that is bad for the competition levels and it is bad ultimately for the consumers.

Ms. CHU. Okay. Thank you.

Mr. GOODLATTE. I thank the gentlewoman. The gentleman from New York, Mr. Nadler, is recognized for 5 minutes.

Mr. NADLER. I thank the Chairman.

Mr. Gustafson, Mr. Watt discussed the issue of product markets. What do you see as the relevant product markets for antitrust purposes that should be analyzed as part of this merger and in which product markets would concentration under the merger cause the most concern and could divestitures in any of these market alleviate those concerns?

Mr. GUSTAFSON. Congressman, I think that there is—probably the FTC will ultimately decide that there is more than one market here. There certainly seems to be markets that—at this stage of our investigation that large plan sponsors is probably a market, the specialty drugs may very well be a market. So I think that there is—mail order may be a market. Probably not, but it is possibly a different marketplace. But ultimately I think there is more than one market.

The question about whether divestitures would be a solution to this merger, it is probably too early to tell, but there are certainly some things that you could consider in terms of divestiture that would be useful. One is the speciality drug companies that these two merger partners own. Another would be the mail order businesses that they own or part of the mail order businesses, because both of those instances would lessen their grip on the national accounts.

Mr. NADLER. Thank you.

Mr. Snow, you testified that the merger would give the new combined company greater power to negotiate prices with drug companies and therefore would result in lower drug prices.

Mr. SNOW. Correct.

Mr. NADLER. Would you say the same principle would apply if we were to say that Medicare could negotiate drug prices with the pharmaceutical companies and if we let them negotiate the prices, instead of prohibiting them by law, the market power of Medicare would cause a great reduction in drug prices for Medicare?

Mr. SNOW. Scale does drive better pricing. It does.

Mr. NADLER. So Medicare would have tremendous volume pricing power if the law were changed to enable them to negotiate and use their pricing power to negotiate cheaper drug prices instead of prohibiting them?

Mr. SNOW. Technically, yes. I would also tell you though that it is not uncommon for PBMs in the private sector to bump up against Medicaid best price when they could have done better had the government not set that floor. So it is a double-edged sword.

Mr. NADLER. I didn't follow that.

Mr. SNOW. So there is already today Medicaid best price legislation that says that no one can negotiate a price that is better than Medicaid.

Mr. NADLER. That is lower?

Mr. SNOW. Yes. So they by definition must always have best price.

Mr. NADLER. And the best price is what Medicaid pays?

Mr. SNOW. Yes, it is what Medicaid pays and it is what the government has negotiated with that manufacturer on Medicaid. And all I am saying is that Medicaid best price legislation has become a floor below which we can't negotiate.

Mr. NADLER. But we prohibit Medicaid from negotiating that price, do we not?

Mr. SNOW. Medicaid demands. It is the same issue. They demand that they get best price, which means the manufacturer says you can't do better than that. If government negotiates, manufacturers will say, well, you know, I am going to have to keep the prices high

because I can't afford to do this, and they basically create artificial—artificial floors below which you can't negotiate.

Mr. NADLER. I don't understand what you are saying at all. Let's go back to basics for a moment. I really just don't understand what you are saying, and I am generally not that incomprehending—uncomprehending.

We had a major political argument that said Medicare, I am not familiar with the data on Medicaid, but Medicare should or should not be able to negotiate prices, and Medicare should negotiate prices because with their volume pricing they can get better prices. That is the argument.

You are saying that if your two companies merge because you have greater market power you are able to negotiate lower prices, which seems to be the same argument. And you said a moment ago that that would be a valid argument, that scale does matter. Now you are telling me that Medicaid has—do they negotiate the price?

Mr. SNOW. No. They have what is called Medicaid best price.

Mr. NADLER. So in other words, they can't be negotiate the price. So that is a separate—they should be able to negotiate the price, would follow from your logic, to get better prices.

Mr. SNOW. Government as a whole with their scale should.

Mr. NADLER. Fine. That was my question. We could save a lot of money if government could use its scale to negotiate prices, as your two companies could save money by combining and using your power of scale to negotiate prices. Thank you.

Now, my next question, let me ask Mr. Lech, I was going to ask this question and maybe it was what Mr. Marino was referring to before, I don't know. But small pharmacies I understand are not allowed to combine—actually, Mr. Snow, small pharmacies are not allowed to combine to negotiate because that is a violation of antitrust. Now, it seems to me that maybe we should allow them to do that. Maybe that is what Mr. Marino is referring to in his legislation, to allow them to get together, because then they could get presumably a better situation.

But you said a few moments ago, Mr. Snow, that—I think it was you that said it, that small pharmacies get together now in co-ops sort of——

Mr. SNOW. They do, in group purchasing organizations.

Mr. NADLER. And that does not violate the antitrust laws?

Mr. SNOW. No.

Mr. LECH. But it doesn't achieve the negotiations that you are referring to, because it is not binding on any of the pharmacies, and the PSAOs, I guess in a perfect world what Mr. Snow said would be true, that they are able to negotiate better prices. The reality is it is not what is seen to happen.

Mr. NADLER. Well, let me ask Mr. Snow one last question because I see my time has expired. It went very fast.

Given the greater concentration that would result if this merger went through, would you think it would be fair and right to allow an antitrust exemption for independent pharmacies so they could have a reasonable basis for negotiating with you?

Mr. SNOW. I personally don't believe they need it because of us, because as I have mentioned earlier and George has mentioned

earlier as well, we need retail pharmacies. They are an essential part of what we do.

Mr. NADLER. But in terms of enabling them to survive——

Mr. SNOW. If you want natural competition to occur, you have to believe the companies are not going to do something that is not in their best interests. We need these retail pharmacies. As I mentioned in my oral testimony, 85 percent of all the prescriptions we do for all of our members come from retail pharmacies.

Mr. NADLER. That is very nice, but it is not responsive to my question. My question really is, obviously you want to get the best price you can from the pharmaceutical companies and you want to sell the drug to the pharmacies, not for the lowest price possible from their point of view. They want the lowest price. You are the middleman, right?

Mr. PAZ. Sir, we are not wholesalers, sir. The retail pharmacies buy their own drugs and then we reimburse them for what they buy. We are not the wholesaler. We only buy drugs direct that go through our mail order.

