The American Antitrust Institute

5/11/09

Commentary: **The FTC Should Issue a Second Request on Express Scripts' Proposed Acquisition of Wellpoint's PBM Business**

An AAI White Paper

David Balto[1]

On April 13, 2009, Express Scripts, Inc. ("Express Scripts") announced its proposed acquisition of Wellpoint's Pharmacy Benefit Manager ("PBM") subsidiary, Next RX. The American Antitrust Institute ("AAI")[2] believes that this acquisition poses a threat of significant anticompetitive harm in the PBM services market by combining two of the four largest national PBMs. Accordingly, the AAI urges the Federal Trade Commission ("FTC") to issue a Second Request and conduct a thorough investigation of the competitive effects of this merger.

Executive Summary

The AAI urges the FTC to conduct a full Second Request investigation of the Express Scripts/Wellpoint transaction for the following reasons:

- ***The merger is likely to reduce competition for the provision of PBM services to some group of plan sponsors, especially large plan sponsors.***[3] Currently, CVS/Caremark, Express Scripts, and Medco are, by far, the three largest PBMs serving large plan sponsors. Express Scripts' proposed acquisition of WellPoint's Next RX business reduces the key providers of PBM services to large plan sponsors and may result in higher prices, less innovation, and increased barriers to entry. After the merger the three largest PBMs will have a combined market share exceeding 80%. Moreover, the three national PBMs have significant cost advantages from economies of scale and scope in drug purchasing, mail order distribution, and specialty pharmaceuticals. The remaining PBMs will be unable to

---

1 The author is a senior fellow for the American Antitrust Institute and also of the Center for American Progress. He served as the Assistant Director for the Office of Policy & Evaluation in the Bureau of Competition of the Federal Trade Commission. This paper relies entirely on public information. With its investigatory power, the FTC may find additional or contrary facts that could change this paper's analysis or conclusions.

2 The American Antitrust Institute is an independent Washington-based non-profit education, research, and advocacy organization. Our mission is to increase the role of competition, assure that competition works in the interests of consumers, and challenge abuses of concentrated economic power in the American and world economy. For more information, please see www.antitrustinstitute.org. This paper has been approved by the AAI Board of Directors. A list of our contributors of $1,000 or more is available on request.

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

constrain anticompetitive conduct because of their smaller size, geographic limitations, and lack of ability to secure rebates.

- ***The merger poses a significant threat of coordinated interaction by eliminating a disruptive firm from the market.*** We believe that there is a significant risk of coordinated interaction in the PBM market. The market is dominated by a small number of firms and there are substantial entry barriers. Moreover, a lack of transparency makes it difficult for plan sponsors to determine whether they are receiving the full benefits from their arrangement with the PBM. The acquisition of WellPoint's PBM business increases the risk of coordinated interaction. WellPoint offered PBM services on a capitated basis, sharing the risks of increased drug spend with the plan sponsors. Moreover, since Next RX is owned by an integrated insurance company its incentives to join and facilitate collusion are significantly different than the three largest PBMs whose revenue is solely based on their PBM business. Eliminating the potentially disruptive force of Next RX will pose the threat of significant harm to consumers.

- ***The merger may lead to increased prices in the distribution of certain specialty pharmaceuticals.***[4] Specialty pharmaceuticals, which are 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. Each of the major PBMs has acquired specialty pharmaceutical companies in the past three years, demonstrating the competitive significance of internalizing these operations. Those PBMs have rapidly increased the prices of those specialty pharmaceuticals after those acquisitions were consummated. In particular, Express Scripts has imposed substantial price increases on several specialty pharmaceuticals after acquiring specialty pharmaceutical manufacturers or entering into exclusive distribution arrangements. By acquiring, WellPoint's specialty pharmaceutical business Express Scripts will be able to exercise market power and increase prices for these vital drugs.

- ***The merger will increase the threat of monopsony or oligopsony power in the reduction of services for the delivery of pharmaceutical services.*** The national full service PBMs already possess the ability and incentive to exercise market power over retail independent and chain pharmacies, and do so by reducing reimbursement rates and engaging in deceptive and fraudulent conduct. Reimbursement from PBMs is a major source of revenue for retail pharmacies. The merger could allow the three remaining large national PBMs to decrease compensation to the retail pharmacies below competitive levels, ultimately leading to diminished service for consumers.

- ***The FTC should conduct a complete Second Request investigation and not cut short the investigation.*** In the past Administration the FTC cleared significant PBM mergers without an extensive investigation. The CVS/Caremark merger was cleared without a Second Request and the Caremark/AdvancePCS merger was cleared based only on a "quick

[4] Specialty pharmaceuticals are very expensive drugs, typically biotech-developed and protein based drugs that are typically not distributed at a retail pharmacy store. These drugs often require special handling, such as refrigeration. Therefore, there is a need for special distribution capabilities and patient support services.

look" review.[5] During the past decade there have been a series of PBM mergers which have significantly increased concentration in the market. Since the CVS/Caremark and Caremark/AdvancePCS mergers were consummated, concentration levels in the national full service PBM market have become more problematic as the largest PBMs have grown significantly. There is little evidence that these mergers have led to more efficiency or lower prices. Indeed the profits of the largest PBMs have grown and the largest PBM, CVS/Caremark has used its merger to stifle competition and increase costs to consumers. As the AAI Transition Report, The Next Antitrust Agenda, observed: "[a]bandoning enforcement in these key areas leads to significant harm to consumers."[6] This merger eliminates an important competitor from the national market, increasing concentration and the threat of higher prices.

