

**THE EXPRESS SCRIPTS/MEDCO MERGER: COST
SAVINGS FOR CONSUMERS OR MORE PROFITS
FOR THE MIDDLEMEN?**

HEARING

BEFORE THE

SUBCOMMITTEE ON ANTITRUST,
COMPETITION POLICY AND CONSUMER RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

DECEMBER 6, 2011

Serial No. J-112-54

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**THE EXPRESS SCRIPTS/MEDCO MERGER:
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TUESDAY, DECEMBER 6, 2011

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY,
AND CONSUMER RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:30 p.m., in room SD-226, Dirksen Senate Office Building, Hon. Herb Kohl, Chairman of the Subcommittee, presiding.

Present: Senators Kohl, Klobuchar, Franken, Blumenthal, Lee, and Grassley.

**OPENING STATEMENT OF HON. HERB KOHL, A U.S. SENATOR
FROM THE STATE OF WISCONSIN**

Chairman KOHL. Good afternoon. Today we meet to consider a merger in an industry that is central to the way prescription drugs reach the market and the prices health plan sponsors and ultimately consumers pay for these drugs.

Express Scripts and Medco, two of the Nation's three largest pharmacy benefit managers, known as PBMs, seek to merge, forming the Nation's largest PBM. If this merger goes forward, the combined company will administer 1.14 billion prescriptions annually and would handle 41 percent of all prescriptions administered by PBMs. It would be nearly two times larger than its nearest competitor, CVS Caremark.

Over the past decade, PBMs have become major players in the health care industry. By one estimate, 90 percent of individuals with prescription drug coverage receive benefits through a PBM, and PBMs handle approximately two-thirds of all prescriptions written in our country. PBMs serve as middlemen between drug manufacturers, pharmacies, and health plan sponsors.

PBMs do everything from negotiating the prices health plan sponsors pay for drugs to setting the prices pharmacies are reimbursed for dispensing drugs. They also decide which specific drugs make it onto formularies eligible for reimbursement.

In addition to all of these functions, Express Scripts and Medco would control about a 60-percent share of the mail-order pharmacy business which ships drugs in bulk directly to consumers.

Finally, these two PBMs operate "specialty pharmacies," pharmacies that carry drugs used for the treatment of the most rare

and challenging ailments. They would together control over 50 percent of the specialty market after the merger.

Express Scripts and Medco argue that this merger will be beneficial to health plan sponsors and ultimately consumers. They claim that the combined company's scale would give it substantial buying power to drive down drug prices. The merger's critics, however, worry about the consequences of consolidating two major rivals in this very important industry. They question whether the drug price savings that the PBMs claim they will achieve will indeed be passed along to plan sponsors and their benefits or whether they will just go into the pockets of PBM shareholders.

This merger, as critics argue, will also reduce from three to two the number of large PBMs that serve the Nation's largest employers. Currently, 42 of the top Fortune 50 companies utilize Express Scripts, Medco, or CVS Caremark as their PBM. Reducing the number of competitive choices from three to two raises the dangerous possibility that these large companies will have little choice but to pay more for PBM services.

The merging companies argue that there are many other PBMs beyond the Big Three that bid to provide PBM services to large employers. However, many large companies appear to prefer the range of services offered by the three large PBMs and do not seriously consider smaller PBMs.

In this regard, it is notable that no large employer who privately expressed concerns to us wished to testify at today's hearing, often telling us that they feared retaliation from the large PBMs with whom they must do business.

We are also aware of the concerns expressed by pharmacies, both large chain drug stores and small community pharmacists, of what they believe are likely harmful effects of this deal. Pharmacists believe that the PBMs will force consumers to use mail-order services and squeeze the reimbursement rates pharmacies receive from PBMs.

Question: Will pharmacists be able to compete in this new marketplace? Will consumers suffer the loss of in-person services and consultations offered by traditional pharmacists? Or, as the PBMs contend, will this merger wring inefficiencies out of the system of dispensing and paying for prescriptions to the benefit of consumers and the health care system overall?

We have no doubt that this merger will be good for Express Scripts and Medco and for their shareholders. It is very likely that the merging companies will be able to gain efficiencies from merging their overlapping operations. But while this merger may serve these two companies' private interests, our job on the Antitrust Subcommittee is to examine whether this merger will serve the public interest and whether it will benefit or hurt competition and consumers.

There is no question that this merger will have far-reaching and long-lasting effects on the way prescription drugs are paid for, sold, and dispensed. So the burden will be squarely on Express Scripts and Medco to convince us that this merger will not unduly harm competition but, in fact, will benefit the millions of consumers who continue to face rising prescription drug costs.

Let me now turn to our Ranking Member, Senator Mike Lee, for his statement.

STATEMENT OF HON. MIKE LEE, A U.S. SENATOR FROM THE STATE OF UTAH

Senator LEE. Thank you, Mr. Chairman.

Each year Americans spend over \$300 billion on prescription drugs, and that number is only growing. At a time when businesses are strapped for cash, many employers spend as much as 12 percent of their entire budgets on employee health benefits, including coverage for prescription drugs.

This hearing addresses an important issue relative to the cost of prescription drugs in the United States. Pharmacy benefit managers, or PBMs, although relatively unknown to the general consuming public, play a prominent role and an integral role in our health care system. Many consumers have never heard of PBMs, but most, indirectly at least, interact with a PBM each and every time they visit a pharmacy.

The consumer gives a co-payment and receives a medication while the pharmacist seeks reimbursement from a PBM for the remaining balance. The PBM in turn submits a claim for payment of the drug to the health plan sponsor, in most cases the consumer's employer. In this manner, over 250 million Americans receive prescription drug coverage from their employer, union, or the Government through a PBM, with consumers receiving medications at a local pharmacy or perhaps through the mail.

Employers or other health plan sponsors pay PBMs a fee for their work in administering the details of a prescription drug plan. In addition, PBMs make money by keeping a portion of the difference between the price between what the employer pays for the PBM for a drug and what the PBM pays the pharmacy for dispensing that same drug. PBMs also keep a portion of the drug rebates they receive from drug manufacturers and generate profits from their in-house, mail-order, and specialty pharmacies.

There are over 40 PBMs in the country today, but there are only a few large ones. Two of the largest PBMs, Express Scripts and Medco, have announced their intention to merge. This is a transaction of sufficient size to merit the review of antitrust enforcement agencies. It has also attracted the attention of this particular Subcommittee.

I note at the outset that the very nature and value of PBMs is not without some dispute. Critics argue that PBMs are massive corporate middlemen who care only about profits. PBMs under this view seek to dominate the prescription drug market, run retail pharmacies out of business, and automate the world of prescription drugs until consumers have only a non-live person to call, basically a 1-800 number, to consult for advice about their medications.

But those favorable to PBMs suggest and point out that they do provide a valuable administrative service without which the delivery of prescription drug services would be much less effective and would cost employer-sponsored health plans up to 30 percent more each year.

PBMs claim that they are intensely interested in providing more than just medication, that their innovative clinical programs reduce

overall health care costs by increasing patient adherence to drug regimens, and improving the overall health approach of their clients' employees.

Whatever one's overall view of PBMs, I hope that our discussion today can focus on the merits of this proposed merger from the perspective of antitrust. To do so, we must focus our attention on ensuring that the market in which PBMs operate is truly competitive, and in that regard, we would do well to remember the insight made famous by Robert Bork's seminal work, "The Antitrust Paradox": Competition must be understood as the maximization of consumer welfare.

Competition ensures that consumers receive the lowest prices and the best services. In the context of PBMs, competition can drive innovation as PBMs battle one with another to offer prospective clients the best pharmacy network options and clinical management, in addition to cost savings. Insufficient competition may result in higher prescription drug prices for consumers as well as pharmacies being so squeezed for revenue that they are unable to provide the quality of services that consumers presently enjoy.

Throughout this hearing, we must also keep in mind the unique challenges and opportunities present in our health care market. As former Secretary of Health and Human Services Michael Leavitt recently noted, "Lack of coordination in providing health care is a major contributor to overspending. Recently combined health services companies understand that to develop the capacity to improve health care and reduce costs, they must scale and innovate in order to achieve needed efficiencies for payers and providers."

To properly focus our antitrust analysis for this hearing today and to maximize consumers' welfare in terms of prices, service, and quality, we must ensure that PBMs operate in a robustly competitive market while at the same time allowing for the type of consolidation and efficiency that drives innovation and cost savings.

Thank you, Mr. Chairman.

Chairman KOHL. Thank you, Senator Lee.

Senator Grassley.

**STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR
FROM THE STATE OF IOWA**

Senator GRASSLEY. I appreciate the opportunity to give a short statement. I wanted to explain to you and to our witnesses that sometime between 3:30 and 4, I am going to have to go to the other side of the Hill to work on a problem with military hospitals, so if I do not get a chance to ask questions, I will be submitting questions for answer in writing.

Thank you for holding this hearing. Whether people know it or not, this proposed merger will affect them. Prescription drugs are a daily part of many folks' lives. How these drugs are paid for and determining who gets paid what is a complex process. At the heart of all of this are pharmacy benefit managers.

The combination of Express Scripts and Medco would create a company that processes almost one-third of all PBM-administered prescriptions. Basically one in four individuals who receive prescription drugs through a health plan will be impacted. So this is a very important matter, and so this is why the Federal Trade

Commission is taking a look at it, and I expect that the Commission will examine this merger regularly, as they should.

Today this Committee has an opportunity to hear some practical concerns with the merger in a public forum. I am sure there will be much discussion on the legal issues that will be part of the Federal Trade Commission's review. However, we get the chance here at this hearing to listen to those who support and those who oppose the proposed merger. I expect the discussion will be very helpful and informative to us in the Congress as well as to the FTC, where the final decision will be made.

I have heard from a large number of Iowa pharmacists who raise concerns. I am interested to hear about the effects that this merger will have on them and Iowa consumers. There are also transparency and competition issues that deserve discussion, and today is a great opportunity to do that, although those issues of transparency and competition have been around for a long period of time before this proposed merger came up.

So, again, I thank you for holding this very important hearing, Mr. Chairman. Thank you.

Chairman KOHL. Thank you very much, Senator Grassley.
Senator Franken.

**STATEMENT OF HON. AL FRANKEN, A U.S. SENATOR FROM
THE STATE OF MINNESOTA**

Senator FRANKEN. Thank you, Chairman Kohl, for holding this important hearing, and thank you so much for letting me say a couple words about this merger. Like Senator Grassley, I need to leave this hearing early, in my case to preside, and, unfortunately, I too may not be able to ask questions to the panel directly, but if that is the case, I will submit them in writing, and I thank you all for being here, by the way.

This is a very large and a very complex merger, and I have been hearing a tremendous amount about the potential impacts of this merger, both positive and negative, from a wide variety of Minnesotans, so I wanted to say a couple of words.

I should note at the outset that Express Scripts has a very large presence in my State and employs over 1,000 Minnesotans in very good, well-paying jobs, and this means a lot to me and to Senator Klobuchar. And it is something that I have been weighing while looking at this merger, as you can well imagine.

But I have also heard from a significant number of pharmacists across Minnesota, including rural pharmacists, who provide the only outpatient pharmacy option in their towns, as well as from the Minnesota Pharmacists Association. These pharmacists oppose the merger and have told me that they are very concerned that the merger may force them to shut their doors.

I have also heard from other companies with a significant presence in Minnesota, like Super Value, which employs 8,600 Minnesotans. These companies are telling me that this merger will force more patients into mail order and will reduce options and resources for patients who often need the face-to-face advice and consultation that only a pharmacy can really offer. And while this primary question that we are examining is the effect that this merger will have on competition, I cannot ignore the potential effect, obvi-

ously, that it would have on the quality of health and health care that Minnesotans receive.

I am particularly concerned that this type of consolidation will leave very few options for large employers who often rely on the Big Three PBMs to manage and administer their complex prescription drug plans. The Fortune 50 and Fortune 100 firms cover millions of Americans. If this merger will ultimately mean less choice for those companies, that is something we need to be concerned about, and it is something that I hope the FTC is closely examining. In fact, I am quite certain they are.

I have listened to Express Scripts' arguments that combining with Medco will translate into significant discounts from drug manufacturers and will ultimately mean lower rates from employers. We are living in a world with spiraling health care costs, so I am interested in hearing more about how this merger may make a dent in those costs. But I am most interested in hearing how Express Scripts can guarantee that those cost savings will be passed down to its customers and will not just result in higher profits for the company.

This is, as I said, Mr. Chairman and Mr. Ranking Member, a very complex industry, and I am looking forward to hearing from both sides about the pros and cons of this merger. And as I said, if I have to leave before it is time for my questions, I will definitely submit questions for the record.

Thank you again, Mr. Chairman, for holding this hearing and for letting me deliver this brief opening statement. Thank you.

Chairman KOHL. Thank you very much, Senator Franken.

Senator Blumenthal, a few words from you.

**STATEMENT OF RICHARD BLUMENTHAL, A U.S. SENATOR
FROM THE STATE OF CONNECTICUT**

Senator BLUMENTHAL. Thank you very much, Mr. Chairman. I want to join in thanking you for this hearing, which I think addresses a critical area in our economy and in our health care industry and system. And like Senator Franken, I thank you for being here.

It is a complex industry, but it will be judged by the same standards, antitrust and pro-competition standards, as any other complex industry is judged. And my guess is that you will have to be open to modifications in the deal that you have reached, as happens in many of these mergers, or proposed mergers at this point.

Obviously, this industry is among the most lucrative in the country. It is increasingly profitable. The question is: How will consumers be protected from overreaching and excessive profits that are at the expense of competition?

One issue is whether consumers will be driven to mail-order services, as has happened, for example, in Connecticut. That is a big concern not only to the pharmacies that may be affected but also to consumers who may have choices constricted. And ultimately competition is about choices, and the impact of this proposal on choices for consumers will be very, very important.

So understanding all these issues requires an understanding of the concentration in the PBM market that will result, particularly among large employers, as well as the incentives for employers to

affirmatively seek out mail-order options, and I look forward to hearing more from all the witnesses about all of these issues.

Thank you very much, Mr. Chairman.

Chairman KOHL. Thank you very much, Senator Blumenthal. Now I will introduce our witnesses on this panel.

First to testify will be George Paz. Mr. Paz is Chairman and CEO of Express Scripts, a position he has held since 2006. Mr. Paz first joined Express Scripts in 1998 as senior vice president and chief financial officer.

Next to testify today will be David B. Snow, Chairman and CEO of Medco Health Solutions. Mr. Snow joined Medco in March of 2003 after serving as president and chief operating officer at Empire Blue Cross Blue Shield.

Next we will be hearing from Scott Streater. Mr. Streater is the Associate Vice President of Business Development at The Ohio State University Medical Center. Previously he served as the Director and National Account Executive at Medco.

Our next witness who will testify today will be Susan L. Sutter, co-owner of Marshland Pharmacies, which includes facilities in Horicon, Mayville, and Beaver Dam, Wisconsin. She has an outstanding reputation in our State, of which I am very much aware. She has served as president of the Pharmacy Society of Wisconsin and was chairperson for the Wisconsin Pharmacy Examining Board.

Our next witness will be Michael J. Bettiga. Mr. Bettiga is the Executive Vice President and Chief Operating Officer of Shopko Stores Operating Company, headquartered in Green Bay, Wisconsin. Mr. Bettiga served as board chair of the Wisconsin Pharmacy Examining Board.

Our final witness today will be David A. Balto, an antitrust attorney in Washington, D.C., who has previously served as policy director at the Federal Trade Commission. Mr. Balto will be testifying on behalf of Consumers Union, Consumer Federation of America, National Consumers League, U.S. Public Interest Research Group, and the National Legislative Association on Prescription Drug Prices.

We thank you all for appearing at this Subcommittee hearing today, and I will ask you all to stand and raise your right hand as I administer the oath. Do you affirm that the testimony you are about to give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. PAZ. I do.

Mr. SNOW. I do.

Mr. STREATOR. I do.

Ms. SUTTER. I do.

Mr. BETTIGA. I do.

Mr. BALTO. I do.

Chairman KOHL. Thank you so much.

We will turn now for opening statements, first, Mr. Paz, will you please restrict yourself, if possible, to 5 minutes.

STATEMENT OF GEORGE PAZ, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, EXPRESS SCRIPTS, INC., ST. LOUIS, MISSOURI

Mr. PAZ. Mr. Chairman, Ranking Member Lee, and members of the Subcommittee, you have my formal testimony for the record, so let me briefly summarize my vision of what the combination of these two great companies will do. We will lower drug costs that are far too high and improve health outcomes for consumers.

Chairman Kohl, I know you have worked long and hard in the Senate to make prescription drugs more affordable for customers. We share that goal, and this merger will do exactly that.

As the big drug companies merge, as large chain drug stores buy up their competition and demand higher prices, we must become more effective representing the interests of plan sponsors and consumers. Patients, not profits, must come first.

It is the plan sponsors that pay the majority of the cost of drugs and provide the drug benefits for our citizens. It is their money everyone here today should be concerned about protecting.

Mr. Chairman and members of the Subcommittee, I want to highlight three key points: first, PBMs improve patient safety and adherence; second, PBMs save plan sponsors and consumers money; and, third, PBMs drive out waste, fraud, and abuse.

As health care spending continues on an unsustainable trajectory, pharmacy benefit managers have reduced drug costs by 30 percent or more. Each year through innovative technology and products, these savings are passed on to plan sponsors and consumers. We negotiate with the big drug manufacturers and retail pharmacies across the United States to get the best possible price for our clients. Our business model is one of alignment. We make money when plan sponsors and consumers save money. The union of our companies will accelerate our ability to do just that.

The Federal Trade Commission has found this type of bargaining power pro-competitive when it allows a buyer to reduce its cost and decrease prices to consumers. Let me be clear. This merger will in no way decrease the dynamic marketplace within which we operate.

Mr. Chairman, we do not make decisions on behalf of our plan sponsors or consumers. We offer options. It is a plan sponsor's decision whether to promote home delivery. It is a consumer's decision whether to use home delivery or go to a retail pharmacy. In fact, the average American consumer uses multiple pharmacies on a regular basis. Our mission is to reduce the cost of prescription drugs, and that involves measured, tough negotiations with retail pharmacies and pharmaceutical manufacturers.

The GAO found that the average price PBMs negotiated for drugs was 18 percent below the average cash price retail customers pay. Mail-order pharmacies reduce the price of medications by 27 percent over the cash price paid for branded products and 53 percent for generics.

When you consider our role, the most frequent interaction we have with a consumer is at the retail pharmacies across the country. Before a consumer ever receives their medicine, my company runs over 100 safety checks through our innovative advanced tech-

nologies. This is critical because the PBM is the only one with visibility across all pharmacies used by the consumer.

Our systems identify and prevent dangerous drug interactions across all these pharmacies. In addition, our contracts save retail pharmacies \$7.3 billion a year in bad debt because we guarantee their payment.

Finally, everyone knows that health care costs are skyrocketing and need to be better managed. Our continued investments in innovation will improve patient adherence, expand the use of lower-cost generics, and develop more efficient delivery of medicines.

Just yesterday a new economic analysis was released showing Express Scripts' and Medco's innovative strategic platforms have reduced health care expenses by up to \$87 billion a year, \$20 billion of which accrues to the Federal Government.

The merger of our two companies will provide significant opportunities for further cost savings. It is important to note that every 1 percentage point reduction in drug costs generates enough savings to fund 20,000 new jobs in the United States.

In closing, let me say that the combined organization will continue to lower costs for plan sponsors and consumers, drive out waste, and improve safety and health outcomes. That is our vision, and we are committed to achieving it.

Thank you, Mr. Chairman and members of the Subcommittee.

[The prepared statement of Mr. Paz appears as a submission for the record.]

Chairman KOHL. Thank you, Mr. Paz.

Mr. Snow.

STATEMENT OF DAVID B. SNOW, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, MEDCO HEALTH SOLUTIONS, INC., FRANKLIN LAKES, NEW JERSEY

Mr. SNOW. Chairman Kohl, Ranking Member Lee, and members of the Committee, thank you for the opportunity to discuss the proposed merger of Medco Health Solutions and Express Scripts. My name is David Snow, and I am the Chairman and CEO of Medco Health Solutions. Medco is an industry leader in advanced pharmacy. We employ thousands of medical professionals, including more than 3,000 pharmacists and more than a hundred nurses. We deliver a portfolio of clinical and administrative solutions that create value for private and public employers, health plans, labor unions, and Government agencies of all sizes, as well as older Americans served by Medicare Part D drug plans. We take great pride in the innovations Medco has created to improve clinical outcomes at reduced cost.

Everyone recognizes that the ever rising cost of health care in America is unsustainable. The need is insatiable, our resources are not. By merging Medco with Express Scripts, we will significantly accelerate our ability to improve patient care and reduce overall costs across the health care system. So let me get right to what I think we all agree drives affordability and quality in health care: clinical excellence and competition.

In our country, 50 percent of the entire population has one or more chronic or complex diseases. This 50 percent of the population consumes 96 percent of the total dollars spent on prescription

drugs and 75 percent of the total dollars spent in our entire health care system. Remarkably, we know that on average 65 percent of patients stop following the drug treatment protocol their doctor prescribes within 1 year even though their disease is lifelong. This lack of adherence leads to devastating patient outcomes and avoidable costs to our system estimated to total more than \$290 billion annually.

We at Medco are particularly proud of the advanced clinical care standard we have developed specifically to address the needs of patients with chronic and complex conditions. This clinical care revolves around what we call therapeutic resource centers, or TRCs. Our TRCs include more than 1,000 specialist pharmacists who use evidence-based clinical protocols to ensure patients are taking the right medicines and helping them overcome barriers to adherence. Our pharmacists are available 24/7 to counsel patients and to consult with physicians.

The results are impressive. In 2010 alone, our TRCs closed more than 2.3 million gaps in care with an estimated \$900 million in savings from reduced hospitalizations, avoided emergency room visits, and the elimination of other medical expenses. Our larger goal as a Nation should be to save the \$290 billion a year I mentioned earlier by addressing medications that are underprescribed, misprescribed, or simply not taken as directed.

Many people do not realize that the only part of our Nation's health care system that is fully wired today is ambulatory prescription drugs. PBMs have accomplished this, and Medco's innovations have leveraged that fact. Our merger will only further accelerate the transition to wired health care, significantly improving communications among patients, physicians, and pharmacists.

Now I want to briefly touch on our competitive environment. There are not three or four or five or even ten major PBMs. There are more than 40, all competing to provide differentiated value propositions. Today at least ten PBMs serve Fortune 50 companies. Seventeen serve Fortune 500 companies, and at least nine PBMs serve large State accounts. Additionally, nine Fortune 500 companies operate their own PBMs for their employees, and all PBMs are not alike. Some are integrated with retail pharmacies, like CVS Caremark. Some are part of managed care organizations, like UnitedHealth, Aetna, CIGNA, and Prime Therapeutics. And others are entirely independent, such as Catalyst Rx, MedImpact, and SXC.

How fierce is the competition? While Medco has enjoyed much success since it went public in 2003, the marketplace is undergoing significant change. As but one example, for our plan year 2012, Medco has lost \$10 billion in business, losing 40 clients to more than 15 different PBMs. These are the facts, and they dispel the notion that the combination of Medco and Express Scripts represents a threat to consumer and client choice. The reality is that the PBM business is extremely competitive today, and competition will only be enhanced, not diminished, by our merger.

In conclusion, there is enormous opportunity to improve health care outcomes while reducing health care costs. Medco and Express Scripts are committed to continuing the pursuit of real solutions. Our efforts will only be accelerated by this merger.

Mr. Chairman, Ranking Member Lee, and members of the Committee, thank you for receiving my testimony. I would be happy to address any questions you may have.

[The prepared statement of Mr. Snow appears as a submission for the record.]

Chairman KOHL. Thank you very much, Mr. Snow.
Mr. Streator.

STATEMENT OF SCOTT E. STREATOR, ASSOCIATE VICE PRESIDENT, BUSINESS DEVELOPMENT, THE OHIO STATE UNIVERSITY MEDICAL CENTER, COLUMBUS, OHIO

Mr. STREATOR. Chairman Kohl, Ranking Member Lee, and members of the Subcommittee, my name is Scott Streator, and I am honored to testify on the proposed ESI/Medco merger.

My testimony will reflect over 20 years of experience in health care and the PBM industry and most recently serving as a CEO of The Ohio State University Health Plan. This testimony is my own. It does not represent an official position of The Ohio State University. I will, therefore, provide a multifaceted perspective from all industry angles as a payer, a plan administrator, and a provider.

In short, it is clear to me the ESI/Medco merger will further spawn competition that can lead to lower pharmaceutical costs for payers and consumers. Therefore, I am in favor of this merger.

The three sources of greater competition are: one, existing PBMs; two, health plans; and, three, emerging business models as a result of health and payment reform. I will provide a brief summary of each of these and several key market forces.

First, greater competition from the PBM industry. There are a growing number of PBM options that have evolved secondary to strategic acquisitions that have now developed a robust infrastructure. Now these PBMs can support both small and large employers as a result, and they are gaining market share. Several companies are listed in my written testimony as examples.

Further, as the barriers to entry in the PBM market have decreased, new PBM entrants will emerge. Meanwhile, irrespective of the size of the PBM, end payers, like those in our Rx Ohio Collaborative, are developing innovative, transparent contracting initiatives with a single PBM to increase their purchasing value.

For example, at Ohio State University, as one employer in our collaborative, we realized \$10 million savings, or 9 percent, and are currently experiencing a negative 0.4 percent per capita drug trend with Express Scripts.

Now, while there are certain advantages of a large PBM, smaller PBMs and health plans can be more agile in implementing cost-savings programs that can far exceed discounts. While some estimate the combined entity could approach 50 percent of the specialty or biologic market, it is important to note that half the specialty drugs and many future FDA-approved biologics can only be distributed and administered at outpatient settings. Moreover, the pharmaceutical industry has complex distribution and storage requirements that has narrowed their distribution channels, making it less feasible to obtain a biologic at the community pharmacy for a consumer.

In terms of impact on community pharmacy, PBMs contract with community pharmacies on behalf of plan sponsors to form a provider network. While plan sponsors make benefit decisions, not the PBM, consumers should be given choice of their preferred distribution channel, mail or retail. Medicare Advantage is one example. Medicare Advantage plans offer a 90-day retail supply that provides competition to Express Scripts, Medco, and any other PBM mail pharmacy channel.

The second source of greater competition is from health plans or health insurers. In today's new health reform environment, insurance carriers may increasingly decide to in-source the PBM function as evidenced by UnitedHealthcare's recent business decision. Thus, insurance carriers like United, Humana, CIGNA, and various Blue Cross Blue Shields can now offer a competitive alternative to stand-alone PBMs by using their in-house PBM.

Further, with a likelihood of insurance exchanges emerging for individual and small-group markets, the in-sourced PBM offering, coupled with the health insurer, may be an attractive offering to some employers.

This leads me to my final point and third source of increased competition: emerging business models resulting from health payment reform.

Regardless of what ultimately happens with the Affordable Care Act, it is clear the current fee-for-service reimbursement model is evolving from "payment for volume" to "payment for value." How will new financial models alter the PBM landscape? While the answer is unclear at this time as patient-centered medical homes and the emerging accountable care types of organizations grow, managing costs of pharmaceuticals in a silo will be de-emphasized versus effective medication therapy management across the entire care continuum. Thus, both community pharmacy and PBMs can play a vital role, supporting the physician by reviewing and recommending therapies in a given population. We need both community pharmacists and the PBM industry for clinical integration of care.

In conclusion, greater competition from PBMs and health plans is emerging and will continue to advance as a result of the proposed ESI/Medco merger. Lower costs can be generated with greater competition, and thus I support the proposed merger. Moreover, the impact of the Affordable Care Act and health exchanges will provide new opportunities for current and emerging business models.

New reimbursement models will be shifting greater financial risk from insurers to the physician and hospital level. Thus, the PBM landscape will be altered so that the size of the PBM may be less important than the ability to manage and coordinate care at the individual and population level.

Thank you, Mr. Chairman, Ranking Member Lee, and the entire Subcommittee for this opportunity.

[The prepared statement of Mr. Streator appears as a submission for the record.]

Chairman KOHL. Thank you, Mr. Streator.
Ms. Sutter.

**STATEMENT OF SUSAN L. SUTTER, CO-OWNER, MARSHLAND
PHARMACIES, HORICON, WISCONSIN**

Ms. SUTTER. Thank you. Chairman Kohl, Ranking Member Lee, and members of the Subcommittee, thank you for conducting this hearing and providing me the opportunity to share my views regarding the proposed Express Scripts/Medco merger. I am Sue Sutter from Horicon, Wisconsin, and I co-own three independent community pharmacies in rural Dodge County. I am representing the National Community Pharmacists Association, which represents pharmacy owners, managers, and employees of more than 23,000 independent pharmacies. Today I join consumer groups and other small business groups to oppose the proposed merger. If the FTC allows this merger, it will make an already bad situation even worse for small pharmacies and the patients we serve.

The PBM marketplace today is already extremely concentrated with the Big Three PBMs dominating the large employer market. Allowing two of the Big Three to merge will result in unparalleled market concentration in the PBM industry with the merged single entity controlling anywhere from one-third to two-thirds of all prescriptions filled in community pharmacies. This market dominance and significant reduction in competition will result in reduced choices for Federal and State programs and other third-party payers, decreased patient access to community pharmacy services, and ultimately lead to higher prescription costs.

So why are we so concerned? PBMs directly set the reimbursement rates for community pharmacies, and then for us it is take-it-or-leave-it. We are the same pharmacies that are in direct competition with the PBM-owned mail-order pharmacies. Therefore, it is no surprise these PBMs try to shift their patients to their mail-order pharmacies, often against our patients' wishes.

Let me state this again. There is absolutely no negotiating. And we are not crying wolf. If Walgreen's with 7,000 pharmacies in this country has dropped out of the Express Scripts network because they could not negotiate fair terms, how can an independent pharmacy have any chance against these corporate giants? And the merger will make it even harder for us to push back.

Express Scripts and Medco have claimed that, merged, they will create greater efficiencies in the pharmaceutical supply chain. They claim they can do this by squeezing manufacturers and pharmacies. Well, you will have to speak to the manufacturers, but I can tell you there is nothing else left to squeeze with us. Our pharmacies operate on a 2- to 3-percent net profit margin before taxes. In fact, the number of independent pharmacies operating at a loss is now 25 percent.

Even if greater efficiencies were to be created, there are no assurances that these savings would be passed along to plans and consumers. Keep in mind that the PBM industry is virtually unregulated and has a long record of enforcement actions alleging fraudulent and deceptive conduct.

The proposed merger would create the largest mail-order pharmacy in the United States, accounting for close to 60 percent of all mail-order prescriptions processed, and allow the merged entity to corner the market on specialty drugs. Currently, the top PBMs already dominate this market due to the fact that many times they

prevent community pharmacies from filling these prescriptions and direct these highly lucrative prescriptions to their own mail-order pharmacies. This new merged entity would immediately own 52 percent of that market. There is no reason a community pharmacist cannot dispense specialty medications, other than that the PBMs' design state that we cannot. It is just the newest form of anticompetitive behavior we have been dealt by the PBM industry.

This merger will put us at greater risk, yet your neighborhood community pharmacists are truly safety net health care providers for their patients. Here is just one of my own examples.

Twice in the last couple of weeks, I have assisted transplant patients by contacting their physicians and dispensing a needed supply of their medications because it had not arrived from the mail-order pharmacy. Now, if the mail-order pharmacy is so interested in patient care, why wasn't one of their pharmacists on the phone to me making sure that patient got the needed supply?

In conclusion, this proposed merger would: reduce competition in the delivery of pharmacy benefits in this country; reduce patient choice; and mandate using mail-order pharmacy instead of their trusted community pharmacist; and, finally, threaten the very existence of community pharmacies.

I appreciate the opportunity to address the Committee today. I will be happy to answer any questions you might have. Thank you.

[The prepared statement of Ms. Sutter appears as a submission for the record.]

Chairman KOHL. Thank you, Ms. Sutter.

Mr. Bettiga.

STATEMENT OF MICHAEL J. BETTIGA, CHIEF OPERATING OFFICER AND EXECUTIVE VICE PRESIDENT, SHOPKO STORES OPERATING COMPANY, LLC, GREEN BAY, WISCONSIN

Mr. BETTIGA. Mr. Chairman, Ranking Member Lee, and members of the Subcommittee, thank you for the opportunity to testify. My name is Mike Bettiga, and I am the chief operating officer of Shopko, which is a retail merchandise company based in Green Bay, Wisconsin, which operates 149 stores throughout 13 States, all of which have pharmacies. Fifty-seven of these pharmacies serve patients in the great State of Wisconsin.

Shopko is also a proud member of the National Association of Chain Drug Stores on behalf of which I am testifying today. Shopko is concerned about this merger both as a provider of pharmacy services and as an employer of 15,000 employees.

As a pharmacist who has worked in community pharmacy for almost 35 years, I have grave concerns about this proposed merger. It would be a tipping point in PBM market consolidation, harming patients as well as Government and private health plans and employers. There is only one stakeholder that would benefit, and that is the new mega PBM.

Since the proposed merger was announced, many Members of Congress, consumer groups, State insurance commissioners, State Attorneys General, and State legislators have all expressed concerns to the Federal Trade Commission. Indeed, just last week, the nonprofit American Antitrust Institute wrote the FTC asking it to enjoin this merger. This would be a merger of two of the Big Three

PBMs. If approved, nearly 135 million Americans would rely on this mega PBM to manage their prescription benefits. It would control over 40 percent of the national prescription volume, 60 percent of the mail-order pharmacy market, and an excessive amount of the specialty pharmacy market.

Patients in particular would be harmed. They will experience reduced or no choice of their pharmacy providers. More consumers would be forced into using the PBMs' own mail-order facilities. They will see decreased or limited access to essential pharmacy services. They will experience separation of their prescription medication records that could result in potential adverse patient health outcomes. They will encounter disruption in normal, timely prescription service and as a result could potentially suffer decreased medication adherence. Reducing patient choice and access will lead to higher prescription drug costs, potential adverse patient outcomes, and higher downstream health care costs.

When considering this merger, policymakers need to question whether or not PBMs actually reduce health care costs. There is little proof that PBMs pass along their purported savings to health plans, employers, or consumers. In fact, the PBM industry has been fraught with allegations of extensive deceptive and fraudulent practices. In recent years, cases brought by a coalition of over 30 State Attorneys General have resulted in over \$370 million in penalties.

It has been found that PBMs have accepted rebates from manufacturers in return for placing higher-priced medications on prescription drug plans' formularies, switched customers to the higher-priced drugs, and benefited from both the rebate received and the higher-priced drug payment without passing along this enrichment to the health plan or the employer.

At Shopko, we are proud of our firm commitment to serving the needs of all the patients in our communities. However, being able to continue serving the prescription and health care needs of our customers and our neighbors has been threatened by the one-sided nature of pharmacy agreements with PBMs. We have seen firsthand the unilateral nature of these contracts. They are allowed to establish the basis of cost for prescription medications and to change that basis of cost with limited or no notice, especially for generic medications. Claims submitted to the PBM and approved are routinely reviewed retroactively, and payment is recouped due to inaccuracies in the PBM claims adjudication systems. My company experiences these and other PBM injustices each and every day, and this is bound to worsen if this proposed merger is not halted.

Pharmacists help to ensure that patients understand their medications and take them as directed. Pharmacists increase the utilization of generics over brand-name prescription drugs. Pharmacists collaborate with doctors and other local health care providers to assist in medication decisions.

Community pharmacies also provide critical cost-effective services like immunizations, disease state management and monitoring, and health education and screening programs. Together these services improve patients' health and reduce health care costs.

In conclusion, PBMs already use a lack of transparency, failing to pass through rebates from drug manufacturers to consumers and other payers, inflating drug costs for health plans and employers, and lowering payments to pharmacies for their own personal financial gain. Patients would appear to be an afterthought. A mega PBM would have an increased ability to engage in similar egregious conduct to the detriment of consumers, payers, and pharmacy providers.

Thank you for the opportunity to appear, and I welcome your questions.

[The prepared statement of Mr. Bettiga appears as a submission for the record.]

Chairman KOHL. Thanks, Mr. Bettiga.
Mr. Balto.

**STATEMENT OF DAVID A. BALTO, ESQ., LAW OFFICES OF
DAVID A. BALTO, WASHINGTON, DC.**

Mr. BALTO. Chairman Kohl, Ranking Member Lee, and other members of the Committee, thank you for giving me the privilege to testify today on behalf of the Nation's leading consumer groups. We are here with a simple message. We are here to answer Senator Blumenthal's question: How can consumers be protected from overreaching? Senator Blumenthal, there is only one way, and that is for the FTC to go to court and to block this merger.

The consumers wholly agree with the testimony of Ms. Sutter and Mr. Bettiga. Pharmacies play a critical role in health care delivery, and this merger will result in higher prices, less consumer choice, and lower quality of care.

Let us start off by looking at the PBM market itself. As a former antitrust enforcer, I know you need three things for a market to work well—choice, transparency, and a lack of conflict of interest—and in all three regards, my testimony demonstrates that this market receives a failing grade. How do we know? Look at how the profits of the Big Three PBMs have skyrocketed over the past few years. They say they are the best friend of the health care plans, but they are pocketing an increasing portion. Those profits have increased over \$6 billion a year. They are catching up with the health insurance companies in the United States.

In terms of conflict of interest, it is the same problem, Senators Grassley and Kohl, you have focused on in group purchasing organizations. They have a conflict of interest because they have their own operations which they favor, disadvantaging consumers. That is why 30 State Attorneys General, including Senator Blumenthal, brought cases against each of these PBMs.

The critical antitrust issue here, or one of them, is whether or not the market is these 30 or 40 PBMs or it is just the Big Three. The antitrust law is clear, though. A competitor is not somebody who just calls himself a competitor. A competitor is somebody who constrains the market, and in this case the market really is the Big Three.

If you look at the second chart, you can see how the Big Three PBMs are phenomenally larger than the second-tier PBMs, and our testimony documents the advantages they have over the second tier PBMs.

But do not take our opinion. Listen to what the California pension system said about the relevant market. Look at page 6 of my testimony. This is what they said: "You can count the PBMs that can serve organizations of our size on your hand, a couple of fingers, maybe three, and they are frequently the subject of lawsuits." That is what they said, and you do not need a Ph.D. in economics to know that when three go to two, consumers will be harmed and people will pay higher prices.

Consumers care about this merger because if they live in rural areas served by people like Ms. Sutter, they are going to lose or get less service from their most trusted community professionals. Consumers care because they like the one-stop shopping they get when they go to Shopko. Consumers care because they can get cheaper prices when they go to supermarket pharmacies, like Super Value, which actually sell drugs at lower prices than you can get it through the PBM.

Now, a particularly significant harm from this market is in the hundreds of thousands of patients who suffer from diseases that need specialty drugs, like hepatitis C, cancer, the transplant patient that Ms. Sutter mentioned. This merger gives these firms a dominant position in specialty. They are already using their market clout to keep independent specialty pharmacies out of the market. Giving them more clout will enable them to keep even more pharmacies out of the market. Why is that a difference? Because as far as we know, there is not a consumer who would prefer to deal with a 1-800 number or a robot instead of Ms. Sutter.

Finally, let us deal with the question of efficiencies. They said there are significant efficiencies, and they came up with a study yesterday which said there were these astronomical cost savings from PBMs, and this basically recycled old information. What they did not tell you was what are the specific savings from this merger. What they did not tell you is how have the past mergers led to increased savings. We see how they have led to increased profits, but have they really saved consumers money?

The law is clear. In a merger that significantly increases concentration, they must prove extraordinary efficiencies. Thirteen years ago, four drug wholesalers tried to merge, and they had the same efficiency arguments that these folks have, and the court rejected those claims for two reasons:

First, with only two people left in the market, there was no guarantee those efficiencies would be passed on in lower prices to consumers.

Second, competition was a better way for those efficiencies to come about. This is what Judge Sporkin said: "The history of the industry over the past 10 years demonstrates the power of competition to lower cost structures and garner efficiencies as well."

It is competition that makes this market work, and we should not allow these two firms to extinguish that competition.

Thank you, and I welcome your questions.

[The prepared statement of Mr. Balto appears as a submission for the record.]

Chairman KOHL. Thank you, Mr. Balto.

We will turn now to Senator Grassley for his 5 minutes.

Senator GRASSLEY. And I thank you, Mr. Chairman, for that courtesy so I can leave.

My first questions are going to be to Mr. Paz and Mr. Snow, and prior to asking that question, I sent letters quite a while ago as part of my Physicians Payment Sunshine Act asking PBMs about transparency of any financial benefits that a PBM receives from pharmaceutical companies. So we are told that this merger would lead to increased efficiencies and savings which will be passed on to consumers. However, as has been my experience, for example, with GPOs, which Mr. Balto just announced—and Senator Kohl has been involved with that—there are serious questions about where savings actually flow. The issue of transparent becomes even more complicated when we consider allegations that PBMs have a conflict of interest in the way they operate. We are told more transparency is needed to ensure PBMs operate as honest brokers. If we have greater transparency in the process, then we would not be having this discussion.

So I am interested in finding out how much transparency there is in the interactions between sponsors, PBMs, manufacturers, pharmacies, and consumers.

So this question to either or both of you: How do you respond to allegations that PBMs who operate their own mail-order pharmacies, for example, cannot serve as an honest broker? And, second, what can PBMs do to ensure greater transparency to address allegations that I have given to you? And, you know, the extent to which it might sound like I share those allegations, I want information to know whether those allegations are right or wrong. I am trying to get information.

Mr. PAZ. Yes, Senator. First of all, let us break it down into several different groups. We service our men and women in uniform. We are very proud to serve 10 million beneficiaries and active servicemembers. We administer that program on behalf of the Federal Government, and every component of that is transparent. They negotiate with us. They get the pricing, and it is all fully disclosed.

With respect to Mr. Streator's plan—and most all of our plans—these are called passthrough plans, so we negotiate on behalf of the retail pharmacies. What we do, Senator, is we bring together the buying power of all of our plans. Our plan sponsors are very sophisticated buyers, but they specialize in automotive; they specialize in manufacturing; they specialize in retail and all different walks of areas for which they provide services.

What we do is we bring together their drug procurement side, and we negotiate on behalf of all of our plan sponsors to go get the best prices we can from the retail pharmacies. We also believe that the community pharmacist is very important to our business. They have to survive. Our job is to make sure that we find that right mix between taking price down as low as possible so our health plans and our plan sponsors can continue to allow for a benefit to their employees. A 10-percent, 20-percent health increase is not sustainable. We have got to address those issues and drive down prices.

At the same time, we have to be cognizant of Ms. Sutter and all the other pharmacists out there that have to make a living and

have to provide a livelihood for themselves. And so we have to balance those.

As far as transparency is concerned, all of our pricing is disclosed to our plan sponsors. Medicare Part D, all of the Medicare plans, it is regulatorily required, it is statutorily required, that all those prices and all those price points are disclosed. The same way with our clients. They know exactly what they pay us, and they get a full accounting of all the drug spend.

With respect to mail, mail is a choice. Some plans are in dire economic straits today in these tough economic times. As I said in my prepared comments, mail service can save significantly over that of retail. It is not our decision. We cannot walk into any plan and tell them to do something. They choose. We give them a laundry list of options, and they choose what they want to do in order to save money and meet the needs of their employees, weighing access versus cost.

The more narrow the network, the less pharmacies in a network, all the way down to mandatory mail, limits the number of players which can drive costs even further. It is the plan sponsor's decision to decide where they need to be in order to meet the needs of that plan.

So it is not really our choice, Senator. It is the choice of our plan sponsors on whether to choose mail.

Senator GRASSLEY. OK. I will follow up with some questions in writing.

Thank you, Mr. Chairman.

Chairman KOHL. Thank you very much, Senator Grassley.

Mr. Paz, one of the main reasons you argue this merger will benefit consumers is that, because of the large size and buying power of what the combined company would be, you will be able to drive down prices even further by achieving greater discounts or by negotiating for higher rebates.

Now, Express Scripts already has 90 million covered lives. Given your very large size, you already get substantial volume discounts without merging with Medco. How large do you have to be before you maximize your discounts with your suppliers?

Mr. PAZ. If you look at the size of the manufacturers, our market cap is \$20 billion. We are a rather large company. Those of Pfizer, Merck, and others is quite a bit larger. The question is overall clout and the ability to negotiate. We believe we are well positioned to use clinical evidence and drive for patient safety to try to negotiate the best discounts available for our plan sponsors. We believe that drug price inflation alone on the branded side was up 10 percent. Specialty drugs were up 14 percent last year. If we do nothing, the costs of branded drugs go up well over 10 percent in any given year. Those issues have to be addressed, and it is our job to work on behalf of our clients in order to try to bring down those costs so that our plan sponsors continue to offer a benefit for their employees.

Chairman KOHL. Well, I appreciate that, but, you know, when you get to be as big as you are already, I am assuming you drive the hardest possible bargain with your suppliers because you have such clout. So now let us say you add another half or three-quarters clout to what you have already. I am assuming that what you

are getting now is just about as much as they are willing to give you based on your size as it presently exists.

Mr. PAZ. Yes, well, what we said to Wall Street, when we announced this acquisition is that the majority of the synergies in this transaction are not coming from the supply chain. They are coming from efficiencies. Mr. Snow addressed what he is doing with his TRCs, therapeutic resource centers, and his approach to have a disease state specific—addressing specific diseases such as diabetes and asthma. We approach consumer behaviors, and we believe putting our two programs together, the biggest waste that exists today is what Mr. Snow addressed, which is people not staying adherent to their drug regimens.

We believe the savings that are going to come from our acquisition is around twofold: one, better health outcomes, keeping people out of the emergency rooms, people staying more adherent to their drug regimens; and, two, it is the back office efficiencies in areas such as systems and approaches where we can eliminate those costs, which are part of the overall health care costs. If we can eliminate those, we can pass those savings on as well to our plan sponsors.

Chairman KOHL. I appreciate that, and we will get to Mr. Snow. And I noticed in looking at your respective P&L statements, your administrative costs, Mr. Snow, are considerably higher than yours are, Mr. Paz. I assume that you see a lot of efficiency in consolidation and by eliminating a lot of administrative costs, which is the right way to go. I am not being critical of that. But I heard you say just now that significantly increasing discounts over what you are getting right now is really not why you are doing this deal, and you are not nearly as certain as some people might think that this deal will result in far more discounts from your suppliers. There are other ways in which you hope this deal will pay off.

Mr. SNOW. That is correct.

Chairman KOHL. OK. Ms. Sutter, I would like to ask you a question. We have heard reports from pharmacists that there is a tremendous amount of waste associated with mail-order, that consumers often cannot halt the shipping of drugs by a mail-order when they no longer need them. Community pharmacists have told us that consumers have returned to them thousands of dollars worth of unused drugs that these consumers or their relatives receive mail-order shipments from the large PBMs. The pharmacists must by law discard these drugs. This costs the health care system substantial sums of money involved in paying for unused drugs.

Has that been your experience? Is there a lot of waste in connection with mail-order drugs? And if so, why do you think this is happening, Ms. Sutter?

Ms. SUTTER. Yes, it has happened in our pharmacy, and I think as you can see from my written statement, we have—a picture will speak a thousand words as to the kind of things community pharmacists see. These gentlemen talk about having adherence programs, but to have an adherence program, just sending drugs every 30 days does not get to the core issue for these patients. I as a pharmacist and pharmacists across this country have been part of destroying medications with law enforcement drug drops to try to help patients get unneeded medications out. Time after time they

are quoted as stating that 75 percent of the medications bought there are from mail-order pharmacies.

So the patients appear to have routine prescriptions being sent to them, and then when they try to call and make any changes to them, they are having difficulty in getting through to someone that understands that the medication should not be sent any longer.

Chairman KOHL. OK. Mr. Snow, did you want to make a comment a minute ago?

Mr. SNOW. No. I will pass.

Chairman KOHL. OK. Mr. Paz, whatever its benefits, there can be no doubt that this merger will eliminate one of your two main competitors. We know this merger will be good for your bottom line, but our job in this Subcommittee is to be concerned with consumers' bottom lines. Can you explain why it is necessary for you to merge with one of your chief rivals in order to achieve the benefits you claim will be gained by this merger?

Mr. PAZ. Senator, we are facing unprecedented times in regulatory oversight. When we look at CMS, when we look at the exchanges coming into place, the work we have to do and the costs attributed to those items are quite high. I believe by having better operating systems and better approaches, we will be able to help spread those costs and reduce the costs of health care over the larger book of business.

In addition, in our opinion, it still comes down to the best way to save money in the health care system is to focus on quality, and we do. Our pharmacists do not just mail out mail-order prescriptions. We are constantly reaching out to our members, looking at drug interactions, looking at interfaces. Actually, we call often on retail pharmacies where members pick up pharmacies at multiple locations—pick up prescriptions at multiple locations, and we see the interactions that the retailers cannot see, and we help those members work through those situations. We spend a considerable amount of time doing that.

We believe all these pieces coming together will help drive down the cost of health care.

Chairman KOHL. All right. Mr. Lee.

Senator LEE. Thank you, Mr. Chairman, and thanks to all of you for coming today. I would like to start with some questions for Mr. Balto.

Mr. Balto, I was a little surprised that you opened your argument, the very first substantive argument, as I understood it, against this merger moving forward was that PBMs have made substantial profits in recent years. Now, I understand that this has become a very popular mode of attack. I understand that people do not—sometimes some people like to attack a particular company or in this case an entire industry for making profits. But are you really suggesting that considerable profits, the existence of considerable profits is somehow relevant to or dispositive of our antitrust analysis for purposes relevant to this Subcommittee? And if so, how?

Mr. BALTO. I think it is relevant. You know, certainly we do not condemn a market because there are high profits. Things like branded pharmaceuticals, of course, there is a tremendous amount

of risk involved and there is valuable intellectual property involved. I think it is important in a couple respects.

First of all, I think it is tied to the factors I talk about in my testimony about how the market does not function well—

Senator LEE. But they are not getting enough value out of it, the value is not being passed along to the consumer—

Mr. BALTO. If the market was truly competitive, if there was sufficient transparency, this is an intermediary. This is like a credit card or an ATM card. You would expect their profits to be very low if there was sufficient competition and transparency. So—

Senator LEE. That is the middleman part that I referred to—

Mr. BALTO. Right.

Senator LEE [continuing]. In my opening statement.

Mr. BALTO. Second—

Senator LEE. Hang on. Let me just—

Mr. BALTO. Sure.

Senator LEE [continuing]. Push down on that first point, and then you can work the second part into your answer. If that is the case, if this is a worthless middleman, why on Earth does the client base of PBMs—meaning employer-sponsored health plans—why do they continue to go back and back and back to PBMs? In other words, the reason those profits exist, as I understand it, is that someone has decided in corporate America, in a substantial portion of corporate America, that they can save money and thereby extend the value of their dollar, the value of the money that they do devote to employer-sponsored health care plans and get more health care value out of their money if they use PBMs. So are you saying that they are just wasting their money?

Mr. BALTO. No, no. I am not saying it is a waste, but what I am saying is if there were—when you look at this compared to other intermediary markets—and I would be glad to supplement my answers with written answers. But if you look at this compared to other intermediary markets, the profits are fabulously higher, and, you know, I think that is—when you look at the lack of transparency, that is suggesting that there are market problems—there are problems in the market.

Second, I think the number is important in terms of the efficiency argument. They have to demonstrate that the efficiencies will be passed on to consumers. Their profits are skyrocketing. That is suggesting that a large amount is not being passed on.

Senator LEE. OK. But, again, the fact that they continue to go back to PBMs suggests that there is efficiency somewhere, and I do not understand you to be suggesting that the employer-sponsored health care plans are themselves motivated by anything other than a sincere desire to make sure that their health care investment, their investment into their employee health plan, is not maximized.

Mr. BALTO. I totally agree, and one of the important issues here is transparency. Now, they say they like transparency, but right now Medco is fighting the State of Texas on a request for transparency. They continually fight efforts at transparency. If there were adequate transparency—and there are small PBMs who do provide greater transparency—then, you know, perhaps there would be a greater degree of competition.

Senator LEE. OK. Help me understand that, then, because it is my understanding—and correct me if I am wrong—that PBM contracts with plan sponsors typically require a degree of transparency, but they also require that a significant portion of their savings be passed along to the end consumer. For example, it is my understanding that Medco's 10K reports that it passed through its plan sponsors 87.5 percent of manufacturer rebates in 2010. Do you dispute that?

Mr. BALTO. Well, it depends how they calculate rebates, and, you know, because so little of this information is transparent, I think, you know, only if you were able to effectively audit things. There was an important audit done by the Texas teachers and employers system that found that even in those systems where they thought they were getting the rebates back, they actually were not.

Senator LEE. OK. I sense that Mr. Snow would like to respond to something that you have just said.

Mr. SNOW. Thank you, Mr. Lee. I would like to respond. Around the concept of transparency, for starters, Medco has been called the "gold standard" as it relates to transparency. And if you look at what we file on our 10K, we report every quarter every dime we make in rebates. Our clients always have the choice: Do they want the discounts and have us keep rebates, or do they just want a direct passthrough? It is always their choice. And you are correct, 12 percent of rebates we retain at our client's election. A hundred percent are passed back to those who elect it.

So, by the way, in the case of this merger, our clients, Medco's clients, when this merger occurs, because of the nature of our contracts with those clients, will save \$1 billion just because we are going to use best-in-breed contracts that we already have. One billion dollars goes immediately to their bottom lines. That is really economics. That is real savings.

When it comes to what our clients can do, they can audit us anytime, contractual right to do it. And they do it. They look at every element of the contract, every element relative to rebates and pricing and claims processing. They see it all. And they are welcome to do that. We are transparent.

I will also submit to you that we are regulated. For people to think we are an unregulated industry is really a wrong perception. So, for example, we are regulated by every State board of pharmacy in the entire country, all 50 States. We are regulated by every single State insurance department across the country. We are heavily regulated by CMS. We are a large participant in Medicare. We are regulated by the Medicaid laws. We are a heavy participant there. And, you know, we are looked at all the time. Our clients look at us, regulatory entities look at us.

This is not the industry that people talked about being a black box 10 years ago. There have been fundamental changes, and I will tell you, it is a transparent industry where clients know exactly what is going on. They really do.

Senator LEE. OK. I want to dive back into some of these issues if I have a second chance for questions, but I see my time has expired. Thank you, Mr. Chairman.

Chairman KOHL. Thank you, Mr. Lee.
Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much, Senator Kohl, for holding this hearing. As we consider this merger, I am focused on maintaining access to pharmacies for my constituents, ensuring the best patient care and keeping drug prices as low as possible. I think that is what most people are focused on. And I have talked to many people in my State about community pharmacies, and I hear time and time again about the vital role that local pharmacies play, and often patients cannot reach their doctor, so talking to their pharmacist is very important.

Could you talk about how this merger—I guess I would start with you, Ms. Sutter—would affect local pharmacists? But then also you raised this issue of adherence, and I wondered if you could elaborate on that as well. And then I will ask about how PBMs are also involved in that issue? Ms. Sutter?

Ms. SUTTER. Thank you. Let me first speak to the idea of the viability of community pharmacists. As you know, in Minnesota there have been several pharmacies in towns where they were only the pharmacy that have closed.

Senator KLOBUCHAR. That would be Adams, Ashby, Belgrade, Clara City, Collegeville, Comfrey, Erskine, Isanti, Lake Crystal, Lambertton, Le Center, and Orono.

Ms. SUTTER. Why, thank you.

Senator KLOBUCHAR. You are welcome.

[Laughter.]

Ms. SUTTER. And let me update you on some of the data. Even in Wisconsin a group of—a family business for 75 years in the Fox Valley, 12 stores, decided to leave the retail market and only do long-term care. And the CEO of that family business said it was directly related to reimbursement issues.

I just came from a meeting. A colleague in Lexington, Kentucky, closed five stores. His comment to me: “I just could not deal with the Express Scripts contract. It was so concentrated in my area.”

So these are things that are really happening. I came prepared to answer the question as to, well, will I go out of business if this merger goes through. My husband and I have been successful business people for almost 30 years. We are good business people. We have worked through a lot of the different things that present challenges to a small business like ourselves. But we are now facing—and I was very honest in my comments about the average net margin of these pharmacies. We will make very difficult decisions—reduce hours, lay off people, whatever—to try to maintain the businesses that we have. But at some point we will make the decision whether to have our life earnings remain invested in this small business any longer, which is totally—94 percent of my sales are prescription drugs. I am the only pharmacy in Horicon, Wisconsin. I am the only community pharmacy in Mayville, Wisconsin. This threat to the existence of independent community pharmacies is real.

Senator KLOBUCHAR. OK. Mr. Snow, Mr. Paz, if you could talk about, first of all, the adherence issue that Ms. Sutter had raised, but then, second, this larger issue of the closure of rural and independent pharmacies and how you could put anything—you could do anything to stop that from happening if you look at your networks because it is clearly an enormous concern.

Mr. PAZ. Just to put the record straight, there are more pharmacies today than there were 5 years ago across the board. We are up to 68,000 pharmacies throughout the United States, and there are more coming online constantly.

You know, I cannot stop certain pharmacies from going out of business. There are 10,000 McDonald's in the United States, roughly, there are roughly 13,000 Starbucks in the United States, there are 68,000 pharmacies in the United States. There is a lot. Our job is to make sure that people have access to pharmacies, and we have to make sure that they have appropriate access.

So under CMS, CMS has guidelines as to what that means, and we work very hard. I have no desire to force anyone out of business. As a matter of fact, my intention is to work on behalf of the community pharmacists and reimburse them at a higher rate than we do for the big-box retailers. We believe our country needs those small pharmacies, and they do not have the buying power, they do not have the ability to do what the big pharmacy chains—the Walgreens, the CVS's, the Rite-Aids—in this world can do. So our job is to go out and negotiate and try to get better deals for them so that they can, in fact, stay in business and serve.

At the end of the day we have to have those rural pharmacists in rural communities to provide those drugs. If we cannot do that, we do not have a business. Our clients, such as Mr. Streator, are going to insist that we have those opportunities for those pharmacists, and they are not going to stand by and allow us to shut those down.

One last thing before I move on, though. I would like to just point out for the record that we talk a lot about these great increasing profits that the PBMs have. Keep in mind our net income profit level is still only 3 percent. So it is not like these are big, big numbers. We are grocery store-type profits, 3 percent net income profits.

Senator KLOBUCHAR. OK. I have two questions here at the end. I am sorry, Mr. Snow. If I—I have 2 minutes left, and maybe we could do it in writing. The second thing I want to ask about is access to lowest-cost prescription drugs, which is why I support increased usage of generic drugs. I appreciate the Chairman's leadership on that. Can you talk about how the companies could balance this incentive to maintain rebates from brand-name manufacturers with the goal of moving toward generics?

Mr. SNOW. At Medco, we have a generics-first policy, which means we always move to generics as appropriate because it is in the best interests of our clients. As George mentioned earlier, the way we relate with our clients is we have completely aligned interests. Since we pass back the vast majority of rebates, rebates are not a motivator to do brands versus generics. We are rewarded for, as Scott mentioned, keeping their trend line down, and we are, because of the things we do, able to keep trend lines in the negative sometimes or very low relative to the real underlying inflation rate going on.

Our performance and our renewals are tied directly to our ability to contain their costs, and so we are motivated to go to generics wherever possible.

Senator KLOBUCHAR. And I am going to ask our other witnesses here in writing for their response to that as well. I am sorry we cannot do it here.

[The information referred to appears as a submission for the record.]

Senator KLOBUCHAR. I just had one last question. Senator Franken raised the employees really across the country, and I heard you talk about the efficiency gains here. What effect would this merger have on employees of both of your companies in Minnesota and across the country?

Mr. PAZ. Well, as you know, Senator, as you have been gracious enough to come to our site, our Minneapolis is our IT hub, and it will only grow over the years. IT is what we do. Our ability, as David said during his prepared comments, we have a wired system. We have to get to better utilization of e-prescribing. We have got to get to that next level. All that work is done in our Minnesota site.

Now, again, certain areas, such as accounting, legal, some of the back-office functions, those will diminish over time, but we hope we could redeploy those resources, again, moving pharmacists into more consultative roles and helping our patients. That is where we are trying to go with this. We do not have actually numbers at this time. We have not been able to put our two companies together. We have to get through the FTC first.

Mr. SNOW. But the goal of our merger is growth. It is to grow.

Senator KLOBUCHAR. OK. Well, I know we will have some further questions here about the costs and also the effect this is going to have on independent pharmacists. I appreciate everyone being here. Thank you.

Chairman KOHL. Thank you very much, Senator Klobuchar.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I want to join my colleagues in thanking you for this hearing, and thank you to the witnesses for your excellent, really very helpful and instructive testimony.

You know, I am very concerned about this merger simply from the standpoint of its effect on competition. And when I look at, for example, the mail-order pharmacy part of the market, which is about one-fifth of all prescription drug sales, a \$52 billion industry, if this merger is approved, you will control 60 percent of it. Your nearest competitor, CVS Caremark, about 24 percent. And then the competitive landscape is like a cliff to your nearest competitor, about 3 percent. I think it is Aetna. And that power, I think, is fearsome. Under the law it is problematic.

Similarly, in the specialty pharmacy market, this merger, if approved as you have proposed it, will result in an entity that controls 52 percent of the market, and obviously, as you know, the specialty drug market is the most lucrative growth area in the PBM industry. It accounts for 16.3 percent of prescription drug plan spending. It is growing at the rate of about 16 percent or more per year. And so I am interested in knowing what you will do to make this merger more acceptable, in effect what you will do to make it less problematic and more promising for consumers, which, after all, are the chief concern of our antitrust laws. Antitrust laws are

designed to preserve competition so they can protect consumers.
Mr. Snow.

Mr. SNOW. Yes, Senator, thank you for the question. A couple of points.

We, too, are very concerned about the consumer. As George has mentioned earlier, we are very concerned that access to drugs is real, that they can afford them. But—

Senator BLUMENTHAL. Would you be willing to divest the specialty pharmacy market?

Mr. SNOW. Before I go there, I would rather let the FTC opine on the map of our deal before we talk about that. But I would like to point something out, and I would like to submit something for the record.

If you look at mail and mail volumes at Medco, 85 percent of all prescriptions are retail—85 percent—and that has not changed for quite some time. This chart, which came out of—and I submitted this for the record, but it came out of an NACDS data book—simply shows that mail has fundamentally not changed in terms of numbers since 2007. The volumes are going to chain and big-box retailers, and, yes, the independents are losing scripts to the chain and big-box retailers. It is the data. It is not the PBMs, and it is not mail growing exponentially. In fact, more and more retailers are offering 90 days at retail, and you are seeing prices pretty much stay stable because faced with chronic and complex disease people who take drugs for a lifetime find it is easier to comply with 90-day supply, and you are seeing more of that going on right now. So mail is not as large as you indicated, and it is very stable. It is not growing. That is not where the new scripts are going.

Relative to specialty, I would just refer you to Adam Fein's analysis which he submitted where he has done a detailed analysis with real data and says today the combination would give the Medco/Express Scripts merger 31 percent of the specialty business, and that is before accounting for the Medco losses, both UnitedHealthcare, which happens in 2013, as well as from the losses for 2012 that are not in his numbers, which takes us into the mid-to high 20's. And then if you look at the disease level in specialty, which I think is the right way to look at this, there are many, many additional competitors who play in specific specialty diseases who are not even counted in the analysis.

So I believe the market penetration numbers you are talking about are not the numbers that will be looked at when looking at markets.

Senator BLUMENTHAL. So you think that those numbers are in error?

Mr. SNOW. Yes.

Senator BLUMENTHAL. Let me ask you, are there any parts of this business that you would be willing to divest? I know that Mr. Paz is on record saying that he would be unwilling to divest the specialty pharmacy market, for example.

Mr. SNOW. Yes. You know, I think obviously there will be a conversation when it is necessary. When it comes to mail, you know, what is important for us is we offer a continuum of product and service for the clients who hire us. So they are looking for an end-to-end service capability, and to take a piece of that service capa-

bility away really fundamentally harms the client and the patient who we are caring for across that continuum.

So obviously we will talk as we need to as this process moves on, but our focus is going to be, Can we serve the customer and the patient the way we do today? And that will determine what we can and cannot do.

Senator BLUMENTHAL. Mr. Balto, would you have any suggestions as to how this merger should be dealt with by the FTC?

Mr. BALTO. Senator Blumenthal, I think the FTC should go to court as they did in the drug wholesaler case and in Office Depot/Staples and block the merger. You can look at both of those mergers and see consumers are better off because they blocked the merger.

A divestiture of a specialty facility or a mail facility would not do much to restore the competitive equilibrium here. They are still going to have tremendous market clout, which they currently use, even at their limited market clout, to keep independent specialty pharmacies, for example, out of the market. Those offer an important source of service competition and also price competition. That would be lost if this merger is approved.

Senator BLUMENTHAL. Thank you. My time has expired. I thank the Chairman.

Chairman KOHL. I only have one question. Then I will turn to Senator Klobuchar.

Mr. Snow, on November 11th, the New York Times reported that Medco instructed drug stores to not fill prescriptions for the generic version of the blood pressure drug Lipitor for 6 months beginning December 1 when Lipitor's patent expired. According to the story, Pfizer, the manufacturer of Lipitor, negotiated with PBMs for large discounts to prevent pharmacies from dispensing the generic version of Lipitor.

Last week, the New York Times reported that the CVS Caremark PBM had instructed pharmacies that the generic form of Lipitor would not be covered for 29 prescription drug plans it managed for Medicare Part D. If true, these reports would be obviously very disturbing, and it is well understood that utilization of generic drugs, which are in many cases vastly less expensive, are essential to combating rising health care costs.

Now, we understand that Medco has taken issue with the first Times story and claims that Medco was acting at the direction of just one client. The later Times story notes that Medco has now instructed pharmacists to use the generic version of Lipitor, but that Medco's own mail-order service will use Lipitor as its "house generic."

So what is going on here, Mr. Snow? Has Pfizer negotiated discounts with Medco in order to block the generic drug from being utilized, either at drug stores or mail-order? And if so, are all of these discounts being passed on to plan sponsors and Medicare Part D consumers? And even if they are, will not this practice deter generic drug makers from attempting to enter markets?

Mr. SNOW. Thank you, Mr. Kohl. I appreciate that question, and I am happy to answer it.

The New York Times article was very much in error, and they have more recently published clarifications around that, as has

other major papers like the Wall Street Journal. What happens in Medco's case is we always prefer generics first. We do not block retailers from providing generics of any type when they come to market.

There are occasions where specifically a health plan customer who is very big, very sophisticated will negotiate their own arrangement and ask us to administer it. That is what happened for a specific health plan that we manage. They negotiated a direct deal, and we administer it. But for Medco and 99 percent of our book of business, we dispense generics, and, by the way, it is not uncommon in the first 180 days when a new generic comes to market in that exclusive period where you do get competition from the brand manufacturer. But make no mistake about it. They do not compete by giving rebates or anything like that. They compete like a generic manufacturer. By the way, most brand manufacturers these days have a generic manufacturing arm, and the contracts with these firms are just like the generic contracts we have with generic manufacturers who do not manufacture brands.

Our clients, just so you know, relative to Lipitor for the first 12 months are going to save over \$1 billion because of the generic pricing we put together for Lipitor.

Chairman KOHL. Finally, Mr. Paz, in the last few days my staff has received a number of reports from pharmacists that Express Scripts as well as other PBMs were directing them to fill prescriptions with Lipitor rather than its generic alternative. We have received this information directly. Now, you would dispute that?

Mr. PAZ. Two different pieces. One is what Mr. Snow just said. You know, Pfizer has a very good deal on the table. We go to our clients, and we ask them what they would prefer. In other words, if Pfizer was willing to negotiate the discount on its branded product below that of the generic—so, in other words, the prices are cheaper, the member pays a generic co-pay, but the plan sponsor pays less—then we will give them those options. Again, it is up to the plan sponsor to decide how they want to put in the programs.

The world has changed a little bit because Ranbaxy was able to get its approval to come to the market. There was a period—keep in mind Ranbaxy did not get to enter the market until several days after the patent expiration occurred. So there was a period when there was only one brand product and one generic out there, and the brand product was actually cheaper than the generic. Now that Ranbaxy has entered the market, the generics have dropped, and the plans are moving toward the generic. Our job is to bring down the cost, both for the patient and the plan sponsor, and do what is right. We are not tied to whether it is a brand or a generic. We want the lowest cost possible for our members to drive down the cost of health care. That is our most important mission.

Chairman KOHL. All right. Senator Klobuchar?

Mr. STREATOR. Mr. Chairman?

Chairman KOHL. Mr. Streator, then Senator Klobuchar.

Mr. STREATOR. Yes, may I just add a few points?

As a payer and as a health plan, let me just interject a perspective. When we do our due diligence with RFPs, which are fairly sophisticated, we are looking at any corporation or PBM's ability to manage drug trend or the year-over-year change. So this renewal

factor is very important. The success rate of a PBM being renewed is going to be largely tied to how effective they manage the drug trend. So whether it is the brand drug for 6 months or less, the lowest net cost is what is important.

Chairman KOHL. Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much. I want to thank Senator Lee for letting me go ahead here. I have another thing I have to get to, so thank you.

I wanted to follow up on that adherence issue that Ms. Sutter raised, and I think I will start with Mr. Snow and then maybe have Mr. Bettiga respond to this, and this is this idea that when you go to see your pharmacist, they are able to talk to you about how you take your medication and various things so that you get a higher rate of people actually taking their medication, which turns out to be one of the major health care problems we have right now.

Could you talk about how this merger could affect that and how PBMs are involved? And then we will go to Mr. Bettiga to see the concerns here from a pharmacist's standpoint.

Mr. SNOW. Yes, I would be happy to. Thank you. In addition to patients' calling us with chronic or complex disease, they call our pharmacists on average four times a year looking for specific help relative to their benefit and/or their drug and their clinical situation. We have the additional opportunity because of the way we are organized to call the patient when we see that they are not doing what the doctor suggested they do for the disease they have. We use specially trained pharmacists, additional certification in the disease, so let us take diabetes. If we see that our patient is not following the fundamental ABCs of managing diabetes as their doctor prescribed, we will actually call them if it is something that is dangerous and will lead to a very bad outcome, and we will talk to the patient about why they are not adhering to what their doctor asked them to do. We will help them through their misunderstandings, which is often the case, about what drug is supposed to do what for their bodies.

We actually help them get compliant, we monitor that compliance, and we are actually very good at closing what we call gaps in care. And there is a direct correlation between adherence to what the doctor said and the net cost per patient per year. There is a correlation. So if you get a patient 80 percent or more compliant with what the doctor said, it has been shown in diabetes you can cut the cost per diabetic per year in half because they do not become unstable, they do not end up in the emergency room, they do not get hospitalized, they do not have the source of very negative things that happen to people with unmanaged diabetes like amputations and blindness and renal failure.

We manage that, we look for that, we use evidence-based protocols in a wired health care system. And we hope the whole health care system gets wired one of these days because I think enormous opportunities for physicians and others can be leveraged. And, by the way, we are also using that wired capability to work with retail pharmacies so that they, in fact, can see what our pharmacists see and help with those gaps in care. And we are actually helping them. We are doing a number of pilots where we are helping them

get paid for cognitive time with patients managing these gaps in care.

Senator KLOBUCHAR. OK. Mr. Bettiga, why don't you answer? My experience being in community pharmacies, visiting them, is that you hear a lot, you hear those discussions going on.

Mr. BETTIGA. Right, and we hear it every day. And I appreciate, the comments about wired and the work that they have attempted to do, but here is the reality. The reality is that they can provide face-to-face contact and consultation on a daily basis with their patients and the consumers. That is the end root cause of all this, and that is part of our concern. We provide that. At Shopko, we consult on every prescription, whether it is a new prescription, whether it is a refillable prescription, 100 percent of the time in all of our stores.

My concern with this whole thing rests too with the second point on access. At some point in time, if accessibility is limited because of the practices that would go on with a larger entity—and pharmacies are forced to, you know, go out of business or whatever it may be—especially in rural underserved areas, what happens to that contact? What happens to that consultation? What happens to that relationship that an elderly patient may have with that pharmacist that they have known for years? And I would submit that you cannot replace that with an oral phone conversation, with somebody four States away.

Senator KLOBUCHAR. OK. Now, just to end here with the merger, because ultimately it is the FTC that is going to be looking at this in great detail and ruling on this merger. What do you think are the most important dynamics? Each of one of you just give a 30-second answer here, or less. What do you think the FTC should be looking at in evaluating this merger? Mr. Balto, and then we will go down the row.

Mr. BALTO. You know, I think the critical issue is: Is there something that can effectively restore competition here when the market moves from three to two? And I do not think that there are significant—there are significant differences which make a significant difference between the first and the second tier.

In addition, it is the parties' obligation to demonstrate extraordinary efficiencies, and they have not moved very far in doing that so far.

Senator KLOBUCHAR. OK. Mr. Bettiga.

Mr. BETTIGA. The primary issue for myself in our industry is critical access, without a doubt, to the patients, to consumers, and I truly believe that with this merger, with the increased cost containment measures that we have put into effect, it is going to harm community pharmacy potentially, and it is going to result in decreased access, in a decrease in the services, and that face-to-face contact that we provide on a day-in, day-out basis to our consumers.

Senator KLOBUCHAR. OK. Ms. Sutter.

Ms. SUTTER. Well, I certainly agree with Mr. Bettiga's comments about access and face-to-face contact with my patients. I just do not quite understand this conflict of interest that—you know, I am on a hospital board, and, you know, Stark laws do not allow physicians to do this referral pattern in that, but it seems like we have

totally ignored the fact that these entities can have pharmacies that are in direct competition to me, I am their competitor, and they set my rates. That is what I would like the FTC or at least Congress to look into. Why is that allowed in our industry, in our part of health care and it is forbidden, you know, within the hospitals and physicians?

Senator KLOBUCHAR. Mr. Streator.

Mr. STREATOR. Payers today are under obvious increased pressure to reduce costs, so regardless of the FTC, there is a huge role for PBMs to play because right now, as you know, the FDA approves medications on two bases: safety and efficacy. There is no cost efficacy. Until comparative effectiveness, as a research science matures, we as plan sponsors and health plans and payers are relying on the pharmacy benefit managers to help us make those decisions and to put pressure back on manufacturers. Specialty medications often can exceed the cost of \$10,000 per prescription. There are no biosimilars, and we do need this as payers.

Senator KLOBUCHAR. OK. Mr. Snow.

Mr. SNOW. I think the FTC should focus on competition. There are 40 PBMs. They are real PBMs. And there are ten PBMs serving the Fortune 50, 17 serving the Fortune 500. As I told you, we lost \$10 billion worth of business for 2012, and 15 different programs beat us and won that business. So I do think this concept of the one, two, or three is just fundamentally flawed, and I hope the FTC can sort that out.

Senator KLOBUCHAR. Mr. Paz.

Mr. PAZ. Thank you, Senator. I deal with many, many clients similar to Scott in his predicament, where whether it is the university system, whether it is the State employees, whether it is large employers, they are struggling today in this very difficult global economy. It is tough for companies to continue to grow and meet earnings expectations, redeploy capital, and hire new people.

One of the big, big drivers of cost is medical costs. I believe the PBMs have come a long, long way in taking cost out of the equation. We have a long way to go. And I think the thing that the FTC should be looking at is will this merger continue to drive down the cost of health care for the American population. I believe it will. I believe they will find it does, and that is why I believe it will get approved.

Senator KLOBUCHAR. Thank you, all of you.

Chairman KOHL. Thank you, Senator Klobuchar.

Senator Lee.

Senator LEE. Thank you, Mr. Chairman.

Mr. Streator, when we look at market responses to a merger like this one, one of the most important inquiries often focuses on possible barriers to entry into a particular market. In this instance, we might expand that a little bit to say barriers to expansion. In your testimony today, you referred to the fact that there are a number of up and coming PBMs, and I am curious to see whether you think there might be any barriers to their expansion within this market, their progress within the market.

For example, because of the fact that PBMs depend on a certain amount of scale in order to create profits through their negotiations with pharmacies and drug manufacturers, isn't it possible that one

of the smaller PBMs might be rendered less capable of climbing up that ladder within the market as a result of this merger were it to go through?

Mr. STREATOR. Senator Lee, thank you for your question. I can just speak from experience when we have done very sophisticated RFPs and bidding processes. I will not share specific company names, but I will share with you that when we have done these bidding processes, some of the smaller ones were right up there with the top ones. The reason we did not choose them at that time was because they lacked integration in operations. It was not the savings or the innovation. They were quite creative, as I mentioned in my testimony. They were able to be a little more nimble in some various implementations of clinical programs which saved a significant amount of money. But they lacked the infrastructure, and so they have—some that I read on the chart over there to the left of me, companies that are not even on there that are now quite attractive as a payer and as a health plan representative have made acquisitions to be able to integrate their infrastructure that was not there before.

Senator LEE. So, in your opinion, it is not necessarily the case that if the merger were to go through that phenomenon would not continue to exist? Sorry for the double negative there. You see no reason why that trend would not remain the same as a result of this merger?

Mr. STREATOR. Correct. I believe plan sponsors can do greater due diligence than just relying on brokers to tell them who is available in the market. There are a number of viable, attractive PBMs and, as I mentioned earlier, even health plan-owned PBM offerings now. Each have a different set of competitive advantages, and if payers worked diligently to research these, I think there is ample competition, even with this merger.

Senator LEE. I also wanted to talk to you more broadly just about concerns that I developed as a result of conversations I have had with local pharmacies throughout my State on an issue that is very important to them and the role that local pharmacies and individual pharmacists play in the delivery of health care services. Are you confident that this merger would not, in effect, squeeze them out? Are you confident that this merger is not a part of an effort to replace independent pharmacies and local pharmacists?

Mr. STREATOR. As a payer, we have a fiduciary responsibility on behalf of our members. We want the best quality of care for the best dollar, and we need to have access, as I mentioned in my written testimony and my oral testimony today, that we need community pharmacists.

I certainly believe with the emerging health care reimbursement models, this will be even more important.

Senator LEE. OK. Thank you.

Ms. Sutter, I have a question for you. Relating to a study that was conducted in 2005 by the Federal Trade Commission, the FTC conducted this in-depth empirical analysis and found, among other things, the following, and I quote: "that the prices for a common basket of prescription drugs dispensed by PBM-owned mail-order pharmacies were typically lower than the prices charged by retail pharmacies." The study also found, "Competition affords health

plans substantial tools with which to safeguard their interests. Consumers benefit as a result.”

Do you dispute this finding of the FTC?

Ms. SUTTER. Well, I certainly would want to look at it in more detail. When they say my price, the community pharmacist price, is that usual and customary or is it an adjudicated discounted price?

Our biggest concern as community pharmacists is I am contracted with these gentlemen's companies to fill prescriptions at very, very low margins. They sell my services to the payer and price it at some point up here, having no transparency to know whether it is a fair spread for their services. And then with their mail-order pharmacy, they somehow are able to just put their cost of their medication slightly lower. And so when you present a plan to a payer saying mail-order is less expensive than what they got charged by Medco or ESI or a PBM for my services, information and data like that can make it look like that. What we really need to do is look at the transparency of what am I being paid for, the prescription and the services, the 100 percent of the services that I am providing, and what are they charging to the payer.

In addition to that, recently one of the smaller PBMs was at a recent conference, and an individual asked the question of how often do you have payers audit their contracts, and they said less than 5 percent. I have also been told, yes, all this language is in there that they can audit their PBM, but they also have language in there that they have to agree to the auditor and that—

Senator LEE. That who has to agree? That the PBM has to agree to the—

Ms. SUTTER. The PBM and—

Senator LEE [continuing]. Identity of the auditor?

Ms. SUTTER. So I guess I would ask you to dig further into whether—how difficult it is for a payer to actually audit what they are being billed for and understanding what I am being paid for my services before we can really answer that question.

Senator LEE. OK. Help me understand the point then. Are you suggesting that because only 5 percent of the audits that could be conducted, in fact, are being conducted? You think that is due at least in part to clauses in the PBM agreements mandating that the PBM agree to the auditor?

Ms. SUTTER. Well, I am certainly no expert on this, and so some of this is just hearing a PBM official speak to this. My concern is that only less than 5 percent of the payers are ever even attempting to take advantage of their audit abilities in the contract, and then we are also told that many have language that they both have to agree to it.

Senator LEE. OK. So that is much of what you are referring to when you talk about the lack of transparency, is that most of the time that audit is not, in fact, being conducted.

Ms. SUTTER. Exactly.

Senator LEE. Even though it could be, it is not, in fact, happening.

Ms. SUTTER. That is my understanding.

Senator LEE. OK. Thank you.

Mr. STREATOR. Senator Lee, could I interject on that as a payer?

Senator LEE. Yes.

Mr. STREATOR. I believe that is mainly a function of, not the PBM, but how effective plan sponsors negotiate with the PBM and then take advantage of that capability. I know we do routine audits during a contract year, so that is unfortunate that other plan sponsors do not do that, but that is surely a fiduciary responsibility of payers.

Mr. PAZ. For the record, Senator, we have over 450 audits going on as we speak.

Senator LEE. OK. So they do happen.

Mr. PAZ. All the time. Constantly.

Senator LEE. I see that my time has expired. Thank you very much.

Chairman KOHL. Mr. Balto, according to the industry estimates, after this merger the combined Express Scripts/Medco will control about 60 percent of the mail-order business. Should we worry about this high level of concentration in the mail-order marketplace?

Mr. BALTO. I think absolutely, in part because it provides greater leverage for the merged firm to go and force plans and consumers into mail-order, which denies them the opportunity of using their community pharmacy.

Chairman KOHL. All right. Ms. Sutter, we understand that community pharmacies have concerns about PBMs' steering consumers to obtain their prescriptions by mail-order. But isn't it beneficial for consumers to obtain their prescriptions in this way if they wish since it saves them a trip to the drug store? We could understand that pharmacies may not like that consumers utilize mail-order services rather than go to drug stores, but how does greater utilization of mail-order harm consumers? What is your response to that?

Ms. SUTTER. Well, I want to speak to the fact that many of these plan designs—there are plan designs that have mandatory mail requirements, and many patients do not care for that. But the majority of them just offer mail-order. The way they get patients to default to that is that they only charge two co-pays for every three that are acquired at the community pharmacist. So I still have patients that appreciate and value my services enough to financially pay a third co-pay every 90 days to do business with us, but there are a lot of people that that expense is being—they just cannot have that expense, and so they default to the mail-order pharmacy. So they put us on a very unfair playing field when they say that the consumers are free to go to their community pharmacy.

I would challenge them, if they made it absolutely equal, where patients would choose to go to. I think I would win out.

Chairman KOHL. Mr. Snow.

Mr. SNOW. Yes, Senator, I just would like to respond because there is a misunderstanding here. The PBM does not tell their customer how to design their benefits. Typically, when the customer, who is paying the bill—it actually is not us. It is the customer. It is the employer. It is the health plan. It is the State government entity. When they are paying the bill and they look at the difference in cost, they may choose to motivate the consumer with one less co-pay to choose a less expensive place for them, the payer. As George Paz said earlier, we lay out the choices for our customers to choose from, and they make all kinds of different choices. Every-

one is different. But when these choices are made, it is not forced by a PBM.

I can tell you, we are not the boss when it comes to serving our clients. We do what we are asked to do to serve our clients in the way they want to be served.