Mr. NADLER. Yes, sir.

Mr. LECH. That reverts back to the beginning of this conversation when Congressman Conyers asked who are these people and where do they fit in. We welcome—I wish to be able to wrap my arms around the PBM industry and speak with local purchasers of prescription insurance and talk to them as if I could trust everything that they are saying and promoting and marketing to be true. But in the 30 years that I have been practicing, it has gone the other way. And that is why we need legislation like Congressman Marino has introduced.

I would recommend that you read the legislation first. What it does is it offers an exemption, but the exemption is defined. It defines a marketplace. It is not a county-wide or region-wide or every independent pharmacy.

Mr. GOODLATTE. Mr. Lech, I hate to interrupt you, but the gentleman's time has long expired.

Mr. NADLER. I thank the Chairman for his indulgence.

Mr. GOODLATTE. The gentleman from Florida, Mr. Deutch, is recognized for 5 minutes.

Mr. DEUTCH. Thank you, Mr. Chairman.

Mr. Chairman, as I brought up in a letter to the FTC Chairman, I have heard some real concerns from constituents in my district that the acquisition could result in diminished competition, could have a negative impact on healthcare costs, or could jeopardize the overall quality of patient care, and I would like to focus on two of those, if I may. The first is cost.

Mr. Snow, if I understood you correctly, you said that, or if you could elaborate, there would be $1 billion passed back to consumers. I would like to understand that. And then, Mr. Gustafson, after Mr. Snow explains, if you could respond, because I think what you said earlier in your testimony was that past consolidation suggests that there will be higher prices for consumers.

Mr. Snow, could you speak first?

Mr. SNOW. Absolutely. Thank you. So we have contracts with clients today that have 100 percent pass-through of our pricing, of our rebates. So when a merger like this occurs, you actually com-

bine the best-of-breed contracting that we currently have as independent companies today. When you just look at best-of-breed contracts between the two companies post-merger, it results in $1 billion of savings that by definition under our existing contracts with our clients they get immediate benefit for. It goes right back. And when I say client, it is our employer customers and our health plan customers and our State government customers.

Mr. DEUTCH. So Mr. Gustafson, could you help me make some sense of this, because ultimately I am concerned about the I am fact it is going to have on consumers.

Mr. GUSTAFSON. What I had testified about was that when they claim the $1 billion in efficiencies, we need to make sure we document it, because we have had a lot of consolidation in this industry where promises have been made. We have a data set. We can go back and look. When CVS and Caremark merged, they made promises about efficiencies, and when——

Mr. DEUTCH. I am sorry, Mr. Gustafson. What kind of promises were made and what was the result?

Mr. GUSTAFSON. Well, I am not familiar with the specifics of the promises as I sit here, but I know the mergers were defended on the basis that they would provide cost savings which would be passed on. And the data that I have seen suggests that the profits of these companies are soaring, which suggests that they are not passing it on, which suggests that they are taking whatever savings they get and putting them through to their bottom line.

Mr. DEUTCH. I appreciate that. I would like, Mr. Lech, if I could turn to you for a moment. In your testimony you talked about the gradual shift of smaller and medium-sized PBMs being bought out by larger ones and you mentioned that the reduced competition hurts smaller pharmacies like yours.

Can you speak specifically—can you help us understand what that looks like for your customers? Those negotiations with PBMs that have changed, what impact has it had on the customers, on the consumers?

Mr. LECH. Well, the reason it will have a negative effect is basically because it is a take it or leave it contract. The statement was made earlier that, you know, we are very business-minded, savvy people, and if we get a contract that doesn't look good, we are going to say no. Well, that is hard to do. It is not hard to do businesswise, but hard to do in a humane kind of way, to say "Congressman, I can't fill your prescriptions anymore." So access to the pharmacy of their choice and I believe also ultimately the price and the cost.

What we have seen in all these claims of we are going to reduce costs, we are doing to reduce costs, the prescription prices keep going up. The sponsors of the plans keep paying more. The consumers are paying higher copays. The pharmacies are being paid less. So where is the money going?

I would refer back to Mr. Gustafson's recent answer about those profits are going into the corporate.

Mr. DEUTCH. I am sorry, can you just walk through that piece step-by-step? The payments to the pharmacies, the copays, can you just take me through that a little slower?

Mr. LECH. Sure. Year after year we hear claims that the cost of medicine is going to go down, and we are hearing it again, and it was a guarantee I believe I heard, that the price will go down if this merger takes place.

Well, first of all, I can't see how that is going to happen. But as time goes by, year by year, prices continue to go up. So that money is going somewhere, okay, maybe to the manufacturers because of the cost. But look at all the players and what they do.

There is the plan sponsors, let's say the corporate employers of the world—of the country. Their cost to insure their folks for prescriptions are going up. The out-of-pocket expenses in the way of copays are rising for the consumer. The rates being paid to the providers are less. So where is the increased profit going?

Mr. DEUTCH. And, finally, Mr. Lech, that has all happened during a period of consolidation?

Mr. LECH. It happened as consolidation has taken place. I don't know how to directly attribute it.

Mr. DEUTCH. Thank you, Mr. Lech. Unfortunately, I am out of time. Thank you, Mr. Chairman. I yield back.

Mr. PAZ. Could I answer some factual points here?

Mr. GOODLATTE. We are going to allow some of the panelists to ask some additional questions, so we will give him the opportunity to do that if he chooses to.

At this time we will do a second round here. I am going to ask a couple of questions myself and yield to Mr. Watt. And while I do that, I will ask Mr. Marino to take the chair since I am going to have to go to another meeting myself, and then he can ask his questions and yield to any other Members who have questions they would like to ask. And I have two.

First, one to Mr. Lech. Community pharmacies have long complained about allegedly unfair practices by PBMs, and PBMs have long had significant influence in the prescription drug markets. Why will this merger make these alleged problems worse, in your view?

Mr. LECH. Well, the take "take it or leave it" contracts can make it less people that I have to say take it or leave it to. It now is becoming a bigger percentage of my business, which makes it harder for me to negotiate. It gives me less leverage. And again, I would love to believe that when they say they want to work with me and they need me, I have not seen that. It is just talk. So as the company gets bigger, the ability for me as a provider, as a health care—as a pharmacy, it becomes less of an opportunity or less of an actuality that I will be able to—discerning against the bigger party.