THE IMPORTANT COMPETITIVE CONCERNS OF PBM MERGERS

As the country tackles the difficult issue of health care reform, the role of health care intermediaries, such as PBMs and health insurance companies, should receive considerably greater attention. There is increasing evidence that these intermediaries often fail to fulfill the interests of consumers and patients. In part, that is because of the lack of transparency and the opportunities for deception. There are two elements necessary for markets to perform effectively: transparency and choice. Unfortunately the PBM market, dominated by a tight oligopoly which engages in deceptive practices lacks both of these necessary elements to a well functioning market. As the AAI Transition Report observed, there has been a tremendous amount of consolidation in both PBM and health insurance markets and this consolidation has not benefitted consumers of competition.[7]

A recent series of articles in the Wall Street Journal observed that these intermediaries and in particular PBMs have not functioned effectively in the health care context and middlemen often seem to exercise market power:

> [W]hile the Internet, deregulation and relentless corporate cost-cutting have squeezed middlemen elsewhere, the health-care middlemen are prospering. The three largest pharmaceutical benefit managers, for instance, had net income of $1.9 billion last year, a sum that exceeds the annual operating budget of New York's Sloan Kettering cancer center. In corners of the system such as Medicaid managed care and nursing-home drugs, little-known intermediaries rack up tens or hundreds of millions of dollars in profit.[8]

---

5 We note the law firm that represented one of the parties in the Caremark/AdvancePCS merger observed that the investigation was closed on a "quick look" review. *See* http://www.jonesday.com/experience/experience_detail.aspx?exID=S9298. This means that the Commission did not conduct a full investigation of that merger.

6 American Antitrust Institute, The Next Antitrust Agenda 317 (2008).

7 *Id.*

8 Barbara Martinez, et al., "Health-Care Goldmines: Middlemen Strike it Rich," *Wall Street Journal*, A1 (December 29, 2006).

The lack of transparency and the extensive deceptive and fraudulent practices only exacerbate the competitive problems. The PBM industry is plagued with substantial fraudulent, deceptive, and anticompetitive conduct. In the past five years alone, cases brought by a coalition of over 30 State Attorneys Generals (AGs) have secured over $370 million in penalties and fines for deceptive and fraudulent conduct by the three major PBMs. (See Appendix A for list of cases). These cases were brought based on allegations of fraud, misrepresentation to plans, patients and providers, pocketing the plans funds through spread pricing, improper therapeutic substitution, unjust enrichment through secretive kickback schemes, and failure to meet ethical and safety standards. Specifically the states found that the PBMs accepted rebates from manufacturers in return for placing higher priced medications on the formulary, played the "spread" between the prices paid by clients and the price paid at the pharmacy, and favored higher priced drugs that provided PBMs with greater incentives and switched customers from low-cost to the higher-cost medications.

Several investigations of the major PBMs continue by a group of AGs. As a bipartisan group of state legislators has noted:

> We know of no other market in which there has been such a significant number of prominent enforcement actions and investigations, especially in a market with such a significant impact on taxpayers. Simply put, throughout the United States, numerous states are devoting considerable enforcement resources to combating fraudulent and anticompetitive conduct by PBMs. This is because those activities are taking millions of taxpayer dollars and denying government buyers the opportunity to drive the best bargain for the state.[9]

A central problem with the lack of competition is the lack of transparency. In an important decision upholding state regulation of PBMs, one federal court observed, "[w]hether and how a PBM actually saves an individual benefits provider money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider." The court elaborated:

> This lack of transparency also has a tendency to undermine a benefits provider's ability to determine which is the best among competing proposals from PBMs. For example, if a benefits provider had proposals from three different PBMs for pharmacy benefits management services, each guaranteeing a particular dollar amount of rebate per prescription, the PBM proposal offering the highest rebate for each prescription filled could actually be the worst proposal as far as net savings are concerned, because that PBM might have a deal with the manufacturer that gives it an incentive to sell, or restrict its formulary, to the most expensive drugs. In other words, although PBMs afford a valuable bundle of services to benefits providers, they also introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs.[10]

The current concentrated nature of the national full service PBM market only exacerbates these problems and it increases the need for both government enforcement and potential oversight of the

---

9 Letter from Senator Mark Montigny to FTC Chairman Deborah Platt Majoras (May 11, 2005).

10 Pharm. Care Mgmt. Ass'n v. Rowe, 2005 U.S. Dist. LEXIS 2339, at *7-8 (D. Me. Feb. 2, 2005), *aff'd*, 429 F.3d 294 (1st Cir. 2005).