Chairman KOHL. All right. Mr. Balto, one of the most lucrative prescription drug markets today is for specialty drugs that are used for the most serious medical conditions such as cancer. These drugs often require special handling, are often administered intravenously, and are generally much more expensive than other types of medication. Express Scripts and Medco combined will control over 50 percent of the specialty market after this merger. Should we be concerned about such concentration in the specialty market?

Mr. BALTO. Absolutely, and just to make things clear, you should be concerned whether the market share is 50 percent; you should be concerned whether the market share is 30 percent. Express Scripts and Medco, because they will have combined 150 million covered lives, will have the kind of clout that they can go and force exclusivity arrangements upon manufacturers, which we have documented have led to increased prices; that they can have exclusive networks which will keep Mr. Bettiga and Ms. Sutter's pharmacies out of the market, other community specialty pharmacies out of the market; and instead of being able to go to your community specialty pharmacy, you are going to be dealing with a distant mail-order pharmacist. And the problems that Ms. Sutter has documented will exist in a much more severe fashion.

Chairman KOHL. Mr. Paz, at a House hearing on this merger, you said that if you were required by the FTC to divest Medco's specialty pharmacy State as a condition of doing the deal, you would not do the deal. Is that correct?

Mr. PAZ. That is correct, Senator.

Chairman KOHL. Why?

Mr. PAZ. Specialty pharmacy is the fastest-growing—it is lucrative in the sense that it is high cost. It is not our highest profit drivers. That still comes from generic drugs and moving patients into the lower-cost prescription programs. The specialty products in and of themselves are very important for our plan sponsors. These are the drugs that can cost \$10,000, \$15,000 a month for a member. They need to have their arms around it.

There are many specialty pharmacies out there—which are part of our network, by the way—that specialize in a given disease state. However, there are also a lot of pharmacies that may only handle one person with a very limited disease.

One of the advantages that the PBMs can have is that when we bring together pharmacists, doctors, and nurses that specialize in that disease state, we also bring in health care professionals and social workers to help the family. Often these diseases are very debilitating to a family, and helping that family get through the consequence of this is very, very important. We have these people that call on these people constantly and help them. It is a very important part of our business.

Chairman KOHL. All right. We will turn to Senator Franken after this one question.

One of the main arguments, Mr. Paz, for the merger is that, combined, you will be able to develop more innovation and new clinical tools and strategies for cutting costs. And yet we all know that innovation is the fruit of competition and that the more competitors, the more innovation, and the better the consumer is served. You seem to be making an argument to the contrary. Have you come up with a new concept for how capitalism works?

Mr. PAZ. Yes, when you look at UnitedHealthcare entering into this market in a very big way, CIGNA coming into our space in a very big way, Prime Therapeutics coming in in a very big way, innovation is key. We know our role. Our role is to drive down the cost of health care and improve health outcomes for the millions of Americans we service. We have to remain innovation. We have to continue to go to the market. Plan sponsors like Mr. Streater have many, many options. The day we start falling behind innovation is the day our market share will decline. We must stay focused on improving health care.

Chairman KOHL. But competition is what breeds all of that urgency and activity. Would you suggest that if you could also take over Caremark and CVS that would be the best thing for everybody? If you control the whole market, would you then innovate in a way that would not be possible otherwise?

Mr. PAZ. I would tell you that there is plenty of—I do not think we need to buy CVS Caremark, but I would tell you that there is plenty of competition out there and that we are forced—on top of all that, Senator, CMS requires innovation. They are coming to us on a regular basis with new regulations and new requirements, and they are forcing us to go forward. We need to work very closely with CMS in order to come up with new programs, everything from e-prescribing to helping members access drugs to plan design change, on and on and on. It is required in our business.

Chairman KOHL. OK. Mr. Balto.

Mr. BALTO. Can I go back to the conflict of interest issue in the specialty pharmacy area? Because I think it illustrates the problem here, because Mr. Paz owns a—you know, if he just owned a specialty pharmacy, fine, let us compete on the merits. But when he owns a PBM, he knows everything about his competitors. When his competitors get too large, he excludes them from the network. When his competitors get certain customers, he can focus and target those customers. It is those conflicting interests that create a tremendous problem here, and the merger makes it worse by combining his market clout with a dominant position in specialty pharmacy.

Chairman KOHL. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Mr. Paz, two recent reports from the Health and Human Services Office of the Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers, and this ultimately means higher Medicare costs for both beneficiaries and for taxpayers.

You said in your testimony, “Patients, not profits, must come first.” Can you guarantee that the lion’s share of the savings created by your merger would go to consumers?

Mr. PAZ. Under CMS regulations and the way we conduct our business, Senator, 100 percent of the rebates go back to the plan sponsors, and 100 percent of the network pricing goes into the plans. We make administrative fees, which are fully disclosed to our plan sponsors under CMS and Medicare rules.

Senator FRANKEN. Well, then, how is this Inspector General's report possible?

Mr. PAZ. I do not know the answer to that. I am not familiar with that. I would have to look into that. But I would tell you that in our business—and keep in mind we just completed an audit by CMS that came in and audited our business, and there were no issues with respect to transparency or passing through savings.

Mr. SNOW. The same is true for our business.

Mr. PAZ. I cannot speak to other players in the industry, Senator. I do not know what others may have done.

Senator FRANKEN. OK. Health and Human Services Office of the Inspector General found that PBMs are not adequately sharing savings with Medicare patients. I will probably follow up with a written question.

Mr. PAZ. If you do not mind, Senator, we will be happy to follow up with your office and get you some information on this.

Senator FRANKEN. I appreciate that. Thank you so much.

Mr. Paz—I am sorry.

Mr. PAZ. My colleague just advised me that CMS actually disputed those findings. We will follow up with your office and get the information.

Senator FRANKEN. OK. Well, thank you.

I am told that Senator Klobuchar mentioned earlier that over the past couple years 12 communities in Minnesota have lost their only outpatient pharmacy, and this is a huge loss for residents in those communities, especially because Minnesota winters are kind of rough, as you know. When elderly patients have to drive many miles in the dead of winter or have someone drive them to pick up their drugs, I worry. There are currently 141 rural communities in Minnesota that have only one pharmacy.

Medicare Part D only requires that 70 percent of Medicare beneficiaries in rural areas have access to a pharmacy within 15 miles. That means that 30 percent of beneficiaries could live more than 15 miles from their nearest pharmacy, and as I understand it, there is no upper limit. So that means someone could drive conceivably 80, 90 miles to a pharmacy.

Do you agree this is a serious problem for health care in our country and in Minnesota?

Mr. PAZ. Rural pharmacies, Senator, are a very important part of our network. It is not only governed by CMS. CMS clearly sets standards. DOD also sets standards that we have to adhere to on behalf of our men and women in uniform and their beneficiaries. But our plan sponsors, just as importantly, set standards as well. We ought to make sure the record is straight. Forty percent of all prescription drugs are for acute medications, so even if everybody moved to mail-order, 40 percent would still have to be filled. If you have a child with a toothache or you have some problem, you cannot wait to get something in the mail. We would never suggest that

you do. Those drugs have to be there. They have to be accessible, and they have to be ready—

Senator FRANKEN. Right, which is—

Mr. PAZ.—and so we have to have—

Senator FRANKEN.—an argument, I think, that you could make—I think you are not making an argument that—

Mr. PAZ. I am trying to make an argument that we have to keep the rural pharmacies in business, that it is our job to do a very careful balancing.

Senator FRANKEN. And you think this merger will help keep the rural pharmacies in business, Ms. Sutter? I am sorry to—you can feel free to answer after Ms. Sutter does.

Ms. SUTTER. The issue is that the rhetoric of these gentlemen just does not match the reality of what we are dealing with. We have got comments after comments in my written statement about what we are dealing with with these—40 percent—if 40 percent are acute meds, I cannot stay in business only being basically subcontracted to these gentlemen. My patient is the center of this equation. I am with the physician there taking—part of the health care team taking care of them. They are the ones that are on the side providing some assistance in adjudicating a claim. This idea that companies like this can be at the center of resolving health care issues in this country is just ridiculous, quite frankly.

Senator FRANKEN. I think they are just different roles. But I, too, have received tons of calls and letters from community pharmacists in Minnesota who are concerned about this.

Mr. PAZ. I think when you look back, we have done several acquisitions over our history. In 1998, we bought Value Rx, a Minnesota-based company. We have done several acquisitions since then. Almost every time we have been accused that savings would not pass along to the plan sponsors. I think Mr. Streator and all of my clients would contend and argue that what we do, as Mr. Streator said in his comments, his drug trends were less than—were negative. They were not zero or 1 percent. They were negative. That means the cost of their drugs actually came down year over year, is to help them choose the right generics, the right channels, and the right outcomes in order to drive those costs down. And so I do—

Senator FRANKEN. Mr. Streator, you are at a university, is that it?

Mr. STREATOR. Correct, the Ohio State University.

Senator FRANKEN. OK. That is in Columbus, Ohio.

Mr. STREATOR. Correct.

Senator FRANKEN. That is a big community, right? So what we are really talking about, if I recall my question, was about small rural communities.

Mr. PAZ. Mr. Streator services clients all across the State of Ohio, even in rural areas of Ohio.

Mr. STREATOR. That is correct. We have 56,000 members in our health plan, and they are in every county in Ohio. We also work in the Rx Ohio Collaborative that has over 500,000 members all across the country. So, yes, we do need community pharmacies.

Senator FRANKEN. Well, thank you. I appreciate all your testimony and all your answers, and I will get back to you with more

because I did not have the two rounds, but I have got to go myself, and I appreciate all of your being here and I appreciate your calling this hearing, Mr. Chairman. Thank you all.

Chairman KOHL. Thank you, Senator Franken.

Mr. Bettiga, do you want to make a comment or two before we begin to wrap it up?

Mr. BETTIGA. Well, I would like to make a comment to what we were just talking about here because at the end of the day, while I understand that the plan sponsors may be OK in this, at the end of the day the rates to community pharmacies, especially those in the rural areas, et cetera, are dictated by the PBMs. And they talk a lot about past activities with mergers, et cetera. This is not about the past. This is about what happens in the future with one larger entity and what types of rates they will impose on retail and community-based practice, and what does that ultimately mean then to accessibility for those rural patients, those underserved patients that Senator Franken was referencing? And there is a huge concern with that because we just do not know what that next game is going to be.

Chairman KOHL. Anybody else want to make a comment?

[No response.]

Chairman KOHL. I think we have really aired this thing very well, and I appreciate your coming here and giving us your very frank expressions of interest and concern about the direction of this industry.

We will leave the record open for a week. I would again like to thank all of you for being here today. You have added an awful lot to the issue, and once again our appreciation. Thank you.

[Whereupon, at 4:39 p.m., the Subcommittee was adjourned.]

[Questions and answers and submissions for the record follows.]

QUESTIONS AND ANSWERS

Sen. Kohl's Follow-Up Questions for the Record for Hearing on "The Express Scripts/Medco Merger: Cost Savings for Consumers Or More Profits for the Middlemen?"

For David Balto

1. (a) Express Scripts and Medco contend that there are many other PBMs that compete to serve as pharmacy benefits managers for the nation's largest employers and plan sponsors. Do you believe PBMs other than Express Scripts, Medco and CVS Caremark can truly compete for the business of large national employers? Why or why not?

No, second tier PBMs cannot compete in a significant enough fashion for the business of large national employers to serve as a price constraint and competitive influence on Express Scripts, Medco, and CVS Caremark ("the big three").

Large national employers require a PBM that provides a national network of pharmacies. Only the top tier PBMs harness the bargaining power sufficient to demand affordable prices for pharmaceuticals. PBMs outside of the big three lack the negotiating leverage and, as a result, cannot secure comparable levels of rebates. This difference in bargaining power is also present in negotiations with pharmacies, and only the big three PBMs can secure reimbursement rates low enough to control costs at a scale large enough to satisfy the large plan sponsors. Large national employers also seek PBMs that offer a comprehensive set of services. This includes programs designed to limit waste and abuse, programs driven at facilitating regulatory safety protocol, and state-of-the-art technology that tracks the complete profile of the plan beneficiaries. Lastly, a PBM must be a certain size to manage the sheer volume of beneficiary information. Only the big three are large enough to manage the practical demands of administering the prescription drug benefit portion of large health plans.

(b) What would be the consequences for large employers of the loss of competition between Express Scripts and Medco should their merger be approved?

Large employers would be left facing higher prices and less service in the PBM market. The California Public Employees' Retirement System quote from my testimony encompasses this reality: "You can count the PBMs that can serve the organizations of this size on a couple of fingers, maybe three, and they frequently are subject to lawsuits and investigations." Without Medco in this calculation, the number is down to two.

There are a number of effects that large employers are likely to experience after the merger, the brunt of which will ultimately be borne by the end-user – the consumer. Plan sponsors will see an increase in their drug costs – or perhaps better put, a decrease in the savings secured – once the top tier PBMs face less competition. As evidenced by their increasing profits, PBMs are not afraid to keep a windfall portion of the savings they negotiate for themselves. The only constraint on PBMs passing on a bare minimum of savings to the plan sponsors was competition among the big three. Once this competition is lessened, it is likely the PBMs will filter less of the money back to the plans, and more back to themselves.

The top tier PBMs will also increase their efforts to direct distribution through its own channels. This will further marginalize the impact of community pharmacies and specialty

pharmacies, and will render the consumer with virtually no choice in their health care. Community pharmacists and specialty pharmacists both serve integral roles as care providers, and offer a hands-on approach that mail-order simply cannot provide. For those patients suffering from chronic or complex diseases that require difficult-to-administer medicine, the loss of these institutions as care providers will be harmful. The long-term result will be poor administration of vital drugs, which will lead to poorer health and, ultimately, an increase in health care expenses.

Large employers will also likely experience a decline in the provision on ancillary services, such as Medco's highly praised Therapeutic Resource Centers, and Express Scripts "prescription drug adherence plans."¹ It is clear the two companies have an incentive to create these programs and plans now – competition in the market compels them create new ways to serve customers. However, post-merger, this incentive will be dramatically decreased. Not only will the merger fail to encourage more programs, the reduction in competition will likely remove the primary motivation for creating these programs now.

This harm will occur without a procompetitive justification to counterbalance the effects. When pressed by Senator Kohl at the hearing, CEO George Paz confirmed that "significantly increasing discounts over what you are getting right now is really not why [ESI is] doing this deal, and [ESI is] not nearly as certain that this deal will result in far more discounts from suppliers, that there are other ways this will pay off." Senator Kohl challenged the notion that ESI and Medco would really have anything more than a marginal increase in bargaining power after merging, since they both already secure optimal pricing from pharmaceutical manufacturers. Instead, ESI and Medco rest the justifications for this merger on arguments of synergies resulting from merging "back office" operations, and implementing programs that will help reduce waste. Combining administrative chores simply do not help customers, and certainly do not pose nearly enough benefit to outweigh the grave competitive harm.

2. On November 11, the New York Times reported that Medco instructed drug stores to not fill prescriptions for the generic version of the blood pressure drug Lipitor for six months beginning December 1, when Lipitor's patent expired. According to the story, Pfizer, the manufacturer of Lipitor, negotiated with PBMs for large discounts to prevent pharmacies from dispensing the generic version of Lipitor. On November 30, the New York Times reported that the CVS Caremark PBM had instructed pharmacies that the generic form of Lipitor would not be covered for 29 prescription drug plans it managed for Medicare Part D.

We understand that Medco has taken issue with the first Times story, and claims that Medco was acting at the direction of one client. The later Times story notes that Medco has now instructed pharmacists to use the generic version of Lipitor, but that Medco's own mail order service will use Lipitor as its "house generic."

In the last few days my staff has received a number of reports from some pharmacists that Express Scripts and other PBMs were directing them to fill prescriptions with Lipitor rather than its generic alternative. One pharmacist reported to us that, because Lipitor is more expensive

¹ Written Testimony of George Paz, Chairman and Chief Executive Officer of Express Scripts Inc., before the Senate Judiciary Committee Subcommittee on Antitrust, Competition Policy, and Consumer Rights, Hearing on the Proposed Merger between Express Scripts and Medco, December 6, 2011, at 5.

than the generic, “the healthcare system is paying a minimum of \$ 63.26 more each time the brand [name drug] is dispensed instead of the generic.”

What do you make of these reports? Do PBMs have an incentive to block pharmacies from filling prescriptions with lower priced generics as this will reduce the discounts or rebates the PBMs collect from drug manufacturers? How do consumers fare when these type of deals are made? And will this merger make this situation worse?

This well-timed report perfectly illustrates two important points central to the analysis of this transaction: 1) the big three PBMs have inherent and unavoidable conflict of interest between their responsibilities to broker for the best prices on behalf of beneficiaries and their desire to maximize revenue through the vertically integrated PBM, mail-order, and specialty businesses; and 2) they wield considerable market power, and can dictate the terms of formularies and reimbursement to ensure they make as much money as possible, without regard as to whether this is the best price for consumers.

The most likely explanation for the Lipitor situation is that Medco had negotiated for a large rebate from Pfizer in exchange for pushing Lipitor. Medco also likely secures a price below market rate, allowing it to assert that it has negotiated a cost-saving price for consumers. However, as the New York Times story illustrates, the end result is plan sponsors, and ultimately consumers, pay more for drugs so that PBMs can reap windfall profits.

PBMs always have an incentive to drive consumers to the drugs for which they have negotiated the highest rebates. This high-profile example is just one instance in an epidemic of large PBMs sacrificing the consumer for their own financial gain. The merger will only exacerbate this problem. Currently, the behavior of the big three PBMs is often anticompetitive but often reined in by competition in the market. Once this competitive constraint is removed, there will be virtually no check against PBMs wielding their bargaining power for their own benefit, and leaving consumers with no choice but to continue to pay exorbitant prices for health care.

3. According to industry estimates, after this merger the combined Express Scripts/Medco will control about 60% of the mail order business. Should we worry about this high level of concentration in the mail order marketplace? Why or why not?

A mail order industry concentration of 60% is cause for significant concern. This limits patient choice, reduces mail order firms’ incentive to bargain fairly, and jeopardizes the service and care that patients require from their pharmacies. A merger resulting in such a high market concentration is always cause for concern, especially in industries in which entry by competitors is unlikely. In this case, given the PBMs’ exclusive use of its own mail order pharmacies, entry would be unlikely, or irrelevant.

The concern is amplified by the fact that this concentration will be in the hands of the very entities that negotiate drug prices and determine when pharmaceutical substitutions will be made. PBMs face an inherent conflict of interest when they are tasked with negotiating lower reimbursement rates for pharmaceuticals but also are incentivized to increase mail order use, or to substitute certain drugs as a result of their favorable rebate agreements with pharmaceutical

manufacturers. This conflict of interest has led to numerous state enforcement actions, including *States Attorneys General v. Caremark, Inc. et al* (D.D.C. 2008), *States Attorneys General v. Express Scripts, Inc.* (D.D.C. 2008), and *United States ex rel. Hunt, Gauger, Piacentile, et al. v. Merck-Medco Managed Care, L.L.C., et. al.* (E.D.P.A. 2000). In each of these cases, joined by numerous states against the merging parties and the only other remaining top tier PBM, the states alleged that the PBMs had defrauded patients, clients, and the United States through a series of practices, including cancelling or destroying prescriptions, failing to perform pharmacists' services required by law, switching patients' prescriptions to different drugs without the knowledge or consent, and creating false records and billing patients for drugs they never ordered. These cases are clear evidence that PBMs succumb to the conflict of interest inherent in operating the mail order pharmacies, and cannot be trusted as honest brokers for the patients they purport to represent.

The merger will increase the economic incentives for the combined firm to continue these practices, and will augment their ability to do so. With such a high concentration of the mail order market residing in so few firms, customers will have no real choice. Furthermore, as I noted in my testimony, the big three PBMs all require beneficiaries to use the PBM-owned mail order pharmacy. Patients are captive of the deceptive practices, and can only rely on post-hoc, inefficient litigation as a means of combating the fraud and deception rampant in the system.

4. In his testimony, Mr. Streater contended that it is the health plan sponsors that instruct the PBMs how to design pharmaceutical benefit plans, and the PBMs are merely acting at the direction of the plan sponsors. What is your response to this argument? And will this merger reduce the leverage of plan sponsors to insist on specific aspects of plan design, but rather be left more in a "take it or leave it" position?

From my understanding, Mr. Streater's depiction of the PBM/plan sponsor relationship is flawed. PBMs create benefit plans and push plan sponsors towards the products it is most trying to sell. The PBMs set the prices, and offer contract terms with limited flexibility. The New York Times article discussed in question #2 is directly to this point. The story states that Medco claims it was acting at the direction of a client, but this seems unlikely. And even when Medco acquiesced and included the generic, it still refused to do so for its mail-order services. Therefore, we must have a contradiction. Either the plan sponsor who requested brand Lipitor for all prescriptions, or the plan sponsors who complained and asked for generics to be used instead of the more expensive brand, are being denied their request. Such is the nature of the big three's relationships with plan sponsors. Like all harm stemming from this transaction, the merger will exacerbate the problem and make a bad situation worse.

5. In previous testimony before Congress, you've advocated for increased transparency in the PBM marketplace. Specifically, you've contended that PBMs do not adequately disclose reimbursement rates to pharmacies and payments from drug companies. You have also said that transparency can improve competition in the PBM markets.

Yet, Express Scripts has asserted to us that their practices, including pharmaceutical rebate contracts, are transparent and regularly audited by their clients.

Do you agree with Express Scripts, that they operate transparently with their clients? And, in your view, would this proposed merger improve or hamper PBM transparency?

I disagree with Express Scripts' claim that they operate transparently with their clients. While it may be true that Express Scripts does have certain plan designs that offer their clients a certain level of transparency, they artificially raise the cost of these designs to a level that makes them entirely undesirable to most plan sponsors. It is undeniable that, as one court has observed, "a layer of fog"² exists over the PBM industry that prevents most plan sponsors from knowing how much of the savings PBMs actually pass along to the payors.

This merger would hamper PBM transparency. By reducing the number of full-service, national PBMs from three to two, the merger would significantly diminish PBM market rivalry. Robust competition not only constrains prices, but also promotes quality and diversity in services. Accordingly, the remaining two PBMs would be less inclined to offer transparent plan designs.

6. Should the FTC decide to approve the merger, would you recommend the FTC require any conditions to preserve competition?

First off, I must reinforce the fact that the FTC should block the proposed merger. It is Express Scripts' 155 million covered lives--70 million more than the next largest PBM-- that are going to irreparably damage competition in this market and harm American consumers. A divestiture of a portion of their specialty pharmacy or mail-order capabilities will insufficiently address the competitive concerns raised by the merger as Express Scripts will maintain the same ability to drive down reimbursement to pharmacies below competitive levels and drive consumers away from their pharmacy of choice and into their captive services.

If the FTC should decide to approve the merger, I would recommend that the FTC require the companies to divest all affiliated specialty pharmacy and mail-order pharmacy capabilities. Additionally, the FTC should protect consumer choice and competition in the delivery of pharmacy service by prohibiting Express Scripts from restricting pharmacy network access and engaging in exclusive distribution arrangements.

² *Pharm. Care Mgmt. Ass'n v. Rowe*, 2005 U.S. Dist. LEXIS 2339.

Senator Mike Lee
Questions for the Record
David A. Balto, Consumers Union, et. al.

1. At the hearing, you stated that you do not believe the PBM market is currently competitive and that it would become even less competitive should the merger be approved. Mr. Snow of Medco stated that his company lost important contracts and significant business to a number of different competitors during 2010.
 - a. Does Medco's loss of significant business to a number of different competitors in 2010 suggest a competitive market for PBMs, and why or why not?

It is true that Medco lost business during 2010. It is not true that these contract losses do anything to dispel the notion that this is a highly concentrated industry, with only three viable players.

Medco's most significant lost contracts were the Federal Employees Health Benefits Program and the California Public Employees' Retirement System. These funds both opted for CVS/Caremark instead of Medco. Medco also lost MemberHealth LLC to CVS/Caremark. UnitedHealth Group Inc. is an outlier in this analysis. This large insurance company covers over 18 million lives and is the largest American insurer by market value, and was uniquely positioned to bring its PBM function in-house, especially after its purchase of PacifiCare Health Systems in 2005.

It would be inapposite to conclude that Medco's loss of business is evidence of vibrant competition. Instead, most of the covered lives are shifting from one member of the big three to another, with others in a unique position to take matters into their own hands. In fact, UnitedHealth's decision should be seen as evidence that the market lacked competition – the insurer was so unhappy with its PBM options that it chose to absorb the cost internally.

2. At the hearing, you asserted that this merger will result in higher costs for consumers. The Congressional Budget Office estimated that PBMs reduce drug costs by roughly 30 percent per year. Similarly, a 2003 General Accounting Office study found the average price of prescriptions through mail order was 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs, and 53 percent below the retail cash price for generic drugs.
 - a. Do you dispute these findings?

I dispute the GAO findings to the extent that they are taken out of context to suggest a level of savings garnered by mail-order as compared to similarly situated PBM customers without mail-order. The analysis provided by the 2003 GAO report, and often cited by PBM loyalists, actually compares the level of savings that mail-order provides to

“cash-paying customers without third-party coverage.”¹ The difference offered by mail-order is much less stark when compared to PBM retail prices. This report also concedes that the difference between PBM and cash-paying customers “may overstate PBMs’ negotiating success because, absent a PBM, plans would likely manage their own drug benefits and also attempt to negotiate discounts with retail pharmacies.” This quotation is often utilized to insinuate that PBMs, or mail-order through PBMs, offers up to 27% savings on brand name drugs and 53% on generic drugs from what the normal consumer would pay. This is a misrepresentation of the finding, and I dispute the use of this data point to suggest such a conclusion.

Furthermore, this is an old report. The GAO released the report, and the newest data contained therein is from 2002 – nearly a decade old. The PBM market is not the emerging industry that it was in 2002. It has grown in scope, and become extremely consolidated, with only three firms controlling the majority of the market. This report is simply not a reliable source for assessing the modern impact of PBMs.

Much like the GAO report, the Congressional Budget Office’s report relied upon by PBM loyalists is outdated and unreliable. Furthermore, to state that the CBO report simply states that PBMs provide 30% savings to consumers is misstating the report. In this report, the CBO was estimating the likely effects of competing bills on drug price for Medicare patients only. The report is rife with suggestive and predictive language, and in no ways portrays itself to be a comprehensive study or final analysis of the savings generated by PBMs. In fact, the table from which this 30% estimate was taken is entitled “CBO’s Assumptions for Four Prescription Drug Proposals.” This report is too old and too imprecise to be relied upon as support for the conclusion that competition is healthy in the PBM market, much less to suggest that the merger would not substantially lessen competition.

- b. If you agree that PBMs save customers money on prescription drugs, do you view the merged entity as being different from current PBMs in that it will not result in savings for consumers, and why or why not?

There are three conditions necessary for a thriving PBM industry to work. First, there must be real, active competition between PBMs so that they each serve as legitimate price constraints on the rest. Nominal competition is not sufficient. There is already a dearth of competition in the PBM market, especially in the market for large PBMs capable of servicing a large plan sponsor. The California Public Employees’ Retirement System quote from my testimony encompasses this reality: “You can count the PBMs that can serve the organizations of this size on a couple of fingers, maybe three, and they frequently are subject to lawsuits and investigations.” CVS/Caremark is the only firm in the market capable of serving as a price constraint on Express Scripts and Medco. If the merger is allowed to proceed, the result will be a duopoly in which the remaining firms have no incentive to pass through anything but the bare minimum of savings to the consumer.

¹United States General Accounting Office, *Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, at 9, available at <http://www.gao.gov/new.items/d03196.pdf>.

Second, there must be minimal conflict of interest between the PBMs' responsibilities as an agent on behalf of its plan sponsor customers, and its drive to increase profits. To be clear – profits are not bad, nor is profit seeking. However, when an intermediary is tasked with negotiating the lowest price possible, but also financially compensated for preferring one distribution channel over another, the conflict of interest is too great to overcome. Such is the case with the big three PBMs who own and operate their own mail-order facility and specialty pharmacies. The Health & Human Services Office of Inspector General report "Concerns with Rebates in the Medicare Part D Program" illustrates this conflict, concluding "sponsors received rebates when they encouraged beneficiaries to use certain drugs." PBMs are willing to drive the ultimate consumer – the patient – to drugs not prescribed by the physician in order to maximize their profits. This very conflict of interest spurred the Federal Trade Commission to twice intervene in the merger of two PBMs. In 1995 the FTC investigated Eli Lilly's acquisition of PCS, and entered into a consent agreement which required the merging firm to improve transparency, maintain an open formulary, and implement an internal firewall to prevent communications between Eli Lilly and PCS regarding bids, proposals, prices, and other information.² Then, in 1999 the Commission investigated and entered into a virtually identical consent decree with Merck-Medco following the merger of these two firms.³ The takeaway from these cases is clear: conflicts of interest have haunted the PBM market since its earliest days, and the government has proven its willingness to be proactive to respond to competitive harm in the industry.

Third, the PBM market must be transparent. In his testimony ESI CEO George Paz contended that his company was very transparent, and asserted that plan sponsors call the shots, with the PBMs merely accommodating these requests. However, the Health & Human Services Office of Inspector General report referenced above paints a different picture. This report finds that sponsors often have "complex contractual relationships"⁴ that lack transparency, thereby suggesting that there is no accounting or verification mechanism for filings claiming to offer such high pass through rates. This lack of transparency has led to numerous state enforcement actions, including *States Attorneys General v. Caremark, Inc. et al* (D.D.C. 2008), *States Attorneys General v. Express Scripts, Inc.* (D.D.C. 2008), and *United States ex rel. Hunt, Gauger, Piacentile, et al. v. Merck-Medco Managed Care, L.L.C., et. al.* (E.D.P.A. 2000). In each of these cases, joined by numerous states against the merging parties and the only other remaining top tier PBM, the states alleged that the PBMs had defrauded patients, clients, and the United States through a series of practices, including cancelling or destroying prescriptions, failing to perform pharmacists' services required by law, switching patients' prescriptions to different drugs without the knowledge or consent, and creating false records and billing patients for drugs they never ordered. These cases are clear evidence that PBMs

² *In the Matter of Eli Lilly and Company*, FTC File No. 012 3214, available at <http://www.ftc.gov/os/caselist/0123214/0123214.shtm>.

³ *In the Matter of Merck & Co. Inc. and Merck-Medco Managed Care, LLC*, FTC File No. 951 0097, available at <http://www.ftc.gov/os/caselist/c3853.shtm>.

⁴ Department of Health and Human Services, Office of Inspector General, "Concerns with Rebates in the Medicare Part D Program" at ii.

succumb to the conflict of interest inherent in operating the mail order pharmacies, and cannot be trusted as honest brokers for the patients they purport to represent.

The harm that will result from this merger is not the existence of PBMs, but rather the change in the competitive landscape that will result from the merger. And this harm will come without any cognizable efficiencies or increased bargaining leverage. When pressed by Senator Kohl at the hearing, CEO George Paz confirmed that “significantly increasing discounts over what you are getting right now is really not why [ESI is] doing this deal, and [ESI is] not nearly as certain that this deal will result in far more discounts from suppliers, that there are other ways this will pay off.” Senator Kohl challenged the notion that ESI and Medco would really have anything more than a marginal increase in bargaining power after merging, since they both already secure optimal pricing from pharmaceutical manufacturers.

Instead, ESI and Medco rest the justifications for this merger on arguments of synergies resulting from merging “back office” operations, and implementing programs that will help reduce waste. Combining administrative chores simply do not help customers, and certainly do not pose nearly enough benefit to outweigh the grave competitive harm. Unfortunately, none of the Committee members asked Mr. Paz to explain precisely why ESI and Medco need to merge to create these beneficial programs. He listed several such programs in this and his past testimony in September, such as Medco’s Therapeutic Resource Centers, illustrating that the two companies are able and incentivized to implement these programs now. The fact remains that we do not need the merger to incentivize the PBMs to create these programs.

The resulting mega-PBM will be much different than those that were the foundation of the GAO’s 2003 study. The combined ESI/Medco will wield monopoly power while simultaneously expanding its reach into vertical profit centers such as mail-order and specialty, thereby worsening an already alarming conflict of interest. The resulting duopoly will be disincentivized from innovating for the benefit of consumers. Instead, they will be able to completely focus their attention on driving profits to the harm of the ultimate consumer, the patient.

Questions for the Record from Senator Charles E. Schumer
for witnesses at Senator Judiciary Committee Hearing on
“The Express Scripts/Medco Merger:
Cost Savings for Consumers or More Profits for the Middlemen”
December 6, 2011

- How would the merger of Express Scripts and Medco affect community pharmacists’ ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?

The proposed Express Script-Medco merger would limit the ability of community pharmacies to provide quality care and services to their patients and would particularly harm consumers located in rural communities, inner city and other underserved areas. Post-merger, Express Scripts will have a greater ability to drive down reimbursement to pharmacies below competitive levels. Cutting reimbursement to pharmacies which already operate on very minimal margin would force many pharmacies to respond by cutting back on hours, services, and employees. Also posing a serious financial threat for community pharmacies is the fact that Express Scripts-Medco will have a greater incentive and ability to drive patients away from their pharmacies of choice and into their mail order. Losing clients in this manner will furthermore impact the ability of community pharmacies to provide quality service to their patients.

This diminished pharmacy access and service will particularly harm the consumers that reside in rural communities, inner cities, and other underserved areas. Consumers in these areas often depend heavily on their local community pharmacy for a wide-range of acute health care needs. In many cases in rural or inner city communities, the local community pharmacy is the most accessible health care professional. This is why the New York legislature recently passed legislation banning employers and insurers from forcing patients to use mail order plans for prescription drugs.¹ Threatening the financial well-being of community pharmacies and their ability to serve their communities, this merger seriously harms the access rural and inner city patients have to quality pharmacy care.

- How would this merger impact patients and pharmacies in the Medicare Part D program?

Many public programs, such as Medicare Part D, have recognized the conflicts of interest and consumer harm that results from the self-dealing practices of many PBMs and have accordingly addressed these issues with “any willing provider” provisions. Medicare Part D patients will nonetheless be harmed by decreased pharmacy service and access as their local community pharmacy is forced to respond to cuts in compensation by reducing hours,

¹http://assembly.state.ny.us/lcg/?default_fld=&bn=A05502&term=2011&Summary=Y&Actions=Y&Votes=Y&Memo=Y&Text=Y.

services, and employees. Given the reduced rivalry in the PBM market, we can also expect that the major PBMs will charge public payors, such as Medicare Part D, more for their services.

Attempts to introduce transparency into the PBM process have failed. As evidenced in the March 2011 report by the Department of Health and Human Services, Office of Inspector General entitled “Concerns with Rebates in the Medicare Part D Program” Medicare part D “holds sponsors ultimately responsible for accurately reporting rebates and ensuring that their PBMs comply with CMS requirements.” However the report also concludes that plan sponsors are often incapable of adequately managing PBMs due to complex contractual relationships, lack of transparency, and asymmetric auditing practices.

Medco CEO David Snow attempted to assuage these concerns during his testimony by asserting that PBMs are regulated by every state’s board of pharmacy and every state insurance commissioner. However, as best described in a follow-up letter by the National Association of Chain Drug Stores, this is simply not the case.² Furthermore, ERISA is not designed to oversee even the most basic PBM activities, including network formulation, reimbursement arrangements, and claims processing.

Given the aggressive tactics employed by the PBMs, and the lack of regulatory oversight, one can fully expect the merger of Express Scripts and Medco to worsen an already difficult situation for Medicare Part D patients and pharmacies.

- Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?

Simply put, we cannot be sure that this merger will drive the best bargain for patients, public and private payers, and taxpayers. In fact, quite to the contrary, it is very likely that this merger will be harmful to all four. Currently there are three dominant PBMs in the industry that already engage in conduct that proves harmful to consumers at all levels, such as not passing savings on to Medicare customers, and underestimating rebates from pharmaceutical manufacturers. If this merger consummates, this harmful conduct will only be exacerbated.

The Health & Human Services Office of Inspector General report entitled “Medicaid Recovery of Pharmacy Payments from Liable Third Parties” captures some, but not all, or the tactics employed by large PBMs to exploit their ability to exploit their unique position. For instance, PBMs may make it extremely hard to submit a claim, impose

² Letter from Steven C. Anderson, President, NACDS, to the Honorable Senator Herb Kohl, December 13, 2011, available at <http://www.nacds.org/user-assets/pdfs/2011/newsrelease/Comments%20to%20SJC%20on%20PBM%20merger.pdf>.

unreasonable time restrictions, or compel the State to submit information several times before awarding a claim.³

It is important to reemphasize the inherent conflict of interest that PBMs face. On one hand, they provide an intermediary service designed to aggregate bargaining power with the goal of lowering the prices paid to pharmaceutical manufactures and retail pharmacies. On the other hand, they own and operate mail order pharmacies and they have an incentive to maximize the revenues of the mail order facilities. The natural result is an entity that wields significant bargaining power, but passes on only the bare minimum savings to the consumer health plans and Medicare purchasers. Only competition in the market can provide sufficient incentive for PBMs to pass through a greater portion of the savings to the consumers. This merger would eliminate competition, further incentivize the PBMs to pass through fewer savings to consumers, and ensure greater struggle for state Medicare purchasers to obtain full value from their PBM in the future.

With respect to rebates, there is conflicting information. Medco has stated in its 10K filing with the SEC that it only keep 12.5% of the rebates for itself, and presumably passes the other 87.5% on to consumers. However, the Health & Human Services Office of Inspector General report entitled "Concerns with Rebates in the Medicare Part D Program" calls this reporting into question. This report finds that sponsors often have "complex contractual relationships"⁴ that lack transparency, thereby suggesting that there is no accounting or verification mechanism for filings claiming to offer such high pass through rates. Furthermore, this report also notes that "sponsors received rebates when they encouraged beneficiaries to use certain drugs." This means that rebates are not automatically granted to PBM clients, but rather are conditioned upon selecting certain drugs, which may or may not prove to be the most cost-effective or therapeutic. Such a finding calls into question not only the PBMs' ability to manage their conflict of interest, but also their commitment to offering the highest level of care to consumers.

³ Department of Health and Human Services, Office of Inspector General, "Medicaid Recovery of Pharmacy Payments from Liable Third Parties" at 9.

⁴ Department of Health and Human Services, Office of Inspector General, "Concerns with Rebates in the Medicare Part D Program" at ii.

“The Express Scripts/Medco Merger: Cost Savings for Consumers
or More Profits for the Middlemen?”
Questions for the Record submitted by Senator Charles E. Grassley

Questions for Mr. Michael Bettiga:

1. Brick and mortar pharmacies offer important on-site services to customers in the form of reliable direction on dosage and proper use. Some are concerned that the merger will result in more prescriptions being delivered to patients via mail-order. This means consumers may be deprived of face-to-face interaction with their pharmacist. Alternatively, mail order patients may still reach out to local pharmacists who give time and expertise, yet derive no income from the transaction.
 - a. Do you agree with those that say the merger will lead to increased mail-order delivery of prescription medications?

Response: Absolutely, the track record of PBM’s driving prescriptions to their own mail order facilities is irrefutable. In addition the practice is inherently anticompetitive. PBMs determine the income received by pharmacies (by setting pharmacies’ reimbursement rates) and then drive prescriptions to their own mail order facilities, in part by co-pay designs that favor mail order. PBMs already design prescription benefit plans that *require* patients to use the PBM’s *own* mail order facility, or set the retail co-pays so high that patients’ only real choice is to use mail order.

We believe that the merged entity’s ability to shift patients to their mail-order operations will have a direct and harmful impact on patients. It will allow the mega-PBM to limit consumers’ access to their local pharmacies and the vital healthcare services and one-on-one counseling they provide. In addition to dispensing prescriptions, pharmacists counsel patients on a daily basis to ensure that they take their medications as directed by their doctors. They also provide a broad range of critical, cost-effective services such as immunizations, counseling for diseases such as diabetes, and other health education and screening programs. These high quality services result in increased therapeutic benefits of prescription drugs, which improve health outcomes and lower costs. There is simply no substitute for the in-store, face-to-face services provided by community pharmacists.

In addition, mail order businesses consistently dispense more costly brand name drugs and fewer generics than retail community pharmacies. Shifting more patients to mail order lowers the rate of generic dispensing and in turn, increases drug costs. This increased cost will fall on health plans, employers and ultimately, consumers, not PBMs.

However, we do not oppose all mail order pharmacy. We support patient choice. We believe that our patients should have the option of getting their prescription drugs at

our retail locations *or* by mail order, whichever method they prefer. We believe that the merged entity will have greater leverage to require or coerce patients to use their own mail order pharmacy as opposed to providing patients a choice.

- b. How can an individual, who receives mail order drugs, ensure that there are no conflicts with other medicines he or she is taking?

Response: Although mail order pharmacy conducts drug utilization review (“DUR”) to check for adverse interactions, the mail order pharmacist does not necessarily have all the information necessary to conduct a thorough review and lacks the ability to engage in critical face-to-face interaction. If a person chooses the mail order option, they should use the same pharmacy for both mail service and face-to-face service. Retail pharmacies provide both. This way, they can be sure that the pharmacy has their full prescription record.

How does a machine processing prescriptions in another state know this kind of information?

Response: It simply does not have this valuable information. Since PBM mail order pharmacies do not have pharmacists in the patients’ communities, there is no option of a face-to-face interaction between patients and their trusted pharmacists. In contrast, chain pharmacies that have mail order operations provide their pharmacists access to a patient’s record regardless of which location the patient uses.

2. I’m told about 15% of prescriptions are disbursed by mail order. This means about 85% of prescriptions are filled by a pharmacist.
- a. Has there been an overall increase in medications delivered by mail-order or has the number, or percentage, stayed the same over the years?

Response: Mail order expenditures have increased every year since NACDS started tracking them in 1992, and mail order prescriptions have increased every year except 2009.

- b. What types of medications are disbursed via mail order?

Response: Generally, medications for chronic conditions are provided via mail order. It is therefore extremely important for these patients to receive pharmacy services, including medication therapy management and face to face counseling services. Indeed, there is much anecdotal evidence of patients with chronic conditions not adhering to their medication regime to the detriment of their health and healthcare costs generally.

- c. Are all prescriptions appropriate for mail-order delivery?

Response: No, there are a wide variety of medications that are not appropriate for

mail order. Examples include: medications that are needed immediately, medications for acute conditions, medications that require special care and handling, medications that require a face-to-face discussion, medications that require counseling, situations in which a patient needs medication therapy management, and situations in which the pharmacist administers the medication such as immunizations.

Most medications should not be subject to temperature extremes and should not spend hours in blazing hot or freezing cold mailboxes at patients' homes. A number of medications must be kept in a constant state of refrigeration or be kept frozen prior to administration. The mail order option should be used judiciously and should be subject to the patient's choice.

If not, is this expected to change in the future?

Response: This is not expected to change.

- d. Has the industry reached a point where all drugs suitable for mail-order are now shipped via the mail?

Response: Despite PBMs' heavy-handed attempts at requiring patients to use, or steering patients to mail order, most patients still prefer to visit their local pharmacy and have a face-to-face interaction with their pharmacist. Allowing these entities to merge into a mega-PBM with massive mail order capacity will not change patients' needs or preferences for the beneficial services provided by local, community pharmacies that cannot be matched by PBM mail order operations.

Sen. Kohl's Follow-Up Questions for the Record for Hearing on
"The Express Scripts/Medco Merger: Cost Savings for Consumers
Or More Profits for the Middlemen?"

For Mike Bettiga

1. What percentage of your pharmacy business is through the big 3 (Express Scripts, Medco and CVS Caremark) PBMs?

Response: Currently, 46.2% of our business is through the Big 3 PBMs.

2. What is your response to the PBMs' argument that need thriving pharmacies in order to serve consumers, so they have no desire to threaten your business?

Response: Pharmacies are in direct competition with PBMs that own their own mail order pharmacy, which all of the largest ones do. PBMs prefer to have fewer pharmacies because that would mean less competition, and more business, for their own mail order and specialty pharmacies. Even if PBMs provide pharmacy networks to their customers, the plans and employers, they include terms in their agreements with them to drive patients to their own mail order pharmacy. It is the equivalent to allowing coffee shop X to set prices for coffee shop Y to ensure customers go to coffee shop X. I am hard pressed to think of any other industry or commercial relationship where this occurs.

3. Should the FTC decide to approve the merger, would you recommend the FTC require any conditions to preserve competition?

Response: Although there are many potential restrictions that could be discussed with the FTC and state attorneys general, such as divestiture of specialty pharmacies and mail order pharmacies, we could never completely eliminate the anticompetitive impact of such a massive merger and the ultimate impact it will have on critical patient access to community pharmacies and the services that they provide.

4. If the FTC does not approve the merger, pharmacists would still be dealing with three large PBMs with a significant share of the market. How would the situation for pharmacists be worse with two large PBMs as compared to three?

Response: The problems we are experiencing with PBMs would only get worse with this proposed merger. We believe that the merger of two of the three largest PBMs will harm the patients we serve by reducing choice, decreasing access to pharmacy services and ultimately leading to higher prescription drug costs paid by consumers and plan sponsors. The largest PBMs already control the vast majority of the prescription benefits for large national health plans, which provide benefits for our patients. Refusing a contract with one of the Big 3 PBMs would mean decreased patient access to community pharmacies and the valuable pharmacy services we provide.

In addition, the large PBMs – including Express Scripts and Medco – already use their existing market share to dictate contract terms, including plan design, benefit structure, and pricing. Among the business practices for the current two separate PBMs are “take it or leave it” contracts without any form of negotiation even for organizations the size of Shopko. We expect that situation would worsen considerably with a merged entity. That is one key reason we oppose the merger and are seeking legislative relief on PBM practices. Less competition among PBMs will provide them with greater ability to dictate contract terms to health plans and employers. This will allow them to keep even more of the healthcare dollar and increase costs for everyone in the healthcare system. We need more – not less – competition among PBMs to ensure that patients have choice and access to pharmacy services, as well as affordable prescription drug prices.

Senator Mike Lee
Questions for the Record
Michael J. Bettiga, National Association of Chain Drug Stores

1. In your written testimony, you state that “[t]he ability of PBMs to drive prescriptions to their own mail order facilities is inherently anticompetitive.” In a 2005 report, the Federal Trade Commission concluded: “[T]he prices for a common basket of prescription drugs dispensed by PBM-owned mail order pharmacies were typically lower than the prices charged by retail pharmacies. The study also found competition affords health plans substantial tools with which to safeguard their interests. Consumers benefit as a result.”
 - a. Do you dispute the FTC’s findings?

Response: We believe that some of the FTC’s conclusions are flawed because PBMs set the prices that are paid at both mail order and retail pharmacies that participate in their network. They steer patients to their own mail order pharmacies by misappropriating patient information and setting the prices higher at retail pharmacies.

PBMs often boast that discounts for mail order drugs are greater than retail. In practice, however, they may not be cheaper. PBMs limit competition by (a) refusing to allow other mail order pharmacies to fill prescriptions for their client plans, (b) refusing to allow community pharmacies to dispense the same 90-day supplies dispensed by PBM-owned mail order facilities, (c) making retail pharmacies appear more expensive to *consumers* by charging higher patient co-pays that are incommensurate to any alleged difference in the true costs of mail and retail, and (d) making retail pharmacies appear more expensive to *plans* by charging a large spread for drugs dispensed by retail pharmacies and using that spread to subsidize lower prices for the PBM-owned mail order pharmacy, thus making the mail order pharmacy *appear* less expensive. PBMs with their own mail order facilities also increase their profits through practices such as repackaging medications into smaller packages, but charging the same or more for the drugs under a custom, PBM-established National Drug Code (NDC).

With respect to competition, PBMs claim that there is plenty of competition in their industry. In reality, most large employers and health plans rely on the Big 3 PBMs to manage their prescription benefits. For example, 42 of the Fortune 50 are serviced by the Big 3 PBMs. It is unrealistic to think that the regional smaller PBMs have the size and scale to effectively compete for this business now or in the future.

- b. On what is your opinion based that PBMs drive prescriptions to mail-order?

Response: We base our opinion on the interactions we have with PBMs. We see on a daily basis the plan designs that economically coerce patients to use their own mail order pharmacies. PBMs design the benefits so that patients and plans have lower costs when they use the PBM's own mail order pharmacy because they do not allow retail pharmacies to meet this pricing.

2. In your written testimony, you state that "there is no proof that PBMs pass along any savings to plans, employers, or patients."

- a. Do you dispute the assertion of PBMs that many of their contracts specifically provide for a certain percentage of pass through of savings?

Response: PBMs play games with the meaning of "rebates" and "savings." Since PBM operations are opaque, it is impossible to determine exactly how much savings they actually generate. PBMs generate revenue, and keep a substantial portion for themselves. They use excessively complicated accounting schemes that make it impossible to objectively determine what portion of their revenue can be attributed to "rebates" or "savings."

- b. What data or other information would be necessary for PBMs to establish the portion of costs that they are passing through?

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

Questions for the Record from Senator Charles E. Schumer

for witnesses at Senator Judiciary Committee Hearing on

“The Express Scripts/Medco Merger:

Cost Savings for Consumers or More Profits for the Middlemen”

December 6, 2011

- How would the merger of Express Scripts and Medco affect community pharmacists’ ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?

Response: The problems we are experiencing with PBMs would only get worse with this proposed merger. We believe that the merger of two of the three largest PBMs will harm the patients we serve by reducing choice, decreasing access to pharmacy services and will ultimately lead to higher prescription drug costs paid by consumers and plan sponsors. The largest PBMs already control the vast majority of the prescription benefits for large national health plans, which provide benefits for our patients. Refusing a contract with one of the Big 3 PBMs would mean decreased patient access to community pharmacies and the valuable pharmacy services we provide. In addition, the large PBMs – including Express Scripts and Medco – already use their existing market share to dictate contract terms, including plan design, benefit structure, and pricing. Today, among the common business practices for the current two separate PBMs are take it or leave it contracts without any form of negotiation, even for organizations the size of Shopko. We expect that situation would worsen considerably with a merged entity. That is one key reason we oppose the merger and are seeking legislative relief on PBM practices. Less competition among PBMs will provide them with greater ability to dictate contract terms and network rates to health plans, employers and community pharmacy. This will allow them to keep even more of the healthcare dollar and increase costs for everyone in the healthcare system. We need more – not less – competition among PBMs to ensure that patients have choice and access to pharmacy services, as well as affordable prescription drug prices.

This issue is exacerbated in rural communities, inner cities and other underserved areas. This will result in a significant reduction in consumer access to neighborhood pharmacies and at a minimum, reduced choice and convenience. This will not only deprive patients of valuable healthcare services offered by pharmacists, it will directly impact the services pharmacies are able to provide. For instance, it could lead to pharmacies having to close or reduce hours and services, such as less time to consult with patients and longer wait times.

- How would this merger impact patients and pharmacies in the Medicare Part D program?

Response: The impact on public programs would be similar to the effects on private payors and health plans. There will be fewer choices for these programs, and higher prescription drug costs for patients and taxpayers. The Medicare Part D prescription drug benefit continues to operate below Congressional Budget Office projections. Competition and choice are key elements in the success of the Part D plan, and this merger would reduce these critical factors.

- Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?

Response: The merger must be blocked to assure that competition in the large PBM market remains. This would provide the best opportunity for the free enterprise system to work and offer the best bargain for beneficiaries and taxpayers.

**Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer Rights
Hearing on the Express Scripts/Medco Merger
December 6, 2011**

Responses for the Hearing Record

George Paz, Chairman & CEO, Express Scripts, Inc.

Questions for the Record by Senator Herb Kohl

Question 1: It is well understood that Express Scripts and Medco are direct head-to-head competitors. One of the big issues arising out of this merger is the loss of head-to-head competition between your two PBMs. The merger's critics are particularly concerned with its impact on the nation's largest employers and plan sponsors who contract with PBMs for their prescription drug benefit. We understand that you contend that there are many other PBMs who are competitors in the marketplace. However, many believe that the "Big 3" PBMs – Express Scripts, Medco, and CVS Caremark – are the only PBMs that have the scale and offer the services necessary for the nation's largest employers. Indeed, 42 of the top Fortune 50 companies use one of these "Big 3" PBMs. If this is true, this merger will reduce the number of PBMs serving the biggest national employers from three to two.

(a) Why is it that Express Scripts, Medco and CVS Caremark have such a high share of the PBM business of large employers and plan sponsors?

(b) Do you really believe the "second tier" PBMs can serve the nation's largest employers? In the last five years, how many Fortune 100 companies that were your clients have switched to a PBM other than one of the "Big 3"?

(c) For large employers and plan sponsors who can't use smaller PBMs, won't this merger leave them with little choice for PBM services, and vulnerable to higher fees because there will be little incentive to pass on drug price discounts?

Answer 1: We note that because a company's ranking on the Fortune 500 list is based on revenue, not on employee population or the amount of employee prescription drug coverage it purchases, looking at group size is also instructive. By Express Scripts' estimates, more than 40 different PBMs have competed for the large groups (50,000+ lives) that have gone out to bid over the past five years, making clear that this customer segment is highly competitive. Moreover, PBMs have the capability to serve all customer segments—large and small. PBMs offer similar services to their customers regardless of their size. Express Scripts serves no more than a handful of the Fortune 50 companies.

- (a) Express Scripts does not have a large concentration of Fortune 50 accounts.
- (b) PBMs of all sizes have the ability to grow and reposition. In the past five years, we have lost 14% of our Fortune 100 clients—all to PBMs other than Medco or CVS Caremark.
- (c) Express Scripts believes that the marketplace for PBM services will remain robustly competitive after the merger.

Question 2: Ms. Sutter and Mr. Bettiga testified at the hearing that your merger will make it much more difficult for traditional pharmacies to compete. What is your response? Does your business model to encourage mail order threaten the pharmacy business? And do we risk losing traditional pharmacies, and the counseling and customer service benefits that goes with a visit to the local pharmacy?

Answer 2: A primary factor influencing Express Scripts' ability to negotiate favorable retail pharmacy dispensing rates is the location of the pharmacy. If it is an urban area with many retail pharmacies, Express Scripts generally is able to negotiate more favorable rates. If it is a rural area—typically served by independent pharmacies—Express Scripts is unable to negotiate as favorable a rate because we need to have these pharmacies in our network to meet contractual and regulatory access standards. This will not change with the merger and we are not at risk of losing traditional retail pharmacies because of the merger. Moreover, the decision whether to allow, encourage or favor mail order is made by the plan sponsor, not the PBM. However, we do view mail order as a lower cost, safer pharmacy option for consumers.

Question 3: (a) According to industry estimates, after this merger the combined Express Scripts/Medco will control about 60% of the mail order business. Should we worry about this high level of concentration in the mail order marketplace? What would you say to your critics who have concerns about competition in the mail order business?

(b) Some of the merger's critics argue that this level of concentration gives your PBMs an incentive to unduly direct consumers to utilize mail order services. What is your response?

Answer 3: (a) Mail order pharmacy competes with retail pharmacy for prescriptions. Therefore, the more appropriate way to look at the marketplace would be to analyze the total prescription revenue. A recent analysis by Pembroke Consulting estimates that a combined Medco and Express Scripts mail order volume—without accounting for the significant public losses that Medco has announced such as United, CalPers, the Federal Employees Program, IBM and BCBS of North Carolina—will still not be as large as either CVS or Walgreens 2011 retail prescription revenue¹.

¹ Pembroke Consulting, Largest U.S. Pharmacies Ranked By Total Prescription Revenues 2011E, 2012. Available at: <http://www.pembrokeconsulting.com/pdfs/Pembroke-Pharmacy-Market-Share-2011E.pdf>

Largest U.S. Pharmacies Ranked by Total Prescription Revenues, 2011E

Company	Stock Ticker	Filmmoid, 2011 Prescription Revenues ¹ (billions)	Share of 2011 Prescription Revenues	Primary Dispensing Format
CVS Caremark Corporation	CVS	\$40.5	14.8%	Chain drugstore
Walgreens Pharmacy	WAG	\$16.1	5.9%	Mail order pharmacy
Walgreen Company	WAG	\$45.3	16.5%	Chain drugstore
Medco Health Solutions, Inc.	MHS	\$25.8	9.5%	Mail order pharmacy
Wal-Mart Stores, Inc. ²	WMT	\$17.4	6.4%	Mass merchant with pharmacy
Rite Aid Corporation	RAD	\$17.3	6.3%	Chain drugstore
Express Scripts, Inc.	ESRX	\$19.9	7.1%	Mail order pharmacy
The Kroger Company	KR	\$7.0	2.6%	Supermarket with pharmacy
Safeway, Inc.	SWY	\$1.7	0.6%	Supermarket with pharmacy
Target Corporation	TGT	\$3.0	1.1%	Supermarket with pharmacy
Sears Holding Corporation ⁴	SHLD	\$2.4	0.9%	Mass merchant with pharmacy
Supervalu Inc.	SVU	\$2.3	0.9%	Supermarket with pharmacy
All other chains	n/a	\$11.1	4.2%	various
Independent Pharmacies	n/a	\$45.8	16.7%	Independent drugstores
Total		\$273.4	100.0%	

Total may not sum due to rounding.

1. Includes revenues from all pharmacy formats.

2. Excludes revenues from 90-day Maintenance Choice claims filled in CVS retail pharmacies. These revenues are included in Retail Pharmacy.

3. Includes Walmart and Sam's Club stores.

4. Includes Sears and Roebuck.

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(b) Mail order penetration has remained constant over the past decade. It has been the large retail chain drugstores that have grown their market share. Moreover, whether to allow, encourage or favor mail order is a plan sponsor decision.

Question 4: In her written testimony, Ms. Sutter brought forward substantial evidence of waste resulting from mail order shipments of prescription drugs, including allegations that patients on many occasions could not get their PBM to cease shipping unneeded drugs. What is your response to these reports of substantial waste in your mail order business? Do PBMs have an incentive to ship prescription drugs to consumers, whether they need them or not? Don't you get paid for every prescription you mail out?

Answer 4: The waste issue that Ms. Sutter raises is not a mail order pharmacy issue, but rather a larger issue of American society using large amounts of prescription drugs—some appropriately, some inappropriately. Express Scripts has been at the forefront of exploring ways to minimize inappropriate prescription drug overutilization. We were one of the first PBMs to support CMS' decision to move to short-term fills for long-term care residents within the Medicare Part D program. We are not incented to ship drugs to consumers whether they need them or not. We not only do not get paid for shipping drugs that are not ordered, we cannot return the drugs to stock and therefore lose the ingredient cost of the drugs. Inappropriately shipping unordered drug product would be a costly business model.

Question 5: (a) Specialty drugs are an increasingly important component of medical costs. Generally, these drugs are distributed more narrowly than other pharmaceuticals, often on an exclusive or semi-exclusive basis. How will the merger affect the cost and availability of specialty drugs?

(b) What steps would the new, merged company take to ensure that specialty drugs will be distributed in a way that there will not be supply shortages and that prices for these drugs won't increase for consumers?

(c) What assurances can you give us that the new company will not limit distribution of, or charge very high rates for, specialty drugs to competitors who also must distribute or help make these drugs available to consumers at competitive prices?

Answer 5: Specialty medications are used to treat patients with chronic, serious health conditions. While only 1% of plan sponsors' members utilized specialty drugs, the average price in 2010 was \$2,080 per prescription².

(a) Specialty medications that are distributed on an exclusive or limited basis represent a small (approximately 5%) portion of specialty drugs. It typically occurs when the pharmaceutical manufacturer—either by decision or because the FDA has mandated it—seeks to limit the number of pharmacies that handle the drug. A manufacturer's decision to limit distribution could be due to a variety of factors: strict FDA REMS conditions, limited patient base, or particular pharmacy clinical capability. Express Scripts competes for this business just as other pharmacies do, and we typically compete on clinical capabilities, not on size.

(b) The merger itself will have no impact on supply or prices for these drugs. Pharmaceutical manufacturers, not PBMs or specialty pharmacies, determine how limited or exclusive drugs are distributed. The manufacturer makes provisions to ensure that the drug is available to all patients on similar terms regardless of which specialty pharmacy is awarded distribution.

(c) Again, the manufacturer when awarding limited or exclusive distribution arrangements makes provisions to ensure that the product is available to all patients on similar terms. Therefore, the merger itself will have no impact on the availability of these drugs.

Question 6: (a) In the last few days my staff has received a number of reports from some pharmacists that Express Scripts and other PBMs were directing them to fill prescriptions with Lipitor rather than its generic alternative. One pharmacist reported to us that, because Lipitor is more expensive than the generic, [QUOTE] "the healthcare system is paying a minimum of \$63.26 more each time the brand [name drug] is dispensed instead of the generic." Why have we been receiving these reports? Is it true that directing pharmacies to fill prescriptions with Lipitor rather than its generic alternative will cost plan sponsors, Medicare or other payors more than utilization if the generic drug was prescribed?

² Express Scripts, Inc, 2010 Drug Trend Report, 2011. Available at: <http://www.express-scripts.com/research/research/dtr/archive/2010/dtrFinal.pdf>

(b) I have also received reports from pharmacists indicating that Express Scripts denied a Medicare Part D donut hole patient generic Lipitor in favor of branded Lipitor. According to the pharmacist that shared the data and claim forms, the patient was charged the branded, more expensive co-pay. Is Express Scripts denying generic Lipitor for its beneficiaries, particularly those in the Medicare Part D plan? And if so, for these patients in the donut hole, are they paying more for the brand name drug than they would for the generic alternative? Or was the data my office received an isolated incident?

Answer 6: Recent press reports have highlighted Pfizer's effort to maintain market share on the blockbuster atorvastatin, Lipitor® that went generic on November 30, 2011. As you may know, typically when a branded pharmaceutical moves to the generic class, the first-to-file generic manufacturer receives 180-days of market exclusivity. During this initial time period—in the case of atorvastatin, until May of 2012—only the branded drug Lipitor, the first-to-file generic atorvastatin produced by Ranbaxy, and an authorized generic produced by Watson will compete in the marketplace with prices moderating only slightly. It is not until multiple competitors enter in the market in the middle of 2012 when competition will be sufficient for the price of atorvastatin to significantly drop.

(a) It is not necessarily true that plan sponsors are paying more for branded Lipitor®. In fact, they may realize some short term savings. Pfizer approached Express Scripts with an offer of enhanced rebates that would initially make the net cost of Lipitor® less expensive than generic atorvastatin in exchange for covering branded Lipitor on the first tier of the pharmacy benefit instead of the generic. And, as such, we took this offer to our clients as it is ultimately the plan sponsor's decision whether to accept and implement it. However, when communicating to our clients, we recommended against the Lipitor rebate offer for the following reasons:

- (i) A simple "use generics" message to members is a cost savings in the long run for the payer and less risk of member or retail pharmacy confusion on the generic issue.
- (ii) The cost savings at launch are small for the Lipitor rebate option. Moreover, if the generic price of atorvastatin becomes lower during the 180 days of market exclusivity, plan sponsors might end up paying higher costs by selecting the Lipitor rebate option.
- (iii) Given the presence of a Pfizer Lipitor \$4 copay program, market share may be more difficult to move to the generic after the 180 day period of exclusivity expires. Therefore we view the lower the brand share, the better.

Two of our clients have elected to accept Pfizer's rebate offer. For these clients, Lipitor has been placed on the first tier in exchange for deeper rates and the generic will not be

covered. These were client decisions; Express Scripts is merely implementing our clients' benefit design choice.

(b) Of the two clients of ours that accepted the Pfizer enhanced rebate offer, both are charging members less for using the branded Lipitor® than generic atorvastatin. However, one of the clients is treating branded Lipitor® as a preferred brand (tier II) and generic atorvastatin as a non-formulary brand (tier III). Therefore, it is possible that the member of that one client paid a branded copayment—albeit less than what they would have paid for generic atorvastatin. As mentioned above, Express Scripts recommended against the Pfizer rebate offer. However, it is ultimately a plan sponsor decision.

Question 7: In answering a question from me at the hearing, you stated that “the majority of the synergies in this transaction are not coming from the supply chain. They are coming from efficiencies.” Can you describe with specificity what you meant by “efficiencies,” and provide an estimate of the amounts being saved by each “efficiency.”

Answer 7: Express Scripts reiterates that the majority of the synergies in this transaction are not coming from the supply chain. Express Scripts has publicly, conservatively stated that we expect the merger to yield more than \$1 billion in synergies. These come from such areas as combining best practices in direct processing, applying Express Scripts' industry-leading generic penetration capabilities to Medco's client base, eliminating system redundancies, leveraging our productivity and processes across a larger organization, unifying our compliance functions, unifying our information technology platforms, and reducing selling, general and administrative expenses (SG&A). Some efficiencies will also come from improved ability to secure discounts and price concessions from sectors such as pharmaceutical manufacturers and wholesalers, but it is not the majority of the synergies. Express Scripts is sharing detailed information about the expected efficiencies this merger will create with the Federal Trade Commission, but is unable to make them a part of the public record at this time.

Question 8: You testified at length at the hearing that you would pass through any savings you realize from the merger on to your customers. But how do we know that? You have no legal obligation to pass these savings along, do you?

Answer 8: Express Scripts' and Medco's customers will realize savings associated with the merger, some of which Express Scripts will pass onto clients pursuant to contract. In addition, our business model of alignment, whereby we make money when our plan sponsors save money, will ensure that additional savings are passed on. For example:

(a) To the extent we are able to negotiate larger pharmaceutical manufacturer rebates and discounts, and our current client contracts are structured to pass on a percentage of those savings, the client will automatically see savings with the integrated entity.

(b) To the extent the combined company will operate more efficiently—particularly with respect to administrative costs, IT costs and regulatory compliance—the overall operating costs should decrease leading to a lower administrative fee for clients.

(c) By combining our two companies' clinical capabilities, we hope to attack the largest part of pharmacy waste: therapy adherence. By our estimates, not taking medicines as directed leads to as much as \$300 billion in additional costs to the health care system each year. Combining the best-in-breed of our companies clinical programs will help reduce costs over the intermediate and long term.

(d) Applying Express Scripts' industry leading generic penetration capabilities to Medco's client base should lower drug spend for those clients.

Question 9: Are there any conditions on this merger you would accept in order to secure its approval at the FTC?

Answer 9: It would be inappropriate for Express Scripts to speculate on what sorts of conditions the Federal Trade Commission might seek, but Express Scripts does not believe any remedies are warranted.

Questions for the Record by Senator Mike Lee

Question 1: I have heard concerns expressed by pharmacies that they do not have sufficient bargaining power in their negotiations with PBMs such as your company. Some point to Walgreens' failed negotiations with Express Scripts as an example of insufficient bargaining power on the part of pharmacies.

(a) How would the merger affect your interactions with pharmacies and what you are ultimately able to offer consumers?

(b) Do you feel that you need more bargaining power in your interactions with pharmacies?

Answer 1: We expect that our merger will have a positive effect on pharmacies from an operational, day-to-day perspective. The combined company should be able to achieve efficiencies in implementing the myriad legislative and regulatory changes that occur in government programs such as Medicare Part D and Medicaid—many of which affect pharmacies as down-stream entities. Due to access standards contained in client contracts and mandated by the government, pharmacy reimbursement is driven by the number and location of retail pharmacies. In rural areas where pharmacies may be less prevalent, we are less able to negotiate lower rates, and pharmacies in those areas typically command premium reimbursement.

We believe that the marketplace should determine reimbursement. Legislative proposals such as “any willing pharmacy” which mandate all pharmacies must be in network have the well-documented effect of increasing plan sponsor and patient costs³⁴⁵ because pharmacies do not have to compete on price to be included in the network.

Question 2: It is my understanding that only a few PBMs serve most of the Fortune 50 companies.

(a) How much of your overall business comes from this segment of the market?

(b) Do you view this segment of the market as competitive, and if so who are the other PBMs that you see as competing with you for these large contracts?

Answer 2: Express Scripts currently serves approximately 16% of the Fortune 50 companies. By Express Scripts’ own figures, more than 40 different PBMs have competed for the large groups (50,000+ lives) that have gone out to bid over the past five years. Moreover, PBMs have the capability to serve all market segments—large and small. PBMs offer similar services to their customers regardless of their size. As you may know, there are currently more than 20 PBMs serving the Fortune 500. In addition to Medco and CVS Caremark, we see significant competition from PBMs such as United, Catalyst, SXC Corporation, Cigna and Prime Therapeutics to name just a few.

Question 3: Can you please clarify your views of independent community pharmacies and discuss how the merged entity would ensure that consumers are receiving the services they need from community pharmacies?

Answer 3: We value independent community pharmacies. They are a critical component of our service offering. The combined company will ensure that consumers continue to receive services from the community pharmacy of their choice or risk losing our customers to other PBMs.

Question 4: I have heard concerns expressed that the merged entity could design prescription drug plans that economically force patients to use mail order or unfamiliar pharmacies for certain medications, thus diminishing and fragmenting patient care.

(a) Do PBMs currently pressure customers to use mail-order services or other pharmacies that may be unfamiliar to the consumer?

³ Lewin Group, Mail-Service Pharmacy Savings and the Cost of Proposed Limitations in Medicare and the Commercial Sector, 2006. Available at: <http://www.lewin.com/content/publications/3480.pdf>.

⁴ C. Durrance, The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures, *Atl Econ J*, 2009; 37: 409-423.

⁵ GAO, Medicare: Modern Management Strategies Could Curb Fraud, Waste and Abuse (GAO/T-HEHS-95-227, July 31, 1995), available online at <http://archive.gao.gov/t2pbat1/154851.pdf>.

(b) Would the merger in any way affect the manner in which your company structures its contracts with plan sponsors with respect to mail-order services?

Answer 4: The use of mail order has grown over the past decade, but at a rate lower than retail pharmacy. In fact, according to Atlantic Information Services (AIS), total adjusted annual mail-order volume as of first-quarter 2011 was 776 million scripts, a 16% increase over the prior-year figure of 668 million. However, the increase in mail volume lags behind a 20% increase in total volume. Mail-order penetration — the percentage of total scripts filled via mail — has historically remained fairly stable. It is currently 16.32% industry wide. We do not economically force patients to use mail order. Whether to allow, promote or require mail order is a plan sponsor decision, not a PBM decision. Although, many plan sponsors do promote home delivery for its lower costs, convenience, and increased patient safety. After the merger, plan sponsors will continue to make mail order and retail pharmacy network decisions.

Question 5: At the hearing, Susan Sutter expressed concern that a low percentage of clients were exercising their contractual audit rights. Ms. Sutter expressed concern that the low rate of audits was due to contractual terms that require clients use auditors agreed to by the PBM.

(a) How often do clients perform audits of your company?

(b) Do your contracts contain clauses requiring that audits be performed only by auditors agreed to by your company?

(c) Will the merger affect the number of audits performed or the contractual clauses with your clients regarding audits?

Answer 5: As a community pharmacy owner, Ms. Sutter would have very little insight on how often Express Scripts' clients audit us. Of course, how often clients perform an audit is a client decision and varies by client. In 2011 alone, we were audited over 800 times by clients and the government. Under Medicare Part D, CMS is required to audit every plan at least once every three years. The Department of Defense conducts audits of its TRICARE program on an annual—as well as on-going—basis. Express Scripts also regularly engages a national accounting firm to audit ourselves at a global level. We make these audit findings available to clients upon request. Our contracts do not contain clauses requiring that audits be performed only by auditors approved by Express Scripts. Our only requirements for any auditing firm/entity is that they be independent, not affiliated with any pending litigation against us, and that they sign a confidentiality agreement. We expect that the number of audits performed will continue to rise in the coming years. This is due, in large part, to provisions contained within the health reform legislation rather than being merger-specific.

Question 6: I have heard concerns expressed about the effect of the merger on consumer access to specialty drugs.

(a) How do you define the market for specialty drugs, and what share of that market would the merged entity have?

(b) In what ways do you view the merger as allowing you to provide better prices and care to the consumer with respect to specialty drugs?

Answer 6: According to Pembroke Consulting⁶, Express Scripts and Medco would have approximately 31% share of specialty pharmaceutical (as defined by Pembroke) revenues..

Company	Estimated 2010 Specialty Revenues (\$ Billion)	Share of Specialty Revenues
CVS Caremark	\$9.7	25%
Medco (Accredo)	\$7.9	20%
Express Scripts (Caratscript)	\$4.4	11%
Walgreens	\$3.5	9%
BioScrip	\$1.2	3%
Diplomat Specialty Pharmacy	\$0.6	2%
All other retail and specialty pharmacies	\$11.9	30%
Total	\$39.2	100%

Totals may not sum due to rounding. Includes revenues from retail, specialty, and mail pharmacies. Excludes revenues from network pharmacies of PBM-owned specialty pharmacies. Sources: 2011-12 Economic Report on Retail and Specialty Pharmacies, Pembroke Consulting, forthcoming. Published on Drug Channels (<http://www.drugchannels.net>) on December 2, 2011.

PEMBROKE CONSULTING December 2011

It is important to understand that specialty pharmacies compete with retail pharmacies, mail order pharmacies, wholesaler specialty pharmacies, physician offices, outpatient clinics, infusion clinics, in-home nursing care, and in-patient hospital settings in addition to other specialty pharmacies. We believe the combined company will enhance care for patients utilizing specialty drugs. These patients are typically more complex and require more frequent, individualized dosing as well as specialized case management. We are excited about combining Express Scripts' and Medco's complementary clinical programs to create an enhanced offering. We do not suspect that the merger will immediately lower the cost of specialty medications as the drugs are mostly one-of-a-kind, patent-protected therapies. However, we could envision lower costs over time, particularly if the biosimilars marketplace develops.

Question 7: A few witnesses at the hearing asserted that there is no evidence that PBMs pass cost savings through to their clients.

(a) What evidence is there that your company passes through cost savings to its clients?

⁶ Pembroke Consulting, Pharmacy Revenues from Specialty Pharmaceuticals, by Company, 2010, 2011. Available at: <http://www.drugchannels.net/2011/12/pharmacy-market-share-for-specialty.html>

(b) How can consumers be assured that cost savings or other efficiencies from this merger will ultimately benefit them?

Answer 7: Statements asserting that PBMs don't pass cost savings onto clients are typically made by those who do not understand how prescription drug benefits are offered and delivered. When seeking PBM services, plan sponsors often ask for two types of bids: a pass-through bid and a lock-in bid. The pass-through bid guarantees the client all the savings the PBM secures and the PBM gets paid an administrative fee for their services. The lock-in bid guarantees the client a set level of savings and the PBM retains any additional amounts in lieu of an administrative fee. PBMs must aggressively bid discounts if they wish to win the business versus having it awarded to another company. Government clients typically elect pass-through arrangements because they prefer more detailed information. Commercial payers more often choose lock-in because it aligns the PBM to drive more aggressive price reductions. All price discounts and concessions are agreed to in advance of awarding the PBM contract for services and clients are given audit rights to ensure they received the discounts they are entitled to. In the case of Medicare Part D, consumers directly benefit from this competitive PBM landscape through lower program costs and premiums. In fact, the average Medicare Part D premium actually decreased in 2012 from \$30.76 per month to \$30.

Question 8: I have heard concerns expressed about the transparency of PBMs.

(a) Do plan sponsors have full access to the terms of the rebate deals that your company has with drug manufacturers, and if not, why not?

(b) Do plan sponsors have full access to the terms of other aspects of your revenue stream such as the details of the spread in your pricing, and if not, why not?

(c) Insofar as your concerns regarding sharing rebate information (and other information relative to your revenue stream) is related to confidentiality, would you be willing to disclose this information with the protection of a confidentiality agreement, and if not, why not?

Answer 8: Express Scripts negotiates pharmaceutical manufacturer rebates across our entire book-of-business. Express Scripts negotiates with each of our customers as to what percentage of rebates we retain or pass back to the client based on their utilization. Plan sponsors have robust audit rights to ensure that they receive every pharmaceutical manufacturer rebate and discount they negotiated—including access by independent auditors to the rate components of our rebate agreements upon signing a confidentiality agreement. Plan sponsors do not have access to what other plan sponsors have negotiated or receive. This would actually diminish competition and increase prescription drug prices over the long term.

Whether or not plan sponsors have access to retail spread pricing is governed by the type of contract the sponsor has: pass-through or lock-in. Pass-through pricing allows the plan sponsor access to retail spread, lock-in does not. Understandably, lock-in pricing aligns the PBM with

the payer to pursue more aggressive discounting, and commercial plan sponsors often prefer that method of contracting. Express Scripts also provides our clients with a detailed disclosure of our sources of revenue and financial relationships with drug manufacturers.

Question 9: I have heard concerns expressed about the generic utilization rates of the drug plans administered by PBMs. Some data suggests that generic utilization is lower in mail-order than it is in the retail pharmacy setting, and that the generic utilization rate is not particularly high in TRICARE (52%).

(a) Do you dispute the data suggesting that generic utilization rates are higher in the retail pharmacy setting than they are in mail-order and that the generic utilization rate in TRICARE is only about 50%?

(b) If not, how do you account for the lower generic utilization rates associated with your company? Do such rates suggest higher costs for consumers?

Answer 9: Express Scripts business philosophy is one of alignment with the interests of purchasers of pharmacy benefits. When clinically appropriate, we always recommend the generic or lower-cost medicine in place of a more expensive brand-name drug. It is in the best interest of our clients, the purchasers, and their members—and it is where we are most successful in lowering costs while improving health care outcomes. We are proud to be the industry-leading PBM with a generic fill rate of 74.1 percent. When comparing generic fill rates dispensed at retail versus generic fill rates dispensed through mail-order, it is essential for accuracy to account for each channel's overall mix of drugs. This is where many inaccuracies occur in fully understanding the issue. Only long-term, maintenance medications for chronic health care conditions are dispensed at mail order and the majority of those drugs are just beginning to go off patent. When applying the more accurate, industry-standard metric of "dispensed a generic when a generic was available," mail order generic fill rates outperform (and save) that achieved through retail distribution channels. Our philosophy and practice of favoring medically appropriate, less expensive generic medications will continue after the merger.

The Department of Defense's TRICARE generic fill rate of 52% is well below our overall book-of-business due to the unique nature of the program. For example:

- TRICARE, by statute, pays no more than what the Federal Supply Schedule lists for all medications. There are a limited number of branded drugs that, due to federal ceiling prices, are less expensive than their generic counterparts. And TRICARE seeks to maximize these lower cost brands in their benefit design.
- TRICARE places some branded medications as preferred first line agents on some of their step therapy modules (as opposed to only generics like commercial does).

- TRICARE has only seven step therapy modules as compared to our commercial clients that have an average of 17 step therapy modules in place.
- When a new generic for a non-formulary product comes to market, that generic version also takes on a non-formulary status until TRICARE's Pharmacy & Therapeutics Committee changes it. This is unlike commercial where all generics take on a formulary status.
- The Department does not have any "conversion" programs in place to convert beneficiaries from formulary/non-formulary brands to generics. They do have a strict mandatory generic program, and reject DAW-1's, but there are no formal programs in place to do therapeutic conversions.
- TRICARE policy states that all drugs will be classified as formulary, until the Department's P&T Committee decides otherwise. So their formulary is open, unlike many commercial plans whose formularies are more restrictive.

It is important to note that the Department does not have the flexibility to change its benefit structure and processes that a typical commercial customer has. For example, up until this past October, TRICARE's pharmacy copayments had not changed in nearly two decades due to Congressional mandates. The Department has, however, made great strides in increasing their generic fill rate over the past several years. They are actively considering adopting more commercial best practices, and we will continue to work closely with them.

Question 10: At the hearing, there was some disagreement about the degree to which PBMs such as your company are regulated by the federal government and the states.

(a) Please provide brief details on the manner in which the federal government regulates your company.

(b) Please provide brief details on the manner in which state governments regulate your company.

Answer 10: PBMs are extensively regulated at both the state and federal levels. At the Federal level, Express Scripts' core health services (as opposed to regulations as a business in general) is regulated by the Department of Health and Human Services, the Center for Medicare and Medicaid Services, the Food and Drug Administration, the Department of Justice, the Drug Enforcement Agency, the Department of Labor, the Internal Revenue Service, the Department of Veterans Affairs, the Department of Defense (due to being a DoD contractor) and the Federal Trade Commission. At the state level, we comply with the laws and regulations that govern third party administrators, health plans, and utilization review organizations reporting to various state Departments of Insurance, Health and Social Services. Moreover, our Medicare Part D company

is regulated as an insurance company. Additionally, our mail order pharmacies are regulated by the same state Boards of Pharmacy that regulate retail pharmacy. Finally, we expect substantial, additional regulation of PBMs in the soon-to-be-created state-based exchanges being established under the health reform legislation.

Questions for the Record by Senator Charles Schumer

Question 1: How would the merger of Express Scripts and Medco affect community pharmacists' ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?

Answer 1: The merger of Express Scripts and Medco will have no impact on community pharmacists' ability to provide quality care and services to patients. Today, Express Scripts deploys a proprietary, highly efficient technology system that provides critical, patient-specific drug safety and usage information directly to community pharmacies at the point of service. These critical safety checks that see across all pharmacies that a patient may utilize will continue under the combined company.

Question 2: How would this merger impact patients and pharmacies in the Medicare Part D program?

Answer 2: The merger of Express Scripts and Medco will have a positive impact on patients in the Medicare Part D program. It will accelerate lower drug costs for patients and the Part D program. Moreover, the combined company will be better positioned to operationalize legislative and regulatory changes to the Part D program. Finally, Express Scripts and Medco have differing clinical program capabilities. Our vision to take the best-of-breed programs will yield a superior clinical platform that will improve patient care and outcomes.

We do not expect any specific impact to pharmacies in the Medicare Part D program due to this merger.

Question 3: Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?

Answer 3: Express Scripts cannot speak to other participants in the Medicare Part D program or to what the Office of Inspector General found; however, we can provide insight as to how we conduct our Medicare business. One hundred percent of all savings we are able to secure on behalf of our Medicare population accrue back to Part D sponsors, the Federal government and

Medicare patients. On the issue of Part D plan sponsors underestimating the rebates they receive from manufacturers, again, that has not been the case with Express Scripts.

Questions for the Record by Senator Al Franken

Question 1: In your testimony you stated the Centers for Medicare & Medicaid Services (CMS) disputed the findings of the Department of Health and Human Services' Office of Inspector General's March 2011 report on Concerns with Rebates in the Medicare Part D Program. In fact, CMS did not dispute the findings, but it disagreed with the Inspector General's recommendations. The report found that Part D sponsors commonly underestimate the rebates in their bids, leading to higher premiums for beneficiaries, including the government. It also found that sponsors received rebates for encouraging use of certain drugs, and it noted that contracts between sponsors and PBMs often lack transparency necessary to accurately monitor rebates. Finally, it noted that sponsors have a very limited ability to audit PBMs. Please respond directly to these and other concerns raised in this report and indicate how Express Scripts plans to address these transparency issues. Will Express Scripts consider increasing the amount of information that plan sponsors are given, beyond what is required by CMS and Medicare, so that sponsors may accurately account for all of the rebates and discounts in their bids?

Answer 1: In its March 2011 report titled "Concerns with Rebates in the Medicare Part D Program" (OEI-02-08-00050), the Department of Health and Human Services' Office of Inspector General made four recommendations for the Part D program with respect to rebates. The Center for Medicare and Medicaid Services (CMS) which oversees daily the Part D program did not dispute the OIG's findings, but **CMS did disagree with OIG's recommendations.** While Express Scripts cannot speak to other participants in the Part D program, we can provide our insight on the report and how we conduct our Medicare business.