Mr. GOODLATTE. Mr. Paz, do you want to respond to that based upon your——

Mr. PAZ. Yes, please.

If you go back and look at the releases that have come out of the Department of Defense as one case in point, we have heard testimony that, in fact, our efficiencies through mergers and acquisitions hasn't been felt by our plan sponsors. The prices that we put forth in our Department of Defense contract, we have actually exceeded those. We delivered higher savings than was originally promised under the Department of Defense——

Mr. GOODLATTE. What about the small pharmacies like Mr. Lech?

Mr. PAZ. Again, I go back to the same statement, sir. They are a critical component of our offering. We do not want to see Mr.—Mr. Lech go out of business, nor will we put him in that position.

What he fails to mention is that we have access standards under both Federal law and under client contracts which require a certain area you have to go to be able to find a pharmacy for the health and well-being of our members. We comply with all of those rules. Under the Federal standards and underneath, you know, our client contracts, he is an important component of our offering.

Mr. GOODLATTE. Mr. Lech?

Mr. LECH. What Mr. Paz fails to tell you is that the Department of Defense is a special entity, because through the mail they are given larger discounts. Those discounts have not passed on as much to me as an independent pharmacy. So the economies of scale are different with the Department of Defense because their contracting ability is greater than your average corporate purchaser.

Mr. PAZ. The savings, though, is discussed——

Mr. GOODLATTE. I can't go back and forth too many times.

Mr. Gustafson, you testified that the Express Scripts-Medco merger reduces the number of viable providers of PBM services to large plan sponsors from three to two. Why aren't Catalyst, Optum Rx and Prime Therapeutics, which already handled plans for Fortune 50 companies, viable providers of PBM services to large plan sponsors? Catalyst has won contracts for such large employers as Ford Motor Company, Nike, Sprint, Waste Management and Southwest Airlines.

Mr. GUSTAFSON. They are not as big, and when these two combine, they are going to be bigger yet. And when they take that combination, they are going to be able to extract more discounts on the side of the pharmaceutical companies, they are going to be able to direct more to the mail order, they are going to have a bigger control of the specialty pharmacy products. All of that is going to make them more powerful vis—vis the other PBMs.

Optum Rx is a good example because they suffer from another potential problem. UnitedHealth Care, their underlying parent, I guess it is, is a competitor of other plan sponsors. And so there has been a fair amount written about the reluctance of Cigna or Aetna or someone like that to use a PBM like Optum Rx because of the potential issues with respect to data access, things like that.

But I think the question that we ought to address in this is how big is big enough? I mean, if we were talking about a merger of——

Mr. GOODLATTE. Under the antitrust law that is not the issue that we address. The issue that you address is do they have market power that would preclude others from being able to enter the marketplace and offer competitive plans that would maintain the competition that is, in the view of—certainly in my view—in view of the law as it is written, is a desirable thing to have?

Mr. GUSTAFSON. Sure. I agree with that. What I was suggesting was how big is big enough with respect to the efficiencies they claim they can garner by getting together and being bigger? At some point, you know, there are no more efficiencies that can be

gained by getting bigger. They only become able to extract the power that they have——

Mr. GOODLATTE. Well, that is the underlying issue, not how large they have to be and still maintain their efficiency.

But let me yield to the gentleman from North Carolina Mr. Watt and see if he has any additional questions.

Mr. WATT. Well, I have got all kinds of questions. I am not sure what they have to do with the merger, but I am just trying to be a little bit clearer on how this industry fits together.

Somebody help me if I am leaving out somebody. You have got pharmaceutical companies, you have got plans. Those are the insurers, right, or self-employed—self-insured employers, right?

Mr. LECH. Payers.

Mr. WATT. Payers. You have got independent pharmacies. That is Mr. Lech. You have got chain pharmacies. That is Mr. Wiesner and CVS and Rite Aid and——

Mr. SNOW. Walgreens.

Mr. WATT. Walgreens. You have got PBMs, and you have got customers.

Mr. SNOW. You also have big box pharmacies. Walmart, Target, Costco.

Mr. WATT. Retail stores.

Mr. SNOW. Grocery stores.

Mr. WATT. Somebody explain to me quickly how all of these things fit together. I mean, or does it vary from case to case? I know that the pharmacy companies, pharmaceuticals, make the drugs, right? I mean, they got the patents.

Mr. SNOW. Uh-huh.

Mr. WATT. The plans insure people. They cover them. They pay somebody for the drugs. And so between them and the customers, we have independent pharmacies, chain pharmacies, PBMs, retail big box stores.

Mr. LECH. You missed a layer, kind of. You have the manufacturers, you have the payers, you have the pharmacies, and you have the consumers. In between——

Mr. WATT. Well, there are some layers here that—within the pharmacies, independent pharmacies, chain pharmacies, retail stores, PBMs. And I don't know how PBMs relate to independent pharmacies, chain pharmacies, retail stores. Somebody explain to me the role that PBMs plays in this.

Mr. PAZ. Congressman, I would be happy to do that. The PBM is a consultant to the plan's sponsor. Companies are constantly looking at their costs, and they are offering other drugs. There are drug manufacturers that make the drugs, and there are pharmacies that dispense the drugs. There are doctors who write for the prescription.

Mr. WATT. I forgot about the doctors.

Mr. PAZ. It is a very complicated process. We can even get even a little more if we want to throw wholesalers in there that sell to the pharmacies, but we will leave them out for now.

So what our job is to do, our main job, is to help a plan sponsor meet the needs that it has to meet the health care requirements for its employee base. So, for example, a company that is in dire

economic straits that has to cut out costs has to take some fairly tough measures in order to——

Mr. WATT. So you work for the plans?

Mr. PAZ. We work for the plans.

Mr. WATT. You are not in the space except that you own specialty pharmacies and mail order.

Well, maybe I should ask this question: Well, would this merger still be viable if FTC required divestiture of your mail order and specialty drug—I mean, would this still be a desirable merger?

Mr. PAZ. It depends to what degree that takes place.

Mr. WATT. All of it. I mean, you say you work for——

Mr. PAZ. Right.