PBM industry. Careful scrutiny of the proposed Express Scripts/WellPoint merger is necessary to assure that these problems are not heightened by the increased concentration resulting from the merger.

ANALYSIS

The Provision of PBM Services to Large Plan Sponsors May Be Harmed By the Acquisition

The proposed merger could significantly reduce competition in the market for the provision of PBM services to large plan sponsors.[11] In the Caremark/AdvancePCS merger, the FTC reaffirmed that the provision of PBM services to large plan sponsors is a relevant market. (This market was first defined in the Lilly/PCS enforcement action in 1994). This market retains its vitality today. Large employers and unions are dependent on the full range of services that national full service PBMs provide. These entities usually must rely on national full service PBMs, which possess the economies of scale and scope that small PBMs lack.

In this market there are four major PBMs that offer services

PBM	Covered Lives (in millions)
CVS/Caremark	134
Medco	65
Express Scripts	50
Wellpoint	39

This merger will combine the third and fourth largest PBMs, resulting in the second largest PBM with over 89 million covered lives. After the big three, the next largest PBM, MedImpact, has only 27 million covered lives.

Since the approval of the CVS/Caremark and Caremark/AdvancePCS acquisitions, the role of the leading national PBMs has become increasingly developed and prominent. The national full service PBMs have created the broadest range of pharmacy networks and the strongest and lowest cost mail order systems. This buying power by aggregating covered lives and distribution systems provide them significant cost advantages over smaller PBMs. That is why customers are reluctant to move from one of the top tier PBMs.

In addition, since the CVS/Caremark and Caremark/AdvancePCS mergers, the major PBMs have acquired specialty pharmaceutical firms which provide another substantial competitive distinction. Specialty pharmaceuticals are increasingly a critical part of the services sophisticated PBMs offer plan sponsors. This is because specialty pharmaceuticals are far more costly than traditional drugs and plan sponsors are demanding coverage of a broad range of these drugs for their subscribers. Moreover, specialty pharmaceuticals are a major source of revenue for PBMs. In the past three

[11] We identify large plan sponsors as one group of customers that could be harmed by the merger because the Commission addressed those customers in the CVS/Caremark/AdvancePCS investigation. However, even smaller plan sponsors may be adversely affected by the merger and the Commission should investigate that question. Smaller plan sponsors may have even fewer options than large plan sponsors.

years, each of the four national full service PBMs acquired some of the largest specialty pharmaceutical firms, therefore giving them a significant advantage over non-integrated PBMs.[12]

In light of the foregoing developments, it is very likely that smaller second-tier PBMs could not constrain any post-merger anticompetitive conduct.[13] In the Caremark/AdvancePCS merger, the FTC predicted that competition among the remaining full service PBMs, along with "significant additional competition from several health plans and several retail pharmacy chains offering PBM services should suffice to prevent this acquisition from giving rise to a potentially anticompetitive price increase."[14] However, the FTC's predictions about the ability of second-tier PBMs to restrain potential anticompetitive conduct of the four national full service PBMs appear to have missed the mark. First, many of the retail pharmacy PBMs have disappeared (one of the largest, RxAmerica was acquired by CVS). Second, none of the second tier PBMs has grown substantially, in terms of covered lives or prescriptions in the past several years. Finally, the four top tier PBMs consistently retain over 90% of their business. To the extent that each of the major PBMs have lost business, they have primarily lost business to each other rather than to the second-tier PBMs.[15] In fact, the major PBMs suggest that the only competitive threat they face is from each other.

The fact that second-tier PBMs have not gained more business from the largest PBMs is not surprising. The largest PBMs possess substantial economies of scale in terms of purchasing power, mail order operations, and specialty pharmaceuticals that give them a significant cost advantage over the second tier PBMs. To illustrate this difference, consider the simple issue of buying power. CVS/Caremark has over 130 million covered lives, the combined Express Scripts/Wellpoint will have almost 90 million covered lives, and Medco will have over 50 million. The next largest PBM has only 27 million covered lives. If Express Scripts acquires Wellpoint, the three largest PBMs will potentially be able to secure even substantially greater rebates on pharmaceuticals purchased, providing a significant cost advantage over second-tier PBMs.

There is a similar disparity in size between the Express Scripts/Wellpoint, CVS/Caremark, Medco, and remaining PBMs in terms of the number of claims processed and prescriptions dispensed. PBMs are primarily distribution and claims processing businesses and economies of scale are central to cost differences in these types of business. These economies of scale are again a significant differentiating factor between the largest and smaller PBMs. Moreover, the largest PBMs have more sophisticated claims adjudication software, which is critical to handling multiple plans.

Scale economies are also critical in the development of drug cost containment programs and new forms of clinical and therapeutic innovation. Clinical cost containment programs are most effective

---

12 The fact that the major PBMs acquired other specialty pharmaceutical firms rather than expanding their own specialty pharmaceutical operations suggests that internal growth by smaller PBMs into specialty pharmaceuticals is difficult.