- (a) Recommendation 1: CMS Should Take Steps to Ensure That Sponsors More Accurately Include Their Expected Rebates in Their Bids. CMS concurred with this recommendation, but presented the very real dilemma that rebates are generally earned and accrued on a retrospective basis making it difficult to estimate them in advance. Express Scripts is not a direct participant in the Part D program. As such, we understand the issue, but do not actually participate in the Part D bid process. Pharmaceutical rebates serve to reduce the overall cost of the Part D program. Therefore, underestimating Part D rebates yields a higher Part D premium. As Part D is a competitively bid program, if Part D plans underestimate rebates too much, they will lose enrollment (they will also potentially lose the right to service beneficiaries that qualify for premium assistance.) CMS indicated that a more effective way to oversee this issue would be to retrospectively compare rebates actually received and reported versus the rebates built into the bid model. CMS' proposal to retrospectively audit/watch this issue

seems like a reasonable, balanced approach. Implementing the OIG's recommendation would require plans to change their Part D bids all throughout the fall of every year—making it impossible for CMS to set the annual benchmark, thoroughly review bid submissions in a timely manner, or conduct open enrollment. In terms of overall results for seniors and taxpayers, this program is an unqualified success as premiums have declined and total program costs have been billions of dollars less than originally projected.

- (b) Recommendation 2: CMS Should Require Sponsors to Use Certain Methods to Allocate Rebates Across Plans. **CMS disagreed with this recommendation.** Currently CMS allows Part D sponsors to use reasonable methods to allocate rebates—whereas the OIG recommended that CMS pick an allocation method and require all Part D plans to use it. Different Part D sponsors negotiate different types of rebates based on formulary placement, utilization, and other factors. Imposing a standard allocation model is likely to have the opposite effect on the Part D program and actually impede a Part D sponsor's ability to negotiate additional savings. Although, Express Scripts does not directly participate in the Medicare Part D program, we concur that CMS' policy to allow plan sponsors flexibility to innovate with how they allocate their rebates, producing a better result for the program.
- (c) Recommendation 3: CMS Should Ensure Sponsors have Sufficient Audit Rights and Access to Rebate Information. **CMS disagreed with this OIG recommendation.** Express Scripts cannot comment on other Part D sponsors, but can assure the Subcommittee and the OIG that Part D plans have robust audit rights. CMS is vigilant in reminding Part D sponsors of their responsibilities to comply with all Part D rules and regulations. And, CMS and our clients robustly exercise their audit rights. In 2011, we participated in well over 500 Medicare audits. Express Scripts allows its clients full audit rights and has provided directly to Senator Franken a copy of our contractual audit language.
- (d) Recommendation 4: CMS Should Ensure that Sponsors Appropriately Report the Fees that PBMs Collect from Manufacturers. **In disagreeing with the OIG's recommendation,** CMS explains it requires Part D sponsors to report rebates, discounts and price concessions that serve to reduce the cost of Part D drugs on a plan sponsor's Direct and Indirect Remuneration (DIR). They further state that *bonafide service fees* are not DIR because they do not reduce overall drug costs. These are payments by manufacturers for services such as therapy adherence programs or risk evaluation and mitigation strategy (REMS) programs. CMS stated that while *bonafide service fees* are not rebates or discounts, it does collect information on these fees in order to assess if they meet the "fair market value" test. OIG also recommended that CMS further define

bonafide service fees and CMS disagreed. CMS saw no value in attempting to enumerate or define business practices as that could stifle innovation and competitiveness of the program. We concur with CMS and note that CMS' definition of *bonafide service fees* is the same definition as Section 6005 of the Affordable Care Act, as well as the same definition used for Medicaid and other Medicare programs.

Express Scripts believes in and is supportive of transparency—to the government and to our specific clients. We oppose anti-competitive, inappropriate disclosure of proprietary data to the market or to other supply chain participants (pharmaceutical manufacturers and retail pharmacies with whom we compete). This view is shared and supported by decades of research by the Federal Trade Commission and the Congressional Budget Office that such inappropriate disclosure would lead to price signaling and actually have the effect of increasing costs. The purchasers of our services receive voluminous amounts of information on exactly what they are purchasing and the services we are providing.

Question 2: In your testimony, you stated that the proposed merger with Medco would lower costs for sponsors due to discounts from drug manufacturers. What savings does Express Scripts expect to achieve from additional discounts or rebates from drug manufacturers after the merger? What percentage of these savings will be passed on to sponsors?

Answer 2: Express Scripts will not be able to determine exactly how much additional savings due to increased discounts from drug manufacturers will result until the transaction has been completed. That being said, as our rebate agreements are typically negotiated as percentage contracts (Express Scripts passes on approximately 90% of all total rebates—and 100% for Medicare Part D), additional rebate concessions will flow through to clients without re-contracting.

Question 3: Many pharmacists, employers, and consumer groups are concerned that Medco and Express Scripts will result in the closure of rural and independent pharmacies due to lower reimbursement rates and increased use of mail order pharmacies. What increase in business volume and revenue does Express Scripts anticipate after the merger from mail order prescription fulfillment?

Answer 3: Express Scripts knows of no employer group that has expressed concern a combined Express Scripts/Medco would result in the closure of rural pharmacies or increased use of mail order pharmacies. Employer groups and other purchasers of pharmacy benefits want value for their money, access for their members and the ability to choose for themselves what lower cost options they want to include. In more rural, less populous areas where distance between pharmacies is greater, meeting access standards for patients as required by the purchaser's contract or through government regulation is essential. A PBM's ability to negotiate favorable rates on behalf of purchasers is lessened. With regard to the question concerning potential increases in prescriptions being filled by mail order, that is a purchaser decision today and in the

future. These purchasers provide various incentives at their choosing to lower their costs by providing the choice to receive prescriptions by mail. In fact, *Consumers Union* rates the use of mail order pharmacy as a “Best Buy” for consumers interested in stretching their pharmacy dollar.

Question 4: In your testimony, you noted that 40% of all prescription drugs are for acute medications. Many rural and independent out-patient pharmacies have closed, leaving many Americans without local pharmacies to fill their acute medications. Please indicate what percentage and number of Express Scripts current customers have beneficiaries greater than 10 miles from their residence? What will Express Scripts do to ensure that rural and independent pharmacies stay open to meet acute medication needs? Will Express Scripts commit that all beneficiaries of its sponsor plans will have access to a pharmacy within a minimum distance from their residence?

Answer 4: Express Scripts has robust retail pharmacy access for all our plan sponsors. To demonstrate this, Medicare Part D and TRICARE require:

- At least 90 percent of all beneficiaries, on average, in urban areas live within 2 miles of a network retail pharmacy;
- At least 90 percent of all beneficiaries, on average, in suburban areas live within 5 miles of a network retail pharmacy; and
- At least 70 percent of Medicare beneficiaries, on average, in rural areas live within 15 miles of a network retail pharmacy.

Express Scripts not only meets, **but exceeds**, these standards. Specifically:

- 99+ percent of all beneficiaries, on average, in urban areas live within 2 miles of a network retail pharmacy;
- 99+ percent of all beneficiaries, on average, in suburban areas live within 5 miles of a network retail pharmacy; and
- Approximately 95 percent of all beneficiaries, on average, in rural areas live within **10** miles of a network retail pharmacy.

Rural pharmacies are essential partners for Express Scripts in meeting and exceeding the access standards described above. In fact, to attract rural pharmacies for our networks, we typically pay them a premium rate well above that of urban area pharmacies. Many of the challenges faced by rural pharmacies today are similar to those affecting every other health care provider in rural communities. This is a public policy area where we are eager to share our knowledge and experience in furthering approaches to ensuring access to quality, cost-effective health care services for all Americans.

Question 5: Express Scripts' generic utilization rate is alleged to be lower than the rate of generic usage in the retail pharmacy setting. What percentage of pharmaceuticals in your contracts for in-patient pharmacies are generics? What percentage of pharmaceuticals that you sell through mail order are generics? What is the expected percentage of generic pharmaceuticals in contracts for in-patient pharmacies after the merger? What percentage of pharmaceuticals sold through mail order are expected to be generic after the merger?

Answer 5: Express Scripts business philosophy is one of alignment with the interests of purchasers of pharmacy benefits. When clinically appropriate, we always recommend the generic or lower-cost medicine in place of more expensive brand-name drugs. It is in the best interest of our clients, the purchasers, and their members—and it is where we are most successful in lowering costs while improving health care outcomes. We are proud to be the industry-leading PBM with a generic fill rate of 74.1 percent. When comparing generic fill rates dispensed at retail versus generic fill rates dispensed through mail order, it is essential for accuracy to account for each channel's overall mix of drugs. This is where many inaccuracies occur in fully understanding the issue. Only long-term, maintenance medications for chronic health care conditions are dispensed at mail order and the majority of those drugs are just beginning to go off patent. In contrast, a significant portion of prescriptions dispensed at retail stores are acute medications, such as pain medications, anti-inflammatory medication and antibiotics, most of which have been off-patent for some time. When applying the more accurate, industry-standard metric of "dispensed a generic when a generic was available," mail order generic fill rates outperform that achieved through retail distribution channels. Our philosophy and practice of favoring medically appropriate, less expensive medications will continue after the merger.

Question 6: I have heard complaints from pharmacies about a lack of transparency in pricing of pharmacy services to sponsors. Do you share with pharmacies the price for which you contract their services with sponsors? Could you share such information, so that pharmacies are better informed about how their services are being distributed?

Answer 6: The confidential, proprietary information contained in our contracts with our clients belongs to our clients, the purchasers of pharmacy benefits. Retail pharmacies are their vendors, who compete for that business. In no area of business would a purchaser give their vendor information allowing them to set the highest price possible. Over decades of research and decisions, the Federal Trade Commission has found such disclosure of information to be anti-competitive, resulting in increased costs to consumers. The Congressional Budget Office has also supported this view.

Question 7: What percentage change in reimbursement rates can pharmacies expect if Express Scripts merges with Medco?

Answer 7: As discussed in an earlier question, the primary factor affecting retail pharmacy reimbursement is the market where the pharmacy is located. The merger may allow the combined firm to contract more efficiently with its retail network partners on behalf of our clients and their members.

Question 8: Why is the Express Scripts generic utilization so low in TRICARE (52%)? How will you work with the Department of Defense to improve that rate?

Answer 8: The Department of Defense's TRICARE generic fill rate of 52% is well below our overall book-of-business due to the unique nature of the program. For example:

- TRICARE, by statute, pays no more than what the Federal Supply Schedule lists for all medications. There are a limited number of branded drugs that, due to federal ceiling prices, are less expensive than their generic counterparts. TRICARE seeks to maximize these lower cost brands in their benefit design.
- TRICARE places some branded medications as preferred first line agents on some of their step therapy modules (as opposed to only generics like commercial customers do).
- TRICARE has only seven step therapy modules as compared to our commercial clients that have an average of 17 step therapy modules in place.
- When a new generic for a non-formulary product comes to market, that generic version also takes on a non-formulary status until TRICARE's P&T Committee changes it. This is unlike commercial where all generics take on a formulary status.
- TRICARE policy states that all drugs will be classified as formulary, until the Department's P&T Committee decides otherwise. So their formulary is open, unlike many commercial plans whose formularies are more restrictive.
- The Department does not have any "conversion" programs in place to convert beneficiaries from formulary/non-formulary brands to generics. They do have a strict mandatory generic program, and reject DAW-1's, but there are no formal programs in place to do therapeutic conversions.

It is important to note that the Department does not have the flexibility to change its benefit structure and processes that a typical commercial customer has. For example, up until this past October, TRICARE's pharmacy copayments had not changed in nearly two decades due to Congressional mandates. The Department has, however, made great strides in increasing their generic fill rate over the past several years. They are actively considering adopting more commercial best practices, and we will continue to work closely with them.

Questions for the Record by Senator Charles Grassley

Question 1: Brick and mortar pharmacies offer important on-site services to customers in the form of reliable direction on dosage and proper use. Some are concerned that the merger will result in more prescriptions being delivered to patients via mail-order. This means consumers may be deprived of face-to-face interaction with their pharmacist. Alternatively, mail order patients may still reach out to local pharmacists who give time and expertise, yet derive no income from the transaction.

- (a) Do you agree with those that say the merger will lead to increased mail-order delivery of prescription medications?
- (b) How can an individual, who receives mail order drugs, ensure that there are no conflicts with other medicines he or she is taking? How does a machine processing prescriptions in another state know this kind of information?

Answer 1: We agree that brick and mortar pharmacies offer important on-site services to customers. We also note that mail order pharmacies offer these important services telephonically—24 hours a day, seven days a week, 365 days a year with highly skilled, licensed pharmacists and other health care professionals in a convenient, confidential manner.

- (a) Whether to allow, promote or require mail order is a decision of the purchaser of pharmacy benefits. It is, after all, their money (and in some cases the taxpayers' money) and mail order is an effective way of reducing costs. In fact *Consumers Union* rates the use of mail order pharmacy as a "Best Buy" for consumers interested in stretching their pharmacy dollar.
- (b) When a patient covered by an Express Scripts pharmacy benefit plan walks into a pharmacy, they have all 13,000 of Express Scripts' employees standing with them. Before they ever receive that prescription medicine, over 100 safety checks are run through one of the most advanced, high-tech systems in the world. Every other pharmacy in our network across the country has access to this system which provides immediate point-of-sale eligibility, which saves approximately \$7.3 billion in bad pharmacy debt each year. In less than five seconds, we have determined if there is a medically-equivalent, less costly generic drug appropriate for them. We make sure the patient is not on any other medication inappropriate for use with the new prescription. What they pay is reduced on average by 18 percent for a branded drug and 47 percent for a generic. The pharmacies receive safety information to share with the patient and they are assured of the patient's eligibility as well as of payment – removing risk and time-consuming paperwork of what it used to be like 15 years ago. These are all giant leaps forward for patients and pharmacies alike that companies like mine helped create, and made available to over 65,000 pharmacies in every corner of the United States.

Question 2: I'm told about 15% of prescriptions are disbursed by mail order. This means about 85% of prescriptions are filled by a pharmacist.

(a) Has there been an overall increase in medications delivered by mail-order or has the number, or percentage, stayed the same over the years?

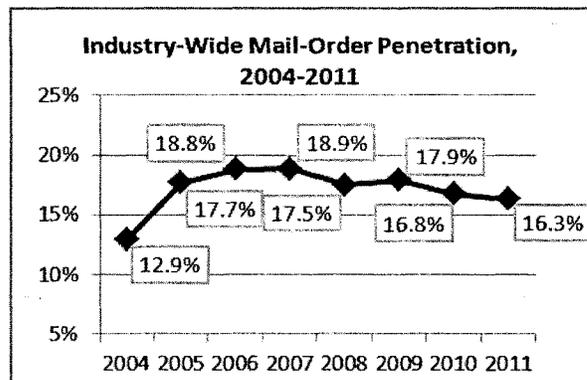
(b) What types of medications are disbursed via mail order?

(c) Are all prescriptions appropriate for mail-order delivery? If not, is this expected to change in the future?

(d) Has the industry reached a point where all drugs suitable for mail-order are now shipped via the mail?

Answer 2: One hundred percent of prescriptions—whether at retail or mail order—are overseen/dispensed by a pharmacist. Mail order pharmacies are pharmacies just like retail pharmacies. They hold the same licenses and follow the same protocols. A major difference between mail order and retail pharmacies, however, is in the number of errors made in filling prescriptions. Mail order facilities operate at a Six Sigma level of performance with an accuracy of 99.995 percent. Retail pharmacies' error rate is 260 times higher than mail order. Increasing utilization of mail order could result in a millions of avoidable, sometimes life-threatening, medication dispensing errors saving the U.S. health care system – and taxpayers – billions of dollars a year.

(a) According to Atlantic Information Services (AIS), total adjusted annual mail-order volume as of first-quarter 2011 was 776 million scripts, a 16% increase over the prior-year figure of 668 million. However, the increase in mail volume lags behind a 20% increase in total volume of all prescriptions. Data from AIS's quarterly survey of PBMs indicate that mail-order growth began declining in 2009 and reached its lowest point since 2005 in 2010 (*DBN 4/30/10, p. 5*). Mail-order penetration — the percentage of total scripts filled via mail — has remained fairly stable throughout this time. It is currently 16.32% industry wide.



SOURCE/METHODOLOGY: AIS's quarterly survey of PBMs and related companies, conducted for *Drug Benefit News*.

*Mail-order prescriptions are multiplied by three to adjust for the fact that they are typically filled in a three-month quantity vs. a one-month quantity for retail scripts. Adjusted mail-order figures were used for calculating penetration and market share in this analysis. Prescription volume figures represent the latest available 12-month count at the time of the survey. Market share refers to the percentage of total mail order scripts reported on this survey. AIS's *Pharmacy Benefit Survey Results* can be downloaded from our subscriber-only website at:

<http://aishealth.com/newsletters/drugbenefitnews/quarterly-survey-results>.

- (b) Only chronic condition, maintenance medications are dispensed at mail order. Express Scripts employs clinical parameters recommending appropriate medications for mail order, but it is typically drugs that the patient is stabilized on and likely to remain on for more than one year.
- (c) Acute medications such as antibiotics are not appropriate for mail order distribution. As the parameters for what is appropriate for mail order are driven by clinical factors, this could evolve in the future based on new-to-market pharmaceuticals. However, it is very likely that acute medications will always be dispensed in the retail setting.
- (d) No. The industry has not reached a point where all drugs suitable for mail order are dispensed through that venue. Whether to allow, promote, encourage or require mail order is the decision of the purchaser of pharmacy benefits, the plan sponsor. By our estimates, nearly 60% of all medications are for chronic conditions and could be dispensed at mail order. However, as noted above, mail order penetration is below 20% industry-wide.

Question 3: Specialty pharmaceuticals are a rapidly expanding industry segment. It is my understanding that there are pharmacies that operate solely to provide specialty drugs. The

pharmacists there play an important role in the proper administration of these drugs, such as fertility drugs and medications for cancer. These drugs require much closer monitoring of dosage and administration than common maintenance medications. A pharmacist is able to counsel patients and provide important information required for these drugs. In addition to the existing specialty pharmacies, the PBMs have expanded their growing mail-order business with their own specialty drug programs. Now, it seems some PBMs are creating networks that exclude the other pharmacies. At first glance, it seems this is an attempt to drive all beneficiaries into the PBM's specialty program.

(a) Currently as separate companies, how many specialty pharmacies are in your respective networks?

(b) Has that number increased or declined over the past 5 or 10 years?

(c) If a Plan Sponsor wanted access to more specialty drug providers are they prohibited from making such a request?

Answer 3: We have expanded our offering to provide specialty pharmacy services over the past decade in response to our clients' need to control the rapidly growing specialty drug spend. In many respects, specialty pharmacy is a mail order pharmacy with expertise in the care services needed for patients who take these high-tech, expensive medications. As such, our specialty pharmacy, CuraScript, competes with retail and specialty pharmacies like our mail order pharmacy competes with retail pharmacies and other mail pharmacies in dispensing traditional oral solid prescriptions. Like mail order, whether to allow, favor or encourage Express Scripts' specialty pharmacy is the decision of the purchaser of pharmacy benefits.

(a) We have approximately 555 pharmacies with specific specialty capabilities in our pharmacy network.

(b) The number of specialty pharmacies has increased over 73% over the past 5 years.

(c) Purchasers of pharmacy benefits are in control of the design of their specialty pharmacy network. They can design their network to be as broad or narrow as they would like to meet their needs.

Question 4: The merger will result in a combined company having control of over 50% of the specialty pharmaceutical market. When the Federal Trade Commission performs its antitrust review, one of its most important duties will be to define the market at issue.

(a) Are specialty drug services considered different and separate from traditional pharmacy services?

(b) If so, could it be possible there is not enough competition in specialty drug services, even if there is adequate competition in the standard pharmaceutical market?

(c) Will the merger still go through if the FTC requires divestiture of the specialty pharmacy services?

Answer 4: We do not believe that a combined Express Scripts/Medco company will have “over 50% of the specialty pharmacy market.” We will not speculate on how the FTC will look at this issue, however, according to Pembroke Consulting⁷, the combined company would have approximately 31% of specialty pharmacy revenue.

⁷ Pembroke Consulting, Pharmacy Market Share for Specialty Drugs, 2010, 2011. Available at: <http://www.drugchannels.net/2011/12/pharmacy-market-share-for-specialty.html>

Senate Judiciary Committee
 Subcommittee on Antitrust, Competition Policy and Consumer Rights
 Hearing on “The Express Scripts/Medco Merger: Cost Savings for Consumers or More
 Profits for the Middlemen?”
 December 6, 2011

Questions for the Record from U.S. Senator Al Franken
 for David Snow, Chairman and CEO, Medco Health Solutions, Inc.

- 1. In your testimony, you stated that Medco has a “generics-first policy.” What percentage of pharmaceuticals in your contracts for in-patient pharmacies are generics? What percentage of pharmaceuticals that you sell through mail order are generics? What is the expected percentage of generic pharmaceuticals in contracts for in-patient pharmacies after the merger? What percentage of pharmaceuticals sold through mail order are expected to be generic after the merger? What accounts for Medco’s lower generic utilization rate as compared to a retail pharmacy?**

We believe that data that shows that generic utilization rates are higher in the retail setting can be explained by adjusting for the mix of drugs dispensed. When comparing “apples to apples,” the rates are similar. Moreover, a review of how quickly generics are dispensed once available for a drug coming off of patent demonstrates Medco’s “generics first” strategy.

Medco’s “generics first” strategy recognizes that in every aspect of our business, when therapeutically appropriate, generics provide the greatest clinical and financial benefit for payors, members and for our company – and incentives are aligned to encourage the optimum use of generics. This is reflected in our rapidly increasing generic dispensing rates across our business.

Medco administers benefit programs for our clients that are accessible to members at retail pharmacies, mail order pharmacies and in certain instances, long-term care facilities. As part of our quarterly performance updates, we publicly report the generic dispensing rates for both our mail order pharmacies and prescriptions filled through retail pharmacies. In the most recent quarter for which data is available (August-October 2011), the retail dispensing rate was 75.4 percent and Medco’s mail order generic dispensing rate was 64.8 percent (a year-over-year increase of approximately 2 percentage points in both the retail and mail channels).

As the Federal Trade Commission (FTC) has cautioned, however, these generic rates must be adjusted to account for the “mix” of drugs. In a 2005 report, the FTC determined that the generic dispensing rate is an “unreliable” measure if it does not take into account the different mix of drugs dispensed through the retail and mail pharmacies, as well as benefit design features and formulary decisions that affect the member’s pharmacy selection.¹ Ninety-day prescriptions – generally prescriptions dispensed via mail – are

¹ Federal Trade Commission Report: “Pharmacy Benefit Managers: Ownership of Mail Order Pharmacies,” August 2005.

largely applicable to chronic therapies such as cholesterol, cardiovascular and diabetes medicines, many of which are relatively new, branded products and, therefore, are not currently available as generics. Proportionally, retail pharmacies tend to dispense a greater share of acute therapies, such as antibiotic and short-term pain medicines, which are largely generic products.

Thus, in light of the FTC's caution about examining the rates after adjusting for this drug mix, it is more accurate and informative to compare generic dispensing rates between retail and mail in those instances when the medication is available in generic form and there is an actual opportunity to dispense a generic. A Government Accountability Office (GAO) report determined, "For drugs where a generic version was available, the retail and mail-order pharmacies dispensed generic drugs at more similar rates – on average 89 percent of the time for retail pharmacies and 87 percent of the time for mail service pharmacies."²

The FTC also found that retail and PBM-owned mail pharmacies substitute generics at similar rates and that the generic substitution rates (GSR) observed "show that (PBM-owned) mail order pharmacies were generally more, rather than less, aggressive in dispensing generic drugs than were other pharmacies...."³

In addition to overall generic dispensing rates, it is also helpful to examine the efficiency of mail order and retail in quickly moving patients to the generic once the patent for a branded medicine expires. This is important because the faster this substitution occurs, the faster payors and patients derive the financial benefits. For instance, a Medco study revealed that within the first week of generic availability for Ambien (zolpidem), generic substitution rates at Medco's mail order pharmacies reached nearly 97 percent, compared with just 76.6 percent at retail for the same time period. In fact, even after six months the retail generic substitution rate did not catch up to the Medco pharmacy's achieved week-one rates.⁴ For Zyprexa, used for treating schizophrenia and bipolar disorder, a generic (olanzapine) became available at the end of October 2011. In the first month, the mail generic dispensing rate was 81.3 percent compared to the retail rate of just 52.8 percent. Finally, for Nasacort AQ, a prescription nasal spray licensed to treat sneezing, runny or stuffy nose, and nasal itching due to allergies, a generic (triamcinolone acetonide) became available in June 2011. After three months, the mail generic dispensing rate was 93.5 percent and the retail rate was 81.6 percent.

With respect to your question about the expected percentage of generics dispensed after the merger – as the acquired company in this transaction, we are not in a position to comment specifically on operations post merger.

² GAO Report: "Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies," January 2003.

³ Federal Trade Commission Report: "Pharmacy Benefit Managers: Ownership of Mail Order Pharmacies," August 2005.

⁴ Medco 2008 Drug Trend Report.

2. What percentage change in reimbursement rates can pharmacies expect if Express Scripts merges with Medco?

As the acquired company in this transaction, we are not in a position to comment on potential changes in reimbursement rates post-merger.

3. I have heard complaints from pharmacies about a lack of transparency in pricing of pharmacy services to sponsors. Do you share with pharmacies the price for which you contract their services with sponsors? Could you share such information, so that pharmacies are better informed about how their services are being distributed?

We do not share the terms of our client contracts with other clients or with suppliers, such as pharmaceutical manufacturers or retail pharmacies. Our mission is to lower the cost of prescription drugs for plan sponsors and the members we mutually serve, and making our pricing terms public would undermine our ability to negotiate the lowest possible price for these plan sponsors. Moreover, we are not aware of any private enterprise that offers suppliers full access to every element of its revenue stream.

However, it is important to note that we operate with complete transparency in the context of our relationships with our plan-sponsor clients. Last year, there were more than 600 audits of our contractual relationships with our clients. All benefit plans are designed at the plan sponsor's direction and, as part of their contract, includes the price that plan sponsors and their members will pay for pharmacy services. Plan sponsors also have complete audit rights to validate that they receive the full benefit of the services for which they have contracted.

Medco's level of transparency with clients has been publicly described as setting the "gold standard" in the PBM industry by state attorneys general.⁵

⁵ Boston Globe, April 27, 2004; Pink Sheet, May 2, 2004.

**“The Express Scripts/Medco Merger: Cost Savings for Consumers
or More Profits for the Middlemen?”**
Questions for the Record submitted by Senator Charles E. Grassley

Questions for Mr. David Snow:

- 1. Brick and mortar pharmacies offer important on-site services to customers in the form of reliable direction on dosage and proper use. Some are concerned that the merger will result in more prescriptions being delivered to patients via mail-order. This means consumers may be deprived of face-to-face interaction with their pharmacist. Alternatively, mail order patients may still reach out to local pharmacists who give time and expertise, yet derive no income from the transaction.**
 - a. Do you agree with those that say the merger will lead to increased mail-order delivery of prescription medications?**

Medco, as a PBM, does not have the power or the ability to direct members to use mail service. The decision to use mail order delivery is made solely by plan sponsors. PBMs offer plan sponsors different benefit design options, and the plan sponsor chooses and implements the benefit designs that best meet their objectives. It is the plan sponsors that select whether, or to what extent, they provide financial incentives to encourage members to use mail order pharmacies.

Members always have the option of filling prescriptions at any pharmacy they select. However, their plan determines the level of reimbursement provided based on the conditions outlined in the plan’s benefit design. This is why, to encourage members to use a lower cost and more efficient delivery channel, many plan sponsors offer a lower co-payment for mail order – just as they may choose to lower co-payments for generics, compared to brands. This reduces costs and ensures plan sponsors can continue to provide access to affordable benefits. In some cases using a retail pharmacy for a prescription that falls under a mandatory mail order plan design could require the patient to pay the full, albeit discounted, retail cost of that prescription.

Also, there are certain types of prescriptions that are not appropriate for mail order pharmacies to dispense, such as acute antibiotics and short-term pain medications. A merger would not alter those circumstances.

Medicines shipped via mail order are largely “maintenance” medications. These are taken by members with chronic or complex conditions to manage their care on a long-term basis. Currently, 70 percent of all maintenance prescriptions (90-day supply) are

dispensed at retail pharmacies; only 30 percent are dispensed through mail order pharmacies.¹

We would also emphasize that our mail order pharmacies provide comprehensive patient counseling by trained pharmacists. Medco employs more than 3,000 pharmacists who assure our clinical quality standards remain the industry standard. They are available around the clock, every day of the year to answer member questions and address concerns – even if those members are using a retail pharmacy. We also offer our members the opportunity to speak with pharmacists who are specifically trained in specialized areas related to chronic and complex conditions – ranging from heart health and cancer care to asthma and diabetes – a capability that is unrivaled in the mainstream retail environment.

b. How can an individual, who receives mail order drugs, ensure that there are no conflicts with other medicines he or she is taking? How does a machine processing prescriptions in another state know this kind of information?

As background, PBMs form the backbone of the safety net that ensures that regardless of where a member may obtain a prescription, through retail or mail order, in Washington, D.C., or Bloomington, Indiana, those prescriptions are reviewed for potential harmful interactions. Specifically, Medco provides the same comprehensive member-safety service alert to the pharmacist when there is a conflict between a newly prescribed medicine and others that the individual is already taking – thereby avoiding adverse drug interactions – regardless of whether the member obtained the prescription at retail or at mail. When a member frequents a retail pharmacy, as part of the process of confirming for the retail pharmacy that a requested medicine is covered under the member's plan and the amount of copay to collect, Medco conducts a safety review of the drug. If a conflict – what we call a drug interaction – is detected, our system sends a message to the pharmacy. This process is called Drug Utilization Review (DUR), and it enables the PBM to provide a safety net even if a member is receiving prescriptions from multiple physicians and filling them at multiple pharmacies including receiving different prescriptions at retail or mail order.

To conduct DUR, pharmacies – including retail pharmacies – can purchase computer programs that check for these drug interactions. A PBM such as Medco operates “behind the scenes” and conducts an instantaneous review on every retail claim that is dispensed by a retail pharmacy and sends this message back to the retail pharmacy so that it can act on it prior to dispensing the drug to the patient. In some instances, the pharmacist may exercise their professional judgment unilaterally to investigate and resolve the conflict, or they may decide to further consult with the patient and/or physician. This review is also conducted on every mail claim.

¹ NACDS Chain Pharmacy Industry Profile 2010-2011.

As noted above, Medco employs more than 3,000 registered pharmacists. For every prescription that our mail order pharmacies receives, a pharmacist reviews the prescription, in addition to checking for any other discrepancies or inconsistencies (e.g., questions about the dosage prescribed or illegible handwriting). A pharmacist personally addresses any safety or other concerns with the prescriber before dispensing a prescription.

This extensive system of checks and balances ensures the medication dispensed is safe to use. In fact, Medco's system is so advanced that we were retained by the government of Sweden to establish a similar capability for that country's national pharmacy infrastructure.

2. I'm told about 15% of prescriptions are disbursed by mail order. This means about 85% of prescriptions are filled by a pharmacist.

As noted above, 100 percent of mail order prescriptions involve review by duly licensed pharmacists. Medco employs more than 3,000 registered pharmacists. For every prescription that our mail order pharmacies receives, a pharmacist reviews the prescription, in addition to checking for any other discrepancies or inconsistencies (e.g., questions about the dosage prescribed or illegible handwriting). A pharmacist personally addresses any safety or other concerns with the prescriber before dispensing a prescription.

a. Has there been an overall increase in medications delivered by mail-order or has the number, or percentage, stayed the same over the years?

There has not been an increase in the percentage of prescriptions delivered by mail order. Data recently released from the National Association of Chain Drug Stores (NACDS) shows that even though all pharmacy segments are filling more prescriptions year over year, the relative share of mail order pharmacy has remained flat, while the share of chain and big-box retail pharmacies, such as CVS and Walgreens or Walmart and Sam's Club, has increased at the expense of the community-based independent pharmacies.² And the basis of that growth for chain and big-box retailers has been fueled in part by the growth of 90-day maintenance prescriptions being filled at those stores and not at mail order. In other words, mail and retail pharmacies are direct competitors for those 90-day prescriptions. As the Federal Trade Commission (FTC) noted last year in a letter stating their concerns with a bill then pending before the Mississippi legislature:

Plan sponsors sometimes encourage patients with chronic conditions who require repeated refills to seek the discounts that 90-day prescriptions and high-volume

² NACDS Chain Pharmacy Industry Profile 2011-2012.

mail-order pharmacies can offer. Mail-order pharmacies, including those owned by PBMs, compete directly with retail pharmacies.³

We have attached a chart in Appendix A that illustrates this pattern.

In fact, Medco data shows that on average, an independent pharmacy loses 64 prescriptions to a chain pharmacy for every single prescription lost to a mail order pharmacy. Nearly half (47 percent) of members who fill prescriptions in an independent pharmacy use more than one pharmacy, including chain and big-box retail pharmacies. If independent pharmacies consolidated these prescriptions they would increase their share by 44 percent.

Although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe our merger will help retail pharmacies compete more effectively and stem these losses to chain pharmacies.

Moreover, highlighting the importance that Medco places on the continued viability of independent retail pharmacies, Medco has partnered with independent pharmacies in Illinois and New Mexico as part of pilot programs to provide additional reimbursement to independent pharmacies. This reimbursement is for providing clinical counseling to members and closing gaps in care that members may have related to the appropriate use of medication.

Interestingly, based on data presented by their own trade association, traditional community-based independent pharmacies continue to grow in number and increase their top-line revenue and bottom-line profits. Between 2009 and 2010, the number of independent pharmacies grew by almost 400 to more than 23,000, representing a \$93 billion industry. Average independent pharmacy sales increased by 3.7 percent in 2009, from \$3.88 million to \$4.03 million.⁴ Pharmacy profits have doubled since 1999, with average profits per pharmacy of almost \$1 million.⁵ In the context of one of the most difficult economic environments in generations, that is an enviable position for any industry.

b. What types of medications are disbursed via mail order?

Medications dispensed via mail order are typically used by patients with chronic and complex conditions such as high cholesterol, cardiovascular disease or diabetes. These patients require medicines on an ongoing basis (i.e., doctor-prescribed medications used for 90 days or longer) to manage their care.

³ FTC letter to The Hon. Mark Formby, Mississippi House of Representatives, March 22, 2011, regarding MS SB 2245, p. 4; accessible at <http://www.ftc.gov/os/2011/03/110322mississippipbm.pdf>.

⁴ National Community Pharmacists Association, 2010 NCPA Digest, October 2010.

⁵ Drug Channels, "Owning a Pharmacy: Still Pretty Profitable", January 25, 2011 (Analysis of 2010 NCPA Digest Data).

c. Are all prescriptions appropriate for mail-order delivery? If not, is this expected to change in the future?

No. Not all prescriptions are appropriate for mail order. Prescriptions for acute therapies such as antibiotics and short-term pain medicines are typically not appropriate for mail order; these are dispensed at retail pharmacies. Mail order delivery is typically used for “maintenance” drugs required by patients with chronic or complex conditions – such as high cholesterol. These patients need to take these medications on a long-term basis to manage their condition. This is not expected to change in the future.

It is important to remember that plan design distinctions between mail and retail are diminishing, not increasing. More plan designs are offering 90-day prescriptions for maintenance medications that can be picked up at retail pharmacies. In fact, CVS Caremark in its business model promotes its belief that this line between mail and retail has been erased completely, as it offers 90-day prescriptions with no distinction between whether they are picked up at the retail store or received by mail. As noted above in our response to Question 2, the FTC has recognized that mail pharmacies “compete directly with retail pharmacies” for this business.⁶

d. Has the industry reached a point where all drugs suitable for mail-order are now shipped via the mail?

No, not all drugs suitable for mail order are currently shipped via the mail. Medications shipped via mail order are typically for “maintenance” medications used by patients with chronic or complex conditions to manage their care on a long-term basis. As mentioned above, 70 percent of all maintenance prescriptions (90-day supply) are currently dispensed by retail pharmacies; only 30 percent are dispensed through mail order.⁷ With growing numbers of retail pharmacies now offering 90-day maintenance plans, we believe there is robust and growing competition from retail pharmacies.

As referenced above, according to recently released NACDS data, all pharmacy segments are filling more prescriptions year over year; however, the relative share of mail order pharmacy has remained flat.

⁶ FTC letter to The Hon. Mark Formby, Mississippi House of Representatives, March 22, 2011, regarding MS SB 2245, p. 4; accessible at <http://www.ftc.gov/os/2011/03/110322mississippipbm.pdf>.

⁷ NACDS Chain Pharmacy Industry Profile 2010-2011

3. **Specialty pharmaceuticals are a rapidly expanding industry segment. It is my understanding that there are pharmacies that operate solely to provide specialty drugs. The pharmacists there play an important role in the proper administration of these drugs, such as fertility drugs and medications for cancer. These drugs require much closer monitoring of dosage and administration than common maintenance medications. A pharmacist is able to counsel patients and provide important information required for these drugs. In addition to the existing specialty pharmacies, the PBMs have expanded their growing mail-order business with their own specialty drug programs. Now, it seems some PBMs are creating networks that exclude the other pharmacies. At first glance, it seems this is an attempt to drive all beneficiaries into the PBM's specialty program.**
- a. **Currently as separate companies, how many specialty pharmacies are in your respective networks?**
- b. **Has that number increased or declined over the past 5 or 10 years?**

Clients have the ability to decide the number of "specialty pharmacies" that are in their network. On the pharmacy benefit side, for most drugs that are considered specialty, pharmaceutical manufacturers do not limit the number of pharmacies that dispense the drugs; any retail pharmacy can dispense specialty drugs to Medco members, and many do. As a result, there are literally thousands of retail pharmacies in Medco's networks that fill prescriptions for specialty products, including self-administered injectables. There are also pharmacies that dispense only specialty products (along with, perhaps, ancillary drugs). These pharmacies focusing on specialty drugs have been growing in size and number.

When assessing the specialty drug marketplace, it is important to remember that a large amount of drug spend for specialty drugs is not adjudicated by PBMs; specialty drugs are also dispensed by medical providers, such as doctors, hospitals and clinics, as well as pharmacies. Additionally, pharmaceutical manufacturers, not PBMs, control whether their drug is dispensed on an exclusive or semi-exclusive basis, and manufacturers retain the ability to revoke the arrangements at their discretion. Moreover, the competition in the specialty drug space is robust and growing.

It is also important to underscore that a large amount of the dispensing of specialty products is not managed by a PBM. As well as being dispensed by pharmacies, specialty drugs can also be dispensed by doctors, and in clinics and hospitals. Depending on the situation, specialty drugs may be paid for under members' medical benefit or under their pharmacy benefit. Medco, as a PBM, only manages the pharmacy benefit. Thus, by considering only the number of pharmacies that dispense specialty products, or a PBM's network, one would exclude a large volume of dispensing of specialty products to individual members, which is a key consideration in examining the overall specialty drug marketplace.

c. If a Plan Sponsor wanted access to more specialty drug providers are they prohibited from making such a request?

Absolutely not. The plan sponsor specifies which specialty drug pharmacies are included in the network for their members.

4. The merger will result in a combined company having control of over 50% of the specialty pharmaceutical market. When the Federal Trade Commission performs its antitrust review, one of its most important duties will be to define the market at issue.

a. Are specialty drug services considered different and separate from traditional pharmacy services?

For a variety of reasons, we do not believe that the specialty pharmacies of the combined company will dispense more than 50 percent of specialty pharmaceuticals. First, as previously discussed, this number does not take into account the numerous ways specialty products are dispensed. As well as being dispensed by pharmacies, specialty drugs can also be dispensed by doctors, and in clinics and hospitals. Depending on the situation, specialty drugs may be paid for under members' medical benefit or under their pharmacy benefit. Medco, as a PBM, only manages the pharmacy benefit. Thus, by considering only the number of pharmacies that dispense specialty products, or a PBM's network, one would exclude a large volume of dispensing of specialty products to individual patients, which is a key consideration in examining the overall specialty drug marketplace.

Many specialty drugs are dispensed by what would be considered traditional retail pharmacies. These are pharmacies that have demonstrated the necessary support for helping patients in the administration of these specialty products. Specialty drugs are often bio-tech medicines defined by one or more characteristics that include: high cost; a higher risk profile or toxicity; and requirements for advanced handling, patient training and drug administration. In the cases where the specialty medicine must be injected or infused and may require the patient to use the services of a hospital, doctor, outpatient clinic or a visiting nurse, those services can be provided through the medical portion of the member's benefit by either the pharmacy or by a medical provider.

Moreover, we believe even lower estimates have been overstated. As you may know, a recent report issued by Adam Fein of Pembroke Consulting has estimated that in 2010 the specialty pharmacies operated by Express Scripts and Medco handled 31 percent of specialty drugs dispensed by specialty pharmacies in the U.S. However, because this figure does not take into account specialty drugs dispensed by physician offices, clinics, hospitals and the like, it necessarily overstates the role played by Medco and Express Scripts in the overall dispensing of specialty drugs.

b. If so, could it be possible there is not enough competition in specialty drug services, even if there is adequate competition in the standard pharmaceutical market?

We believe there is sufficient competition for specialty drugs. As noted above in the answer to subpart (a), depending on the situation, specialty drugs may be paid for under members' medical benefit or under their pharmacy benefit. Medco, as a PBM, only manages the pharmacy benefit. As well as being dispensed by pharmacies, specialty drugs can also be dispensed by doctors, and in clinics and hospitals. The fact that specialty drugs can be covered on either benefit and are dispensed in a variety of practice settings other than a pharmacy helps to ensure robust competition.

Moreover, there are hundreds of specialty drugs (Accredo, the specialty pharmacy owned by Medco counts about 250 specialty drugs) and thousands of pharmacies dispensing the majority of those drugs. All PBMs manage the expenditure on at least some of these drugs, although many specialty drugs are managed as a medical benefit rather than a pharmacy benefit.

As mentioned above, per Adam Fein's recent report, in 2010 the specialty pharmacies operated by Express Scripts and Medco handled 31 percent of specialty drugs dispensed by specialty pharmacies in the U.S. And, again, because this figure does not take into account specialty drugs dispensed by physician offices, clinics, hospitals and the like, it necessarily overstates the role played by Medco and Express Scripts in the overall dispensing of specialty drugs.

c. Will the merger still go through if the FTC requires divestiture of the specialty pharmacy services?

Since this transaction is currently being considered by the FTC, it wouldn't be appropriate for us to comment at this time.

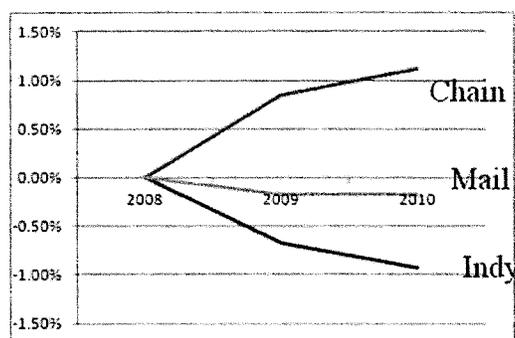
Appendix A

Independent Pharmacies are Losing Share to Chains, Not to Mail

According to NACDS data:⁸

- For several years mail share in the industry has been relatively flat
- While chain share has been growing at the expense of the independent pharmacy

Change in Share



Share calculated by % of total Rx volume

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Mail	5.1%	5.4%	5.5%	5.9%	6.5%	6.8%	6.8%	7.3%	7.4%	7.2%	7.2%
Indy	24.4%	23.6%	22.9%	23.0%	22.7%	21.9%	21.6%	21.3%	20.8%	20.1%	19.8%
Chain	70.6%	71.0%	71.5%	71.1%	70.7%	71.3%	71.6%	71.4%	71.9%	72.7%	73.0%

⁸ NACDS 2011-2012 Chain Pharmacy Industry Profile: Calculated from table 37 "Pharmacy Prescriptions by Type of Store."

Sen. Kohl's Follow-Up Questions for the Record for Hearing on
"The Express Scripts/Medco Merger: Cost Savings for Consumers
Or More Profits for the Middlemen?"

For David Snow

1. It is well understood that Express Scripts and Medco are direct head-to-head competitors. One of the big issues arising out of this merger is the loss of head-to-head competition between your two PBMs. The merger's critics are particularly concerned with its impact on the nation's largest employers and plan sponsors who contract with PBMs for their prescription drug benefit. We understand that you contend that there are many other PBMs who are competitors in the marketplace. However, many believe that the "Big 3" PBMs – Express Scripts, Medco, and CVS Caremark – are the only PBMs that have the scale and offer the services necessary for the nation's largest employers. Indeed, 42 of the top Fortune 50 companies use one of these "Big 3" PBMs. If this is true, this merger will reduce the number of PBMs serving the biggest national employers from three to two.

(a) Why is it that Express Scripts, Medco and CVS Caremark have such high share of the PBM business of large employers and plan sponsors?

We believe there is strong empirical evidence demonstrating that competition in the PBM business – overall, and specifically for large employers – is robust, dynamic and increasing at a rapid pace as the lines blur across traditional competitors, including retail pharmacies, health plans and PBMs. Among the large employers, we do not view Express Scripts and Medco as head-to-head competitors; Medco has not lost a large employer client to Express Scripts in more than three years. Additionally, based on the current dynamics across the pharmacy industry, the historical concept of what some refer to as the "Big Three PBMs" is outdated and has lost whatever relevance it had. We also note that the implementation of the new health care reform law has already begun to change the competitive landscape for PBMs, and this pace of change will further accelerate as different aspects of the law become effective and continue to be implemented.

Large employers already use more than just CVS Caremark, Medco and Express Scripts. Looking at the Fortune 50, according to a July 2011 Morgan Stanley report, nine PBMs serve Fortune 50 companies: Aetna, Catalyst Rx, CVS Caremark, Express Scripts, Medco, Prime Therapeutics, Restat, SXC Health Solutions and OptumRx (owned by UnitedHealth Group). Additionally, two Fortune 50 companies, Costco and Kroger, have their own PBMs.¹ Some of these PBMs are among the nation's fastest-growing organizations, developing scale and capabilities at a rapid pace. In 2011, less than 7 percent of Medco's business came from Fortune 50 companies.

¹ Morgan Stanley, "Healthcare Services & Distribution: Large Employer Market Key to Deal Approval", July 28, 2011.

Medco directly experiences this fierce competition for large employer accounts. Although Medco has enjoyed considerable success since its 2003 spin-off, for our 2012 plan year alone, Medco has lost \$10 billion in business – losing 40 clients, large and small – to more than 15 different PBMs. The PBM competitors who recently won these accounts from Medco include: Aetna, CVS Caremark, Catalyst Rx, Cigna, Envision Pharmaceutical Services, Express Scripts, HealthPlus of Michigan, HealthSpring, SXC Health Solutions, MedImpact Healthcare Systems, OptumRx, Prime Therapeutics and ProAct.

This current dynamic, coupled with the changing landscape triggered by health care reform, refutes the historical idea of a “Big Three” construct in the marketplace. In fact, UnitedHealth, the largest health insurer in the country, has contracts with clients for PBM services that, when consolidated at its PBM, will instantly make it the third largest PBM in the country. UnitedHealth owns its PBM, branded in the marketplace as OptumRx. UnitedHealth today provides PBM services to its many clients by using both Optum Rx, largely for its government clients, and Medco, largely for its commercial clients. UnitedHealth has announced that it will be moving to OptumRx all the PBM services that Medco currently provides, taking in-house the 14 million lives currently served by Medco. On the pharmacy side, United already provides coverage to a number of Fortune 100 clients, including Delta, Hewlett-Packard, Oracle, Apple, Proctor & Gamble, and state plans such as the State of New York.

UnitedHealth has stated publicly that it anticipates that it will continue to grow its PBM. Today, UnitedHealth alone provides medical insurance coverage for 45 percent of the lives associated with the employers in the Fortune 100. This provision of medical benefits creates a natural feeder to support the continuing growth of OptumRx, which is soon expected to exceed \$30 billion in annual revenue as a UnitedHealth subsidiary. In the most recent rankings, UnitedHealth was listed No. 22 in the Fortune 500, with revenues exceeding \$94 billion. As part of its publicly announced growth plans, the company in 2012 expects to invest more than \$115 million in OptumRx, and has already committed to adding more than 600 jobs to its Kansas City mail order facility, which is capable of dispensing more than 100,000 prescriptions a day. OptumRx also has an additional mail order facility in California.

Today, more than 40 PBMs aggressively compete to provide differentiated value propositions for public and private payors of all sizes. Seven PBMs each process more than 150 million prescriptions annually, 12 PBMs serve more than five million members each, and at least 17 PBMs serve large state accounts. Additionally, nine Fortune 500 companies operate PBMs directly for their employees. Thus, regardless of the past dynamics in the market for large employers, it is changing rapidly and will continue to evolve.

(b) Do you really believe the “second tier” PBMs can serve the nation’s largest employers? In the last five years, how many Fortune 100 companies that were your clients have switched to a PBM other than one of the “Big 3”?

As noted above, we do not believe that the historical moniker “Big Three” is applicable to the PBM industry today, and as such, we do not believe that there is a group of “second tier” PBMs. Rather, we believe that there are a large and growing number of PBMs that can serve large employers – and, in fact, do so today. As Scott Streator, associate vice president for business development at Ohio State University Medical Center, testified during the December 6th Senate Judiciary Subcommittee hearing:

While three PBMs have had the majority of market share in the past, there are several companies that have evolved recently with strategic acquisitions to develop a robust infrastructure that can now accommodate large employer needs on all levels. As a result they are gaining market share. For instance Catalyst, SXCI, Navitus, MedImpact, OptumRx, Envision, CVS-Caremark, and Welldyne are several options available in today's PBM marketplace depending on individual or purchasing group needs. Further, as the barriers to entry in the PBM market have decreased, new PBM entrants will emerge such as retail-only PBM models.

As noted above, there are at least nine PBMs that serve Fortune 50 companies, and health care reform has already changed the competitive landscape. We expect that trend to accelerate.

A large number of PBMs service large employers. For example, in April 2011, Cardinal Health, No. 19 on Fortune’s Top 20 list, awarded a three-year contract to Tel-Drug, Inc., a CIGNA HealthCare subsidiary. This marketplace is dynamic with strong competitors growing quickly. As outlined above, Medco in the 2012 plan year alone, lost more than \$10 billion in business at a time when a number of PBM competitors continues to grow, both organically and through acquisitions of their own. Catalyst Rx, for example, recently acquired Walgreens’ PBM unit, and has won several large national employer accounts during the past year, including large employer accounts such as Ford Motor Company, MGM Mirage, Whirlpool and Waste Management. Catalyst already serves Nike, Sprint, Southwest Airlines and Lear Corporation.

Additionally, SXC Health Solutions, No. 1 on Fortune’s 100 Fastest-Growing Companies list, recently agreed to acquire PBM PTRX and mail order pharmacy SaveDirectRx. At one time, SXC was considered more of a data processor for PBMs and other health organizations. But the organization now offers a full-service PBM that competes effectively. SXC’s recent addition of Bravo Health Plan to its roster of clients captured more than \$1 billion in additional drug spend. Just last month, SXC additionally announced its agreement to acquire the HealthTrans PBM. Notable SXC clients include Bravo Health/HealthSpring, Boston Medical Center, Presbyterian Health Plan, Safeway, the University of Michigan, and state-associated plans in Tennessee, Arkansas and Hawaii.

Other PBMs have gained significant market share by differentiating their services. These fast-growing competitors include MedImpact Healthcare Systems, which positions itself as a highly transparent PBM that focuses on offering its clients drug benefit management without operating any of its own pharmacies. MedImpact says it serves eight of the top 10 HMOs in the United States with 35 million members across its book of business – including health plans, state and federal employee programs, private employers, unions, hospitals, insurance carriers and third-party administrators

In addition, as we noted above, UnitedHealth's OptumRx has emerged as a formidable competitor for the business of major employers. In fact, UnitedHealth already has contracts for pharmacy management for Fortune 100 companies, such as Delta, Hewlett-Packard, Oracle, Apple, Procter & Gamble and large state government employee plans such as the State of New York – and Optum Rx will be taking over the mail order and claims administration work currently handled by Medco. We estimate that after bringing in-house the UnitedHealth business currently processed by Medco, OptumRx will serve 14 million additional lives and will record annual revenues exceeding \$30 billion. Since being acquired by UnitedHealth in 2005, Optum Rx has increased its managed prescription volume by six-fold. OptumRx has tremendous growth potential as it leverages the resources of its parent, UnitedHealth, which in 2010 earned profits of \$4.6 billion. As a senior UnitedHealth executive noted on a recent earnings call:

We've been working on improving OptumRx consistently over the last three or four years and believe that we, actually, are quite competitive right now, and we'll continue to be even more competitive. We're hearing from consultants that OptumRx is well positioned, has a rising profile in the national accounts market in particular and is increasingly seen as a thoughtful alternative to the big PBMs.²

(c) For large employers and plan sponsors who can't use smaller PBMs, won't this merger leave them with little choice for PBM services, and vulnerable to higher fees because there will be little incentive to pass on drug price discounts?

No, we do not believe that is the case. Based on our experience, large employers can and do use a number of PBMs. As discussed above, large employers use a significant number of PBMs today, and that number is likely to increase. At least nine PBMs today serve Fortune 50 companies, and 17 PBMs serve the Fortune 100. Please refer to our answers to subparts (a) and (b) above for more detail.

² Jacqueline B. Kosecoff from transcript of UnitedHealth Group's Earnings Call Discussion of Q3 2011 Results, October 2011

All PBMs share one common characteristic: they are awarded business based on their ability to deliver the greatest value for clients and their members, thus ensuring a market dynamic that incentivizes them to deliver the lowest possible drug pricing. As Medco experienced by virtue of its \$10 billion in recent losses, clients are demanding and will change their PBM readily.

2. Ms. Sutter and Mr. Bettiga testified at the hearing that your merger will make it much more difficult for traditional pharmacies to compete. What is your response? Does your business model to encourage mail order threaten the pharmacy business? And do we risk losing traditional pharmacies, and the counseling and customer service benefits that goes with a visit to the local pharmacy?

It is important to understand that PBMs such as Medco respond to the demands of clients, and that clients demand that their PBMs provide both a retail and mail network for their members. Retail pharmacies are an integral part of health care in America, and Medco recognizes its obligation to provide a comprehensive, convenient and cost-competitive retail option as part of its core suite of services.

Even if this were not Medco's desire, it is a market requirement. Retail dispensing of prescriptions remains the dominant method by which members receive their pharmaceuticals, and our clients demand that we provide robust retail networks. Mail order services represent only about 15 percent of prescriptions dispensed today in the United States; the other 85 percent are dispensed through retail channels. Moreover, there are vast numbers of prescriptions that are not suitable for mail order, such as acute antibiotics and 30-day prescriptions. Medco's client contracts, as well as regulations, require Medco to provide certain access levels to retail pharmacies for our members.³ Client demand and these regulatory requirements ensure that we work collaboratively with retail pharmacies to ensure they remain in our networks.

Moreover, the perception that independent pharmacies have been losing prescriptions to mail order pharmacies is simply unsupported by the relevant data; however, independents have been losing significant prescription volume to chain pharmacies and big-box retailers, including supermarkets and mass merchants. Data recently released from the National Association of Chain Drug Stores (NACDS) shows that even though all pharmacy segments are filling more prescriptions year over year, the relative share of mail order pharmacy has remained flat, while the share of chain and big box retail pharmacies, such as CVS and Walgreens or Walmart and Sam's Club, has increased at the expense of the community-based independent pharmacies.⁴ And the basis of that growth for chain and big box retailers has been fueled in part by the growth of 90-day maintenance prescriptions being filled at those stores and not at mail order. In other

³ It is important to note that Medco, as a Medicare Part D Prescription Drug Plan, is required by law to ensure that beneficiaries have "convenient access to network pharmacies" – meaning they live within a certain distance of a pharmacy. In addition, under the terms of its client agreements, Medco is contractually obligated to ensure that its retail pharmacy network meets exacting proximity requirements so all plan members can readily access a retail pharmacy, e.g., generally speaking, members in urban areas must live within one mile of a pharmacy, suburban members must live within three miles and those living in rural areas must live within five miles of a retail pharmacy.

⁴ NACDS Chain Pharmacy Industry Profile 2011-2012.

words, mail and retail pharmacies are direct competitors for those 90-day prescriptions. As the Federal Trade Commission (FTC) noted last year in a letter stating their concerns with a bill then pending before the Mississippi legislature:

Plan sponsors sometimes encourage patients with chronic conditions who require repeated refills to seek the discounts that 90-day prescriptions and high-volume mail-order pharmacies can offer. Mail-order pharmacies, including those owned by PBMs, compete directly with retail pharmacies.⁵

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We would also emphasize that our mail order pharmacies provide comprehensive patient counseling by trained pharmacists. Medco employs more than 3,000 pharmacists who assure our clinical quality standards remain the industry standard. They are available around the clock, every day of the year to answer member questions and address concerns – even if those members are using a retail pharmacy. We also offer our

⁵ FTC letter to The Hon. Mark Formby, Mississippi House of Representatives, March 22, 2011, regarding MS SB 2245, p. 4; accessible at <http://www.ftc.gov/os/2011/03/110322mississippiipbm.pdf>.

⁶ National Community Pharmacists Association, 2010 NCPA Digest, October 2010.

⁷ Drug Channels, "Owning a Pharmacy: Still Pretty Profitable", January 25, 2011 (Analysis of 2010 NCPA Digest Data).

members the opportunity to speak with pharmacists who are specifically trained in specialized areas related to chronic and complex conditions – ranging from heart health and cancer care to asthma and diabetes – a capability that is unrivaled in the mainstream retail environment.

3. (a) According to industry estimates, after this merger the combined Express Scripts/Medco will control about 60% of the mail order business. Should we worry about this high level of concentration in the mail order marketplace? What would you say to your critics who have concerns about competition in the mail order business?

We do not believe that the industry estimate of 60 percent is accurate. For example, the market share estimates do not reflect Medco's significant pending business losses, which represent about 25 percent of our 2011 book of business and \$10 billion in lost revenue. Moreover, the estimates do not reflect that retail pharmacies today also dispense 90-day prescriptions for members with chronic and complex conditions – the types of prescriptions dispensed by mail order pharmacies. The line has been blurred between "retail" and "mail." In fact, CVS Caremark in its business model promotes its belief that this line has been erased completely, as it offers 90-day prescriptions with no distinction between whether they are picked up at the retail store or received by mail. As noted above in our response to Question 2, the FTC has recognized that mail pharmacies "compete directly with retail pharmacies" for this business.⁸

Medicines shipped via mail order are largely "maintenance" medications. These are taken by patients with chronic or complex conditions to manage their care on a long-term basis. Currently, 70 percent of all maintenance prescriptions (90-day supply) are dispensed at retail pharmacies; only 30 percent are dispensed through mail order pharmacies.⁹ With growing numbers of retail pharmacies now offering 90-day maintenance plans, we believe there is robust and growing competition from retail pharmacies.

In addition to retail pharmacies, competition across mail order pharmacies is vigorous. There are at least 32 different companies that own and operate mail order facilities. At least eight of these operate two or more facilities.

This means that any industry estimates of mail order share need to be adjusted based on these conditions: reflecting Medco's significant pending business losses – business that is going to 15 different competitors; the share of 90-day prescriptions that are dispensed by retail; and an acceleration in the competition across the PBM space – driven, in part, by the phased implementation of health care reform.

⁸ FTC letter to The Hon. Mark Formby, Mississippi House of Representatives, March 22, 2011, regarding MS SB 2245, p. 4; accessible at <http://www.ftc.gov/os/2011/03/110322mississippiipbm.pdf>.

⁹ NACDS Chain Pharmacy Industry Profile 2010-2011.

(b) Some of the merger's critics argue that this level of concentration gives your PBMs an incentive to unduly direct consumers to utilize mail order services. What is your response?

Medco, as a PBM, does not have the power or the ability to direct members to use mail service. The decision to use mail order delivery is made solely by plan sponsors. PBMs offer plan sponsors different benefit design options, and the plan sponsor chooses and implements the benefit design that best meets its objectives. It is the plan sponsors that select whether, or to what extent, they provide financial incentives to encourage members to use mail order pharmacies.

Members always have the option of filling prescriptions at any pharmacy they select. However, their plan determines the level of reimbursement provided based on the conditions outlined in the plan's benefit design. To encourage members to use a lower cost and more efficient delivery channel, many plan sponsors offer a lower co-payment for mail order – just as they may choose to lower co-payments for generics, compared to brands. This reduces costs and ensures plan sponsors can continue to provide access to affordable benefits. In some cases using a retail pharmacy for a prescription that falls under a mandatory mail order plan design could require the patient to pay the full, albeit discounted, retail cost of that prescription.

Moreover, for certain entities – insured business in many states and Medicare Part D business – provisions known as “Any Willing Provider” laws do not allow plan sponsors to offer incentives or direct members to mail order.

Finally, as noted above, there are certain types of prescriptions that are not appropriate for mail order pharmacies to dispense, such as acute antibiotics and short-term pain medications. A merger would not alter those circumstances.

4. In her written testimony, Ms. Sutter brought forward substantial evidence of waste resulting from mail order shipments of prescription drugs, including allegations that patients on many occasions could not get their PBM to cease shipping unneeded drugs. What is your response to these reports of substantial waste in your mail order business? Do PBMs have an incentive to ship prescription drugs to consumers, whether they need them or not? Don't you get paid for every prescription you mail out?

Medco's pharmacists work hard to prevent waste and, in the process, safeguards patients' health, while saving patients, plans and their sponsors significant sums of money. The Medco pharmacy ships prescription medications as authorized by our patients. In fact, even so-called “mandatory” mail programs are a misnomer. By design, even these plans typically allow – and even encourage – that patients receive the first several 30-day fills at retail pharmacies. This allows a physician to ensure that the patient has stabilized on the proper medication before a larger 90-day quantity is dispensed, reducing waste and optimizing clinical care. When patients no longer want authorized medications after they

have shipped, we have processes in place for handling returns and crediting patients and their plans, as appropriate.

Our clients hire us to make prescription medications more affordable. Accountability to our clients creates a very strong incentive to manage waste. With regard to incentives to ship medications to consumers, we are highly incented to ship only those medications our patients need.

5. (a) Specialty drugs are an increasingly important component of medical costs. Generally, these drugs are distributed more narrowly than other pharmaceuticals, often on an exclusive or semi-exclusive basis. How will the merger affect the cost and availability of specialty drugs?

Generally, the overall majority of specialty distribution is broad, not narrow. Although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe the merger will create operational efficiencies and purchasing scale that will help to further reduce the cost of providing specialty pharmacy care for our clients and their members. When assessing the specialty drug space, it is important to remember that a large amount of drug spend for specialty drugs is not adjudicated by PBMs, and that specialty drugs are dispensed by medical providers as well as pharmacies. Additionally, pharmaceutical manufacturers, not PBMs, control whether a drug is dispensed on an exclusive or semi-exclusive basis, and retain the ability to revoke the arrangements at their discretion. Moreover, the competition in the specialty drug space is robust and growing.

Depending on the situation, specialty drugs may be paid for under members' medical benefit or under their pharmacy benefit. Medco, as a PBM, only manages the pharmacy benefit. On the pharmacy benefit side, for most drugs that are considered specialty, pharmaceutical manufacturers do not limit the number of pharmacies that dispense the drugs; any retail pharmacy can dispense specialty drugs to Medco members, and many do. As a result, there are literally thousands of retail pharmacies in Medco's networks that fill prescriptions for specialty products, including self-administered injectables. As well as being dispensed by pharmacies, specialty drugs can also be dispensed by doctors, and in clinics and hospitals.

Pharmaceutical manufacturers can, in certain circumstances, limit the number of pharmacies that distribute a specialty product. The decision to limit the number of distributing pharmacies and the conditions that a pharmacy must meet in order to become a limited distributor are decisions fully within the control of the pharmaceutical manufacturer. They do this, in part, because this may be associated with drug-approval requirements specified by the Food and Drug Administration (FDA) for the management and safety of these medicines or because of special handling requirements. The pharmaceutical manufacturers retain the ability to determine which pharmacies dispense the drugs.

(b) What steps would the new, merged company take to ensure that specialty drugs will be distributed in a way that there will not be supply shortages and that prices for these drugs won't increase for consumers?

Shortage of supply is an issue that arises with the manufacturer and the FDA, and is not created by a PBM or a pharmacy. Our mission, as a PBM, is to ensure that the right patient gets the right drug at the right time in accordance with the physician's prescription and the client's plan design. Our clients demand that we maintain an inventory to ensure that their members can obtain their drugs.

Our pharmacies will not have the ability to create shortages that would drive up prices. There are multiple channels by which specialty drugs are dispensed to members. Retail pharmacies dispense specialty products, as do physician offices, clinics, hospitals and other clinical settings. Depending on the circumstances, payment for specialty medicines can be covered under the member's medical benefit through the health insurance plan or the pharmacy benefit program.

As you may know, a recent report issued by Adam Fein of Pembroke Consulting has estimated that in 2010 the specialty pharmacies operated by Express Scripts and Medco handled 31 percent of specialty drugs dispensed by specialty pharmacies in the U.S. Furthermore, because this figure does not take into account specialty drugs dispensed by physician offices, clinics, hospitals and the like, it necessarily overstates the role played by Medco and Express Scripts in the overall dispensing of specialty drugs.

Although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe the merger will create operational efficiencies and purchasing scale that will help to further reduce the cost of providing specialty pharmacy care for our clients and their members.

(c) What assurances can you give us that the new company will not limit distribution of, or charge very high rates for, specialty drugs to competitors who also must distribute or help make these drugs available to consumers at competitive prices?

As outlined in the previous response, a significant number of entities provide specialty drugs, creating a highly dynamic and competitive environment that will ensure consumers have access to these medicines at competitive prices. For drugs where a pharmaceutical manufacturer has decided to limit the number of distributors, that manufacturer has the ability to add or delete pharmacies at its discretion. It retains ultimate control over distribution. The control exercised by the pharmaceutical manufacturer will prevent any pharmacy – owned by a PBM or not – from limiting distribution of the product.

6. In your written statement, you stated that “Under the terms of our existing contracts alone, we project that at least \$1 billion in savings from the merger will be passed back to our clients annually starting immediately.” Please explain with specificity from where the purported \$1 billion in merger specific efficiencies will come, and the basis for your assertion that the savings will amount to “at least \$ 1 billion.”

The merger of Medco and Express Scripts will result in immediate savings to our clients and, ultimately, to consumers. Today, each of our companies has a separately negotiated agreement with each pharmaceutical manufacturer. We know that one or the other company has the better purchasing terms, providing the lowest overall price. As a merged corporation, we would use the terms of the best contracts that currently exist in making these purchases, which are in the tens of billions of dollars. We project that at least \$1 billion in savings from the merger will be passed back to our clients annually – starting immediately. Sharing these savings with our clients is part of our contractual requirements, certifiable by us and independently auditable by our clients.

7. At the hearing, I stated during my questioning of you that “significantly increasing discounts over what you are getting right now is really not why you are doing this deal, and you are not as certain as some people might think that this deal will result in far more discounts from your suppliers. There are other ways in which you hope this deal will pay off.” You responded “That is correct.” Please state with specificity what are these “other ways.”

During the hearing, this question was directed to Mr. Paz, and we expect he will be addressing this question in his written response. However, as reinforced in our written testimony, we strongly believe the combination of Medco and Express Scripts makes strategic sense for plan sponsors and members. Each company employs a fundamentally different business model, and combining the best attributes of each will create an enhanced capability to lower prices and improve quality care for members. Aside from our ability to negotiate lower drug prices, we believe the merger creates value in other ways. Specifically:

- The merger will allow the companies to streamline operations and implement each other’s best practices. Our ability to drive higher volumes through a combined network with fixed overhead also will create efficiencies to reduce the unit cost of medications for plan sponsors and members. Savings from these synergies are estimated at \$1 billion, which is in addition to the \$1 billion that will flow through to clients as contractually required.
- The merger will allow us to more effectively combat fraud, waste and abuse, which is estimated at about 1 percent of all prescription spending, or \$3 billion a year. We will enhance our ability to help state and federal law enforcement in their efforts to shut down so-called “pill mills” that fraudulently bill the health care system. We will do

this by more effectively monitoring claims data to detect patterns of potential fraud and abuse.¹⁰

- The merger will allow us to apply our advanced technology platforms across all elements of the expanded company. This enables us to seamlessly integrate prescription management at both mail order and retail with our plan sponsor and member services organizations and to facilitate collaboration with physicians to deliver the benefits of new science more quickly to members. The combined entity will advance the transition to wired health care – building on our strong foundation to improve communications among payors, patients, physicians and pharmacists, enabling real-time, secure access to vital member information, enhancing drug-interaction screening and furthering the cause of evidence-based medical practice.
- The merger will combine our collective and complementary expertise to close gaps in care – attacking the estimated \$290 billion in avoidable medical spending annually resulting from patients’ non-adherence to their prescribed medications. This represents an opportunity that equates to about 13 percent of all health expenditures.¹¹
- The merger will enable us to amplify our impact in helping reduce overall health care costs by improving the quality of patient care. This will make American business more competitive – creating a healthier, more productive workforce, preserving existing jobs and creating new jobs in the future.¹² This will also drive greater savings in the Medicare and Medicaid programs without the need to reduce benefits.

8. Are there any conditions on this merger you would accept in order to secure its approval at the FTC?

Since this transaction is currently being considered by the FTC, it wouldn’t be appropriate for us to comment at this juncture.

¹⁰Pharmaceutical Care Management Association, “Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers,” July 2011.

¹¹ New England Health Care Institute, “Thinking Outside the Pillbox: A System-wide Approach to Improving patient medication Adherence for Chronic Disease,” August 12, 2009 and Jonathan Orszag, “The Economic Benefits of Pharmacy Benefit Managers,” December 2011.

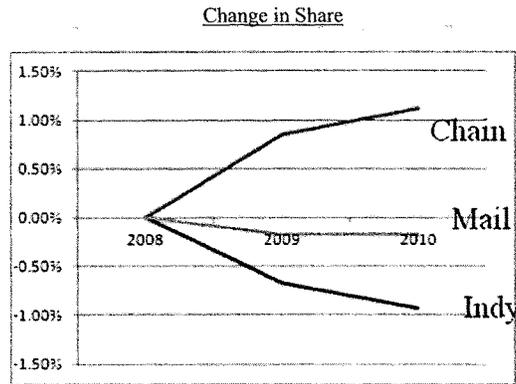
¹²David Cutler and Neeraj Sood, “New Jobs Through Better Health Care,” Center for American Progress, January 2010.

Appendix A

Independent Pharmacies are Losing Share to Chains, Not to Mail

According to NACDS data:¹³

- For several years mail share in the industry has been relatively flat
- While chain share has been growing at the expense of the independent pharmacy



Share calculated by % of total Rx volume

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Mail	5.1%	5.4%	5.5%	5.9%	6.5%	6.8%	6.8%	7.3%	7.4%	7.2%	7.2%
Indy	24.4%	23.6%	22.9%	23.0%	22.7%	21.9%	21.6%	21.3%	20.8%	20.1%	19.8%
Chain	70.6%	71.0%	71.5%	71.1%	70.7%	71.3%	71.6%	71.4%	71.9%	72.7%	73.0%

¹³ NACDS 2011-2012 Chain Pharmacy Industry Profile: Calculated from table 37 "Pharmacy Prescriptions by Type of Store."

Senator Mike Lee
Questions for the Record
David B. Snow, Medco

- 1. I have heard concerns expressed by pharmacies that they do not have sufficient bargaining power in their negotiations with PBMs such as your company. Some point to Walgreens' failed negotiations with Express Scripts as an example of insufficient bargaining power on the part of pharmacies.**

- a. How would the merger affect your interactions with pharmacies and what you are able to offer consumers?**

Retail pharmacies have been – and will continue to be – an indispensable component of the services we deliver to our plan sponsors and their members, regardless of the merger. It is important to understand that PBMs such as Medco respond to the demands of clients, and that clients demand that their PBMs provide both a retail and mail network for their members. Retail pharmacies are an integral part of health care in America, and Medco recognizes its obligation to provide a comprehensive, convenient and cost-competitive retail option as part of its core suite of services.

Even if this were not Medco's desire, it is a market requirement. Retail dispensing of prescriptions remains the dominant method by which members receive their pharmaceuticals, and our clients demand that we provide robust retail networks. Mail order services represent only about 15 percent of prescriptions dispensed today in the United States; the other 85 percent are dispensed through retail channels. Moreover, there are vast numbers of prescriptions that are not suitable for mail order, such as acute antibiotics and 30-day prescriptions. Medco's client contracts, as well as regulations, require Medco to provide certain access levels to retail pharmacies for our members.¹ Client demand and these regulatory requirements ensure that we work collaboratively with retail pharmacies to ensure they remain in our networks.

Moreover, the perception that independent pharmacies have been losing prescriptions to mail order pharmacies is simply unsupported by the relevant data; however, independents have been losing significant prescription volume to chain pharmacies and big-box retailers, including supermarkets and mass merchants. Data recently released from the National Association of Chain Drug Stores (NACDS) shows that even though all pharmacy segments are filling more prescriptions year over year, the relative share of mail order pharmacy has remained flat, while the share of chain and big-box retail pharmacies, such as CVS and Walgreens or Walmart and Sam's Club, has increased at the expense of the community-based independent pharmacies.² The

¹ It is important to note that Medco, as a Medicare Part D Prescription Drug Plan, is required by law to ensure that beneficiaries have "convenient access to network pharmacies" – meaning they live within a certain distance of a pharmacy. In addition, under the terms of its client agreements, Medco is contractually obligated to ensure that its retail pharmacy network meets exacting proximity requirements so all plan members can readily access a retail pharmacy, e.g., generally speaking, members in urban areas must live within one mile of a pharmacy, suburban members must live within three miles and those living in rural areas must live within five miles of a retail pharmacy.

² NACDS Chain Pharmacy Industry Profile 2011-2012.

growth for chain and big-box retailers has been fueled, in part, by 90-day maintenance prescriptions that are increasingly filled at retail stores and not at mail order. In other words, mail and retail pharmacies are now direct competitors for those 90-day prescriptions, blurring the line between the two pharmacy channels. As the Federal Trade Commission (FTC) noted last year in a letter commenting on a bill that was pending before the Mississippi legislature:

Plan sponsors sometimes encourage patients with chronic conditions who require repeated refills to seek the discounts that 90-day prescriptions and high-volume mail-order pharmacies can offer. Mail-order pharmacies, including those owned by PBMs, compete directly with retail pharmacies.³

We have attached a chart in Appendix A that illustrates this pattern.

In fact, Medco data shows that on average, an independent pharmacy loses 64 prescriptions to a chain pharmacy for every single prescription lost to a mail order pharmacy. Nearly half (47 percent) of members who fill prescriptions in an independent pharmacy use more than one pharmacy, including chain and big-box retail pharmacies. If independent pharmacies consolidated these prescriptions they would increase their share by 44 percent.

Although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe our merger will help retail pharmacies compete more effectively and stem these losses to chain pharmacies.

Highlighting the importance that Medco places on the continued viability of independent retail pharmacies, Medco has partnered with independent pharmacies in Illinois and New Mexico as part of pilot programs to provide additional reimbursement to independent pharmacies. This reimbursement is for providing clinical counseling to members and closing gaps in care that members may have related to the appropriate use of medication.

Interestingly, based on data presented by their own trade association, traditional community-based independent pharmacies continue to grow in number and increase their top-line revenue and bottom-line profits. Between 2009 and 2010, the number of independent pharmacies grew by almost 400 to more than 23,000, representing a \$93 billion industry. Average independent pharmacy sales increased by 3.7 percent in 2009, from \$3.88 million to \$4.03 million.⁴ Pharmacy profits have doubled since 1999, with average profits per pharmacy of almost \$1 million.⁵ In the context of one of the most difficult economic environments in generations, that is an enviable position for any industry.

³ FTC letter to The Hon. Mark Formby, Mississippi House of Representatives, March 22, 2011, regarding MS SB 2245, p. 4; accessible at <http://www.ftc.gov/os/2011/03/110322mississippiphm.pdf>.

⁴ National Community Pharmacists Association, 2010 NCPA Digest, October 2010.

⁵ Drug Channels, "Owning a Pharmacy: Still Pretty Profitable", January 25, 2011 (Analysis of 2010 NCPA Digest Data).

b. Do you feel that you need more bargaining power in your interactions with pharmacies?

Our mission is to lower drug costs and improve health outcomes for our plans' sponsors and the members we mutually serve. Although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe the Express Scripts-Medco combination would make us more effective at representing their interests as we negotiate with large drug manufacturers and chain/big-box drugstores for the lowest possible prescription drug costs.

2. It is my understanding that only a few PBMs serve most of the Fortune 50 companies.

a. How much of your overall business comes from this segment of the market?

In 2011, only 6.8 percent of Medco's business came from Fortune 50 companies.

b. Do you view this segment of the market as competitive, and if so who are the other PBMs that you see as competing with you for these large contracts?

We believe there is strong empirical evidence demonstrating that competition in the PBM business – overall, and specifically for large employers – is robust, dynamic and increasing at a rapid pace as the lines blur across traditional competitors, including retail pharmacies, health plans and PBMs. Among the large employers, we do not view Express Scripts and Medco as head-to-head competitors; Medco has not lost a large employer client to Express Scripts in more than three years. Additionally, based on the current dynamics across the pharmacy industry, the historical concept of what some refer to as the “Big Three PBMs” is outdated and has lost whatever relevance it once had. We also note that the implementation of the new health care reform law has already begun to change the competitive landscape for PBMs, and this pace of change will further accelerate as different aspects of the law become effective and continue to be implemented.

Large employers already use more than just CVS Caremark, Medco and Express Scripts. Looking at the Fortune 50, according to a July 2011 Morgan Stanley report, nine PBMs serve Fortune 50 companies: Aetna, Catalyst Rx, CVS Caremark, Express Scripts, Medco, Prime Therapeutics, Restat, SXC Health Solutions and OptumRx (owned by UnitedHealth Group). Additionally, two Fortune 50 companies, Costco and Kroger, have their own PBMs.⁶ Some of these PBMs are among the nation's fastest-growing organizations, developing scale and capabilities at a rapid pace. In 2011, only 6.8 percent of Medco's business came from Fortune 50 companies.

⁶ Morgan Stanley, “Healthcare Services & Distribution: Large Employer Market Key to Deal Approval”, July 28, 2011.

Medco directly experiences this fierce competition for large employer accounts. Although Medco has enjoyed considerable success since its 2003 spin-off, for our 2012 plan year alone, Medco has lost \$10 billion in business – losing 40 clients, large and small – to more than 15 different PBMs. The PBM competitors that recently won these accounts from Medco include: Aetna, CVS Caremark, Catalyst Rx, Cigna, Envision Pharmaceutical Services, Express Scripts, HealthPlus of Michigan, HealthSpring, SXC Health Solutions, MedImpact Healthcare Systems, OptumRx, Prime Therapeutics and ProAct.

This current dynamic, coupled with the changing landscape triggered by health care reform, refutes the historical idea of a “Big Three” construct in the marketplace. In fact, UnitedHealth, the largest health insurer in the country, has contracts with clients for PBM services that, when consolidated at its PBM, will instantly make it the third largest PBM in the country. UnitedHealth owns its PBM, branded in the marketplace as OptumRx. UnitedHealth today provides PBM services to its many clients by using both OptumRx, largely for its government clients, and Medco, largely for its commercial clients. UnitedHealth has announced that it will be moving to OptumRx all the PBM services that Medco currently provides, taking in-house the 14 million lives currently served by Medco. On the pharmacy side, UnitedHealth already provides coverage to a number of Fortune 100 clients, including Delta, Hewlett-Packard, Oracle, Apple, Proctor & Gamble, and state plans such as the State of New York.

UnitedHealth has stated publicly that it anticipates that it will continue to grow its PBM. Today, UnitedHealth alone provides medical insurance coverage for 45 percent of the lives associated with the employers in the Fortune 100. This provision of medical benefits creates a natural feeder to support the continuing growth of OptumRx, which is soon expected to exceed \$30 billion in annual revenue as a UnitedHealth subsidiary. In the most recent rankings, UnitedHealth was listed No. 22 in the Fortune 500, with revenues exceeding \$94 billion. As part of its publicly announced growth plans, the company in 2012 expects to invest more than \$115 million in OptumRx, and has already committed to adding more than 600 jobs to its Kansas City mail order facility, which is capable of dispensing more than 100,000 prescriptions a day. OptumRx also has an additional mail order facility in California.

Today, more than 40 PBMs aggressively compete to provide differentiated value propositions for public and private payors of all sizes. Seven PBMs each process more than 150 million prescriptions annually, 12 PBMs serve more than five million members each, and at least 17 PBMs serve large state accounts. Additionally, nine Fortune 500 companies operate PBMs directly for their employees. Thus, regardless of the past dynamics in the market for large employers, today’s marketplace is changing rapidly and will continue to evolve.

3. Can you please clarify your views of independent community pharmacies and discuss how the merged entity would ensure that consumers are receiving the services they need from community pharmacies?

Our clients demand that we provide members with broad and convenient access to a comprehensive network of pharmacies. As we elaborated in the response to Question 1, above, retail pharmacies provide a critically important service across the health care continuum, and we consider independent community pharmacies indispensable to the success and viability of the overall pharmacy network.

As the acquired party in this transaction, we are not in a position to comment on specific operational matters post merger. However, there is nothing that we believe would alter the fact that independent pharmacies remain critical to the success of the enterprise.

4. I have heard concerns expressed that the merged entity could design prescription drug plans that economically force patients to use mail order or unfamiliar pharmacies for certain medications, thus diminishing and fragmenting patient care.

a. Do PBMs currently pressure customers to use mail-order services or other pharmacies that may be unfamiliar to the consumer?

No, they do not. Medco, as a PBM, does not have the power or the ability to direct members to use mail service. The decision to use mail order delivery is made solely by plan sponsors. PBMs offer plan sponsors different benefit design options, and the plan sponsor chooses and implements the benefit design that best meets its objectives. It is the plan sponsors that select whether, or to what extent, they provide financial incentives to encourage members to use of mail order pharmacies.

Members always have the option of filling prescriptions at any pharmacy they select. However, their plan determines the level of reimbursement provided based on the conditions outlined in the plan's benefit design. This is why, to encourage members to use a lower cost and more efficient delivery channel, many plan sponsors offer a lower co-payment for mail order – just as they may choose to lower co-payments for generics, compared to brands. This reduces costs and ensures plan sponsors can continue to provide access to affordable benefits. In some cases, using a retail pharmacy for a prescription that falls under a mandatory mail-order plan design could require the patient to pay the full, albeit discounted, retail cost of that prescription.

Also, there are certain types of prescriptions that are not appropriate for mail order pharmacies to dispense, such as acute antibiotics and short-term pain medications. A merger would not alter those circumstances.