Mr. WATT. I don't have any agenda here. When I used to practice law, I say this quite often in this Committee—when I practiced law, I never asked a question that I didn't know the answer to. I have the freedom now to ask questions that I don't know the answer to. I don't know the answer to this.

Mr. PAZ. Mail order is a very important component to our offering. It helps us drives down costs for those clients that need that type of offering. There is also——

Mr. WATT. This would not be a desirable merger if the FTC says you have got to get rid of your mail order.

Mr. PAZ. That is correct, Congressman.

Mr. WATT. And would it be a desirable merger if the FTC says you have to get rid of your—what is the other thing?

Mr. PAZ. Specialty.

Mr. WATT. Specialty.

Mr. PAZ. It would not, sir.

Mr. WATT. That wasn't a trick question. I wasn't trying to trip anybody up. I was just trying to figure out how all this fit together.

Mr. PAZ. Thank you.

Mr. WATT. I think I understand it better, unless somebody got some other just angle that I need to understand.

Mr. WIESNER. Not really a different angle, just a couple of comments to piggyback on some of your comments.

When you are referring to a chain pharmacy, NACDS, of course, the National Association of Chain Drug Pharmacies has a large membership. Overwhelmingly that membership consists of very small regional chains. So they are not the large national chains that people think about.

Mr. WATT. You are not CVS and Walgreens.

Mr. WIESNER. They are members of NACDS, but if you look at my company, we are a regional chain located in one State. I believe in your State, there is a small chain that is located only in your State.

Mr. WATT. Who is that?

Mr. WIESNER. Kerr Drugs. So if you think of it in that terms, we are faced many, many times with the exact same challenges that Mr. Lech and independent pharmacies are. We do not necessarily have that large scale, but we are an important part of those communities in that particular regard.

Mr. WATT. My time has expired. Is it Carr, or is it Kerr, K-E-R-R?

Mr. WIESNER. K-E-R-R.

Mr. WATT. They pronounce it Kerr?

Mr. WIESNER. Yes.

Mr. WATT. I thought I had seen it K-E-R-R, but then you said Kerr. I never associated that with K-E-R-R.

Mr. WIESNER. Is it possible to make one last comment?

Mr. MARINO. [presiding.] Surely.

Mr. WIESNER. Sure. I think it is really important to understand the different channels for drug distribution. We are talking a lot about retail pharmacy, we are talking about mail-order pharmacy. We are also talking about specialty drugs.

Specialty we need to really keep on the radar screen for costs. The new products that are coming forth in the future, the vast majority of those are going to be specialty drugs. They may or may not be available in your community pharmacies. So that is an important ingredient to the success of any PBM as to how they manage the specialty program, and it is also a great revenue source. So I don't want specialty drugs to go unnoticed in this particular conversation.

And each of those different channels, whether they be retail community pharmacy, mail order which they own, or specialty which they own, exist under different contractual agreements. So what I receive at my level versus theirs is different.

Mr. WATT. Stop.

May I ask one?

Mr. MARINO. Take all the time you need, Mr. Watt.

Mr. WATT. I know he wants all the time he wants. There is an ulterior motive here, but that is all right. That is good. We all understand.

Ms. Kanwit, FTC has the authority, I presume, under the statute to require divestiture, right?

Ms. KANWIT. They have remedies, sir. They have a guideline, not only merger guidelines, but a remedies guideline, along with the Department of Justice, and so they can look at some divestiture issues in an appropriate context. But it is very detailed about when they can look and what the implications of divestiture might be for the merged entity, yes.

Mr. WATT. Mr. Gustafson, what is your take on the divestiture question I raised before? And then I am going stop and yield back.

Mr. GUSTAFSON. I think it is certainly something that the FTC should look at. I mean, what makes this potential combination a concern is the fact that they do have the mail-order operations and the specialty pharmaceuticals, because it increases the leverage they have in the marketplace. And so I think it is certainly an option that the FTC ought to explore. But I think that you heard that they are not interested in this merger if they have to be divested of those services.

Mr. WATT. Can they explore it, Ms. Kanwit?

Ms. KANWIT. I have a response to that. Specialty is really critical, as you just heard Mr. Paz and Mr. Snow comment. I mean Teva just came out with a multiple sclerosis drug which would cost upwards of 42-, $45,000 a year. We are talking very, very expensive drugs. One of things PBMs do that the FTC has found is drive down costs by negotiating with pharmaceutical companies. So if you want a PBM to go and negotiate for lower costs, you certainly

want them negotiating on things like specialty drugs, which, by the way, many of which are coming down the pipeline right now and are really going to be critical in the decade coming ahead.

Mr. WATT. Can they do that as an independent PBM as opposed to an owner of a specialty drug?

Ms. KANWIT. There are PBMs out there that do nothing but specialty, specialty companies.

Mr. WATT. I yield back. The more questions I ask, the more questions I have. So I am going to stop.

Mr. MARINO. Thank you, Mr. Watt.

I am going yield myself a couple minutes. Mr. Wiesner, what type of transparency would you as a pharmacist like to see concerning clarity for PBMs?

Mr. WIESNER. Transparency is a large issue. If we look back on past history and past behavior, as I indicated in my testimony, there have been lots of allegations. Lots of State attorney generals that have brought charges against various PBMs. And that all stems from the fact that they are not transparent in their explanation of what their true costs are. They are not transparent in the rebate process. They basically have two contracts. One is with the buyer, the payer of their services; the other is with provider, the retail pharmacy. In each of those cases, those are all hidden costs in their particular organization.

The allegation, of course—or not allegation. The assumption is that they are driving down costs. If they are driving down costs, as a gentleman said a little bit earlier, they would be able to return $1 billion based on 100 percent transparency.

I guess my question is why can't we have 100 transparency at all times? Why do we have to have 80 percent at times and 100 percent at others.

Mr. SNOW. Could I respond to that?

Mr. MARINO. Sure.

Mr. SNOW. I offer clients when we go to market, they have choices. They can get the price discounts and we keep portions of rebate, or they get 100 percent of rebate. It is equal to the same net cost to them. It is their choice.

In our business, benefit design, contract structure is 100 percent always our client's choice. And by the way, everything they choose is auditable, so there is transparency. Some of the things that are being talked about are history from a long time ago that has since been rectified because of the actions that occurred 10 years ago.

