NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

December 13, 2011

The Honorable Herb Kohl
Chairman
Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer Rights
224 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Kohl:

Re: Correcting the Record

On behalf of the National Association of Chain Drug Stores (NACDS), I would like to thank you again for the opportunity for our member, Michael J. Bettiga of Shopko Stores, to testify at the December 6 hearing "The Express Scripts/Medco Merger: Cost Savings for Consumers or More Profits for the Middlemen?" We appreciate your keeping the hearing record open for a week for follow-up information. NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists.

We agree with your opening comment that employers do have considerable concerns about this merger, but are reluctant to voice their concerns publicly due to fear of retaliation by the entities seeking to merge. This reluctance and fear illustrates clearly many of our concerns about the proposed merger and the impact it would have on health plans and employers. The large PBMs wield similar power over pharmacies, as was discussed during the hearing.

We felt compelled to write to you and correct statements made during the hearing by Mr. Paz and Mr. Snow. We believe that these witnesses obfuscated facts in an effort to portray their companies in a better light, downplaying many of their companies' objectionable activities that would certainly worsen if the two companies were allowed to merge.

Mr. Snow testified that his company, Medco, is regulated by every state board of pharmacy and every state insurance commissioner. This is not correct. PBMs have generally been successful in opposing efforts at state regulation. First, with respect to regulation by every state board of pharmacy, for the vast majority of state boards of pharmacy, PBMs are regulated only to the extent that they own a mail order pharmacy and only the activities of that mail order pharmacy are regulated by any board of pharmacy. Only a couple of states directly regulate the activities of a PBM through a board of pharmacy, and the regulation in those states is weak, at best. As such, boards of pharmacy are limited in their oversight of PBMs. Second, we know of only a few state

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insurance agencies that regulate PBMs directly through a registration process. Rather, it is our understanding that state insurance agencies directly regulate health insurers who then subcontract with PBMs. A number of states have passed legislation to regulate some PBM activities, such as PBM practices concerning audits of pharmacies. PBMs, however, have been successful in rendering these legislative proposals toothless, because most of this legislation has no enforcement mechanism. We suggest you explore this matter further with the National Association of Insurance Commissioners. Similarly, self-funded health plans are regulated federally through ERISA. However, ERISA provisions are not designed to regulate the basic activities in which PBMs engage including network formulation, reimbursement arrangements, and basic claims processing practices that would be relevant to PBM functions. This lack of a regulatory framework for the oversight of PBMs operating in the private insurance marketplace is deeply troubling.

Mr. Snow testified that there has been no growth in the mail order pharmacy segment. From 2009 to 2010, all prescription expenditures increased only by 1.8%, reflecting economic conditions. However, of this $4.8 billion increase, $1.3 billion (or 27% of the increase) went to mail order expenditures. While growth among all prescription expenditures may have been relatively flat in recent years, one-quarter to one-third of the limited prescription growth went to the mail order segment. The mail order segment is faring better than other prescription market segments, and gaining on those other segments. PBMs also argue that the number of retail pharmacies continues to rise. Actually, the number of pharmacies is shrinking relative to the number of prescriptions filled by retail pharmacies. In 2000, there were about 19 pharmacies for every one million prescriptions, but by 2010, there were only about 16 pharmacies per one million prescriptions.

Mr. Snow mentioned that there is plenty of competition in the PBM market, citing that there would be 40 PBMs to compete with the merged entity. However, the market for PBM services is actually much more limited than portrayed by Mr. Snow. Large employers and health plans generally need large PBMs to handle their businesses. Smaller PBMs simply cannot compete effectively with the large players. Mr. Snow testified that 10 PBMs serve the Fortune 50, however, 42 of those companies are serviced by the "Big Three" PBMs, two of which are Medco and Express Scripts (ESI). In fact, Shopko Stores owned and operated a PBM subsidiary in the 1990's. Mr. Bettiga was responsible for the operations of that PBM. Shopko made the decision to sell its PBM to Medco due in part to the fact that Shopko could not compete with the large PBMs, such as Medco. The large PBMs have far more negotiating power and resources to offer health plans and employers, which smaller PBM operations cannot provide.

Both Mr. Snow and Mr. Paz argued, as PBMs frequently do, that they do not decide anything when designing prescription benefits; they merely follow the orders of the health plans and employers. We believe that these assertions are misleading.
PBMs design the benefit plans and determine the costs. Because of that, it is our view

PBMs steer the health plans and employers toward the items they most want to sell. They set prices in a way that pushes orders for products and services (mail order, brands with big rebates, etc.) that the PBMs want customers to order, and creates disincentives for services (e.g., retail) and items (e.g., drugs from manufacturers that don't pay kickbacks) that the PBMs don't want their customers to order.