13 By non-integrated we mean PBMs without mail order or specialty pharmaceutical operations.

14 *See* Federal Trade Commission, "Statement, In the Matter of Caremark Rx, Inc./AdvancePCS," (February 11, 2004), available at http://www.ftc.gov/opa/2004/02/Caremarkadvance.htm.

15 *See* Lehman Brothers, "Medco Health Solutions 5" (December 4, 2006) (observing that in 2006, 29 percent of Medco's new business was from Caremark and 31 percent was from Express Scripts; in 2007, 33 percent was from Caremark and 26 percent was from Express Scripts).

when supported by a strong database based on a large number of covered lives. Moreover, these clinical cost containment programs have large fixed costs associated with having pharmacists, RNs, and qualified staffs interact with physician and patients. The largest PBMs are more effective at these types of clinical and therapeutic programs and that is another important distinction recognized by plan sponsors. Moreover, the success of new clinical innovation strategies is dependent on these economies of scale.[16]

The foregoing analysis does not to criticize the exercise of buyer power by PBMs or their efforts to assist plan sponsors in controlling costs. Rather, it recognizes that only competition can ensure that the benefits of the exercise of buyer power are actually passed on to the ultimate consumers -- the plan sponsors who purchase PBM services. Without competition, consumers cannot be assured that increased buying power will lead to lower prices.

There are Significant Barriers to Entry and Expansion

The parties may suggest that second-tier PBMs serve as a competitive restraint, or could expand to become a more significant restraint. The facts belie this possibility. The four largest PBMs consistently report that they retain over 90 percent of their business when contracts are rebid.[17] The covered lives of smaller PBMs have not increased significantly over the past several years. Smaller PBMs primarily have adopted a niche strategy aimed at smaller governmental and private plan sponsors. The fact that PBMs owned by health plans are being divested suggests that these smaller PBMs have limited viability. These smaller PBMs lack the economies of scale and scope to effectively compete with the four major PBMs. Not surprisingly, on the rare occasions where the large PBMs lose business, it is primarily to other large PBMs.

The following may be significant barriers to expansion by the second-tier firms:

- Second-tier PBMs operate at a significant cost disadvantage;
- Second-tier PBMs lack mail order and specialty pharmaceutical operations and the lack of such operations only increases their cost disadvantage;
- Second-tier PBMs lack the reputation to handle large plan sponsors; and
- There are significant switching costs involved in moving from one PBM to another.

Reputational barriers can be an important barrier to expansion. PBM services--especially claims processing and clinical management--are heavily dependent on economies of scale and the ability to guarantee the highest level of performance. Thus, large plan sponsors will look for a proven track record and the experience of handling other sophisticated plan sponsors before seriously considering other PBMs.[18] That explains why the retention rate of the largest PBMs is so high.

---

16 Medco Health Solutions, Presentation at Wachovia Securities Healthcare Conference (January 30, 2007).

17 The fact that the same 3-4 firms have dominated the market since at least the time of the Lilly/PCS consent decree should create a significant level of skepticism about claims of ready expansion into the top tier. The 90 percent retention rate suggests that there are significant switching costs to converting to other PBMs.

18 *See United States v. United Tote, Inc.*, 768 F. Supp. 1064, 1078 (D. Del. 1991) (describing importance of reputational barriers).

In other mergers, the courts have found these types of impediments to be significant barriers to entry and expansion. For example, as the court observed in the FTC's successful challenge to the drug wholesalers mergers: "[t]he sheer economies of scale and scale and strength of reputation that the Defendants already have over these wholesalers serve as barriers to competitors as they attempt to grow in size."[19] We believe the same conclusion will be true for the PBM market.

The Merger Poses a Significant Risk of Coordinated Interaction

The merger may pose a particular threat of coordinated action in the provision of PBM services to large plan sponsors. Structurally, the market is susceptible to coordination – it is highly concentrated and that level of concentration has increased over time. It seems clear there are significant barriers to entry and expansion.

In the FTC actions against the Lilly/PCS and Merck/Medco mergers the FTC recognized and alleged the potential risks of coordinated interaction. Those risks have become more significant as concentration has increased. Moreover, there are several bases for coordination among PBMs, including coordination on customers, types of services offered, pricing to pharmacies, terms of service, pricing and other factors.

The unique role of WellPoint is important to the analysis. Of the four major PBMs, Next RX is the only one owned by a health insurance company. As such it has different financial incentives and capabilities than the three other large PBMs. PBM services are an ancillary product for WellPoint – thus, it has less of an incentive to exercise market power in PBM services and has greater financial resources to disrupt the market. Not surprisingly, WellPoint has never been the subject of any of the numerous multistate enforcement actions, since it has less of an incentive to "game the system." Unlike one of the three largest PBMs, Wellpoint has much more to lose in its overall insurance business if a plan sponsor finds out there has been fraud or deception. Similarly, unlike the big three PBMs, mail order is not a significant profit center for WellPoint, so there is less of an incentive to impose egregious policies to force consumers to mail order.[20] Simply, because of its ownership by an insurance company, Next RX is more likely to remain an "honest broker" for plan sponsors and is less likely to follow coordination by the three largest firms.