Mr. MARINO. Mr. Snow, would I as a consumer have that ability to obtain that information and to explore that transparency?

Mr. SNOW. At a consumer level, what we do today, we have taken this very far, we have smartphone technology. You can download the app for free where you, in fact, can, with your technology, look at the cost of your drugs, at the various locations of those drugs; you can look at the cheaper alternatives; you can discuss it with your doctor at the time of prescribing. We show them their copay, their coinsurance, what the net savings would be on an annual basis if they ask their physician to use an equivalent drug that was generic.

We are making every step we possibly can to lever technology to create a well-informed consumer, because we believe that also

helps the health care system reform itself if, in fact, the consumers become a prudent buyer of care. We are committed to that.

Mr. MARINO. I have a question concerning—and I am going to be fair on this. Mr. Snow, I think it was you that said you wanted—did you enter a document into the record, a report of some nature, or was it Mr. Paz?

Could you explain to me what that document is and who prepared it?

Mr. PAZ. Yes. It is a document that basically looks at the cost of drugs, and if, in fact, for every 1 percent of waste we can take out of the system, we can—it equates to 20,000——

Mr. MARINO. Who prepared it?

Mr. PAZ. A group called PCMA, the Pharmaceutical Care Management Association.

Mr. MARINO. Is that in any way linked with your organizations, or is it a representative?

Mr. PAZ. We belong to that just like they belong to NACDS.

Mr. MARINO. Okay. Now, Mr. Lech, being fair, you entered something into the record, correct? What was that?

Mr. LECH. I entered in pictures that were sent in, actual pictures, of medications that were in consumers' houses, of medication that was sent to them at times not requested.

Mr. MARINO. Okay. Who prepared that report?

Mr. LECH. The pictures were put together by NCPA from their members, but the information came from consumers.

Mr. MARINO. Okay. Thank you.

Mr. Paz, as a consumer, would I have a choice in purchasing from PBMs, your company that is consolidated, specialty drugs and mail-order drugs from where they are purchased from or where they are sent from? Do I have that choice, or is it your mail-order company that I have to purchase those drugs from?

Mr. PAZ. In the majority of the cases, there are a few that you would you would not have a choice, but the majority of the cases, you would have that choice.

Mr. MARINO. Is that offered to the consumer?

Mr. PAZ. Yes. The consumer decides which pharmacy to go to. The consumer decides whether or not they want to use mail order. That is all a consumer choice.

Mr. MARINO. Thank you.

0Mr. Lech, your hand has gone up there.

Mr. LECH. You know what the option is if they don't use a mail order?

Mr. MARINO. What is that?

Mr. LECH. They will pay full price.

Mr. PAZ. No, sir, that is not correct. They pay a copay. They pay a copay at Mr. Lech's pharmacy, or they pay a copay at my pharmacy, mail order. There is no difference.

Mr. MARINO. I don't want to get into a debate here, but it is noted.

I have no further questions. Mr. Watt?

Mr. WATT. I have no further questions.

Mr. MARINO. No further questions. I see no one else sitting here.

Lady and gentlemen, I want to thank you very much for being here. I was a little longer than we anticipated.

I have some housekeeping to take care of. Without objection, all Members will have 5 legislate days to submit to the Chair additional written questions for the witnesses, which we will forward and ask the witnesses to respond as promptly as they can do so that their answers may be made a part of the record.

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

With that, again I thank the witnesses, and the hearing is adjourned.

[Whereupon, at 5:56 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Responses to Questions for the Record

George Paz, Chairman and CEO, Express Scripts, Inc.

For the United States House of Representatives

Committee on the Judiciary

Subcommittee on Intellectual Property, Competition and the Internet

September 20, 2011

Question #1: ***In your testimony and that of Mr. Snow, you discussed the savings that could accrue to your clients from merging the companies. Could you please explain this further, how would it work and what you think those savings might be?***

By combining the best of breed at Express Scripts and Medco Health Solutions, we estimate more than $1 billion in savings to our clients, patients and the overall healthcare system. These savings result from supply chain improvements, the combination of clinical offerings and operational efficiencies by combining the two companies operations. This estimate is conservative and represents the immediately available savings opportunities.

Express Scripts and Medco each negotiate with drug makers for discounts on behalf of tens of millions Americans. By combining these negotiations into a single entity, we anticipate additional price concessions from brand drug makers both for retail pharmacy utilization and product purchasing for our home delivery pharmacies. These supply chain improvements are not merely hypothetical. As a result of recent acquisitions, Express Scripts has been able to improve pricing for our customers by hundreds of millions of dollars. This has been true for Medicare Part D plans, TRICARE, and private purchasers nationwide.

Perhaps the area where we may have underestimated savings the most surrounds the clinical offerings of the two companies. Each company possesses sophisticated tools to address medication non-adherence, waste, fraud, and abuse. Express Scripts continues to focus on modifying consumer behavior so individual patients make the right decisions to promote health through lower cost therapies and delivery channels. Medco focuses on treating chronic diseases to close gaps in care that otherwise would result in wasteful prescription drug spending. The new Express Scripts will have an incredible opportunity, and also a social responsibility, to save clients and patients part of the more than $400 billion wasted in the pharmacy benefit each year[1].

[1] Express Scripts Drug Trend Report (2011). Available at: http://www.express-scripts.com/research/studies/drugtrendreport/2010/dtrFinal.pdf.

In order to meet the needs of our clients and patients, Express Scripts will need to rationalize its footprint to ensure wasteful or duplicate operations cease. The remainder of the $1 billion savings occur from this category of spending that is currently shared among smaller populations of lives. These savings are consistent with the goal of continuously improving healthcare to ensure efficient operations.

Pharmacy benefit managers (PBMs) have a long history of saving clients and patients money on prescription drugs. A recent study of the industry by Visante found that PBMs will save payors nearly $2 trillion over the next decade[2]. Express Scripts is committed to continuing this trend of saving American families at the pharmacy counter.

