National Community Pharmacists Association's Statement for the Record
United States House Subcommittee on Antitrust, Commercial, and Administrative Law
Hearing: "Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets"
March 7, 2019

Dear Chairman Cicilline, Ranking Member Sensenbrenner, and Members of the Subcommittee:

The National Community Pharmacists Association ("NCPA") appreciates the opportunity to submit this statement on the Subcommittee's hearing titled, "Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets." NCPA represents America's community pharmacists, including 22,000 independent community pharmacies. Together they represent a $76 billion health care marketplace, employ 250,000 individuals on a full or part-time basis, and provide pharmacy services to millions of patients every day.

In this statement, NCPA will address the potential implications consolidation in the industry, including the recently consummated merger of Express Scripts ("ESI") and Cigna as well as the CVS Health Corporation/Aetna merger, for which a consent decree is currently under review at the United States District Court for the District of Columbia. NCPA will highlight how consolidation in the health care industry may be contributing to higher costs and negatively impacting patient choice. In particular, to address pharmacy benefit manager ("PBM") market dominance, NCPA has long argued for additional scrutiny of PBMs, including their inherent conflicts of interest, lack of transparency, and one-sided take-it-or-leave-it contract negotiations with independent pharmacies. We urge Congress to work with the antitrust agencies to take a closer look at PBM consolidation and vertical mergers in the health care market for their effects on patient access, costs, and competition and whether the purported savings from these mergers will, in fact, be passed on to customers.

Continued Consolidation Will Lead to Decreased Competition and Fewer Choices for Patients

Recent consolidation among major PBMs and health plans has contributed to increasing health care costs and negatively impacted consumer choice. Health care costs have continued to rise despite previous vertical mergers. Continued vertical healthcare consolidation could further impede competition and foreclose any meaningful entry into the market, leading to fewer choices and higher healthcare costs. In addition, these huge entities increasingly rely on limited preferred networks that have negatively impacted consumer choice. For example, not all Medicare Part D ("Part D") sponsors and their PBMs prioritize access to local community pharmacies in their preferred networks. Instead, these networks are often limited to a smaller number of select pharmacies and regularly exclude community pharmacies even when such pharmacies are willing to accept the terms and conditions of a Part D sponsor's network. As a result, seniors' choice of pharmacy is limited and their access to quality care is hindered, especially in underserved areas. For this reason, NCPA is concerned that with consolidation, major PBMs will continue to limit their networks and further worsen patient choice and access.

The CVS/Aetna merger is an example of a specific transaction that is likely to significantly decrease competition for pharmacy products and services. Although CVS and Aetna agreed to sell Aetna's Part D prescription drug plan business to address their horizontal competitive overlap as a condition of approval of the deal, substantial anticompetitive concerns were not addressed. In fact, Aetna's Part D

assets were sold to WellCare Health Plans, Inc. who uses CVS Caremark as their PBM. Therefore, this divestiture of Aetna's Part D business essentially maintains CVS' market share instead of resolving any anticompetitive concerns.

CVS Caremark, the PBM for CVS, is the second largest PBM in the U.S., accounting for nearly 34% of covered lives.[1] This significant market share allows CVS Caremark (as well as the other largest PBMs) to exercise undue market leverage and generate outsized profits for themselves. Community pharmacies have very little negotiating power when contracting with PBMs like CVS Caremark, and routinely must agree to take-it-or-leave-it contracts to be part of a PBM's pharmacy network. In some cases, even if a pharmacy is willing to accept onerous contract terms, the PBM will exclude certain pharmacies from their preferred networks altogether, limiting patient choice and access. Having the opportunity to be part of a plan's preferred network can be critical, as nearly all Part D plans include preferred networks that offer lower co-pays to beneficiaries.

The merger of the largest pharmacy chain/PBM with a major health plan shows how health care consolidation will only solidify these problems with respect to competition and patient choice, especially in underserved areas. CVS Caremark, for example, already routinely steers patients to its own pharmacies based on the prescription benefit design that it has structured for plan customers. One plan design CVS Caremark offers, ironically called Maintenance Choice, generally limits patients to the pharmacy of their choice for only the prescription's first fill. Thereafter, in order to benefit from their prescription insurance, the consumers' "choice" is a CVS retail or CVS mail order pharmacy.