Next RX has already demonstrated its potentially disruptive role in the market. Unlike the three dominant PBMs, it offers capitated contracts to plan sponsors in which it shares the risk of increased drug spend. These capitated contracts service as an important competitive constraint in the market and dampen the ability of the large PBMs to coordinate and change higher prices. Moreover, they are a different product offering which makes coordination more difficult. Thus, WellPoint may act as a maverick in the market. The DOJ and FTC have successfully challenged mergers in the past where the merger would eliminate a maverick in the market. Thus, the FTC should fully explore this issue in its investigation.

---

[19] *FTC v. Cardinal Health, Inc*., 12 F. Supp. 34, 57 (D.D.C. 1998); *see United States v. Rockford Memorial Hosp*., 898 F.2d 1278, 1283-84 (7th Cir. 1990) ("the fact [that fringe firms] are so small suggests that they would incur sharply rising costs in trying almost to double their output … it is this prospect which keeps them small").

[20] Only 10% of WellPoint's prescriptions are through mail order compared to 24% for Express Scripts.

The Provision of Specialty Pharmacy Distribution Services May be Harmed by the Acquisition

Express Scripts' acquisition of WellPoint's PBM business could pose competitive problems in the distribution of specialty pharmaceuticals. Specialty pharmaceuticals are expensive drugs, which often must be taken in the maintenance basis. In the past four years, each of the large PBMs recognized the competitive significance of the distribution of specialty pharmaceuticals by acquiring major specialty pharmaceutical distributors in the past three years. In other cases the major PBMs have entered into exclusive distribution arrangements. Express Scripts is currently the second largest specialty pharmaceutical distributor in the U.S. behind Medco. The proposed transaction would make the combined entity even more dominant in individual specialty pharmaceutical markets.

These recent acquisitions of specialty pharmaceutical manufacturers by PBMs have already resulted in significant competitive harm. Express Scripts has acquired two specialty pharmaceutical manufacturers – Priority Healthcare and Curascript. In addition it has entered into exclusivity arrangements with some manufacturers. Many of those acquisitions or distribution alliances have led to substantial increases in the prices of several specialty pharmaceuticals. Perhaps the most troubling example, involves Express Scripts. Once it secured exclusive distribution rights it raised the price of a vital drug to treat thousands of children suffering from epilepsy, H.P. Acthar Gel, from $1,600 a vial to $23,000 a vial, an increase of over 1400%. This is just one of several examples of PBMs imposing dramatic price increases. As the New York Times observed "in recent years, drug benefit managers like Express Scripts have built lucrative side businesses seemingly at odds with [the mission of delivering the best price]."[21]

As the Commission recognized in its recent enforcement action against Ovation, there is tremendous potential for pharmaceutical firms, including PBMs to acquire drugs for highly vulnerable populations and rapidly increase prices in an anticompetitive fashion. In the Ovation matter Commissioner Rosch explained how an acquisition of this type might be anticompetitive, even if it did not eliminate a horizontal competitor, because it eliminated a reputational barrier that prevented anticompetitive conduct.[22]

We urge the Commission to explore Commissioner Rosch's theory in this and other matters involving pharmaceutical manufacturers. Controlling pharmaceutical costs is increasingly critical to the nation's efforts to manage its overall exploding healthcare costs. Pharmaceutical manufacturers and PBMs are increasingly looking for opportunities to find and exploit untapped market power. The specialty pharmaceutical acquisitions by PBMs, including the Express Scripts/WellPoint merger are a good place for the Commission to explore this new form of harmful conduct.

In addition, the FTC should explore if this merger will lead to anticompetitive effects in the PBM service market through the loss of a reputational constraint. Currently, WellPoint does not have an incentive to use its PBM services to exploit consumers or exercise its potential market power. Exploiting that power might convince customers to go elsewhere for other more lucrative products

---

21 Milt Freudenheim, "The Middleman's Markup" April 19, 2008, available at http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63&sec=&spon=&pagewanted=all.

22 Concurring Statement of Commissioner J. Thomas Rosch, *Federal Trade Commission v. Ovation Pharmaceuticals, Inc. available at* http://www2.ftc.gov/os/caselist/0810156/081216ovationroschstmt.pdf.

that WellPoint produces, primarily its health insurance products. In the Ovation matter, that reputational constraint prevented Merck from fully exploiting any potential monopoly power over the drugs it sold to Ovation; once that constraint was removed Ovation rapidly increased prices. Express Scripts has already shown its willingness to engage in this type of strategy in the Acthar Gel example. This merger should be scrutinized to determine if the elimination of a reputational barrier would harm consumers in the PBM services market.

Finally, the Commission should consider the evidence from these past acquisitions of specialty pharmaceutical manufacturers in evaluating the parties' alleged claims that this merger will be efficient or will benefit consumers. Although the PBMs may suggest their recent acquisitions, such as acquisitions of specialty pharmaceutical firms, have benefitted consumers, the reality is to the contrary.