Question #2: ***Could you please explain what the access to pharmacy standards are for the Medicare Part D program as well as those most common for your private sector clients? Do you believe these standards advantage or disadvantage independent community pharmacies?***

The Centers for Medicare and Medicaid Services has adopted access standards for the Part D program that assure convenient access to prescription drugs pharmacies across the country (not including home delivery pharmacies). These standards are consistent with private sector client contracts, and require:

- In urban areas, 90% of beneficiaries must live within two miles of a network pharmacy
- In suburban areas, 90% of beneficiaries must live within five miles of a network pharmacy
- In rural areas, 70% of beneficiaries must live within 15 miles of a network pharmacy.

In many ways, these access standards advantage independent community pharmacies. Because independent community pharmacies are frequently found in suburban and rural settings, these provisions mandate the inclusion of these very independent community providers in the network so that we can meet access standards. In these situations, pharmacies have significant leverage over PBMs and plan sponsors and command a premium above reimbursement of pharmacies in urban settings. This advantage is demonstrated by the industry profit margin, which exceeded 20% for every year of the last decade[3].

Question #3: ***During the hearing, you and several witnesses discussed group purchasing organizations called Pharmacy Services Administrative Organizations that exist today where***

[2] Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers. Visante (2011). Available at http://www.pcmanet.org/images/stories/uploads/2011/Sept2011/pbms%20savings%20study%202011%20final.pdf.

[3] NCPA Digest (2010). Accessed at http://www.ncpanet.org/index.php/ncpa-digest-sponsored-by-cardinal-health.

independent community pharmacies are able to band together to achieve greater volume discounts on purchases of prescription drugs and other medical supplies. How do these organizations operate and what is their role in price negotiation?

The independent pharmacy's business model has become highly developed over the years, with the vast majority of independent pharmacies nationwide joined in sophisticated purchasing cooperatives and buying groups. Pharmacy Services Administration Organizations (PSAOs) join independent pharmacies together to purchase the medications dispensed in their pharmacy and administer contracting with PBMs.

The PSAO contracts with plans and PBMs, so that the individual pharmacies receive negotiating representation in larger numbers. At Express Scripts, some of the larger PSAOs are larger than many of the big-name, nationally known pharmacy chains. PSAOs give independent pharmacies access to pooled purchasing power, negotiating leverage, and profit-generating business techniques normally associated with large chain pharmacy corporations. Essentially acting as provider groups, through PSAOs, independent pharmacy owners gain access to a range of profit-generating programs.

Question #4: ***What role do you see the community pharmacy or corner drugstore playing in terms of the delivery of medications to customers? How would that role change after this merger?***

Community pharmacies are essential to the healthcare delivery system in the United States. In many communities, pharmacists are the sole local provider of health care. Express Scripts wants to continue to see the practice of pharmacy thrive and improve to service our beneficiaries.

In 2009, even as the nation faced a challenging economic climate, independent pharmacies added 474 new locations[4]. This growth is important to the growth of our network to addresses the evolving needs of our clients and patients.

Question #5: **Where do you expect to find savings that will reduce the cost of healthcare as a result of this merger? Do you anticipate any savings in connection with your relationship with the pharmacies as a result of the merger? If so, where or how will those savings occur?**

Express Scripts and Medco have publicly pledged that this merger will result in at least $1 billion in savings. We expect these savings to come from increased operational efficiencies and better negotiating leverage with the drug manufacturing supply chain. Pharmacy reimbursement is not typically driven by size of the negotiating parties, but rather by the geographical location of the pharmacy due to network access and adequacy standards.

[4] NCPA Digest (2010). Accessed at http://www.ncpanet.org/index.php/ncpa-digest-sponsored-by-cardinal-health.

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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

Hearing:

"The Proposed Merger between Express Scripts and Medco"

Tuesday, September 20, 2011

3:30 P.M.

2141 Rayburn House Office Building

Thank you, Chairman Goodlatte, and members of the subcommittee. My name is Adam Fein. I appreciate the opportunity to present my views about the proposed merger of Express Scripts and Medco Health Solutions. As I will explain, this merger will enhance efficiency and reduce costs for the U.S. health care system, which dispenses 4 billion prescriptions annually.[1] I will also explain why the merger will not have an anticompetitive impact on pharmacies.

First, a few words about my industry experience and knowledge of these issues. I am an expert in 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 make better decisions about their commercial strategies.

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. I also publish detailed industry reports on the economics of pharmacies, wholesalers, and pharmacy benefit managers, or PBMs. Over the past few months, both advocates and opponents of the proposed merger of Express Scripts and Medco Health Solutions have cited my research and writings to support their positions. For example, Drug Channels was cited last week by Representatives Waxman, Pallone, and Degette in their letter to Federal Trade Commission Chairman Jon Leibowitz regarding the merger. I welcome the opportunity to provide my own perspectives directly to the committee.

The information and data that I will share with you is based on my own independent opinions and analysis. I should note that on September 6 of this year, Express Scripts retained me to advise it on the competitive issues in the pharmacy industry related to its

merger with Medco. My comments about the merger in *The Wall Street Journal*, *The New York Times*, and other publications were made long before Express Scripts approached me.

In my comments, I will refer to a PBM's clients as "plan sponsors" or "payers." PBMs administer prescription-drug plans for people with third-party insurance through a self-insured employer, health insurance plan, labor union, or government plan.

The evidence clearly shows that PBMs make the U.S. pharmaceutical distribution and reimbursement system more efficient. It is my contention that the merger of Express Scripts and Medco Health Solutions will enhance these pro-competitive, cost-reducing efficiencies for consumers and plan sponsors. At the same time, a combined company will face vigorous competition for the business of plan sponsors, so we can reasonably anticipate that the plan sponsors will benefit from any enhanced efficiency.

Many independent pharmacies claim that the merger of Express Scripts and Medco Health Solutions will be anticompetitive. They argue that a larger PBM will (1) impose unfavorable contract terms on community pharmacies, and/or (2) limit patient access to pharmacy care.

I will explain the flawed premises behind these arguments. I will show that the pharmacies' positions are not supported by objective industry data. What's more, they ignore financial information collected and published by the community pharmacies themselves.

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

1. The combined Express Scripts/Medco PBM will make the U.S. pharmaceutical distribution and reimbursement system more efficient.
2. The combined company will not be in a position to limit access to retail pharmacies.
3. Pharmacies have power against PBMs that will prevent the creation or exercise of monopsony power.