As the largest pharmacy chain in the United States with approximately 9,700 retail locations and significant share in many geographic markets, the merged entity is likely to be able to use its dominant position to increase payments to its own CVS pharmacies and effectively foreclose other pharmacies from its networks, a practice that other health care entities could engage in as well if this trend of health care consolidation continues.

Further, some states have found that CVS and other large PBMs engage in questionable pricing and reimbursement practices towards pharmacies. Last year, the Kentucky Department of Insurance fined CVS Caremark a $1.5 million civil penalty for violations related to reimbursements to pharmacists, including claim denial violations and providing inaccurate information.[2] In addition, the Auditor of the State of Ohio found that Ohio, where CVS Caremark is the PBM for four of Medicaid's five managed care plans, was charged around $225 million in spread amounts for Medicaid prescription drugs in a one-year period while other pharmacies were reimbursed at, or below, cost.[3] Of the total $225 million, Optum Rx was paid $28.9 million in spread. The report also confirmed that these drastic reimbursement cuts from the Ohio Medicaid PBMs caused a significant amount of independent pharmacy closures in the state.

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[1] According to CVS, it has 90 million PBM plan members. *See* CVS, *available at* https://cvshealth.com/about/facts-and-company-information. The Pharmaceutical Care Management Association testified that PBMs administer drug plans for more than 266 million Americans. *See also* Testimony of Mark Merritt, PCMA.

[2] Kentucky Department of Insurance Issues Penalty Against PBM, CaremarkPCS Health LLC, a subsidiary of CVS Caremark, Commonwealth of Kentucky Public Protection Cabinet Department of Insurance, *available at* http://ppc.ky.gov/Lists/News%20Releases/Kentucky%20Department%20of%20Insurance%20Issues%20Penalty%20Against%20PBM,%20CaremarkPCS%20Health%20LLC,%20a%20subsidiary%20of%20CVS%20Caremark.pdf.

[3] Ohio's Medicaid Managed Care Pharmacy Services, Auditor of State Report (Aug. 16, 2018), *available at* https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

Lastly, the Auditor General in Pennsylvania conducted a similar investigation, indicating that three PBMs made between $2 million and nearly $40 million on spread pricing.[4] **Thus, NCPA recommends that Congress work with the antitrust agencies to more thoroughly evaluate the effects of consolidation on the health care market to ensure that plan sponsors and consumers continue to have competitive choices.**

No Evidence to Support that the Purported Cost Savings of Consolidation Will Be Passed on to Consumers

Merging parties typically state that proposed transactions will create efficiencies and save hundreds of millions of dollars for consumers. They often do not explain, however, whether or how those purported savings will be passed on to consumers. The largest PBMs already claim their size enables them to achieve significant efficiencies and cost savings. As patients' out of pocket costs and premiums continue to rise, there is evidence to suggest that these savings are not, in fact, being passed on to consumers. NCPA suggests that whether the purported cost savings will be passed on to consumers remains unclear.

As discussed above, using the example of the CVS/Aetna merger, many patients that visit CVS Minute Clinics are likely to pick up their drugs at the CVS pharmacy. Yet, there is ample evidence that many times CVS pharmacies are not the lowest cost providers. In fact, Consumer Reports determined that CVS pharmacies often have the highest retail prices, which were found to be 400% higher than independent pharmacies' retail prices for the same prescription drugs.[5]

In addition, CVS will have every incentive to force more patients into their own mail order pharmacy, disingenuously arguing that mail order will likely lower costs. It is a common misconception that steering patients into mail order will lower drug costs for consumers.[6] Evidence demonstrates that mail order pharmacies consistently dispense costlier brand-name drugs and fewer generics than retail pharmacies.[7] Using data from industry source, IQVIA, the average mail order prescription is $626.44 compared to under $60 at a community pharmacy. As a "price giver" and a "price taker," mail order firms can manipulate pricing schemes. Plan Sponsors (employers, the federal government, individual purchasers) are often misled into thinking their overall prescription drug costs will be lowered by moving to mail order. In fact, the Centers for Medicare and Medicaid Services ("CMS") has determined that mail order does not result in cost savings in Part D.[8] **Therefore, NCPA urges Congress and the agencies to evaluate whether cost savings actually occur post-merger and to monitor whether these savings would indeed be passed on to consumers.**

