ORAL STATEMENT

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Good morning Chairman Pryor, Ranking Member Wicker, and members of the Committee. Thank you for allowing me the opportunity to speak before you this morning on the critical issue of fair competition in the independent community pharmacy industry. My name is Mark Riley, and I have been an independent pharmacist for over thirty years, and I currently serve as national treasurer of the National Community Pharmacists Association (NCPA).

In addition to my duties as a national officer for NCPA, I have owned East End Pharmacy in a small town outside of Little Rock, Arkansas for the last 26 years. I currently serve as the executive vice president of the Arkansas Pharmacists Association, where I have been for the last 6 years.

I have spent my entire career serving patients in the independent community pharmacy marketplace and advocating for a level playing field throughout the pharmacy industry. I've also worked as a pharmacy consultant for ten years within the Pharmacy Benefit Manager (PBM) industry. My background has afforded me the opportunity to work on a variety of challenges and problems that are anti-competitive in nature within our healthcare industry, and I would like to take this opportunity to discuss just a few of those with you today.

The first issue that I would like to address is **Retail Class of Trade** pricing. In the United States, pharmaceuticals are sold by the pharmaceutical manufacturers at different prices to different entities, such as retail pharmacies, hospital pharmacies, long-term care pharmacies, and mail-order pharmacies. Historically, the differences in pricing have not substantially affected retail pharmacies because retail pharmacies are not competing for patients in hospitals or long term care facilities. However, mail order pharmacies pose a different threat to the retail pharmacies because mail order pharmacies are competing for the same patients as retail pharmacies, and the mail order pharmacies are doing so using preferentially priced prescription medications. This results in mail order pharmacies buying prescription medications at prices that retail pharmacies cannot access and this is why we are concerned with mail order pricing being included in the calculation of Average Manufacturer Price (AMP). This discrepancy in pricing is fundamentally unfair and does not promote true competition.

This leads to my second issue today, **Mail Order Pharmacy**. Because of the preferential pricing afforded mail order pharmacies, one might assume that mail order prescriptions are cheaper. However, in my experience, this is not the case. Mail order is steeped in deceptive pricing schemes that are intended to dupe employers into believing that they are saving money. If you would turn to Exhibit 1 in your handout, I will walk you through how pharmacy benefit managers (PBMs) and their mail order pharmacies deceive their clients.

Prescription medications are currently priced based on Average Wholesale Prices (AWPs), which are determined by the drug manufacturer. The PBMs have devised ways to change the AWPs to their advantage.

INSERT RETAIL vs. MAIL ORDER PRICING.

As you can see, PBMs sell their so-called "savings" in terms of percentages – not real dollars. This is only one of the games that the PBMs use to deceive purchasers of prescription drugs. This leads to the third issue I wanted to address today, **PBM Spread Pricing**.

Spread pricing is another game that the PBMs use which thwarts competition by making local community pharmacy prices look inflated. Simply put, the PBMs pay the pharmacy one amount and charge the purchasers a larger amount, but lead the purchasers to believe that the larger amount was actually paid to the pharmacy. In reality, the PBM pockets the difference. Please turn to Exhibit 2.

Let me give you a real world example from my home state of Arkansas. I helped a local company evaluate their prescription drug expenses to determine if their PBM had been using spread prices on them. What I discovered was alarming. During the two month period that I reviewed, the company was charged, on average, $22.55 per prescription in hidden spreads that were being pocketed by the PBM. This

essentially doubled the total cost that the employer spent on prescription medications, and the employer was led to believe that this money was paid to the pharmacy. In the most egregious example, the pharmacy was paid $14.40 for a cholesterol lowering drug, but the PBM charged the employer $126.72. Why such as a large spread? Just because the PBM could. How can a community pharmacy compete fairly when the true amount paid to them is virtually irrelevant to the ultimate cost to the purchaser?

This leads to the final issue I want to address this morning, the **CVS/Caremark Merger**. This ill-advised merger, approved by the FTC, takes the "smoke and mirrors" practices of the PBMs to a whole new level, and its effects are obviously anti-competitive. In addition to the acts I have previously discussed, the merger now allows CVS/Caremark to monitor and utilize every aspect of the community pharmacy transaction to their own advantage.

Imagine a business that gets to determine which of its competitors can compete for the customers, how much the competitor will be paid, and then captures all of the data from the competitor's transaction and uses this data to solicit the competitor's customers. This scenario is exactly what CVS/Caremark is doing. CVS/Caremark in its PBM capacity controls the pharmacy network, controls the amount paid to its competing community pharmacies, and controls all of the data from the transaction, which is being supplied to its retail pharmacy division.

Mr. Chairman, these are just a few of the problematic, anti-competitive issues that community pharmacies and their patients are facing due to the PBMs. I thank you for the opportunity to speak before the Committee today, and I welcome any questions that you may have.