4. Previous PBM concentration has not hurt pharmacies economically and is unlikely to do so in the future.

1) The combined Express Scripts/Medco PBM will make the U.S. pharmaceutical distribution and reimbursement system more efficient.

I begin by highlighting how PBMs bring economic efficiencies to the U.S. pharmaceutical system and how those efficiencies translate into lower costs for consumers and the PBM's plan sponsor clients. Where appropriate, I will relate these facts to the proposed merger of Express Scripts and Medco.

- **A PBM establishes a network of retail pharmacies so that consumers with prescription drug insurance can readily fill their prescriptions.** A consumer with a prescription drug benefit plan must use a pharmacy that accepts payment for that plan. These networks greatly enhance the efficiency of the U.S. health care system. PBMs have electronic communications systems that link them to their network's retail and mail-service pharmacies. This allows quick and efficient processing of a consumer's prescription.

- **PBMs assemble networks of pharmacies willing to accept discounted pricing in exchange for access to consumers with third-party prescription drug insurance.** Network pharmacies accept discounted pricing in exchange for access to a plan's members.[2] A PBM negotiates with community pharmacies on the behalf of its many plan sponsor clients. A pharmacy can decide whether or not to participate in any individual PBM's network.

  Network contracts between a pharmacy PBM and a pharmacy are non-exclusive. Therefore, joining one PBM's network does not prevent a pharmacy from joining another PBM's network. Nearly all community pharmacies participate in all major

PBM networks, so the combination of Express Scripts and Medco will enable even further efficiencies in PBM-pharmacy communication.

The cost-saving benefit for plan sponsors can be illustrated by examining a retail pharmacy's business with an uninsured consumer. The most recent annual financial survey of independent drugstores found that about one out of eight prescriptions went to consumers without third-party insurance.[3]

Very few individual consumers have the knowledge and understanding about pharmacy economics to negotiate with their pharmacist or ask for lower prices. Nor do they have sufficient purchasing power on their own to negotiate lower prices. It is not surprising, therefore, that a pharmacy's gross profit margin from uninsured prescriptions was three times as high as the profit from a third-party paid prescriptions.[4] Thus, PBMs ensure that pharmacies do not overcharge the U.S. health care system for prescription drugs or a pharmacist's counseling services.

- **PBMs extract price concessions from manufacturers of brand-name drugs.** PBMs force manufacturers of therapeutically comparable, brand-name drugs to compete for placement on the plan sponsor's formulary—the list of prescription drugs approved for reimbursement by the plan sponsor contracting with a PBM. A PBM will recommend preferred status on the formulary for those products that offer the most competitive pricing and rebates (along with efficacy and safety). The merger of Express and Medco will create a larger PBM with more negotiating power versus that of manufacturers.

  These rebates provide direct savings for plan sponsors. I estimate that PBMs pass back to plan sponsors more than 80% of rebates received from brand-name pharmaceutical manufacturers.[5] A plan sponsor can also choose a contract that passes back 100% of rebates.

- **PBMs establish cost-saving mail-order pharmacies for dispensing refills of maintenance medications.** Maintenance medications are drugs taken on a recurring basis to treat chronic illnesses and conditions. Mail-order pharmacies operate very efficiently by buying in bulk and using automated dispensing machines. PBM-owned mail pharmacies provide deeper price discounts to the plan sponsor. They then share a portion of the savings with consumers in the form of a lower co-payment. A survey of nearly 400 employer-based prescription drug plans found that brand-name prescriptions dispensed from a mail pharmacy were 5.8% cheaper for the employer and $25 per prescription cheaper for the consumer.[6]

- **The merger of Express Scripts and Medco will allow the combined company to purchase generic drugs at a much lower cost during the upcoming wave of brand-name patent extensions.** Brand-name drugs with $80 billion in sales will lose exclusivity and face generic competition over the next five years.[7] After 2016, the value of newly launched generics will drop significantly. The merger of Express Scripts and Medco will increase purchasing power, allowing the company to capture the available savings from generic drug manufacturers during this time-limited window of opportunity.

2) The combined company will not be in a position to limit access to retail pharmacies.

Some have suggested that a combined Express Scripts/Medco would unilaterally attempt to limit access to community pharmacies. In my analysis, this conclusion misunderstands the relationship between a PBM and its plan sponsor client, and presumes that the PBM would intentionally act against its own best interests.

Some critics of the merger argue that a PBM can make unilateral decisions about benefit design or network structure. This is simply not true.

In the commercial market, the payer—an employer or health plan—chooses the overall prescription drug benefit it will offer to members or employees. The options could include, say, the number of pharmacies available to plan members or the particular incentives for using a mail-order pharmacy. The payer does this while making tradeoffs among plan costs, quality, and access. The PBM then implements these choices for the plan sponsors.

The payer may rely on internal staff, an independent consultant, or its PBM for advice. But it is crucial to understand that the plan sponsor—the PBM's client—makes the ultimate decision. A survey of 417 employers (both large and small) found that the responsibility for pharmacy benefit design fell to the in-house human resources staff or an outside consultant at two-thirds of the companies. PBMs were responsible for benefit design at only 14 of the 417 companies surveyed.[8]

To cut costs, for example, plan sponsors can choose more selective pharmacy networks. In a selective network model, pharmacy network size is reduced by 50% to 80%. Thus, the consumer can choose any pharmacy within the network, but the network has only 10,000 to 30,000 pharmacies vs. the 61,000 total community pharmacies in the United States.

A pharmacy will offer bigger discounts or a lower dispensing fee to be in a more selective network because each pharmacy in such a network will fill a larger percentage of prescriptions for the plan. These networks are estimated to save employers 38% for retail generic prescriptions and 10% for retail brand prescriptions.[9] This choice to use a selective network is made by a plan sponsor, not by a PBM.

In my assessment, any attempt by the combined company to artificially limit consumer access would quickly backfire if the PBM could not attract enough pharmacies to participate in its network. Convenient beneficiary access to network pharmacies is a key component of the PBM's value proposition to its plan sponsor clients. In many situations, the precise level of beneficiary access is contractually specified between the PBM and the plan sponsor. One example is the access stipulated in the TRICARE pharmacy program for our nation's military personnel.