Mr. Paz testified that his PBM is completely transparent with respect to manufacturer rebates and discounts and used ESI's relationship with the Department of Defense (DoD) as an example. This characterization of ESI's relationship with DoD as an example of how ESI operates is misleading in this context. ESI acts as a pharmacy benefit administrator (PBA) with respect to the DoD prescription benefit. It has no role in negotiating discounts with drug manufacturers, as these prescriptions are eligible for Federal Ceiling Price (FCP) discounts. These discounts, negotiated by DoD, and not Express Scripts, are significantly greater than the discounts ESI obtains in its other lines of business. Furthermore, since there is no PBM middleman, DoD can be confident that it receives 100% of all discounts and rebates.

Moreover, PBMs receive significant revenue from drug manufacturers that they define as other types of revenue besides rebates, and thus can avoid disclosing such revenue to health plans and employers and still claim to be "100% transparent" about rebates. This unreported revenue is often characterized as: "cost effectiveness rebates," "grants," "loans," "therapeutic switching fees," or "data selling."[1] "Transparency" should mean that a health plan or employer has a right to review rebates and that no unreported monies are retained by the PBM. Unfortunately, this is not the definition by which most PBMs abide[2].

Mr. Paz testified that ESI is currently undergoing approximately 450 audits. We would ask that Mr. Paz clarify exactly who is auditing and in what capacity. Our understanding is that the rights of health plans and employers to audit PBMs are circumscribed and that the audits are typically conducted by persons picked by the PBMs themselves.

Mr. Paz, referencing a report from the GAO, testified that PBMs have had tremendous success in driving down prescription drug costs. Upon a closer reading, it appears that this success may have been overstated. Mr. Paz cited the GAO report in testifying that PBMs receive "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." The discounts cited by Mr. Paz do not accurately reflect the findings of the GAO report. The report identified these percentages of discounts when comparing the prices paid by PBM participants for

[1] See: http://www.pharmacybenefitsacademy.com/documents/HayesBootCamp.pdf,
[2] Ibid. See also: Rentmeester, Christy A., et al., Rebates and Spreads: Pharmacy Benefit Management Practices and Corporate Citizenship; Journal of Health Politics, Policy, and Law, Vol. 33, No. 5, October 2008, p. 943; Siracuse, Mark V., et al; Undocumented source of pharmacy benefit manager revenue; Am J Health-Syst Pharm, Vol. 65, March 15, 2008, p. 552.

medications obtained through a mail order setting to the cash prices paid by individuals, without insurance, in the retail setting, which constitutes only 10 percent of the market. The figures cited by Mr. Paz do not apply to prescriptions obtained in retail pharmacies by PBM participants, which is a much larger segment of the population.

Additionally, it is unclear what level of savings PBMs actually do achieve. The same GAO report referenced by Mr. Paz stated "[t]hese price savings may overstate PBMs' negotiating success because, absent a PBM, plans would likely manage their own drug benefits and also attempt to negotiate discounts with retail pharmacies."[3] The GAO report went on to say that "[w]hile PBMs negotiated prices significantly lower than a cash-paying customer would pay, these discounts may overstate the level of savings plans achieve from using PBMs since no benchmark exists to accurately determine what discounts plans would obtain without a PBM."

Thank you again for the opportunity for Mike Bettiga to testify about our membership's grave concerns with this proposed merger. Past and present PBM actions are a mere foreshadowing of what we can expect if these two giant PBMs are allowed to merge into a "mega PBM." If this merger is allowed to proceed, patients will be faced with reduced access to retail pharmacies and pharmacy services as the combined entity shifts patients to mail order and dominates specialty pharmacy. We believe that you should consider the testimony of Mr. Paz and Mr. Snow as illustrative of how their respective companies presently conduct themselves, which would only be exacerbated by a merger.

Finally, Mr. Chairman, we respectfully request for these reasons and those expressed during the hearing, that you write to the FTC and oppose the merger.

Sincerely,

Steven C. Anderson, IOM, CAE
President and CEO

[3] U.S. General Accounting Office. Effects of Using Pharmacy Benefit Manager on Health Plans, Enrollees and Pharmacies. January 2003. http://www.gao.gov/new.items/d03196.pdf