Statement of the National Community Pharmacists Association (NCPA)

The United States Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights

The Federal Trade Commission (FTC) and United States Department of Justice (DOJ) Antitrust Oversight Hearing

June 9, 2010

Summary of NCPA Statement

NCPA recommends that the FTC/DOJ:

1. Revise the 1996 Antitrust Enforcement Policy in Healthcare Guidelines to include pharmacist collaboration;
2. Encourage and support federal and state efforts to regulate pharmacy benefit managers; and
3. Implement a comprehensive enforcement action against CVS Caremark to address the concerns of independent pharmacies and their patients

Chairman Kohl, Ranking Member Hatch, and Members of the Subcommittee:

NCPA welcomes and appreciates this opportunity to provide input and suggestions regarding the antitrust oversight and guidance of the FTC and the DOJ particularly as it relates to pharmacy care providers and the health care arena in general. NCPA represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. The nation’s independent pharmacies, independent pharmacy franchises and independent chains dispense nearly half of the nation’s retail prescription medicines. NCPA strongly believes in the missions of the antitrust enforcement agencies and that this Subcommittee’s oversight of those agencies is important to assure effective antitrust enforcement for all consumers.

NCPA encourages the FTC/DOJ to update their 1996 Antitrust Enforcement Policy in Health Care Guidelines to reflect the current health care marketplace

The FTC and DOJ jointly issued the Statements of Antitrust Enforcement Policy in Health Care in 1996 to provide guidance to health care providers and related entities about the agencies’ enforcement policies in this area. This document also provides examples of types of collaboration among these providers or entities that the agencies would not challenge as violative of the antitrust laws—or those within antitrust “safety zones.” Needless to say, there have been tremendous changes in the delivery of health care services in the United States since 1996, and these guidelines are now out-of-date.
When the 1996 guidelines were issued, then-FTC Commissioner Christine Varney wrote, “[t]he health care marketplace is undergoing rapid change, and it is primarily through an open dialogue with all involved in the health care industry that the Agencies can continue to provide appropriate and relevant antitrust guidance.” We believe that revision of these Guidelines is long overdue and that the time is ripe in light of the passage and pending implementation of health care reform legislation.

The permissible scenarios cited in the 1996 health care guidelines are primarily focused on collaborative efforts among physicians or hospitals and do not mention pharmacists, pharmacies or other types of healthcare providers. We urge the FTC with the DOJ to revise the guidelines and start by initiating a dialogue with a variety of healthcare practitioners, including pharmacists, to gain an understanding of the types of collaboration that are being explored or contemplated by providers and the ways in which these efforts can positively impact the quality of patient care and lower overall healthcare costs. The need for an updated version of these guidelines has been noted by Congressional leaders on a number of occasions in the recent past. An initial letter to this effect was sent to the FTC/DOJ in June 2007 by Senators Kohl, Specter, Grassley, Durbin and Whitehouse. Most recently in a letter dated November, 3, 2009, Senators Leahy, Kohl, Specter, Grassley, Whitehouse and Feinstein also urged the FTC and the DOJ to revise these same guidelines based on the fact that “clear and user-friendly guidance would reduce barriers to coordination and innovation ultimately leading to cost efficiencies in the health care system” particularly given the fact that significant health care reform appeared imminent.

**The Asheville Project is a successful example of pharmacist collaboration to provide medication therapy management (MTM) for chronic disease states**

One example of successful collaboration among pharmacists that has had significant demonstrable patient outcomes is the Asheville Project—an undertaking that utilized a network of community pharmacies to combat chronic disease states. Community pharmacists are often more accessible than other health care providers and provide a wide variety of services beyond the simple dispensing of drugs. In addition, community pharmacies are often located in rural or inner city areas, typically underserved by other types of health care providers. Community pharmacies can serve an important role in reducing costs, while improving healthcare results, especially if there is greater clarity about pharmacy collaboration under the antitrust laws.

The “Asheville Project” began in 1996 as an effort by the city of Asheville, NC, a self-insured employer, to provide education and personal oversight for employees with chronic health problems such as diabetes, asthma, hypertension and high cholesterol. According to the Centers for Disease Control and Prevention, chronic diseases make up 75% of the annual health care bill. Diabetes alone affects 18.2 million people and costs $132 billion a year, including lost productivity and disability. In the Asheville Project, patients were paired with pharmacists from one of twelve network community pharmacies who served as coaches to these at-risk patients, monitored medication adherence and encouraged and facilitated lifestyle changes. These pharmacists were paid on a fee-for-service basis patterned after a federal claims model for these clinical services-- now broadly referred to as medication therapy management or MTM. The results in terms of patient outcomes as well as the savings to the employer were astounding. In 1996, the city spent an average of $6,127 a year on each of its 48 diabetic
employees. By the end of 1997, expenditures for these employees had been cut in half, to $3,554 per patient. The average sick time among the diabetic employees dropped from 12.6 days per employee each year to 6 days and has remained at 6 or below since 1999. Since the Asheville Project was launched, thousands of people in the Asheville area have taken control of their diabetes, cholesterol, hypertension and asthma as the model has been expanded to include other diseases over the years. Six employers and more than 1,200 people currently participate in the project in the Asheville area. Using the Asheville Project as a model, similar programs sprang up in West Virginia, North Dakota, Kentucky, Georgia, Ohio and Wisconsin and demonstrated similar success rates in terms of positive health care outcomes and cost savings.