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[4] Auditor General DePasquale, *Bringing Transparency & Accountability to Drug Pricing* (Dec. 2018), *available at* https://www.paauditor.gov/Media/Default/Reports/RPT_PBMs_FINAL.pdf.
[5] Gill, Lisa L., Shop Around for Lower Drug Prices, (Apr. 5, 2018), *available at* https://www.consumerreports.org/drug-prices/shop-around-for-better-drug-prices/.
[6] Carroll, Norman V., A Comparison of the Costs of Dispensing Prescriptions through Retail and Mail Order Pharmacies, *available at* http://www.ncpanet.org/pdf/leg/feb13/comparison_costs_dispensing_prescriptions_retail_mail_order.pdf.
[7] Johnsrud M, Lawson KA, Shepherd MD. Comparison of mail-order with community pharmacy in plan sponsor cost and member cost in two large pharmacy benefit plans. J Manage Care Pharm 2007; 13:122-134.
[8] Part D Claims Analysis: Negotiated Pricing Between General Mail Order and Retail Pharmacies, *available at* https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/downloads/negotiated-pricing-between-general-mail-order-and-retail-pharmaciesdec92013.pdf.

Several States have Acknowledged the Need of Protections from Consolidation

States are increasingly raising concerns about recent health care mergers. For example, Georgia, New York, and California obtained concessions from CVS and Aetna prior to approving the deal. Georgia obtained several patient and pharmacy protections before approving the merger, requiring that CVS/Aetna invite non-CVS health care providers and pharmacies to join its networks; allow patients to use any health care provider if that provider accepts the same conditions as those within the network; disclose the amount of rebates it receives from drug makers and how much of those it passed on to insurers; and that CVS/Aetna must not require patients to use CVS-owned pharmacies.[9]

In New York, regulators set conditions on the merger, including enhanced consumer and health insurance rate protections, privacy controls, cybersecurity compliance, and a $40 million commitment to support health insurance education, enrollment, and other consumer health protections.[10] Regulators required that participating provider networks for insured products will maintain access to non-chain New York pharmacies for three years. Lastly, in California, regulators approved the merger only if CVS and Aetna agreed to keep premium increases "to a minimum."[11]

Similarly, California and New York imposed conditions on the ESI/Cigna merger prior to approving the vertical integration of a PBM and a health insurance company. The California Department of Managed Health Care approved the deal provided that ESI and Cigna do not increase premiums to cover acquisition costs and, as in CVS/Aetna, keep premium rate increases to a minimum.[12] In addition, New York's Department of Financial Services approved the transaction on the conditions that Cigna and Express Scripts maintain their current networks of providers, "including pharmacies," adopt a firewall policy to separate competitively sensitive information, and required that the deal would be subject to ongoing regulatory oversight.[13] **Significant concerns have been validated at the state level through these concessions as states acknowledge that the CVS/Aetna and ESI/Cigna mergers will likely impose anticompetitive restrictions on patient access to their preferred pharmacies and health care providers.**

[9] *As CVS and Aetna Prepare to Merge, Georgia Wins Major Concessions*, Georgia Watch (Nov. 27, 2018), *available at* https://www.georgiawatch.org/as-cvs-and-aetna-prepare-to-merge-georgia-wins-major-concessions/.
[10] John Commins, *CVS-Aetna Merger Gets NY Approval, to be Finalized This Week*, Health Leaders (Nov. 26, 2018), *available at* https://www.healthleadersmedia.com/cvs-aetna-merger-gets-ny-approval-be-finalized-week.
[11] *DMHC Approves CVS's Acquisition of Aetna*, Press Release, Department of Managed Health Care (Nov. 15, 2018), *available at* http://www.dmhc.ca.gov/Portals/0/Docs/DO/pressRelease111518_1.pdf?ver=2018-11-15-100917-533.
[12] Cigna-Express Scripts Undertakings (Dec. 11, 2018), *available at* http://www.dmhc.ca.gov/Portals/0/Docs/DO/FinalCigna-ExpressScriptsUTs.pdf.
[13] Application by Cigna Corporation and Halfmoon Parent, Inc. for Approval to Acquire Control of Medco Containment Insurance Company of New York (Dec. 12, 2018), *available at* https://www.dfs.ny.gov/system/files/documents/2019/01/cigna_opinion_decision_12132018.pdf.