The Acquisition May Lessen Competition in the Purchase by PBMs of Pharmacy Services from Retail Pharmacies Harming Consumers through a Reduction in Service and Choice

The acquisition poses competitive concerns over the exercise of monopsony power. One of the most important aspects of PBM services is the provision of distribution of drugs through pharmacies. As the Commission is aware, pharmacies play a critical role in providing services to consumers and educating them about the different alternatives in the market place. Pharmacies have also played an essential role in the creation and implementation of Medicare's pharmaceutical benefit program.

As a general matter, buyer power issues need greater scrutiny in merger investigations, especially those involving healthcare providers. As AAI observed in The Next Antitrust Agenda, there were very few recent mergers challenged based on buyer power concerns. The relatively lax approach may be based on several mistaken assumptions. Buyer power does not necessarily result in benefits to consumers especially where the buyer also possesses market power in the downstream market. Moreover, when the PBM buys pharmacy services it may not be acting in the interest of the ultimate consumer – its interests may be to expand its own retail or mail order sales and raise the costs of the rival pharmacy. Thus, it has the incentive to use reduced reimbursement to drive its rivals from the market, which ultimately may harm consumers in reduced service, convenience and choice.

The Next Antitrust Agenda provided an in depth review of how buyer power can harm competition in a variety of environments. It focused on how the lack of seller alternatives could ultimately harm consumers and how buyer power could occur at lower market shares than seller power. The Report specifically analyzed how a PBM merger could harm consumers through the loss of service, diversity and choice. It discusses a hypothetical merger among PBMs and noted that increased buyer power would not necessarily benefit competition or consumers. The Report observes that because of a PBM merger that increases buyer power "[d]iversity and consumer choice are more likely when individually owned pharmacies compete in the retail market," but as a result of the merger "many of these small pharmacies may find it difficult to survive."[23] That loss of service, convenience, and consumer choice is a significant concern for consumers who rely on community pharmacies for their greater level of service and convenience.

[23] American Antitrust Institute, The Next Antitrust Agenda 125 (2008).

Past PBM mergers have led to a significant increase in monopsony or oligopsony power, harming the ability of pharmacies to deliver adequate services to consumers. These problems are far more severe in pharmacy markets than markets involving other health care providers, since PBMs are not only payment intermediaries, but also are competitors since PBMs have mail order operations that compete against pharmacies and the largest PBM. So PBMs have an even greater incentive and ability to foreclose pharmacies and raise their costs. The CVS/Caremark merger, which combined the largest pharmacy chain with the largest PBM have exacerbated these problems, creating a single firm which appears to use its PBM operations strategically to raise rivals costs, which ultimately will raise prices to consumers and limit consumer choice.

The proposed acquisition increases the harm from monopsony or oligopsony effects by enabling the combined firm, either alone or in combination with the other remaining national full service PBMs to reduce the dispensing fees paid to retail pharmacies. As we explain at length in The Next Antitrust Agenda, the "competitive effects of buyer power are quite different depending on whether it is monopsony power against powerless suppliers or countervailing power against large suppliers with market power."[24] The former can be competitively beneficial, forcing suppliers to reduce costs (although there can be problematic effects from a wealth transfer or discrimination). Monopsony or oligopsony power can be problematic because it will lead to reduced output and higher prices.

In this case there is a significant threat on the exercise of monopsony power and an adverse impact on consumers and community pharmacies. Community pharmacies operate at very low margins. The vast majority of revenue for community pharmacies is from dispensing prescriptions. A reduction in dispensing fees by the merged firm could drive many community pharmacies out of business, or force them to reduce hours or the level of service. Recent litigation has demonstrated how a reduction in reimbursement in a relatively small set of drugs could drive thousands of community pharmacies out of business.[25] This merger poses an even greater threat to the service, convenience and choice offered by community pharmacies.

We respectfully disagree with the observations of the FTC in the Caremark/AdvancePCS merger that characteristics of the PBM market made such an exercise of monopsony power unlikely.[26] In that statement the FTC suggested that monopsony concerns were not significant because: (1) contracts are individually negotiated and (2) the post-merger market share is not great enough to

---

[24] *Id*. at 103.

[25] In a recent consideration of a proposed settlement of Average Wholesale Price litigation Judge Patti Saris required the parties to renegotiate the settlement and narrow its scope because of the potential impact on community pharmacies, which would have diminished pharmacy services and threatened the viability of many pharmacies. *New England Carpenters Health Benefits Fund v. First DataBank, Inc. et al*, Case No. 05-cv-11148 (D. Mass 2005). The proposed settlement would have reduced the AWP of approximately 8000 National Drug Codes (NDCs) by 5%. There was evidence that this reduction could have driven up to 50% of community pharmacies out of business. In response, the Court ordered the settling parties to reduce the number of NDCs in the settlement to approximately 1400.