Medicines shipped via mail order are largely “maintenance” medications. These are taken by members with chronic or complex conditions to manage their care on a long-term basis. Currently, 70 percent of all maintenance prescriptions (90-day supply) are dispensed at retail pharmacies; only 30 percent are dispensed through mail order pharmacies.⁷

We would also emphasize that our mail order pharmacies provide comprehensive patient counseling by trained pharmacists. Medco employs more than 3,000 pharmacists who assure our clinical quality standards remain the industry standard. They are available around the clock, every day of the year to answer member questions and address concerns – even if those members are using a retail pharmacy. We also offer our members the opportunity to speak with pharmacists who are specifically trained in specialized areas related to chronic and complex conditions – ranging from heart health and cancer care to asthma and diabetes – a capability that is unrivaled in the mainstream retail environment.

b. Would the merger in any way affect the manner in which your company structures its contracts with plan sponsors with respect to mail-order services?

Medco’s current contracts with its plan sponsors and any new contracts entered into prior to the merger closing date will remain in effect after the merger, and cannot be changed without the consent of the plan sponsor. Although as the acquired company we are not in a position to comment specifically on operations post-merger, nothing will alter the fact that the decision to use mail order delivery is made solely by plan sponsors.

5. At the hearing, Susan Sutter expressed concern that a low percentage of clients were exercising their contractual audit rights. Ms. Sutter expressed concern that the low rate of audits was due to contractual terms that require clients use auditors agreed to by the PBM.

a. How often do clients perform audits of your company?

We operate with complete transparency in the context of our relationships with our plan-sponsor clients. Plan sponsors perform audits at their discretion – as frequently as they choose in accord with the terms they have negotiated as part of their agreement with Medco. As Mr. Streater testified at the hearing, his organization takes an aggressive position on audits and takes full advantage of these privileges. Last year, there were more than 600 audits of our contractual relationships with our clients.

⁷ NACDS Chain Pharmacy Industry Profile 2010-2011.

b. Do your contracts contain clauses requiring that audits be performed only by auditors agreed to by your company?

Every contract is unique, containing terms and conditions that are agreeable to both parties. As a general policy, Medco allows any entity selected by the client to conduct claims audits on the client's behalf. For rebates, the FTC and other government agencies have specifically noted that making the rebate information public would raise health care costs. Thus, for rebate audits, Medco is agreeable to all of the Top 100 stand-alone auditing firms, as well as others by mutual agreement.

We would emphasize that Medco's level of transparency with clients has been publicly described by state attorneys general as setting the "gold standard" in the PBM industry.⁸

c. Will the merger affect the number of audits performed or the contractual clauses with your clients regarding audits?

Given that audits are initiated by plan-sponsor request, the number of audits that may be conducted in the future is a metric that is determined by the plans themselves; therefore, we are unable to offer an accurate prediction. However, we have seen a trend of increasing audits by clients, and we see nothing that would alter that trend.

6. I have heard concerns expressed about the effect of the merger on consumer access to specialty drugs.

a. How do you define the market for specialty drugs and what share of that market would the merged entity have?

Generally, the overall majority of specialty drug distribution is broad, not narrow. When assessing the specialty drug space, it is important to remember that a large amount of drug spend for specialty drug is not adjudicated by PBMs; specialty drugs are also dispensed under the medical benefit by providers such as doctors, hospitals and clinics, as well as pharmacies. Additionally, pharmaceutical manufacturers, not PBMs, control whether their drugs are dispensed on an exclusive or semi-exclusive basis, and manufacturers retain the ability to revoke the arrangements at their discretion. Moreover, the competition in the specialty drug space is robust and growing.

Given this broad and fractured specialty market, depending on the situation, specialty drugs may be paid for under members' medical benefit or under their pharmacy benefit. Medco, as a PBM, only manages the pharmacy benefit. As a result, when

⁸ Boston Globe, April 27, 2004; Pink Sheet, May 2, 2004.

considering “share” in specialty, it would be incomplete and misleading to include only the number of pharmacies that dispense specialty products, or a PBM’s network. The fact that specialty drugs can be covered on either benefit and are dispensed in a variety of practice settings other than a pharmacy means that the market for specialty medicines is much broader and much more competitive, which works to the benefit of payors and patients alike.

Moreover, there are hundreds of specialty drugs (Accredo, the specialty pharmacy owned by Medco counts about 250 specialty drugs) and thousands of pharmacies dispensing the majority of those drugs. Clients have the ability to decide the number of “specialty pharmacies” that are in their network. On the pharmacy benefit side, for most drugs that are considered specialty, pharmaceutical manufacturers do not limit the number of pharmacies that dispense the drugs; any retail pharmacy can dispense specialty drugs to Medco members, and many do. As a result, there are literally hundreds of retail pharmacies in Medco’s networks filling prescriptions for specialty products, including self-administered injectables. There are also pharmacies that dispense only specialty products (along with, perhaps, ancillary drugs). Pharmacies focusing primarily or exclusively on specialty drugs have been growing in size and number.

As you may know, a recent report issued by Adam Fein of Pembroke Consulting has estimated that in 2010 the specialty pharmacies operated by Express Scripts and Medco handled 31 percent of specialty drugs dispensed by specialty pharmacies in the U.S. Because this figure does not take into account specialty drugs dispensed by physician offices, clinics, hospitals and the like, it necessarily overstates the role played by Medco and Express Scripts in the overall dispensing of specialty drugs.

As to the market size after the merger, although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe the merger will create operational efficiencies and purchasing scale that will help to further reduce the cost of providing specialty pharmacy care for our clients and their members.

b. In what ways do you view the merger as allowing you to provide better prices and care to the consumer with respect to specialty drugs?

By integrating specialty pharmacies with core PBM functions, both Medco and Express Scripts have separately realized high rates of patient adherence, increased ability to close gaps in care and better coordination of care for patients with comorbidities.⁹ We believe this level of care will only be enhanced post merger.

The merger of Medco and Express Scripts will result in immediate savings to our clients and, ultimately, to consumers. Under the terms of our existing contracts alone, we project that at least \$1 billion in savings from the merger will be passed back to

⁹ Jonathan Orszag, Kevin Green, “The Economic Benefits of Pharmacy Benefit Managers,” December 2011.

our clients annually starting immediately. These savings are part of our contractual requirements, certifiable by us and independently auditable by our clients, and include savings related to specialty pharmacy.

7. A few witnesses at the hearing asserted that there is no evidence that PBMs pass cost savings through to their clients.

a. What evidence is there that your company passes through cost savings to its clients?

It is important to realize that clients determine the nature of their contract with Medco. Bluntly stated, if PBMs did not deliver value to clients, they would cease to exist.

We have a large number of sophisticated clients, and those clients liberally exercise their discretion to define the form and content of their contract with Medco. Often during the RFP process, Medco supplies different pricing options to the potential plan sponsor, and the plan sponsor chooses the pricing option it believes returns the greatest value aligned to their plan objectives. Thus, a large percentage of our drug spend is with clients that have negotiated "pass through" pricing of retail pharmacy reimbursement rates, and have chosen to keep all the manufacturer rebates connected to the prescription drug use of their members. Medco's public filings state that across its book of business, close to 90 percent of all rebates are passed through to clients – up from about 50 percent just a few years ago, reflecting the trends in client rebate-retention preferences and Medco's contracting flexibility.

In addition to this direct evidence of value delivered to clients, the savings benefits of PBMs generally have been thoroughly documented in studies by economists; government agencies such as the Congressional Budget Office (CBO), Government Accountability Office (GAO), and the FTC; health industry analysts; and clinical researchers. Recently, a report issued by Jonathan Orszag of Compass Lexecon extrapolated from a CBO estimate that PBMs deliver savings of as much as 30 percent compared to unmanaged drug spending levels. Orszag wrote:

Simply taking this estimate of cost savings derived by two PBMs – Medco and Express Scripts – the savings to health plan sponsors and consumers are roughly \$51 billion per year. But Medco and Express Scripts estimate that they currently derive greater savings through larger discounts from drug manufacturers and retail network partners and benefit plans and consumers in other ways that would not be fully captured in the CBO estimates, such as their more extensive clinical offerings. Including these benefits, these two firms alone save consumers up to roughly \$87 billion per year.¹⁰

¹⁰ Jonathan Orszag, Kevin Green, "The Economic Benefits of Pharmacy Benefit Managers," December 2011.

b. How can consumers be assured that cost savings or other efficiencies from this merger will ultimately benefit them?

The merger of Medco and Express Scripts will result in immediate savings to our clients and, ultimately, to consumers. As but one example, today, each of our companies has a separately negotiated agreement with each pharmaceutical manufacturer. We know that one or the other company has the better purchasing terms, providing the lowest overall price. As a merged corporation, we would use the terms of the best contracts that currently exist in making these purchases, which are in the tens of billions of dollars. We project that at least \$1 billion in savings from the merger will be passed back to our clients annually – starting immediately. Sharing these savings with our clients is part of our contractual requirements, certifiable by us and independently auditable by our clients. Consumers, who are members of our clients, will receive the benefit of the efficiencies through their employers or health plans.

8. I have heard concerns expressed about the transparency of PBMs.

a. Do plan sponsors have full access to the terms of the rebate deals that your company has with drug manufacturers, and if not, why not?

An FTC study, as well as FTC letters and other studies, have highlighted that making the specific contractual rebate terms between PBMs and drug manufacturers publicly available would lessen competition and ultimately increase the costs of drugs for plan sponsors and consumers. For this reason, the terms of the rebate agreements are not made public. In fact public disclosure of rebate agreements is unnecessary because every client has the ability to audit its contract with Medco. These audits ensure that plan sponsors have complete visibility into every element of their contract. This allows them to ensure they receive all the rebates to which they are entitled, consistent with our agreements with drug manufacturers and the plan's agreement with Medco. Depending upon the client, plan sponsors may or may not have direct access to the agreements themselves. This is, again, because of the need for confidentiality. Many of our clients, including health plans, are also our competitors. These clients on occasion decide to negotiate their own rebate agreements directly with drug manufacturers. If they had direct access to our contracts it would decrease competition and increase health care costs.

Conversely, government clients often have the right to review the rebate agreements directly. For example, for the Federal Employee Health Benefit Program plans, the Office of Personnel Management's Office of the Inspector General has – on more than one occasion – received direct access to the rebate agreements in order to audit the contracts at Medco directly. Similarly, the Centers for Medicare & Medicaid Services (CMS) and the Health and Human Services' OIG received direct access to the agreements for audit purposes.

b. Do plan sponsors have full access to the terms of other aspects of your revenue stream such as the details of the spread in your pricing, and if not, why not?

Plan sponsors, as part of their contract with Medco, can determine the level to which they want to audit Medco – it is part of the negotiation process. In fact, a number of plans have contracted to allow auditors to audit Medco’s revenue stream. Again, it is worth noting that Medco’s level of transparency with clients has been publicly described by state attorneys general as setting the “gold standard” in the PBM industry.¹¹

c. Insofar as your concerns regarding sharing rebate information (and other information relative to your revenue stream) is related to confidentiality, would you be willing to disclose this information with the protection of a confidentiality agreement, and if not, why not?

The terms of our rebate agreements are often made available directly to plan sponsors as a matter of contract between Medco and that plan. But the terms are always made available to auditors as part of reviews conducted by the plan sponsors. For example, if a pharmaceutical manufacturer were also a plan sponsor, Medco would not make the terms of competing manufacturers’ rebate contracts available; to do so would decrease competition. Similarly, many of our clients, including health plans, are also our competitors. Those clients on occasion decide to negotiate their own rebate agreements directly with drug manufacturers. If they had direct access to our contracts it would decrease competition and increase health care costs. Moreover, it is important to remember as part of the contracting process, clients choose the percentage of rebates they would like to receive, and the level, if any, that they would allow Medco to retain. Thus, the client, from the contracting phase onward, is aware of rebates that it is receiving and the audit rights it has.

In instances where rebate information requests are received from plan sponsors that are not in a position to decrease competition, such as government plans, the terms of the rebate agreements can be viewed directly by the plan. For example, for Medicare Part D, the aggregate rebate dollars are disclosed to the government, and the government is allowed to directly access and audit the rebate agreements.

9. I have heard concerns expressed about the generic utilization rates of the drug plans administered by PBMs. Some data suggests that generic utilization is lower in mail-order than it is in the retail pharmacy setting.

¹¹ Boston Globe, April 27, 2004; Pink Sheet, May 2, 2004.

- a. Do you dispute the data suggesting that generic utilization rates are higher in the retail pharmacy setting than they are in mail-order?**
- b. If not, how do you account for the lower generic utilization rates associated with mail-order? Do such rates suggest higher costs for consumers?**

We believe that data that shows that generic utilization rates are higher in the retail setting can be explained by adjusting for the mix of drugs dispensed. When comparing “apples to apples,” the rates are similar. Medco’s “generics first” strategy recognizes that in every aspect of our business, when therapeutically appropriate, generics provide the greatest clinical and financial benefit for payors, members and for our company – and incentives are aligned to encourage the optimum use of generics. This is reflected in our rapidly increasing generic dispensing rates across our business.

Medco administers benefit programs for our clients that are accessible to members at retail pharmacies, mail order pharmacies and in certain instances, long-term care facilities. As part of our quarterly performance updates, we publicly report the generic dispensing rates for both our mail order pharmacies and prescriptions filled through retail pharmacies. In the most recent quarter for which data is available (August-October 2011), the retail dispensing rate was 75.4 percent and Medco’s mail order generic dispensing rate was 64.8 percent (a year-over-year increase of approximately 2 percentage points in both the retail and mail channels).

As the FTC has cautioned, however, these generic rates must be adjusted to account for the “mix” of drugs. In a 2005 report, the FTC determined that the generic dispensing rate is an “unreliable” measure if it does not take into account the different mix of drugs dispensed through the retail and mail pharmacies, as well as benefit design features and formulary decisions that affect the member’s pharmacy selection.¹² Ninety-day prescriptions – generally prescriptions dispensed via mail – are largely applicable to chronic therapies such as cardiovascular and diabetes medicines. Many widely prescribed medicines in these chronic-care categories are relatively new, branded products and, therefore, are not currently available as generics. Proportionally, retail pharmacies tend to dispense a greater share of acute therapies, such as antibiotic and short-term pain medicines, which are largely generic products.

Thus, in light of the FTC’s caution about examining the rates after adjusting for this drug mix, it is more accurate and informative to compare generic dispensing rates between retail and mail in those instances when the medication is available in generic form and there is an actual opportunity to dispense a generic. A Government Accountability Office (GAO) report determined, “For drugs where a generic version was available, the retail and mail-order pharmacies dispensed generic drugs at more

¹² Federal Trade Commission Report: “Pharmacy Benefit Managers: Ownership of Mail Order Pharmacies,” August 2005.

similar rates – on average 89 percent of the time for retail pharmacies and 87 percent of the time for mail service pharmacies.”¹³

The FTC also found that retail and PBM-owned mail pharmacies substitute generics at similar rates and that the generic substitution rates (GSR) observed “show that (PBM-owned) mail order pharmacies were generally more, rather than less, aggressive in dispensing generic drugs than were other pharmacies...”¹⁴

In addition to overall generic dispensing rates, it is also helpful to examine the efficiency of mail order and retail in quickly moving patients to the generic once the patent for a branded medicine expires. This is important because the faster this substitution occurs, the faster payors and patients derive the financial benefits. For instance, a Medco study revealed that within the first week of generic availability for Ambien (zolpidem), generic substitution rates at Medco’s mail order pharmacy reached nearly 97 percent, compared with just 76.6 percent at retail for the same time period. In fact, even after six months the retail generic substitution rate did not catch up to the Medco pharmacy’s achieved week-one rates.¹⁵ For Zyprexa, used for treating schizophrenia and bipolar disorder, a generic (olanzapine) became available at the end of October 2011. In the first month, the mail generic dispensing rate was 81.3 percent compared to the retail rate of just 52.8 percent. Finally, for Nasacort AQ, a prescription nasal spray licensed to treat sneezing, runny or stuffy nose, and nasal itching due to allergies, a generic (triamcinolone acetonide) became available in June 2011. After three months, the mail generic dispensing rate was 93.5 percent and the retail rate was 81.6 percent.

10. At the hearing, there was some disagreement about the degree to which PBMs such as your company are regulated by the federal government and the states.

a. Please provide brief details on the manner in which the federal government regulates your company.

b. Please provide brief details on the manner in which state governments regulate your company.

As both a pharmacy and a PBM, to operate in good standing, Medco maintains more than 2,500 licenses and registrations at the federal and state levels combined. Thus, we are extensively regulated at both the federal and state levels.

The following entities have direct oversight over Medco:

- The Centers for Medicare and Medicaid Services (CMS)

¹³ GAO Report: “Federal Employees’ Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies,” January 2003.

¹⁴ Federal Trade Commission Report: “Pharmacy Benefit Managers: Ownership of Mail Order Pharmacies,” August 2005.

¹⁵ Medco 2008 Drug Trend Report.

- The Drug Enforcement Agency (DEA)
- The National Association of the Boards of Pharmacy
- State Departments of Insurance
- State Boards of Pharmacy

The following entities have indirect oversight over Medco through our clients:

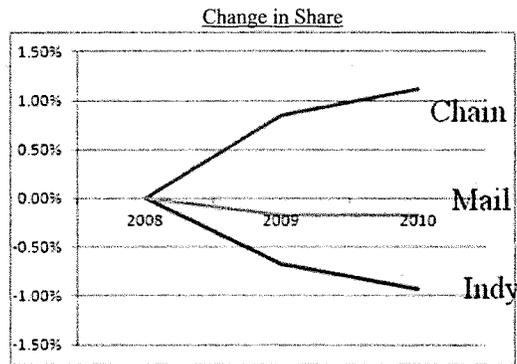
- The Office of Personnel Management (OPM)
- CMS
- State Medicaid agencies
- State Departments of Insurance
- State auditors

Appendix A

Independent Pharmacies are Losing Share to Chains, Not to Mail

According to NACDS data:¹⁶

- For several years mail share in the industry has been relatively flat
- While chain share has been growing at the expense of the independent pharmacy



Share calculated by % of total Rx volume

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Mail	5.1%	5.4%	5.5%	5.9%	6.5%	6.8%	6.8%	7.3%	7.4%	7.2%	7.2%
Indy	24.4%	23.6%	22.9%	23.0%	22.7%	21.9%	21.6%	21.3%	20.8%	20.1%	19.8%
Chain	70.6%	71.0%	71.5%	71.1%	70.7%	71.3%	71.6%	71.4%	71.9%	72.7%	73.0%

¹⁶ NACDS 2011-2012 Chain Pharmacy Industry Profile: Calculated from table 37 "Pharmacy Prescriptions by Type of Store."

Questions for the Record from Senator Charles E. Schumer
for witnesses at Senator Judiciary Committee Hearing on
“The Express Scripts/Medco Merger:
Cost Savings for Consumers or More Profits for the Middlemen”
December 6, 2011

1. How would the merger of Express Scripts and Medco affect community pharmacists’ ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?

It is important to understand that PBMs such as Medco respond to the demands of clients, and that clients demand that their PBMs provide both a retail and mail network for their members. Retail pharmacies are an integral part of health care in America, and Medco recognizes its obligation to provide a comprehensive, convenient and cost-competitive retail option as part of its core suite of services.

Even if this were not Medco’s desire, it is a market requirement. Retail dispensing of prescriptions remains the dominant method by which members receive their pharmaceuticals, and our clients demand that we provide robust retail networks. Mail order services represent only about 15 percent of prescriptions dispensed today in the United States; the other 85 percent are dispensed through retail channels. Moreover, there are vast numbers of prescriptions that are not suitable for mail order, such as acute antibiotics and 30-day prescriptions. Medco’s client contracts, as well as regulations, require Medco to provide certain access levels to retail pharmacies for our members.¹ Client demand and these regulatory requirements ensure that we work collaboratively with retail pharmacies to ensure they remain in our networks.

Moreover, the perception that independent pharmacies have been losing prescriptions to mail order pharmacies is simply unsupported by the relevant data; however, independents have been losing significant prescription volume to chain pharmacies and big-box retailers, including supermarkets and mass merchants. Data recently released from the National Association of Chain Drug Stores (NACDS) shows that even though all pharmacy segments are filling more prescriptions year over year, the relative share of mail order pharmacy has remained flat, while the share of chain and big-box retail pharmacies, such as CVS and Walgreens or Walmart and Sam’s Club, has increased at the expense of the community-based

¹ It is important to note that Medco, as a Medicare Part D Prescription Drug Plan, is required by law to ensure that beneficiaries have “convenient access to network pharmacies” – meaning they live within a certain distance of a pharmacy. In addition, under the terms of its client agreements, Medco is contractually obligated to ensure that its retail pharmacy network meets exacting proximity requirements so all plan members can readily access a retail pharmacy, e.g., generally speaking, members in urban areas must live within one mile of a pharmacy, suburban members must live within three miles and those living in rural areas must live within five miles of a retail pharmacy.

independent pharmacies.² And the basis of that growth for chain and big-box retailers has been fueled in part by the growth of 90-day maintenance prescriptions being filled at those stores and not at mail order. In other words, mail and retail pharmacies are direct competitors for those 90-day prescriptions. As the Federal Trade Commission (FTC) noted last year in a letter stating their concerns with a bill then pending before the Mississippi legislature:

Plan sponsors sometimes encourage patients with chronic conditions who require repeated refills to seek the discounts that 90-day prescriptions and high-volume mail-order pharmacies can offer. Mail-order pharmacies, including those owned by PBMs, compete directly with retail pharmacies.³

We have attached a chart in Appendix A that illustrates this pattern.

In fact, Medco data shows that on average, an independent pharmacy loses 64 prescriptions to a chain pharmacy for every single prescription lost to a mail order pharmacy. Nearly half (47 percent) of members who fill prescriptions in an independent pharmacy use more than one pharmacy, including chain and big-box retail pharmacies. If independent pharmacies consolidated these prescriptions they would increase their share by 44 percent.

Although as the acquired company we are not in a position to comment specifically on operations post-merger, we believe our merger will help retail pharmacies compete more effectively and stem these losses to chain pharmacies.

Highlighting the importance that Medco places on the continued viability of independent retail pharmacies, Medco has partnered with independent pharmacies in Illinois and New Mexico as part of pilot programs to provide additional reimbursement to independent pharmacies. This reimbursement is for providing clinical counseling to members and closing gaps in care that members may have related to the appropriate use of medication.

Interestingly, based on data presented by their own trade association, traditional community-based independent pharmacies continue to grow in number and increase their top-line revenue and bottom-line profits. Between 2009 and 2010, the number of independent pharmacies grew by almost 400 to more than 23,000, representing a \$93 billion industry. Average independent pharmacy sales increased by 3.7 percent in 2009, from \$3.88 million to \$4.03 million.⁴ Pharmacy profits have doubled since 1999, with average profits per pharmacy of almost \$1 million.⁵ In the context of one of the most difficult economic environments in generations, that is an enviable position for any industry.

We would also emphasize that our mail order pharmacies provide comprehensive patient counseling by trained pharmacists. Medco employs more than 3,000 pharmacists who assure our clinical quality standards remain the industry standard. They are available around the

² NACDS Chain Pharmacy Industry Profile 2011-2012.

³ FTC letter to The Hon. Mark Formby, Mississippi House of Representatives, March 22, 2011, regarding MS SB 2245, p. 4; accessible at <http://www.ftc.gov/os/2011/03/110322mississippiipbm.pdf>.

⁴ National Community Pharmacists Association, 2010 NCPA Digest, October 2010.

⁵ Drug Channels, "Owning a Pharmacy: Still Pretty Profitable", January 25, 2011 (Analysis of 2010 NCPA Digest Data).

clock, every day of the year to answer member questions and address concerns – even if those members are using a retail pharmacy. We also offer our members the opportunity to speak with pharmacists who are specifically trained in specialized areas related to chronic and complex conditions – ranging from heart health and cancer care to asthma and diabetes – a capability that is unrivaled in the mainstream retail environment.

2. How would this merger impact patients and pharmacies in the Medicare Part D program?

As the acquired company, we are not in a position to comment specifically on operations post-merger. However, generally speaking, given the success of the Medco Medicare Prescription Drug Plan (PDP), including the services offered through both mail order and participating retail pharmacies, we believe the merger will further benefit members and these retail pharmacies.

As background, since 2006, Medco has offered an individual PDP. Our PDP was the first and only national plan to be awarded a 5-star rating from the Centers for Medicare and Medicaid Services (CMS). For 2011, Medco currently offers two Medicare drug benefit plan options for beneficiaries, including a low premium, basic benefit plan as mandated by statute and a benefit plan with enhanced coverage that exceeds the standard Part D benefit plan, available for an additional premium. We also offer numerous customized benefit plan designs to employer-sponsored group retiree plans under the Medicare Part D prescription drug benefit, and we serve as the PBM inside of other large, national and regional Part D plans. As with our own PDP, Medco's focus is on ensuring a positive beneficiary experience and offering fully compliant, Medicare Part D operations.

Moreover, as a recent study by Jonathan Orszag has underscored, PBMs control drug spending by making prescription management more efficient. PBMs do this by driving higher use of generics and other lower-cost medications, negotiating favorable drug prices from manufacturers and retail pharmacies, and dispensing prescriptions via lower cost channels, such as mail order pharmacies.⁶ In the context of Medicare Part D, the savings delivered by Medco, Express Scripts and other PBMs are passed on to the federal government as a result of lower Medicare Part D costs and, ultimately, passed on to beneficiaries.

⁶ Jonathan Orszag, Kevin Green, "The Economic Benefits of Pharmacy Benefit Managers," December 2011.

3. **Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?**

While we cannot vouch for the actions and performance of all PBMs, we can speak to our own policies and practices. Our Part D contracts with plan sponsors are transparent. Our plans are aware of all the rebates that are received by Medco and pay Medco the same amount for a retail prescription as Medco has reimbursed the retail pharmacy. Medco's Medicare offerings have been thoroughly evaluated and are in compliance with all CMS regulations. All rebates, whether retained by Medco or passed back to the plan sponsor, are fully reported to the plan and to CMS as required under CMS regulations. We believe this ensures that rebate benefits are flowing through the system to help mitigate costs for beneficiaries and taxpayers. Medco's rebate arrangements have been audited directly by the government several times.

With respect to the issue of estimating the rebates that PBMs receive from manufacturers, we have reviewed what we believe to be the relevant OIG reports. We understand that OIG specifically noted that it was plan sponsors – and not PBMs – who are believed to underestimate rebates in their bids, which has led to higher beneficiary premiums. Further to this issue, OIG recommended that CMS should take additional steps to enhance plan sponsors' audit rights and access to rebate information so that plans can accurately report their rebates to CMS.

As a point of fact, CMS did not concur with the OIG's recommendations with respect to the need for more transparency related to rebate information. CMS regulations already require plan sponsors to include provisions in their contracts with PBMs specifying that plans can monitor PBMs' performance on an ongoing basis. Additionally, CMS guidance informs Part D plans that they should audit PBM rebate information to identify waste, fraud and abuse. CMS maintains that this existing regulatory framework strikes an appropriate balance – encouraging contract negotiations between plan sponsors and PBMs that provide for sufficient disclosure to enable plan sponsors to comply with CMS reporting requirements – while recognizing that PBMs view certain information as confidential due to the extremely competitive nature of their industry.

CMS also indicated that it has already imposed sufficient requirements on Part D sponsors with respect to contracts with PBMs in order to address the government's need for transparency. For example, existing regulations require that in their PBM contracts all Part D sponsors include provisions that the entities allow HHS (including CMS and the OIG) to access, audit, evaluate and inspect any information related to the plan's Part D operations. This includes information concerning rebate arrangements between the sponsor and its PBM.

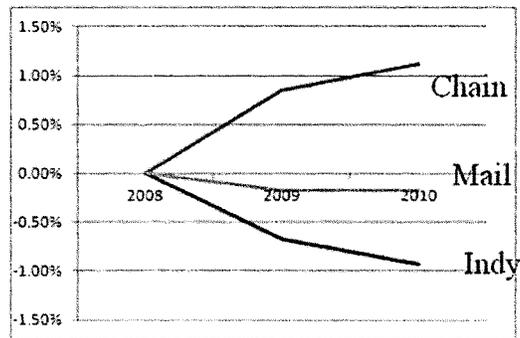
Appendix A

Independent Pharmacies are Losing Share to Chains, Not to Mail

According to NACDS data:⁷

- For several years mail share in the industry has been relatively flat
- While chain share has been growing at the expense of the independent pharmacy

Change in Share



Share calculated by % of total Rx volume

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Mail	5.1%	5.4%	5.5%	5.9%	6.5%	6.8%	6.8%	7.3%	7.4%	7.2%	7.2%
Indy	24.4%	23.6%	22.9%	23.0%	22.7%	21.9%	21.6%	21.3%	20.8%	20.1%	19.8%
Chain	70.6%	71.0%	71.5%	71.1%	70.7%	71.3%	71.6%	71.4%	71.9%	72.7%	73.0%

⁷ NACDS 2011-2012 Chain Pharmacy Industry Profile: Calculated from table 37 "Pharmacy Prescriptions by Type of Store."



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January 7, 2012

Senator Patrick J. Leahy
Chairman, Senate Judiciary Committee
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Leahy:

Thank you for the opportunity to provide testimony at the Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy and Consumer Rights on December 6, 2011. I appreciate the subsequent questions submitted from Committee Members on the proposed Express Scripts-Medco merger and the question at hand: "Cost Savings for Consumer or More Profits for the Middlemen?"

Per your request, please find each of the "Questions for the Record," copied verbatim in italics in the attachment, with my responses immediately following. This testimony is my own, and does not represent an official position of The Ohio State University.

Also as requested, I have marked minor changes on the transcript from my December 6, 2011 testimony and returned it to your office in a separate mailing.

Again, thank you for the invitation. Should you have further questions, please do not hesitate to contact me at (614) 292-9277.

Sincerely,

Scott Streator
Associate Vice President, Business Development
The Ohio State University Medical Center

Attachments (3)
Attachment 1: Streator QFR Response to Schumer
Attachment 2: Streator QFR Response to Lee
Attachment 3: Streator QFR Response to Kohl

Questions for the Record from Senator Charles E. Schumer
for witnesses at Senator Judiciary Committee Hearing on
“The Express Scripts/Medco Merger:

Cost Savings for Consumers or More Profits for the Middlemen?”

Respondent: Scott Streator, The Ohio State University Medical Center

- *Question: How would the merger of Express Scripts and Medco affect community pharmacists' ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?*

As established, the Pharmacy Benefit Manager (PBM) acts as a “middleman,” or intermediary, between the payers of healthcare and the providers (pharmacists). They also act as an intermediary for the entire pharmaceutical supply chain including the critical pharmaceutical manufacturer component. The PBM mirrors medical insurance functionality that also acts as an intermediary on behalf of payers to contract with physicians and hospitals to form a health plan network. Therefore, it is incumbent the PBM, acting on behalf of payers, strikes a balance between competitive reimbursement rates and a sufficient number of providers in a given geographic area to ensure access to care.

This merger should not negatively affect patients in rural communities, inner cities, or other underserved areas. Furthermore, this merger has the potential of strengthening the business relationships between payers and providers, especially where access is limited. From a payer perspective, it was encouraging to hear the comments from George Paz, CEO of Express Scripts, at the hearing on December 6, 2011. Mr. Paz reiterated the importance and need to strengthen the business relationship with community pharmacy including adequate reimbursement.

Oftentimes payers require PBMs to guarantee specific industry-access standards. For example, PBM contract guarantees may stipulate that 95% of their plan participants (employees and covered dependents) have a network pharmacy within five miles. These standards help in the PBM comparison and contract negotiations phase so that accurate comparisons of various PBM networks can be made to meet payers' specifications. Once a PBM contract is secured, the PBM provides an auditable pharmacy access report, often with financial guarantees to ensure the access standards are routinely met.

Certainly the 2007 merger of CVS and Caremark blurred the traditional payer-provider function. I believe this proposed PBM merger of two entities *not owned* by a retail pharmacy, could strengthen the community pharmacy-PBM relationship. My experience with ESI and Medco has demonstrated the ability for customized networks to be furnished by adding particular community pharmacies to meet specific, local needs in rural, inner-city or underserved populations.

- *Question: How would this merger impact patients and pharmacies in the Medicare Part D program?*

Medicare Advantage programs have grown to capture approximately 25% of all Medicare patients. These relatively new, privately-administered programs offer expanded choice from traditional Medicare and the integrated Part D pharmacy benefit has provided welcomed economic relief to patients who were “cash-only” in the past.

Medicare patients are extremely price sensitive. In terms of the impact on patients in the Medicare Part D program, this merger could further expand the competitiveness between the current Medicare Part D and Medicare Advantage programs resulting in reduced costs for consumers. The reduced costs may originate from efficiencies in this proposed merger and the growing Medicare Advantage/Part D competition.

Due to an expanded benefit, Medicare Part D has certainly contributed to positive financial gains by community pharmacy. Community pharmacies have a growth opportunity to support this increasing benefit by attracting and retaining new Medicare patients. Medicare Part D requires patients to have choice for their drug distribution. That is, for the 90-day supply, a Medicare Part D member chooses community or a mail pharmacy. The merger will not affect this choice.

As other retail industries have adapted to “big box” retailers and internet giants such as Amazon, community pharmacy will need to diversify its business model. For example, diversifying reimbursement so pharmacists are not just compensated for “volume” (drug dispensing/distribution), but are paid for “value” (clinical skills in optimizing medication therapy for patients and their physicians). The medical literature is replete with examples of poor outcomes resulting from medication mismanagement, yet pharmacy reimbursement is largely focused on volume.

Consequently, pharmacies in the Part D program can provide additional value to Medicare Part D patients with aggressive 90-day pricing, medication therapy management and supporting physicians in the emerging patient-centered medical home delivery models. These community pharmacy competitive solutions are independent of the ESI-Medco decision.

- *Question: Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG*

reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?

The influx of the baby boomer generation and the increased attractiveness of alternative private plans versus traditional Medicare will accelerate growth and competition in the Medicare Advantage/Part D market. For example, Aetna's December 15, 2011 Investor Conference report projected a 10-fold membership growth in their Medicare suite of services. The increased competition emanates from large, national or regional health plans, smaller hospital-owned Medicare Advantage plans and, of course, the direct Medicare D plan offerings for Medicare beneficiaries.

Value to payers, patients and taxpayers is a function of reduced costs and/or improved quality for the given health expenditure. Therefore, reducing costs is both the opportunity and challenge for the industry on behalf of these customer entities. With dozens of options for Medicare recipients, price sensitivity is the predominant factor in selecting a particular Part D or Medicare Advantage plan.

The OIG report raised questions related to the PBM's financial value and in particular pharmaceutical manufacturer rebate administration and end-user savings. These would be concerning if there were limited competition offering Medicare PDP services and no regulatory oversight.

Moreover, in response to the OIG report, the Centers for Medicare and Medicaid Services December 16, 2011 memo did not concur with several of the OIG recommendations related to rebate administration and PBM contractual relationships. In particular, CMS emphasized they hold each Part D sponsor accountable for compliance with all Part D requirements, irrespective of delegated responsibility. CMS acknowledges the complexity of rebate allocation and requires Part D sponsors to use appropriate methodologies reflecting various differences in formulary, plan design and utilization patterns that can vary market to market.

As a result, with the increased competition and already existing price sensitivity in the Medicare D and Medicare Advantage market, this proposed merger will accelerate the competitive responses of the industry to provide the best value to patients in both public and private health payer arenas.

Questions for the Record from Senator Mike Lee“The Express Scripts/Medco Merger:Cost Savings for Consumers or More Profits for the Middlemen?”Respondent: Scott Streator, The Ohio State University Medical Center

1. *In your written testimony, you discuss emerging changes in the models for healthcare. In particular, you discussed how an increased emphasis on value over volume, and on outcomes over simply providing services, may affect the PBM market.*
 - a. *Question: What role do you see in this new market for a large PBM, such as the merged entity, if the merger is approved?*

In the new health payment-reform market, there are growth opportunities irrespective of the PBM size. One on hand, the smaller PBMs may have competitive advantages over large PBMs with enhanced flexibility to implement customized programs that support “accountable care” types of organizations where the insurance risk shifts from payers to physician/hospital providers.

Payers want increased value for their health investment as evidenced by new payment incentives. For example, if a physician or hospital is financially at risk to prevent a hospital readmission, it will be imperative to have an electronic flow of information from all providers and payers (including the PBM) to ensure medication compliance and medication therapy management is conducted to prevent an avoidable hospital readmission. Thus the size of the PBM is less important as the ability to flexibly integrate, coordinate and manage the care of a given population for improved health outcomes and cost savings.

Meanwhile, larger PBMs can leverage scale and national coordination efforts for employers dispersed across large geographical areas. Also, larger PBMs may have additional capacity to leverage important policy considerations on behalf of plan sponsors. For example, large PBMs acting as “middlemen,” can advocate for increased competition in the biotech industry with “bio-generics.” Finally, large PBMs can create national partnerships with community pharmacy for integrated medication therapy management programs that reward improved health and medication outcomes versus simple drug distribution reimbursement only.

2. *I have heard concerns expressed about the effect of the merger on consumer access to specialty drugs.*
- a. *Question: What effect do you see the merger having on the market for specialty drugs?*

The proliferating “specialty” drug classes, known as biologics, have been managed by the PBMs due to unique distribution requirements, monitoring and patient education requirements. The Express Scripts-Medco merger will provide a sizeable purchasing platform that payers can benefit. While some believe the combined specialty market share will approach 50% with this proposed merger, it is important to note that half of specialty drugs and many new biologics can only be distributed and administered at physician offices or outpatient settings that will effectively reduce this market share. Regardless, the PBM industry provides the market response on behalf of plan sponsors and consumers to help manage and mitigate these costly mediations that average more than \$2,000 per month, but can exceed more than \$10,000 per month. Furthermore, the combined purchasing power of larger PBMs should underscore the need for an accelerated bio-generics pathway approval.

Another important consideration is the narrow distribution channels for complex biologic products required by the biotech/pharmaceutical manufacturers. Below are three examples where the manufacturer has established clinical quality standards that have narrowed distribution away from both community pharmacy and the large PBM specialty pharmacies.

Example 1

Product: Cayston

Manufacturer: Gilead

Disease State: Cystic Fibrosis Infection.

Specialty pharmacy providers: CF Services Inc., Foundation Care, IV Solutions, Pharmaceutical Spec. Inc.

Notes: The manufacturer, Gilead, requires clinical pharmacists to be specialized in Cystic Fibrosis; the product is administered via inhalation necessitating the pharmacy to have specialized compounding capabilities.

Example 2

Product: Prolastin-C

Manufacturer: Talecris

Disease state: A1A deficiency

Specialty pharmacy provider: Centric Exclusive

Notes: Alpha 1 deficiency is undertreated disease; the manufacturer requires a specialty

pharmacy with capabilities in genetic testing for the disease.

Example 3

Product: Caprelsa

Manufacturer: Astrazeneca

Disease state: Thyroid cancer

Specialty pharmacy provider: Biologics Exclusive

Notes: The market is estimated at 2000 patients nationwide; therefore, the manufacturer required a focused pharmacy for the small patient base.

Finally, with new product entrants and health payment reform models emerging where the financial risk shifts to physicians/hospitals, biotech/specialty manufacturers may direct their distribution to outpatient units directly, thereby by-passing the PBM or specialty pharmacy distribution channel altogether.

3. *I have heard concerns expressed about the merged entity's share of mail-order prescriptions filled in the United States.*

- a. *Question: What role does mail-order play for your organization with respect to how it evaluates contracting with one PBM as opposed to another?*

As one of Ohio's largest employers, The Ohio State University values both the community and mail pharmacy options and provides choice at the individual member level. With over 55,000 employees and dependents living across all 88 counties in Ohio, access to prescription medication is imperative for population health and cost containment. Similarly, employers in our 540,000-member Rx Ohio Collaborative value both mail-order pharmacy, as a home delivery service, and the face-to-face interaction provided by local community pharmacists.

At Ohio State University, approximately 90% of our prescriptions are filled at community pharmacies while 10% are filled by mail order. For both formulary brand and non-formulary brands, there is a 30% co-insurance at both mail and community pharmacies while generics have lower copayments.

In terms of evaluating PBM's mail pharmacy program there are many factors to be considered as each employer, or coalition of employers, determines the best "weighting" based on plan sponsors needs. Following are some examples:

Generic Medications--What is the overall discount for generic medications and does it apply to all generics or only to those medications with two or more generic manufacturers? Is it a guaranteed overall discount and how is this reported to the plan sponsor? How long will the guarantee be in place, one year or longer? Will the pricing improve over the contract's lifespan? How are members notified if there is a shortage or a substitution? What is the generic dispensing rate and successful conversion from appropriate brand drugs by the PBM's mail pharmacy? What is the dispensing error rate?

Branded Medications-- Many of the same questions also pertain to brand and specialty brand products. In addition, what is the PBM's rebate guarantee? Is it for all brand medications or just "formulary" brand products? What is the success rate in converting to generics? How often can audits and rebate audits be performed?

Compliance--How is compliance measured? How is drug safety monitored, improved and communicated with patient and the prescriber?

Systems--How flexible are the systems to make plan-sponsor specific request such as a customized formulary? How well do they integrate data and how can plan sponsors access data?

Clinical Programs--What clinical programs are implemented at the mail order pharmacy (and community pharmacy) for enhanced value? How effective are they with patients, community pharmacists and prescribers? How is the effectiveness measured?

Customer Service- Like any service industry, plan sponsor account services and member services determine the overall customer experience. The PBM's customer service function generally supports the mail distribution service. Therefore the effectiveness of the PBM's customer service operations is crucial in the overall evaluation.

Oftentimes site visits to both the mail and customer's service operations are conducted before a final PBM selection is made. The use of industry consultants, whether retained as employees or outsourced, is often used in the RFP/bidding process. The Ohio State University has leveraged in-house industry expertise with academia to form a best-in-class purchasing model to carefully select, monitor and augment the PBM functionality for supporting self-insured employers in Ohio.

b. Question: What effect do you see the merger having on competition among PBMs with respect to mail-order offerings?

The combined entity will leverage existing scale, purchasing power and "best in class" services between both organizations that current plan sponsors may not be presently

receiving from either of the organizations. Competitor PBMs will need to offer other distinctive services to effectively compete. As listed above, there are numerous services, beyond discounts, that could be leveraged across the competitive landscape to improve the value equation.

There is one additional point for consideration. This potential merger should not prohibit community pharmacy from creating and launching their own innovative market solutions for plan sponsors. For example, if retail pharmacy can leverage its purchasing power, integrate clinical functions with physicians and offer greater value versus mail pharmacy, plan sponsors would welcome new delivery models that reflect health payment reform trajectory.

Questions for the Record from Senator Herb Kohl“The Express Scripts/Medco Merger:Cost Savings for Consumers or More Profits for the Middlemen?”Respondent: Scott Streator, The Ohio State University Medical Center

- *Question: In your written testimony, you contend that it is the health plan sponsors that instruct the PBMs how to design pharmaceutical benefit plans, and the PBMs are merely acting at the direction of the plan sponsors. But will this merger reduce the leverage of plan sponsors to insist on specific aspects of plan design, leaving plan sponsors more in a “take it or leave it” position?*

Plan sponsors fiduciary responsibilities include thorough due diligence in the selection and ongoing management of benefit provider organizations including PBMs. When expertise or resources are lacking, many choose qualified industry experts such as national consultants or coalition consultation services. The advantage of plan sponsors banding together increases their purchasing power that spawns new service requirements and new models all together from the chosen PBM.

There are competitive advantages and unique value offerings across the horizon of large and small PBMs, health plan-owned PBMs and fully-integrated health care delivery systems. Without the PBM function, pharmaceutical manufacturers would offer a “take it or leave it” pricing position.

Plan sponsors are seeking value from their provider network, from physicians, hospitals and pharmacists. The retained benefit provider, whether a health plan and/or PBM, should respond to plan sponsor requirements and offer creative solutions. Regardless, the plan sponsor makes the final decision. With this proposed merger, the fiduciary decision and responsibility will not change.



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 Subcommittee on Antitrust, Competition Policy and Consumer Rights
 "The Express Scripts/Medco Merger:
 Cost Savings for Consumers or More Profits for the Middlemen?"
 December 6, 2011
 Questions for the Record

Kohl1

Q. What percentage of your pharmacy business is through the big 3 (Express Scripts, Medco and CVS Caremark) PBMs?

A. Fully, 40% of our pharmacy business is subject to contracts with the big 3 PBMs.

Kohl2

Q. What is your response to the PBMs' argument that they need thriving pharmacies in order to serve consumers, so they have no desire to threaten your business?

A. Senator Kohl, with respect to this statement by the PBMs, the rhetoric does not match the reality. PBMs impose significantly below cost reimbursement rates on community pharmacies, blatantly attempt to shift our patients to their own mail order facilities, aggressively and abusively audit independents, and fail to adequately pay us for medication therapy management services. With friends like these, who needs enemies, as the saying goes.

Pharmacy patients need thriving pharmacies to insure access to quality care, and health plan sponsors generally understand and support this requirement including most government-funded plans. On the other hand, PBMs have historically treated community pharmacies as targets of opportunity to generate revenue and profit streams.

- For example, PBMs created a practice known as the "retail spread" where they contract with health plans at a higher drug price and require community pharmacies to dispense the drug at a lower price. The PBMs pocket the difference – the spread – as profit. PBMs use this practice to squeeze independent pharmacies' reimbursements while not necessarily passing through the full benefit of lower provider reimbursements to health plans.

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- PBM-owned mail order pharmacies clearly compete with independent pharmacies for 90-day supplies of maintenance medications that are taken by patients with chronic conditions such as diabetes, hypertension and high cholesterol. They use their access to health plans to sell mandatory mail plan designs at the expense of independent community pharmacy.
- PBMs also engage in what we call “for profit” pharmacy audits. Independent pharmacies support audits that reduce fraud, waste and abuse. However, PBM pharmacy audits include recoveries for harmless clerical errors that in some cases occurred many years ago. PBMs routinely retain all or a significant portion of pharmacy audit recoveries.

Finally, it is worth noting that the PBM industry seems committed to significantly reducing the number of independent pharmacies that participate in PBM pharmacy networks, despite a lack of evidence that there are any true economic or social welfare benefits by doing so. For example, Wilkinson Consulting, a PBM consulting firm, published a blog on February 18, 2011 (<http://blog.wbcbbaltimore.com/tag/restricted-pharmacy-network/>) that pointed out that so-called “right-sized networks should be considered by health plans since, ... few plan sponsors need the 60,000 store broad network.” Additionally, press reports have stated that in their recent disputes with Walgreens, both CVS Caremark and Express Scripts have argued in favor of including restricted access networks. Adam Fein of Pembroke Consulting, a consultant paid by the PBMs, wrote on June 24, 2010 that “I see the pharmacy and Pharmacy Benefit Management (PBM) industries at a tipping point. It is just a matter of time before smaller, preferred networks are a regular feature of the industry landscape.” (<http://www.drugchannels.net/2010/06/exclusive-walmarts-pitch-for-smaller.html>) In spite of this rhetoric, there seems to be little consideration given to the impact that alleged “right sizing” will have on our communities and the corresponding new limitations that will be imposed on patients’ access to their community pharmacies. This assumes that all pharmacies are created equal, which is not the case. Patients consistently rank independent community pharmacies the highest among all pharmacies in customer satisfaction and loyalty. Moreover, evidence suggests that independent pharmacies produce better patient outcomes from medication use because of the behavioral modifications we are able to achieve with our patients. This results in their taking medications more appropriately and greater adherence.

Community pharmacists are strongly opposed to these efforts to limit patient access and choice through the creation of these limited access networks. It is ironic that these “right-sized networks” would actually mean that pharmacy patients will have less access to care and fewer choices as where they receive their prescriptions and medication counseling services. Of course, these networks would be right-sized for the PBMs as they will enable them to reap even larger profits at the expense of the patients and plans they are supposed to serve.

Kohl3

Q. Should the FTC decide to approve the merger, would you recommend the FTC require any conditions to preserve competition?

A. We think the FTC should reject the merger because it is anti-competitive and will lead to higher prices, reduced access, and lower quality of care for consumers and health plans. In the

regrettable event that the FTC decides to approve the merger, it should require, at a minimum, Express Scripts to divest of all pharmacy operations including, specialty and mail order pharmacies. It is not appropriate for a company that maintains vertical control of community pharmacies by setting reimbursement rates and through audits and other business practices to compete horizontally with their own multi-billion dollar pharmacy operations. This limits or eliminates competition without necessarily providing real savings and improved service to consumers and health plans. Further, the FTC should require PBMs to assume fiduciary responsibility to act in the best interest of the health plans. This should include full transparency in contracting and the elimination of mandatory mail order plan designs since these schemes deliver "captive" patients to PBMs. We refer to them as captives since these patients have no individual choice in terms of where they receive their pharmacy care. If a PBM mail order facility doesn't deliver an acceptable level of service or care the beneficiaries are trapped there until the health plan decides to change PBMs or the plan design for all beneficiaries.

Kohl4

Q. If the FTC does not approve the merger, community pharmacists would still be dealing with three large PBMs with a significant share of the market. How would the situation for community pharmacists be worse with two large PBMs as compared to three?

A. The premise of your question captures the dire situation that independent pharmacies and their patients face today. Can things get worse still? We absolutely think things will be worse not only for independents but for patients and their health plans. For instance, we think that there will be less competition for 90-day prescriptions once the largest and third largest mail order pharmacies are merged. Already, large plans such as CalPERS have stated that there is a limited choice of PBMs that possess the operational scope to handle large plan requirements. Witness Scott Streater acknowledged this issue in his testimony when he said that smaller PBMs did not have the infrastructure and operations to meet his employer's needs:

[In response to questions from Senator Lee, Mr. Streater responded this way: "Senator Lee, thank you for your question. I can just speak from experience, when we have done very sophisticated RFPs (bidding processes) - I won't share specific company names - but I will share with you that when we've done these bidding processes, some of the smaller ones were right up there with the top ones. The reason we didn't choose them at that time was because they lacked integration and operations. It wasn't the savings or the innovation; they were quite creative as I mentioned in my testimony. They were able to be a little more nimble in some various implementation of some clinical programs which save a significant amount of money but they lacked the infrastructure, and so they have - some that aren't even on that chart over there to the left of me, and some companies that are not even on there- that are now quite attractive as a payor and as a health plan representative - if they made acquisitions to be able to integrate their infrastructure that wasn't there before."]

Reducing this number from three to two is important. Additionally, with only two mega PBMs controlling most large employer plans, the pharmacy network contracting will have as its primary focus PBM profits rather than the preservation of a thriving pharmacy network that affords patients and health plans access to quality care and outcomes while controlling cost. The

current ESI/Walgreens dispute gives testament to this likely outcome. In addition to reimbursement issues, there are press reports that ESI seeks power to determine what drugs are classified as generics and which ESI networks Walgreens will be included in or excluded from. If a company the size of Walgreens is offered take it or leave it PBM contracting that it obviously has concluded threatens its viability, what does that say about the chances of small business pharmacies? It's important to note that most informed observers have concluded that CVS Caremark is the de facto winner in the ESI/Walgreens dispute.

However, regardless of the FTC's decision, I join NCPA in supporting legislation which brings transparency between the PBMs and their clients in the commercial space as well as the public programs. We support S. 1058, the *Pharmacy Competition and Consumer Choice Act*, which a) provides a basic level of protection to consumers regarding their choice in where they obtain their prescription medications; b) saves money by making the inner workings of PBMs more transparent to plan sponsors so they know whether they are getting a good deal; c) curbs burdensome audit practices of independent pharmacies.

Transparency helps the market work better. It allows plan sponsors and payers, including large corporations and governments, to confirm that a PBM is in fact providing the service it was hired to do: to secure low drug costs. Without transparency, a plan sponsor has no way to verify that their PBM is sharing manufacturer rebates or that the PBM is negotiating the lowest possible costs for specific drugs. Lastly, I would add that I join NCPA in supporting Section 6 transparency provisions for PBMs of your own legislation, S. 1699, the *Prescription Drug Cost Reduction Act*.

Schumer1

Q. How would the merger of Express Scripts and Medco affect community pharmacists' ability to provide quality care and services to their patients—particularly in rural communities, inner cities and other underserved areas?

A. I have pharmacies in two communities in which they are the only community pharmacy. The concept that by accepting lower reimbursement terms to receive increased prescription volume just doesn't work in these settings.

Patient access to care will change with a reduced number of independent pharmacies particularly in rural areas.... Remember that access to care also takes into account how far patients have to travel to obtain prescriptions and counseling around such key health outcome strategies as increasing adherence. According to the National Institute of Health, increasing medication adherence is a \$290B annual saving opportunity for the health care system.

The PBM industry is committed to restricted access networks that will reduce the typical pharmacy network from 60,000 pharmacies to a number below 20,000. This will in most cases translate into pharmacy networks that are comprised of large chains augmented with a handful of independents to address geographic areas not serviced by the large chains. PBMs profits are enhanced by lowering reimbursements to a reduced number of pharmacies while being able to offer that reduced number of stores increased prescription volume. In creating an access issue, these networks will provide PBMs an opportunity to push mandatory mail order for 90-day of supplies of maintenance drugs particularly for those areas where network coverage is thin.

Schumer2

Q. How would this merger impact patients and pharmacies in the Medicare Part D program?

A. While estimates vary, we believe that 25% of all Part D lives will be concentrated in ESI Medco Part D plans. The remaining Part D lives will be distributed among dozens of other plans. We think this significant concentration in one plan is bad for the Part D program, for beneficiaries, and the Federal government.

This past year the OIG released a report regarding rebates within the Medicare Part D Program for the year 2008. Within that report, the OIG found that PBMs retained \$24 million worth of the drug manufacturer rebates for the Part D program in 2008. This represents \$24 million dollars worth of savings that were not passed on to patients or to Medicare. This report demonstrates that PBMs already use their leverage in negotiations with Part D plans to capture some of the savings that should be passed on to patients and/or Medicare. In other words, Part D beneficiaries are already paying higher premiums than they should for their Part D benefits.

Essentially, the PBMs have a stranglehold on the Part D plans. The Part D plan sponsors need the PBMs to administer the plans, and therefore, the PBMs call all of the shots. It is not unlike the stranglehold that the PBMs have on the large employers, which according to Sen. Kohl's opening statement are so afraid of the power that the PBMs hold over them that they will not even testify before Congress against the ESI-Medco merger. Further consolidation within the

PBM industry will only make matters worse. A merger between ESI and Medco will only serve to allow PBMs to negotiate for the retention of even more savings and rebates than they already retain, thereby further increasing the costs for patients and Medicare. Simply, a merged ESI-Medco entity will tighten the PBM stranglehold on plan sponsors even further.

Further evidence of PBMs' power over plan sponsors is demonstrated by the OIG's finding of a lack of transparency in the relationship between PBMs and Part D plan sponsors. The OIG's report went so far as to find that the lack of transparency may result in plan sponsors not having enough information to provide oversight over the PBMs. In other words, the PBMs are so powerful that they can prevent plan sponsors from monitoring/auditing them for certain wrongdoing and abuse.

The OIG found that the PBMs within the Part D program have so much leverage over plan sponsors that they are able to dictate what information plan sponsors can learn about Part D rebate contracts and rebate amounts negotiated by the PBMs. The OIG found that most plan sponsors were unaware of all of the contract terms that determine the rebates that they received from manufacturers. The PBMs dictate to the plan sponsors what information they can see and what information they cannot see.

In many cases, PBMs limit the extent to which a plan sponsor can audit that PBM. This lack of transparency results in plan sponsors being unable to verify whether certain fees collected by PBMs should be considered rebates or bona fide service fees. The former, if appropriately designated, should be passed on in the form of savings to patients and/or Medicare. The "trust me" attitude of PBMs towards plan sponsors raises questions about whether the PBMs have something to hide. It goes without saying that a merged ESI-Medco entity's ability to control the flow and transparency of information will only be stronger than the PBM control exercised in the current PBM environment.

PBMs use their market power to leverage negotiations with Part D plans. More bluntly, the PBMs already exercise significant control over and practically dictate what information plan sponsors have access to and how much plan sponsors can effectively guard against PBM wrongdoing. If the ESI-Medco merger is approved, the resulting company will have even more power to dictate contract terms with plan sponsors, withhold information from plan sponsors and, ultimately, retain more savings for themselves instead of passing them along to patients and Medicare.

From the pharmacy perspective, PBMs, within the Part D program, provide the service of structuring preferred networks and negotiating pharmacy reimbursement on behalf of Part D plan sponsors. These PBMs use their market leverage to negatively impact community pharmacy in two ways. First, PBMs often own their own mail order pharmacy and use their market leverage to encourage or steer patients within a given Part D plan away from independent community pharmacies to PBM-owned mail order pharmacies. Second, PBMs use their market power to lower reimbursement rates for pharmacies servicing Part D plan patients. Of course, the savings generated by the lower reimbursement rates are not necessarily passed on to plan sponsors.

If the ESI-Medco transaction is approved, then the merged entity will have even more power and strength to dictate Part D plan terms that encourage or steer Part D patients towards mail order as a preferred pharmacy. Part D plan sponsors will be under more pressure to accept contract terms, which promote mail order pharmacy because they will have fewer choices of PBMs with which to contract. Post-merger, with only two large national PBMs accounting for a large percentage of prescription volume, independent community pharmacies will have to accept PBM-dictated low reimbursement terms or be locked out of the Part D plan network connected to that PBM.

Schumer3

Q. Two recent reports from the Health & Human Services Office of Inspector General have found that PBMs are not adequately sharing savings with Medicare patients and that PBMs underestimate the rebates they receive from manufacturers—ultimately resulting in higher Medicare costs for both beneficiaries and taxpayers. Based on the findings of the OIG reports, how can we be assured that this merger will drive the best bargain for patients, for public and private payers, and for taxpayers?

A. Based on the OIG reports, all indications assure us that the merger will drive a worse bargain for patients, Medicare and taxpayers. To briefly reiterate the points outlined in the immediately preceding answer, increasing PBM consolidation and market power will only serve to allow PBMs to dictate one-sided contract terms between themselves and Part D plan sponsors and between themselves and network pharmacies. These new contract terms likely will result in greater profits for the PBM and higher costs or less savings for patients, Medicare, taxpayers and pharmacies. A merged ESI-Medco will serve as a “middleman on steroids,” with the power to draw out substantial profits, on PBM-dictated terms, from the Part D program, while driving up drug costs for millions of Part D beneficiaries and the federal government, as well as endangering the continuing financial viability of independent community pharmacies across the country. In the end, if independent community pharmacies go out of business, millions of Part D beneficiaries, particularly in rural areas, will lose access to the valuable products and services that independent community pharmacists provide.

Lee

Q. At the hearing, you expressed concerns for the viability of community pharmacies in light of the growth of PBMs and in the event the merger is approved. I understand there to be some data suggesting that gross profit margins for independent drugstores have remained fairly steady over the past 10 years (ranging from 22% to 24%), and that the number of independent pharmacy locations has likewise not changed significantly during that time period (with about 20,000 in 2000 and about 20,000 in 2010). It is my understanding that hundreds of community pharmacies in fact opened their doors just this last year.

- Do you dispute this data?
- On what do you base your opinion that the existence of community pharmacies is threatened?

A. Senator, coming from a predominantly rural state, we know you must appreciate the importance of small businesses to the economy of Utah. We also know that you appreciate that independent community pharmacies are often times the primary health care provider in many rural towns and communities. The number of independent pharmacies as a percentage of all community pharmacies has decreased since 2000. Chain operated pharmacies comprise about 60% of all community pharmacies at this point. Between 2000 and 2006, the number of independent community pharmacies decreased from 24,841 to 24,500, but since the implementation of Medicare Part D that number has fallen to 23,064, where it stands today. In fact, between 2006 and 2007, the overall number of independent community pharmacies fell by 1,152 or 5%. A large portion of these closings occurred in rural communities, such as those found in Utah, with many rural communities seeing their sole pharmacy close. Given the strong economic headwinds facing small businesses, especially community pharmacies, we know you join us in congratulating the entrepreneurial business men and women who have opened community pharmacies over the past few years.

Unfortunately, the PBMs are distorting financial data to make it appear that independent pharmacies are financially healthy. For example, pharmacies do not take home the “gross margin”, they take home the “net margin.” The net profit margin is the only appropriate figure to use – and it has decreased to about 3%, with the number of independent community pharmacies operating at a loss increasing from 14% in 2006 to 23% in 2010. Furthermore, an additional 23% of independent community pharmacies made a net profit of between 0% and 2% in 2010. The fact is, 46% of all community pharmacies had a net profit of 2% or less in 2010. *(The gross profit margin is 22%-24% but includes payroll expenses and other operating expenses which came in at 21% in 2010, leaving 3% net profit.)*

A misconception exists that pharmacies make better profit margins on Medicare Part D prescriptions. The fact is, pharmacy gross margins on Medicare Part D are only 18%, a full 4% to 6% below overall gross profit margins. These low margins have resulted in increased pharmacy closings and in greater numbers of pharmacies operating at a net profit loss. Further decreases in reimbursements due to the Express-Scripts/Medco merger could affect whether a small independent pharmacy can remain open to serve patients.

Independent pharmacies derive more than 90% of their business from prescriptions, unlike chains which derive about 65% and big box stores which derive less than 10%. Given that most independent pharmacies operate at 2 to 3 percent net profit margin before taxes, small changes to prescription reimbursement can mean the difference between keeping their doors open, shuttering the store, or laying off workers. If a single PBM can control 40 to 60% of the average pharmacy's business, with more than 90% of that being prescriptions, it doesn't take long to see how a small independent is more at the mercy of the whims of the PBMs than chains or big box stores.

Lee2

Q. At the hearing, some witnesses asserted that big-box store pharmacies have had a larger impact on independent community pharmacies (in terms of diverting business) than have PBM owned mail-order pharmacies. PBMs further assert that they have real incentives to preserve the independent drugstore industry, as those stores are needed, among other reasons, to satisfy plan sponsor requirements for pharmacy network adequacy.

- Do you dispute the assertion that big-box store pharmacies have diverted more business from independent community pharmacies than have PBM-owned mail-order pharmacies?
- Do you dispute the assertion that PBMs have real incentives to preserve independent community pharmacies in their networks?

A. Yes, I do dispute the PBMs' assertion about the impact of big-box store pharmacies on independent community pharmacies. Independent community pharmacists are well known for the quality and breadth of their pharmacy and other health related services and thus have successfully competed for years within markets that contain big-box pharmacy competition. This is healthy competition on a level playing field in which the patient is in control of the choice. The PBMs can't deliver the professional services we do as pharmacists, which is vitally needed for patients to understand their medications, so they default to creating plan designs that financially disadvantage patients that want face-to-face contact with a pharmacist.

I also absolutely dispute the assertion that PBMs have real incentives to preserve independent community pharmacies in their networks. I recall arguing with a PBM that one of our pharmacies was greater than 15 miles from another competitor and thus met the qualifying requirement for a rural rate contract. They refused because one of our other pharmacies that had no choice but to sign their normal contract was within 15 miles.

In fact, after the hearing, an Express Script executive assured me that their company was concerned about patient access in their networks. When I told her of our experience with rural rates and being the only pharmacies in these two communities, she stated it must not have made it to her desk. This whole idea of real incentives to preserve independent community pharmacies is just one more area that the rhetoric is in no way matching the reality.

Independent pharmacies understand that fair competition is needed and occurs in virtually every industry and market. Most independents believe they can compete with chain pharmacies on quality and level of service, factors that many patients desire. Our concern is not rooted in fair competition from any source, but rather in those egregious business practices that PBMs have

adopted and use to promote unfair competition that harms not only small business pharmacies but their patients and health plans.

Pharmacy patients need thriving pharmacies to insure access to quality care, and health plan sponsors, including most government funded plans, generally understand and support this requirement. On the other hand, PBMs have historically treated community pharmacies as targets of opportunity to generate revenue and profit streams in most cases placing the long term viability of independents in jeopardy.

It is worth noting that the PBM industry seems committed to significantly reducing the number of independent pharmacies that participate in PBM pharmacy networks. Over the last couple of years, there has been a steady drumbeat of blogs and articles supporting so-called restricted access or "right-sized" networks. I point to a Wilkinson Consulting blog on February 18, 2011 (<http://blog.wbcbbaltimore.com/tag/restricted-pharmacy-network/>) that highlighted PBM Trends for 2012. This PBM consulting firm points out that so-called "right-sized networks should be considered by health plans since,....few plan sponsors need the 60,000 store broad network. In most cases a 18,000 to 30,000 store option fits the bill and provides enhanced discounts that are well worth consideration." Additionally, press reports have stated that in their recent disputes with Walgreens both CVS Caremark and Express Scripts have argued in favor of including restricted access networks. Adam Fein of Pembroke Consulting, a PBM leaning firm, wrote on June 24, 2010 that "I see the pharmacy and Pharmacy Benefit Management (PBM) industries at a tipping point. It is just a matter of time before smaller, preferred networks are a regular feature of the industry landscape." (<http://www.drugchannels.net/2010/06/exclusive-walmarts-pitch-for-smaller.html>) This means pharmacy patients will have less access to care and PBMs will reap huge profits.

The PBM industry seems committed to restricted access networks that will reduce the typical pharmacy network from 60,000 pharmacies to a number below 20,000. This will in most cases translate into pharmacy networks that are comprised of large chains augmented with a handful of independents to address areas not serviced by the large chains. PBMs profits are enhanced by lowering reimbursements to a reduced number of pharmacies while being able to offer that reduced number of stores increased prescription volume. In creating an access issue, these networks will provide PBMs an opportunity to push mandatory mail order for 90-day of supplies of maintenance drugs particularly for those areas where network coverage is thin.

Only those PBMs that don't own community stores have an "incentive" to utilize independents to fill prescriptions for medications to treat acute conditions since they have no competing pharmacies. PBMs that have retail and/or mail order and specialty pharmacy operations that directly compete with independents to dispense medications have very little incentive to utilize independents.

Lee3

Q. I have heard concerns expressed about the transparency of PBMs.

- In your experience, do employers and other plan sponsors understand their pharmacy benefit plans?

- What additional transparency provisions would you support and why?

A. While the pharmacy benefit is the most often used health benefit, it represents less than 20 percent of the overall health benefit cost. For this reason, health plan sponsors focus the vast majority of their attention on the medical benefit. But it is vitally important that health plan sponsors understand that pharmacy is a fulcrum of care and can reduce the medical cost associated doctor office and ER visits as well as hospitalizations. So, merely getting a drug at the cheapest price is not the end of the story. It is safe to say that there are varying degrees of expertise and understanding exhibited by health plan sponsors regarding pharmacy benefit plan designs, contracting, pricing, performance guarantees, etc.

Linda Cahn, an expert in pharmacy benefit contracting, has written and documented many examples of how PBMs have historically prevented health plans from realizing the full benefit of their pharmacy spend. As an example, generics represent a huge savings opportunity to most plans but PBM contracting schemes led Ms. Cahn to conclude that virtually no health plan is maximizing generics savings. I would recommend an article that Ms. Cahn authored and appears in the November 2010 edition of Managed Care Magazine where she clearly demonstrates how PBMs interfere with health plans ability to receive the full benefit of generic savings.

As to increased transparency, I would suggest the following steps be taken:

1. Require PBMs in all cases to "pass-through" to health plan its actual drug cost. This would include drugs dispensed at retail, mail order and specialty central fill.
2. PBMs should eliminate all "spread pricing" (i.e. The practice in which the PBM pays for drug at one price but invoices the health plan at a far steeper price). Hidden "spreads" can be created on virtually any drug related expenditure. So-called rebate management fees are charged to health plans above and beyond the PBM retention of client generated manufacturer rebates. Walgreens claims that "at the same time, as retail pharmacies have had flat or declining profits per prescription, Express Scripts has increased its gross profit per script as an intermediary by more than 13 percent annually from 2005-2010." Walgreens rightly concludes that: "(w)hen this "spread" results in profits of an intermediary rising faster than providers, the intermediary is taking profits out of the healthcare system and increasing costs."
3. PBMs should be required to be fiduciaries, mandated to act in the best interest of health plans it serves.
4. Forbid PBMs from requiring "mutual approval" of any auditor that health plans designates to conduct an audit of the PBM. As it stands now, PBMs can veto any selected auditor. PBMs can limit the number and/or frequency of audits. Many PBMs require auditors to sign PBM "Confidentiality Agreements" that typically require auditors not to disclose key information to their own clients, i.e. the health plan that requested the audit.
5. PBMs should disclose the process and inputs to its Maximum Allowable Cost (MAC) applicable to generics. PBMs require pharmacies to agree to contracts in which prices are not disclosed nor the methodology as to how the prices are determined. We support transparency

between the PBM and the client/plan sponsor on MAC pricing—such the weekly methodology established in S. 1058, the *Pharmacy Competition and Consumer Choice Act*.

6. PBMs should transfer all “recoveries” from PBM-conducted community pharmacy audits to health sponsors. PBMs create a revenue and profit from stream from pharmacy audits that health plans don’t necessarily share. Clerical errors/typos “recoveries” often can become a focus as opposed to true fraud, waste and abuse.

7. Eliminate Manufacturer Rebate Schemes. Drug manufacturers “reward” PBMs for promoting their brands. Rebates are offered only for single-source drugs for which there are no generics. Rebates represent a very significant source of PBM revenues. Often PBMs promote drugs that yield the highest rebates, not ones that are necessarily in the patient's best interest (most efficacious). PBMs have historically retained rebates, now in some limited cases, they’re being forced to share them with plan sponsors.

8. Eliminate or require disclosure of Mail Order Complex Schemes. Mail order is still very much a complex component of pharmacy benefit management that is largely opaque to plan sponsors. PBM-owned captive mail-order facilities can create a significant conflict of interest as the pharmacy administrator is also a seller. PBMs with captive facilities have been accused of engaging in non-transparent mail-order practices to increase profits including drug switching, repackaging and failing to promote starter dosages: pushing mail-order scripts for 90-versus 30-day supplies. The recent CalPERS settlement with CVS Caremark is a top of mind example of some of these practices becoming points of contention and concern to health plans (<http://www.sacbee.com/2011/12/16/4127584/calpers-vendor-cvs-caremark-agrees.html>). Mail order pharmacy audits are largely controlled by their PBM owners. We would be happy to work with you on pushing forward some of these transparency concepts.

Lee4

Q. In your written testimony and at the hearing, you suggested that independent community pharmacies have little bargaining power in their negotiations with PBMs. It is my understanding that many independent pharmacies (80% by one estimate) participate in Pharmacy Services Administration Organizations (“PSAO”), which bring pharmacies together to gain leverage in their negotiations with PBMs.

- Does your pharmacy belong to a PSAO?
- Do you dispute the existence or prevalence of PSAOs?
- Do you view PSAOs as effective in their negotiations with PBMs, and why or why not?

A. Yes, we belong to a PSAO. We joined a PSAO about five years for administrative efficiencies since we no longer had any success in trying to negotiate any contracts. I would agree that the approximate number of independent pharmacies represented by a PSAO approaches 80%. However, despite PSAOs’ representation of independent pharmacies in the marketplace, their effectiveness to negotiate meaningful changes to contract terms and conditions posed to them by PBM’s is extremely limited.

First, and most importantly, PSAOs are at a competitive disadvantage when attempting to negotiate contract terms and conditions with a PBM as compared to chain pharmacies. If a chain pharmacy organization declines participation in a PBM's proposed contract, the PBM cannot go to the individual chain pharmacy locations and solicit them independently for participation. Thus, when a chain says "no" to a contract, it means "no". The PBM does not get any of that chain's pharmacies in its network. So a PBM has to seriously consider whether it needs any of the chain's locations before it walks away from the negotiations.

On the contrary, when PSAOs are attempting to negotiate terms and conditions with a PBM on behalf of their independent pharmacies, the same does not hold true. In the case of a PSAO, they can say "no" to a PBM contract, but due to antitrust laws, the PSAO cannot force nor advise their pharmacies not to consider an offer that a PBM may make directly to the pharmacy (bypassing the PSAO). Thus, the PBM always has the ultimate negotiating tactic available to them against the PSAO. That is, if they can't work out a deal with the PSAO, then the PBM can solicit some or all of the pharmacies directly to fulfill their network requirements. A PSAO is always negotiating with "one arm tied behind its back." Thus, the net result is often that a PBM will build their base pharmacy network for a particular contract with chain pharmacies that they "must have," and then offer contracts directly to none or only a limited number of independent pharmacies to fill out any remaining network requirements they have with their customer, the plan sponsor/payer. Often, because of the significant market share held by a particular PBM, an independent pharmacy feels they have no choice but to settle for a "take it or leave it" offer from the PBM.

Grassley1

Q. Brick and mortar pharmacies offer important on-site services to customers in the form of reliable direction on dosage and proper use. Some are concerned that the merger will result in more prescriptions being delivered to patients via mail-order. This means consumers may be deprived of face-to-face interaction with their pharmacist. Alternatively, mail order patients may still reach out to local pharmacists who give time and expertise, yet derive no income from the transaction.

- Do you agree with those that say the merger will lead to increased mail-order delivery of prescription medications?
- How can an individual, who receives mail order drugs, ensure that there are no conflicts with other medicines he or she is taking? How does a machine processing prescriptions in another state know this kind of information?

A. Yes, we agree that the merger will potentially increase mail order utilization. ESI currently implements several mail order schemes to make it more difficult for pharmacy patients to chose community pharmacies. For instance, one such scheme requires current community pharmacy patients to call an Express Scripts 1-800 number to "opt-out" of mail order. If the patient doesn't make the call, the patient must pay a large portion, if not all, of the cost of the prescription at community pharmacies. If the patient calls, he or she will be subjected to an on-going marketing campaign to move to mail order. With only two choices of large PBMs if this transaction is not blocked, the patient's right to chose their pharmacy will be quickly eliminated either by the PBM moving patients to proprietary mail order or to its own retail pharmacies.

During the hearing, the PBM executives stated that with their technology and systems, the PBMs are communicating to community pharmacists about what other medications our patients were receiving. This is simply not an accurate statement. It is our routine practice to ask patients what other medications they are taking because there is no such communication being transmitted back from the PBM to us.

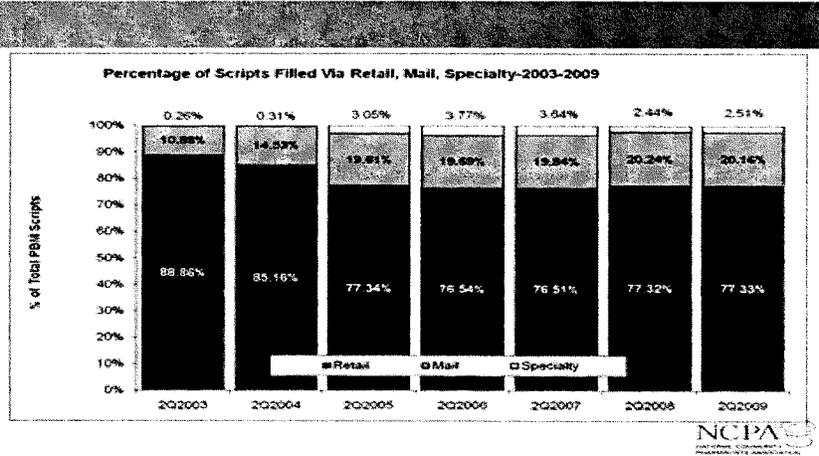
While the large PBM-owned mail order pharmacies like to tout that they have corporate pharmacists that mail order patients can call, patients are likely to get a different pharmacist via the 1-800 number (assuming they get through to a human in a reasonable amount of time and do not forgo the call altogether). The telephone pharmacist most likely is many miles away from the patient and the patient doesn't have an ongoing relationship with the pharmacist. Consider a senior citizen on a complex medication regime using such a method for medication therapy management. Is the trust there? Is the communication there? Is there a full understanding of the patient's history or other issues? A retrospective analysis of data published over 40 years found that in-store face-to-face counseling was the most effective at driving patient adherence. (Modes of Delivery for Interventions to Improve Cardiovascular Medication Adherence; Sarah L. Cutrona, MD, MPH; Nitesh K. Choudhry, MD, PhD; Michael A. Fischer, MD, MPH; Amber Servi, BA; Joshua N. Liberman, PhD; Troyen A. Brennan, MD, JD; and William H. Shrank, MD, MSHS; Am J Managed Care. 2010;16(12):929-942.)

Grassley2

Q. I'm told about 15% of prescriptions are disbursed by mail order. This means about 85% of prescriptions are filled by a pharmacist.

- Has there been an overall increase in medications delivered by mail-order or has the number, or percentage, stayed the same over the years?
- What types of medications are disbursed via mail order?
- Are all prescriptions appropriate for mail-order delivery? If not, is this expected to change in the future?
- Has the industry reached a point where all drugs suitable for mail-order are now shipped via the mail?

A. The actual number of mail order prescriptions has increased as has the total number of overall prescriptions. The actual percentage of mail order has increased to about 20% - see chart below (AIS Pharmacy Benefit Trend Data 2000-2009).



As a relative percentage of the total number of prescriptions, mail order prescriptions have remained relatively flat. Patients continue to choose community pharmacies. A recent study found, in 2011, only 55% of mail order customers surveyed said they were “very satisfied” with their pharmacy while 77% of independent pharmacy patients said they were “very satisfied.” (PULSE Pharmacy Satisfaction Data, Full Industry Report March 2011, Boehringer Ingelheim, pp19)

To the degree that patients have a choice, independent community pharmacies can compete for maintenance medications that are used to treat chronic conditions and are traditionally the type of

medications shipped via mail. To the degree that PBMs use misinformation and complex schemes to mandate mail order, independents will not be able to compete.

You ask if all prescriptions are appropriate for mail order. There are a number of medications that should not be provided by mail-order because of the cost of waste, storage concerns, education requirements, etc. There are also types of patients that should not be using mail-order. We routinely work with senior patients that are trying to stay living independently in their homes. Medication management is often one of their challenges. Mail order pharmacies send 90-days supplies with no special packaging to assist these patients in their homes. In addition, the PBMs do not provide any reimbursement in their plan designs to make such adherence packaging an option for the senior still living in their home.

In looking at the question more broadly, the PBMs that promote mandatory mail insist that mail order is right for everyone in all circumstances. We believe that mail order is not for everyone. Mail order is not appropriate for patients on complex regimens with multiple prescriptions since it can negatively impact patient adherence. A PBM study released just this past summer concluded that mandatory mail appears to cause some members to discontinue therapy prematurely, particularly those without previous mail service pharmacy experience. This can result in increased medical cost driven by more ER and doctor visits as well as hospital stays. (Adherence to Medication Under Mandatory and Voluntary Mail Benefit Designs Joshua N. Liberman, PhD; David S. Hutchins, MHSA, MBA; Will H. Shrank, MD; Julie Slezak, MS; and Troyen A. Brennan, JD, MD *Am J Managed Care*. 2011;17 (7):e260-e269)

Mail order is not the answer for health plans seeking to maximize generic savings. The Big 3 PBMs' mail order pharmacies dispense generics less than 62% of the time while community pharmacies dispensed generics 73% of the time. A study concluded that generic dispensing ratios were lower in mail-order than in the community pharmacies by 10.3% - 11.3% - even when comparing the same market basket of drugs (Clark BE PhD, Syracuse MV, PharmD, PhD, Garis RI MBS, PhD Comparison of mail-service and retail community pharmacy claims in 5 prescription benefit plans, pp1).

For every 1 percent increase in generic utilization, health plans can expect to save 2.5% (Prescription Drug Costs and the Generic Dispensing Ratio; J N. Liberman, PhD, M. Christopher Roebuck, MBA, *Journal of Managed Care Pharmacy*, Sept. 2010, pp. 502-506, Vol. 16, No. 7).

SUBMISSIONS FOR THE RECORD



The American Antitrust Institute

November 30, 2011

The Honorable Jon Leibowitz
 Chairman
 Federal Trade Commission
 600 Pennsylvania Avenue NW
 Washington, D.C. 20580

Re: Proposed Merger of Express Scripts, Inc. and Medco Health Solutions

Dear Chairman Leibowitz,

On behalf of the American Antitrust Institute, we write to express our concern that Express Scripts' acquisition of Medco poses a threat to substantially lessen competition in the provision of pharmacy benefit manager services throughout the United States.¹ The combination of two of the three largest national PBMs and the additional vertical integration it fosters threaten to lessen competition and raise prices to large plan sponsors and, ultimately, consumers. The AAI urges the FTC to seek to enjoin the merger.

The proposed merger would reduce the key providers of PBM services to large plan sponsors from three to two.² The three largest PBMs currently control over 80 percent of the large plan sponsor market; the combined Express Scripts-Medco firm alone would control approximately 50 percent of that market.³ As developed below, because of the structure of the relevant market, there are substantial barriers to entry and expansion. The three national full service PBMs already have significant cost advantages from economies of scale and from vertical integration in mail order and specialty pharmacy distribution. When faced with these difficult entry and expansion barriers, the remaining second tier PBMs cannot adequately constrain potential anticompetitive conduct because of their smaller size, geographic limitations, lack of buyer power, and, in some cases, perceived conflicts regarding their corporate affiliation with large plan sponsors. The proposed merger threatens to substantially lessen competition in this market segment, resulting in increased prices to plan sponsors and ultimately consumers.

¹ The AAI is an independent Washington-based non-profit organization addressing antitrust issues from the perspective of increasing competition and ensuring that competition works to benefit consumers through vigorous public and private antitrust enforcement. For more information, please see www.antitrustinstitute.org. This letter has been approved by the AAI Board of Directors. A list of our contributors of \$1,000 or more is available upon request.

² Large plan sponsors are large entities that establish and manage health care plans that require broad PBM service offerings, often on a national scope. These are generally large employers, unions, and government agencies.

³ The FTC defined in the Lilly/PCS enforcement action and reaffirmed its view in the Caremark/AdvancePCS merger that one relevant market is the provision of PBM services to large plan sponsors "by national full-service PBM firms." Statement of the FTC, *In re Caremark, Rx/Advance PCS*, File No. 031 0239, Feb. 11, 2004.

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I. The Merger is Likely to Harm Competition in the Market for the Provision of PBM Services to Large Plan Sponsors

CVS Caremark, Express Scripts, and Medco are by far the three largest PBMs serving large plan sponsors. Over 40 of the “Fortune 50” largest corporations rely on them for PBM services. Because of their sheer size and potential to offer exclusive distribution contracts, the big three PBMs have a significantly greater ability to secure discounts and rebates from drug suppliers, and they are able to secure inclusion of more pharmacies at lower cost in their pharmacy networks. Their vast mail order and specialty operations similarly enable them to provide a wider range of services, and they have broader technological capability and better claims processing. Not surprisingly, when one of the big three PBMs loses a large plan sponsor it is almost inevitably to another one of the big three.

Large employers and unions have become dependent on the full range of services that national full service PBMs provide.⁴ Although there are numerous smaller PBMs, they often face regional limitations, serve a special niche market (such as government entities), or do not have a full menu of services such as mail order and specialty pharmacies or the development of drug cost containment programs and new forms of clinical and therapeutic innovation which are highly dependent on economies of scale. Smaller PBMs typically lack adequate claims processing capabilities to service national accounts (particularly if adding a new customer significantly increases their number of covered lives), and they have a limited ability to secure (1) discounts or rebates from drug suppliers and (2) lower dispensing fees from pharmacies.