Continued Consolidation Will Only Exacerbate Existing PBM Market Power and Conflicts of Interest

PBMs already have extraordinary market power; the top three PBMs control approximately 85-89% of the market: 238 million lives[14] out of 266 million lives. [15] This dominance has allowed PBMs to leverage their market power to the detriment of plan sponsors (government and commercial payors), providers, and consumers. Additionally, PBMs claim that they help plan sponsors generate savings by negotiating rebates, however, recent reports have shown the opposite. A report from 2017 found that PBMs have been utilizing their market power to try to increase their profits and encourage higher list prices for prescription drugs, which increases co-pays for patients.[16]

PBMs are manipulating the system to increase their own profits at the expense of consumers, employers, and government programs. PBMs have a unique vantage point in the middle of the supply chain to have access to critical claims and financial data by their contracts with manufacturers and pharmacies and due to their multitude of revenue streams. They negotiate rebates with pharmaceutical manufacturers and determine which drugs are included on PBM formularies, ultimately determining what drugs patients will have access to and at what cost. They also contract with employers to manage their prescription drug benefit, and in doing so, heavily influence prescription drug benefit designs.

PBMs' inherent conflicts of interest in the health care marketplace warrant further scrutiny. Each of the largest PBMs own mail order pharmacies and specialty pharmacies. PBMs also contract with all other retail pharmacies to form pharmacy networks that are direct competitors to the PBM-owned pharmacies. PBMs regularly design plans, including plans with preferred networks, that require or incentivize patients to use the PBM-owned pharmacy option over a retail pharmacy. Moreover, when a PBM contracts with a retail pharmacy, PBMs have wide latitude in setting requirements for a pharmacy to be included in a network: the PBM determines how much the pharmacy will be reimbursed, which drugs will be covered, the day supply that the pharmacy can dispense, the patient co-pay, and many other factors. PBMs also routinely audit retail pharmacies and through this process have access to purchasing records and invoices.

When PBMs own mail order or specialty pharmacies, they utilize such road blocks to steer patients to PBM-owned pharmacies. Specifically, in the specialty pharmacy space, due to the lack of an industry-wide definition of a specialty drug, PBMs arbitrarily define high-cost drugs as "specialty drugs" and encourage or require that beneficiaries fill these prescriptions at PBM-owned or affiliated specialty pharmacies. Forcing patients, particularly those who have complex conditions and require specialty drugs, to get their prescriptions from a pharmacy with which it has no personal relationship severely limits patients' choice and may impact the quality of care and adherence. **Because PBMs are hindering patient choice and access, while steering patients towards costlier drugs, we urge Congress to**

[14] Mathematical calculation based on number of covered lives CMS/Caremark, UnitedHealth and ESI self-reported.
[15] Council of Economic Advisers, Reforming Biopharmaceutical Pricing at Home and Abroad, Feb. 2018, *available at* https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf; *see also* testimony of PCMA CEO Mark Merritt before the U.S. House of Representatives Energy & Commerce Committee Subcommittee on Health, December 13, 2017.
[16] Steve Pociask, "Pharmacy Benefit Managers: Market Power and Lack of Transparency," Am. Consumer Inst. ConsumerGram (2017), *available at* http://www.theamericanconsumer.org/wp-content/uploads/2017/03/ACI-PBM-CG-Final.pdf.

encourage the antitrust agencies to closely examine PBM-owned mail order and specialty pharmacies for conflicts of interest misconduct.

Ongoing Post-Merger Review is Necessary

The federal antitrust agencies are tasked with reviewing and approving health care consolidation transactions to evaluate the impact of these mergers on the "quality of goods or services."[17] The agencies' purview of merger review as it relates to health care settings may not be comprehensive enough to consider the impact on patients and the quality of care. NCPA believes that while reviewing health care mergers, the effects of the transaction on the quality of care is a necessary component.

In addition, while NCPA values the agencies' pre-merger review processes, we believe it is inadequate in assessing the actual effects once a health care merger becomes operational. **Therefore, NCPA recommends that Congress and the antitrust agencies create an ongoing post-health care consolidation evaluation process. We also suggest that Congress work with the agencies to streamline an open and continuous dialogue between all stakeholders to assure patient access to care.**

Conclusion

In conclusion, NCPA appreciates the subcommittee's efforts to closely examine the effects of health care market consolidation and anticompetitive conduct. As established above, these issues cannot be solved without addressing the role of PBMs. Members of this subcommittee should be concerned with PBM anticompetitive conduct, as well as the trend of large vertical mergers like CVS/Aetna and ESI/Cigna. We urge Congress to collaborate with the antitrust agencies to ensure patient care is considered and prioritized during health care merger review.

[17] Federal Trade Commission, Merger Review, *available at* https://www.ftc.gov/enforcement/merger-review.