[26] *See* Federal Trade Commission, "Statement, In the Matter of Caremark Rx, Inc./AdvancePCS," (February 11, 2004), available at http://www.ftc.gov/opa/2004/02/Caremarkadvance.htm at pp 2-3. We urge the Commission to revisit its conclusions in that merger. First, the numerous state enforcement actions suggest that the benefits of any increased buying power may simply be pocketed by the PBMs. Second, the investigation was resolved by a quick look instead of a complete investigation.

expect a monopsony effect. Finally, the statement suggested that increased buying power would increase PBM margins and some of those margins would be passed on to PBM clients.

We believe the facts and economic theory do not support the FTC's conclusion. First, community pharmacies are not given the "privilege" of negotiating contracts with PBMs – PBMs present them contracts on a "take it or leave it basis." There is no evidence that community pharmacies have any type of negotiating power. Second, the FTC applied too high a threshold in analyzing the market shares necessary to raise monopsony or oligopsony concerns. The market shares in this merger are significant enough to pose monopsony concerns. As explained in The Next Antitrust Agenda, monopsony power concern can exist at relatively low market shares, even below 20%.[27] Third, the question of benefits to the plans is ambiguous at best. PBMs typically refuse to disclose to plans the amount of reimbursement to pharmacies and sometimes are deceptive about the reimbursement level. Because of the lack of transparency and market concentration, plans typically cannot bargain with PBMs to share the increased margins from reduced reimbursement. Indeed, the several AG enforcement actions and recent audits by state governments have found that PBMs often pocket the reductions in pharmacy costs. In any case, even if there were some alleged savings to the plans, the ultimate consumer may be harmed in a reduction of service and convenience if lower premiums force community pharmacies to cut back services, hours, or exit the market.

Finally, monopsony concerns are not new to the PBM market. There are several on-going private litigation cases alleging the exercise of monopsony power either by the national full service PBMs individually or collectively with each other.

The FTC Should Issue a Second Request

There has been significant PBM consolidation in the past 8 years. Unfortunately, the FTC has failed to conduct a thorough investigation of any of these mergers. Most recently, the CVS/Caremark merger was cleared without a Second Request. That was unlike the Clinton Administration when Second Requests were issued in several PBM mergers and enforcement actions were taken against the Lilly/PCS and Merck/Medco mergers.

We believe this lack of enforcement has led to diminished competition and harm to consumers. In our Transition Team report we highlighted the important role of healthcare intermediaries, like PBMs and the lack of enforcement in the past Administration:

> In the absence of federal enforcement, there has been a tremendous increase in consolidation in the health insurance and PBM markets and a significant number of state and private enforcement actions against all these entities. The health insurance market has experienced a rapid consolidation, and the vast majority of metropolitan markets have become highly concentrated. A similar trend has occurred in the PBM market. Abandoning enforcement in these key areas leads to significant harm to consumers.[28]

---

[27] American Antitrust Institute, The Next Antitrust Agenda 104 (2008).

[28] *Id.* at 317.

We hope the FTC takes a different direction. This merger is an critical opportunity for the FTC to reevaluate the assumptions and theoretical arguments that may have served as the basis for earlier non-enforcement decisions. Moreover, this merger may lead to increased PBM consolidation. Thus the FTC should conduct a thorough investigation to accurately assess the competitive impact of this merger.

CONCLUSION

PBMs serve an important role in the health care delivery system. In light of increasing pharmaceutical expenditures and the critical role of PBMs in health care reform, it is even more important for the FTC to ensure that the PBM market is competitive. The promise of PBM cost containment is dependent on competition that compels PBMs to pass on cost savings to plan sponsors. Given the potential substantial harm to competition that may result from this merger, the AAI urges the FTC to issue a Second Request and conduct a thorough investigation.

CONTACT INFORMATION

David Balto, 202-577-5424
Albert Foer, 202-362-8704

Appendix A - -Federal and State Litigation Regarding Pharmacy Benefit Managers

January 2009

From 2004 – 2008, the three major PBMs (Medco, CVS Caremark, and Express Scripts) faced six major federal or multidistrict cases over allegations of fraud; misrepresentation to plans, patients, and providers; improper therapeutic substitution; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases resulted in over $371.9 million in damages to states, plans, and patients so far. The most prominent cases were brought by a coalition of over 30 states and the Department of Justice. Below is a summary of these six cases. Note that the regulatory provisions of many of these settlements will expire within the next 2-10 years.

---

1. *United States v. Merck & Co., Inc., et. al* (also cited as *United States of America v. Merck-Medco Managed Care L.L.C., et al.)* (E.D. Pa.)

Settled: October 23, 2006

Damages: $184.1 million

States participating: Arizona, California, Connecticut, Delaware, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nevada, New York, North Carolina, Oregon, Pennsylvania, Texas, Vermont, Virginia, and Washington.

Claims:

Whistleblower lawsuits, filed under the federal False Claims Act and state False Claims Acts against Medco Health Solutions, Inc., alleged that Medco:

- systematically defrauded government-funded health insurance by accepting kickbacks from manufacturers in exchange for steering patients to certain products;
- secretly accepted rebates from drug manufacturers;
- secretly increased long term drug costs by switching patients away from cheaper drugs; and
- failed to comply with state-mandated quality of care standards.