There is no evidence that second tier PBMs have taken market share from the large national PBMs in the years since the Caremark/Advance PCS merger. To the contrary, the facts suggest that the second tier PBMs are unable to compete in the large plan sponsor market segment.⁵ There are several significant barriers to expansion by second tier PBMs. First, they operate at a significant cost disadvantage. Second, they often lack vertically integrated mail order and specialty pharmacy operations or maintain small, less comprehensive operations. These limited service offerings also increase their cost disadvantage. Third, plan sponsors face significant switching costs involved in moving from one PBM to another. Finally, smaller PBMs lack the reputation gained by actually having large plan sponsors as customers, which makes it difficult to show that they can handle the comprehensive needs of large plan sponsors.⁶

⁴ For example, although whistleblower litigation involving the California Public Employees’ Retirement System (Calpers), the country’s largest public pension fund, recently settled allegations that CVS Caremark engaged in fraud in contracts with Calpers, Calpers nonetheless signed a new three year contract with CVS Caremark for \$575 million per year. Marc Lifsher, *CalPERS Signs Pharmacy Benefits Deal with CVS Caremark*, Los Angeles Times, June 21, 2011, <http://articles.latimes.com/2011/jun/21/business/la-fi-calpers-caremark-20110621>. This evidence strongly suggests the ability of the large national PBMs to withstand potential competition from the second tier PBMs.

⁵ See generally David Balto, Commentary, *The FTC Should Issue a Second Request on Express Scripts’ Proposed Acquisition of Wellpoint’s PBM Business: An AAI White Paper*, at 6 (May 11, 2009) (discussing the big three PBMs’ high retention rate of customers in this market space, disappearance of retail pharmacy-based PBMs, and lack of market share increase by second tier PBMs).

⁶ See, e.g., *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1283-84 (7th Cir. 1990) (explaining that “the fact [that fringe firms] are so small suggests they would incur sharply rising costs in trying almost to double their output,” which impedes their ability to expand); *United States v. United Tote, Inc.*, 768 F. Supp. 1064, 1075 (D. Del. 1991) (discussing importance of reputational barriers in antitrust analysis); *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 57 (D.D.C. 1998).

Several second tier PBMs have been suggested as a possible source of competition lost by the proposed merger. However, those PBMs lack the attributes of rivals and lack essential capabilities, and the proposed merger will make it even more difficult for them to compete. For example, United Healthcare is currently Medco's largest customer, but their contract will not be renewed when it expires on December 31, 2012. At that time, customers will be transitioned into United Healthcare's in-house PBM, OptumRx. Because of its resources, OptumRx has perhaps the most potential to compete for large plan sponsors, and yet it still faces an uphill climb. It will be difficult to carve out drug plans from employers that use a rival health insurer for other benefits because rival health insurance companies may be reluctant to give United Healthcare access to their patient data.

By market share, MedImpact Healthcare Systems, Inc. is the largest second tier PBM. MedImpact is not fully integrated, and it serves approximately 32 million members nationwide, which still places it far behind CVS Caremark (85 million) or Express Scripts-Medco (155 million) and limits its ability to absorb a large part of their customer base. To absorb 10 percent of Express Scripts-Medco business, or an additional 15.5 million covered lives, MedImpact would have to increase its capacity by almost 50 percent. Because MedImpact does not own specialty or mail order pharmacies, it cannot compete for the business of large plan sponsors that require and depend on a full array of PBM services at the lowest cost.

Catalyst is a rare example of a second tier PBM that does serve some large plan sponsors. Out of the "Fortune 50" companies, Catalyst currently offers PBM services to Ford Motor Company and Walgreens. But Catalyst's ability to serve a small number of large plan sponsors does not automatically translate into an ability to serve a large number of additional large plan sponsors within a reasonable time after the acquisition in question. In contrast to Catalyst's two "Fortune 50" companies, Medco serves twenty, CVS Caremark serves thirteen, and Express Scripts serves nine. With 18 million covered lives, Catalyst would have to increase its claims processing capacity by almost 50 percent to absorb even 5 percent of the business of a post-merger Express Scripts-Medco company.

II. The Proposed Merger is Likely to Lead to the Exercise of Enhanced Buyer Market Power in the Market for Specialty and Mail Order Pharmacy Distribution

One of the most important aspects of PBM services involves the establishment of pharmacy networks to distribute drugs and provide counseling. Pharmacies play a critical role in providing services to consumers, such as educating them about drug side effects, drug interaction and the different alternatives available to them in the market place. Pharmacies have also played an essential role in the creation and implementation of Medicare's pharmaceutical benefit program. Any analysis of cost savings in this retail market must consider the loss of these services.

The major PBMs possess the ability and incentive to exercise buyer power over retail pharmacies because the business from these PBMs is a major source of their revenue. The proposed merger would heighten the risk that these major PBMs would push compensation to many retail pharmacies below what would be competitive levels, ultimately leading to higher prices and lost jobs. An adverse impact on the delivery of pharmaceutical services at the retail level should be sufficient by itself to raise serious concerns about the proposed merger.

In recent years, federal and state agencies have become more sensitive to the exercise of buyer power as a potential antitrust concern. Although there are situations where buyer power can offset

market power at another level in the industry, buyer power does not necessarily result in benefits to consumers, especially when the buyer has an incentive to lessen competition upstream and divert business to its vertically integrated affiliates. That incentive would increase the merged firm's willingness to drive down price (here, price takes the form of reimbursement rates) to lessen competition in the local pharmacy market, which can then ultimately harm consumers through higher prices, reduced services, and reduced choice.

Express Scripts and Medco both own specialty and mail order pharmacy operations, and a merged Express Scripts-Medco company would control over 50 percent of the specialty market and process 60 percent of all mail order prescriptions. One effect of a greatly enlarged Express Scripts-Medco PBM would be expanded control of patient data. The merged company would likely have the incentive and ability to use this data to move patients to its own specialty and mail order pharmacy operations. This concern is real in light of CVS Caremark's demonstrated ability to use data received in its PBM capacity to boost sales of its CVS pharmacies.

One way a PBM exercises buyer power is by negotiating with drug manufacturers. The PBM agrees to place the drug manufacturer's drug (or drugs) on the formulary, and in exchange, the drug manufacturer gives the PBM a rebate for its drugs. As the PBM market further consolidates, the PBMs are able to exert more buyer power against the drug manufacturers by demanding larger rebates. The drug manufacturers give in to these demands because the PBMs ensure a high volume of prescriptions through formulary placement, as well as access to their pharmacy networks and their own mail order and specialty pharmacies. The PBMs' buyer power could increase to the point where declining profits on these drugs force drug manufacturers to significantly reduce, or, in some cases, forgo their research and development expenditures altogether.

The combined Express Scripts-Medco firm and CVS Caremark may also reduce the dispensing fees paid to retail pharmacies through their buying power. Because of the high level of consolidation among the three large PBMs that serve large plan sponsors, the proposed merger will increase the PBMs' seller market power, creating an incentive to raise prices, not lower them. In addition to the harm to patients resulting from reduced services and convenience if the exercise of buyer power drives independent retail pharmacies out of business, the large PBMs are likely to profit from the diversion of business to their specialty and mail order pharmacies, and are unlikely to pass on these gains to their direct customers—the plan sponsors.

III. The Merged Firm Would Have the Ability and Incentive to Exclude Rivals in the Provision of Specialty Pharmacy Services

Specialty pharmaceuticals, which are generally 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. Specialty drugs often require special handling and administration and are used to treat serious and complex diseases. Each of the three major PBMs has acquired specialty pharmaceutical companies in recent years, reducing the number of independent specialty pharmacies and giving the major PBMs power over the downstream specialty pharmacy distribution chain. Some critics have suggested that it is a common business practice for these PBMs to prevent other pharmacies from dispensing specialty drugs and to force patients to use the PBM's mail order facility, thereby foreclosing competition from rival pharmacies. If true, these restricted networks disrupt the continuity of care and degrade health outcomes by forcing patients to switch away from their pharmacy of choice.

As they expand their ownership of specialty pharmacies and mail order operations, the major PBMs continue to expand exclusive distribution arrangements with pharmaceutical manufacturers. By securing control over 50 percent of the specialty market, Express Scripts-Medco could increase its leverage to restrict pharmacy network access and enter into exclusivity arrangements with drug manufacturers. Both of these practices are likely to increase post-merger.

In the past, Express Scripts has imposed substantial price increases after becoming the sole distributor of certain drugs.⁷ This suggests that these acquisitions and distribution alliances have led to increased prices as well as decreased service and consumer choice in providers of several specialty drugs. The proposed merger thereby increases the ability and incentive for Express Scripts-Medco to engage in anticompetitive conduct and threatens to increase specialty drug prices and limit patient access to critical medications.

IV. The Merged Firm Would Have the Ability and Incentive to Exclude Rivals in the Provision of Mail Order Pharmacy Services

Although mail order pharmacy services provide cost savings in some instances and are increasingly important to sophisticated plan sponsors, the proposed merger would create the largest mail order pharmacy in the United States, accounting for nearly 60 percent of all mail order prescriptions processed. This poses several potential competitive threats. First, further consolidation of the PBM market would exacerbate the competitive disadvantages that smaller, second tier PBMs without vertically integrated mail order operations already face. The second tier PBMs that lack mail order operations must contract for outside mail order pharmacy services, which costs the PBM more than providing the service in-house. Second, consolidation of mail order pharmacies threatens to lead to anticompetitive self-dealing. A vertically integrated PBM can channel prescriptions to its own mail order facilities instead of to retail pharmacy competitors, even if the cost of filling the prescription is more than it would be at a local pharmacy competitor. This increases profits and siphons customers away from other mail order facilities.

Despite claimed cost savings, mail order pharmacies may actually raise costs to consumers and plans. Because PBMs exercise their buyer power through negotiating the formulary, the PBMs are more likely to have brand-name drugs on their formularies instead of generic drugs, and are more likely to dispense the brand-name drugs instead of the generic drugs through their mail order services. A PBM may select a drug for its formulary because it will receive a higher rebate from the manufacturer. When the PBM owns the mail order pharmacy, it does not share the rebate. Instead, it retains the rebate as profit, and charges the plan sponsor for processing the transaction both as a pharmacy and as a PBM. However, there is no evidence that the PBM then passes this cost savings on to the plan sponsor, which may lead to higher costs for the consumer. If allowed to proceed, the merger would reduce the competitive pressure for PBMs to pass these savings on to plan sponsors because there would be only two PBMs that possess the broad range of services that a large plan sponsor requires.

⁷ For example, the price of H.P. Acthar Gel, an injectable anti-seizure medication designed for treating children with a rare form of epilepsy, jumped from \$1,600 a vial to \$23,000 a vial after Express Scripts was given sole distributorship rights. Milt Freudenheim, *The Middleman's Markup*, New York Times, April 19, 2008, <http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63&pagewanted=all>.

The survival of small community pharmacies may also be threatened by the PBMs' mail order businesses. The PBMs that own mail order pharmacies have incentives to guide customers to use their mail order prescription services. Considering only the potential cost savings of mail order pharmacy services also ignores the fact that mail order pharmacies do not provide many of the services offered by traditional community pharmacists that many customers prefer. A reduction in dispensing fees by the merged Express Scripts-Medco company could drive many community pharmacies out of business. Community pharmacies do not meaningfully negotiate with PBMs; PBMs offer them contracts on a "take it or leave it" basis.⁸ This is not an argument about protecting inefficient competitors, but rather is about protecting innocent able competitors from unbounded muscle power.

V. Conclusion

The merger will likely cause anticompetitive harm in the provision of PBM services to the large plan sponsors market segment. Because of the large PBMs' vertical integration and enhanced buyer power, the merger will also likely cause anticompetitive harm in the specialty pharmacy and mail order pharmacy market segments. For these reasons, we urge the FTC to seek to enjoin the merger.

Respectfully submitted,



Dan Gustafson, Advisory Board Member



Albert A. Foer, President

cc: Edith Ramirez, Commissioner
Julie Brill, Commissioner
J. Thomas Rosch, Commissioner
Richard Feinstein, Bureau of Competition

⁸ Express Scripts even appears to be making a "take it or leave it" offer to Walgreens—one of the largest chain pharmacies—in negotiations of new terms for a contract that is set to expire at the end of the year. Although Walgreens has reached tentative deals with some regional health plans to continue filling prescriptions for plan members if it is unable to reach a deal with Express Scripts, analysts predict that Walgreens will ultimately agree to the terms offered by Express Scripts. Although losing access to 7,760 Walgreens retail pharmacies would anger members of plans using Express Scripts services, Express Scripts has far more leverage because most benefit plans are already locked in for the next year and are not expected to move to a new PBM when they expire. By contrast, it is estimated that Walgreens would lose about \$5 billion, or 7 percent of its revenue, if it lost its place in the Express Scripts pharmacy network. David Nicklaus, *Walgreens, Express Scripts Continue Skirmishes Over Contract*, Saint Louis Today, Oct. 21, 2011, http://www.stltoday.com/business/columns/david-nicklaus/article_86bec659-80f7-5b70-a6eb-ba6b51d141ee.html.

Testimony of David A. Balto

on behalf of

**Consumers Union, Consumer Federation of America, National Consumers
League, U.S. Public Interest Research Group, and the National Legislative
Association on Prescription Drug Prices**

**To the Committee on the Judiciary,
Subcommittee on Antitrust, Competition
Policy and Consumer Rights
United States Senate**

**Regarding "The Express Scripts/Medco Merger: Cost Savings for Consumers
or More Profits for the Middlemen?"**

Tuesday, December 6, 2011

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202 577 5424**

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Introduction

Mr. Chairman Kohl, Ranking Member Lee, and other distinguished members of the Senate Judiciary Committee, I want to thank you for giving me the opportunity today to speak about the severe competitive problems that may arise from Express Scripts' proposed acquisition of Medco Health Solutions. I am testifying today on behalf of the nation's leading consumer groups including Consumers Union, Consumer Federation of America, National Consumers League, U.S. Public Interest Research Group, and the National Legislative Association on Prescription Drug Prices.¹ As detailed in my testimony, this merger of two of the three largest pharmacy benefit managers ("PBMs") raises serious competitive concerns and could potentially lead to significantly higher prices and diminished service for healthcare consumers.

My testimony today is based on my experience of over a quarter century as an antitrust practitioner, the majority of which was spent as a trial attorney in the Antitrust Division of the Department of Justice, and in several senior management positions, including Policy Director at the Federal Trade Commission's ("FTC") Bureau of Competition and attorney advisor to Chairman Robert Pitofsky. I helped bring some of the first antitrust cases against PBMs and have testified before Congress, regulators, and state legislatures over ten times on PBM competition.²

I am here with a simple message for this Committee. The loss of competition caused by this merger will make it more likely for Express Scripts to charge *more* for its services and to pass along *less* of the savings they obtain to their customers, the plan sponsors, ultimately harming the millions of consumers who need these services. Express Scripts and Medco are two of the three largest PBMs and the merger will create a dominant PBM with 155 million covered

¹ See Appendix A for a brief description of each group.

² In the present FTC investigation of this merger I represent a number of employers, unions, health plans, consumer advocacy groups, pharmacies, a PBM, and specialty pharmacy groups. (My testimony today solely reflects the views of the consumer groups I represent).

lives—70 million more covered lives than the next largest competitor—and over five times as large as the fourth largest firm. Express Scripts-Medco would alone control approximately 50 percent of the large plan sponsor market, 60 percent of all mail order prescriptions, and over 50 percent of the specialty pharmacy market. And although the merging parties assert various efficiencies as justification for this merger, these proffered efficiencies do not outweigh the anticompetitive effects and consumer harm that is likely to result from this transaction.

All consumers will suffer as service and access to their retail pharmacies declines and they are increasingly denied a choice and service. Express Scripts will have greater power to steer plan participants to its own captive mail order and specialty pharmacy operations, reducing choice for all plan participants and quality for many.³ Additionally, Express Scripts will have a greater ability to drive down reimbursement to pharmacies *below competitive levels* resulting in diminished access to valuable pharmacy services, higher prices, and lost jobs.

The thousands of vulnerable consumers who need specialty drugs will be particularly harmed. These include the millions of patients suffering from diseases such as hemophilia, multiple sclerosis, Crohn's Disease, infertility, HIV/AIDS, and many forms of cancer. The merger will enable Express Scripts to increasingly force these patients to use only their specialty pharmacy and prevent consumers from using their trusted local specialty pharmacy. As these specialty patients are considerably more vulnerable and typically utilize rather complex and expensive treatments, and are more dependent on the services of their community pharmacist, increases in price and diminished service and choice will especially harm this group of consumers.

The Federal Trade Commission ("FTC") is thoroughly investigating this merger and should challenge it because it raises significant threats to competition. The anticompetitive effects and resulting consumer harms which I would like to emphasize include:

- Higher Prices and Reduced Service: This merger will reduce the number of major PBMs from three to two. The diminished competition in the PBM market will allow PBMs to charge plan sponsors more for their services, as well as reduce the quality or variety of their ancillary services. Both results would ultimately be felt by consumers in the form of higher cost health plans and drugs;
- Forcing Consumers into Mail Order/ Denying Patient Choice: With an increased incentive and ability to force consumers into their captive mail-order and specialty pharmacy operations, Express Scripts-Medco will prevent many consumers from using their pharmacy of choice. Some consumers favor the convenience and superb service of their community pharmacy and others prefer the convenience of one stop shopping at a supermarket pharmacy. Mail order fails to provide many consumers with the necessary level of service and counseling.
- Degrading Pharmacy Access and Service: Express Scripts-Medco will have the ability to drive reimbursement to pharmacies down below competitive levels. Cutting reimbursement to pharmacies which already operate on very minimal

³ Express Scripts and Medco have already force patients into their captive pharmacy operations leaving many consumers with complaints of reduced choice as well as poor service. Consumers can share these complaints on the "Share Your Story" page of www.PBMWatch.com.

margins would force many pharmacies to respond by raising prices or cutting back on hours, services, and employees. In the end, consumers would be harmed by less access, diminished service, and higher prices.

In addition to taking into account the potential harm to consumers that may result from this particular transaction, I call on the FTC to go beyond this merger and investigate the presence of anticompetitive conduct in the PBM market. The major PBMs' dominance is preserved through a series of exclusionary arrangements that diminish competition and harm consumers with decreased service and higher prices. Further competition and consumer protection enforcement action is necessary to prevent the substantial ongoing harm in this market. This subcommittee should call on the FTC to act.

I. A Broken Market.

PBMs are like other healthcare intermediaries that manage transactions by forming networks and transferring information and money. As a former antitrust enforcer I know that the fundamental elements for a competitive market are transparency, choice and a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access, there are agency relationships and securing adequate information may be difficult.

Why are choice, transparency, and a lack of conflicts of interest important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering fair prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire.⁴ In both of these respects the PBM market is fragile at best. There is certainly a lack of choice especially for those plans that are dependent on the top tier big three PBMs (Medco, Express Scripts and CVS Caremark). And PBM operations are very obscure and a lack of transparency makes it difficult for plans including government buyers to make sure they are getting the benefits they deserve.

When dealing with intermediaries, it is particularly critical that there are no conflicts of interest. A PBM is fundamentally acting as a fiduciary to the plan it serves. The service a PBM provides is that of being an "honest broker" bargaining to secure the lowest price for drugs and drug dispensing services. When a PBM has an ownership interest in a drug company or has its own mail order or specialty pharmacy dispensing operations, it is effectively serving two masters and may no longer be an "honest broker."

Finally, where these factors – choice, transparency and lack of conflicts of interest are absent – often regulation is necessary to fill the gap. And Congress has enacted some regulation

⁴ Leading consumer groups have come out in support of legislation requiring greater transparency of PBMs. See Consumer Federation of America, U.S. PIRG, and NLARx letter to Congresswoman Nancy Pelosi in support of Representative Weiner's amendment to H.R. 3200, requiring transparency by PBMs who contract with health plans in the national insurance exchange or with public plans (August 20, 2009).

that provides a degree of transparency under the Affordable Care Act. But unlike other aspects of the healthcare delivery system, PBMs remain basically unregulated.

What is the result of this dysfunctional market? PBMs entered the health care market as “honest brokers” or intermediaries between health care entities. However, the role of the PBM has evolved over time and increasingly PBMs are able to “play the spread” – by not fully sharing the savings they secure. As a result PBM profits have skyrocketed. From 2003 to 2010, the three largest PBMs—Medco, CVS Caremark and Express Scripts— have seen their profits increase by almost 600% from \$900 million to almost \$6 billion (see Figure-1).

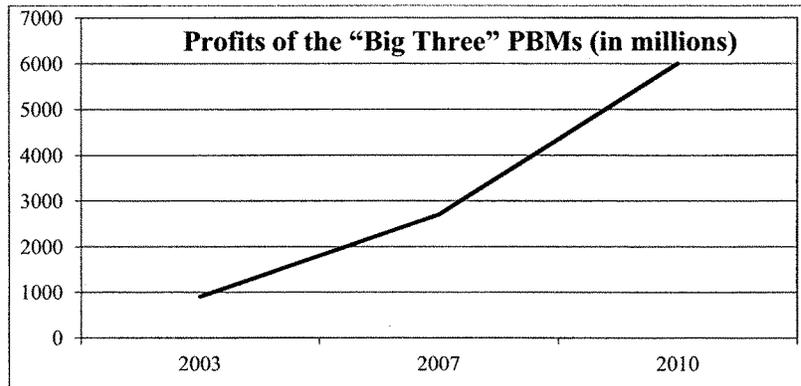


Figure-1

Facing weak transparency standards, the big three PBMs frequently engage in a wide range of deceptive and anticompetitive conduct that ultimately harms and denies benefits to consumers. Some PBMs secure rebates and kickbacks in exchange for exclusivity arrangements that may keep lower priced drugs off the market. PBMs may switch patients from prescribed drugs to an often more expensive drug to take advantage of rebates that the PBM receives from drug manufacturers. In addition, PBMs derive enormous profits from the ability to “play the spread” between pharmaceutical manufacturers, pharmacies, and health care plans. In the past 6 years alone, a coalition of over 30 state attorneys general have brought several cases attacking unfair, fraudulent and deceptive conduct. Between 2004 and 2008, the three major PBMs have been the subject of six major federal or multidistrict cases 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 resulted in over \$371.9 million in damages to states, plans, and patients so far.

There are three very important lessons here: (1) the fundamental elements of a well functioning market are absent; (2) plans and consumers have already suffered substantial harm from deception, fraud and other egregious practices; and (3) we should be skeptical of claims of cost savings in an environment where profits are skyrocketing.

II. Health Plan Sponsors and Ultimately, Consumers Will Be Harmed by the Merger

Everyone acknowledges there is currently a top tier of PBMs that are the core to competition in the market. The key to PBM operations is exploiting the economies of scale they secure through size. If this merger is not challenged Express Scripts would become phenomenally larger than the remaining PBMs – it will have 155 million covered lives, over 70 million more than the next biggest PBM, CVS/Caremark. The second tier PBMs are far smaller (see Figure-2).

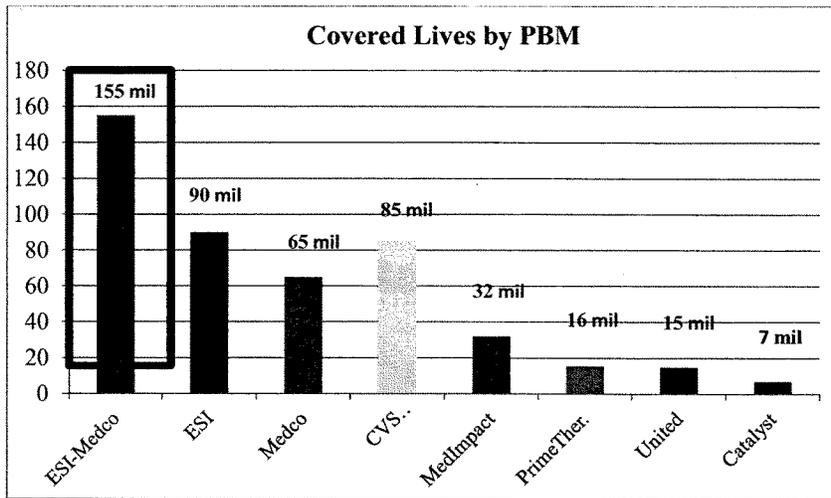


Figure- 2

CVS Caremark, Express Scripts, and Medco make up this top tier and serve a majority of the largest plan sponsors. In fact, over 40 of the “Fortune 50” largest corporations rely on these big three for PBM services. A significant number of employers, unions and health plans view the three major PBMs as their only viable options. Therefore, when one of the major PBMs loses a large contract it is almost always picked up by another of the three. Since the Caremark/Advance PCS merger, there is no evidence that second tier PBMs have taken market share from the big three. Tom Dressler, a board member for the California Public Employees’ Retirement System (Calpers), the country’s largest pension fund, spoke to this dependence and

said, “You can count the PBMs that can serve the organizations of this size on a couple of fingers, maybe three,’ and they frequently are subject to lawsuits and investigations.”⁵

For those plan sponsors that depend on the big three PBMs, this merger would reduce the number of viable alternatives from three to two—a significant loss of competition. While some will claim that the second tier will serve as a sufficient price constraint on the remaining two PBMs, this assertion is misguided. As concluded by the American Antitrust Institute on this point,

The three national full service PBMs already have significant cost advantages from economies of scale and from vertical integration in mail order and specialty pharmacy distribution. When faced with these difficult entry and expansion barriers, the remaining second tier PBMs cannot adequately constrain potential anticompetitive conduct because of their smaller size, geographic limitations, lack of buyer power, and, in some cases, perceived conflicts regarding their corporate affiliation with large plan sponsors.⁶

There are seven main distinctions that prevent the second-tier PBMs from effectively constraining the big three, including:

- **Reduced Purchasing Power:** Because of their size, smaller PBMs wield less negotiating power with drug manufacturers than the big three. The second tier is therefore unable to secure comparable levels of rebates and to effectively compete on price.
- **Less Control of Pharmacy Reimbursement:** Second-tier PBMs also have less negotiating power with retail pharmacies and are to secure as low reimbursement rates as the big three.
- **Mail Order:** Second tier PBMs generally do not have their own mail-order pharmacy operations and if they do, their operations function at a higher cost.
- **Specialty Pharmacies:** Unlike Express Scripts and Medco who operate the two largest specialty pharmacy businesses, respectively, Curascript and Accredo, second-tier PBMs typically do not have in-house specialty pharmacy operations.
- **Claims Processing:** Second-tier PBMs generally have much less capacity for claims processing.
- **Clinical Management Services:** The big three PBMs compete on several services, among them the management of the utilization of covered medications by balancing clinical effectiveness with costs; providing clinical cost containment

⁵ Brin, Dinah. “CVS, Seeking Calpers Pact, Faces Trial Over Past Work for Fund.” *The Wall Street Journal*, (May 18, 2011). Available at <http://online.wsj.com/article/BT-CO-20110518-711687.html>.

The dependence on the three national PBMs is also highlighted by the California Public Employees’ Retirement System’s (CalPERS) recent decision to sign a contract with CVS Caremark, despite allegations that the PBM had defrauded the pension fund. Lifsher, Marc. “CalPERS Signs Pharmacy Benefits Deal with CVS Caremark.” *Los Angeles Times* (June 21, 2011).

⁶ American Antitrust Institute. Letter to Chairman Leibowitz regarding the Proposed Merger of Express Scripts, Inc. and Medco Health Solutions (November 30, 2011).

programs for large plan sponsors; and providing sophisticated service innovations and clinical tools aimed to encourage the best clinical outcomes for patients. These services are most effective when supported by a large number of covered lives. Second-tier PBMs generally lack the resources or scale to offer these services.

- Reputation: Because of the cost and complexity of the relationship, health plans simply cannot afford to risk contracting with a PBM that may lack the capacity or experience to manage an account of their size. Accordingly, health plans often rely extensively on reputation and reference accounts of a certain size when making PBM contracting decision. Thus, second-tier PBMs often find themselves in a catch-22, needing more large contracts in order to prove their capacity to earn more contracts.

Under the antitrust laws, firms are included in a relevant market to the extent they constrain the ability of the merged firm to raise prices. Just because some firms provide similar services does not mean they are all included in the relevant market. As the courts have observed “the mere fact that a firm may be termed a competitor in the overall marketplace does not necessarily require that it be included in the relevant product market for antitrust purposes.”⁷

Not only does the second tier fail to serve as an effective constraint on the big three PBMs as of now, but the proposed merger will exacerbate the gap between tiers and make it even more difficult for these smaller PBMS to compete.

For plan sponsors that depend upon the big three PBMs, this merger is a consolidation from three firms to two. The effects of the merger, therefore, would significantly harm large purchasers of PBM services and ultimately, their plan participants—the ultimate consumers—in three ways.

First, the market will immediately lose a major competitor. Medco’s presence directly constrains the ability of Express Scripts and CVS/Caremark to raise prices, eliminate services, or mismanage the handling of beneficiaries’ pharmaceutical benefit services.

Second, the merged entity will inherit a dominant market position. This may result in an increase in price or degradation of services. The services that PBMs provide plan sponsors are often overlooked in the discussion of this merger, but are very important, and are the direct result of head-to-head competition among the big three. Following the merger, there will be less need for competition, and less incentive for the merged firm to continue offering as many ancillary services.

Third, the big three already impose exclusive networks on plan sponsors, and require them to fulfill mail order and specialty services through their own subsidiaries. The merged entity will have even more incentive, and even more power, to engage in this exclusionary conduct. Plan sponsors may soon see their choices limited by Express Scripts/Medco, and find themselves with little recourse.

⁷ Federal Trade Commission v. Cardinal Health, Inc., 12 F.Supp.2d 34, 45 (D.D.C. 1998). (Quoting Federal Trade Commission v. Staples, Inc., 970 F. Supp. 1066, 1075-1076 (D.D.C. 1997)).

III. Pharmacy Access and Service Will Be Harmed

The proposed merger will harm consumers by increasing the ability for Express Scripts to force patients into their captive drug distribution operations, and exercise monopsony market power over retail pharmacies.⁸ The three major PBMs have strong incentives to make customers use their wholly-owned mail order pharmacy operations. Accordingly, the major PBMs often restrict network options to drive consumers to their operations.

An Express Scripts-Medco will control over 40 percent of prescription drug volume.⁹ With increased dominance in both the PBM and mail-order spheres, the merged firm will be better positioned to restrict patient choice in pharmacy and force consumers into mail-order. Mail-order may be more costly, may result in significant waste, and fails to provide the level of convenience and counseling that many consumers require. Consumers may have existing relationships with a community pharmacy and may not wish to leave the pharmacist they know and trust to be served by a mail order robot. Others simply enjoy the ability to one-stop-shop and prefer the convenience of their supermarket pharmacy. The bottom line is that patients have a whole array of preferences when it comes to pharmacy care and consumers are left worse-off when they are unable to choose the level of service they desire.

⁸ Courts and enforcement agencies recognize the consumer harm that may result from granting or enlarging monopsony power. *See, e.g.* North Jackson Pharmacy Inc. vs. Caremark Rx, Inc. 385 F. Supp. 2d 740, 749 (N.D. Ill. 2005) (explaining “The exercise of [monopsony] power causes competitive harm because the monopsonist or the group will shift some purchases to a less efficient source, supply too little output to the downstream market, or do both.”); *United States v. UnitedHealth Group Inc. and PacifiCare Health Systems Inc.* Case No. 1:05CV02436 (D.D.C. 2006) (holding that the merger of two health insurance companies would result in anticompetitive in the purchase of physician services. The Department of Justice’s Competitive Impact Statement alleged “Since physicians have a limited ability to encourage patient switching, the merger will significantly increase the number of physicians in Tucson and Boulder who are unable to reject United’s demands for more adverse contract terms. Thus, the acquisition will give United the ability to unduly depress physician reimbursement rates in Tucson and Boulder, likely leading to a reduction in quantity or degradation in the quality of physician services.”). Current scholarship also supports the notion that monopsony power poses potential harm to consumers. For instance, former Assistant Director at the Federal Trade Commission John B. Kirkwood’s most recent article concludes that antitrust policymakers should recalibrate their analysis of monopsony in merger review, and argues they should “protect small, competitive sellers from monopsonistic exploitation.” Kirkwood also distinguishes the FTC’s statements regarding the Caremark and Advance PCS merger, challenging the idea that an increase in buying power is a countervailing benefit, and not a presumptively anticompetitive effect. Kirkwood explains that the idea of increased buying power constituting a procompetitive benefit only applies when the result is a bilateral monopoly, and requires three assumptions: the selling entity has market power, transactions costs prevent parties from reaching efficient outcomes otherwise, and monopsonists can increase supply through demand, which will have a collateral procompetitive impact on price. However, when these assumptions are not met, the benefit of increased buying power is lost. In this case, there is no pharmacy side monopoly power, or reason to believe that the monopsonists will increase supply through demand, since patients and not PBMs provide the supply (and in fact the demand is likely to decrease, since ESI will channel more sales through their own captive mail-order pharmacy. *See* John B. Kirkwood, *Buyer Power and Merger Policy*, at 57-60, *available at* <http://ssrn.com/abstract=1809985>.

⁹ Letter from Senator Harkin to Jon Leibowitz regarding the proposed Express Scripts, Medco merger (October 17, 2011).

This merger will also harm consumers as it would allow the remaining two national PBMs to shrink the number of community pharmacies. By lowering reimbursement to community pharmacies, the big three PBMs already make it difficult for these high-value health care providers to survive. The transaction would exacerbate this trend, and result in community pharmacies lessening their services or, worse – closing their doors.

Express Scripts and Medco portray this as a benefit of the merger. They claim they are lowering consumer prices by allowing them to pay less for drugs. But does this argument hold water? First, the PBMs skyrocketing profits suggests that the benefits from restricted networks may not benefit consumers, but rather, the PBMs themselves. Second, reduced reimbursement is not necessarily good for consumers, especially in healthcare markets. When monopsony power forces healthcare providers to accept less money for services, it is likely that the consumer will suffer through a lessening of quality of service. As the Third Circuit explained in a case alleging that an insurer (Highmark) reduced reimbursement to a hospital (West Penn). The insurer argued that there was no problem because lower reimbursement would lead to lower premiums, but the Court rejected the argument:

[E]ven if it were true that paying West Penn depressed rates enabled Highmark to offer lower premiums, it is far from clear that this would have benefitted consumers, because the premium reductions would have been achieved only by taking action that tends to diminish the quality and availability of hospital services.¹⁰

The market power resulting from the proposed merger will harm consumers as it will allow the remaining two PBMs to decrease compensation to retail pharmacies below competitive levels. Why should consumers care? Because their community pharmacist is the most trusted professional they deal with. Because retail pharmacies provide consumers with valuable clinical services and counseling, often free of charge. Because some pharmacies, especially supermarket pharmacies, offer drugs at lower prices than the PBMs, such as through \$4/month generic programs. Anticompetitive cuts to reimbursement jeopardize these types of programs that consumers highly value. As retail pharmacies are already economically efficient and operate on very minimal margins, these cuts to pharmacy reimbursement would, in the end, likely result in harm to consumers.

IV. Specialty Pharmacy Patients Will Face Reduced Service and Higher Costs

The anticompetitive impact of this merger on prices, service, and consumer choice are particularly profound for the thousands of patients suffering from hemophilia, HIV/AIDS, Crohn's Disease, multiple sclerosis, hepatitis, infertility, and many form of cancer, who require specialty pharmaceuticals. This merger would combine the two largest specialty pharmacy businesses, Express Scripts' Curascript and Medco's Accredo, giving the joint company a 52 percent share of this market (see Figure-3). This incredible consolidation of the specialty market is of particular concern given the fact that specialty drugs are expected to be the single greatest cost-driver in pharmaceutical spending over the next decade. The cost of specialty drugs is rising

¹⁰ West Penn Allegheny Health System, Inc. v. UPMC, 627 F. 3d 85(3rd Cir. 2010).

rapidly—increasing by 19.6 percent in 2010 and expected to reach as high as 27.5 percent by 2013.¹¹ Meanwhile, by 2016, 8 of the top 10 prescription drugs are expected to be specialty.¹²

Specialty pharmacies manage the highly-expensive and very complex treatments for the most intricate and serious illnesses. The service they provide is both distinct and significant from other retail pharmacies. Beyond merely dispensing drugs, specialty pharmacies help administer complex treatments, assist physicians in monitoring patient therapy, and play an important role in medication compliance and improved health outcomes. Specialty pharmacies educate patients on effective utilization, monitor side effects, and partner with physicians to identify ineffective medications and recommend treatment changes. Specialty pharmacies play an active role in providing continuity of patient care to ensure that costs are minimized and health outcomes improve.

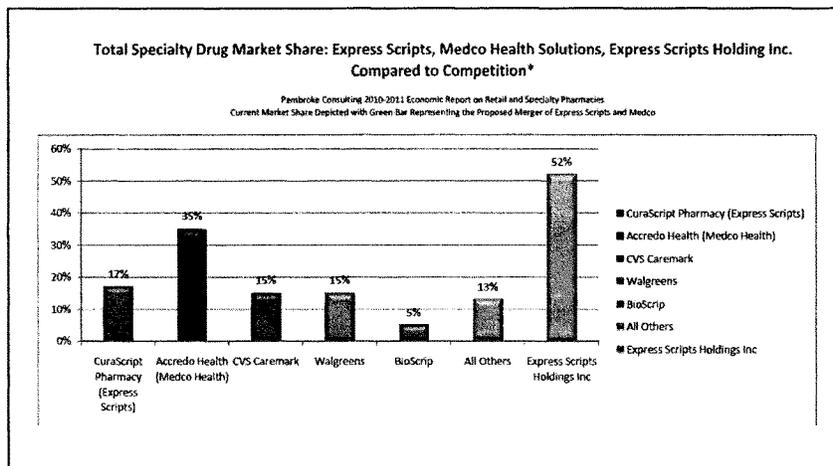


Figure- 3

The ownership of specialty pharmacies creates the conflict of interest problem described earlier. At times, these PBMs have used their market clout to extract exclusivity arrangements from manufacturers significantly increasing the price of drugs. Take the case of H.P. Acthar Gel, a drug for severe epilepsy whose price jumped from \$1,600 a vial to \$23,000 after Express Scripts was named the sole distributor.¹³ These PBMs have also created exclusive specialty networks to prevent retail pharmacies in their network from dispensing specialty drugs. Express

¹¹ Express Scripts. *2010 Drug Trend Report: A Market and Behavioral Analysis* (April 2011).

¹² Medco Health Solutions. *2011 Drug Trend Report*. (2011).

¹³ Freudenheim, Milt. "The Middleman's Markup." *The New York Times* (April 19, 2008).

Scripts and Medco in particular steer plan participants towards their captive specialty pharmacy (which in turn forces the plan participants to use the PBM's captive mail order facility).

Restrictive networks and steering practices rob consumers of the choice to use their preferred pharmacy and method of distribution; and—with this important rivalry gone—consumers also miss out on the benefits of vigorous competition including lower prices and improved service. These restrictive networks deny patients a choice in provider and, given the high-touch nature of services in this area, this choice is highly valued by many consumers. As both Express Scripts and Medco control sizable specialty pharmacy operations, their combination necessarily presents potential harm to consumers that depend on the high-cost products and services that are of great, and even life-altering, significance to patients in the specialty drug market.

Restricting networks can also lead to disruptions in the continuum of care which degrade health outcomes and increase healthcare costs. Patients on specialty drugs often require regular contact and counseling from their pharmacist (who is often assisted by a nurse). For many disease states, the pharmacist and nurse regularly contact the patient to make sure the drug is properly administered, taken on time, and the drug is working effectively. Disrupting this patient-provider relationship in complex and expensive treatment of very sensitive health conditions imposes significant harm to both the consumer and the health plan. Many patients have been harmed by inadequate care from these restrictive pharmacy networks¹⁴ and that has led patient advocacy groups, such as the Hemophilia Federation of America, to publicly oppose such network designs.¹⁵

With even greater dominance in the upstream PBM market, a merged Express Scripts-Medco will have an increased incentive and ability to engage in this anticompetitive practice of restricting networks and forcing patients to their own specialty businesses. These restrictive networks, likely to increase post-merger, threaten to restrict patient choice, lead to disruptions in care, increase specialty drug prices, and limit patient's access to critical medications.

V. Efficiencies Do Not Outweigh the Potential Harm to Consumers

Express Scripts' and Medco's proffered efficiencies do not pass antitrust scrutiny, and certainly do not satisfy the burden of outweighing the above-described anticompetitive effects of the transaction. Antitrust law only recognizes efficiencies that are cognizable, verifiable, and merger-specific. The Merger Guidelines provide that "efficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by a reasonable means" and "cognizable efficiencies are merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service."¹⁶ The Supreme Court has never condoned the notion that an otherwise anticompetitive merger can be legally procompetitive based solely on the efficiencies created. Although lower courts have embraced this theory, they have also

¹⁴ Kimes, Mina. "The decline of the specialty pharmacy." *Fortune* (October 25, 2010).

¹⁵ Hemophilia Federation of America. "HFA Statement of Position." <http://hemophiliafed.org/old-list/single-source-provider>.

¹⁶ MERGER GUIDELINES § 10.

noted that in cases of extreme market consolidation, such as would occur from Express Scripts' acquisition of Medco, defendants must demonstrate "proof of extraordinary efficiencies."¹⁷ The Guidelines support this proposition, stating "when the potential adverse competitive effect of a merger is likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive."¹⁸ Merging parties with large market shares in a constrained market have a stiff burden to overcome to survive scrutiny under the Clayton Act. The parties at hand fail to overcome this burden.

Federal Courts have already addressed the question of whether, and to what extent, the burden of demonstrating an "extraordinary" efficiency is satisfied in a merger to duopoly in which the combined firm proffers to benefit consumers through additional cost savings. In *Federal Trade Commission v. Cardinal Health, Inc.*¹⁹ the Federal District Court for the District of Columbia considered whether increased buying power through the merger of national drug wholesalers constituted a cognizable efficiency sufficient to offset competitive concerns. The court concluded that the benefits did not outweigh the concerns, concluding that the savings were not likely to be passed on to consumers, and that the efficiencies were not specific to the merger. The court, in finding for the FTC, explained "much of the savings anticipated from the mergers could also be achieved through continued competition in the wholesale industry. While it must be conceded that the mergers would likely yield the cost savings more immediately, the history of the industry over the past ten years demonstrates the power of competition to lower cost structures and garner efficiencies as well."²⁰

The efficiencies offered by the combining firms can be boiled down to two basic arguments: the merger will increase Express Scripts' buying power, and therefore enable it to better control healthcare costs; and the combined firm will be able to implement a series of clinical management programs to oversee the quality of care. Neither of these proposed efficiencies is cognizable or merger-specific.

Express Scripts' contention that it will pass on saving to consumers does not satisfy antitrust concern. The law readily recognizes that cost savings must be passed on to consumers to count as a countervailing efficiency. With only two competitors left in the market, there is no guarantee that the savings will be passed on to consumers. As noted earlier the big three PBMs are among the most profitable companies in America. Annual profits for these companies skyrocket annually, suggesting they are not passing on the savings to consumers as they say they will. Federal Courts have acknowledged the likelihood of merging parties to reap higher profits rather than sharing the savings with consumers, stating "while reducing the costs of doing business provides several advantages for the merged firm, these advantages could show up in higher profits instead of benefiting customers or competition."²¹

The argument that Express Scripts will harness its augmented buying power to the benefit of the consumer is not a cognizable efficiency sufficient to overcome the presumption of

¹⁷ *Federal Trade Commission v. HJ Heinz Co.*, 246 F. 3d 708, 720 (D.C. 2001).

¹⁸ MERGER GUIDELINES § 10.

¹⁹ 12 F.Supp.2d 34 (D.D.C. 1998).

²⁰ *Id.* at 63.

²¹ *F.T.C. v. CCC Holdings*, 605 F. Supp. 2d 26, 74 (D.D.C. 2009).

anticompetitive effects from the merger. Both Express Scripts and Medco already have massive buying power. Either of these firms controls enough of the market that they could unilaterally seek this improved price, or could seek to improve their negotiating position through internal growth rather than merger.

The policies and programs that Express Scripts aims to implement are neither cognizable nor merger-specific. To date, Express Scripts never explained how the merger would actually facilitate the creation of these programs where they do not already exist, or why they have been unable to do so before now. With the current three-firm top tier PBM structure, competition compels these firms to invest in such programs. It is more likely that we would lose these beneficial programs, rather than gain them, after the consummation of the merger. The Merger Guidelines provide for analysis in situations in which the consumer gains a nominal benefit in price reduction, but suffers an overall loss in quality of service, providing "purported efficiency claims based on lower prices can be undermined if they rest on reductions in product quality or variety that customers value."²²

VI. Conclusion

By severely diminishing competition in the PBM market, the proposed merger of Express Scripts and Medco stands to impart significant harm on healthcare consumers. In the form of higher priced health plans and drugs, plan participants will bear the cost of the competition lost for large plan sponsors. As reimbursement is driven below competitive levels for pharmacies, the pharmacy access and service many consumers value will degrade. And with increased dominance, the joint-firm will continually deny patient choice by forcing consumers, including specialty patients with complex therapy needs, away from the service they trust into inferior mail order programs. The Federal Trade Commission should challenge the proposed transaction because it raises significant threats to competition and accordingly, the interests of American consumers.

²² MERGER GUIDELINES § 10.

Appendix A

The Consumer Federation of America (CFA) is composed of over 280 state and local affiliates representing consumer, senior, citizen, low-income, labor, farm, public power and cooperative organizations, with more than 50 million individual members. CFA represents consumer interests before federal and state regulatory and legislative agencies, participates in court proceedings and conducts research and public education.

Consumers Union, publisher of *Consumer Reports*, is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves.

The National Legislative Association on Prescription Drug Prices (NLARx) is a nonpartisan, nonprofit organization founded and directed by state legislators. Our mission is to assist legislators who seek to work jointly across state lines to make prescription drugs more affordable and accessible to people in the United States, especially by reducing prescription drug prices.

The National Consumers League is America's oldest consumer organization, representing consumers and workers on marketplace and workplace issues since 1899. NCL provides government, businesses, and other organizations with the consumer's perspective on concerns including child labor, privacy, food safety, and medication information.

U.S. PIRG, the federation of state Public Interest Research Groups (PIRGs), stands up to powerful special interests on behalf of the American public, working to win concrete results for our health and well-being. With a strong network of researchers, advocates, organizers and students in state capitols across the country, we take on the special interests on issues, such as product safety, political corruption, prescription drugs and voting rights, where these interests stand in the way of reform and progress.

Appendix B

Related Testimony on Pharmacy Benefit Managers

David Balto, Testimony before Department of Labor on Fee Disclosures to Welfare Benefit Plans (Dec 7, 2010). Available at <http://www.dol.gov/ebsa/pdf/1210-AB08-CAPAF.pdf>.

David Balto, Testimony before House Judiciary Committee, Subcommittee on Courts and Competition Policy on Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients "The Need for a New Antitrust Paradigm in Health Care" (Dec 1, 2010). Available at <http://judiciary.house.gov/hearings/pdf/Balto101201.pdf>.

David Balto, Testimony before the Ohio Senate on S.B. 154 (Feb 23, 2010). Available at http://www.americanprogressaction.org/issues/2010/02/pdf/balto_testimony_pbms.pdf.

David Balto, Testimony before US Senate Commerce, Science and Transportation Committee "The Effects of Regulatory Neglect on Health Care Consumers" (July 16, 2009). Available at http://www.americanprogressaction.org/issues/2009/07/pdf/balto_care_testimony.html.

David Balto, Testimony before US House Judiciary Committee on The Impact of Our Antitrust Laws on Community Pharmacies and Their Patients" (Oct 18, 2007). Available at <http://judiciary.house.gov/hearings/pdf/Balto071018.pdf>.



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

Statement of:

Michael J. Bettiga, R.Ph.

Chief Operating Officer and Executive Vice President

Shopko Stores

Green Bay, Wisconsin

On Behalf of:

The National Association of

Chain Drug Stores

For:

United States Senate

Committee on the Judiciary

Subcommittee on Antitrust,

Competition Policy and Consumer Rights

Hearing on:

“The Express Scripts/Medco Merger:

Cost Savings for Consumers or More Profits for the Middlemen?”

December 6, 2011

2:30 p.m.

226 Dirksen Senate Office Building

National Association of Chain Drug Stores (NACDS)
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Alexandria, VA 22314
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United States Senate
December 6, 2011
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On behalf of the National Association of Chain Drug Stores (NACDS), I am pleased to submit a statement for the hearing on “The Express Scripts/Medco Merger: Cost Savings for Consumers or More Profits for the Middlemen?” My name is Mike Bettiga. I am a pharmacist and have worked in numerous capacities for Shopko Stores for almost 35 years. Presently, I am the Chief Operating Officer and Executive Vice President at Shopko. Shopko is a multi-department retailer that operates in the Midwest, Northern Plains, and Western U.S.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies, and employ more than 3.5 million employees, including 130,000 full-time pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. The total economic impact of all retail stores with pharmacies transcends their \$900 billion in annual sales. Every \$1 spent in these stores creates a ripple effect of \$1.81 in other industries, for a total economic impact of \$1.76 trillion, equal to 12 percent of GDP.

Express Scripts and Medco are two of the “Big Three PBMs” in the U.S. The proposed merger of these two PBM giants poses significant anti-competitive threats to numerous U.S. industries and markets. If allowed, this merger would have grave consequences for consumers and the nation’s community pharmacies that serve them, as well as for health plans and employers that utilize PBM services, specialty pharmacy services, and mail order pharmacy services. NACDS opposes this merger and has urged FTC to block it. In September, the FTC issued a “Second Request” to Express Scripts and Medco to gather more data on the merger. According to media reports, only 4% of similar proposed deals in 2010 were issued a Second Request by the FTC. This merger has received the attention of not only FTC and this Committee, but also numerous other Members of Congress, numerous state Insurance Commissioners, state Attorneys General, and state legislators, who have all asked FTC to give this proposed merger a high level of scrutiny.

Background on PBMs

PBMs manage and administer the prescription drug benefits of more than 210 million Americans. Employers and health plans contract with PBMs to manage and administer prescription drug benefits (as opposed to medical benefits) as part of overall health benefits. PBMs construct and manage drug formularies and use these formularies to negotiate rebates and discounts with pharmaceutical manufacturers. Manufacturers provide rebates and discounts to PBMs as “rewards” for placing their brand drugs on formularies, promoting these products and driving brand usage. In the process, PBMs act as “double agents” working simultaneously for employers/plans (administering patients’ pharmacy benefits) and drug manufacturers (maximizing market share via formulary inclusion). PBMs often tout their ability to negotiate these rebates and cost savings and claim that they benefit plans and patients. However, there is no proof that PBMs pass along any savings to plans, employers, or patients, nor do they generally disclose the rebates. In practice, many PBMs retain a large percentage of these rebates even though they are generated by the plans’ pharmacy spend. Formularies and rebates drive the usage of selected drugs, thereby maximizing the rebates PBMs can extract from drug manufacturers and incentivizing PBMs to increase the dispensing of certain drugs, even if it increases the plans’ costs (i.e., by dispensing brand drugs rather than generic drugs). These rebates and discounts are a significant source of PBM revenue, which often creates a conflict of interest between the PBMs’ and the patients’ and plans’ interests.

The PBM then contracts with community pharmacies to provide prescription drugs and pharmacy services to the plans’ beneficiaries. The payment from a PBM to a pharmacy for dispensing a prescription drug differs from the amount a PBM charges a plan for the same prescription drug, to the benefit of the PBM. Plans sponsors are typically unaware of this difference, commonly referred to as the “spread.” PBMs profit not only from the spread, but also from additional administrative fees charged to the plan for processing the claim. Many PBMs also own mail order pharmacies that they encourage consumers to

use instead of community pharmacies. In addition, Express Scripts and Medco each separately own two of the largest specialty pharmacy companies in the U.S.

As an industry, PBMs are virtually unregulated. They may have tangential regulatory compliance for insurance related processes through their relationships with health plans and employers. A handful of states directly regulate some PBM functions, such as how they conduct audits of pharmacies, and some state boards of pharmacy regulate them to the extent that their activities can be construed as practicing pharmacy. The vast majority of their remaining functions and activities are unregulated, as there are no state or federal authorities with direct jurisdiction over them.

Overview of Concerns

The proposed merger of Express Scripts and Medco would result in unparalleled market concentration in an already extremely limited marketplace. Because of several mergers and acquisitions over the past decade, the number of large PBMs has declined significantly since 2000 and the concentration among these large PBMs has increased during that time. The market for national prescription drug plans is currently concentrated in just three PBMs. If the merger proceeds, there will be a reduction in competition in already highly-concentrated markets, including those involving PBM services, as well as mail order distribution services and specialty pharmaceutical services.

The proposed merger would be a tipping point in terms of PBM concentration that would have a considerable anti-competitive impact on employers, health plans, federal employee benefit plans, and TRICARE, along with their beneficiaries. The post-merger PBM marketplace would have markedly reduced choice for all patients and consumers, as well as governmental, employer and third-party payors.

Reduced PBM Competition

As two of the “Big Three” PBMs, Express Scripts and Medco control 50-60% of the national overall prescription drug volume.¹ If this merger is approved, more than one-third of all Americans (roughly 135 million people) would rely on the new “mega PBM” to manage their prescription benefits.² This “mega PBM” alone would control over 40% of the national prescription drug volume.³ Certain classes of customers such as large, complex health plans would be left with only two choices for PBM services, the merged entity and the one remaining large PBM. For these large plans that typically choose one of the “Big Three” PBMs, the proposed merger would create a firm with more than 50% market share. Smaller regional PBMs would be unable to constrain anticompetitive conduct because of their smaller size, geographic limitations, and lack of ability to secure rebates.

This substantial reduction in competition will harm purchasers of PBM services and the purchasers’ beneficiaries by limiting consumer choice, reducing transparency, reducing access to pharmacy services, and increasing costs to the beneficiaries.

Anti-Competitive Concentration in the PBM Market

The proposed merger will lead to anticompetitive concentration in the PBM market, resulting in market foreclosure practices that harm purchasers of PBM services and consequently, consumers of pharmacy services. Specifically, the merged PBM will have an incentive to use its increased market power as both a seller and a purchaser of pharmacy services to impose unfavorable contract terms on community pharmacies. Consequently, this “mega PBM” would have the ability to raise prices for health plans and patients, limit access to pharmacy patient care and force patients to use the PBM’s mail order pharmacies rather than their trusted community pharmacies, driving up costs for employers, health plans and other federal and state programs.

PBMs operate unregulated and in an opaque manner. They claim that they save money by negotiating rebates and discounts from drug manufacturers and negotiating lower reimbursement rates from pharmacies. However, as mentioned above, there is no proof that they pass along any of this purported savings to health plans, employers or consumers. In fact, the PBM industry has been fraught with allegations of extensive deceptive and fraudulent practices. In recent years, cases brought by a coalition of over 30 State Attorneys General have resulted in over \$370 million in penalties for deceptive and fraudulent conduct.⁴ It was found that PBMs accepted rebates from manufacturers in return for placing higher priced medications on prescription drug plans' formularies, switched customers to the higher priced drugs that were paid for by the health plan/employer, and benefitted from both the rebate received and the higher priced drug payment without passing along the enrichment to the health plan/employer. In essence, PBMs use lack of transparency to negotiate higher rebates from drug manufacturers, higher drug prices for health plans/employers, and lower payments to pharmacies, while keeping the gains for themselves. We can expect a "mega PBM" to have freer reign to engage in similar egregious conduct.

As middlemen, PBMs claim that their ability to negotiate with drug manufacturers and pharmacies reduces overall prescription drug costs. However, despite their claims, overall prescription drug spending continues to steadily increase. Moreover, recent studies show that PBMs' mail order pharmacies have lower generic dispensing rates than retail community pharmacies.⁵ A "mega PBM" would be even more likely to increase drug costs by shifting more patients to mail order, which utilizes more expensive, brand name drugs. This increased cost would be borne by health plans, employers, and ultimately consumers.

Our concerns about the anti-competitive nature of this proposed merger were recently echoed by the American Antitrust Institute (AAI) in a letter to FTC, in which AAI urges

FTC to enjoin the merger. In addition, AAI explains why second-tier PBMs are not able to compete with the “Big Three” PBMs, and the proposed merger would make it even more difficult for them to compete. AAI also describes the anticompetitive harm the merger would cause in the specialty pharmacy and mail order pharmacy segments.

Concerns about Specialty Pharmacy and Mail Order Services

Specialty pharmaceuticals are high cost drugs required by patients undergoing intensive therapies for chronic, complex, relatively rare and/or potentially life-threatening illnesses. Industry experts anticipate that sales of specialty pharmaceuticals will account for an increasing dollar share of all drugs consumed, estimated to be 27% of all drug sales by 2015.⁶

The merger would combine two of the three largest suppliers of specialty pharmacy services, creating an entity with more than 50% share of all specialty pharmacy sales. CuraScript (owned by Express Scripts) and Accredo (owned by Medco) are the two largest specialty pharmacies in the U.S. Combined, these two entities account for an estimated 52% of all specialty pharmaceuticals in the U.S.; this would be enough power to stifle competition in the specialty pharmacy market and command even higher prices. Both PBMs have attempted to significantly increase prices of specialty pharmaceuticals in recent years. We can expect an even greater effort to do this should the merger be approved.

The merger will also create the largest mail-order pharmacy accounting for close to 60% of all mail-order prescriptions processed in the U.S.⁷ The merged company will have even more market power to reduce patient access to community pharmacies and force consumers and employers to use its own captive mail order operation. Although the merging firms may claim that shifting prescriptions to mail order prescriptions from retail community pharmacies will drive down drug costs to consumers, their increased market

power is likely to result in an artificially high reduction in prescriptions filled through community pharmacies, and increased costs for payors and beneficiaries.

The ability of PBMs to drive prescriptions to their own mail order facilities is inherently anticompetitive. Congress has recognized the potential for this type of abuse, and in Medicare, this type of “self dealing” in the case of physicians is illegal. Moreover, PBMs determine the income received by pharmacies (by setting pharmacies’ reimbursement rates) and then directly compete with pharmacies by driving prescriptions to their own mail order facilities. Further consolidation of PBMs and mail order pharmacies, in addition to the lack of transparency in PBM operations, will further exacerbate these conflicts. The result will be increased costs for public programs such as Medicare, beneficiaries, private health plans and employers, and the American taxpayer.

In addition, the merged entity’s ability to shift patients to its mail-order operations will have a direct and harmful impact on patient care. It will allow the mega PBM to limit consumers’ access to their local pharmacies and the vital healthcare services and one-on-one counseling they provide. As mentioned recently by Medco CEO David Snow, PBM mail order pharmacies utilize robots as opposed to pharmacists.⁸ In addition to dispensing prescriptions, pharmacists counsel patients on a daily basis to ensure that they take their medications as directed by their doctors. They also provide a broad range of critical, cost-effective services such as immunizations, counseling for diseases such as diabetes, and other health education and screening programs. These high quality services increase the therapeutic benefits of prescription drugs, which improve health outcomes and lowers costs. Robots in remote facilities cannot provide these personal, customized services. There is simply no substitute for the in-store, face-to-face services provided by pharmacists.

Conclusion

NACDS thanks the Committee for consideration of our comments on the proposed merger of Express Scripts and Medco. We are deeply concerned about the anti-competitive impact the merger would have and are extremely skeptical that the American public can trust a “mega PBM” to look out for the best interests of patients and payors, or to pass any purported “savings” along to beneficiaries and other consumers. These concerns are compounded by the fact that the PBM industry as a whole is virtually unregulated.

¹ Atlantic Information Services (“AIS”), 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill’s Guide to Rx Channel – An Investor Handbook, May 10, 2011.

² Bloomberg, Express Scripts-Medco Deal May Spur Purchases by Rivals, July 22, 2011.

³ Atlantic Information Services (“AIS”), 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill’s Guide to Rx Channel – An Investor Handbook, May 10, 2011.

⁴ The American Antitrust Institute, “Commentary: The FTC Should Issue a Second Request on Express Scripts’ Proposed Acquisition of Wellpoint’s PBM Business,” May 11, 2009.

⁵ See 2010-2011 Prescription Drug Cost and Plan Benefit Design Report at 28, available at http://www.benefitdesignreport.com/Portals/0/2010-2011_BDR_R1.pdf.

⁶ See CVS Caremark Corp., 2010 Annual Report at <http://www.annualreports.com/HostedData/AnnualReports/PDFArchive/cvs2010.pdf> (citing ModernHealthcare.com).

⁷ AIS 2011 data.

⁸ See, for example, <http://blog.pharmexec.com/2011/10/11/medco-ceo-champions-robots-over-pharmacists/>; accessed November 26, 2011.

The Economic Benefits of Pharmacy Benefit Managers¹

by

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December 5, 2011

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I. Executive Summary

Health care spending in America is on an unsustainable trajectory. A variety of factors – including demographic changes, increased utilization of health care services, and high rates of chronic and complex disease – are driving rapid growth in health care spending. The Centers for Medicare and Medicaid Services (CMS) projects that the growth in prescription drug spending will average 7.1 percent per year from 2011 through 2020.⁴ If costs per enrollee in Medicare and Medicaid grow at the same rate over the next four decades as they have over the past four decades, those two programs *alone* will increase from five percent of GDP today to 20 percent of GDP in 2050.⁵ Escalating health care costs also make it more difficult for employers to provide quality health benefits to their workers and reduce employment and wages. Approximately 12 percent of employer costs today are for employee health benefits.⁶

Approximately one-half of adults in the U.S. have chronic diseases or complex health conditions.⁷ This population segment accounts for 96 percent of drug spending⁸ and 75 percent of total health care expenditures nationwide.⁹ For the vast majority of chronic and complex diseases – 88 percent – drugs are a first, logical choice for medical intervention.¹⁰ However, recent research from the New England Healthcare Institute reports that up to 50 percent of all U.S. patients do not take their medications as prescribed, and patients' non-adherence is estimated to cost up to \$290 billion in "avoidable medical spending" every year.¹¹ Similarly, Express Scripts has estimated that pharmacy-related waste in health care spending exceeded \$403 billion in 2010 alone and could exceed \$1.2 trillion between 2010 and 2014.¹² The dual

⁴ Centers for Medicare & Medicaid Services (2011), National Health Expenditure Projections 2010-2020, available at <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

⁵ Peter Orszag, "Health Costs are the Real Deficit Threat," *The Wall Street Journal*, May 15, 2009.

⁶ Toni Johnson, "Healthcare Cost and U.S. Competitiveness," Council on Foreign Relations, March 23, 2010, available at <http://www.cfr.org/health-science-and-technology/healthcare-costs-us-competitiveness/p13325>.

⁷ Centers for Disease Control and Prevention, "Chronic Diseases and Health Promotion," available at <http://www.cdc.gov/chronicdisease/overview/index.htm#ref2>.

⁸ David Snow (2010), "The Case for Smarter Medicine: How Evidence-Based Protocols Can Revolutionize Healthcare," p. 9, available at <http://medco.mediaroom.com/index.php?s=17884>.

⁹ *Ibid.*

¹⁰ *Ibid.*, p. 10.

¹¹ New England Health Care Institute, "Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease," August 12, 2009, p. 1, available at http://www.nehi.net/publications/44/thinking_outside_the_pillbox_a_systemwide_approach_to_improving_patient_medication_adherence_for_chronic_disease.

¹² Express Scripts Drug Trend Report 2010, p. 8.

goal of containing drug spending and better managing the total costs of chronic conditions is key to addressing the nation's health care cost problem.

Pharmacy benefit managers (PBMs) help to lower health care costs. PBMs currently play a vital role containing costs and improving patient outcomes by serving more than 215 million Americans through health insurance plans, labor unions, private and governmental employers, and Medicare prescription drug plans.¹³ PBMs improve prescription drug therapy management for patients and deploy a variety of tools to contain drug costs for payers. PBMs have evolved beyond their core service of prescription drug management to also focus on improving health outcomes and providing treatment solutions for patients with chronic and/or complex conditions.

PBMs' ability to contain spending will be critical in the coming years as health care reform expands coverage at a time of extreme budgetary pressures at both the federal and state levels. Health care reform also calls for several changes in the delivery of care, such as state health insurance exchanges and accountable care organizations (ACOs). PBMs are well placed to adapt to these changes and help spur innovation with their "wired" technology platforms that efficiently integrate prescription management at both mail order and retail and allow communication with pharmacists and physicians in real time for evidence based clinical management.

- **PBMs Reduce Drug Costs by Approximately 30 Percent Per Year**

- Empirical evidence demonstrates that PBMs deliver cost savings for consumers, labor unions, employers, health plans and government programs. The benefits PBMs produce in containing costs have been thoroughly documented in studies by economists, government agencies such as the Congressional Budget Office (CBO), Government Accountability Office (GAO), and the Federal Trade Commission (FTC), health industry analysts, and clinical researchers. The Congressional Budget Office (CBO) estimated that PBMs have the potential to save as much as 30 percent in total drug spending relative to unmanaged purchasing.¹⁴ Similarly, a more recent private-sector report estimates that PBMs will save plan sponsors and consumers almost \$2 trillion (about 35 percent) from 2012 to 2021, compared to drug expenditures made without PBMs in the following categories:¹⁵

¹³ Visante, "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," September 2011 ("Visante 2011"), p. 3. (A report prepared for the Pharmaceutical Care Management Association.)

¹⁴ Congressional Budget Office, "Issues in Designing a Prescription Drug Benefit for Medicare," October 2002, Table 6 at 40 available at <http://www.cbo.gov/ftpdocs/39xx/doc3960/10-30-PrescriptionDrug.pdf>.

¹⁵ Visante 2011, p. 3 and Figure 5 at 17.

Increased Use of Generics and Preferred Brands	11% – 16%
Manufacturer and Pharmacy Discounts	22% – 28%
Utilization Management and Adherence Programs ¹⁶	-1% – 1%
Total	30% – 40%

- PBMs control drug spending primarily by leveraging their advanced technology platforms to make prescription management more efficient, driving higher use of generics and other lower cost medications, negotiating favorable drug prices from manufacturers and retail pharmacies, dispensing prescriptions via lower cost channels, such as mail-order pharmacies, and through evidence-based clinical programs.
- By helping to contain health care costs and improving patient outcomes, PBMs help public and private sector employers to offer more and better health benefits to their employees. Elsewhere, the benefits of PBM cost savings show up as lower prices for health care services, gains in effective wages, increased employment, and reduced spending for government payers.
- PBMs also help to rein in other health costs and improve health outcomes by boosting patient adherence to drug therapies,¹⁷ detecting and closing gaps in care and preventing adverse drug interactions. Patient non-adherence is estimated to cost up to \$290 billion per year – which represents about 13 percent of all health expenditures. A significant body of peer-reviewed literature shows that non-adherence takes a significant toll on health and leads to higher health care costs. For example, one estimate shows that non-adherence to prescribed medications accounts for nearly 20 percent of all hospitalizations and almost 125,000 deaths each year.¹⁸ Research also indicates that patients who adhere to their medication regimens have better health outcomes and use fewer health care services – including urgent care and inpatient services – compared to patients who are non-adherent. Notably, researchers state that while improving medication adherence results in higher prescription drug costs, these costs are often more than offset by savings in other types of medical spending.¹⁹

¹⁶ Although there may be a net increase in drug utilization due to increased patient adherence, and therefore a “negative savings” in drug spending, there is an associated greater savings from an overall health care cost perspective since better medication adherence reduces other health care costs.

¹⁷ See, e.g., O. Kenrik Duru, Julie A. Schmittiel, et al. (2010), “Mail-Order Pharmacy Use and Adherence to Diabetes-Related Medications,” *American Journal of Managed Care*, 16(1), 33, 37.

¹⁸ Mediaplanet, “Medication Non-Adherence,” March 2011, p. 10, available at [http://www.cardinal.com/mps/wcm/connect/0ba69c00464d3b23b998fb690e45094f/Washington+Post+Special+Section+\(March+2011\).pdf?MOD=AJPERES&CACHEID=0ba69c00464d3b23b998fb690e45094f](http://www.cardinal.com/mps/wcm/connect/0ba69c00464d3b23b998fb690e45094f/Washington+Post+Special+Section+(March+2011).pdf?MOD=AJPERES&CACHEID=0ba69c00464d3b23b998fb690e45094f).

¹⁹ One study found lower disease-related medical costs associated with higher medication adherence for patients with diabetes and hypercholesterolemia. (Michael C. Sokol, Kimberly A. McGuigan, et al. (2005), “Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost,” *Medical Care*, 43(6), 521.) Similarly, a 2011 *Health Affairs* study documented substantial cost savings from improved medication adherence for individuals with chronic vascular disease through reduced inpatient hospital days and emergency department visits. (M. Christopher Roebuck, Joshua N. Liberman, et al. (2011), “Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending,” *Health Affairs*, 30(1), 91, available at <http://content.healthaffairs.org/content/30/1/91.full.pdf+html>.) Another study found that patients with chronic myeloid leukemia (CML) who adhered to their medication more than 85 percent of the time have fewer hospitalizations than non-adherent patients, and the costs of the hospitalizations are lower, too: \$3,758 vs. \$44,498. (Eric Q. Wu, Nicolas Beaulieu, et al. (2010), “Healthcare Resource Utilization and Costs Associated with Non-

- PBM's growing role in the clinical management of chronic diseases or complex health conditions is particularly important given that these patients account for approximately 96 percent of drug spending and 75 percent of total health care expenditures nationwide.
- **Medco and Express Scripts Save Clients Between \$51 Billion and \$87 Billion Per Year**
 - Simply analyzing the cost savings derived by Medco and Express Scripts – as estimated above using the 30 percent CBO savings estimate – we calculate that Medco and Express Scripts save plan sponsors and consumers roughly \$51 billion per year.²⁰
 - But Medco and Express Scripts estimate that they currently derive greater savings through larger discounts from drug manufacturers and retail network partners and benefit plans and consumers in other ways that would not be fully captured in the CBO estimates, such as their more extensive clinical offerings.²¹ Therefore, Medco and Express Scripts estimate that together they save consumers roughly \$87 billion per year.
 - To further quantify savings, we also compared the prices paid by Medco plan members at retail pharmacies to the usual and customary (“U&C”) prices typically paid by cash-paying customers using data that Medco compiles in the ordinary course of business. As shown in Figure 1,²² these data show that Medco plan members paid substantially lower prices than cash-paying customers. For brand drugs purchased at chain pharmacies, these data show that on average, the prices paid by Medco plan members during the 2008 to September 2011 period were 20 percent less than the prices paid by cash paying customers as measured by the U&C price. For generic drugs, the average price for Medco plan members was 57 percent less than the price paid by cash paying customers.

Adherence to Imatinib Treatment in Chronic Myeloid Leukemia Patients,” *Current Medical Research & Opinion*, 26(1), 61, 63-64.)

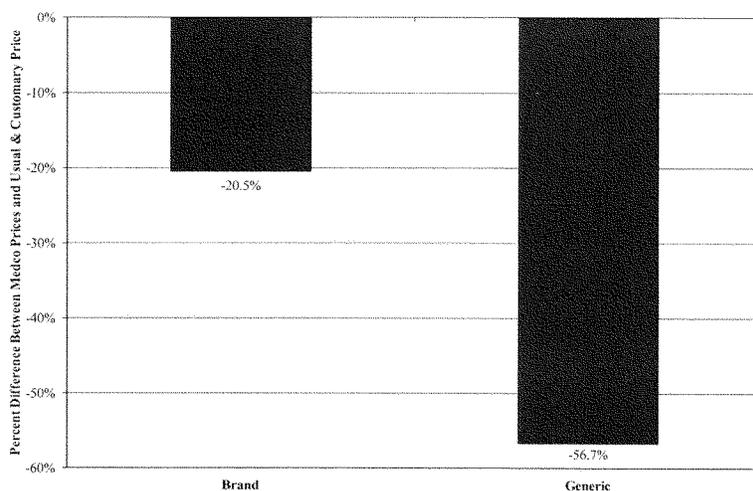
²⁰ Calculated as 30 percent of estimated Medco and Express Scripts AWP spending during 2010.

²¹ For example, by integrating specialty pharmacies with core PBM functions, Medco and Express Scripts provide better coordinated care and have realized high rates of patient adherence, increased ability to close gaps in care, coordinate care for patients with co-morbidities, and provide other clinical benefits.

²² Note: 2011 is through September 30, 2011. Source: Medco provided data file, ftc cash pay 20111011.xls.

Figure 1

Prices Paid by Medco Plan Members are Substantially Lower Than Those Paid by Cash Customers
2008 - 2011



- o The savings delivered by Medco, Express Scripts, CVS/Caremark, SXC, Catalyst and other PBMs are passed on to public and private employers and labor unions in the form of lower prices for health care, to the federal government as a result of lower Medicare Part D costs, and to individuals who purchase insurance on their own. Based on the 2010 savings estimates provided by the companies, we estimate how these savings were distributed among the Medicare Program (Federal Government (Part D) + Medicare Beneficiaries), labor unions and employer and individual plans as summarized in Table 1 below.

Table 1

Medco and Express Scripts Estimated 2010 Client Savings Relative to Unmanaged Spending	
Medicare Program (Federal Government (Part D) + Medicare Beneficiaries)	\$21.7 billion
Labor Unions	\$3.5 billion
Employers and Individuals	\$61.9 billion
TOTAL	\$87.1 billion

- o These cost savings are derived from a variety of sources. For example:
 - Express Scripts uses data-driven models and other tools to curb health care costs stemming from non-adherence and increasing use of the most efficient and safest

delivery channels. Express Scripts estimates that it saved each member \$11 per year by moving them to value-enhanced pharmacies and up to \$27 per year by elevating adherence rates for patients in its home delivery program.²³

- The merging firms use a variety of tools to mitigate health care costs associated with chronic and complex conditions. Medco's Therapeutic Resource Centers (TRCs) are clinical programs that use specialized pharmacists and advanced systems to personalize pharmacy care for patients with chronic conditions and complex therapeutic needs. Medco estimates that TRCs closed more than 2.3 million clinical gaps in care in 2010 alone with estimated health cost savings of \$900 million.²⁴

As rising health care costs continue to confront both public and private payers, the need for innovative solutions becomes ever more pressing. By better containing health care costs and improving patient outcomes, PBMs help produce lower entitlement program spending and a healthier workforce. In some cases, PBM savings manifest themselves in the form of employers offering cheaper and/or better health benefits to their members. Elsewhere, the benefits show up as gains in effective wages, increased employment or reduced spending for cash-strapped government payers.

²³ Express Scripts Drug Trend Report 2010, p. 16.

²⁴ Medco 2010 Annual Report, p. 2.

II. What Do Pharmacy Benefit Managers Do And How Do They Benefit the U.S. Economy?

A. U.S. health care spending is on an unsustainable growth trajectory and pharmacy benefit managers are well positioned to help meet this challenge.

The role of pharmacy benefit managers (PBMs) in containing prescription drug costs and improving management of chronic conditions is increasingly important to the U.S. economy. As discussed above, U.S. health care spending is on an unsustainable growth trajectory. PBMs help manage drug benefits for some 215 million Americans in both commercial and government health care programs.²⁵ Health care program sponsors contract with PBMs to process and pay prescription drug claims, to secure discounts and rebates from prescription drug manufacturers, and to manage broad networks of pharmacies including both community pharmacies and mail-order service pharmacies. PBMs also play an important clinical role in support of quality, cost-effective patient care by helping to ensure that patients take medications as prescribed; use the lowest-cost, clinically safe and effective medication; avoid taking multiple medications that may interact with one another adversely; and are incentivized to use the most cost-effective delivery channel, when appropriate. Appendix A provides an overview of the key functions PBMs perform in the management of drug benefits.

B. Medco and Express Scripts reduce health care costs for their clients by between \$51 billion and \$87 billion per year.

Consistent with the literature showing that PBMs generate large cost savings, Medco and Express Scripts have reduced health care costs for their clients by between \$51 billion and \$87 billion per year. Simply analyzing the cost savings derived by Medco and Express Scripts – as estimated using the 30 percent CBO savings estimate – we calculate that Medco and Express Scripts save plans and consumers roughly \$51 billion per year.²⁶ But Medco and Express Scripts currently derive greater savings through larger discounts from drug manufacturers and retail network partners and benefit plans and consumers in other ways that would not be fully captured in the 2002 CBO estimates, including their more extensive clinical offerings that we describe below. Including these additional cost savings not included in the CBO estimate, Medco and

²⁵ Visante 2011, p. 3.

²⁶ Calculated as 30 percent of estimated Medco and Express Scripts average AWP spending for 2010.

Express Scripts estimate that they save consumers an additional \$36 billion per year – or roughly \$87 billion per year, in total.

Medco and Express Scripts estimated the savings generated for different types of plan sponsors during 2010 in three categories: (i) retail discounts, (ii) mail discounts, and (iii) rebates from drug manufacturers. Savings for the retail and mail channels represent the total client discount dollars off of Average Wholesale Price (“AWP”) for each respective channel. Since AWP prices are similar to the prices paid by unmanaged cash paying customers at retail pharmacies, this method approximates the amount that PBMs save plan sponsors compared to unmanaged spending.²⁷ The calculation represents the entire discount realized by plan sponsors and consumers – it does not attempt to apportion the discount between them. Savings for the rebate category represent the total dollars of rebates passed through to clients in each year. In addition to these three categories, Medco also estimated savings for a fourth category: savings from clinical programs. The savings for the clinical programs category are estimated by Medco using a claim-based methodology that compares the patient’s claims activity before and after an intervention as a result of the various specific programs.²⁸

The savings delivered by Medco, Express Scripts, CVS/Caremark, SXC, Catalyst and other PBMs are passed on to public and private employers and labor unions in the form of lower prices for health care, to the federal government as a result of lower Medicare Part D costs, and to individuals who purchase insurance on their own. Based on the 2010 savings estimates provided by Medco and Express Scripts, we estimate how these savings were distributed among the Medicare Program (Federal Government (Part D) + Medicare Beneficiaries), labor unions and employer and individual plans as summarized in Table 2 below. In addition, if the savings

²⁷ In studies of PBM savings, the reference prices for unmanaged plan members are frequently measured by the prices paid by cash-paying customers at retail pharmacies. (See, e.g., United States General Accounting Office, “Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees and Pharmacies,” GAO-03-196, January 2003, (“2003 GAO Study”), available at <http://www.gao.gov/new.items/d03196.pdf>.) Medco has compiled information in the ordinary course of business on the usual and customary prices charged to cash-paying customers for a sample of brand and generic drugs over time. These data show that cash-paying consumers generally paid significantly more than AWP during the 2008 to 2010 for brand drugs and significantly less than the generic AWP for generic drugs. While the average discount from generic AWP was larger than the average premium over brand AWP, the fact that brand drugs account for substantially larger dollar volume of purchases implies that on an overall spending basis, the average difference between AWP and U&C prices is relatively small.

²⁸ The specific programs included in the Medco analysis include Concurrent Drug Utilization, POS Plan Management, Preferred Drug Step Therapy, Prior Authorization, Smart Rules, Rational Med, and Therapy Management. Medco receives fee income for some of its clinical programs. These fees are approximately \$4.17 per eligible member per year across the Medco book of business. In comparison, the estimated clinical savings average approximately \$385 per eligible member per year.

from Express Scripts Medicare plans were distributed similarly as those of Medco's plans, the \$21.7 billion estimated Medicare savings could be divided further into savings of approximately \$13.4 billion for the Federal Government (Part D) and \$8.3 billion for Medicare beneficiaries.²⁹ Calculated savings to the federal government reflect lower government payments for the heavily government-subsidized Medicare Part D program. Specifically, the government experiences lower annual costs for Medicare Part D premium subsidies, reinsurance subsidies and low-income beneficiary subsidies (both premium and cost sharing) as a result of lower drug benefit costs. Furthermore, the government has reduced outlays for the retiree drug subsidy (RDS) whereby the government subsidizes a portion of total drug benefit costs for employers offering qualified drug coverage to Medicare beneficiaries. Medicare beneficiaries also directly benefit from lower premiums and/or lower cost sharing. Savings to employers and employees, as well as individuals purchasing insurance reflect lower premium and/or cost sharing as a result of lower drug benefit costs.

Table 2

Medco and Express Scripts Estimated 2010 Client Savings Relative to Unmanaged Spending	
Medicare Program (Federal Government (Part D) + Medicare Beneficiaries)	\$21.7 billion
Labor Unions	\$3.5 billion
Employers and Individuals	\$61.9 billion
TOTAL	\$87.1 billion

C. PBMs effectively deploy a variety of tools to reduce prescription drug spending

PBMs use multiple tools to contain prescription drug spending. A well-designed drug benefits program typically begins with a comprehensive formulary which lists the drugs that the plan will cover in each of many therapeutic categories. The formulary is compiled by the plan's Pharmacy and Therapeutics (P&T) Committee which is made up of pharmacists and physicians from different specialties who evaluate drugs in various therapeutic categories on a variety of criteria including effectiveness and safety.³⁰ Financial data also are considered in development

²⁹ A more detailed description of the methodology for allocating savings can be found in Appendix B.

³⁰ Federal Trade Commission, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," August 2005, ("2005 FTC Study"), pp. 10-11, available at <http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitprt.pdf>.

of formularies, however, “[d]ecisions are based, first and foremost, on appropriate care for the member.”³¹ While PBMs consult extensively with plan sponsors in all areas of plan design, the final decisions are made by the plan sponsor, not the PBM. Given the formulary, and other elements of the plan design, PBMs drive down net drug costs by leveraging the volume of their customer bases, encouraging the use of lower cost products including generic drugs, conducting utilization management programs, and delivering medications to patients via low-cost, mail-order pharmacies. In 2010, the growth in prescription drug spending slowed to 3.5 percent. The Center for Medicare and Medicaid Services (CMS) has recognized the role of PBM tools, such as use of incentives to stimulate the use of lower cost generic drugs, in achieving this result.³²

There is a diverse array of competitors in the PBM industry. The FTC’s 2005 PBM Study estimated that about 40-50 PBMs operate in the US.³³ Similarly, the Pharmacy Benefit Management Institute’s directory lists more than 40 members operating today.³⁴ While many PBMs are “stand-alone” independent firms – such as Express Scripts, Medco, Catalyst, SXC and MedImpact – other PBMs are affiliated with major health insurers or health plans (such as United Health, Aetna, CIGNA, and Kaiser). One of the largest PBMs, CVS Caremark, is a combination of a PBM and a retail drug chain, and another large retail drug chain Walgreens recently sold its PBM. These examples and many others show that plan sponsors have many diverse alternatives available when choosing a PBM.

In addition, the PBM industry is one where changes in business models and repositioning by competitors can have a significant impact on competition. For example, industry analysts estimate that Medco has recently lost as much as 33 percent of its revenue base, of that, approximately one-half is attributed to United Health’s decision to take its PBM functions in-house, another eight percent of Medco’s revenue base will now go to CVS (CalPERS, FEP, UAM), and the remaining eight percent will be divided up between other PBMs such as Prime Therapeutics (BCBSNC) and others.³⁵ The Chairman and CEO of Medco, David Snow,

³¹ 2005 FTC Study, p. 11.

³² Sean P. Keehan, Andrea M. Sisko, et al. (2011), “National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth,” *Health Affairs*, 30(8), 1596, 1600, available at <http://content.healthaffairs.org/content/early/2011/07/27/hlthaff.2011.0662.full.pdf+html>.

³³ 2005 FTC Study, p. v.

³⁴ Note, this may not include all PBMs as companies must pay a fee to be listed in PBMI’s directory. (Pharmacy Benefit Management Institute, “PBM Directory,” available at <http://www.pbmi.com/pbmdir.asp>.)