Most PBM contracts last only for one, two, or three years. Plan sponsors can and do switch PBMs if they are dissatisfied with a PBM's performance or with the beneficiaries' access to network pharmacies.

3) Pharmacies have power against PBMs that will prevent the creation or exercise of monopsony power.

Another criticism of the Express Scripts-Medco merger is that the combined entity will impose unfavorable contract terms on community pharmacies. But in reality, the pharmacy industry's concentration and organization create countervailing power against any attempted exercise of anticompetitive monopsony power by the new company post-merger.

The community pharmacy industry has been consolidating for some time. The three largest drugstore chains—CVS, Walgreens, and Rite Aid—comprise more 19,500 retail pharmacy locations.[10] Six other large retail chains—Walmart, Kroger, Safeway, Target, Kmart, and Supervalu—account for a further 13,500 pharmacy locations.[11] Together, these nine companies represent more than half of all U.S. community pharmacy locations.

The risk to a PBM can be seen in today's marketplace. Walgreens, for example, is currently in a dispute with Express Scripts. Walgreens stated: "Walgreens can contract directly with plan sponsors, or help plan sponsors establish a custom retail pharmacy network, if consistent with their current PBM agreements."[12]

Smaller pharmacies also have negotiating power with PBMs. I estimate that more than 80% of independent pharmacy owners participate in Pharmacy Services Administration Organizations, or PSAOs, to leverage their influence in contract negotiations with PBMs. 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. These benefits include pooled contractual negotiating power,

centralized claims payment, and reconciliation of prescription payment activity. Many PSAOs tout their ability to increase reimbursement relative to contracts between a single pharmacy and a PBM.

Three of the country's largest PSAOs are owned and operated by drug wholesalers that rank among the 30 largest U.S. corporations on the Fortune 500. These wholesalers have revenues of more than $275 billion. They distribute more than 85% of all prescription drugs in the United States. My research finds that 10,000 independent-drugstore owners rely on the three largest wholesalers' PSAOs to negotiate and administer contracts between PBMs and independent pharmacies.[13] This corporate ownership provides a further negotiating advantage for independent drugstores—one that will be sustained after the merger.

Taken together, these economic realities show a sophisticated pharmacy industry that has negotiating leverage and scale against PBMs.

4) Previous PBM concentration has not hurt pharmacies economically and is unlikely to do so in the future.

The merger of Express Scripts and Medco Health Solutions will further increase the concentration of the PBM business. However, the PBM industry has been consolidating for some time with few observable, negative effects on community pharmacies. There is no reason to suggest that this circumstance will change with another merger.

While the concentration of prescription claims processed in community retail pharmacies has increased substantially in recent years, there is little evidence of economic harm to smaller, pharmacist-owned independent pharmacies. 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.[14]

What's more, the National Community Pharmacists Association has conducted member surveys documenting that gross profit margins for independent drugstores have remained in a consistent range from 22% to 24% throughout the past 10 years.[15] Data from the U.S. Census Bureau also show that the drugstore industry's profit margins have been stable for at least the past 17 years.[16]

Note that PBMs have a powerful incentive to preserve the independent drugstore industry, thereby counterbalancing the growth and influence of the largest chains. Independent drugstores are crucial members of a PBM's network in rural areas, which are often uneconomic for chains. In 2010, 64% of pharmacies in rural areas were independent drugstores.[17]

Conclusion

I thank the committee for considering my statement. The merger of Express Scripts and Medco Health Solutions will improve the efficiency of the U.S. pharmacy distribution and reimbursement system without anticompetitive impacts on either plan sponsors or pharmacies.

I am available to answer any questions about my statement.

ENDNOTES

[1] *The Use of Medicines in the United States: Review of 2010*, IMS Institute for Healthcare Informatics, April 2011, 8.
[2] For example, an Office of Inspector General study of Part D plans found that PBMs negotiated lower drug prices with pharmacies in exchange for the pharmacies being in the PBM's networks. *Medicare Part D Pharmacy Discounts for 2008*, Office of Inspector General, OEI-02-10-00120, November 2010.
[3] *2010 NCPA Digest*, National Community Pharmacy Association, October 2010, 27.
[4] Ibid. Note that the Federal Trade Commission's detailed analysis of confidential pharmacy pricing data came to similar conclusions. When compared to consumers with insurance coverage, consumers without insurance paid an average of 15% more for each brand-name drug prescription and 50% more for generic drugs. See *Pharmacy Benefit Managers: Ownership of Mail Pharmacies*, Federal Trade Commission, August 2005, 36.
[5] In 2010, Medco Health Solutions reported receiving $5.8 billion in rebates from brand-name pharmaceutical manufacturers. Only 12.5% of total rebates were retained by Medco, while 87.5% were passed back to Medco's clients. See Medco Health Solutions, 10-K filing, filed 2/22/11, 55.
[6] *The 2010-11 Prescription Drug Benefit Cost and Plan Design Report* (Pharmacy Benefit Management Institute, 2010) summarizes plan design details and contract information from 372 employers representing 5.8 million plan members.
[7] "Medco's Latest Update on the Generic Wave," Drug Channels, September 8, 2011. Available at http://www.drugchannels.net/2011/09/medcos-latest-update-on-generic-wave.html.
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[9] "Pharmacy Profits in Preferred Networks with PBM Transparency," Drug Channels, January 13, 2011. Available at http://www.drugchannels.net/2011/01/pharmacy-profits-in-preferred-networks.html.
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[11] *Ibid.*
[12] "The Value of Walgreens," Walgreens white paper, September 2011. Available at http://www.drugstorenews.com/sites/drugstorenews.com/files/WAG_White_Papers.pdf.
[13] *The 2011-12 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors*, Pembroke Consulting, Inc., September 2011. Available at http://www.pembrokeconsulting.com/wholesale.html.
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[15] *2010 NCPA Digest*, National Community Pharmacy Association, October 2010, 7.
[16] "Drugstore Margins Jump in New Gov't Data," Drug Channels, May 5, 2011. Available at http://www.drugchannels.net/2011/05/drugstore-margins-jump-in-new-govt-data.html.
[17] *2011-12 NACDS Chain Pharmacy Industry Profile*, 15.