The Joint FTC/DOJ health care guidelines should be updated to allow the collaboration of pharmacists to provide clinical services and the ability to effectively negotiate with health insurance companies and PBMs for adequate reimbursement rates that would allow them to provide these services.

NCPA would welcome the revision of the antitrust health care guidelines to include various types of pharmacist collaboration—like medication therapy management-- demonstrated by the Asheville Project. Pharmacists are increasingly gaining recognition for the integral role that they play in encouraging preventative care and promoting wellness given their subject matter expertise and access to the communities in which they serve. Allowing pharmacists to collaborate and negotiate with insurers and PBMs for adequate reimbursement for such services would ensure that more consumers would have access to this type of innovative care and reduce overall health care costs.

The newly passed federal health care reform legislation clearly recognizes the importance of preventative care and the management of chronic disease states as an important tool in reducing prescription drug spending as well as overall health care costs. Specifically, the legislation requires qualified health plans to provide coverage for all preventative services rated “A” or “B” by the U.S. Preventative Services Task Force effective September 2010. Some of these highly-rated preventative services include tobacco cessation intervention and diabetes and high blood pressure screening and management. In addition, the legislation authorizes $100 million in grant funding to states for preventative health programs including tobacco cessation, weight control and diabetes management effective January 2011 as well as a 1% increase in federal matching funds for states whose Medicaid programs provide coverage for all preventative services recommended by the U.S. Preventative Services Task Force.

The implementation of these preventative health care services by the states will most likely require increased collaboration among health care providers and pharmacists are uniquely qualified to provide these services. Support for the expansion of medication therapy management programs is growing in both the public and private sectors as well. In recognition of the past successes and future potential of medication therapy management in the areas of cost savings and patient outcomes for patients with chronic disease states, CMS requires all Medicare Part D plans to offer MTM to assist beneficiaries with multiple chronic diseases who take multiple Part D eligible drugs. NCPA urges the FTC/DOJ to
recognize the expanded role that pharmacists can play in increasing efficiencies in the health care system, and to revise the guidelines to permit these activities.

**NCPA Urges the FTC/DOJ to Examine Potentially Anticompetitive Actions by Pharmacy Benefit Managers and to encourage both federal and state legislation to regulate these entities**

In the past year the Congressional debate over healthcare began to identify how health care intermediaries such as health insurance companies and Pharmacy Benefit Managers (PBMs) take advantage of the lack of competition in health care markets and the complexity of healthcare financing to harm consumers. Although these entities are supposed to control and reduce healthcare costs, often they engage in apparently fraudulent and deceptive conduct that result in employers and consumers paying more.

For several years, NCPA and its members have worked to educate Congress, state legislators and healthcare plans about the questionable and anticompetitive conduct of PBMs that negatively affect patients. Through a period of consolidation in the last decade, the PBM industry is now dominated by three large companies -- Medco, CVS Caremark and ExpressScripts – which now collectively administer 80% of insured prescriptions and 90% of insured mail order prescriptions. In addition, each company reports annual revenues exceeding $15 billion dollars. Unfortunately this market has consolidated due to a lack of antitrust enforcement. PBMs are middlemen that were originally designed to lower transaction costs between pharmacies and health insurance plans but have been allowed to operate unchecked—with no consistent regulatory structure or oversight. Because of the complexity of the market and the significant concentration the profits for the three largest PBMs have skyrocketed in the last four years, from about $900 million to over $3 billion annually.

When a PBM contracts with retail pharmacies, the PBM is able to determine how much the pharmacy will be reimbursed, which drugs will be covered, the days supply that the pharmacy can dispense, and the patient co-pay, as well as other factors. A conflict of interest exists, in that most PBMs own a mail order pharmacy that competes with the retail pharmacies that are part of the PBM network. Between 2004 and 2008, a coalition of over 20 state attorneys general brought cases against each of the three major PBMs over allegations of fraud; misrepresentation to plan sponsors, patients and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases have resulted in over $370 million in damages returned back to states, plans and patients so far.

There is clearly a need for greater regulation of PBMs. Congress recognized this in healthcare reform by requiring that PBMs that participate in either the health care exchanges or Medicare Part D provide plans with a basic level of transparency. Unfortunately in the past, the FTC on several occasions discouraged state legislation designed to elicit common-sense disclosures from the PBMs. This opposition to transparency seems puzzling. After all, information enables a buyer to determine what is being sold. Assistant Attorney General for Antitrust Christine Varney highlighted the importance of transparency when she said “I am a firm believer in what Justice Brandeis said in another context:
‘Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.’ Markets work better and attempted harms to competition are more likely to be thwarted when there is increased transparency to consumers and government about what is going on in an industry.”