³⁵ Morgan Stanley, “Healthcare Services & Distribution,” July 28, 2011, p. 3.

discussed these and other recent examples of PBM innovation and competition.³⁶ Despite this variety of competitors, in some of the discussion that follows, we focus on specific programs and capabilities of the merging firms because we have more detailed information about their offerings. However, this disproportionate focus on the merging firms does not imply that the many other competitors in the marketplace do not also provide substantial benefits to consumers and plan sponsors.

1. Promote use of lower cost drugs

a) Driving Generic Drug Utilization

PBMs and health insurers increase the use of generics through a variety of benefit design and utilization management tools. As shown in Figure 2³⁷, Medco and Express Scripts have increased their generic dispensing rates significantly in recent years. In 2010, Medco's generic prescription dispensing rate reached 71 percent,³⁸ which resulted in incremental savings of \$3.7 billion to Medco clients and members.³⁹ Express Scripts' generic dispensing rate was nearly 72 percent.⁴⁰ Medco estimates that its clients have realized cumulative savings of approximately \$23 billion from increases in generic utilization since 2006.⁴¹ These savings reflect both the effects of PBM tools that encourage generic utilization, and the increased availability of generic medications over time. Savings from increasing generic utilization have increased over time as the rate of price increases for brand drugs has far exceeded that of generic drugs – in 2009 average brand drug prices increased by over nine percent whereas generic drug prices rose by less than one percent.⁴²

³⁶ Written Testimony of David Snow Before the House Judiciary Committee, Subcommittee on Intellectual Property, Competition and the Internet, Hearing on the Proposed Merger Between Express Scripts and Medco, September 20, 2011, pp. 3-6.

³⁷ Sources: Medco Health Solutions 2007 10-K, p. 34; Medco Health Solutions 2010 10-K, p. 42; Medco Health Solutions 10-Q, June 25, 2011, p. 17; Express Scripts 2005 10-K, p. 33; Express Scripts 2007 10-K, p. 31; Express Scripts 2008 10-K, p. 36; Express Scripts 2010 10-K, p. 31; and Express Scripts 10-Q, June 30, 2011, p. 21.

³⁸ Medco Drug Trend Report 2011, p. 3.

³⁹ "Medco Chairman and CEO David Snow Addresses Shareholders, Highlighting Another Year of Growth, Innovation and Substantial Client Savings - With More to Come," Medco Health Solutions Press Release, May 24, 2011, available at <http://medco.mediaroom.com/index.php?s=17872&item=40156>.

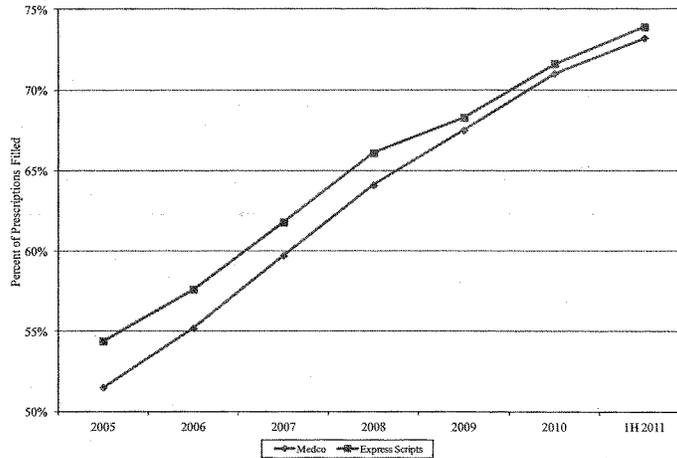
⁴⁰ Express Scripts 2010 10-K, p. 31.

⁴¹ "Medco Health Solutions Inc Q3 2011 Earnings Conference Call – Final Transcript," October 26, 2011, p. 4 available at <http://seekingalpha.com/article/302339-medco-health-solutions-ceo-discusses-q3-2011-results-earnings-call-transcript>.

⁴² Medco Drug Trend Report 2010, p. 7.

Figure 2

Medco and Express Scripts Have Substantially Increased Generic Dispensing Rates in Recent Years



While the historical savings from generics are very substantial, there are additional opportunities to derive even greater savings – by maximizing the use of currently available generics and capitalizing on the upcoming “generic wave” which will affect many high-cost drug categories. Express Scripts estimates that the health care system could save \$56.7 billion annually by achieving maximum generic fill rates within each therapy class for currently available generic drugs.⁴³ The savings potential from the use of generics in coming years will grow considerably: According to estimates, \$89 billion in branded drug sales will lose patent protection over the next five years, and more than \$50 billion in U.S. brand drugs – accounting for about 20 percent of current plan drug spending – will open to generic competition from late 2011 through 2013.⁴⁴

PBMs use a variety of tools to encourage the use of generic drugs when appropriate. One tool PBMs use to motivate members to utilize generic drugs is tiered copayments. These are

⁴³ Express Scripts Drug Trend Report 2010, p. 9.

⁴⁴ Generic Pharmaceutical Association, “Savings Achieved Through Use of Generic Pharmaceuticals 2000-2009,” July 2010, pp. 3-4 and Medco Drug Trend 2011, p. 48.

explicit incentives to consumers to choose lower-cost drugs.⁴⁵ Some plans waive copayments altogether for generic drugs.⁴⁶ Another method is to require members to pay the full-price difference between a generic and branded drug if they refuse the generic alternative. Medco found that plans with a strong “pay the difference” program achieved higher substitution rates (61.2 percent) compared to plans without a “pay the difference” requirement (52.8 percent).⁴⁷

PBMs also can influence generic utilization through the extensive use of mail-order pharmacy services, which enables PBMs to influence more directly generic substitution and offer generic alternatives shortly after they enter the market. When a new generic medication is introduced to the market, PBMs will often stock the medication prior to its introduction date, communicate with physicians and patients about the new product, and convert prescriptions from the branded drug to the generic on an expedited basis as soon as the medication is available.⁴⁸ Medco found that new generics entering the market replaced 92.4 percent of their brand name counterparts through its mail-order pharmacy within the first week of release, compared to a substitution rate of 54.1 percent achieved at retail pharmacies.⁴⁹ Over the course of the first year of introduction of a generic, retail pharmacies had a lower generic dispensing rate than Medco; such lower generic dispensing rates resulted in approximately \$430 million higher health care costs.⁵⁰

PBMs also increase generic dispensing rates through communications with both physicians and plan members. Some plans offer physicians periodic “report cards,” which track generic prescribing behaviors. With the assistance of its PBM, one large Medco customer used this tool to increase its generic dispensing rate by 12 percentage points, resulting in savings of 18 percent in total plan cost for the employer and out-of-pocket savings for the company’s employees.⁵¹ Similarly, Medco found that plan members who were presented cost savings options through an online tool were more likely to convert to a generic medication. In fact, 51

⁴⁵ Pharmacy Benefit Management Institute, “PBM 101 White Paper Series: Drug Benefit Management Strategies,” 2009 (“PBM 101”), p. 3 and 2005 FTC Study, p. 11.

⁴⁶ PBM 101, p. 6.

⁴⁷ David B. Snow (2007), “Maximizing generic utilization: The power of pharmacy benefit management,” *Journal of Generic Medicines*, 5(1), 27 (“Snow 2007”), 32.

⁴⁸ *Ibid.*, p. 33.

⁴⁹ Snow 2007, p. 33 and Figure 4. Further, Medco reported during the first week of its release in 2007 the generic for Ambian, zolpidem, Medco mail-order pharmacy achieved a generic substitution rate of 97 percent, 20 percentage points higher to retail pharmacies’ generic substitution rate of 77 percent over the same period. (Medco Drug Trend Report 2008, p. 10.)

⁵⁰ Snow 2007, pp. 33-34.

⁵¹ *Ibid.*, pp. 36-37.

percent of those studied converted to a generic drug, and an additional seven percent converted to a lower-cost therapeutic equivalent drug; each conversion yielded an average annual savings of \$171 per member.⁵²

b) Therapeutic Interchange

Two plans surveyed by the GAO reported savings ranging from one percent to 4.5 percent from therapeutic interchange programs, where a clinically appropriate and less costly alternative drug was dispensed.⁵³ PBMs use therapeutic interchange programs to encourage physicians and patients to use formulary or preferred formulary drugs.⁵⁴ Therapeutic interchanges are programs where PBMs identify a suitable substitute drug in the same therapeutic class – even if not chemically equivalent – as the originally prescribed drug.⁵⁵ The interchange for a substitute drug can be either branded-to-branded or branded-to-generic, depending upon the physician’s final approval.⁵⁶ When a prescribed drug is identified by a PBM as having a therapeutic equivalent on the PBM’s formulary, the PBM contacts the prescribing physician and offers the opportunity to prescribe the substitute medication.⁵⁷

c) Prior Authorization, Step Therapy, and Refill-too-Soon

Express Scripts estimates that plans that make use of the full range of clinical programs including step therapy, prior authorization, and others, can save roughly 11 percent of annual drug costs compared to plans that use none of these programs.⁵⁸ Similarly, Medco estimates that its clinical programs have saved roughly \$305 per eligible member per year during the 2008 to 2010 period.⁵⁹ Prior authorization (PA) is a process by which the PBM must approve a

⁵² Ibid., pp. 36-37. On generic savings see also, Visante 2011, p. 11-13 and Jack Hoadley, “Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In The Literature,” Kaiser Family Foundation, March 2005, pp. 32-33, available at <http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51885>.

⁵³ 2003 GAO Study, p. 13.

⁵⁴ 2005 FTC Study, p. 13 and 2003 GAO Study, pp. 13-14.

⁵⁵ 2005 FTC Study, p. 13.

⁵⁶ Ibid.

⁵⁷ PriceWaterhouseCoopers, “The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation,” July 2004, (“PWC 2004”), p. 7 (A report prepared for the Pharmaceutical Care Management Association.) and 2005 FTC Study, p. 13.

⁵⁸ Written Testimony of George Paz Before the House Judiciary Committee, Subcommittee on Intellectual Property, Competition and the Internet, Hearing on the Proposed Merger Between Express Scripts and Medco, September 20, 2011, p. 3.

⁵⁹ Medco receives fee income for some of its clinical programs. These fees are approximately \$4.17 per eligible member per year across the Medco book of business.

physician's or patient's request for a drug before the plan sponsor will pay for it. In some instances, physicians must give clinical justification for the prescription prior to receiving approval,⁶⁰ while in other instances drugs not included in the PBMs' formulary require PA.⁶¹ These authorizations, which are often required for medications that are particularly expensive or prone to misuse, can help control drug costs.⁶² A GAO study found that PA produced savings ranging from one percent to six percent of plan spending for drugs that either were not dispensed or were substituted with less costly alternatives, for particular plans that were studied.⁶³

Step therapy is a plan design tool in which the plan will only cover more expensive drugs if patients try and fail therapy with less expensive alternatives, such as generic drugs, over-the-counter drugs, or less expensive brand drugs.⁶⁴ Express Scripts estimates that its step therapy efforts can produce savings of \$30 or more per member each year.⁶⁵ One study analyzing 2005 data reported that a step therapy effort requiring patients to use a generic antidepressant prior to use of a brand-name drug resulted in drug cost savings of nine percent for the entire class of antidepressants, equal to approximately \$1.8 billion in the first year of the intervention.⁶⁶

To limit overuse – or fraudulent diversion – of medications, nearly all PBMs use refill-too-soon interventions. These measures prevent a patient from refilling a prescription until a certain percentage of the prior prescription is exhausted.⁶⁷

2. Negotiate lower net drug costs for customers

The key economic role of PBMs in negotiating favorable prices from drug manufacturers has been discussed in many studies.⁶⁸ PBMs have significant negotiating leverage because they

⁶⁰ 2005 FTC Study, pp. 13-14. *See also*, PBM 101, p. 6.

⁶¹ PWC 2004, p. 13.

⁶² 2005 FTC Study, p. 14 and 2003 GAO Study, p. 13.

⁶³ *Ibid.*

⁶⁴ 2005 FTC Study, p. 14. *See also*, PBM 101, p. 7.

⁶⁵ Express Scripts Drug Trend Report 2010, p. 16.

⁶⁶ Jeffrey D. Dunn, Eric Cannon, et al., (2006), "Utilization and Drug Cost Outcomes of a Step-Therapy Edit for Generic Antidepressants in an HMO in an Integrated Health System," *Journal of Managed Care Pharmacy*, 12(4), 294.

⁶⁷ Pharmacy Benefit Management Institute, "Prescription Drug Benefit Cost and Plan Design Report 2010-11," 2010, p. 34.

⁶⁸ *See, e.g.*, 2005 FTC Study; Department of Justice and Federal Trade Commission "Improving Health Care: A Dose of Competition," July 2004, Chapter 7, available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>; Federal Trade Commission, "FTC-DOJ Hearings on Health Care and Competition Law and Policy – Panel Discussion: Pharmacy Benefit Managers," June 26, 2003, available at <http://www.ftc.gov/ogc/healthcarehearings/030626ftctrans.pdf>; 2003 GAO Study; Patricia Danzon (2000), "Making Sense of Drug Prices," *Regulation*, 23(1), 56 available at

are able to pool large volumes of prescription drug purchases across their entire customer bases, and because they can influence the use of particular drugs within a therapeutic class through preferred placement on a formulary and other incentives for consumers. It is this unique ability to influence consumer and prescriber behavior that gives PBMs a major advantage over other large participants in the distribution chain such as retail chains and drug wholesalers in negotiating discounts and rebates.

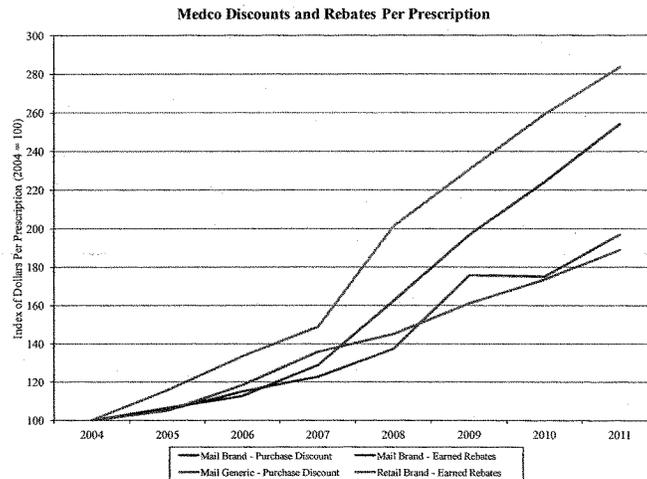
Based on an annual survey of health plans, the average rebate collected per prescription for each brand name drug dispensed at retail increased from \$2.57 in 2007 to \$7.87 in 2010; the average rebate collected for brand name drugs dispensed via mail order rose from \$10.79 in 2007 to \$25.97 (or an increase of \$3.59 to \$8.65 based on a 30-day supply) in 2010.⁶⁹ Similarly, data on the actual rebates and discounts negotiated by Medco with drug manufacturers and wholesalers also provides strong evidence that such rebates and discounts have increased substantially as Medco has grown over time (see Figure 3).⁷⁰

<http://www.cato.org/pubs/regulation/regv23n1/danzon.pdf>; Benjamin Klein and Andres Lerner (2008), "The Law and Economics of Bundled Pricing: LePage's, PeaceHealth and the Evolving Antitrust Standard," *Antitrust Bulletin* 53(3), 555; United States Department of Health & Human Services, "Report to the President Prescription Drug Coverage, Spending, Utilization, and Prices," April 2000, Chapter 3, *available at* <http://aspe.hhs.gov/health/reports/drugstudy/chap03.htm>; Özden Gür Ali and Murali Mantrala (2010), "Pharma Rebates, Pharmacy Benefit Managers and Employer Outcomes," *Health Care Management Science*, 13(4), 281.

⁶⁹ Pharmacy Benefit Management Institute, "Prescription Drug Benefit Cost and Plan Design Report 2010-11," 2010, p. 29.

⁷⁰ Note: 2011 is as of July 2011 forecast. Source: Medco provided data file, Medco Scale Trend Statistics (Aug 2011) Vers 3.xls.

Figure 3



While the potential cost saving benefits of PBM bargaining power have been widely recognized, some critics of PBMs have argued that some PBMs may have monopsony power in their dealings with retail pharmacists.⁷¹ These claims reflect a basic confusion between buying power, which likely benefits plan sponsors and consumers, and monopsony power which has the potential to harm consumers. The FTC has clearly recognized this crucial distinction and the potential benefits of increased buying power in the PBM industry specifically in its statement regarding the 2004 Caremark acquisition of AdvancePCS.⁷² In particular, the FTC states:

We also considered whether the proposed acquisition would confer monopsony (or oligopsony) power on PBMs when they negotiate dispensing fees with retail pharmacies. It is important not to equate market concentration on the buyer side with this kind of power. For example, a shift in purchases from an existing source to a *lower-cost, more efficient* source is not an exercise of monopsony power. Nor do competition and consumers suffer when the

⁷¹ See, e.g., Statement of Dan E. Gustafson, Before the House Committee on the Judiciary, Subcommittee on Intellectual Property, Competition and the Internet, Hearing on The Proposed Merger between Express Scripts and Medco" September 20, 2011, p. 14-15. Monopsony is a structure of a market in which there is one buyer facing many sellers. It is the opposite of monopoly where one seller faces many buyers.

⁷² Statement of the Federal Trade Commission, *In the Matter of Caremark Rx, Inc./AdvancePCS*, File No. 031 0239, pp. 2-3, available at <http://www.ftc.gov/os/caselist/0310239/040211ftcstatement0310239.pdf> (note omitted).

increased bargaining power of large buyers allows them to obtain lower input prices without decreasing overall input purchases. This bargaining power is procompetitive when it allows the buyer to reduce its costs and decrease prices to its customers.

...

At most, the acquisition is likely to increase the bargaining power of the merged PBM and to increase its shares (and correspondingly reduce the pharmacies' shares) of the gains flowing from contracts between the PBM and the pharmacies. It is likely that some of the PBM's increased shares would be passed through to PBM clients. Although retail pharmacies might be concerned about this outcome, a reduction in dispensing fees following the merger could benefit consumers.⁷³

In addition to recognizing this conceptual difference between buying power which can benefit consumers and monopsony power, there also is no empirical basis for believing that modest reductions in payments to retail pharmacies that the merged firm may be able to negotiate would result in financial difficulties for pharmacies or a significant reduction in the marketplace output of pharmacy services. In fact, the aggregate gross profits of pharmacies reported by the US Census Bureau have increased by 37.4 percent from \$43.5 billion in 2004 to \$59.8 billion in 2009, even though pharmacy reimbursement rates have trended down over this period.⁷⁴ To illustrate the small magnitude of any potential impact on pharmacies, even if we assume that (say) 25 percent of the publicly disclosed estimated \$1 billion in annual savings to plan sponsors and consumers came from lower reimbursement to retail pharmacies, the resulting \$250 million in annual savings would constitute less than one-half of one percent of the estimated pharmacy industry gross profit of \$60 billion per year.

In addition, if the primary concern of some analysts is for the health of independent pharmacies (rather than the entire retail pharmacy sector), several additional points must be recognized. First, public policy should focus on overall economic efficiency and consumer welfare, not protection of any particular type of pharmacy.⁷⁵ Second, PBMs have no economic

⁷³ Ibid. Similarly, a joint report by the FTC and Department of Justice stated, "One panelist noted that a large customer base enables the largest PBMs with the most covered lives to drive the market share of any one pharmaceutical drug product and, therefore, obtain the lowest prices from pharmaceutical manufacturers." (Department of Justice and Federal Trade Commission, "Improving Health Care: A Dose of Competition," July 2004, Chapter 7, p. 11, (note omitted) available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.)

⁷⁴ Adam J. Fein, "2010-11 Economic Report on Retail and Specialty Pharmacies," Pembroke Consulting, December 2010 ("Fein 2010"), Exhibit 24 at 33 and US Census 2009 Annual Retail Trade Report, Gross Margin, March 31, 2011, available at <http://www.census.gov/retail/>.

⁷⁵ It is widely recognized that some retail pharmacy groups have been strident opponents of PBM cost containment tools for many years. Such opposition has included strong advocacy for state and Federal legislation that would

incentive to benefit other retail formats at the expense of independent pharmacies. A diverse and competitive pharmacy industry helps PBMs achieve their business goals of providing convenient and affordable retail networks to plan sponsors. More than 60,000 retail pharmacies – which represent more than 95 percent of all United States retail pharmacies – participate in one or more of Express Scripts’ and Medco’s networks.⁷⁶ The independent pharmacies’ membership in the Express Scripts and Medco networks plays an important role in their business, driving a large amount of incremental customer traffic to their stores. As another example, PBM care innovations allow independent pharmacies to deliver enhanced levels of service to their customers. For example, as discussed below, Medco has partnered with community pharmacies in innovative programs to help them achieve better adherence results for their patients.

Some PBM opponents also have argued that the cost savings PBMs generate from their ability to negotiate favorable deals with pharmaceutical manufacturers and retail network partners often are not passed through to plan sponsors.⁷⁷ However, this reflects a misunderstanding of typical PBM contracting practices and the economics of the industry. PBM contracts with plan sponsors typically require that PBMs pass on a very large fraction of the savings they negotiate with drug manufacturers and retail network partners. For example, Medco’s 10-K reports that it passed through to its customers 87.5 percent of manufacturer rebates in 2010.⁷⁸ The economic evidence also indicates that plan sponsors who prefer contract structures with such high rates of pass-through are able to negotiate for such contracts. For example, in its recent 2011 letter commenting on proposed PBM regulation in Mississippi, the

make PBM tools significantly less effective. The FTC has opposed such legislation on numerous occasions. See, for example, Federal Trade Commission, Letter to Honorable James L. Seward, August 8, 2011, p. 2, *available at* <http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf>. Federal Trade Commission, Letter to the Honorable Mark Formby, March 22, 2011, pp. 2-3, 8, *available at* <http://www.ftc.gov/os/2011/03/110322mississippiipbm.pdf>.
⁷⁶ Express Scripts 2010 Annual Report, p. 6; Express Scripts 2010 10-K, p. 2; and Medco Health Solutions 2010 10-K, p. 9.

⁷⁷ For example, David Balto recently argued that “there is little reason to expect a dominant PBM to pass on savings to consumers.” (David Balto, “Step Up to the Plate: FTC Needs to Stop the Express Scripts-Medco Merger,” *TheHill.com*, November 2, 2011, *available at* <http://thehill.com/opinion/op-ed/191497-step-up-to-the-plate-ftc-needs-to-stop-the-express-scripts-medco-merger>.) See also, Statement of Dan E. Gustafson, Before the House Committee on the Judiciary, Subcommittee on Intellectual Property, Competition and the Internet, Hearing on The Proposed Merger between Express Scripts and Medco, September 20, 2011, p. 16.

⁷⁸ Medco Health Solutions 2010 10-K, p. 55. Similarly, Express Scripts stated in its 2010 10-K that “Historically in the PBM industry, competition in the marketplace has also caused many PBMs, including us, to reduce the prices charged to clients for core services and share a larger portion of the formulary fees and related revenues received from pharmaceutical manufacturers with clients.” (Express Scripts 2010 10-K, p. 16.)

FTC staff reiterated that “competition affords health plans substantial tools with which to safeguard their interests” in contracting with PBMs.⁷⁹

For other categories of PBM savings, such as increased mail order and generic dispensing, pass-through of savings occurs automatically under existing contracts, because mail order and generic drugs are substantially less costly for plan sponsors. In addition, for those categories of cost savings that are not subject to such “automatic” pass-through mechanisms, such efficiencies reduce the PBM’s costs, allowing it to compete more aggressively in the marketplace. Economic analysis indicates that such efficiencies also are likely to benefit consumers over time as they increase the incentive and ability of the firm to reduce prices, provide better products, and expand output in other ways.

3. Lower costs using mail order pharmacy

Mail order pharmacies allow PBMs to offer lower prices on prescription drugs, achieve higher rebates through improved formulary compliance, increase generic dispensing rates, and automate systems for reviewing prescriptions to elevate rates of adherence to chronic medications and detect other gaps in care. According to Medco data, clients using Medco’s mail order pharmacy more than 40 percent of the time in 2008 saw absolute drug costs decline year-over-year – completely offsetting the effects of inflation and increased utilization.⁸⁰ Indeed, Medco projects that the use of mail order will produce more than \$1.93 billion in savings to Medco clients in 2012.⁸¹ Express Scripts estimates savings of up to \$27 per member each year have been realized from the use of mail order.⁸²

Health plan members also benefit from generally lower co-payments at mail order and the convenience of receiving a 90-day supply of their prescriptions delivered to their homes. For

⁷⁹ Federal Trade Commission, Letter to the Honorable Mark Formby, March 22, 2011, p. 2, *available at* <http://www.ftc.gov/os/2011/03/110322mississippibm.pdf>. In addition to the different contract options offered by Medco and Express Scripts, there are numerous competing PBMs in the marketplace that aggressively promote their services based on a high degree of “transparency” to potential clients (e.g., Navitus, Catalyst Rx). There are also many external consultants whom offer expertise and sophisticated tools to assist plan sponsors in evaluating PBM offerings. Notably, both Medco and Express Scripts have recently been certified as meeting the standards of business transparency adopted by the HR Policy Association, an organization representing the chief human resource officers of more than 325 large private sector employers in the United States. (“HR Policy Association Announces 2012 PBM Transparency In Pharmaceutical Purchasing Solutions Participants,” September 13, 2011, *available at* <http://www.hrpolicy.org/downloads/2011/11-119%202012%20TIPPS-Certified%20PBMs%20Press%20Release.pdf>.)

⁸⁰ Data provided by Medco.

⁸¹ *Ibid.*

⁸² Express Scripts Drug Trend Report 2010, p. 16.

example, recent survey data show that under the most common plan design in 2010, the average copayment for a 90-day supply of medication from mail order was \$53.63, compared to a copayment for a 30-day supply at retail of \$25.93, making the mail option more economical for the patient over the 90-day comparison period ($\$25.93 \times 3 = \77.79).⁸³ One study found that nearly 80 percent of employers did not have to pay dispensing fees when using mail-order pharmacies, compared to the average \$1.62 dispensing fee at retail pharmacies.⁸⁴

Medco, Express Scripts and other PBMs can offer low-cost mail-order pharmacies because they operate such facilities at a large scale and leverage efficiencies through automated dispensing pharmacies. They can additionally utilize on-line ordering, integrated voice-response systems, and point-of-care technologies.⁸⁵

The efficiencies of mail-order pharmacies and PBMs are well recognized by CBO, GAO, the FTC, and the research community. A 2003 GAO study found the average price of prescriptions through mail order was 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs, and 53 percent below the retail cash price for generic drugs.⁸⁶ The FTC, citing its own research, has stated that "Mail order pharmacies typically are less expensive than retail pharmacies, for both health plans and consumers."⁸⁷ U.S. officials also have recognized the benefits of mail-order pharmacies and PBMs. In a letter to state governors earlier this year, HHS Secretary Kathleen Sebelius listed mail order as one way states could purchase drugs more effectively for their Medicaid programs.⁸⁸ The FTC has also highlighted the benefits of PBMs and mail-order pharmacies in letters sent to both Mississippi and New York government agencies in 2011.⁸⁹

⁸³ Pharmacy Benefit Management Institute, "Prescription Drug Benefit Cost and Plan Design Report 2010-11," 2010, p. 18.

⁸⁴ Fein 2010, p. 38.

⁸⁵ Mail-order pharmacies are able to review, record, and interpret incoming prescriptions, screen for interactions based on each patient's drug history profile, resolve benefit issues with rules set by plan sponsors, resolve clinical or prescription clarification issues with physicians, and collect co-payments from patients. Image-based technology is used to improve access to prescription orders and increase processing efficiency. Following order processing, prescriptions are approved for dispensing and electronically routed to one of the firm's mail-order dispensing pharmacies, which are networked into one integrated systems platform. Automated technology is used to dispense tablets and capsules, as well as original packaging. (Medco Health Solutions 2010 10-K, p. 8.)

⁸⁶ 2003 GAO Study p. 4.

⁸⁷ Federal Trade Commission, Letter to Honorable James L. Seward, August 8, 2011, p. 2, *available at* <http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf>.

⁸⁸ U.S. Department of Health & Human Services, "Sebelius Outlines State Flexibility and Federal Support Available for Medicaid," February 3, 2011, *available at* <http://www.hhs.gov/news/press/2011pres/01/20110203c.html>.

⁸⁹ Federal Trade Commission, Letter to the Honorable Mark Formby, March 22, 2011, *available at* <http://www.ftc.gov/os/2011/03/110322mississippiibm.pdf> and Federal Trade Commission, Letter to Honorable

4. Manage specialty drug spending

PBMs can play a vital role in the management of specialty drugs. In general, the utilization of specialty drugs – drugs for complex medical conditions that require special handling either in delivery from pharmacy to the patient or in administration of the medication, or both – has grown rapidly in recent years and is projected to continue as the fastest growing category of drug spending.⁹⁰ Express Scripts estimates that by 2014, specialty drug spending will constitute 22 percent of total worldwide drug spending and up to 40 percent of U.S. drug spending, including both medical and pharmacy spending.⁹¹ Because of this rapid current and projected growth, health plan sponsors increasingly face serious challenges in managing spending on high-cost biologics and other specialty medications.

One factor underlying specialty drug spending is the growth in patients with chronic or complex conditions, which can require highly innovative and expensive medications to treat. Roughly 50 percent of U.S. adult population is treated for a chronic or complex condition,⁹² and those conditions represent 96 percent of drug costs in the U.S. and 75 percent of medical expenses.⁹³ A 2005 study estimates that poor management of chronic and complex conditions can lead to \$350 billion in unnecessary health care costs annually.⁹⁴

Specialty pharmacies have evolved in order to address the needs of some of the most complex and costly patient conditions within this category of chronic medication users. Some PBMs have integrated wholly-owned specialty pharmacies to complement their mail-order pharmacies to achieve many of the similar economies of scale and scope that are associated with

James L. Seward, August 8, 2011, *available at*, <http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf>. The FTC also noted several potential economic benefits from integrating complementary functions such as PBM operations and mail order pharmacies within a single firm, including the elimination of “double markups” in the supply chain, savings in transactions costs and better alignment of incentives. (2005 FTC Study, p. xvi.)

⁹⁰ See, e.g., Fein 2010, Exhibit 37 at 53.

⁹¹ Express Scripts Drug Trend Report 2010, p. 5. Similarly, USA Today recently reported that specialty drugs represent the fastest growing segment of employer health plan spending. (Julie Appleby, “Specialty drugs offer hope, but can carry big price tags,” USA Today, August 22, 2011, *available at* <http://www.usatoday.com/money/industries/health/drugs/story/2011/08/Specialty-drugs-offer-hope-but-can-carry-big-price-tags/50090368/1/>)

⁹² David Snow (2010), “The Case for Smarter Medicine: How Evidence-Based Protocols Can Revolutionize Healthcare,” p. 9, *available at* <http://medco.mediaroom.com/index.php?s=17884>. See also, Centers for Disease Control and Prevention, Chronic Diseases and Health Promotion, *available at* <http://www.cdc.gov/chronicdisease/overview/index.htm#ref2>.

⁹³ David Snow (2010), “The Case for Smarter Medicine: How Evidence-Based Protocols Can Revolutionize Healthcare,” pp. 9-10, *available at* <http://medco.mediaroom.com/index.php?s=17884>.

⁹⁴ David Snow, “Healthcare Reform: The Future is Now,” May 14, 2010, p. 4, *available at* <http://www.colorado.edu/mcldb/goldlab/Slide%20Decks/19.%20David%20Snow%20slides.pdf>.

mail-order pharmacies, but focused specifically on dispensing specialty medications and managing patients with chronic conditions.

Express Scripts has extended its PBM benefit management tools to specialty drugs, which often fall under a patient's medical benefit rather than under the outpatient pharmacy benefit. Express Scripts estimates that 55 percent of specialty drug spend occurs under a patient's medical benefit.⁹⁵ Industry analysts have identified various advantages to plan sponsors from moving specialty drug spending to the pharmacy benefit, including "better contracting and purchasing of drug product and potentially improved patient outcomes from higher compliance as the PBM would work with the specialty drug manufacturer to negotiate rebates in exchange for formulary position, helping manage patient utilization and assurance of payment."⁹⁶

Specialty pharmacies will likely achieve even greater cost savings with the evolution of "biosimilars" when innovator patents expire. There are 46 biotech products with patent expirations through 2020, totaling \$42.3 billion in potential savings from biosimilars.⁹⁷ Biosimilars present a large opportunity for cost savings to patients and plan sponsors given the rising costs of branded specialty drugs. PBMs and their integrated specialty pharmacies will play a critical role in encouraging utilization of biosimilars, helping plans and patients realize significant savings.

5. Manage pharmacy network reimbursement

Another tool PBMs use to manage prescription drug benefits is pharmacy network cost management. PBMs contract with retail pharmacies and negotiate payment rates for covered drugs on behalf of a plan sponsor.⁹⁸ A GAO study that examined the pharmacy benefits for federal employees illustrates how successful PBMs have been in negotiating with retail pharmacies. The study found the average price PBMs negotiated for drugs from retail pharmacies was about 18 percent below the average cash price customers would pay at retail pharmacies for 14 selected brand-name drugs.⁹⁹ The price differential was even greater for

⁹⁵ Express Scripts Drug Trend Report 2010, p. 18.

⁹⁶ Citigroup, "Pharmacy Benefits Managers and Distributors," January 27, 2011, p. 29.

⁹⁷ U.S. Drug spend estimates are based on IMS Health data for 2009, manufacturer reported U.S. sales or a percent of manufacturer reported worldwide annual sales of the drug. Market availability of biosimilars based on expected patent expiration dates current as of November 2010 plus two years. Changes may occur due to litigation, patent challenges, or other factors.

⁹⁸ 2005 FTC Study, pp. 3-4.

⁹⁹ 2003 GAO Study, p. 9.

generic drugs, with PBMs negotiating costs 47 percent below the average cash price for four selected generic drugs.¹⁰⁰ As shown in Figure 1 above, Medco data confirm that Medco plan members continue to receive much larger discounts than cash-paying customers. For brand drugs purchased at chain pharmacies, these data show that on average, the prices paid by Medco plan members during the 2008 to September 2011 period were 20 percent less than the prices paid by cash paying customers as measured by the U&C price. For generic drugs, the average price for Medco plan members was 57 percent less than the price paid by cash paying customers.

Retail pharmacies are willing to offer these discounts to be included in a PBM's network because they will realize substantial incremental sales from plan members that are managed by the PBM, including both pharmacy sales and sales of other products carried in their stores. Pharmacies often compete by offering discounts depending on the size of the PBM's member base; pharmacies offer greater discounts to earn the business a plan or PBM may offer.¹⁰¹ Since PBMs often manage benefits for many health plans covering a large number of plan members, individual health plans typically benefit from the additional bargaining power that a PBM can bring to the negotiation of pharmacy network reimbursement contracts.¹⁰² Express Scripts also has estimated savings of up to \$11 per member each year by incentivizing customers to use retail pharmacies that offer lower prices.¹⁰³

6. Efficiencies from PBMs advanced technology platforms

As discussed above, many of the efficiencies provided by PBMs, are facilitated by their "wired" technology platforms that efficiently integrate prescription management at both mail order and retail and allow communication with pharmacists and physicians in real time for efficient evidence based clinical management. PBMs have made major contributions to industry efficiency and patient care by continually innovating their pharmaceutical care technology and information systems.

¹⁰⁰ Ibid.

¹⁰¹ 2005 FTC Study, p. 5 and United States Department of Health and Human Services Office of Inspector General, "Memorandum Report: Medicare Part D Pharmacy Discounts for 2008," OEI-02-10-00120, November 17, 2010, available at <http://oig.hhs.gov/oei/reports/oei-02-10-00120.pdf>.

¹⁰² See, 2005 FTC Study, p. 5.

¹⁰³ Express Scripts Drug Trend Report 2010, p. 16.

7. Detect fraud and abuse

Prescription fraud and abuse – which can be perpetrated by individuals as well as pharmacies – affects all stakeholders, and translates into higher premiums and out-of-pocket costs for consumers.¹⁰⁴ Approximately one percent of prescription drug costs are estimated to result from fraud, waste, and abuse, resulting in hundreds of millions of dollars in unnecessary health care costs.¹⁰⁵ With nearly four billion prescription drug claims processed per year, detecting and preventing fraud and abuse is crucial to controlling overall health care spending.¹⁰⁶

PBMs use real-time claims processing to try to identify fraud immediately. Additionally, PBMs operate advanced programs to monitor claims at the patient, pharmacy, and physician level to try to identify fraud and abuse after it has occurred. PBMs can identify individuals who fill multiple prescriptions at multiple pharmacies as likely fraud candidates or flag a pharmacy whose claims jump sharply in a given period of time.¹⁰⁷ PBMs also audit their contracted pharmacies to ensure they are not engaging in fraud and abuse.¹⁰⁸ Examples of pharmacy fraud include manipulating the coding and payment system to receive higher reimbursement, or overcharging payers for drugs dispensed.¹⁰⁹ These efforts will likely be even more effective with the combined data and technology of the merged firm.

Express Scripts and Medco employ many sophisticated tools to combat and prevent fraud, waste and abuse (FWA). Express Scripts' FWA program features the identification of potential problem pharmacies, members, and prescribers with unusual or excessive utilization patterns. Express Scripts estimates that implementing their FWA program has the potential to

¹⁰⁴ National Health Care Anti-Fraud Association, "Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers," October 6, 2010, p. 4, available at <http://www.sas.com/resources/asset/health-insurance-third-party-white-paper-nhcaa.pdf>.

¹⁰⁵ Pharmaceutical Care Management Association, "Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers," July 2011, p. 1, available at http://pcmanet.org/images/stories/uploads/2011/July2011/PCMA_Fraud_Waste_and_Abuse_in_Retail_Pharmacy_July_2011.pdf.

¹⁰⁶ IMS Health Channel Distribution by Prescriptions, April 7, 2011, available at http://www.imshealth.com/deployedfiles/ims/Global/Content/Corporate/Pres%20Room/Top-line%20Market%20Data/2010%20Top-line%20Market%20Data/2010_Distribution_Channel_by_RX.pdf.

¹⁰⁷ Statement for the Record of the Pharmaceutical Care Management Association Submitted to the United States House Of Representatives Committee On Ways And Means Subcommittee On Oversight, Hearing on Improving Efforts to Combat Health Care Fraud, March 2, 2011, p. 1, available at <http://waysandmeans.house.gov/UploadedFiles/PCMASubmissionForTheRecord1.pdf>.

¹⁰⁸ *Ibid.*

¹⁰⁹ Pharmaceutical Care Management Association, "Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers," July 2011, p. 2, available at http://pcmanet.org/images/stories/uploads/2011/July2011/PCMA_Fraud_Waste_and_Abuse_in_Retail_Pharmacy_July_2011.pdf.

provide substantial cost savings to clients. A return on investment of approximately 3:1 (\$0.88 PMPY) may be achieved through the FWA program's proactive analytics, data mining, and investigational services.¹¹⁰ In 2010, Express Scripts' Network Audit program audited more than one million claims resulting in more than \$58 million in overpayments identified and credited to clients.¹¹¹ Express Scripts has referred over 300 member, physician, and pharmacies to law enforcement in 2011.¹¹²

D. PBMs' clinical programs can improve health outcomes and lower overall health care costs

Medication is broadly recognized as a vital and effective tool for preventing and treating a broad array of health conditions -- prescriptions are the first line of defense for nearly 90 percent of illnesses.¹¹³ However, research shows that there are widespread problems with how medications are used. One study estimates that 50 percent of all U.S. patients do not take their medications as prescribed and in other cases needed drugs are not prescribed.¹¹⁴

Patient non-adherence to prescribed medication therapy is estimated to cost up to \$290 billion per year -- which represents about 13 percent of all health expenditures.¹¹⁵ A significant body of peer-reviewed literature shows that non-adherence takes a significant toll on health and leads to higher health care costs. For example, non-adherence to prescribed medications accounts for nearly 20 percent of all hospitalizations and almost 125,000 deaths each year.¹¹⁶ Research also indicates that patients who adhere to their medication regimens have better health outcomes and use fewer health care services -- including urgent care and inpatient services -- compared to patients who are non-adherent. Notably, researchers state that while improving medication adherence results in higher prescription drug costs, these costs are often more than offset by

¹¹⁰ Data provided by Express Scripts.

¹¹¹ *Ibid.*

¹¹² *Ibid.*

¹¹³ David Snow (2010), "The Case for Smarter Medicine: How Evidence-Based Protocols Can Revolutionize Healthcare," p. 10, available at <http://medco.mediaroom.com/index.php?s=17884>.

¹¹⁴ World Health Organization, "Adherence to Long-Term Therapies: Evidence for Action," 2003, pp. 7, 156, available at http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf.

¹¹⁵ New England Health Care Institute, "Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease," August 12, 2009, p. 1, available at http://www.nehi.net/publications/44/thinking_outside_the_pillbox_a_systemwide_approach_to_improving_patient_medication_adherence_for_chronic_disease.

¹¹⁶ Mediaplanet, "Medication Non-Adherence," March 2011, p. 10, available at [http://www.cardinal.com/mps/wcm/connect/0ba69c00464d3b23b998fb690e45094f/Washington+Post+Special+Section+\(March+2011\).pdf?MOD=AJPERES&CACHEID=0ba69c00464d3b23b998fb690e45094f](http://www.cardinal.com/mps/wcm/connect/0ba69c00464d3b23b998fb690e45094f/Washington+Post+Special+Section+(March+2011).pdf?MOD=AJPERES&CACHEID=0ba69c00464d3b23b998fb690e45094f).

savings in other types of medical spending.¹¹⁷ One study found lower disease-related medical costs associated with higher medication adherence for patients with diabetes and hypercholesterolemia; the authors found that every dollar spent on diabetes medication saves \$7 in medical costs (see Figure 4).¹¹⁸ Similarly, a 2011 *Health Affairs* study documented substantial cost savings from improved medication adherence for individuals with chronic vascular disease through reduced inpatient hospital days and emergency department visits.¹¹⁹ Drug spending accounts for approximately 10 percent of total health care spending nationwide while hospital and physician services together account for roughly 50 percent of expenditures.¹²⁰ By addressing the 10 percent of spending through better adherence, less waste, and greater use of lower cost treatments, PBMs can also help reduce the 50 percent of national spending to yield an amplified savings effect.

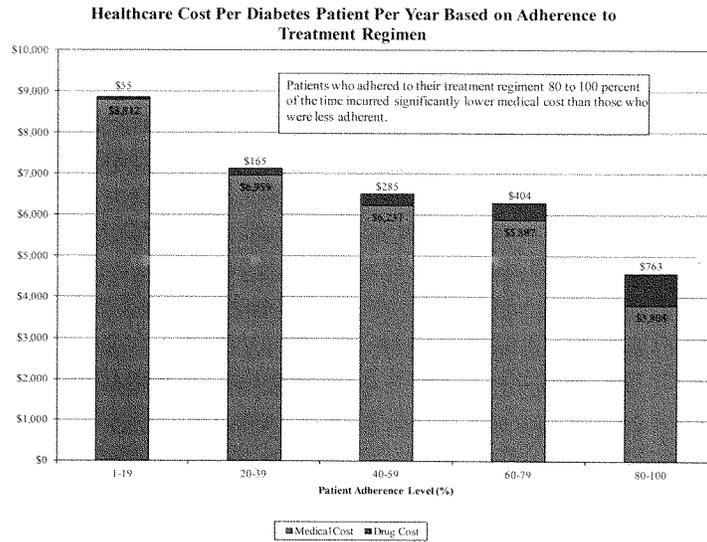
¹¹⁷ One study found lower disease-related medical costs associated with higher medication adherence for patients with diabetes and hypercholesterolemia. (Michael C. Sokol, Kimberly A. McGuigan, et al. (2005), "Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost," *Medical Care*, 43(6), 521.) Similarly, a 2011 *Health Affairs* study documented substantial cost savings from improved medication adherence for individuals with chronic vascular disease through reduced inpatient hospital days and emergency department visits. (M. Christopher Roebuck, Joshua N. Liberman, et al. (2011), "Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending," *Health Affairs*, 30(1), 91, available at <http://content.healthaffairs.org/content/30/1/91.full.pdf+html>.) Another study found that patients with chronic myeloid leukemia (CML) who adhered to their medication more than 85 percent of the time have fewer hospitalizations than non-adherent patients, and the costs of the hospitalizations are lower, too: \$3,758 vs. \$44,498. (Eric Q. Wu, Nicolas Beaulieu, et al. (2010), "Healthcare Resource utilization and Costs Associated with Non-Adherence to Imatinib Treatment in Chronic Myeloid Leukemia Patients," *Current Medical Research & Opinion*, 26(1), 61, 63-64.)

¹¹⁸ Source: Michael C. Sokol, Kimberly A. McGuigan, et al. (2005), "Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost," *Medical Care*, 43(6), 521, Table 2 at 525 and Figure 1 at 526 available at <http://www.americanhealthstrategy.com/pdfs/Resources/Evidence%20Based%20Literature/Impact%20of%20Medication%20Adherence%20on%20Hospitalization%20Risk%20and%20Healthcare%20Costs.pdf>.

¹¹⁹ M. Christopher Roebuck, Joshua N. Liberman, et al. (2011), "Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending," *Health Affairs*, 30(1), 91, available at <http://content.healthaffairs.org/content/30/1/91.full.pdf+html>.

¹²⁰ Centers for Medicare & Medicaid Services (2011), National Health Expenditure Projections 2010-2020, available at <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

Figure 4



PBMs improve patient health outcomes using programs that help optimize the selection of appropriate drugs, avoid prescribing errors, and help ensure that patients adhere to their prescribed therapy. Medco and Express Scripts both have developed proprietary evidence based clinical programs to promote safe, effective, and appropriate use of specialty and non-specialty drugs. For example, Medco has devoted substantial resources to employ specialist pharmacists with extensive training in the medications used to treat particular chronic and complex conditions. Express Scripts’ Consumerology initiative applies advanced behavioral science to identify and change common behaviors that prevent patients from adhering to their prescription medications.

Medco’s Therapeutic Resource Centers (TRCs)

Medco Therapeutic Resource Centers operate based on the theory that specialization leads to better pharmacy care for members with chronic and complex conditions. Medco specialist pharmacists receive additional specialized training in the chronic conditions that are generally associated with significant medical costs and resulting gaps in care, such as diabetes,

heart disease, asthma and cancer. The pharmacists that focus on a particular disease category practice together in TRCs dedicated to that disease category to facilitate research and sharing of knowledge and expertise among pharmacy staff in a particular specialty. Most of Medco's TRC pharmacists now have up to five years of working experience in their specialty.

Medco TRCs deploy 1,100 specially trained pharmacists who provide treatment support to improve patient outcomes in high-cost clinical areas, including diabetes, cardiology, neurology/psychiatry, pulmonary conditions, and oncology. Specialist pharmacists within the TRCs can reach out to a patient to provide support and counseling, clarify any confusion regarding treatment regimen, and assess and address any barriers that may be impeding access to care. The model is designed to address medication safety and gaps in care, specifically:

1. Omissions of essential therapy (e.g. patient with diabetes not on cholesterol lowering medications);
2. Adherence with essential therapy (e.g. patient with diabetes not taking oral hypoglycemic medications); and
3. Omissions of essential laboratory testing (e.g. patient with diabetes not getting a routine blood test to gauge how well patients are managing the disease).

1. Promoting appropriate medication use and improving medication adherence

PBMs promote appropriate medication use and improve medication adherence through a variety of approaches. Medco used its TRCs to close more than 2.3 million clinical gaps in care¹²¹ in 2010 *alone* with a projected savings of approximately \$900 million.¹²² Patients under the care of Medco TRCs consistently have higher compliance rates with evidence-based quality-of-care metrics than patients receiving traditional pharmacy care. For example, Medco estimates that its TRC interventions lowered the health care costs of patients with hypertension by \$700 per patient annually compared to traditional pharmacy.¹²³ Medco found similar effects for patients that used its cardiovascular TRC.¹²⁴

¹²¹ Gaps in care include non-adherence to prescribed therapy and omissions (when a clinically appropriate therapy is not prescribed or initiated).

¹²² Medco 2010 Annual Report, p. 2.

¹²³ Medco TRC Update, 2009, p. 2.

¹²⁴ Kenneth Klepper (2010), "Perspectives: Closing Gaps in Care with Advanced Pharmacy," p. 15 available at <http://medco.mediaroom.com/index.php?s=17884>.

Similarly, Medco's analysis indicates that TRCs have made significant improvements in care for patients with diabetes, which is generally accepted as one of the most pervasive, preventable, and treatable chronic conditions nationwide. A recent Medco analysis of 600,000 patients showed that TRCs closed 81 percent of gaps in care related to patients with diabetes not adhering to diuretic medications.¹²⁵ The same analysis demonstrated that TRCs closed 74 percent of gaps in care related to patients with high cholesterol not adhering to statin medications.¹²⁶

Similarly, Express Scripts found significant improvements in adherence over a control group in a trial of over 4,500 members taking maintenance medications for diabetes, high blood pressure/heart disease and high cholesterol.¹²⁷ To improve adherence, Express Scripts has predictive models for chronic conditions to identify specific patterns and characteristics that indicate, in advance, whether an individual member is at increased risk for non-adherence.¹²⁸ This helps the company create proactive programs to increase adherence among patients identified as not likely to take their drugs as prescribed.¹²⁹ Such tools include an automated voice messaging system to remind patients at risk of non-compliance to refill their prescriptions, and a pilot program called "GlowCaps" which remind patients to take their medication daily with

¹²⁵ "New Data: Advanced Pharmacy Model Significantly Reduces Gaps in Care for Patients with Chronic and Complex Conditions; Improves Clinical and Financial Outcomes," Medco Health Solutions Press Release, November 21, 2008, available at <http://medco.mediaroom.com/index.php?s=17872&item=28015>.

¹²⁶ *Ibid.*

¹²⁷ Express Scripts Drug Trend Report 2010, p. 17.

¹²⁸ For example, Express Scripts Vice President of Research Sharon Frazee stated: "The things we learn from the predictive models allow us to design better programs that help all of our patients and clients that pay for our services. You have to continually look for insights that can lead to better solutions that benefit everyone. ... Combined with the organization's advanced understanding of human behavior, the results are adherence scores that are far more accurate, informative and actionable than previously possible." ("Prescribing a Healthier Life," available at <http://www.sas.com/success/expressscripts.html>.) See also, Express Scripts Drug Trend Report 2010, p. 15.

¹²⁹ For example, Express Scripts chief scientist Bob Nease recently reported their studies have identified four types of patients whom do not adhere to their prescriptions. "The first is people who simply forget to take their medications every day. The second is a different kind of issue, which is procrastinating on getting a renewal. ... There's a much smaller fraction of patients who have issues with costs and they benefit from moving to a lower-cost drug or a lower-cost delivery channel or pharmacy. In the fourth case, there are patients who have real clinical issues: they think the drug is not working, they think it has side effects, or they're feeling medicalized." Nease said once the cause is identified for non-adherence to therapy, solutions can be presented. "So for people with who have a hard time remembering to take their medications, we give them reminders. ... We help people get renewals if they need it. For people who are having issues with costs, we help them find a lower-cost option. And then for patients who have side effects or think the drug is not working, we can connect them with one of our pharmacists." (Jim Doyle, "Why won't up to half of patients take their medicine?" St. Louis Post-Dispatch, September 2, 2011, available at http://www.stltoday.com/business/local/article_d0eaccb6-2a51-500f-b878-980ae4813963.html.)

blinking or beeping caps, which can also report patient use data back to Express Scripts.¹³⁰ Express Scripts also has a home delivery program that allows members the choice of using Express Scripts' mail-order pharmacy or a retail pharmacy. According to Express Scripts, adherence is up to eight percent higher for patients in this program¹³¹ and savings are estimated at \$27 per member per year.¹³²

Other studies have found similar conclusions.¹³³ For example, a study of three drug classes – antidiabetics, antihyperlipidemics, and antihypertensives – found that compliance for taking medication prescribed by a doctor was 7 to 8 percent higher for people using mail order.¹³⁴

Retail Pharmacy-Based Approaches

PBMs are also piloting programs that help retail pharmacists improve adherence among their customers. For example, Medco's assessment of a 26-week program with community pharmacies throughout Illinois showed improved adherence. The initiative used a clinical database which identified 2,400 patient adherence gaps and the patients' local pharmacists were then sent "gap in care" alerts.¹³⁵ Community pharmacists received training to improve patient counseling and use of these techniques improved adherence for 74 percent of the discovered gaps.¹³⁶ By applying these techniques, community pharmacists filled 48 percent more prescriptions and closed 27 percent more adherence gaps than a control group of pharmacies.¹³⁷ The initiative's success in Illinois has prompted Medco to expand the program to New Mexico and Florida.

¹³⁰ Citigroup, "Pharmacy Benefits Managers and Distributors," January 27, 2011, p. 30.

¹³¹ Express Scripts 2009 Annual Report, p. 7.

¹³² Express Scripts Drug Trend Report 2010, p. 16.

¹³³ See, e.g., Julie A. Schmittiel, Andrew J. Karter, et al. (2011), "The Comparative Effectiveness of Mail Order Pharmacy Use vs. Local Pharmacy Use on LDL-C Control in New Statin Users," *Journal of General Internal Medicine*, 1(26), 1; O. Kenrik Duru, Julie A. Schmittiel, et al. (2010), "Mail-Order Pharmacy Use and Adherence to Diabetes-Related Medications," *American Journal of Managed Care*, 16(1), 33, 33, 37; J. Tang and R. Faris (2008), "Exploring the Impact of Different Dispensing Systems on Medication Compliance and Persistence in Multiple Sclerosis Patients using Pharmacy Claims Data," *Journal of the International Society for Pharmacoeconomics*, 11(3), A144.

¹³⁴ O. Kenrik Duru, Julie A. Schmittiel, et al. (2010), "Mail-Order Pharmacy Use and Adherence to Diabetes-Related Medications," *American Journal of Managed Care*, 16(1), 33, 33, 37.

¹³⁵ Medco Health Solutions Illinois Pilot Project.

¹³⁶ *Ibid.*

¹³⁷ *Ibid.*

2. Improving adherence and health outcomes from specialty pharmacy management

As mentioned earlier, some PBMs, have integrated specialty pharmacy services as a component of overall PBM services in order to provide clinical and cost management for patients taking specialty drugs. Specialty pharmacy medications have unique characteristics; they often require that the pharmacist engage in significantly more patient and physician interaction, in addition to other services that are specific to the product being dispensed, such as intravenous administration, unique packaging, and courier service delivery due to temperature requirements of the drug compound. Through the integration of specialty pharmacy as a component of PBM services, with the added benefit of targeted clinical management of complex chronic diseases, patients enjoy a higher level of care, which results in positive patient outcomes. For example, Medco combines its TRCs with its Accredo Health Group specialty pharmacy unit to offer teams of specialized pharmacists, registered nurses, and patient service representatives that dispense and monitor specialty drugs to patients and provide additional educational services, such as how to self-administer specialty medications and how to cope with side effects.¹³⁸

Such efforts allow PBMs to provide an integrated package of services to patients and plan sponsors, leading to improvements in care. For example, many patients with chronic and complex diseases take a number of different medications for both their primary condition and other conditions they may have. In a traditional non-integrated setting, some of these medications might be filled by a retail pharmacy, some by the PBMs mail order pharmacy, and some by an independent specialty pharmacy. However, none of these pharmacists may have the complete picture on all the medications the patient is taking and whether the patient is adhering to their therapy regimen.

In contrast, the integration of pharmacy benefits under the PBM umbrella implies that all patient data is combined and pharmacy care can be coordinated by PBMs to screen for adverse drug interactions, review patient dosing and adherence with all medications, provide coordinated counseling on ways to improve care or adherence or avoid side effects, contact and counsel physicians on these issues, and so on.

Research shows that distribution of medication through specialty pharmacies with focused clinical management often produces better outcomes when compared with retail

¹³⁸ Medco Health Solutions 2010 10-K, pp. 8-9.

pharmacy. Studies indicate that specialty pharmacies improve adherence, thereby reducing utilization of costly health care services. For example, a retrospective analysis examined pharmacy and medical claims for rheumatoid arthritis (RA) patients and compared health care costs and outcomes for specialty and retail pharmacy customers.¹³⁹ The study found that patients who filled RA medications through a specialty pharmacy had:

- 16 percent higher adherence rate
- \$1,534 lower annual medical costs, other than prescription drugs
 - 5.9 percent fewer patients had an office visit
 - 2.3 percent fewer patients had an ER visit
 - 1.3 percent fewer patients were hospitalized

3. Reducing inappropriate medication use and medication errors with drug utilization review and mail order

One of the ways PBMs promote safe and effective use of medications by patients is by sharing drug utilization information across the retail, mail order, and specialty drug dispensing platforms. The sharing of a patient's drug utilization history with pharmacists at the point of care through a PBM's IT infrastructure, irrespective of the dispensing environment, plays a key role in the avoidance of potential drug/drug interactions and inappropriate use of medications. Utilizing this IT infrastructure overcomes the limitations of having only a single pharmacy's drug information for the patient or relying on a patient or caregiver's recall of a current prescription regimen to check against for potential medication issues.

PBMs' drug utilization review (DUR) programs identify adverse drug interactions and suggest effective therapies. DUR can take many forms, including reviews related to drug-age, drug-gender, drug-allergy, drug-gene, as well as drug-drug. DUR programs examined by a peer-reviewed study found these tools achieved an average savings of 6.9 percent on total drug spend.¹⁴⁰

¹³⁹ Jane Barlow, et al., "Impact of Specialty Pharmacy Management on Medication Compliance, Medical Utilization, and Costs for Patients with Rheumatoid Arthritis" presentation at the American College of Rheumatology's 73rd Annual Meeting, October 16, 2009.

¹⁴⁰ William J. Moore, (2000), "System wide Effects of Medicaid Retrospective Drug Utilization Review Programs," *Journal of Health Politics, Policy and Law* 25(4): 653, as cited in Jack Hoadley, "Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In The Literature," Kaiser Family Foundation, March 2005, available at <http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51885>.

Mail order pharmacies automate the entire process of dispensing prescription drugs, resulting in fewer dispensing errors that may put patients at risk. One study in the *Journal of the American College of Clinical Pharmacy* found that highly automated mail service pharmacies dispensed prescriptions with 23-fold greater accuracy than retail pharmacies.¹⁴¹ The mail service error rate was zero in several of the most critical areas, including dispensing the correct drug, dosage, and dosage form.

4. More effective medication use from pharmacogenomics research

Thanks to scientific and technological breakthroughs, pharmacogenomics is widely recognized to hold promise for identifying optimal medications and doses based on individuals' genetic information. For example, the American Medical Association has stated that pharmacogenomics has the potential to lead to tailored drug therapy allowing for more powerful medications, less adverse side effects, and more accurate doses dependent on the patient.¹⁴² In 2010, the National Institutes of Health announced plans to spend \$161.3 million over five years to expand its Pharmacogenomics Research Network.¹⁴³

Some industry analysts project that PBMs will play a pivotal role in applying genetics to health care benefits management. Some PBMs such as Medco have been investing heavily to increase their capabilities and expertise in these areas.¹⁴⁴ Medco has invested substantial resources in recent years to facilitate the use of pharmacogenomic tools through close integration of pharmacogenomic testing into pharmacy benefit management. Medco's personalized medicine programs identify plan members who may benefit from such genetic testing, provide comprehensive information resources to the physician and the member to evaluate the potential benefits of testing, and coordinate the testing, laboratory analysis, and feedback of testing results to the member's physician.¹⁴⁵ Medco's specialist pharmacists and genetic counselors with advanced training and experience are available to assist physicians and patients with interpreting

¹⁴¹ J. Russell Teagarden, Becky Nagle, et al. (2005), "Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice," *Journal of the American College of Clinical Pharmacy*, 25(11), 1629, 1633.

¹⁴² American Medical Association, "Pharmacogenomics," available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-science/genetics-molecular-medicine/current-topics/pharmacogenomics.page>.

¹⁴³ "NIH Expands Network Focused on How Genes Affect Drug Responses," National Institutes of Health, September 7, 2011, available at http://www.nigms.nih.gov/News/Results/pgrnII_20100709.htm.

¹⁴⁴ See, e.g., Deutsche Bank, "Rx Benefit Manger Survey Straight from the Minds of Key PBM Decision Makers," June 30, 2010, pp. 5, 26-27.

¹⁴⁵ Medco Health Solutions, "Our Programs," available at http://www.medcohealth.com/medco/corporate/home.jsp?ltSess=y&articleID=CorpPM_PersonalizedMedicine.

test results and considering therapy changes.¹⁴⁶ The identification of promising member candidates for these programs is facilitated by the analyses of PBM databases of pharmacy and medical claims which permit insights into medications prescribed, other drugs that patients may be taking, any genetic testing results, and the overall health status of patients.¹⁴⁷

Medco research shows that this type of close integration of pharmacogenomic testing into pharmacy benefit management can be an important step in facilitating wider use of pharmacogenomic research. For example, Medco conducted a survey of over 10,000 physicians with the American Medical Association (AMA) regarding attitudes toward gene testing. They found that although 98 percent of respondents believed genetics affect drug response, only 10 percent considered themselves informed enough about pharmacogenomic testing to use it with their patients.¹⁴⁸ Further, the 10 percent of doctors who believed they were well informed were twice as likely to order the genetic tests for their patients as doctors who were merely aware of pharmacogenomics.¹⁴⁹ Accordingly, Medco concluded that clinician education initiatives would be key to encouraging the wider adoption of pharmacogenomic tools.

Some PBMs also are taking the lead in determining how the use of pharmacogenomic testing will benefit patients in selecting the most appropriate drug treatment. For instance, a study conducted by Medco Research Institute and the Mayo Clinic found a simple genetic test reduces the rate of hospitalization for patients on the widely prescribed blood thinner, warfarin, by nearly one-third.¹⁵⁰ Similarly, Medco discovered patients who use Plavix, another widely prescribed blood thinner, in combination with heartburn medications increase their risk of heart attack by 74 percent. This allowed the company to place safety warnings in its system to alert

¹⁴⁶ Ibid.

¹⁴⁷ Jane Barlow, "Gene Testing Stakes a Claim in the Health Benefits marketplace," *Formulary*, July 15, 2011, ("Barlow"), p. 3, available at <http://formularyjournal.modernmedicine.com/formulary/Pharmacoeconomics/Gen-testing-stakes-a-claim-in-the-health-benefits/ArticleStandard/Article/detail/679086>.

¹⁴⁸ Ibid. Similarly, cardiologist Eric Topol, Director of Scripps Translational Science Institute in La Jolla, has described the important role played by PBMs in advancing pharmacogenomics: "While physicians and the life science industry have done little to advance the use of testing for drug-gene interactions, now the pharmacy benefit managers (PBMs) Medco and CVS/Caremark, which collectively administer the employer prescription plans for nearly 100 million Americans, are stepping up. They are introducing wide-scale genotyping for certain drugs, like Plavix or Tamoxifen, and many anti-cancer medications. . . . It has caught the medical community by surprise, but may be just the thing that is needed to bring the marked progress in genomics forward for patients." (Adam J. Fein, "PBMs, Not Physicians, Stepping Up for Genomics," *Drug Channels*, August 24, 2010, available at <http://www.drugchannels.net/2010/08/pbms-not-physicians-stepping-up-for.html>.)

¹⁴⁹ Barlow, pp. 3-4.

¹⁵⁰ Medco 2010 Annual Report, p. 5.

pharmacists to potential danger even before the FDA issued an advisory.¹⁵¹ For Medco pharmacy patients, this discovery resulted in a 28 percent reduction in the use of this combination of drugs.¹⁵² Another study conducted by the Medco Research Institute found the breast cancer drug tamoxifen is ineffective in women who have certain genetic variations that affect how the drug is metabolized.¹⁵³

E. Benefits from PBMs in Medicare

A large portion of prescription drug spending – more than one-third – is through government programs, such as Medicare and Medicaid.¹⁵⁴ Spending on these programs is rising rapidly. The Centers for Medicare & Medicaid Services (CMS) projects that federal prescription drug spending will climb 7.2 percent per year from 2015 through 2020 (Figure 5) due to a variety of factors including the expansion of public health coverage under the Affordable Care Act and the continued aging of the U.S. population.¹⁵⁵ In light of this dramatic growth in prescription drug spending, and the intense budgetary pressures at both state and federal levels, the use of effective tools to ensure that these dollars are spent efficiently is critical.

¹⁵¹ “New study: A Common Class of GI Medications Reduce Protection Against Heart Attack in Patients Taking Widely Prescribed Cardiovascular Drug,” Medco Health Solutions Press Release, November 11, 2008, *available at* <http://medco.mediaroom.com/index.php?s=17872&item=28012>.

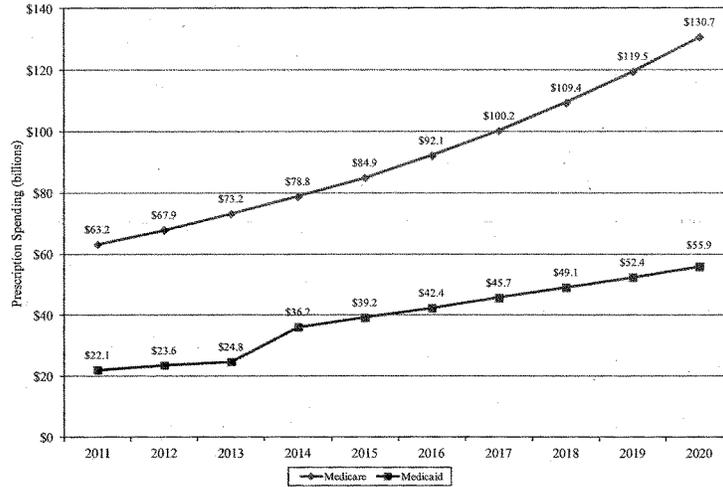
¹⁵² Based on a Medco analysis of Medco data.

¹⁵³ Ronald E. Aubert, Eric J. Stanket, et al., “Risk of Breast Cancer Recurrence in Women Initiating Tamoxifen with CYP2D6 Inhibitors,” presented at 2009 American Society of Clinical Oncology (ASCO) Annual Meeting, May 30, 2009, *available at* <https://www.medcoresearchinstitute.com/community/oncology/tamoxifen>.

¹⁵⁴ Kaiser Family Foundation, “Prescription Drug Trends,” May 2010, p. 2, *available at* <http://www.kff.org/rxdrugs/upload/3057-08.pdf>.

¹⁵⁵ Sources: Centers for Medicare & Medicaid Services (2011), National Health Expenditure Projections 2010-2020, *available at* <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf> and Sean P. Keehan, Andrea M. Sisko, et al. (2011), “National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth,” *Health Affairs*, 30(8), 1596, 1600, *available at* <http://content.healthaffairs.org/content/early/2011/07/27/hlthaff.2011.0662.full.pdf+html>.

Figure 5
CMS Projected Prescription Drug Expenditures in Medicare and Medicaid
2011 - 2020



Last year, 34.5 million people, out of Medicare’s 47.5 million total beneficiaries, chose to participate in Medicare Part D drug plans.¹⁵⁶ At the core of the Medicare Part D program is the notion that health plans and PBMs will compete against one another, innovating new ways to control costs, and lowering costs for both Medicare beneficiaries and the federal treasury. From the inception of planning for Part D, Congress chose to have private sector health plans and PBMs administer the program. The goal was to leverage PBMs’ established skills and tools, purchasing arrangements with pharmaceutical manufacturers and vast pharmacy networks, rather than to reinvent these assets.

In 2009, Part D program spending reached \$52.5 billion, which included monthly subsidies to plans, reinsurance for high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to retirees who are

¹⁵⁶ 2011 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 13, 2011, p. 4 and Table IV.B8 at 181, available at <https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf>.

Medicare beneficiaries.¹⁵⁷ Although Part D expenditures are increasing, data show that program spending growth is slower than anticipated. CMS data indicates the average Medicare Part D prescription drug plan premium in 2012 will drop from the original 2003 estimate of \$41 to a far lower average of \$30.¹⁵⁸ PBMs play a significant role in containing costs of the Part D program using the programs and tools described above.

According to PricewaterhouseCoopers, PBMs are on track to save Medicare and its beneficiaries \$469 billion from 2006-2015 relative to unmanaged drug expenditures (Table 3).¹⁵⁹

Table 3
Savings Resulting from Medicare PDPs Using PBM Tools
as Estimated by PriceWaterhouseCoopers

	2006	2007	2008	2009	2010	2006-2015
Unmanaged* Drug Expenditures by Part D Enrollees	\$105.0	\$114.3	\$124.8	\$136.4	\$149.4	\$1,642.0
Total Drug Expenditures by Medicare Part D Enrollees**	\$75.0	\$81.7	\$89.1	\$97.4	\$106.7	\$1,173.0
Total Savings Achieved by Medicare Part D Plans	\$30.0	\$32.7	\$35.6	\$39.0	\$42.7	\$469.0

Notes: *Unmanaged drug expenditures are equivalent to retail pharmacy purchases with no pharmacy benefit management support.
**Total drug expenditures on Part D include both the government share and the share paid by Medicare beneficiaries in the form of premiums, copayments/coinsurance and other out-of-pocket costs. Part D enrollees include individuals covered by PDPs or MA-PDPs.

One of the primary reasons Part D program costs have been lower than expected year after year is greater than anticipated generic drug use.¹⁶⁰ The CBO concluded that the use of generic medications in Medicare Part D saved beneficiaries and the program about \$33 billion in 2007, while an additional \$14 billion in savings was expected as first-time generics enter the

¹⁵⁷ Medicare Payment Advisory Commission, "Report to Congress: Medicare Payment Policy," March 2011, Chapter 13, p. 318, available at http://medpac.gov/chapters/Mar11_Ch13.pdf.

¹⁵⁸ "PCMA: Part D Plans and PBMs Continue to Deliver Savings in Medicare," PCMA News Release, August 4, 2011, available at <http://pcmanet.org/pcma-part-d-plans-and-pbms-continue-to-deliver-savings-in-medicare>.

¹⁵⁹ PriceWaterhouseCoopers, "Medicare Part D: An Assessment of Plan Performance and Potential Savings," January 2007 ("PWC 2007"), Exhibit 3, available at http://pcmanet.org/images/stories/uploads/2007/01/2008-03-25_Research_PwC20Medicare20Savings20and20Generics20Report20200620Jan202007.pdf. (A report prepared for the Pharmaceutical Care Management Association.)

¹⁶⁰ Department of Health and Human Services Office of Inspector General, "Generic Drug Utilization in the Medicare Part D Program," November 2007, p. i, available at <http://oig.hhs.gov/oei/reports/oei-05-07-00130.pdf>.

market through 2012.¹⁶¹ For each percentage point increase in overall generic utilization, Part D drug spending falls by an estimated \$12 billion over the 2007 to 2015 period. If PDPs were able to increase their generic dispensing rate by five percentage points, savings could increase by \$58 billion over the 2007 to 2015 period.¹⁶²

In addition to the PBM tools discussed above, PBMs' ability to negotiate contracts that increase consumer usage of generics also is an important driver of increased generic utilization in Part D. An OIG study of six selected Part D sponsors and their PBMs found that PBMs negotiate pharmacy contracts that encourage generic utilization and other cost saving measures. Specifically, the OIG study found that:¹⁶³

- Certain PBM-pharmacy contracts allow additional payments to the pharmacy if it achieved certain levels of generic drug use among Part D beneficiaries
- Several sponsor-PBM contracts include benchmarks ("generic effective rates") requiring PBMs to provide a minimum average discount for generics among its network pharmacies
- PBM-pharmacy contracts often contain clauses paying pharmacies the lesser of a cash price or the negotiated Average Wholesale Prices (AWP) discount-based reimbursement

In addition to encouraging patients to use generics, PBMs in Part D can encourage therapeutic substitution, in which higher-cost drugs are substituted in favor of lower-cost, generic equivalents. CBO estimates that if single-source brand-name prescriptions in seven classes in Part D had been switched to generic drugs from the same class, prescription drug costs would have been reduced by \$4 billion in 2007, or seven percent of total payments to plans and pharmacies in that year.¹⁶⁴

As with commercial plans, another source of PBM savings in Part D is through the use of mail-order pharmacies. A study published in the *Journal of Medical Economics* found that Part D beneficiaries who received their diabetes medications through a mail-service pharmacy achieved greater adherence than those using retail pharmacies – 49.7 percent vs. 42.8 percent,

¹⁶¹ Congressional Budget Office, "Effects of Using Generic Drugs on Medicare's Prescription Drug Spending," September 2010, p. ix, available at <http://www.cbo.gov/ftpdocs/118xx/doc11838/09-15-PrescriptionDrugs.pdf>

¹⁶² PWC 2007, p. i.

¹⁶³ United States Department of Health and Human Services Office of Inspector General, "Memorandum Report: Medicare Part D Pharmacy Discounts for 2008," OEI-02-10-00120, November 17, 2010, pp. 5-6, available at <http://oig.hhs.gov/oei/reports/oei-02-10-00120.pdf>

¹⁶⁴ Congressional Budget Office, "Effects of Using Generic Drugs on Medicare's Prescription Drug Spending," September 2010, p. viii, available at <http://www.cbo.gov/ftpdocs/118xx/doc11838/09-15-PrescriptionDrugs.pdf>

respectively.¹⁶⁵ Medication adherence in Medicare Part D presents a challenge to ensuring positive patient outcomes, as described earlier. Specific to Medicare, improving adherence to medications has been shown to offset spending in other areas of Medicare, specifically Part A and B costs, based on recently published peer-reviewed research.¹⁶⁶ One study concluded that implementation of Part D was followed by “significant reductions” in non-drug medical spending, particularly on acute- and post-acute care for elderly Medicare beneficiaries with limited prior drug coverage.¹⁶⁷

F. PBM cost savings and clinical benefits enhance consumer welfare, employment, competitiveness and economic growth

From an economic perspective, health insurance is a cost of hiring workers, just as wages and salaries are. At roughly 12 percent of payroll, health care typically is one of the most costly benefit expenses for employers.¹⁶⁸ Accordingly, reducing the growth of health costs increases the quantity of labor demanded by employers at given levels of wages and benefits. On the supply side of the labor market, most workers are willing to accept somewhat lower wages and salaries to receive attractive health care benefits. Accordingly, when health care cost growth is reduced, the benefits to workers typically reflect a combination of more and better benefits, increased wages and increased employment.

There has been a significant amount of economic research on the effects of high and rising health care costs on economic performance. Many employers cite the high cost of providing health care as a significant impediment to providing comprehensive benefits to their

¹⁶⁵ Lihua Zhang, Armen Zakharyan, et al. (2011), “Mail-Order Pharmacy Use and Medication Adherence among Medicare Part D Beneficiaries with Diabetes,” *Journal of Medical Economics*, 14(5), 562.

¹⁶⁶ Bruce Stuart, Amy Davidoff, et al. (2011), “Does Medication Adherence Lower Medicare Spending among Beneficiaries with Diabetes?” *Health Services Research*, 46(4), 1180.

¹⁶⁷ J. Michael McWilliams, Alan Zaslavsky, et al. (2011), “Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage,” *Journal of the American Medical Association*, 306(4), 402, 407-8.

¹⁶⁸ Toni Johnson, “Healthcare Cost and U.S. Competitiveness,” Council on Foreign Relations, March 23, 2010, available at: <http://www.cfr.org/health-science-and-technology/healthcare-costs-us-competitiveness/p13325>; “Employer Health Insurance Costs and Worker Compensation,” The Henry J. Kaiser Family Foundation Snapshots: Health Care Costs, February 2011, available at <http://www.kff.org/insurance/snapshot/Employer-Health-Insurance-Costs-and-Worker-Compensation.cfm>; and David Cutler and Neeraj Sood, “New Jobs Through Better Health Care,” Center for American Progress, January 2010, available at http://www.americanprogress.org/issues/2010/01/new_jobs_health.html.

employees and even to increased hiring.¹⁶⁹ Recent studies have also concluded that reducing the cost of quality patient care will make American businesses more competitive – creating a healthier, more productive workforce, preserving existing jobs, and creating new jobs in the future.¹⁷⁰ In June 2009, President Obama’s Council of Economic Advisers released a large scale economic study of the benefits to the economy of health care reform that slows the rate of growth of health care costs. They estimated that slowing the annual growth rate of health care costs by 1.5 percentage points would produce economic benefits of the following types:¹⁷¹

- Increase real gross domestic product (GDP) by more than two percent in 2020 and nearly eight percent in 2030;
- Increase household income for a family of four by \$2,600 by 2020 (in 2009 dollars), and \$10,000 by 2030;
- Raising employment by approximately 500,000 workers each year; and
- Dramatically improve future federal budget deficits because the federal government pays for a large and increasing fraction of health care.

The cost savings and other benefits produced by PBMs would be expected to produce similar categories of economic benefits. In many cases, such cost savings show up in the form of public and private sector employers and plan sponsors offering more and better drug benefits to their members. In other cases, they will show up as gains in effective wages or reduced spending for cash-strapped government payers. By containing costs and improving patient outcomes, PBMs improve competitiveness and consumer welfare, while easing fiscal burdens on employers and government health programs.

PBM savings benefit the federal government via lower Medicare Part D costs and will also reduce subsidy payments for low-income individuals in plans sold through the state-based

¹⁶⁹ Increases in health insurance costs for small business are often cited as a reason for not hiring. Dennis Tootelian, director of the Center for Small Business at Cal State Sacramento said, “If healthcare costs and other costs go up, it’s going to make it more difficult for small businesses to hire.” (Duke Helfand, “Health insurance rate hikes hitting California small businesses could hurt state’s economic recovery,” *Los Angeles Times*, May 26, 2010, available at <http://articles.latimes.com/2010/may/26/business/la-fi-smallbiz-insurance-20100526>.) Similarly, the 2011 Chase Economic Outlook Study, released in June 2011 reported that 72% of companies surveyed regarding their economic outlook and hiring plans were “very concerned” about rising health care costs; and the remaining 27% were “somewhat concerned.” (JPMorgan Chase & Co., “2011 Chase Economic Outlook Study,” June 2011, p. 2.)

¹⁷⁰ See, e.g., David Cutler and Neeraj Sood, “New Jobs Through Better Health Care,” Center for American Progress, January 2010, available at http://www.americanprogress.org/issues/2010/01/new_jobs_health.html; Katherine Baicker and Amitabh Chandra (2006), “The Labor Market Effects of Rising Health Insurance Premiums,” *Journal of Labor Economics*, 24(3), 609; and David M. Cutler and Brigitte C. Mandrian (1998), “Labor Market Responses to Rising Health Insurance Costs: Evidence on Hours Worked,” *The Rand Journal of Economics*, 29(3), 509.

¹⁷¹ Executive Office of the President Council of Economic Advisers, “The Economic Case for Health Care Reform,” June 2009, p. 1.

health insurance exchanges created by the Affordable Care Act beginning in 2014. Lower drug benefit costs in the exchanges will reduce federal expenditures because the federal government will subsidize premiums and cost sharing for low-income beneficiaries in the exchanges.

The FTC staff also highlighted the importance of PBM efficiencies to consumers in its August 2011 opposition to a proposed New York bill that would reduce PBMs ability to contain costs using mail order pharmacies. The FTC stated: “For some consumers, increased costs may mean higher out-of-pocket prices for prescription drugs. For other consumers, it may mean that prescription drug benefits are curtailed or eliminated. Scaled-back drug benefits are likely to create pressing financial concerns for many consumers, and may even lead to additional health problems. As an article in *Health Affairs* noted, ‘when costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions.’”¹⁷²

III. Conclusions

As health care costs continue their relentless upward march at a time of economic hardship and severe budget pressures, the need for innovative solutions continues to grow. The benefits provided by PBMs in containing costs and improving health outcomes have been thoroughly documented in studies by economists, government agencies such as the CBO, GAO, and FTC, health industry analysts, and clinical researchers. In addition, Express Scripts and Medco have each established a long track record of successful operations in their “core” PBM functions, and each has also made substantial investments to develop unique and innovative capabilities that are delivering positive results to plan sponsors and patients.

By containing costs and improving patient outcomes, PBMs reduce the cost of providing effective drug management solutions. In some cases, such cost savings manifest themselves in the form of public and private sector employers and plan sponsors offering better health benefits to their members. Elsewhere, the benefits will show up as gains in employment and effective wages or reduced spending for cash-strapped government payers. In addition, patients also benefit substantially from improvements in the quality of pharmacy care.

¹⁷² Federal Trade Commission, Letter to Honorable James L. Seward, August 8, 2011, p. 4, available at, <http://www.ftc.gov/os/2011/08/110808healthcarecomment.pdf>.

Appendix A: PBM Functions

PBM Functions	Description
Claims processing and fulfillment	PBMs provide technological platforms to communicate with pharmacists and physicians in real-time for efficient claim processing.
Plan design	PBMs work with plan sponsors to develop drug benefit program plans that incentivize compliance with the plan's formulary through copayments, coinsurance, and/or deductibles. These incentives can include differential copayments, denial of coverage for non-formulary drug purchases, and other incentives for use of mail-order pharmacies.
Generic dispensing	PBMs help control costs by increasing usage of generic medications. Some of the tools PBMs use to encourage generic utilization include mail order and plan design that incentivizes use of generics.
Negotiate favorable drug pricing with drug manufacturers and wholesalers	<p>PBMs often negotiate substantially larger rebates and discounts than wholesalers or retailers.</p> <p>The contracts between PBMs and drug manufacturers often provide that the pharmaceutical manufacturer will pay a rebate for being placed on a formulary, and additional rebates if the PBM can achieve certain specified sales or market share targets, and preferred placement of certain drug products on the PBM's formulary. PBMs typically pass through a large fraction of such rebates to plan sponsors.</p>
Retail pharmacy network management	PBMs contract with retail pharmacies and negotiate reimbursement rates for covered drugs on behalf of a plan. In general, the PBM negotiates a discount rate on payments to retail pharmacies as a discount off of the average wholesale price or maximum allowable cost of a drug plus a dispensing fee.
Therapeutic interchange	Therapeutic interchange programs are used by PBMs to identify opportunities to substitute with a safe and effective, lower-cost therapeutic alternative. The interchange for a substitute drug can be either branded-to-branded or branded-to-generic; either way, physician approval is required.
Drug utilization review (DUR)	<p>PBMs' DUR programs review how physicians prescribe drugs and how patients utilize those drugs. Reviews can be done two ways: concurrently or retrospectively.</p> <p>Concurrent DURs check for drug interactions between prescribed drugs to limit adverse reactions, prescribed duplicative therapies and early or late refills (an indicator for over/under consumption) by the customer.</p>

	Retrospective DURs allow PBMs to identify physicians with a tendency to prescribe high-cost drugs when there are opportunities to prescribe therapeutic alternatives that provide safe, cost-effective therapy.
Clinical prior authorization	Prior authorization requires that a physician/patient receive PBM approval for a drug before it is covered by a plan sponsor. These authorizations are often required on medications that are particularly expensive or prone to misuse.
Step therapy	Step therapy is a plan design tool in which the plan will only cover more expensive drugs if patients fail on less expensive therapeutically-equivalent alternatives such as generic drugs, over the counter drugs or cheaper brand drugs.
Refill-too-soon intervention	Refill-too-soon interventions prevent a patient from filling a prescription until a certain percentage of the prior prescription is exhausted. Nearly all PBMs use refill-too-soon interventions to limit overuse of medications that may unnecessarily increase costs to employers.
Efficiencies of mail order pharmacy	PBMs are able to lower costs for clients through use of mail-order by taking advantage of purchasing scale, increased use of generic drugs, higher rebates through formulary compliance, and highly automated systems for reviewing prescriptions for compliance issues and dispensing the medications.
Management of specialty drug spending	PBMs often employ specialist pharmacists with extensive training in the medications used to treat particular chronic and complex conditions.
Detecting fraud and abuse	PBMs monitor claims to detect patterns of potential abuse or fraud.