Settlement:

- A preliminary settlement in April of 2004:
    - Required Medco to pay $29.1 million to participating states and affected patients;
    - Placed restrictions on the company's ability to switch drugs;
    - Imposed measures to increase transparency; and
    - Required Medco to adopt the American Pharmacists Association code of ethics for employees.

- The final settlement, brokered in October 2006 required Medco to:
    - Pay an additional $155 million;
    - Enter into a consent degree regulating drugs switching and mandating greater transparency; and
    - Enter into a Corporate Integrity Agreement (CIA) as a condition of Medco's continued participation in government health programs.

  The Corporate Integrity Agreement will expire in 2011.

2. *United States of America, et al. v. AdvancePCS, Inc. (Case No. 02-cv-09236)(E.D. Pa.)*

Filed: 2002

Settled: September 8, 2005

Damages: $137.5 million

Claims:

Whistleblower lawsuit, filed under the Federal False Claims Act, alleging that Advance PCS (now part of CVS Caremark):

- Knowingly solicited and received kickbacks from drug manufacturers in exchange for favorable treatment of those companies' products;
- Paid improper kickbacks to existing and potential customers to induce them to sign contracts with the PBM;
- Submitted false claims in connection with excess fees paid for fee-for-service agreements; and
- Received flat fee rebates for inclusion of certain heavily utilized drugs.

Settlement:

A settlement in September, 2005 required Advance PCS, Inc., to:

- Pay a $137.5 million settlement and face a five-year injunction;
- Submit to regulations designed to promote transparency and restrict drug interchange programs;
- Enter into a five-year Corporate Integrity Agreement; and
- Develop procedures to ensure that any payments between them and pharmaceutical manufacturers, clients, and others do not violate the Anti-Kickback Statute of Stark Law.

3. *United States of America, et al v. Caremark, Inc. (Case No. 99-cv-00914)(W.D. Tex.)*

Filed: 1999
Pending as of January 2009

States participating: *Arkansas, California, DC, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, New Hampshire, New Mexico, North Carolina, Tennessee, Texas, Utah and Virginia.*

Claims:

This case is prosecuted under the Federal False Claims Act and numerous state False Claims Statutes. It alleges that Caremark (now part of CVS Caremark):

- Submitted reverse false claims to the Government in order to avoid, decrease or conceal their obligation to pay the government under several federal health insurance programs including Medicaid, Indian Health Services, and Veterans Affairs/Military Treatment Facilities.

4. *States Attorneys General v. Caremark, Inc.*

Filed: February 14, 2008

Settled: February 14, 2008

Damages: $41 million

States participating: *Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia and Washington.*

Claims:

Complaint against Caremark by 29 Attorneys General alleges that Caremark:

- Engaged in deceptive trade practices by encouraging doctors to switch patients from originally prescribed brand drugs to different brand name drugs.
- Did not inform clients that Caremark retained all the profits reaped from these drug switches; and
- Restocked and re-shipped previously dispensed drugs that had been returned to Caremark's mail order pharmacies.

Settlement:

In conjunction with the complaints, states issued a consent decree/final judgment that required Caremark to:

- Pay a collective settlement of $41 million;
- Significantly change its business practices by imposing restrictions on drug switches and creating greater transparency;
- Apply a code of ethics and professional standards; and
- Refrain from restocking and re-shipping returned drugs unless permitted by law.

5. *State Attorneys General v. Express Scripts*

Settled: May 27, 2008

Damages: $9.3 million to states, plus up to $200,000 to affected patients

States participating: Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington.

Claims:

State Attorneys general settled consumer protection claims alleging that Express Scripts:

- Engaged in deceptive business practices by illegally encouraging doctors to switch their patients to different brand name drugs; and
- Illegally increased their spreads and rebates from manufacturers without passing the savings on to the plans.

Settlement:

The settlement required Express Scripts to:

- pay $9.3 million to the states, plus up to $200,000 in reimbursements to affected patients.
- Accept restrictions on drug switching practices;
- Increase transparency for plans, patients and providers; and
- Adopt a certain code of professional standards.

6. *Local 153 Health Fund v. Express Scripts (In re Express Scripts, Inc. Pharmacy Benefits Management Litigation)* (Case No. 4:05-md-01672-SNL)

Case consolidated: April 29, 2005
Pending as of January 2009

Claims:

This case, filed in the Eastern District of Missouri, alleges that Express Scripts:

- Retained undisclosed rebates from manufacturers;
- Enriched itself by creating a differential in fees;
- Failed to pass on or disclose discounted drug rates and dispensing fees;
- Gained kickbacks from drug manufacturers in exchange for favoring certain drugs on the formulary;
- Circumvented "Best Pricing" rules to artificially inflate AWP; and

- Enriched itself with bulk purchase discounts that it failed to pass on to the plaintiffs.