NCPA respectfully requests that the agencies support both federal and state efforts to rein in the questionable documented practices of these entities.

**NCPA Appreciates the Current FTC Investigation Into Alleged Anticompetitive Conduct of CVS-Caremark and Encourages the Agency to Continue Its Efforts**

NCPA respectfully requests that the FTC vigorously continue its investigation into the alleged anticompetitive conduct of the CVS Caremark Corporation. The merger of CVS and Caremark was cleared by the FTC in November 2007 and combined CVS- the largest pharmacy chain- with Caremark, the second largest PBM. The root of the problem is the company’s dual role as both prescription drug plan administrator for approximately 82 million Americans and as the owner of 7,000 drug stores. That inherent conflict of interest apparently allows the company to leverage independent community pharmacies into unfavorable reimbursement contracts in order to claim that they offer a broad pharmacy network for patients. However, then, CVS Caremark effectively steers patients to fill prescriptions at its own mail order or retail pharmacies — effectively becoming both payors of and competitors with community pharmacies.

Since the merger, NCPA has been inundated with hundreds of complaints about the company’s conduct. Patients, who are the direct targets of these tactics, resent now being steered against their will to CVS Caremark’s mail order and retail pharmacies. Savings promised by CVS Caremark have seemingly vanished into thin air. Sensitive patient information is apparently being accessed by the company not for valid health reasons of payment, treatment and operations, but simply to pursue an even greater market share.

After raising these concerns, NCPA officials and over 80 community pharmacy owners were granted an opportunity to present evidence of CVS Caremark’s anticompetitive and anti-privacy practices at the FTC headquarters on May 13, 2009. Additional, bipartisan support was provided, after hearing about the complaints from their constituents (whether they were patients or pharmacists) by U.S. Senators Sherrod Brown (D-Ohio), Byron Dorgan (D-N.D.), Russ Feingold (D-Wis.), Amy Klobuchar (D-Minn.), Frank Lautenberg (D-N.J.), Mark Pryor (D-Ark.) and Roger Wicker (R-Miss.), and U.S. Representatives Michael Acuri (D-N.Y.), Robert Aderholt (R-Ala.), Marion Berry (D-Ark.), Jo Bonner (R-Ala.), John Boozman (R-Ark.), Judy Chu (D-Calif.), Lloyd Doggett (D-Texas), Jim Gerlach (R-Pa.), Walter Jones (R-N.C.), Larry Kissell (D-N.C.), Robert Latta (R-Ohio), Michael Rogers (R-Ala.), Linda Sanchez (D-Calif.), Jan Schakowsky (D-Ill.) and Anthony Weiner (D-N.Y.) in a series of letters that among other things called for, “the FTC to reopen the CVS Caremark merger investigation and determine if the acquisition poses a threat of reducing competition or whether CVS is engaging in any unfair or deceptive business practices.”

In August 2009, the FTC heeded those concerns by launching an investigation into CVS Caremark, which later disclosed this development to its shareholders. More recently over 24 states have joined
the investigation. The complaints from consumers and pharmacies all document actions by CVS Caremark to drive community pharmacies from the market and reduce choices and services to consumers. In some cases, confidential information is used to drive patients from rival independent pharmacies to a CVS pharmacy. In other cases, CVS Caremark limits consumers’ access to either CVS stores or CVS mail order. We have heard numerous complaints of how aggressive auditing is used to recoup funds from community pharmacies on minor technicalities. Some of these actions have a particular pernicious effect on community pharmacies and patients in rural markets, where health care options are more limited. Patients told they can only use CVS Caremark often face a long trip to the closest CVS or a significant wait for their medicine through the mail—losing their access to a local pharmacist familiar with their health needs and history.

When the CVS Caremark transaction was announced the company made two commitments: to be “agnostic” about the choice of pharmacy (in other words not to discriminate), and to have a firewall to keep CVS and Caremark separate. Neither of those commitments have been adhered to as CVS has increasingly used Caremark as a tool to drive rival pharmacies from the market. Ultimately consumers lose.

NCPA greatly appreciates the active investigation of CVS Caremark by the FTC and the states thus far. We urge the FTC and the states to take a comprehensive enforcement action to fully resolve the concerns identified by community pharmacies and their patients.

**Conclusion**

NCPA appreciates the opportunity to share our suggestions and concerns with the Subcommittee. In conclusion, NCPA recommends that the FTC/DOJ: (1) revise the 1996 Antitrust Enforcement Policy in Health Care Guidelines to include pharmacist collaboration; (2) encourage and support federal and state efforts to regulate pharmacy benefit managers; and (3) take comprehensive enforcement action against CVS Caremark to address the concerns of independent pharmacies and their patients.