Appendix B: Calculating the Historical Savings Distributions

Historical savings delivered to customers, including the federal government, were provided by Medco and Express Scripts. The savings estimates provided by Medco were somewhat more detailed, allowing a more detailed allocation of savings for the Medicare drug benefit programs as described below. The savings amounts determined for the federal government, Medicare beneficiaries and employers/individuals were estimated using the quantified savings estimates provided by the companies along with company-specific historical experience with their commercial and Medicare Part D covered lives.

Background on Part D Financing

The Medicare Part D drug benefit is heavily subsidized by the federal government which pays approximately 74.5% of the nationwide premium cost of a statutorily defined “standard benefit” for all Part D enrollees (direct subsidy payments and reinsurance payments). The federal government subsidizes other Part D costs through reinsurance payments and low-income subsidy (LIS) premium contributions and LIS cost-sharing. Medicare beneficiaries pay for the remaining portion of the cost of the drug benefit in the form of beneficiary premiums and cost sharing. Medicare beneficiaries also pay the full amount of the cost of drug coverage for “enhanced” benefits which are the portion of drug coverage that exceeds the statutorily defined benefit for Part D.

The federal government incurs additional Part D-related costs by subsidizing retiree drug coverage provided by employers (Retiree Drug Subsidy or RDS). The government subsidizes 28% of allowable costs for this program.¹⁷³

Allocation of savings across lines of business

The savings estimates were distributed to savings in the Part D program, savings for retiree drug subsidy (RDS) program and RDS employers, labor unions and savings in the group market and individual market. These were allocated using the estimated percent drug spending in each of these areas. In Table 2, the employer/individual savings represent the savings allocated to the group and individual markets. For the individual market, we assume that the health plan sponsor passes the full amount of savings through to the consumer. For group plans, we assume health plans pass through the full amount of the savings to employers who then share some portion of those savings with employees. For the RDS program, the portion of the savings that was attributable to employers and beneficiaries was allocated to the employer/individual savings group.

Distribution of Part D savings between Medicare beneficiaries and the Federal government

In order to distribute the Part D savings between the federal government, employers and beneficiaries, savings were determined separately for the Part D program and the RDS program.

¹⁷³ Subsidy payments equal 28 percent of each qualifying retiree’s allowable prescription drug costs between the applicable cost threshold and cost limit. Allowable costs are actual incurred costs (i.e., net of discounts rebates, and similar price concessions).

The federal portion of the Part D costs includes government spending on premiums, reinsurance and LIS payments. Beneficiary savings include savings for their portion of premium payments and cost-sharing as well as savings attributable to enhanced benefits. In order to determine the total federal contribution for premiums, reinsurance and LIS premium and cost-sharing payments, historical data were used to determine the portion of federal payments to total gross costs based on historical LIS membership in the plans. The savings were then allocated to the federal government based on the estimation of their total contribution to Part D gross costs.

RDS program savings were allocated to the government and to employers who would pass savings to enrollees. While the government contribution for allowable costs is 28%, we used organization specific historical information to determine the federal contribution of total costs for RDS supported plans. We then allocated the federal portion of savings to the government for the RDS program and the remaining portion of the savings was allocated to employer/individual savings in Table 2.

The total savings to the federal government for Part D was calculated by combining the portion of the Part D program savings and RDS savings attributable to the federal government.

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Statement of:

Adam J. Fein, President, Pembroke Consulting, Inc.

To:

United States Senate

Judiciary Committee

Subcommittee on Antitrust, Competition Policy and Consumer Rights

Hearing:

"The Express Scripts/Medco Merger: Cost Savings for Consumers or More
Profits for the Middlemen?"

Tuesday, December 6, 2011

2:30 P.M.

Dirksen 226

Page 1 of 11

Thank you, Chairman Kohl, and members of the subcommittee. My name is Adam Fein. I appreciate the opportunity to present my views about the proposed merger of Express Scripts and Medco Health Solutions into a larger Pharmacy Benefit Manager, or PBM.

PBMs administer prescription-drug plans for people with third-party insurance through a self-insured employer, health insurance plan, labor union, or government plan. Independent pharmacy owners claim that the merger of Express Scripts and Medco Health Solutions will be anticompetitive because a larger PBM will (1) impose unfavorable contract terms on community pharmacies, (2) limit patient access to pharmacy care, and (3) exclude rivals for specialty pharmacy services.

As I will explain, this merger will not have an anticompetitive impact on retail or specialty pharmacies. I will show that the pharmacies' positions are not supported by objective industry data. What's more, pharmacy owners' claims are contradicted by financial information collected and published by the community pharmacies themselves. I will also discuss how and why anticompetitive activity will be constrained in the highly competitive specialty drug dispensing market.

First, a few words about my industry experience and knowledge of these issues. I am an expert in the complex economic interactions within the U.S. pharmacy distribution and reimbursement system. I earned my Ph.D. in Managerial Science and Applied Economics from the Wharton School of Business at the University of Pennsylvania. A significant portion of my doctoral dissertation was devoted to analyzing the history and evolution of the pharmaceutical distribution industry. As president of Pembroke Consulting, Inc., a management consulting and research firm based in Philadelphia, I help executives at the country's leading pharmaceutical manufacturers improve their commercial strategies.

I also write the influential website Drug Channels (www.DrugChannels.net). There, I analyze news and research related to pharmaceutical economics and the drug distribution system. I also publish detailed industry reports on the economics of pharmacies, wholesalers, and PBMs. Over the past few months, both advocates and opponents of the

proposed merger of Express Scripts and Medco Health Solutions have cited my research and writings to support their positions. I welcome the invitation to provide my perspectives directly to the Committee.

The information and data that I will share with you are based upon my own, independent opinions and analysis. I should note that on September 6 of this year, Express Scripts retained me to advise it on the competitive issues in the pharmacy industry related to its merger with Medco. My comments about the merger in *The Wall Street Journal*, *The New York Times*, and other publications were made long before Express Scripts approached me.

I will now discuss five observations based upon my knowledge of this industry:

1. The combined Express Scripts/Medco PBM will not be in a position to limit access to retail pharmacies.
2. Pharmacies have leverage against PBMs.
3. Previous PBM concentration has not hurt pharmacies economically and is unlikely to do so in the future.
4. Pharmaceutical manufacturers will prevent any attempted anticompetitive behavior for specialty pharmacy services.
5. Competition for specialty pharmacy services will increase, further limiting the ability of a large specialty pharmacy to engage in anticompetitive conduct.

1) The combined Express Scripts/Medco PBM will not be in a position to limit access to retail pharmacies.

Pharmacy advocates have suggested that a combined Express Scripts/Medco would unilaterally attempt to limit access to community pharmacies. In my analysis, this conclusion misconstrues the relationship between a PBM and its plan sponsor client, and presumes that the PBM would intentionally act against its own best interests.

These critics of the merger argue that a PBM can make unilateral decisions about benefit design or network structure. This is simply not true. The payer chooses the overall

prescription drug benefit it will offer to members or employees. The options could include, say, the number of pharmacies available to plan members or the particular incentives for using a mail-order pharmacy. The payer does this while making tradeoffs among plan costs, quality, and access. The PBM then implements these choices for the plan sponsors.

PBMs, for example, assemble networks of pharmacies willing to accept discounted pricing in exchange for access to consumers with third-party prescription drug insurance.¹ A PBM also negotiates with pharmacies on behalf of its many plan sponsor clients. Convenient beneficiary access to network pharmacies is a key component of the PBM's value proposition to its plan sponsor clients. Nearly all community pharmacies participate in all major PBM networks.

In my assessment, if the PBM could not attract enough pharmacies to participate in its network, any attempt by the combined company to artificially limit consumer access would quickly backfire. In many situations, the precise level of beneficiary access is contractually specified between the PBM and the plan sponsor. One example is the access stipulated in the TRICARE pharmacy program for our nation's military personnel.

To cut costs, a plan sponsor can choose a more selective pharmacy network. In a selective network model, pharmacy network size is reduced by 50% to 80%. Thus, the consumer can choose any pharmacy within the network, but the network has only 10,000 to 30,000 pharmacies vs. the 61,000 total community pharmacies in the United States.

A pharmacy will offer bigger discounts or a lower dispensing fee to be in a more selective network, because each pharmacy in such a network will fill a larger percentage of prescriptions for the plan. These networks are estimated to save employers 38% for retail generic prescriptions and 10% for retail brand prescriptions.²

It is crucial to understand that the choice to use a selective network is made by a plan sponsor, not by a PBM. The payer may rely on internal staff, an independent consultant, or its PBM for advice. But the plan sponsor—the PBM's client—makes the ultimate decision. A

2011 survey of 274 employers (both large and small) found that the responsibility for pharmacy benefit design fell to the in-house human resources staff, insurance carrier, or an outside consultant at three-quarters of the companies. PBMs were responsible for benefit design at only 14 of the 274 companies surveyed.³

Most PBM contracts last for only one, two, or three years. Plan sponsors can and do switch PBMs if they are dissatisfied with a PBM's performance or with the beneficiaries' access to network pharmacies.

2) Pharmacies have leverage against PBMs.

Another criticism of the Express Scripts-Medco merger is that the combined entity will impose unfavorable contract terms on community pharmacies. In reality, the pharmacy industry's concentration and organization create countervailing power against any attempted exercise of anticompetitive monopsony power by the newly merged company.

The community pharmacy industry has been consolidating for more than a decade. The three largest drugstore chains—CVS, Walgreens, and Rite Aid—comprise more than 19,500 retail pharmacy locations.⁴ Six other large retail chains—Walmart, Kroger, Safeway, Target, Kmart, and Supervalu—account for a further 13,500 pharmacy locations.⁵ Together, these nine companies represent more than half of all U.S. community pharmacy locations.

A pharmacy can decide whether or not to participate in any individual PBM's network. Network contracts between a pharmacy PBM and a pharmacy are non-exclusive. Therefore, joining one PBM's network does not prevent a pharmacy from joining another PBM's network.

The risk to a PBM can be seen in today's marketplace. Walgreens, for example, is currently in a dispute with Express Scripts. Walgreens' CEO, Gregory Wasson, recently reiterated the company's intention to move forward without Express Scripts by communicating directly with plan sponsors.⁶ Walgreens expects to achieve 97% to 99% of its fiscal 2011

prescription volume in fiscal 2012 even if the company is not part of Express Scripts' network after January 2012.⁷

Smaller pharmacies also have negotiating power over PBMs. I estimate that more than 80% of independent pharmacy owners participate in Pharmacy Services Administration Organizations, or PSAOs, to leverage their influence in contract negotiations with PBMs. The typical PSAO represents thousands of pharmacies. It gives a group of independent pharmacies access to benefits normally associated with large, multi-location chain pharmacy corporations. These benefits include pooled contractual negotiating power, centralized claims payment, and reconciliation of prescription payment activity. Many PSAOs tout their ability to increase reimbursement relative to contracts between a single pharmacy and a PBM.

Three of the country's largest PSAOs are owned and operated by drug wholesalers that rank among the 30 largest U.S. corporations on the Fortune 500. These wholesalers have revenues of more than \$275 billion. They distribute more than 85% of all prescription drugs in the United States. My research finds that 10,000 independent-drugstore owners rely on the three largest wholesalers' PSAOs to negotiate and administer contracts between PBMs and independent pharmacies.⁸ This corporate ownership provides a further negotiating advantage for smaller drugstores—one that will be sustained after the merger.

Taken together, these economic realities show a sophisticated pharmacy industry that has negotiating leverage and scale against PBMs.

3) Previous PBM concentration has not hurt pharmacies economically and is unlikely to do so in the future.

The PBM industry has been consolidating with no observable, negative effects on community pharmacy profit margins. There is no reason to suggest that this circumstance will change with another merger.

While the concentration of prescription claims processed in community retail pharmacies has increased substantially in recent years, there is little evidence of economic harm to smaller, pharmacist-owned independent pharmacies. Over the past 10 years, the number of independent pharmacy locations has remained almost the same—20,896 in 2000 vs. 20,835 in 2010.⁹

What's more, the National Community Pharmacists Association has conducted member surveys documenting that gross profit margins for independent drugstores have remained consistent—ranging from 22% to 24% over the past 10 years.¹⁰ Data from the U.S. Census Bureau, which include independent drugstores and chains, confirm that the drugstore industry's profit margins have been stable for at least the past 17 years.¹¹

Independent pharmacy profit margins on prescriptions (excluding front-end sales) have been increasing, not declining, over the past five years. Gross margins on prescription sales were 23.3% in 2010 vs. 21.5% in 2006.¹² Prescription profit margins have increased consistently since the launch of Medicare Part D, although there was a slight decline of 10 basis points from 2009 to 2010.

Note that PBMs have a powerful incentive to preserve the independent drugstore industry, thereby counterbalancing the growth and influence of the largest chains. Independent drugstores are crucial members of a PBM's network in rural areas, which are often uneconomic for chains. In 2010, 64% of pharmacies in rural areas were independent drugstores.¹³

4) Pharmaceutical manufacturers can prevent any attempted anticompetitive behavior for specialty pharmacy services.

Specialty pharmaceuticals are costly drugs for patients undergoing intensive therapies for chronic and complex illnesses. These products tend to be more complex to maintain, distribute, administer, and monitor than traditional drugs. They are also much more expensive than traditional pharmaceuticals. In 2010, the average cost per specialty

prescription was about \$2,100,¹⁴ compared with an average cost for a traditional drug prescription of only \$55.¹⁵

Together, Express Scripts and Medco Health Solutions will become a larger dispenser of specialty pharmaceuticals. However, manufacturers of specialty drugs exert tight control over this business, which will prevent the combined company from excluding competing pharmacies or engaging in other anticompetitive conduct.

Manufacturers of a specialty drug limit the number of pharmacies eligible to dispense its specialty product. Specialty drugs serve relatively small patient populations, so a manufacturer can reach the entire market with a limited number of pharmacies. These drugs have special handling and storage requirements.

Manufacturers strategically choose pharmacies with the distinctive capabilities required to efficiently and effectively serve patients, providers, and payers. Only pharmacies that meet a manufacturer's criteria are allowed to inventory and dispense these complex, delicate therapies. Other selection criteria can include distribution efficiency, patient safety, and product security.

In 2010, \$39.2 billion in specialty drugs was dispensed by retail, mail, and specialty pharmacies.¹⁶ In 2010, CVS Caremark was the largest dispenser of specialty drugs via its Caremark specialty pharmacies, CVS retail stores, and CarePlus retail specialty pharmacies. I estimate that CVS Caremark accounted for 25% of revenues from pharmacy-dispensed specialty drugs, that Medco accounted for 20% of revenues, and that Express Scripts accounted for 11% of revenues.¹⁷

Despite the size of these three companies, numerous pharmacies with specialty drug capabilities compete vigorously to dispense these expensive therapies on behalf of manufacturers. Any licensed pharmacy can dispense a specialty drug as long as the product can be purchased through an authorized wholesale distribution channel.

Pharmacies dispensing specialty drugs are operated by such organizations as health plans, pharmaceutical wholesalers, hospital systems, retail pharmacy chains, home health care providers, and PBMs. There are also many independent specialty pharmacies, some of which are among the fastest-growing U.S. companies.¹⁸

Given the range of alternative specialty pharmacy providers, there is no compelling reason why the presence of a larger pharmacy would compel a manufacturer to exclude other pharmacies. The network size and composition are determined by the manufacturer. In my experience, a typical network for a specialty drug contains between 5 to 20 pharmacies. Very few products have an exclusive arrangement with a single specialty pharmacy provider. A manufacturer always retains the option to expand its network and add more pharmacies, further limiting the risk of anticompetitive action by a large specialty pharmacy.

5) Competition for specialty pharmacy services will increase, further limiting the ability of a large specialty pharmacy to engage in anticompetitive conduct.

An unprecedented volume of brand-name drugs will lose exclusivity and face generic competition over the next five years. Revenues in the pharmaceutical industry will shift from traditional brand-name drugs to specialty drugs over the next few years. In 2016, 7 of the top 10 best-selling drugs (by revenue) are projected to be specialty drugs.¹⁹ From 2015 through 2020, prescription drug spending growth is forecast to average 7.2% as the generic dispensing rate plateaus and newer, more expensive specialty drugs are approved.²⁰

This projected growth is encouraging market entry and will increase competition for specialty pharmacy services, further limiting the potential for anticompetitive action by a larger specialty pharmacy. In addition to the many pharmacies that already have specialty capabilities, new sources of competition are rapidly emerging:

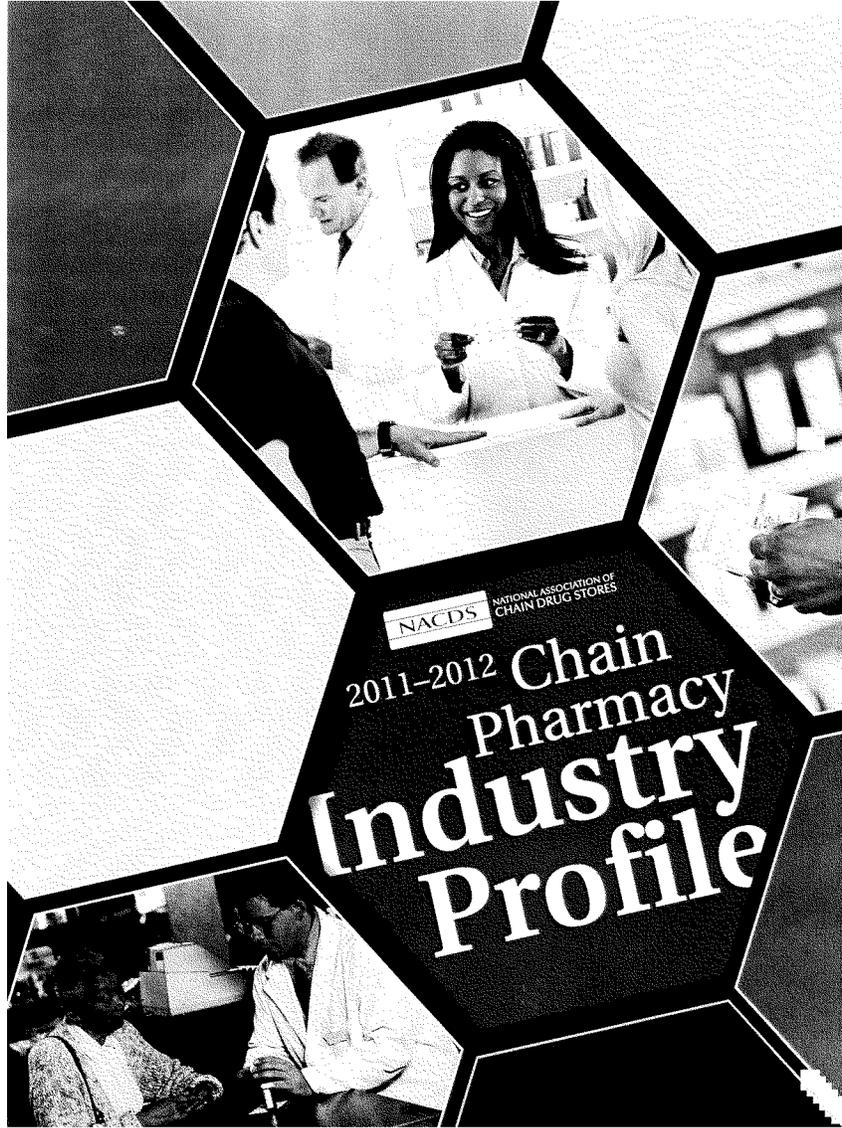
- **Independent retail community pharmacies are organizing into collaborative networks to penetrate the specialty market.** Examples include the Armada Specialty Pharmacy Network, the Community Specialty Pharmacy Network, and Specialty First. These networks support retail community pharmacy dispensing of specialty drugs by providing contracting, clinical support, and other services.
- **Private-equity firms are targeting specialty pharmacy for growth capital investments.** In 2010, there were seven platform deals—initial acquisitions that are usually followed by other acquisitions to grow the business.²¹ Investor interest continues in 2011.
- **Accreditation organizations are lowering barriers to entry.** Independent accreditation organizations help community pharmacies develop and verify their capabilities to manufacturers and third-party payers. Examples include URAC and the JCAHO (Joint Commission on Accreditation of Healthcare Organizations).

Conclusion

The merger of Express Scripts and Medco Health Solutions will improve the efficiency of the U.S. pharmacy distribution and reimbursement system without anticompetitive impacts on plan sponsors or pharmacies. I thank the Committee for considering my analysis and am available to answer any questions concerning it.

ENDNOTES

- ¹ For example, an Office of Inspector General study of Part D plans found that PBMs negotiated lower drug prices with pharmacies in exchange for the pharmacies' being in the PBM's networks. *Medicare Part D Pharmacy Discounts for 2008*, Office of Inspector General, OEI-02-10-00120, November 2010.
- ² "Pharmacy Profits in Preferred Networks with PBM Transparency," Drug Channels, January 13, 2011. Available at <http://www.drugchannels.net/2011/01/pharmacy-profits-in-preferred-networks.html>.
- ³ *The 2011-12 Prescription Drug Benefit Cost and Plan Design Report*, Pharmacy Benefit Management Institute, 8.
- ⁴ "PoweRx 50," *Drug Store News*, May 2, 2011.
- ⁵ *Ibid.*
- ⁶ "Earnings at Walgreen Surge 69%," *The Wall Street Journal*, September 28, 2011.
- ⁷ Walgreen Co, Form 8-K, filed 11/9/11, 1.
- ⁸ *The 2011-12 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors*, Pembroke Consulting, Inc., September 2011. Available at <http://www.pembrokeconsulting.com/wholesale.html>.
- ⁹ *2011-12 Chain Pharmacy Industry Profile*, National Association of Chain Drug Stores, August 2011, 12.
- ¹⁰ *2011 NCPA Digest*, National Community Pharmacy Association, October 2010, 6.
- ¹¹ "Drugstore Margins Jump in New Gov't Data," Drug Channels, May 5, 2011. Available at <http://www.drugchannels.net/2011/05/drugstore-margins-jump-in-new-govt-data.html>.
- ¹² "The True Economics of Pharmacy Ownership," Drug Channels, October 18, 2011. Available at <http://www.drugchannels.net/2011/10/true-economics-of-pharmacy-ownership.html>.
- ¹³ *2011-12 NACDS Chain Pharmacy Industry Profile*, 15.
- ¹⁴ *2010 Drug Trend Report*, Express Scripts, 63.
- ¹⁵ *Ibid.*, 37.
- ¹⁶ "Pharmacy Market Share for Specialty Drugs, 2010," Drug Channels, December 2, 2011. Available at <http://www.drugchannels.net/2011/12/pharmacy-market-share-for-specialty.html>. The \$39.2 billion figure excludes the revenues of wholesalers and specialty distributors that sell specialty pharmaceuticals to pharmacies or non-retail outlets, such as physician offices or hospitals.
- ¹⁷ Note that these market share estimates differ significantly from my previous estimates published in late 2010. The discrepancy is explained in "Pharmacy Market Share for Specialty Drugs, 2010."
- ¹⁸ There are 10 independent specialty pharmacies on the 2011 Inc. Magazine list of the fastest-growing private companies in the U.S. The average three-year revenue growth rate of these 10 pharmacies is 208%.
- ¹⁹ See "Top 10 Drug of 2016," Drug Channels, July 19, 2011. Available at <http://www.drugchannels.net/2011/07/top-ten-drugs-of-2016.html>.
- ²⁰ "National Health Spending Projections Through 2020: Economic Recovery And Reform Drive Faster Spending Growth," Health Affairs, July 2011. Available at <http://content.healthaffairs.org/content/early/2011/07/27/hlthaff.2011.0662.full.pdf>.
- ²¹ "Specialty Pharmacy's Investor Interest Should Continue Into '11," *Specialty Pharmacy News*, January 2011.





Pharmacies. The face of neighborhood healthcare.

One patient-pharmacist interaction at a time, neighborhood pharmacies demonstrate that they are the face of neighborhood healthcare. Pharmacies also contribute to overall community health, which includes the well-being of patients, economic vitality, and good jobs. Traditional drug stores, supermarkets, and mass merchants, as well as suppliers of products sold in the pharmacy and front-end departments, contribute valuably to each of these attributes.

The data in this report quantify many important aspects of the industry's value, in the front end and pharmacy alike.

In addition to the information included in this resource, NACDS invites readers to learn more about the role of pharmacy and the proactive activities of NACDS at the NACDS website – www.NACDS.org. Specifically, NACDS emphasizes:

Enhancing Healthcare through the Value of Pharmacy

Improving healthcare quality, access and affordability likely will remain a focus of public policy into the future. One of the ways that pharmacies can help to improve patient care and reduce healthcare costs is through enhancement of medication adherence, which refers to patients' correct use of the correct medications. Failure to take medications appropriately has been estimated to impose \$289 billion annually in direct and indirect costs.¹ Simply put, non-adherence leads to long-term health problems, diminished productivity and quality of life, and more costly treatments, particularly with chronic conditions. One opportunity to address this situation is pharmacist-delivered medication therapy management (MTM) – programs that

¹ Source: Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease, NEHH, August 2009.

help foster adherence and help prevent adverse events. In North Carolina's CheckMeds NC program, face-to-face MTM services for Medicare patients were shown to deliver a return-on-investment of \$13.55 for every \$1 invested. Studies have also shown that increasing adherence to medications reduces total healthcare costs – more than the cost of the medications.^{2,3} To help patients maintain good health, today's pharmacies also offer a variety of healthcare screenings and innovative programs for a wide range of health conditions.

Recognizing the Economic Vitality of Stores with Pharmacies

The total economic impact of retail stores with pharmacies reaches well beyond their \$900 billion in annual sales. In fact, based on an analysis by NACDS, retail stores with pharmacies have a total annual economic impact of \$1.76 trillion, based on 2010 data.⁴ That is the equivalent of approximately 12% of the gross domestic product. Every one dollar spent in these stores creates a ripple effect of \$1.81 throughout other segments of the economy. That includes agriculture; manufacturing; construction; transportation and warehousing; finance and insurance; information technology; real estate; educational services; professional, scientific and technical services; and many more. However, public policy – such as pharmacy reimbursement models for government programs that reimburse pharmacies at less than their cost for some drugs – can jeopardize the ability of pharmacies to perform their vital role in healthcare delivery, as well as their ability to help drive the economy.

Availability of Business Opportunities at NACDS Meetings and Conferences

Each year, NACDS presents second-to-none meetings and conferences designed to facilitate strategy development among business partners, to present educational opportunities, and to bring buyers and sellers together within new and existing relationships alike. NACDS pledges that through membership in the association and participation in these events, companies will see a return on their investment in NACDS.

Please visit www.NACDS.org for more information about these and other aspects of NACDS and pharmacy that relate directly to your work. Thank you for your engagement with NACDS.

2 Does Medication Adherence Lower Medicare Spending among Beneficiaries with Diabetes? Bruce Stuart et al., Health Services Research, Article first published online: 17 MAR 2011 | DOI: 10.1111/j.1475-6773.2011.01250.x
3 Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending, M. Christopher Roebuck et al., Health Affairs January 2011 30:191-95. doi:10.1377/hlthaff.2009.1087
4 Estimate based on RIMS II multipliers produced by the Regional Product Division of the Bureau of Economic Analysis on 6/27/2011, 2002 benchmark and 2008 regional data. Type II multiplier.

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Introduction

This is the fourteenth edition of the Industry Profile. NACDS has collected statistics that provide background and serve as a basis for comparison of operational performance for chain pharmacy companies. This publication provides information on the chain pharmacy industry, as well as on community retail pharmacy in general.

Many of the statistics in this publication are updated throughout the year on a regular basis.

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Community Pharmacy in America: The Story Behind the Face of Neighborhood Healthcare

Community retail pharmacy is essential to the healthcare delivery system. Its convenience, pharmacist consultations, and ability to help patients take their medications as prescribed and prevent other health problems deliver remarkable value.

For most Americans, the community retail pharmacy is their community health resource center, offering easy, convenient access to a trusted health professional. Indeed, pharmacists are among America's most trusted professionals who, working in alliance with other healthcare providers, play a pivotal role in monitoring and maintaining patient health.

Today, two out of every three patients who visit a doctor leave with a prescription. As medical science advances and doctors rely more and more on drug therapy, outpatient prescription drug use is now at an all-time high. In 2010, 3.68 billion prescriptions were filled in retail pharmacies – a 28% increase since 2000.

Chain pharmacy represents the largest component of pharmacy practice, comprising over 22,000 traditional chain drug stores and an additional 17,000 pharmacies within supermarkets and mass merchant stores. The chain drug industry has more than 140,000 pharmacist positions (approximately 130,000 full-time equivalents) and more than 190,000 pharmacy technician positions, and fills 73% of prescriptions dispensed annually in the United States.

Between 2009 and 2010, retail sales in traditional drug stores rose 1.9%, with prescription sales rising 2.0%. Overall, the retail prescription market reached \$266.4 billion in 2010, and chain pharmacies accounted for about 60% of retail prescription dollars (\$159 billion).

This thriving business has also secured pharmacies' place as valuable economic and business resources in their communities. In 2010, community retail pharmacies and their associated retail stores employed more than 3.5 million people and generated sales of more than \$900 billion.

The chain pharmacy industry is growing in other ways as well. The pharmacist's role has grown and evolved over the years to become more inclusive of patients' healthcare needs as a whole. Patients can now look to their pharmacy as a total healthcare provider, and today's pharmacists play an important role in improving patient outcomes.

Pharmacists help patients with healthcare advice and guidance on their general prescription or over-the-counter medication information. Pharmacists are often on the front lines to guide patients through their evolving healthcare needs. Much of a pharmacist's time is spent interacting with patients, identifying possible drug interactions, and advising how to best use an over-the-counter medication.

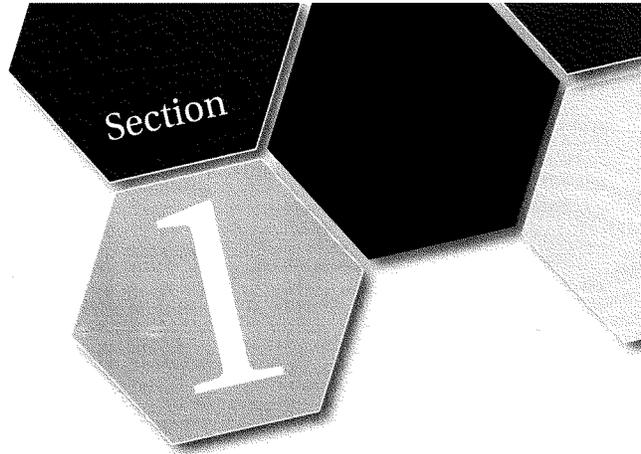
In the age of convenience – with 24-hour and drive-through pharmacies – pharmacists understand the need for fast and effective prescription and healthcare information. Pharmacists seek money-saving alternatives for their patients such as offering generic substitutions or discussing the availability of various prescription drug coverage plans.

Today's pharmacies offer a variety of healthcare screenings and programs for a wide range of ailments and illnesses so that patients may maintain a healthy lifestyle. Pharmacies are creating, or partnering with, centers and clinics where patients can obtain information on asthma and diabetes as well as take screening tests for blood pressure, cholesterol, and osteoporosis, or receive flu shots. Often the centers and clinics are staffed by a nurse, resident, or clinical pharmacist practitioner. Several health policy visionaries have cited these venues as potential solutions to more costly options in healthcare delivery, and the future of these clinics and centers is at the heart of strategic discussions within companies and from an industry-wide perspective.

The chain pharmacy industry looks forward to promoting the safe use of medications and providing patients with the medications they need with the help of local community retail pharmacists they know and trust.

NACDS: The Voice of Chain Pharmacy

The National Association of Chain Drug Stores (NACDS) represents traditional drug stores along with supermarkets and mass merchants with pharmacies. Its more than 130 chain member companies include regional chains with a minimum of four stores to national companies numbering their stores in the thousands. NACDS members also include more than 900 suppliers of pharmacy and front-end products, and nearly 70 international members representing 22 countries. Chains operate more than 40,000 pharmacies, and employ a total of more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions yearly, and have annual sales of over \$900 billion. For more information about NACDS, visit www.NACDS.org.



Background and Basic Data

The chain pharmacy industry is part of a highly competitive environment commonly referred to as community retail pharmacy. Retail pharmacies sell prescription drugs, over-the-counter medications, and a wide range of other products directly to consumers. Community retail pharmacy is generally defined to include retail stores accessible to the general public in a specific location on a walk-in basis. This includes all community retail stores with a pharmacy, and excludes mail order, hospitals, long-term care, physicians' offices, and clinics.

Stores must have pharmacy sales to be considered part of community retail pharmacy. However, they do not need to be traditional drug stores. Retail community pharmacies may operate within supermarkets, mass merchant or discount stores, or even convenience stores. This section provides background information on typical stores such as average sales, employment, store size, asset value, and inventories. Using the information provided, one can answer questions such as:

- What percentage of sales comes from the pharmacy as opposed to the rest of the store?
- How many people does a typical store employ?

Defining Community Pharmacy and the Chain Pharmacy Industry

For purposes of the Chain Pharmacy Industry Profile, a chain pharmacy company is defined as one that operates four or more pharmacies open to the general public. These pharmacies include traditional drug store formats as well as pharmacies located in supermarkets and mass merchant or discount stores.

Only traditional drug stores are identified by chain or independent status throughout the Industry Profile. Supermarkets and mass merchants may also be either independent or chain, but the vast majority are chains and for the purposes of this document they are generally counted as chain pharmacies.

Manufacturers' Sales of Prescription Drugs

In 2010, manufacturers' sales of prescription drugs reached \$307.4 billion, a 2.4% increase from 2009. These prescription drugs reach consumers in a variety of ways: some are distributed through hospitals, long-term care facilities, or home healthcare providers; some are dispensed to patients at clinics, HMOs, or physicians' offices. A growing share of prescriptions is purchased through mail-order pharmacies. Community retail pharmacies have lost market share, but still account for a majority of prescription drug sales.

Figure 1 provides a breakdown of manufacturers' prescription drug sales by type of pharmacy.

Community retail pharmacies and mail-order pharmacies, combined, accounted for \$220.0 billion of the \$307.4 billion in manufacturer sales in 2010. Chain pharmacies are the largest segment of retail pharmacy. Figure 2 breaks down retail pharmacy prescription drug sales by type of store. Sales by chain pharmacies, including traditional chain drug stores, mass merchants, and supermarkets, account for nearly 60% of retail pharmacy sales, measured in total dollars. Mail-order pharmacy sales are over 23% of all retail dollar sales.

Figure 1. 2010 Manufacturer Sales of Prescription Drugs, \$307.4 Billion

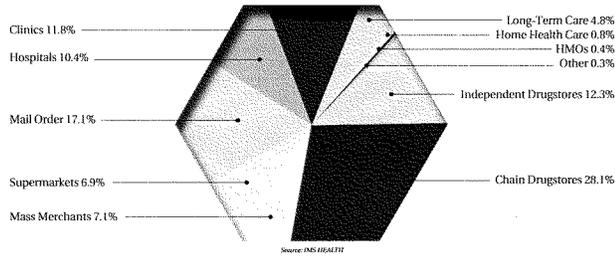
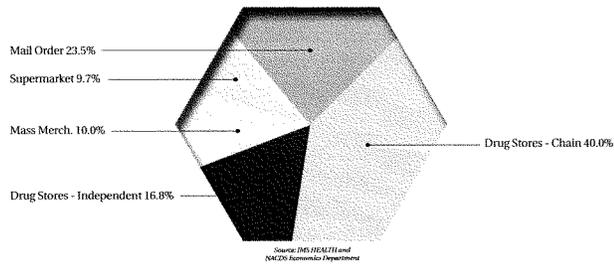


Figure 2. Retail Pharmacy Prescription Drug Sales, \$266.4 Billion, by Type of Store, 2010



Community Retail Pharmacy Stores: Where, What Kind, and How Many

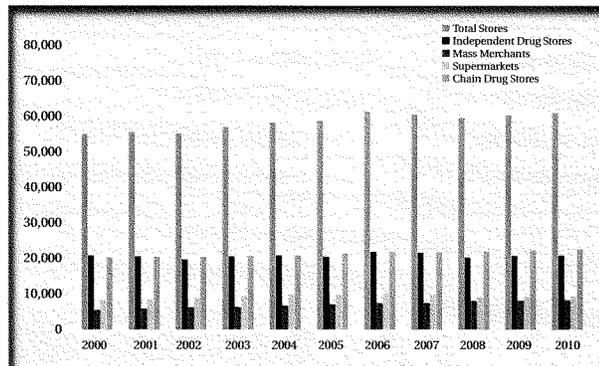
Community retail pharmacy is comprised of many different types of stores. Table 1 and Figure 3 present trends in total store counts for traditional drug stores, supermarkets, and mass merchants from 2000–2010. The number of community retail pharmacies increased during this period. However, the average number of prescriptions per pharmacy has increased from about 51,500 in 2000 to about 61,600 in 2010.

Table 1. Community Retail Pharmacy Outlets by Type of Store, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total Stores	55,011	55,581	55,200	57,082	58,275	56,183	56,948	60,568	59,604	60,393	61,036
Drug Stores	41,194	41,140	40,095	41,283	41,680	41,915	39,347	43,326	42,408	43,059	43,430
Chain	20,298	20,493	20,346	20,704	20,849	21,349	21,865	21,721	22,090	22,267	22,595
Independent	20,896	20,647	19,749	20,579	20,831	20,566	21,893	21,605	20,318	20,792	20,835
Mass Merch.	5,549	5,910	6,254	6,362	6,777	7,146	7,438	7,504	8,081	8,137	8,273
Supermarket	8,268	8,531	8,851	9,437	9,818	9,771	10,163	9,738	9,115	9,197	9,333

Source: NACDS estimates based on IMS HEALTH and NCPDP data.

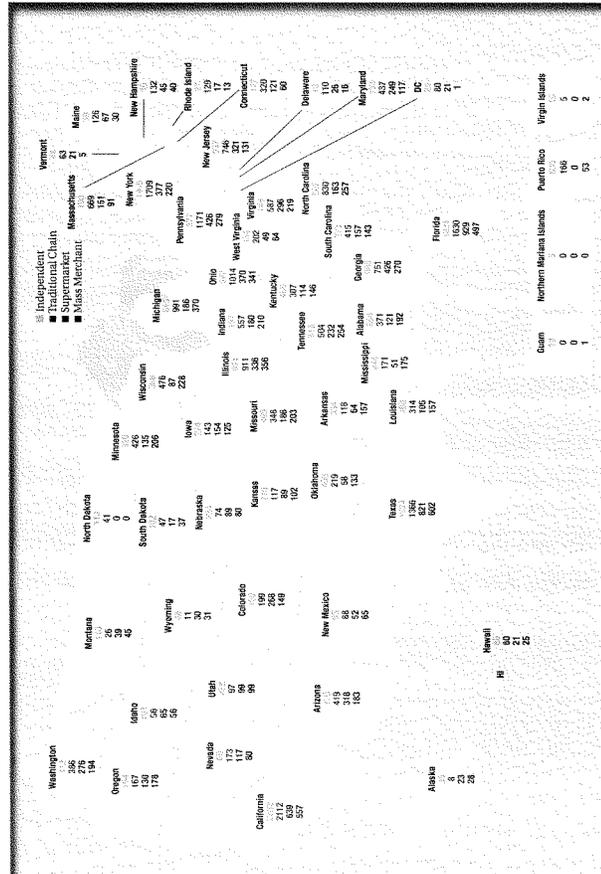
Figure 3. Community Retail Pharmacy Outlets by Type of Store, 2000-2010



While the number of community retail pharmacies is trending upward, the mix of stores is changing. Independent drug stores have continued to hold steady in 2010. The number of pharmacies in supermarkets increased slightly but is still down significantly from 2006 and 2007. Mass merchant pharmacies continue to increase. Total retail pharmacies number over 60,000.

Community retail pharmacies are integral parts of communities all across the United States. Figure 4 shows the numbers of different types of community retail pharmacies in each state, the District of Columbia, and several U.S. territories.

Figure 4. Community Retail Pharmacy Outlets by Location, 2010



Community Retail Pharmacy Store Characteristics

What does a typical community retail pharmacy look like? What are the broad defining characteristics that differentiate a supermarket from a mass merchant or a traditional chain drug store? Naturally, one obvious difference is the range of non-pharmacy products. But the physical and financial characteristics of stores are different, too. Table 2 shows some of the distinctive characteristics of drug stores, supermarkets, and mass merchants.

Table 2. Type of Store and Store Characteristics, 2010

Store Characteristic	Traditional Drug Store	Traditional Chain Drug Store	Independent Drug Store	Supermarket with Pharmacy	Mass Merchant with Pharmacy
Selling Space ¹		9,317	3,188	49,721	142,848
Number of Employees ²	556,699	425,827	130,872	1,136,931	1,945,725
Number of Employees per Store ³	14.3	21.1	6.9	101.2	222.5
Total Sales ⁴	\$222,266,000	\$166,032,702	\$56,233,298	\$254,872,508	\$429,849,937
Total Pharmacy Sales ⁵	\$151,278,928	\$106,582,478	\$44,696,451	\$25,943,971	\$26,552,984
Average Annual Sales ⁶	\$5,117,799	\$7,348,205	\$2,698,982	\$27,308,744	\$59,722,034
Average Annual Pharmacy Sales ⁷	\$3,483,282	\$4,717,082	\$2,145,258	\$2,779,810	\$3,209,596
Percent Pharmacy Sales ⁸	68.06%	64.19%	79.48%	10.18%	6.18%
Number of Stores ⁹	43,430	22,595	20,835	9,333	8,273

1. Source: Chain Store Guide Information Service Directories of a) Drug Store and HBC Chains, b) Supermarket, Grocery, and Convenience Store Chains, and c) Discount and General Merchandise Stores; compiled by NACDS Economic Department.
2. Source: United States Bureau of Labor Statistics, Quarterly Census of Employment and Wages and NACDS Estimates.
3. Source: Number of employees divided by number of stores.
4. Source: United States Department of Commerce, Retail Sales Data.
5. Source: IMS HEALTH Manufacturer Sales plus Retail Margin.
6. Source: Total sales divided by number of stores.
7. Source: Pharmacy sales divided by number of stores.
8. Source: Pharmacy sales divided by total sales.
9. Source: IMS HEALTH, United States Bureau of Labor Statistics, Quarterly Census of Employment and Wages, NCPDP, and NACDS Estimates.

Traditional chain drug stores tend to be much larger than independent drug stores. As a result, non-pharmacy sales account for a larger percentage of overall sales in traditional chain drug stores. Supermarket and mass merchant stores also have substantial volume in non-pharmacy categories.

The community retail pharmacy industry is geographically diverse. Most stores (90%) are located in Core Based Statistical Areas (CBSAs). Core Based Statistical Area is the official term for a functional region based around an urban center with a population of at least 10,000. Chain drug stores are more concentrated in urban areas (94.5%). Independent pharmacies are more common in rural areas, but 80.9% are still located in CBSAs. Rural pharmacies have declined over the past year, reflecting the continuing urbanization of the country.

Table 3 shows the urban-rural breakdown of chain and independent pharmacies. Note that we use CBSA status as a proxy for urban/suburban and rural areas. It is important to recognize that some areas within a CBSA may be considered rural by other definitions.

Nearly all Americans (93%) live within 5 miles of a community retail pharmacy. The average distance to a community retail pharmacy within a CBSA is 1.16 miles. Outside of CBSAs, the average distance to a community retail pharmacy is 9.2 miles.

Table 3. Average Distance to Nearest Pharmacy, by Core Based Statistical Area (CBSA) Status, 2011

Location	Average Distance
Within CBSAs	1.16
Outside CBSAs	4.51
Within CBSAs, Distance > 5 miles	9.21
Outside CBSAs, Distance > 5 Miles	12.88
Overall	1.37

Source: NCPDP Pharmacy File, ArcGIS Census Tract Files, and NACDS Economics Department.
Core Based Statistical Area is the official term for a functional region based around an urban center of at least 10,000 people, based on standards published by the Office of Management and Budget (OMB) in 2000.

Nearly a third of the rural population (29%) has to travel at least 5 miles to get to a retail pharmacy, where only 4.4% of the population within CBSAs has to travel at least 5 miles to a pharmacy. If the sample is limited to people for whom the nearest pharmacy is at least 5 miles away, the average distance to a pharmacy for people within a CBSA jumps to more than 9 miles. For people outside of a CBSA, the average distance to a pharmacy is nearly 13 miles. The estimated population outside of CBSAs that has to travel at least 5 miles to a pharmacy is 5.6 million people.

Note that all distances are measured as the crow flies (in a straight line). Actual travel distance may be longer depending on available transportation routes.

Table 4. Urban/Rural Breakdown of Retail Community Pharmacies, 2010

	CBSA	Non-CBSA	Total
Independent	16,865	3,970	20,835
Mass Merchant	7,499	774	8,273
Supermarket	8,990	343	9,333
Traditional Chain	21,499	1,096	22,595
	54,853	6,183	61,036
Independents as % of total stores:	30.7%	64.2%	34.1%
% of Independents in CBSAs:	80.9%		
% of Chains in CBSAs:	94.5%		
Overall:	89.9%		

Source: NCPDP Pharmacy File, July 2011, and NACDS Economics Dept.

State by State Information

The composition of community pharmacy varies considerably from state to state. This section presents general information on sales, employment, payroll, and total taxes paid. Tables 5–8 present this information for traditional chain drug stores, independent drug stores, supermarkets, and mass merchants, respectively.

Number of Stores

The total number of traditional drug stores, mass merchants, and supermarkets per state was estimated using the U.S. Bureau of Labor Statistics Quarterly Census of Employment and Wages for 2010. These totals were reconciled with state by state totals for 2010 from the list of pharmacy licenses published by NCPDP.

For traditional drug stores, the estimated state total was further broken down into chain and independent stores using two sources: the NCPDP pharmacy list from July 2010 and the Chain Store Guide Information Services (CSGIS) database from November 2010. In these tables, franchise operations such as Medicine Shoppe International, Health Mart, and Sav-Mor Drugs are included as independent drug stores. The states with the largest number of traditional chain drug stores are California, New York, Florida, Texas, and Pennsylvania.

For mass merchants and supermarkets, the state total consists of only those stores that have pharmacies. These were estimated using Quarterly Census of Employment and Wages data adjusted proportionally to match NCPDP's state totals and CSGIS totals for consistency.

Estimated Dollar Sales: Estimated dollar sales by state were calculated based on estimated payroll, and used the state ratio of payroll to sales for drug stores for 2010 from the Quarterly Census of Employment and Wages. Dollar sales were broken down between chain drug stores and independents using a ratio of 3:1, the approximate ratio of average store sales between chains and independents.

For mass merchants and supermarkets, estimated dollar sales were based on payroll using payroll-to-sales ratio for each state for mass merchants and for supermarkets from the Quarterly Census of Employment and Wages. Dollar sales for mass merchants and supermarkets with pharmacies were based on sales ratios of stores with pharmacies and without pharmacies.

Estimated Sales per Store: Total estimated sales for the state divided by the total number of stores. All other per store statistics are based on totals divided by number of stores.

Number Employed During Year: Forecasted estimate based on Quarterly Census of Employment and Wages data.

Estimated Payroll: Forecasted estimate based on Quarterly Census of Employment and Wages data.

Estimated Taxes Paid: Based on the numbers presented in Tables 10–13.

Table 5. Traditional Chain Drug Stores: State by State Estimates of Number of Stores, Sales, Employment, Payroll, and Taxes Paid, 2010

State	Number of Stores	Estimated Dollar Sales (\$00)	Estimated Sales Per Store (\$000)	Number Employed During Year	Estimated Payroll (\$000)	Estimated Payroll Per Store (\$00)	Estimated Taxes Paid (\$00)	Estimated Taxes Paid per Store (\$00)
Alabama	371	\$2,758,494	\$7,435	6,603	\$243,584	\$657	\$128,976	\$348
Alaska	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Arizona	419	\$2,122,228	\$5,065	5,497	\$213,160	\$509	\$75,537	\$180
Arkansas	118	\$893,345	\$7,571	2,299	\$80,427	\$682	\$31,609	\$268
California	2,112	\$17,002,243	\$8,050	42,622	\$1,736,202	\$823	\$697,940	\$330
Colorado	199	\$1,734,429	\$8,716	4,906	\$181,781	\$913	\$41,926	\$211
Connecticut	320	\$3,532,132	\$11,038	7,220	\$247,460	\$773	\$105,172	\$329
DC	80	\$682,670	\$8,533	1,715	\$56,468	\$706	\$20,890	\$261
Delaware	110	\$504,468	\$4,586	1,433	\$48,206	\$438	\$8,579	\$78
Florida	1,630	\$9,590,023	\$5,883	24,853	\$897,705	\$551	\$280,605	\$172
Georgia	751	\$3,763,224	\$5,011	10,294	\$368,720	\$491	\$104,921	\$140
Hawaii	60	\$823,426	\$13,724	1,726	\$60,695	\$1,012	\$25,215	\$420
Idaho	56	\$371,806	\$6,639	1,088	\$36,910	\$659	\$14,274	\$255
Illinois	911	\$7,117,667	\$7,813	23,806	\$725,763	\$797	\$271,895	\$298
Indiana	557	\$3,398,507	\$6,101	9,391	\$318,794	\$572	\$126,584	\$227
Iowa	143	\$1,108,175	\$7,749	3,246	\$100,079	\$700	\$39,533	\$276
Kansas	117	\$905,764	\$7,742	2,566	\$84,663	\$724	\$34,722	\$297
Kentucky	307	\$2,483,077	\$8,088	5,987	\$219,556	\$715	\$83,565	\$272
Louisiana	314	\$2,491,325	\$7,934	6,218	\$217,832	\$694	\$71,046	\$226
Maine	126	\$1,018,441	\$8,083	2,425	\$85,160	\$676	\$32,149	\$255
Maryland	437	\$2,668,262	\$6,106	6,502	\$228,511	\$523	\$80,204	\$184
Massachusetts	669	\$6,517,882	\$9,743	15,563	\$520,056	\$777	\$228,791	\$342
Michigan	991	\$6,142,830	\$6,199	16,497	\$579,637	\$585	\$204,502	\$206
Minnesota	426	\$2,587,807	\$6,075	6,658	\$245,847	\$577	\$84,245	\$198
Mississippi	171	\$1,383,274	\$8,089	3,578	\$121,745	\$712	\$56,844	\$332
Missouri	348	\$2,902,511	\$8,341	7,446	\$259,068	\$744	\$85,387	\$245
Montana	26	\$194,944	\$7,498	585	\$19,533	\$751	\$3,309	\$127
Nebraska	74	\$722,238	\$9,760	1,893	\$61,960	\$837	\$23,780	\$321
Nevada	173	\$925,280	\$5,348	2,691	\$104,099	\$602	\$31,573	\$183
New Hampshire	132	\$948,751	\$7,188	2,527	\$73,429	\$556	\$16,080	\$122
New Jersey	746	\$7,539,296	\$10,106	16,627	\$610,549	\$818	\$245,051	\$328
New Mexico	88	\$706,586	\$8,029	1,866	\$64,935	\$738	\$22,327	\$254
New York	1,709	\$16,119,904	\$9,432	36,703	\$1,224,000	\$716	\$408,577	\$239
North Carolina	830	\$5,888,698	\$7,095	15,347	\$534,965	\$645	\$195,115	\$235
North Dakota	41	\$371,268	\$9,055	880	\$31,266	\$763	\$11,510	\$281
Ohio	1,014	\$6,497,201	\$6,407	17,741	\$581,111	\$573	\$213,198	\$210
Oklahoma	219	\$1,919,513	\$8,765	4,673	\$161,869	\$739	\$62,215	\$284
Oregon	167	\$1,112,461	\$6,661	3,299	\$114,362	\$685	\$18,782	\$112
Pennsylvania	1,171	\$7,140,024	\$6,097	21,069	\$661,467	\$565	\$219,322	\$187
Rhode Island	129	\$1,210,566	\$9,384	2,492	\$91,454	\$709	\$39,266	\$304
South Carolina	415	\$2,473,799	\$5,961	6,407	\$227,400	\$548	\$82,411	\$199
South Dakota	47	\$267,876	\$5,699	895	\$25,423	\$541	\$7,752	\$165
Tennessee	504	\$4,082,092	\$8,099	10,149	\$390,165	\$774	\$164,995	\$327
Texas	1,366	\$10,683,357	\$7,821	25,457	\$969,882	\$710	\$310,403	\$227
Utah	97	\$880,474	\$9,077	2,313	\$85,772	\$884	\$30,349	\$313
Vermont	63	\$502,777	\$7,981	1,357	\$45,666	\$725	\$15,178	\$241
Virginia	587	\$3,418,134	\$5,823	9,466	\$316,239	\$539	\$98,645	\$168
Washington	386	\$3,276,458	\$8,488	9,036	\$336,851	\$873	\$108,511	\$281
West Virginia	202	\$1,440,421	\$7,131	3,349	\$117,205	\$590	\$52,464	\$260
Wisconsin	476	\$3,035,187	\$6,376	8,371	\$281,385	\$591	\$95,083	\$200
Wyoming	11	\$85,576	\$7,780	239	\$8,738	\$794	\$2,252	\$205
Total	22,424	\$166,032,702	\$7,404	84,257	\$3,030,205	\$670	\$5,283,756	\$236

Table 6. Independent Drug Stores: State by State Estimates of Number of Stores, Sales, Employment, Payroll, and Taxes Paid, 2010

State	Number of Stores	Estimated Dollar Sales (000)	Estimated Sales Per Store (000)	Number Employed During Year	Estimated Payroll (000)	Estimated Payroll Per Store (000)	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)
Alabama	554	\$1,466,859	\$2,648	3,287	\$121,245	\$219	\$63,868	\$115
Alaska	35	\$129,927	\$3,712	373	\$15,240	\$435	\$2,271	\$65
Arizona	120	\$255,385	\$2,128	525	\$20,349	\$170	\$7,761	\$65
Arkansas	334	\$882,295	\$2,642	2,169	\$75,883	\$227	\$25,534	\$76
California	2,382	\$6,923,112	\$2,906	16,024	\$653,472	\$274	\$237,190	\$100
Colorado	160	\$514,773	\$3,217	1,315	\$48,718	\$304	\$11,284	\$71
Connecticut	147	\$633,336	\$4,308	1,106	\$37,892	\$258	\$17,891	\$122
DC	28	\$96,953	\$3,463	200	\$6,588	\$235	\$2,823	\$101
Delaware	12	\$30,215	\$2,518	52	\$1,753	\$146	\$523	\$44
Florida	1,224	\$2,672,694	\$2,184	6,221	\$224,702	\$184	\$74,503	\$61
Georgia	683	\$1,252,174	\$1,833	3,121	\$111,778	\$164	\$31,112	\$46
Hawaii	86	\$421,043	\$4,896	824	\$28,959	\$337	\$10,356	\$120
Idaho	101	\$237,044	\$2,347	654	\$22,190	\$220	\$6,960	\$69
Illinois	624	\$1,823,616	\$2,922	5,435	\$165,707	\$266	\$67,373	\$108
Indiana	187	\$466,123	\$2,493	1,051	\$35,676	\$191	\$14,748	\$79
Iowa	274	\$749,017	\$2,734	2,073	\$63,920	\$233	\$23,002	\$84
Kansas	270	\$733,127	\$2,715	1,974	\$65,125	\$241	\$21,086	\$78
Kentucky	456	\$1,313,699	\$2,881	2,964	\$108,705	\$238	\$37,749	\$83
Louisiana	486	\$1,371,083	\$2,821	3,208	\$112,385	\$231	\$34,667	\$71
Maine	59	\$185,696	\$3,147	378	\$13,292	\$225	\$5,121	\$87
Maryland	152	\$376,971	\$2,480	754	\$26,494	\$174	\$10,811	\$71
Massachusetts	190	\$779,039	\$4,100	1,473	\$49,233	\$259	\$23,370	\$123
Michigan	845	\$1,925,060	\$2,278	4,689	\$164,747	\$195	\$54,870	\$65
Minnesota	320	\$721,433	\$2,254	1,667	\$61,558	\$192	\$22,301	\$70
Mississippi	344	\$980,044	\$2,849	2,399	\$81,638	\$237	\$29,875	\$87
Missouri	469	\$1,399,413	\$2,984	3,345	\$116,382	\$248	\$35,224	\$75
Montana	118	\$306,037	\$2,594	885	\$29,551	\$250	\$5,125	\$43
Nebraska	224	\$761,689	\$3,400	1,910	\$62,518	\$279	\$21,520	\$96
Nevada	69	\$146,816	\$2,128	358	\$13,840	\$201	\$4,213	\$61
New Hampshire	40	\$119,551	\$2,989	255	\$7,417	\$185	\$2,057	\$51
New Jersey	597	\$2,227,998	\$3,732	4,435	\$162,868	\$273	\$68,395	\$115
New Mexico	95	\$276,080	\$2,906	672	\$23,367	\$246	\$7,581	\$80
New York	1,945	\$6,620,170	\$3,404	13,924	\$464,342	\$239	\$161,374	\$83
North Carolina	507	\$1,359,953	\$2,682	3,125	\$108,927	\$215	\$38,811	\$77
North Dakota	113	\$357,258	\$3,162	809	\$28,724	\$254	\$9,568	\$85
Ohio	582	\$1,418,798	\$2,438	3,394	\$111,179	\$191	\$40,381	\$69
Oklahoma	400	\$1,238,771	\$3,097	2,845	\$98,551	\$246	\$31,757	\$79
Oregon	164	\$397,686	\$2,425	1,080	\$37,436	\$228	\$6,813	\$42
Pennsylvania	877	\$1,985,053	\$2,263	5,260	\$165,131	\$188	\$58,199	\$66
Rhode Island	27	\$113,862	\$4,217	174	\$6,381	\$236	\$3,488	\$129
South Carolina	373	\$814,142	\$2,183	1,920	\$68,129	\$183	\$23,230	\$62
South Dakota	102	\$204,265	\$2,003	647	\$18,391	\$180	\$4,683	\$46
Tennessee	516	\$1,517,410	\$2,941	3,464	\$133,152	\$258	\$46,950	\$91
Texas	1,574	\$4,439,104	\$2,820	9,778	\$372,522	\$237	\$121,997	\$78
Utah	222	\$706,945	\$3,184	1,765	\$65,435	\$295	\$20,004	\$90
Vermont	44	\$131,122	\$2,980	316	\$10,631	\$242	\$3,766	\$86
Virginia	149	\$373,388	\$2,506	801	\$26,757	\$180	\$9,726	\$65
Washington	312	\$977,213	\$3,132	2,434	\$90,758	\$291	\$27,195	\$87
West Virginia	154	\$407,064	\$2,643	851	\$29,785	\$193	\$12,030	\$78
Wisconsin	368	\$868,851	\$2,361	2,157	\$72,514	\$197	\$23,792	\$65
Wyoming	46	\$123,940	\$2,694	334	\$12,180	\$265	\$2,822	\$61
Total	20,160	\$56,233,298	\$2,789	130,872	\$4,654,153	\$231	\$1,627,750	\$81

Table 7. Supermarkets with Pharmacies: State by State Estimates of Number of Stores, Sales, Employment, Payroll, and Taxes Paid, 2010

State	Number of Stores	Estimated Dollar Sales (000)	Estimated Sales Per Store (000)	Number Employed During Year	Estimated Payroll (000)	Estimated Payroll Per Store (000)	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)
Alabama	121	\$2,602,229	\$21,506	13,338	\$262,380	\$2,168	\$111,105	\$918
Alaska	23	\$572,402	\$24,887	2,361	\$62,931	\$2,736	\$9,918	\$431
Arizona	318	\$13,007,488	\$40,904	55,248	\$1,395,727	\$4,389	\$321,743	\$1,012
Arkansas	64	\$1,037,629	\$16,213	5,452	\$98,856	\$1,545	\$45,401	\$709
California	639	\$18,164,338	\$28,426	67,334	\$1,868,522	\$2,924	\$624,578	\$977
Colorado	268	\$10,433,135	\$38,930	41,208	\$1,115,496	\$4,162	\$200,517	\$748
Connecticut	121	\$3,669,274	\$30,325	15,618	\$385,184	\$3,183	\$103,078	\$852
DC	21	\$323,798	\$15,419	1,443	\$41,796	\$1,990	\$9,567	\$456
Delaware	26	\$829,109	\$31,889	3,317	\$80,061	\$3,079	\$14,154	\$544
Florida	929	\$23,284,800	\$25,064	117,525	\$2,548,358	\$2,743	\$600,419	\$646
Georgia	426	\$10,500,101	\$24,648	49,250	\$1,014,591	\$2,382	\$239,457	\$562
Hawaii	20	\$600,270	\$30,014	2,413	\$63,548	\$3,177	\$33,253	\$1,663
Idaho	65	\$1,723,196	\$26,511	7,045	\$151,247	\$2,327	\$124,750	\$1,919
Illinois	336	\$7,436,714	\$22,133	30,995	\$638,049	\$1,899	\$276,286	\$822
Indiana	180	\$3,978,982	\$22,105	20,327	\$387,245	\$2,151	\$118,123	\$656
Iowa	154	\$4,177,360	\$27,126	25,098	\$439,741	\$2,855	\$116,341	\$755
Kansas	89	\$2,712,346	\$30,476	12,238	\$221,560	\$2,489	\$203,559	\$2,287
Kentucky	114	\$2,444,586	\$21,444	10,966	\$206,484	\$1,811	\$68,628	\$602
Louisiana	105	\$1,536,192	\$14,630	7,946	\$151,579	\$1,444	\$38,822	\$370
Maine	67	\$1,632,637	\$24,368	7,954	\$158,916	\$2,372	\$42,692	\$637
Maryland	249	\$7,988,131	\$30,474	29,169	\$767,484	\$3,082	\$206,807	\$831
Massachusetts	151	\$5,491,232	\$36,366	28,765	\$595,692	\$3,945	\$160,881	\$1,065
Michigan	186	\$3,448,717	\$18,541	16,299	\$335,722	\$1,805	\$97,581	\$525
Minnesota	135	\$3,415,390	\$25,299	17,501	\$360,473	\$2,670	\$104,666	\$775
Mississippi	51	\$929,356	\$18,223	4,611	\$85,609	\$1,679	\$78,084	\$1,531
Missouri	186	\$4,232,595	\$22,756	21,276	\$423,649	\$2,278	\$141,884	\$763
Montana	39	\$830,477	\$21,294	3,732	\$80,046	\$2,052	\$13,737	\$352
Nebraska	89	\$1,751,875	\$19,684	10,277	\$166,418	\$1,870	\$46,384	\$521
Nevada	117	\$4,667,546	\$39,894	17,827	\$482,248	\$4,122	\$108,983	\$931
New Hampshire	45	\$1,694,226	\$37,649	9,239	\$161,553	\$3,590	\$28,994	\$644
New Jersey	321	\$6,706,298	\$20,892	28,735	\$723,156	\$2,253	\$208,252	\$649
New Mexico	52	\$1,523,532	\$29,299	6,701	\$157,838	\$3,035	\$39,498	\$760
New York	377	\$4,082,411	\$10,829	19,205	\$421,389	\$1,118	\$104,278	\$277
North Carolina	163	\$3,758,513	\$23,058	16,944	\$311,032	\$1,908	\$107,270	\$658
North Dakota	0							
Ohio	370	\$9,496,070	\$25,665	44,995	\$902,326	\$2,439	\$255,767	\$691
Oklahoma	58	\$1,070,862	\$18,463	5,341	\$100,830	\$1,738	\$64,210	\$1,107
Oregon	130	\$3,748,697	\$28,836	16,239	\$390,624	\$3,005	\$63,189	\$486
Pennsylvania	426	\$12,729,801	\$29,882	60,241	\$1,231,803	\$2,892	\$363,155	\$852
Rhode Island	17	\$513,893	\$30,229	2,426	\$52,304	\$3,077	\$16,289	\$958
South Carolina	157	\$4,465,255	\$28,441	19,869	\$405,428	\$2,582	\$169,694	\$1,081
South Dakota	17	\$295,474	\$17,381	1,818	\$29,904	\$1,759	\$15,821	\$931
Tennessee	232	\$5,605,009	\$24,160	24,845	\$500,780	\$2,159	\$397,438	\$1,713
Texas	821	\$31,756,661	\$38,680	129,232	\$2,823,527	\$3,439	\$895,807	\$1,091
Utah	99	\$3,473,074	\$35,082	15,475	\$322,107	\$3,254	\$133,921	\$1,353
Vermont	21	\$395,352	\$18,826	2,081	\$40,874	\$1,946	\$11,703	\$557
Virginia	296	\$8,756,560	\$29,583	36,800	\$833,946	\$2,817	\$385,620	\$1,303
Washington	276	\$8,047,860	\$29,159	31,925	\$858,255	\$3,110	\$204,340	\$740
West Virginia	49	\$964,839	\$19,691	4,355	\$82,489	\$1,683	\$50,015	\$1,021
Wisconsin	87	\$2,497,503	\$28,707	12,613	\$219,421	\$2,522	\$67,968	\$781
Wyoming	30	\$268,713	\$8,957	1,237	\$26,013	\$867	\$5,575	\$186
Total	9,333	\$254,872,508	\$27,309	1,136,931	\$25,185,210	\$2,699	\$7,850,201	\$841

Table 8. Mass Merchants with Pharmacies: State by State Estimates of Number of Stores, Sales, Employment, Payroll, and Taxes Paid, 2010

State	Number of Stores	Estimated Dollar Sales (000)	Estimated Sales Per Store (000)	Number Employed During Year	Estimated Payroll (000)	Estimated Payroll Per Store (000)	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)
Alabama	192	\$6,348,305	\$33,064	35,038	\$743,477	\$3,872	\$415,931	\$2,166
Alaska	28	\$2,304,011	\$82,286	8,478	\$198,226	\$7,080	\$39,732	\$1,419
Arizona	183	\$6,957,781	\$38,021	33,739	\$711,338	\$3,887	\$469,861	\$2,568
Arkansas	157	\$6,307,527	\$40,175	25,114	\$467,583	\$2,978	\$400,717	\$2,552
California	557	\$42,273,307	\$75,895	168,443	\$4,294,580	\$7,710	\$3,476,966	\$6,242
Colorado	149	\$9,147,805	\$61,395	42,787	\$882,728	\$5,924	\$349,877	\$2,348
Connecticut	60	\$4,556,095	\$75,935	18,144	\$423,770	\$7,063	\$283,929	\$4,732
DC	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Delaware	16	\$1,125,425	\$70,339	4,948	\$99,506	\$6,219	\$19,196	\$1,200
Florida	497	\$32,597,270	\$65,588	145,247	\$3,071,766	\$6,181	\$2,005,341	\$4,035
Georgia	270	\$11,867,458	\$43,954	53,273	\$1,164,714	\$4,314	\$562,967	\$2,085
Hawaii	25	\$3,169,098	\$126,764	10,316	\$277,476	\$11,099	\$173,709	\$6,948
Idaho	56	\$2,964,369	\$52,935	13,896	\$271,593	\$4,850	\$218,015	\$3,893
Illinois	356	\$23,140,972	\$65,003	106,915	\$2,185,577	\$6,139	\$1,537,421	\$4,319
Indiana	210	\$7,631,246	\$36,339	43,725	\$707,250	\$3,368	\$536,891	\$2,557
Iowa	125	\$3,930,835	\$31,447	21,662	\$377,224	\$3,018	\$251,626	\$2,013
Kansas	102	\$4,693,451	\$46,014	23,855	\$467,527	\$4,584	\$353,452	\$3,465
Kentucky	146	\$5,712,089	\$39,124	30,068	\$552,311	\$3,783	\$355,557	\$2,435
Louisiana	157	\$7,892,467	\$50,270	37,648	\$760,818	\$4,846	\$371,583	\$2,367
Maine	30	\$1,093,591	\$36,453	5,179	\$102,809	\$3,427	\$61,788	\$2,060
Maryland	117	\$8,787,434	\$75,106	35,060	\$754,546	\$6,449	\$552,277	\$4,720
Massachusetts	91	\$5,883,591	\$64,655	24,712	\$589,632	\$6,479	\$390,853	\$4,295
Michigan	370	\$24,471,992	\$66,141	106,616	\$2,175,116	\$5,879	\$1,511,583	\$4,085
Minnesota	206	\$12,058,632	\$58,537	56,904	\$1,173,963	\$5,699	\$828,140	\$4,020
Mississippi	175	\$4,411,375	\$25,208	23,840	\$434,222	\$2,481	\$345,862	\$1,976
Missouri	203	\$8,729,323	\$43,002	43,669	\$883,696	\$4,353	\$443,467	\$2,185
Montana	45	\$1,161,859	\$25,819	5,947	\$107,621	\$2,392	\$19,260	\$428
Nebraska	80	\$3,968,305	\$49,604	22,167	\$389,696	\$4,871	\$231,905	\$2,899
Nevada	80	\$3,020,096	\$37,751	15,254	\$300,839	\$3,760	\$201,921	\$2,524
New Hampshire	40	\$1,865,863	\$46,647	8,206	\$165,187	\$4,130	\$31,722	\$793
New Jersey	131	\$9,095,956	\$69,435	34,242	\$810,512	\$6,187	\$647,290	\$4,941
New Mexico	65	\$1,924,349	\$29,605	10,482	\$195,834	\$3,013	\$108,284	\$1,666
New York	220	\$18,221,912	\$82,827	74,266	\$1,658,295	\$7,538	\$861,342	\$3,915
North Carolina	257	\$9,048,116	\$35,207	45,642	\$868,227	\$3,378	\$554,373	\$2,157
North Dakota	0							
Ohio	341	\$19,477,839	\$57,120	100,431	\$1,870,247	\$5,485	\$1,156,929	\$3,393
Oklahoma	133	\$6,475,880	\$48,691	28,786	\$612,848	\$4,608	\$380,235	\$2,859
Oregon	178	\$11,085,033	\$67,893	46,834	\$1,082,883	\$6,084	\$202,780	\$1,139
Pennsylvania	279	\$11,935,335	\$42,779	63,705	\$1,146,334	\$4,109	\$751,789	\$2,695
Rhode Island	13	\$394,876	\$30,375	1,703	\$38,177	\$2,937	\$28,036	\$2,157
South Carolina	143	\$3,865,117	\$27,029	19,696	\$374,242	\$2,617	\$242,876	\$1,698
South Dakota	37	\$1,020,993	\$27,594	5,756	\$96,265	\$2,602	\$53,263	\$1,440
Tennessee	254	\$12,980,286	\$51,103	60,208	\$1,257,663	\$4,951	\$1,027,969	\$4,047
Texas	602	\$20,433,997	\$33,944	91,070	\$1,933,782	\$3,212	\$1,276,858	\$2,121
Utah	99	\$3,285,783	\$33,190	14,359	\$283,021	\$2,859	\$211,718	\$2,139
Vermont	5	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Virginia	219	\$10,858,385	\$49,582	50,857	\$991,064	\$4,525	\$636,953	\$2,908
Washington	194	\$16,770,941	\$86,448	64,519	\$1,496,796	\$7,715	\$1,079,278	\$5,563
West Virginia	64	\$1,105,175	\$17,268	5,728	\$107,342	\$1,677	\$75,867	\$1,185
Wisconsin	228	\$11,683,155	\$51,242	50,783	\$1,156,303	\$5,072	\$642,980	\$2,820
Wyoming	31	\$945,503	\$30,500	4,979	\$93,461	\$3,015	\$42,531	\$1,372
Total	8,217	\$429,849,937	\$52,312	1,945,725	\$40,824,377	\$4,968	\$26,433,801	\$3,217

Table 9. Estimated Sales by Tax Category and Type of Store, 2010

	Prescriptions	Food	Health and Beauty Aids	OTCs	General Merchandise (includes Health and Beauty Aids and OTCs)
Chain Drug Stores	64.19%	6.8%	6.04%	6.98%	28.97%
Independent Drug Stores	79.48%	N/A	0.59%	1.36%	20.52%
Mass Merchants	6.18%	17.7%	4.04%	2.13%	76.11%
Supermarkets	10.18%	74.48%	2.53%	2.06%	15.34%
Chain Drug Stores	\$106,592,478	\$11,351,772	\$10,022,823	\$11,595,961	\$48,098,453
Independent Drug Stores	\$44,696,451	N/A	\$330,075	\$763,765	\$11,536,847
Mass Merchants	\$26,552,984	\$76,119,205	\$17,349,013	\$9,166,383	\$327,177,748
Supermarkets	\$25,943,971	\$189,822,383	\$6,437,660	\$5,261,203	\$39,106,154

Source: AC Nielsen, U.S. Department of Commerce Bureau of Economic Analysis, NACDS Economics Department.

Tax Estimate Breakdown by State

Taxes paid vary by state. 2010 tax rates, along with estimated sales by category from the previous section, were used to develop estimates of taxes paid by category. The estimates are presented in Tables 10–13.

Number of Stores: Estimated as described in the previous section.

Estimated Taxes Paid: Total of state income tax, sales tax, real estate tax, unemployment insurance, and federal income tax. This total does not include alcoholic beverage taxes, motor fuel sales taxes, tobacco sales taxes, other selective sales taxes, and does not include license fees of any kind.

Estimated Taxes Paid by Store: Equals estimated taxes paid divided by the number of stores.

Estimated State Income Tax: Equals state corporate income tax rate times earnings before interest and taxes (EBIT). EBIT is estimated as 4% of total sales.

Estimated Sales Tax: Sales tax estimates were calculated by multiplying estimated category sales by their respective sales tax rate. The estimated category sales for each type of retail outlet are shown in Table 9 above.

Estimated Real Estate Tax: Estimated at an average of \$1,000 per store and distributed proportionally by sales.

State Unemployment Insurance: Estimated at 0.7% of payroll.

Federal Income Tax: Federal income tax was calculated by multiplying EBIT by 35%, the approximate corporate income tax rate for 2010 for chain drug stores.

Total Taxes Collected by State: Reference information taken from the U.S. Bureau of the Census. More than \$715 billion in taxes were collected by the states in 2010. Six states (California, Tennessee, Illinois, Florida, New York, and Pennsylvania) accounted for over 45% of the business taxes paid by traditional chain drug stores.

Estimated 2010 State Taxes Paid: Total estimated taxes paid minus federal income tax.

Table 10. Traditional Chain Drug Stores: State by State Estimates of Taxes Paid by Category, 2010

State	Number of Stores	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)	Estimated State Income Tax (000 \$)	Estimated Sales Tax (000 \$)	Estimated Real Estate Tax (000 \$)	State Unemployment Insurance (000 \$)	Federal Income Tax (000 \$)	Total Taxes Collected by State, 2010 (000 \$)	Estimated 2010 State Taxes Paid (000 \$)
Alabama	371	\$128,976	\$348	\$57,377	\$31,965	\$554	\$462	\$38,619	\$8,181,918	\$90,358
Alaska	8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Arizona	419	\$75,537	\$180	\$4,744	\$40,576	\$120	\$385	\$29,711	\$10,199,338	\$45,825
Arkansas	118	\$31,609	\$268	\$1,858	\$16,749	\$334	\$161	\$12,507	\$7,279,215	\$19,102
California	2,112	\$697,840	\$330	\$48,096	\$406,348	\$2,382	\$2,984	\$238,031	\$104,840,520	\$459,809
Colorado	199	\$41,826	\$211	\$2,570	\$14,571	\$169	\$343	\$24,282	\$8,586,401	\$17,644
Connecticut	320	\$106,172	\$329	\$8,477	\$46,583	\$147	\$505	\$48,450	\$12,205,994	\$55,722
DC	80	\$26,890	\$261	\$2,179	\$9,005	\$38	\$120	\$9,557		\$11,532
Delaware	110	\$8,379	\$78	\$1,404	\$0	\$0	\$12	\$7,063	\$2,769,731	\$1,517
Florida	1,630	\$280,605	\$172	\$16,878	\$126,503	\$1,224	\$1,740	\$134,260	\$31,498,998	\$146,345
Georgia	751	\$104,921	\$140	\$7,225	\$43,607	\$683	\$721	\$52,885	\$14,782,779	\$52,236
Hawaii	60	\$25,215	\$420	\$1,686	\$11,794	\$86	\$121	\$11,528	\$4,837,862	\$13,687
Idaho	56	\$14,274	\$255	\$904	\$7,988	\$101	\$76	\$5,205	\$2,951,763	\$9,089
Illinois	911	\$271,895	\$298	\$16,627	\$153,330	\$624	\$1,666	\$99,647	\$29,761,862	\$172,247
Indiana	557	\$126,584	\$227	\$9,244	\$68,917	\$167	\$657	\$47,579	\$13,796,427	\$79,005
Iowa	143	\$39,533	\$276	\$4,255	\$19,262	\$274	\$227	\$15,514	\$6,809,344	\$24,018
Kansas	117	\$34,722	\$297	\$1,159	\$20,432	\$270	\$180	\$12,681	\$6,495,996	\$22,041
Kentucky	307	\$63,565	\$207	\$4,768	\$43,160	\$456	\$419	\$34,763	\$9,531,507	\$48,802
Louisiana	314	\$71,046	\$226	\$6,378	\$28,869	\$486	\$435	\$34,879	\$8,757,557	\$36,168
Maine	126	\$32,149	\$255	\$2,910	\$14,752	\$59	\$170	\$14,258	\$3,489,953	\$17,891
Maryland	437	\$80,204	\$184	\$7,044	\$35,197	\$152	\$455	\$37,356	\$15,223,523	\$42,849
Massachusetts	669	\$228,791	\$342	\$18,250	\$118,011	\$190	\$1,089	\$91,250	\$20,050,292	\$17,541
Michigan	991	\$204,502	\$206	\$9,730	\$106,772	\$845	\$1,155	\$86,000	\$22,626,247	\$118,502
Minnesota	426	\$84,245	\$198	\$8,115	\$39,114	\$320	\$466	\$36,229	\$17,208,877	\$48,016
Mississippi	171	\$56,844	\$332	\$2,213	\$34,671	\$344	\$250	\$19,366	\$6,268,804	\$37,479
Missouri	348	\$85,387	\$245	\$5,805	\$37,956	\$469	\$521	\$40,635	\$9,703,459	\$44,752
Montana	26	\$3,309	\$127	\$421	\$0	\$118	\$41	\$2,729	\$2,142,809	\$580
Nebraska	74	\$23,780	\$321	\$1,805	\$11,507	\$224	\$132	\$10,111	\$3,809,266	\$13,669
Nevada	173	\$31,573	\$183	\$0	\$18,361	\$69	\$188	\$12,954	\$5,835,963	\$18,619
New Hampshire	132	\$16,080	\$122	\$2,581	\$0	\$40	\$177	\$13,283	\$2,124,984	\$2,798
New Jersey	746	\$245,051	\$328	\$21,713	\$116,027	\$697	\$1,164	\$105,550	\$25,927,891	\$139,501
New Mexico	88	\$22,327	\$254	\$1,718	\$10,491	\$95	\$131	\$9,892	\$4,413,968	\$12,435
New York	1,709	\$408,577	\$239	\$36,624	\$141,759	\$1,945	\$2,569	\$225,679	\$63,529,354	\$182,898
North Carolina	830	\$196,115	\$235	\$13,002	\$98,090	\$507	\$1,074	\$82,442	\$21,511,278	\$112,674
North Dakota	41	\$11,510	\$281	\$760	\$5,378	\$113	\$62	\$5,198	\$2,645,695	\$6,313
Ohio	1,014	\$213,198	\$210	\$16,893	\$103,521	\$582	\$1,242	\$90,961	\$23,583,596	\$122,237
Oklahoma	219	\$62,215	\$284	\$3,685	\$30,929	\$400	\$327	\$26,873	\$7,079,965	\$35,341
Oregon	167	\$18,782	\$112	\$2,812	\$0	\$164	\$231	\$15,574	\$7,475,135	\$3,207
Pennsylvania	1,171	\$219,322	\$187	\$22,825	\$94,185	\$877	\$1,475	\$99,960	\$30,169,122	\$119,362
Rhode Island	129	\$39,266	\$304	\$3,486	\$18,630	\$27	\$174	\$16,948	\$2,568,851	\$22,318
South Carolina	415	\$82,411	\$199	\$3,958	\$42,998	\$373	\$449	\$34,633	\$6,803,724	\$47,778
South Dakota	47	\$7,752	\$165	\$0	\$3,837	\$102	\$63	\$3,750	\$1,304,487	\$4,001
Tennessee	504	\$164,995	\$327	\$8,491	\$98,129	\$516	\$710	\$57,149	\$10,513,788	\$107,846
Texas	1,366	\$310,403	\$227	\$10,683	\$146,797	\$1,574	\$1,782	\$149,567	\$39,399,251	\$160,836
Utah	97	\$30,349	\$313	\$1,409	\$16,230	\$222	\$162	\$12,327	\$5,092,415	\$18,023
Vermont	63	\$15,178	\$241	\$1,368	\$6,632	\$44	\$95	\$7,039	\$2,511,387	\$8,139
Virginia	587	\$98,645	\$168	\$6,563	\$43,417	\$149	\$663	\$47,854	\$16,411,055	\$50,791
Washington	386	\$108,511	\$281	\$0	\$61,696	\$312	\$632	\$45,870	\$16,106,154	\$62,640
West Virginia	202	\$52,464	\$260	\$3,918	\$27,991	\$154	\$234	\$20,166	\$4,655,034	\$32,298
Wisconsin	476	\$95,083	\$200	\$7,673	\$43,964	\$368	\$586	\$42,493	\$14,368,569	\$52,590
Wyoming	11	\$2,252	\$205	\$0	\$992	\$46	\$17	\$1,198	\$2,117,100	\$1,054
Total	22,424	\$5,414,672	\$241	\$422,547	\$2,617,899	\$20,160	\$29,808	\$2,324,458	\$794,554,611	\$3,090,214

Table 11. Independent Drug Stores: State by State Estimates of Taxes Paid by Category, 2010

State	Number of Stores	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)	Estimated State Income Tax (000's)	Estimated Sales Tax (000's)	Estimated Real Estate Tax (000's)	State Unemployment Insurance (000's)	Federal Income Tax (000's)	Total Taxes Collected by State, 2010	Estimated 2010 State Taxes Paid (000)
Alabama	554	\$63,868	\$115	\$30,511	\$12,038	\$554	\$230	\$20,536	\$8,181,918	\$43,332
Alaska	35	\$2,271	\$65	\$391	\$0	\$35	\$26	\$1,819	\$4,518,023	\$452
Arizona	120	\$7,761	\$65	\$571	\$3,458	\$120	\$37	\$3,575	\$10,199,338	\$4,186
Arkansas	334	\$25,534	\$76	\$1,835	\$10,861	\$334	\$152	\$12,352	\$7,279,215	\$13,182
California	2,382	\$237,190	\$100	\$19,584	\$117,179	\$2,382	\$1,122	\$96,924	\$104,840,520	\$149,267
Colorado	160	\$11,284	\$71	\$763	\$3,063	\$160	\$92	\$7,207	\$8,586,401	\$4,077
Connecticut	147	\$17,891	\$122	\$1,520	\$7,280	\$147	\$77	\$8,867	\$12,285,904	\$9,024
DC	28	\$2,823	\$101	\$309	\$1,114	\$28	\$14	\$1,357	\$1,466	\$1,466
Delaware	12	\$523	\$44	\$84	\$0	\$12	\$4	\$423	\$2,769,731	\$100
Florida	1,224	\$74,503	\$61	\$4,704	\$30,722	\$1,224	\$435	\$37,418	\$31,498,998	\$37,085
Georgia	683	\$31,112	\$46	\$2,404	\$10,276	\$683	\$218	\$17,530	\$14,782,779	\$13,581
Hawaii	86	\$10,356	\$120	\$862	\$3,455	\$86	\$58	\$5,895	\$4,837,862	\$4,461
Idaho	101	\$6,960	\$69	\$576	\$2,918	\$101	\$46	\$3,319	\$2,951,703	\$3,641
Illinois	624	\$67,373	\$108	\$4,260	\$36,578	\$624	\$300	\$25,531	\$29,781,862	\$41,842
Indiana	187	\$14,748	\$79	\$1,268	\$6,694	\$187	\$74	\$6,526	\$13,796,427	\$8,223
Iowa	274	\$23,002	\$84	\$2,876	\$9,220	\$274	\$145	\$10,486	\$6,809,344	\$12,515
Kansas	270	\$21,086	\$78	\$938	\$9,476	\$270	\$138	\$10,264	\$6,492,996	\$10,822
Kentucky	456	\$37,749	\$83	\$2,522	\$16,171	\$456	\$207	\$18,292	\$9,531,507	\$19,357
Louisiana	406	\$34,667	\$71	\$3,510	\$11,252	\$406	\$225	\$19,105	\$8,757,557	\$15,472
Maine	59	\$5,121	\$87	\$531	\$1,905	\$59	\$26	\$2,600	\$3,489,953	\$2,521
Maryland	152	\$10,811	\$71	\$995	\$4,323	\$152	\$53	\$5,278	\$15,223,923	\$5,533
Massachusetts	190	\$23,370	\$123	\$2,181	\$9,899	\$190	\$103	\$10,907	\$20,050,292	\$12,464
Michigan	845	\$54,870	\$65	\$3,049	\$23,897	\$845	\$328	\$26,951	\$22,626,247	\$27,919
Minnesota	320	\$22,301	\$70	\$2,262	\$9,502	\$320	\$117	\$10,100	\$17,208,677	\$12,201
Mississippi	344	\$29,675	\$87	\$1,508	\$14,075	\$344	\$168	\$13,721	\$6,268,004	\$16,155
Missouri	469	\$35,224	\$75	\$2,799	\$12,130	\$469	\$234	\$19,592	\$9,703,459	\$15,632
Montana	118	\$5,125	\$43	\$661	\$0	\$118	\$62	\$4,285	\$2,142,809	\$641
Nebraska	224	\$21,520	\$96	\$1,904	\$8,395	\$224	\$134	\$10,664	\$3,809,266	\$10,856
Nevada	69	\$4,213	\$61	\$0	\$2,063	\$69	\$25	\$2,055	\$5,835,963	\$2,157
New Hampshire	40	\$2,057	\$51	\$325	\$0	\$40	\$18	\$1,674	\$2,124,984	\$383
New Jersey	587	\$68,395	\$115	\$6,417	\$29,879	\$587	\$310	\$31,192	\$25,927,891	\$37,203
New Mexico	95	\$7,581	\$80	\$671	\$2,903	\$95	\$47	\$3,865	\$4,413,968	\$3,716
New York	1,945	\$161,374	\$83	\$15,041	\$50,731	\$1,945	\$975	\$92,682	\$63,529,354	\$68,692
North Carolina	507	\$38,811	\$77	\$3,003	\$16,043	\$507	\$219	\$19,039	\$21,511,278	\$19,772
North Dakota	113	\$9,568	\$85	\$732	\$3,665	\$113	\$57	\$5,002	\$2,645,695	\$4,566
Ohio	582	\$40,381	\$69	\$3,689	\$16,009	\$582	\$238	\$19,863	\$23,583,596	\$20,518
Oklahoma	400	\$31,757	\$79	\$2,378	\$11,437	\$400	\$199	\$17,343	\$7,079,985	\$14,414
Oregon	164	\$6,813	\$42	\$1,005	\$0	\$164	\$76	\$5,568	\$7,475,135	\$1,245
Pennsylvania	877	\$58,199	\$66	\$6,346	\$22,818	\$877	\$368	\$27,791	\$30,169,122	\$30,409
Rhode Island	27	\$3,488	\$129	\$328	\$1,527	\$27	\$12	\$1,594	\$2,568,851	\$1,894
South Carolina	373	\$23,230	\$62	\$1,303	\$10,022	\$373	\$134	\$11,298	\$6,803,724	\$11,832
South Dakota	102	\$4,683	\$46	\$0	\$1,676	\$102	\$45	\$2,860	\$1,304,487	\$1,824
Tennessee	516	\$46,950	\$91	\$3,156	\$21,792	\$516	\$242	\$21,244	\$10,513,788	\$25,707
Texas	1,574	\$121,997	\$78	\$4,439	\$53,152	\$1,574	\$684	\$62,147	\$39,399,251	\$39,850
Utah	222	\$20,004	\$90	\$1,131	\$8,630	\$222	\$124	\$9,897	\$5,092,415	\$10,106
Vermont	44	\$3,766	\$86	\$357	\$1,507	\$44	\$22	\$1,836	\$2,511,387	\$1,930
Virginia	149	\$9,726	\$65	\$717	\$3,577	\$149	\$56	\$5,227	\$16,411,055	\$4,499
Washington	312	\$27,195	\$87	\$0	\$13,032	\$312	\$170	\$13,681	\$16,106,154	\$13,514
West Virginia	154	\$12,030	\$78	\$1,107	\$5,011	\$154	\$80	\$5,699	\$4,655,034	\$6,332
Wisconsin	368	\$23,792	\$65	\$2,196	\$8,913	\$368	\$151	\$12,164	\$14,368,569	\$11,628
Wyoming	46	\$2,822	\$61	\$0	\$1,017	\$46	\$23	\$1,735	\$2,117,100	\$1,086
Total	20,160	\$1,627,750	\$81	\$149,781	\$661,382	\$20,160	\$9,161	\$787,266	\$704,554,611	\$840,484

Table 12. Supermarkets with Pharmacies: State by State Estimates of Taxes Paid by Category, 2010

State	Number of Stores	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)	Estimated State Income Tax (000's)	Estimated Sales Tax (000's)	Estimated Real Estate Tax (000's)	State Unemployment Insurance (000's)	Federal Income Tax (000's)	Total Taxes Collected by State, 2010	Estimated 2010 State Taxes Paid (000)
Alabama	121	\$111,105	\$918	\$54,126	\$19,349	\$265	\$934	\$36,431	\$6,181,918	\$74,674
Alaska	23	\$9,918	\$431	\$1,722	\$0	\$17	\$165	\$8,014	\$4,518,023	\$1,904
Arizona	318	\$321,743	\$1,012	\$29,078	\$106,562	\$130	\$3,967	\$182,105	\$10,199,338	\$199,638
Arkansas	64	\$45,401	\$709	\$2,158	\$28,214	\$120	\$382	\$14,527	\$7,279,215	\$30,874
California	639	\$624,578	\$977	\$51,383	\$313,509	\$593	\$4,713	\$254,301	\$104,840,520	\$370,278
Colorado	268	\$200,517	\$748	\$15,458	\$35,929	\$182	\$2,885	\$146,064	\$8,586,401	\$54,453
Connecticut	121	\$103,078	\$852	\$8,806	\$41,744	\$65	\$1,093	\$51,370	\$12,285,994	\$51,708
DC	21	\$9,567	\$456	\$1,034	\$3,809	\$9	\$101	\$4,533		\$5,033
Delaware	26	\$14,154	\$544	\$2,308	\$0	\$6	\$232	\$11,608	\$2,769,731	\$2,547
Florida	929	\$600,419	\$646	\$40,981	\$224,334	\$890	\$8,227	\$325,987	\$31,498,998	\$274,432
Georgia	428	\$239,457	\$562	\$20,160	\$68,366	\$482	\$3,448	\$147,001	\$14,782,779	\$92,455
Hawaii	20	\$33,253	\$1,663	\$1,229	\$23,430	\$20	\$169	\$8,404	\$4,837,862	\$24,849
Idaho	65	\$124,750	\$1,919	\$4,191	\$95,069	\$72	\$493	\$24,125	\$2,951,703	\$100,625
Illinois	336	\$278,286	\$822	\$17,372	\$152,418	\$213	\$2,170	\$104,114	\$29,761,862	\$172,172
Indiana	180	\$118,123	\$656	\$10,823	\$50,071	\$101	\$1,423	\$55,706	\$13,796,427	\$62,417
Iowa	154	\$116,341	\$755	\$16,041	\$39,858	\$203	\$1,757	\$58,483	\$6,809,344	\$37,858
Kansas	89	\$203,559	\$2,287	\$3,472	\$161,106	\$152	\$857	\$37,973	\$6,492,996	\$165,596
Kentucky	114	\$68,638	\$602	\$4,694	\$28,770	\$172	\$768	\$34,224	\$9,531,507	\$34,404
Louisiana	105	\$38,822	\$370	\$3,933	\$12,683	\$134	\$558	\$21,507	\$8,757,557	\$17,316
Maine	67	\$42,692	\$637	\$4,665	\$14,580	\$32	\$557	\$22,857	\$3,489,953	\$19,835
Maryland	249	\$206,807	\$831	\$20,033	\$78,406	\$93	\$2,042	\$106,234	\$15,223,923	\$100,573
Massachusetts	151	\$160,881	\$1,065	\$15,375	\$66,539	\$76	\$2,014	\$76,877	\$20,050,292	\$84,004
Michigan	186	\$97,581	\$525	\$5,463	\$42,451	\$244	\$1,341	\$48,282	\$22,626,247	\$49,299
Minnesota	135	\$104,666	\$775	\$10,711	\$44,771	\$138	\$1,231	\$47,815	\$17,208,877	\$56,851
Mississippi	51	\$78,084	\$1,531	\$1,487	\$63,165	\$98	\$323	\$13,011	\$6,268,804	\$65,073
Missouri	186	\$141,884	\$763	\$8,465	\$72,436	\$237	\$1,469	\$59,256	\$9,703,459	\$82,627
Montana	39	\$13,737	\$352	\$1,794	\$0	\$55	\$261	\$11,627	\$2,142,809	\$21,110
Nebraska	89	\$46,384	\$521	\$4,378	\$16,624	\$137	\$719	\$24,526	\$3,809,266	\$21,858
Nevada	117	\$108,983	\$931	\$0	\$42,320	\$69	\$1,248	\$65,346	\$5,835,963	\$43,638
New Hampshire	45	\$28,994	\$644	\$4,608	\$0	\$20	\$647	\$23,719	\$2,124,984	\$5,275
New Jersey	321	\$208,252	\$649	\$19,314	\$92,823	\$216	\$2,011	\$93,888	\$25,927,891	\$114,364
New Mexico	52	\$39,498	\$760	\$3,705	\$13,942	\$52	\$469	\$21,329	\$4,413,988	\$18,169
New York	377	\$104,278	\$277	\$9,275	\$36,266	\$239	\$1,344	\$57,154	\$63,529,354	\$47,125
North Carolina	163	\$107,270	\$658	\$8,299	\$45,035	\$130	\$1,186	\$52,619	\$21,511,278	\$54,651
North Dakota	0								\$2,645,695	
Ohio	370	\$255,767	\$691	\$24,690	\$94,678	\$305	\$3,150	\$132,945	\$23,583,596	\$122,822
Oklahoma	58	\$64,210	\$1,107	\$2,056	\$46,663	\$124	\$374	\$14,992	\$7,079,985	\$49,218
Oregon	130	\$63,189	\$486	\$9,477	\$0	\$94	\$1,137	\$52,482	\$7,475,135	\$10,707
Pennsylvania	426	\$363,155	\$852	\$40,695	\$139,580	\$447	\$4,217	\$178,217	\$30,189,122	\$184,938
Rhode Island	17	\$16,289	\$958	\$1,480	\$7,437	\$7	\$170	\$7,195	\$2,568,851	\$9,094
South Carolina	157	\$90,147	\$574	\$7,144	\$18,900	\$198	\$1,391	\$62,514	\$6,803,724	\$27,633
South Dakota	17	\$15,821	\$931	\$0	\$11,533	\$24	\$127	\$4,137	\$1,304,487	\$11,684
Tennessee	232	\$397,438	\$1,713	\$11,658	\$305,276	\$294	\$1,739	\$78,470	\$10,513,788	\$318,968
Texas	821	\$689,460	\$840	\$31,757	\$202,853	\$1,211	\$9,046	\$444,593	\$39,399,251	\$244,867
Utah	99	\$133,921	\$1,353	\$5,557	\$78,483	\$174	\$1,083	\$48,823	\$5,092,415	\$65,298
Vermont	21	\$11,703	\$557	\$1,075	\$4,936	\$11	\$146	\$5,535	\$2,511,387	\$6,168
Virginia	296	\$385,620	\$1,303	\$16,813	\$243,550	\$89	\$2,576	\$122,592	\$16,411,055	\$263,028
Washington	276	\$204,340	\$740	\$0	\$89,239	\$196	\$2,235	\$112,670	\$18,106,154	\$91,670
West Virginia	49	\$50,015	\$1,021	\$2,624	\$33,520	\$58	\$305	\$13,508	\$4,655,034	\$36,507
Wisconsin	87	\$67,968	\$781	\$6,314	\$25,703	\$104	\$883	\$34,965	\$14,368,569	\$33,003
Wyoming	30	\$5,231	\$174	\$0	\$1,339	\$43	\$87	\$3,762	\$2,117,100	\$1,469
Total	9,333	\$7,563,964	\$810	\$67,882	\$3,339,237	\$9,044	\$79,585	\$3,568,215	\$704,554,611	\$3,995,749

Table 13. Mass Merchants with Pharmacy: State by State Estimates of Taxes Paid by Category, 2010

State	Number of Stores	Estimated Taxes Paid (000)	Estimated Taxes Paid per Store (000)	Estimated State Income Tax (000 \$)	Estimated Sales Tax (000 \$)	Estimated Real Estate Tax (000 \$)	State Unem-employment Insurance (000 \$)	Federal Income Tax (000 \$)	Total Taxes Collected by State, 2010	Estimated 2010 State Taxes Paid (000)
Alabama	192	\$415,931	\$2,166	\$132,045	\$192,273	\$603	\$2,134	\$88,676	\$8,181,918	\$327,055
Alaska	28	\$39,732	\$1,419	\$6,930	\$0	\$29	\$516	\$32,256	\$4,518,023	\$7,476
Arizona	183	\$469,861	\$2,568	\$15,554	\$354,743	\$100	\$2,055	\$97,409	\$10,199,338	\$372,452
Arkansas	157	\$400,717	\$2,552	\$13,120	\$297,228	\$534	\$1,529	\$88,305	\$7,279,215	\$312,411
California	557	\$3,476,966	\$6,242	\$19,583	\$2,753,986	\$1,312	\$10,258	\$591,826	\$104,840,520	\$2,885,140
Colorado	149	\$349,877	\$2,348	\$13,553	\$205,520	\$128	\$2,606	\$128,069	\$8,586,401	\$221,807
Connecticut	60	\$283,929	\$4,732	\$10,935	\$208,005	\$99	\$1,105	\$63,785	\$12,285,994	\$220,143
DC	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Delaware	16	\$19,196	\$1,200	\$3,133	\$0	\$6	\$301	\$15,756	\$2,769,731	\$3,441
Florida	497	\$2,005,341	\$4,035	\$57,371	\$1,481,872	\$891	\$8,846	\$456,302	\$31,498,998	\$1,548,979
Georgia	270	\$562,967	\$2,085	\$22,786	\$370,309	\$485	\$3,244	\$166,144	\$14,782,779	\$396,823
Hawaii	25	\$173,709	\$6,948	\$6,490	\$122,171	\$52	\$628	\$44,367	\$4,837,862	\$129,341
Idaho	56	\$218,015	\$3,893	\$7,209	\$168,369	\$89	\$846	\$41,501	\$2,951,703	\$176,514
Illinois	356	\$1,537,421	\$4,319	\$54,057	\$1,152,429	\$450	\$6,511	\$323,874	\$29,761,862	\$1,213,544
Indiana	210	\$536,891	\$2,557	\$20,757	\$406,442	\$192	\$2,663	\$106,637	\$13,796,427	\$430,054
Iowa	125	\$251,626	\$2,013	\$15,094	\$179,908	\$273	\$1,319	\$55,032	\$6,809,344	\$196,595
Kansas	102	\$353,452	\$3,465	\$6,008	\$280,047	\$237	\$1,453	\$65,708	\$6,492,996	\$287,744
Kentucky	146	\$355,557	\$2,435	\$10,967	\$262,356	\$434	\$1,831	\$79,969	\$9,531,507	\$275,588
Louisiana	157	\$371,583	\$2,367	\$20,205	\$238,036	\$555	\$2,293	\$110,495	\$8,757,557	\$261,089
Maine	30	\$61,788	\$2,060	\$3,125	\$43,002	\$36	\$315	\$15,310	\$3,489,953	\$46,478
Maryland	117	\$552,277	\$4,720	\$23,199	\$403,829	\$90	\$2,135	\$123,024	\$15,223,923	\$429,253
Massachusetts	91	\$390,853	\$4,295	\$16,474	\$290,399	\$105	\$1,505	\$82,370	\$20,050,292	\$308,483
Michigan	370	\$1,511,583	\$4,085	\$38,764	\$1,122,904	\$814	\$6,493	\$342,608	\$22,626,247	\$1,188,975
Minnesota	206	\$828,140	\$4,020	\$37,816	\$617,738	\$299	\$3,465	\$168,821	\$17,208,877	\$659,319
Mississippi	175	\$345,862	\$1,976	\$7,058	\$274,968	\$624	\$1,452	\$61,759	\$6,268,804	\$284,103
Missouri	203	\$443,467	\$2,185	\$17,459	\$300,680	\$458	\$2,659	\$122,211	\$9,703,459	\$321,256
Montana	45	\$19,260	\$428	\$2,510	\$0	\$122	\$362	\$16,286	\$2,142,809	\$2,994
Nebraska	80	\$231,905	\$2,899	\$9,918	\$164,830	\$251	\$1,350	\$55,556	\$3,869,266	\$176,348
Nevada	80	\$201,921	\$2,524	\$0	\$158,647	\$64	\$929	\$42,281	\$5,835,963	\$159,640
New Hampshire	40	\$17,122	\$793	\$5,075	\$0	\$25	\$500	\$26,122	\$2,124,984	\$5,600
New Jersey	131	\$647,290	\$4,941	\$26,196	\$491,370	\$295	\$2,085	\$127,343	\$25,927,891	\$519,947
New Mexico	85	\$108,284	\$1,666	\$4,680	\$75,942	\$83	\$638	\$26,941	\$4,413,988	\$81,343
New York	220	\$861,342	\$3,915	\$41,400	\$559,204	\$1,108	\$4,523	\$255,107	\$63,529,354	\$606,235
North Carolina	257	\$554,373	\$2,157	\$19,978	\$404,561	\$391	\$2,780	\$126,674	\$21,511,278	\$427,899
North Dakota	0									\$2,645,695
Ohio	341	\$1,156,929	\$3,393	\$50,642	\$826,990	\$491	\$6,116	\$272,690	\$23,983,596	\$884,239
Oklahoma	133	\$380,235	\$2,859	\$12,434	\$275,013	\$373	\$1,753	\$90,662	\$7,079,885	\$289,573
Oregon	178	\$302,780	\$1,739	\$30,551	\$0	\$187	\$2,852	\$169,190	\$7,475,135	\$33,590
Pennsylvania	279	\$751,289	\$2,695	\$38,155	\$542,010	\$650	\$3,880	\$167,095	\$30,169,122	\$594,695
Rhode Island	13	\$28,036	\$2,157	\$1,137	\$21,252	\$15	\$104	\$5,528	\$2,568,851	\$22,508
South Carolina	143	\$242,878	\$1,698	\$6,184	\$181,122	\$259	\$1,199	\$54,112	\$6,800,724	\$188,764
South Dakota	37	\$53,263	\$1,440	\$0	\$38,523	\$96	\$351	\$14,294	\$1,304,487	\$38,989
Tennessee	254	\$1,027,969	\$4,047	\$26,990	\$815,023	\$556	\$3,667	\$181,724	\$10,513,788	\$846,245
Texas	602	\$1,276,858	\$2,121	\$20,434	\$963,573	\$1,228	\$5,546	\$286,076	\$39,399,251	\$990,782
Utah	99	\$211,718	\$2,139	\$5,257	\$159,306	\$220	\$874	\$48,001	\$5,092,415	\$165,717
Vermont	5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	\$2,511,387
Virginia	219	\$636,353	\$2,908	\$20,048	\$460,889	\$102	\$3,097	\$152,017	\$16,411,055	\$484,536
Washington	194	\$1,079,278	\$5,563	\$0	\$810,286	\$269	\$3,929	\$234,793	\$16,106,154	\$844,485
West Virginia	64	\$75,867	\$1,185	\$3,006	\$56,904	\$136	\$349	\$15,472	\$4,655,034	\$60,385
Wisconsin	228	\$642,980	\$2,820	\$29,535	\$446,430	\$358	\$3,093	\$163,564	\$14,368,569	\$479,416
Wyoming	31	\$42,531	\$1,372	\$0	\$28,947	\$44	\$303	\$13,237	\$2,117,100	\$29,294
Total	8,217	\$26,424,624	\$3,216	\$1,034,739	\$19,239,705	\$16,214	\$118,484	\$6,015,523	\$704,554,611	\$20,409,102

Top Chain Pharmacy Companies

Although many people think of chain pharmacy as traditional drug stores, a list of the top chain pharmacy companies illustrates how diverse the retail pharmacy environment is. Tables 14 and 15 show the top chain pharmacy companies by pharmacy sales and by number of pharmacies in 2010.

The top companies by number of prescriptions are shown in Table 16.

Table 14. Top Chain Retail Pharmacy Companies, by Pharmacy Sales, 2010

Rank	Company	Pharmacy Sales (in millions)	Total Sales (in millions)
1	Walgreen Co.	43,823	67,420
2	CVS Caremark Corporation	38,994	57,345
3	Rite Aid Corporation	17,086	25,200
4	Wal-Mart Stores, Inc.(1)	15,616	260,261
5	The Kroger Co.	7,886	70,080
6	Safeway Inc.	3,695	41,050
7	The Stop & Shop Supermarket Corporation	3,465	68,881
8	Target Corporation	3,033	67,390
9	Sears Holdings Corporation	2,495	15,593
10	SUPERVALU INC.	2,313	28,911
11	Sam's Club	1,781	49,459
12	Publix Super Markets, Inc.	1,558	25,135
13	Costco Wholesale dba Costco Pharmacies	1,449	76,255
14	Medicine Shoppe International	1,436	1,595
15	H.E. Butt Grocery Co.	1,223	15,100
16	Giant Eagle, Inc.	980	8,600
17	Albertson's LLC	888	3,700
18	Meijer, Inc.	659	14,653
19	Wegmans Food Markets, Inc.	624	4,953
20	Fred's Inc.	589	1,842
21	Fred Meyer	584	8,715
22	Kinney Drugs	557	743
23	Winn-Dixie	507	7,248
24	Shopko Stores Operating Co., LLC	506	2,300
25	Hy-Vee	476	6,484

Results reflect end of fiscal year 2010.

(1) U.S. stores division only reflects discount stores, supercenters, and neighborhood markets.
Source: CSGIS Directory of Drug Store and HBC Chains, accessed 6/15/2011.

Table 15. Top Chain Retail Pharmacy Companies, by Number of Pharmacies, 2010

Rank	Company Name	Stores	Pharmacies
1	Walgreen Company	7,709	7,709
2	CVS Caremark Corp.	7,182	7,108
3	Rite Aid Corporation	4,714	4,714
4	Walmart Stores Inc. (1)	3,815	3,800
5	The Kroger Co.	2,458	1,969
6	Target Corporation	1,755	1,584
7	Safeway Inc.	1,694	1,362
8	Sears Holding Corporation	1,307	981
9	SUPERVALU INC.	2,394	805
10	Publix Super Markets Inc.	1,045	805
11	Royal Ahold	918	665
13	Medicine Shoppe International Inc.	657	657
14	Sam's Club	609	519
15	Costco Wholesale Corp.	582	465
16	Winn-Dixie Stores Inc.	484	379
17	Fred's Inc.	359	313
18	Albertson's LLC	235	235
19	Hy-Vee Inc.	224	229
20	Giant Eagle Inc.	224	210
21	Great Atlantic & Pacific Tea Company Inc.	362	204
22	Meijer Inc.	190	195
23	H.E. Butt Grocery Co.	340	189
24	Save Mart Supermarkets	241	155
25	Shopko Stores Operating Co. LLC	142	142
25	Hy-Vee	478	6,484

(1) U.S. stores division only reflects discount stores, supercenters, and neighborhood markets.
Counts are for June 2010.
Source: CSGS Directory of Drug Store and HBC Chains, accessed 6/15/2011.

Table 16. Top Chain Retail Pharmacy Companies, by Prescription Share, 2010

Rank	Company	Prescription Share	Rank	Company	Prescription Share
1	Walgreen Co.	21.3%	14	Sam's Club	0.7%
2	CVS Caremark Corporation	16.8%	15	H-E-B	0.6%
3	Rite Aid Corporation	8.1%	16	Giant Eagle, Inc.	0.5%
4	Wal-Mart Stores, Inc.	6.1%	17	Albertson's, LLC	0.4%
5	The Kroger Co.	4.0%	18	Meijer, Inc.	0.4%
6	Target Corporation	1.8%	19	Winn-Dixie Stores, Inc.	0.4%
7	Royal Ahold	1.4%	20	Fred's	0.3%
8	Medicine Shoppe International, Inc.	1.3%	21	USA Drug	0.3%
9	Safeway Inc.	1.3%	22	Hy-Vee Inc.	0.3%
10	SUPERVALU INC.	1.2%	23	Shopko Stores	0.3%
11	Sears Holdings Corporation	1.1%	24	The Great Atlantic & Pacific Tea Company	0.3%
12	Publix Super Markets, Inc.	1.1%	25	Fred Meyer, Inc.	0.3%
13	Costco Wholesale dba Costco Pharmacies	0.9%			

Source: CSGS Directory of Drug Store and HBC Chains, 2010, and NCPDP store database, July 2010.
Source: CSGS online Directory of Drug Store and HBC Chains and NCPDP Economics Department.

Industry Consolidation: Mergers and Acquisitions

The retail pharmacy industry continues to consolidate. Companies also continue to acquire individual stores or groups of stores from competitors to expand or strengthen their market position.

Mergers are driven in part by the cost savings that can be found when different functions, such as distribution, purchasing, and management, are combined. Because integration may take some time, an acquisition that will eventually increase earnings of a company may temporarily reduce profits. Table 17 presents the most recent mergers and acquisitions in the chain drug industry.

Table 17. Recent Mergers, Acquisitions, and Transfers of Store Ownership

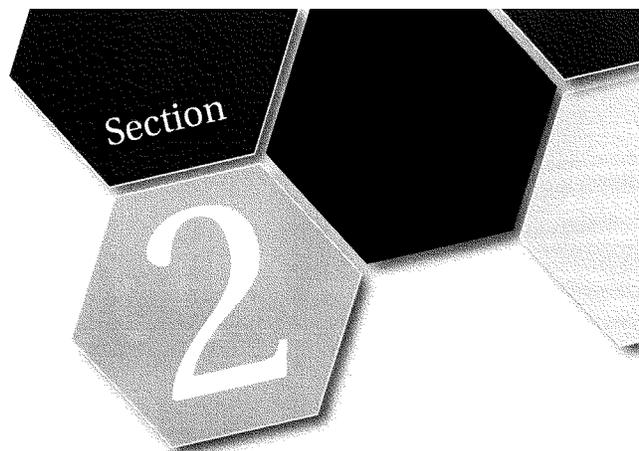
Year	Buying Company	Acquisition	# of stores	Notes
2010	Walgreens	Duane Reade	257	Includes corporate office and 2 distribution centers.
2010	Walgreens	Eaton Apothecary	12	
2010	Walgreens	Graymark Healthcare Inc.	18	Apothecary/Rx pharmacies
2010	Walgreens	USA Drug		Pharmacy files from 17 Super D and Rite's stores
2010	Walgreens	Farmacias El Amal	3	3 stores plus files from 11 stores
2010	Walgreens	Katz Group	25	Snyder Drug Stores in MN
2009	Walgreens	Drug Fair	33	Walgreens purchased prescription files for 2 additional Drug Fair locations.
2009	Southern Family Markets	Bruno's Supermarkets LLC	56	31 stores will continue to operate under Bruno's and Food World banners
2009	Walgreens	Rite Aid	12	7 in San Francisco, CA, 5 in eastern ID
2008	CVS Caremark	Longs Drug Stores	521	Includes RxAmerica pharmacy benefit management company.
2008	Kroger	Farmers Jack (under A & P)	20	41 Farmers Jack sites bought by independent grocers; 2 warehouses and 25 stores for sale after July 2007.
2008	Arcadia Resources, Inc.	PrairieStone Pharmacy, LLC	-200	management company that provides services to retail pharmacies
2008	Walgreens	Farmacias El Amal	20	41 stores to continue operation under Farmacia El Amal
2008	Spartan Stores	VC's	32	17 supermarkets, 15 pharmacies
2008	Rite Aid	Spartan's Pharm Stores	12	2 other stores sold in a separate transaction
2008	Publix Super Markets	Albertsons LLC	49	
2008	CVS	Snyder's	23	19 in MN, 4 in MT
2007	Rite Aid	Brooks Eckerd	1850	
2007	Walgreens	FamilyMeids	53	Asset purchase agreement 2/14/07.
2006	Longs Drug	Network Pharmaceuticals	21	
2006	Walgreens	Happy Harry's	76	
2006	CVS	Albertsons	703	Freestanding stores only.
2006	SUPERVALU	Albertsons	1124	
2006	Cerberus Capital Management	Albertsons	655	
2005	Rite Aid	Shelly's	5	2 stores converted to Rite Aid format, 3 to transfer pharmacy files.
2005	Walgreens	Medic	23	
2005	Omicare	NeighborCare Inc.	30	
2004	USA/Super D	Med-X	22	Plus distribution center
2004	USA/Super D	May's Drug Stores	39	
2004	CVS Corp.	Eckerd Corp.	1260	
2004	Brooks Pharmacy	Eckerd Corp.	1540	
2004	Brooks Pharmacy	Pelton's	3	
2004	Albertson's	Shaw's Supermarkets	202	
2004	DrugMax	FamilyMeids	82	
2003	Medicine Shoppe International	Medicap	179	
2003	Walgreens	Hi-School	17	
2003	Inland Retail Real Estate Trust	Eckerd Corp.	19	Acquisition of Assets

Table 17. Recent Mergers, Acquisitions, and Transfers of Store Ownership (cont.)

Year	Buying Company	Acquisition	# of stores	Notes
2002	Brooks Pharmacy	Albertsons Inc.-New England Osco Drugstores	80	Acquisition of Assets
2002	J M Smith Corp	CornerDrugstore.com (SymRx Inc)	n/a	Acquisition of Assets
2002	Rite Aid	CVS	11	4 stores in Flint, MI, 4 in Toledo, OH, 3 in Canton, OH
2002	CVS	Rite Aid	15	9 stores in Columbus, OH, 6 stores in Cincinnati, OH
2002	Jean Coutu Grp/Brooks Pharmacy	Osco Drugs	80	
2001	Navarro Discount Drugs	Fedco Drugs	4	
2001	Aurora Pharmacy	Coppe Food Center	12	
2001	Snyder's Drug Stores (Katz Group)	Vic Deep Discount (div. of Drug Emporium)	12	
2001	Snyder's Drug Stores (Katz Group)	F & M Super Drug Stores	12	
2001	Snyder's Drug Stores (Katz Group)	Drug Emporium	70-80	
2001	Big A Drug Stores	Drug Emporium	15	
2001	Eckerd Corp. (J. C. Penney Co., Inc.)	Stewart-Wood Drug	1	
2001	CVS	Drug Emporium		Asset purchase: inventory, prescription files. Drug Emporium closes 18 Georgia stores, 20 California stores
2001	Pathmark Stores	Grand Union	6	
2001	Snyder's Drug Stores (Katz Group)	Independents	6	6 total independent drug stores acquired
2001	Famlymeds	Integrated Pharmacy Solutions (subsidi. of Aetna, US)	38	
2001	Snyder's Drug Stores (Katz Group)	Drug Emporium	81	
2001	Longs Drugs Stores	Drug Emporium	2	
2001	Big A Drug Stores	Drug Emporium	15	
2001	CVS	Grand Union	10	Store leases acquired
2001	Snyder's Drug Stores (Katz Group)	Park Pharmacy, Park Rapids, and Synder Drug	3	Purchase of 3 total independent stores
2000	Snyder's Drug Stores (Katz Group)	Tobin's Drug Stores	2	
2000	Snyder's Drug Stores (Katz Group)	The Family Pharmacy	1	
2000	Snyder's Drug Stores (Katz Group)	Peterson Snyder's Drug*	1	Previously operated as a Snyder's independent retailer
2000	CVS	Starlander Pharmacy (div. Of Bergen Brunswig Corp.)		Specialty pharmacy, part of which is a wholesaler/distributor. 3 walk-in pharmacies, 14 mail-distribution centers
2000	Duane Reade	Value Drug	5	
2000	Eckerd Corp. (J. C. Penney Co., Inc.)	Gresham's (Chain)	7	
2000	Snyder's Drug Stores (Katz Group)	Western Drug of Billings	7	
2000	Longs Drugs Stores	Rite Aid	31	
2000	Park Pharmacy Corp.	Dougherty's Pharmacy Inc.	1	
2000	Park Pharmacy Corp.	MIN Enterprises Inc.	1	
2000	Park Pharmacy Corp.	Total Pharmacy Supply Inc.	1	
2000	Kaire Holdings Inc.	Classic Care Pharmacy	1	
2000	Park Pharmacy Corp.	Amedisys Infusion Pharmacy Operations		
2000	CVS Corp.	Thrifty Rexall Drugs	1	
2000	Kerr	CVS	3	2 stores to remain open, 1 pharmacy's files to be transferred
2000	Kerr	Eckerd	1	Store to be closed, pharmacy's files to be transferred
1999	Medicap Pharmacies, Inc.	Gollish Pharmacies, Inc.		
1999	D.A.W.	Eaton Apothecary (80% subsidi. of Nyer Medical Group)	3	
1999	Horizon Pharmacies, Inc.	Save-More Drugs	1	
1999	Horizon Pharmacies, Inc.	Jones Low Priced Drugs	2	
1999	Horizon Pharmacies, Inc.	Fulton Drug*	1	Mail-order and Internet pharmacy, Starscripts.
1999	Horizon Pharmacies, Inc.	Blake Pharmacy, Brennan Pharmacy Downtown, The Prescription Center, Save-More Drugs, Inc., Strossack Eagle Drug, Inc.	5	5 total independent pharmacies purchased
1999	Horizon Pharmacies, Inc.	Fountainview Pharmacy	1	
1999	Horizon Pharmacies, Inc.	Jones Low Priced Drugs Inc.	2	
1999	Fry's Food Stores (Kroger)	Smith's Food and Drug Stores (Fred Meyer, Inc.)	37	FTC agreement: 2 Fry's and 1 Smith's to be sold
1999	Anchor Pharmacies	Independents	2	

Table 17. Recent Mergers, Acquisitions, and Transfers of Store Ownership (cont.)

Year	Buying Company	Acquisition	# of stores	Notes
1999	Medicine Shoppe Pharmacies	Food Lion	0	New or remodeled Food Lions in selected markets to become Medicine Shoppes
1999	Medicine Shoppe Pharmacies	Kash n' Karry (div. of Food Lion)	50	Existing pharmacies in Kash's stores to become Medicine Shoppe franchises
1999	Melrose Trading Company	Medicine Shoppe (India)	5	5 franchises
1999	Longs Drugs Stores	Rite Aid	35	Of 35, 1 closed; original plan to purchase 38, lease negotiations ongoing for other 6
1999	Longs Drugs Stores	Drug Emporium/Western Drug Distributors	20	
1999	Drug Emporium Inc.	Vix Stores	12	
1999	Duane Reade	Love's (Chain)	6	
1999	Duane Reade	Love Stores	10	
1999	Katz Group	Snyder's Drug Stores (Chain)	141	
1999	Albertson's*	American Drug Stores Co. (Chain)	1558	As part of FTC agreement, Albertson's has divested 144 stores
1999	Raley's	Albertson's	27	Part of Albertson's divestiture
1999	Certified Grocers of California, Ltd.	Albertson's	31	Part of Albertson's divestiture
1999	Ralph's Grocery Company (Subsidiary of Kroger)	Albertson's	42	Stores included Albertson's, Lucky, Super Saver, Monte Mart, 40 stores, 2 sites; part of Albertson's divestiture
1999	Stater Brothers Markets	Albertson's	44	Stores included Albertson's, Lucky, 43 stores, 1 site; part of Albertson's divestiture
1999	Vons Companies, Inc.	Albertson's	5	4 stores, 1 site; part of Albertson's divestiture
1999	Eckerd Corp. (J. C. Penney Co., Inc.)	Genovese Drug Stores, Inc. (Chain)	141	
1999	Phar-Mor, Inc.*	Pharmhouse Corp., Rx Place	32	Stores to operate as Phar-Mor, Pharmhouse, The Rx Place
1999	Rite Aid Corporation	Edgell Drugs Inc.	25	
1999	Palm Beach Pharmacies	FEDCO, Inc. (Florida)	20	
1999	Drug Emporium Inc.	Vix Deep Discount*	12	Includes 11 Vix stores and 1 Vixi Herbs outlet. Operated by Tops Markets Inc., div. of Ohld International
1999	Jean Couti Grp./Brooks Pharmacy	City Drug Stores (Chain)	11	Of the 11 stores, 10 have pharmacies
1999	Eckerd Corporation	The Chemist Shop	1	
1999	Arrow Corp.	KPC Medical Management	18	Pharmacies in clinics
1999	Arrow Pharmacy & Nutrition Centers (Arrow Corp.)	Super Sav-On Drugs	18	
1999	Arrow Pharmacy & Nutrition Centers (Arrow Corp.)	Kaiser Permanente's NE division	17	
1999	Snyder's Drug Stores (Chain)	Unnamed independents	5	5 total independent pharmacies purchased
1999	Sav-Mor Drugs	Efros Drugs, FRD Sav-Mor Pharmacy, Ian's Discount Pharmacy, Procs Pharmacy and Robert's Sav-Mor	6	6 total independent pharmacies purchased
1999	ICN Pharmaceuticals	retail pharmacies	88	
1999	Health Script Pharmacy Services	Rx West, Inc.	1	
1999	Power Cell	Park Pharmacy	1	
1999	CVS	Century City Drug, Pace Blvd, City Drugs	2	2 total acquisitions
1998	Lewis Drugs/Sioux Valley Hospitals and Health System	Family Drug Stores	11	
1998	Albertson's*	Buttrey Food and Drug Stores Co.	44	As part of the FTC agreement, Albertson's divested 6 of its own stores and 9 Buttrey units for a net gain of 29
1998	CVS	Arbor Drugs (Chain)	207	
1998	Duane Reade	Rock Bottom Stores	38	
1998	Longs Drugs Stores	Western Drug Distributors*	20	Drug Emporium of Washington & Oregon
1998	CVS	Thriftyway Pharmacy Associates	16	
1998	NeighborCare	Health Care Professionals	2	
1998	Scott's Food Stores (div. of SuperValu)	Ketsch Drug Stores (Chain)	14	Eleven freestanding units and 3 in-store pharmacies
1998	Horizon Pharmacies, Inc.	Briar Grove Pharmacy, Kirkwood Pharmacy, Interurban Pharmacy*	3	Acquisition of an independent chain of three retail pharmacies in Houston, TX
1998	Horizon Pharmacies, Inc.	Holland Drug Store	2	
1998	Horizon Pharmacies, Inc.	Barrett Drug, Belen Sav-on Drug, Conolly-Herry Drug, Inc., Drug Towne Pharmacy, Ernie's Sav-on Drug, Highlands Ranch Pharmacy, R & R Professional Pharmacy, Inc., St. John's Drug, Steeville Drug	9	9 total independent pharmacies purchased
1998	Raley's Supermarket and Drug Centers	Nob Hill Foods	27	To be operated as wholly-owned subsid. with no name change



Financial Information/ Non-Prescription Sales

This section presents general information on community pharmacies.

Included are:

- General financial information by type of store;
- Warehousing and distribution;
- Inventory/sales ratios;
- Technology;
- Internet sales;
- Employee issues; and
- Non-prescription sales.

General Financial Information by Type of Store

Every type of community retail pharmacy invests resources into developing ideal physical location and appropriate inventory standards. Whether the chain store is a traditional chain drug store, a supermarket, or a mass merchant, capitalizing the return on this investment is a must. The following information is provided to evaluate investment returns for each type of store based on these measures:

- Profitability, valuation, operational, and financial ratios; per capita sales; and
- Gross margin.

The values in the following tables are best used as both an industry average and as comparative devices between different types of retail stores. Note the information on these measures is not available for particular chain stores, only for the major industry groups to which the chain drug stores belong. Still, these data should provide a useful comparison for chain drug stores when assessing their own business performance.

Profitability, valuation, operational, and financial ratios assist the investor in assessing the value of their investment. Each type of retail pharmacy has distinctive financial performance measures, as shown in Table 18.

Per capita sales is a measure of how much an individual spends in a particular type of store. Table 19 shows that in 2010 the average consumer spent \$719 in traditional drug stores. For a family of four this amount would have totaled \$2,877. Similarly, the average spending per person in grocery stores was \$1,688, or about \$6,753 annually per four-member family. On a monthly basis, average per capita spending in a drug store is about \$60 and in a food store is \$141.

Per capita sales in drug stores increased about 55% from 2000 to 2010, at an average rate of 4.5% per year. The rate of growth for per capita sales has decreased slightly over the past few years and is related to the increased use of generic drugs. Per capita sales grew very slowly in supermarkets over the same period, increasing by 18% overall or about 1.7% per year. Mass merchants (including discount department stores, warehouse clubs, and superstores) continue to experience higher than average growth in per capita sales. Per capita sales at these stores increased over 62% between 1999 and 2009, increasing by an average of about 4.9% per year. The average person now spends nearly as much per year in discount department stores, warehouse clubs, and superstores as in grocery stores.

Table 18. Financials by Industry for Publicly Held Companies

Industry Name	Biotechnology	Computer Software/Svcs	Computers/Peripherals	Drug	E-Commerce	Food Processing	Healthcare Information	Internet	Medical Services	Medical Supplies	Pharmacy Services	Retail (Special Lines)	Retail Store	Retail/Wholesale Food	Toiletries/ Cosmetics	Total Market
Number of Firms	121	333	129	337	56	121	33	239	162	264	21	157	43	32	19	7066
EBITDASG&A/Sales	78.48%	64.65%	34.73%	81.88%	52.42%	30.69%	61.12%	59.90%	26.82%	32.80%	21.82%	37.27%	28.34%	22.28%	64.48%	43.72%
After-tax Operating Margin	14.69%	18.85%	9.59%	24.68%	9.65%	8.80%	12.85%	17.19%	7.65%	8.78%	4.25%	5.33%	4.25%	3.69%	8.53%	15.68%
Net Margin	11.84%	13.69%	5.95%	17.97%	5.94%	5.51%	7.40%	12.02%	4.13%	6.96%	2.56%	2.01%	2.84%	1.85%	5.24%	3.08%
Price/BV	3.82	5.05	4.78	3.34	3.96	3.40	4.95	5.35	2.00	3.44	2.47	2.84	2.67	3.51	8.19	2.28
ROE	4.41%	22.09%	21.82%	18.60%	6.17%	23.20%	10.75%	12.26%	14.27%	18.67%	9.56%	11.66%	15.85%	15.06%	40.50%	9.94%
ROC	12.50%	41.44%	39.75%	25.05%	17.11%	18.50%	17.99%	33.78%	18.15%	21.62%	13.20%	20.58%	15.36%	16.73%	24.62%	18.01%
Price/Current EPS	35.13	32.49	30.26	33.22	60.67	22.45	127.59	52.53	18.22	36.58	16.41	28.69	18.42	20.70	24.72	29.57
Price/Sales	4.89	3.15	1.32	2.93	2.68	0.89	2.79	4.59	0.55	1.23	0.57	0.63	0.47	0.44	1.16	1.12
Value/Sales	4.79	2.98	1.28	3.04	2.57	1.11	2.95	4.24	0.70	1.28	0.66	0.67	0.57	0.54	1.37	1.53
Accounts Receivable/Sales	13.69%	18.47%	15.47%	18.52%	11.45%	9.34%	19.67%	9.17%	7.49%	10.67%	5.88%	3.60%	2.37%	2.38%	8.19%	16.42%
Inventory/Sales	14.93%	0.70%	4.37%	11.51%	1.45%	10.97%	0.96%	2.18%	0.62%	9.14%	8.75%	14.04%	10.43%	6.01%	12.32%	13.23%
Accounts Payable/Sales	5.05%	4.55%	10.92%	8.56%	4.59%	9.48%	3.57%	7.83%	11.20%	9.48%	5.99%	7.34%	7.40%	5.80%	5.85%	12.57%
Cash/Sales	81.84%	34.42%	17.84%	25.68%	33.89%	4.36%	21.68%	44.68%	8.60%	9.02%	2.21%	6.22%	2.72%	1.66%	10.11%	15.99%
Non-cash Working Capital/Sales	8.69%	-7.26%	-1.62%	10.14%	-10.02%	6.01%	2.41%	-3.10%	-6.78%	7.91%	4.93%	6.91%	1.56%	1.05%	8.99%	8.69%
Working capital/ Sales	90.53%	27.16%	16.22%	35.83%	23.86%	10.38%	24.09%	41.58%	1.82%	16.93%	7.14%	13.13%	4.28%	2.71%	19.09%	24.68%
Growth in EPS (5-year)	18.42%	20.83%	16.77%	13.36%	7.92%	4.63%	8.71%	18.28%	17.34%	12.02%	27.50%	8.19%	13.48%	5.73%	5.63%	13.27%
Growth in Sales (5-year)	35.06%	15.26%	6.87%	24.88%	20.32%	15.24%	8.78%	13.71%	12.36%	12.87%	43.68%	3.93%	0.49%	11.10%	-0.49%	12.79%
Growth in Dividends (5-year)	NA	23.41%	30.60%	19.00%	NA	12.41%	NA	NA	9.69%	21.58%	12.67%	21.25%	11.64%	15.82%	16.33%	13.23%

Source: Damodaran Online, <http://pages.stern.nyu.edu/~adamodar/>, data drawn 7/20/2011. Data are for 2009.

Table 19. Estimated Per Capita Sales, By North American Industrial Classification System (NAICS) Code for Drug Stores, Grocery Stores, and Mass Merchants, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Drug Stores (NAICS 44611)	\$464	\$497	\$535	\$571	\$578	\$607	\$641	\$672	\$694	\$712	\$719
Grocery Stores (NAICS 4451)	\$1,428	\$1,469	\$1,461	\$1,476	1,506	\$1,548	\$1,582	\$1,632	\$1,684	\$1,665	\$1,688
Discount Department Stores, Warehouse Clubs and Superstores (NAICS 452112 and 45291)	\$990	\$1,075	\$1,143	\$1,202	\$1,285	\$1,371	\$1,452	\$1,526	\$1,585	\$1,575	\$1,599

Source: Annual Retail Trade Survey, U.S. Bureau of Census, and Department of Commerce retail sales data and Census Estimates.

Gross margin is the difference between the cost of goods and revenue received. Gross margin must cover the entire cost of running the business for a retail operation to be profitable. It is also a measure of the value that a company adds with its services. Table 20 shows gross margins for several types of businesses that include retail pharmacies.

Table 20. Retail Sales, Retail Purchases, Gross Margin, and Gross Margin as Percent of Sales, 1992-2010*
(Numbers are as reported in annual retail trade survey.)

	1992	1993	1994	1995	1996	1997	1998	1999	2000
<i>Drug Stores (NAICS 44611)</i>									
Retail Sales (000)	\$77,806	\$79,720	\$82,006	\$85,851	\$91,821	\$98,833	\$108,426	\$121,293	\$130,867
Retail Purchases (000)	\$57,974	\$59,069	\$61,231	\$64,660	\$68,886	\$73,737	\$80,588	\$91,520	\$97,882
Gross Margin (000)	\$19,832	\$20,651	\$20,775	\$21,191	\$22,935	\$25,096	\$27,838	\$29,773	\$32,985
Gross Margin as Percent of Sales	25.5%	25.9%	25.3%	24.7%	25.0%	25.4%	25.7%	24.5%	25.2%
<i>Grocery Stores (NAICS 4451)</i>									
Retail Sales (000)	\$337,925	\$341,855	\$351,056	\$356,932	\$366,075	\$373,072	\$378,675	\$394,724	\$402,988
Retail Purchases (000)	\$255,595	\$258,502	\$265,630	\$267,156	\$273,955	\$278,255	\$280,707	\$290,069	\$294,963
Gross Margin (000)	\$82,330	\$83,353	\$85,426	\$89,776	\$92,120	\$94,817	\$97,968	\$104,655	\$108,025
Gross Margin as Percent of Sales	24.4%	24.4%	24.3%	25.2%	25.2%	25.4%	25.9%	26.5%	26.8%
<i>Discount Department Stores (NAICS 452112)</i>									
Retail Sales (000)	\$93,871	\$103,405	\$111,793	\$118,661	\$121,936	\$128,049	\$131,411	\$136,545	\$139,637
Retail Purchases (000)	\$72,955	\$79,712	\$87,969	\$92,892	\$95,903	\$99,604	\$93,960	\$97,432	\$97,965
Gross Margin (000)	\$20,916	\$23,693	\$23,824	\$22,824	\$22,083	\$24,532	\$23,695	\$26,307	\$34,777
Gross Margin as Percent of Sales	22.3%	22.9%	21.3%	19.2%	18.1%	19.2%	18.0%	19.3%	24.9%
<i>Warehouse Clubs and Superstores (NAICS 45291)</i>									
Retail Sales (000)	\$40,025	\$46,628	\$57,756	\$65,101	\$73,079	\$81,919	\$98,493	\$118,809	\$139,614
Retail Purchases (000)	\$34,313	\$39,738	\$48,431	\$53,501	\$58,649	\$65,255	\$83,251	\$100,491	\$117,255
Gross Margin (000)	\$5,712	\$6,890	\$9,325	\$7,959	\$11,345	\$12,442	\$15,129	\$17,296	\$16,365
Gross Margin as Percent of Sales	14.3%	14.8%	16.1%	12.2%	15.5%	15.2%	15.4%	14.6%	11.7%
<i>Electronic Shopping and Mail Order (NAICS 4541)</i>									
Retail Sales (000)	\$35,252	\$40,725	\$47,093	\$52,741	\$61,174	\$70,136	\$80,366	\$94,361	\$113,877
Retail Purchases (000)	\$19,307	\$22,946	\$26,870	\$30,108	\$35,215	\$41,223	\$48,319	\$58,554	\$70,652
Gross Margin (000)	\$15,945	\$17,779	\$20,223	\$18,213	\$21,020	\$23,064	\$26,911	\$29,982	\$32,848
Gross Margin as Percent of Sales	45.2%	43.7%	42.9%	34.5%	34.4%	32.9%	33.5%	31.8%	28.8%
<i>All Retail Businesses, excluding motor vehicle and parts dealers.</i>									
Retail Sales (000)	\$1,396,363	\$1,468,300	\$1,567,786	\$1,641,662	\$1,737,978	\$1,818,990	\$1,897,426	\$2,043,007	\$2,191,188
Retail Purchases (000)	\$983,791	\$1,034,943	\$1,104,767	\$1,151,001	\$1,215,675	\$1,270,208	\$1,318,337	\$1,422,210	\$1,522,684
Gross Margin (000)	\$412,572	\$433,357	\$463,019	\$445,094	\$477,845	\$500,365	\$529,297	\$555,184	\$590,195
Gross Margin as Percent of Sales	29.5%	29.5%	29.5%	27.1%	27.5%	27.5%	27.9%	27.2%	26.9%

Source: U.S. Bureau of the Census Annual Retail Trade Survey.
* 2010 gross margin data will not be available until April 2012. Because gross margin information is competitively sensitive, it is not collected by NACDS from members.

Table 20. Retail Sales, Retail Purchases, Gross Margin, and Gross Margin as Percent of Sales, 1992-2010* (cont.)
(Numbers are as reported in annual retail trade survey.)

	2001	2002	2003	2004	2005	2006	2007	2008	2009
<i>Drug Stores (NAICS 44611)</i>									
Retail Sales (000)	\$141,781	\$153,946	\$165,591	\$169,387	\$179,384	\$191,352	\$202,527	\$210,985	\$218,219
Retail Purchases (000)	\$106,791	\$114,165	\$123,515	\$127,173	\$135,293	\$143,820	\$153,944	\$159,210	\$158,045
Gross Margin (000)	\$34,990	\$39,781	\$42,076	\$42,214	\$44,091	\$47,532	\$48,583	\$51,775	\$60,174
Gross Margin as Percent of Sales	24.7%	25.8%	25.4%	24.9%	24.6%	24.8%	24.0%	24.5%	27.6%
<i>Grocery Stores (NAICS 44511)</i>									
Retail Sales (000)	\$418,596	\$420,288	\$428,300	\$441,277	\$457,620	\$472,108	\$491,842	\$512,095	\$510,555
Retail Purchases (000)	\$301,323	\$300,474	\$304,867	\$314,187	\$327,178	\$336,916	\$352,022	\$367,084	\$368,669
Gross Margin (000)	\$117,273	\$119,814	\$123,433	\$127,090	\$130,442	\$135,192	\$139,820	\$145,011	\$141,886
Gross Margin as Percent of Sales	28.0%	28.5%	28.8%	28.8%	28.5%	28.6%	28.4%	28.3%	27.8%
<i>Discount Department Stores (NAICS 452112)</i>									
Retail Sales (000)	\$141,708	\$137,545	\$132,497	\$134,171	\$133,232	\$135,470	\$134,926	\$130,113	\$126,426
Retail Purchases (000)	\$100,237	\$98,448	\$92,666	\$91,773	\$93,663	\$93,604	\$93,253	\$89,098	\$86,055
Gross Margin (000)	\$41,471	\$39,097	\$39,831	\$42,398	\$39,569	\$41,866	\$41,673	\$41,015	\$40,371
Gross Margin as Percent of Sales	29.3%	28.4%	30.1%	31.6%	29.7%	30.9%	30.9%	31.5%	31.9%
<i>Warehouse Clubs and Superstores (NAICS 45291)</i>									
Retail Sales (000)	\$164,716	\$191,252	\$216,286	\$242,330	\$271,920	\$297,956	\$324,963	\$352,121	\$356,470
Retail Purchases (000)	\$139,454	\$159,238	\$172,391	\$194,726	\$214,180	\$237,841	\$255,063	\$276,880	\$274,629
Gross Margin (000)	\$25,262	\$32,014	\$43,895	\$47,604	\$57,740	\$60,115	\$69,900	\$75,241	\$81,841
Gross Margin as Percent of Sales	15.3%	16.7%	20.3%	19.6%	21.2%	20.2%	21.5%	21.4%	23.0%
<i>Electronic Shopping and Mail Order (NAICS 4541)</i>									
Retail Sales (000)	\$114,844	\$122,313	\$134,368	\$154,144	\$175,923	\$202,434	\$223,885	\$228,545	\$234,667
Retail Purchases (000)	\$70,689	\$74,144	\$81,351	\$94,588	\$110,116	\$125,274	\$139,997	\$144,054	\$149,734
Gross Margin (000)	\$44,155	\$48,169	\$53,017	\$59,556	\$65,807	\$77,160	\$83,888	\$84,491	\$84,933
Gross Margin as Percent of Sales	38.4%	39.4%	39.5%	38.6%	37.4%	38.1%	37.5%	37.0%	36.2%
<i>All Retail Businesses, excluding motor vehicle and parts dealers</i>									
Retail Sales (000)	\$2,250,784	\$2,314,053	\$2,425,097	\$2,612,275	\$2,806,640	\$2,978,482	\$3,094,011	\$3,164,245	\$2,961,670
Retail Purchases (000)	\$1,539,073	\$1,601,946	\$1,662,362	\$1,798,774	\$1,945,972	\$2,073,857	\$2,157,750	\$2,226,160	\$2,052,979
Gross Margin (000)	\$691,711	\$712,107	\$762,735	\$813,501	\$860,668	\$904,625	\$936,261	\$938,085	\$908,691
Gross Margin as Percent of Sales	30.7%	30.8%	31.5%	31.1%	30.7%	30.4%	30.3%	29.6%	30.7%

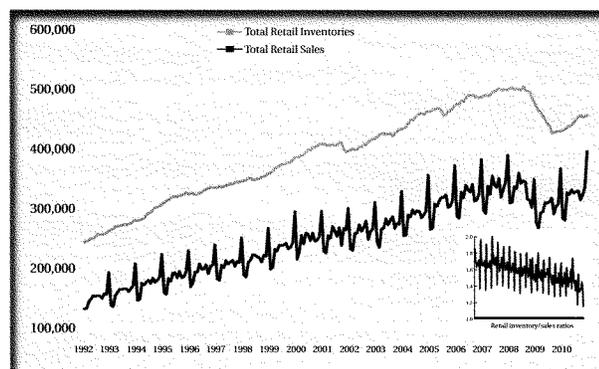
Source: U.S. Bureau of the Census Annual Retail Trade Survey
 * 2010 gross margin data will not be available until April 2012. Because gross margin information is competitively sensitive, it is not collected by NACDS from members.

Across all retail businesses, gross margins have remained fairly steady over the period from 1992 to 2009. For most of the 2000s, gross margin have been around 25%. In the early part of the last decade, gross margins were higher but they have fallen back to more typical levels. Drug store gross margins hovered around 25%, for most of the decade, but jumped in 2009. Grocery store gross margins increased from about 25% in the 1990s to about 28% in the 2000s, while gross margins for discount department stores increased from about 20% in the first years of the period to over 31% by 2009. Warehouse clubs and superstores operate with lower gross margins, roughly 23% in 2009. For comparison, the average gross margin for mail-order and Internet retailers was about 36% in 2009.

Inventory/Sales Ratios

Inventory levels indicate how well a retailer is able to forecast demand, or the retailer's ability to find the delicate balance between minimizing inventory investment and making sure there are sufficient goods on hand to service customer needs. Studying the relationship between sales and inventory is a good way to measure operational performance. Retail inventory/sales ratios are not available specifically for drug stores, but inventory/sales ratios are available for the entire retail industry. In 2010, overall inventory/sales ratios fell from 2009 levels, continuing a longer term trend that is apparent in Figure 5. From 2000 to 2010, average inventory/sales ratios fell 13.8%. Figure 5 shows inventory and sales levels as well as the inventory/sales ratio over time for retail trade.

Figure 5. Retail Inventories, Sales, and Retail Inventory/Sales Ratio, 1992-2010



Technology

Online pharmacy has demonstrated its convenience to a subset of customers, and the chain pharmacy industry has embraced the Internet and online sales as an extra service for their customers. As a result, the number of chain pharmacy companies with Internet sites and online Internet pharmacies continues to flourish. As of June 2011, there were 233 web home pages affiliated with domestic chain pharmacy companies. Seventy-two of these sites include an online pharmacy that offers at least prescription refills.

Table 21. Chain Pharmacy Companies with Internet Sites and Internet Pharmacy

Home Pages of Domestic Chain Pharmacy Companies	233
Domestic Chain Pharmacy Web Sites with Online Pharmacy	72

Source: NACDS Economics Department and Chain Store Guide Information Services.

Although these sites offer consumers the choice to receive their prescriptions by mail, many customers also order online and pick up prescriptions at the store. The National Association of Boards of Pharmacy developed the Verified Internet Pharmacy Practice Sites (VIPPS) program in the spring of 1999. The program was developed to provide consumers with reliable means to identify those online pharmacies that have proven their ability and authorization to dispense pharmaceuticals to the public in the jurisdictions listed on the VIPPS website. Twenty-eight pharmacy websites are currently VIPPS certified. NACDS emphasizes the difference between websites that are affiliated with licensed pharmacies and those that operate as illegitimate online drug-sellers.

While there are no reliable statistics relating to the share of retail prescription sales that are placed online, there are reliable statistics from the U.S. Bureau of the Census for retail sales of drugs, health aids, and beauty aids by electronic shopping and mail-order houses. Sales of these products totaled \$71.3 billion dollars in 2009, with \$5.99 billion (or 8.4%) considered e-commerce (<http://www.census.gov/econ/estats/2009/table6.xls>).

Employees

Pharmacy employee salaries vary by state and by the type of store they work in. Table 22 shows average wages by store type by state. The wages presented in Table 22 are for all employees, including pharmacists and part-time employees. These figures are helpful by representing the costs to the store for the average employee for the year. These figures are affected by labor turnover, the management/staff ratios, and the cost of living in the particular state. No breakdown is available for chain drug stores compared to independent drug stores. Average wages reflect the mix of employees traditionally used in each type of community retail pharmacy. This number will go proportionally up or down based on the labor status of the staff included in the calculation. For example, more than 10% of employees in traditional drug stores are pharmacists, while less than 1% of all employees in supermarkets and mass merchants are pharmacists.

Detailed statistics from 2010 are presented in Table 23. The three major store types – traditional drug store, mass merchant, and supermarket – all rely heavily on transaction-related personnel: clerical staff, cashiers, or stock clerks. Many are part-time employees, and some figures will reflect this type of staffing. Approximately 50% of all employees in stores with pharmacies are in occupations related to transactions. Another 11% of drug store employees and more than 20% of supermarket and mass merchant employees are office and administrative support personnel.

Table 22. State by State Estimates of Wages per Employee, by Type of Store, 2010

State	Traditional Drug Store	Supermarkets with Pharmacy	Mass Merchants with Pharmacy	State	Traditional Drug Store	Supermarkets with Pharmacy	Mass Merchants with Pharmacy
Alabama	\$36,888.79	\$19,670.96	\$21,218.91	Montana	\$33,407.92	\$21,451.19	\$18,095.57
Alaska	\$40,807.45	\$26,652.80	\$23,380.50	Nebraska	\$32,733.44	\$16,193.41	\$17,579.67
Arizona	\$38,781.00	\$25,262.90	\$21,083.70	Nevada	\$38,682.15	\$27,052.28	\$19,722.19
Arkansas	\$34,988.13	\$18,132.65	\$18,618.04	New Hampshire	\$29,055.00	\$17,486.04	\$20,129.94
California	\$40,781.99	\$27,750.10	\$25,495.71	New Jersey	\$36,721.33	\$25,165.98	\$23,669.89
Colorado	\$37,054.36	\$27,069.93	\$20,630.95	New Mexico	\$34,790.04	\$23,554.68	\$18,663.35
Connecticut	\$34,276.04	\$24,663.39	\$23,355.53	New York	\$33,348.39	\$21,941.92	\$22,329.20
DC	\$32,927.33	\$28,967.92	N/A	North Carolina	\$34,857.86	\$18,356.56	\$19,022.58
Delaware	\$33,628.92	\$24,135.59	\$20,109.41	North Dakota	\$35,513.86		
Florida	\$36,120.91	\$21,883.49	\$21,148.62	Ohio	\$32,755.87	\$20,053.73	\$18,622.25
Georgia	\$35,818.54	\$20,600.65	\$21,863.15	Oklahoma	\$34,642.54	\$18,877.41	\$21,289.81
Hawaii	\$35,173.33	\$26,336.05	\$26,896.31	Oregon	\$34,661.99	\$24,055.07	\$23,121.58
Idaho	\$33,932.68	\$21,468.65	\$19,544.85	Pennsylvania	\$31,394.92	\$20,447.74	\$17,994.49
Illinois	\$30,487.04	\$20,585.26	\$20,442.10	Rhode Island	\$36,696.68	\$21,557.21	\$22,414.00
Indiana	\$33,945.87	\$19,050.30	\$16,174.82	South Carolina	\$35,489.91	\$20,404.95	\$19,001.15
Iowa	\$30,830.32	\$17,521.16	\$17,414.10	South Dakota	\$28,412.98	\$16,447.54	\$16,724.94
Kansas	\$32,988.33	\$18,103.91	\$19,598.85	Tennessee	\$38,444.02	\$20,155.81	\$20,888.74
Kentucky	\$36,674.79	\$18,829.42	\$18,368.55	Texas	\$38,098.20	\$21,848.45	\$21,234.03
Louisiana	\$35,034.88	\$19,075.23	\$20,208.92	Utah	\$37,075.22	\$20,814.01	\$19,709.74
Maine	\$35,119.89	\$19,979.84	\$19,852.14	Vermont	\$33,646.74	\$19,645.33	N/A
Maryland	\$35,142.97	\$26,312.05	\$21,521.33	Virginia	\$33,407.43	\$22,661.66	\$19,487.22
Massachusetts	\$33,416.76	\$20,708.82	\$23,860.27	Washington	\$37,280.67	\$26,883.33	\$23,199.32
Michigan	\$35,135.12	\$20,597.14	\$20,401.43	West Virginia	\$34,996.06	\$18,940.36	\$18,738.17
Minnesota	\$36,924.85	\$20,503.96	\$20,630.56	Wisconsin	\$33,614.06	\$17,396.81	\$22,769.28
Mississippi	\$34,028.58	\$18,566.61	\$18,214.35	Wyoming	\$36,521.64	\$21,032.15	\$18,770.87
Missouri	\$34,793.31	\$19,912.50	\$20,236.31	Total	\$35,359.06	\$20,981.58	\$22,151.92

Source: Bureau of Labor Statistics Quarterly Census of Employment and Wages and NACDS Economics Department.

Table 23. Employment by Occupation for Drug Stores, Supermarkets, and Department Stores, 2010

Code	Occupation	Drug Stores		Supermarkets		Department Stores ¹		Other General Merchandise Stores ²	
		Employment	As Percent of Total	Employment	As Percent of Total	Employment	As Percent of Total	Employment	As Percent of Total
00-0000	Industry Total	985,440	100.00	2,475,670	100.00	1,518,480	100.00	1,519,870	100.00
11-0000	Management Occupations	14,930	1.52	36,870	1.49	23,500	1.55	17,290	1.14
11-1021	General and Operations Managers	9,950	1.01	27,400	1.11	10,780	0.71	13,460	0.89
13-0000	Business and Financial Operations Occupations	4,910	0.50	10,020	0.40	9,420	0.62	7,670	0.50
13-1022	Wholesale and Retail Buyers, Except Farm Products	1,240	0.13	4,990	0.20	530	0.03	1,180	0.08
13-2011	Accountants and Auditors	1,560	0.16	1,020	0.04	40	0.00	150	0.01
15-0000	Computer and Mathematical Occupations	840	0.09	820	0.03	110	0.01	460	0.03
27-0000	Arts, Design, Entertainment, Sports, and Media Occupations	430	0.04	9,720	0.39	11,520	0.76	3,020	0.20
27-1023	Floral Designers	100	0.01	7,370	0.30				
27-1026	Merchandise Displayers and Window Trimmers	60	0.01	1,730	0.07	10,800	0.71	1,630	0.11
29-0000	Healthcare Practitioners and Technical Occupations	332,430	33.73	45,360	1.83	36,340	2.39	41,170	2.71

Table 23. Employment by Occupation for Drug Stores, Supermarkets, and Department Stores, 2010 (cont.)

Code	Occupation	Drug Stores		Supermarkets		Department Stores ¹		Other General Merchandise Stores ²	
		Employment	As Percent of Total	Employment	As Percent of Total	Employment	As Percent of Total	Employment	As Percent of Total
29-1051	Pharmacists**	117,850	11.96	22,520	0.91	17,620	1.16	14,010	0.92
29-1111	Registered Nurses	1,510	0.15						
29-2052	Pharmacy Technicians	181,200	7.32	22,680	0.92	17,300	1.14	23,130	1.52
31-0000	Healthcare Support Occupations	35,100	3.56	7,690	0.31				
31-9095	Pharmacy Aides	33,470	3.40	7,670	0.31				
33-0000	Protective Service Occupations	400	0.04	5,050	0.20	28,110	1.85	12,820	0.84
33-9032	Security Guards	350	0.04	4,670	0.19	19,540	1.29	2,700	0.18
35-0000	Food Preparation and Serving Related Occupations	4,190	0.43	291,660	11.38	24,330	1.60	23,350	1.54
37-0000	Building and Grounds Cleaning and Maintenance Occupations	2,230	0.23	18,970	0.77				
39-0000	Personal Care and Service Occupations	6,640	0.67	1,100	0.04				
39-5012	Hairdressers, Hairstylists, and Cosmetologists	5,180	0.53	150	0.01	17,410	1.15		
41-0000	Sales and Related Occupations	419,000	42.52	1,051,210	42.46	797,370	52.51	856,500	56.35
41-1011	First-Line Supervisors/Managers of Retail Sales Workers			130,260	5.26	88,600	5.83	143,390	9.43
41-2011	Cashiers	194,640	19.75	838,260	33.86	219,360	14.45	342,770	22.55
41-2021	Counter and Rental Clerks	690	0.07	8,890	0.36	2,450	0.16	820	0.05
41-2031	Retail Salespersons	129,670	13.16	62,860	2.54	477,510	31.45	352,270	23.18
41-9011	Demonstrators and Product Promoters	2,790	0.28	3,430	0.14	670	0.04	7,920	0.52
43-0000	Office and Administrative Support Occupations	112,030	11.37	597,010	24.12	448,520	29.54	342,730	22.55
45-0000	Farming, Fishing, and Forestry Occupations			1,280	0.05				
49-0000	Installation, Maintenance, and Repair Occupations	3,430	0.35	4,420	0.18				
51-0000	Production Occupations	21,510	2.18	184,270	7.44	17,980	1.18	50,000	3.29
51-3011	Bakers			40,160	1.62	1,860	0.12	11,760	0.77
51-3021	Butchers and Meat Cutters			89,550	3.62			6,000	0.39
51-9132	Photographic Processing Machine Operators	9,930	1.01						
53-0000	Transportation and Material Moving Occupations	27,070	2.75	220,000	8.89	65,160	4.29		
53-3032	Truck Drivers, Heavy and Tractor-Trailer	110	0.01	850	0.03				
53-3033	Truck Drivers, Light Or Delivery Services	16,000	1.62	2,480	0.10	180	0.01		
53-7062	Laborers and Freight, Stock, and Material Movers, Hand	2,180	0.22	42,810	1.73				
53-7064	Packers and Packers, Hand	4,330	0.44	165,270	6.68				

¹ Includes mass merchants described as discount department stores.
² Includes mass merchants described as warehouse clubs and supercenters.
 These occupations are representative of those employed in the industries. Subcategories may not total because not all subcategories are shown.
 Source: Occupational Employment Survey, Bureau of Labor Statistics, May 2010.

Non-Prescription Sales

Many stores have substantial non-prescription sales. These consist of various types of merchandise for each type of store, comprising a different percentage of sales in each. This section details dollar amounts and percentages of front-end sales by category. Additional information is available about the specific merchandise mix of traditional chain drug stores. This information is based on line-of-business census data, which collects specific information on sales by category for traditional drug stores.

Figure 6 shows the 2010 traditional chain drug store merchandise mix (by dollar sales). Prescription drugs continue to be the most important category, accounting for about 64% of sales. This percentage has dropped slightly for the past few years, due to increased use of generic drugs and discount generic programs. Many other categories contribute substantially to total sales in traditional chain drug stores. In particular, food sales have shown strong growth for the past few years.

Figure 6. 2010 Traditional Chain Drug Store Merchandise Mix

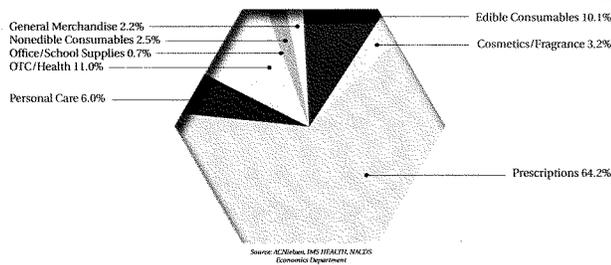


Table 24 provides information on total sales, front-end sales, and health and beauty aid (HBA) sales by type of pharmacy. HBA sales tend to be associated with pharmacy sales; stores with pharmacies have higher HBA sales than stores without.

Table 24. Total Sales, Front-End Sales, and HBA Sales, by Category of Store, 2010 (in millions)

	Total Sales	Pharmacy Sales	Front-End Sales	HBA Sales*
Drug Stores (NAICS 44611)	\$222,266	\$151,279	\$70,987	\$10,353
Traditional Chain Drug Stores	\$166,033	\$106,582	\$59,450	
Independent Drug Stores	\$56,233	\$44,696	\$11,537	
Grocery Stores (NAICS 4451)	\$521,721	\$25,944	\$495,777	\$8,381
Supermarkets with Pharmacy	\$254,873	\$25,944	\$228,929	\$4,983
Discount Department Stores (NAICS 452112), and Warehouse Clubs and Superstores (NAICS 45291)	\$494,288	\$26,553	\$467,735	\$18,637
Mass Merchants with Pharmacy	\$429,850	\$26,553	\$403,297	\$16,814

* HBA (health and beauty aids) is part of total front-end sales. Excludes OTC products.
 *Source: U.S. Department of Commerce, IMS HEALTH, ACNielsen, and NACDS Economics Department.

Many prescription products have been authorized for sale as over the counter (OTC) medications. The switch from prescription to OTC typically shifts purchases from third-party payers to consumers, and returns pricing power to the retailer. A substantial number of products have switched since 1995 and are listed in Table 25.

Table 25. Rx to OTC Switch Products, 1995-2010

Ingredient	Adult Dosage	Product Category	Date of OTC Approval	Product Examples
famotidine (NDA)	10 mg, up to 20 mg/day	acid reducer	4/28/1995	Pepcid AC (B&I/Merck)
ibuprofen suspension 100mg/5ml for pediatric use (NDA)	7.5 mg/kg up to 4 times a day	internal analgesic/antipyretic	6/16/1995	Children's Motrin (McNeil Consumer)
cimetidine (NDA)	200 mg up to twice per day	acid reducer	6/19/1995	Tagamet HB (SmithKline)
ketoprofen (NDA)	12.5 mg every 4 to 6 hours	internal analgesic	10/16/1995	Orudis KT (Whitehall-Robins), Actron (Bayer)
ranitidine (NDA)	75 mg up to twice per day	acid reducer	12/19/1995	Zantac 75 (Warner Wellcome)
butoconazole nitrate (NDA)	2.0% cream and applicators (3 days)	antifungal	12/26/1995	Femstat 3 (Procter & Gamble)
minoxidil (NDA)	2.0% topical solution	hair grower	2/9/1996	Rogaine (Pharmacia & Upjohn)
nicotine polacriflex (NDA)	2 mg and 4 mg gum	smoking cessation	2/9/1996	Nicorette (SmithKline Beecham)
nizatidine (NDA)	75 mg up to twice daily	acid reducer	5/9/1996	AXID AR (Whitehall-Robins Healthcare)
micronazole nitrate (NDA)	2.0% cream and 200-mg inserts	antifungal	4/16/1996	Monistat 3 (Ortho)
nicotine transdermal system (NDA)	15 mg, patch	smoking cessation	7/3/1996	Nicotrol (McNeil Consumer)
clotrimazole (NDA)*	1% cream & 200 mg inserts	antifungal	7/29/1996	Gyne-Lotrimin 3 (Schering-Plough)
nicotine transdermal system (NDA)	21, 14, & 7 mg patch	smoking cessation	8/2/1996	Nicoderm CQ (SmithKline Beecham), Habitrol (Novartis) (Nov. 12, 1999)
bentoquatam (NDA)*	5% lotion	poison ivy protection	8/28/1996	Ivy Block (EnviroDerm)
chromolyn sodium (NDA)	4% nasal solution	allergy prevention & treatment	1/6/1997	Nasalacrom (McNeil Consumer)
tioconazole (NDA)	6.5% vaginal ointment	antifungal	2/11/1997	Vagista-1 (Bristol-Myers Squibb), Monistat 1 (McNeil)
loperamide/simethicone (NDA)*	2 mg loperamide, 125 mg simethicone	antidiarrheal/antigas	6/26/1997	Imodium Advanced (McNeil Consumer)
triclosan (dentifrice) (NDA)*	0.30% triclosan/0.243% fluoride	antigingivitis	7/11/1997	Total (Colgate-Palmolive)
ketoconazole (NDA)	1% shampoo	dandruff shampoo	10/10/1997	Nizoral (Johnson & Johnson Consumer Products)
minoxidil (NDA)*	5.0% topical solution	hair grower	11/17/1997	Rogaine Extra Strength for Men (Pharmacia & Upjohn)
aspirin /caffeine / acetaminophen(NDA)**	250 mg/65 mg/250 mg	migraine	1/14/1998	Excedrin Migraine (Bristol-Myers Squibb)
micronazole nitrate (NDA)*	4.0% cream	antifungal	3/30/1998	Monistat 3 (Advanced Care Products)
terbinafine hydrochloride (NDA)	1.0% cream	antifungal	3/9/1999	Lamisil AT (Novartis)
cimetidine suspension (NDA)*	Suspension	acid reducer	7/9/1999	Tagamet HB 200 (SmithKline Beecham)
naproxen Na, pseudoephedrine HCl (NDA)*	220 mg naproxen Na, 120 mg pseudoephedrine HCl	analgesic/decongestant	11/29/1999	Aleve Cold & Sinus (Bayer Consumer Care)
ibuprofen (NDA)**	200 mg	migraine	2/25/2000	Motrin Migraine Pain (McNeil Consumer Healthcare)
ibuprofen (NDA)**	200 mg	migraine	3/16/2000	Advil Migraine Liqui-Gels (Whitehall-Robins)
docosanol (NDA)*	10% cream	cold sore/fever blister	7/25/2000	Abreva Cream (Avarir Pharmaceuticals)
famotidine, calcium carbonate, magnesium hydroxide (NDA)*	10 mg famotidine, 800 mg calcium carbonate, 165 mg magnesium hydroxide	heartburn, acid indigestion	10/17/2000	Pepcid Complete (B&I/Merck)

Table 25. Rx to OTC Switch Products, 1995-2010 (cont.)

Ingredient	Adult Dosage	Product Category	Date of OTC Approval	Product Examples
butsafine hydrochloride (NDA)	1.0% cream	athlete's foot, jock itch, ringworm	12/7/2001	Lotrimin Ultra (Schering-Plough)
ibuprofen, pseudoephedrine HCl, suspension for pediatric use (NDA)*	100 mg ibuprofen, 15 mg pseudoephedrine HCl/5 mL; 5 or 10 mL up to 4 times a day	analgesic/decongestant	4/18/2002	Children's Advil Cold (Wyeth)
guaifenesin extended-release tablet (NDA)	600 or 1200 mg once or twice a day	expectorant	7/12/2002	Mucinex (Adams Respiratory Therapeutics)
nicotine polacrifex troche/lozenge (NDA)*	2 mg and 4 mg	smoking cessation	10/31/2002	Commit (GlaxoSmithKline)
loratadine (NDA)	10 mg/day	antihistamine	11/27/2002	Claritin Tablets, Claritin Bedi Tabs, Claritin Syrup (Schering-Plough)
loratadine, pseudoephedrine sulfate (NDA)	10 mg loratadine, 240 mg pseudoephedrine sulfate daily	antihistamine/decongestant	11/27/2002	Claritin-D 12 Hour Extended Release Tablets, Claritin-D 24 Hour Extended Release Tablets (Schering-Plough)
omeprazole magnesium	20 mg/day	acid reducer to treat frequent heartburn	6/20/2003	Prilosec OTC (Procter & Gamble)
loratadine (NDA)**	10 mg/day	hives relief	11/15/2003	Claritin hives relief (Schering-Plough)
diphenhydramine citrate & ibuprofen (NDA)*; diphenhydramine HCl & ibuprofen potassium (NDA)*	400 mg ibuprofen and 78 mg diphenhydramine citrate or 30 mg diphenhydramine HCl at bedtime	analgesic/sleep-aid	12/23/2005	Advil PM (Wyeth)
ecamsule (combined with avobenzone and octocrylene (NDA)*)	2% ecamsule; 2% avobenzone; 10% octocrylene	sunscreen	7/21/2006	Anthelios SX (L'Oréal)
levonorgestrel (NDA)	Two 0.75-mg tablets, with the second one taken 12 hours after the first	contraceptive	8/24/2006	Plan B (Duramed)
polyethylene glycol 3350 (NDA)	17 g (teaspoonful) of powder per day in 8 oz of water	laxative	10/6/2006	MiraLAX (Schering-Plough)
ketotifen (NDA)	0.025% ophthalmic solution	antihistamine eye drops	10/19/2006	Zaditor (Novartis)
orlistat (NDA)	60 mg, 180 mg daily max.	weight loss aid	2/7/2007	Alli (GlaxoSmithKline)
cetirizine HCl & pseudoephedrine HCl (NDA)	5 mg cetirizine and 120 mg pseudoephedrine	antihistamine/decongestant	11/9/2007	Zyrtec-D (McNeil)
cetirizine HCl (NDA)	1 mg/mL (children's syrup), 5 mg and 10 mg (tablets and chewable tablets)	antihistamine, hives relief	11/16/2007	Zyrtec (McNeil)
lansoprazole (NDA)	15 mg/day	acid reducer to treat frequent heartburn	5/18/2009	Prevacid 24 HR (Novartis)
levonorgestrel (NDA)	1.5 mg	contraceptive	7/10/2009	Plan B One Step (Duramed)
omeprazole and sodium bicarbonate (NDA)	20 mg omeprazole and 20 mg sodium bicarbonate	acid reducer to treat frequent heartburn	12/11/2009	Zegerid OTC (Schering-Plough)
ibuprofen and phenylephrine HCl (NDA)	200 mg ibuprofen and 10 mg phenylephrine HCl	analgesic/decongestant	5/27/2010	Advil Congestion Relief (Pfizer)
fexofenadine hydrochloride (NDA)	30 mg, 60 mg, 180 mg, 30 mg/5 mL	antihistamine	1/24/2011	Allegra (Chatterm)
fexofenadine hydrochloride and pseudoephedrine HCl (NDA)	60 mg, 120 mg	antihistamine/decongestant	1/24/2011	Allegra D 12-Hour (Chatterm)
fexofenadine hydrochloride and pseudoephedrine HCl (NDA)	180 mg, 240 mg	antihistamine/decongestant	1/24/2011	Allegra D 24-Hour (Chatterm)

* FDA approval for OTC marketing is on an interim basis pending adoption of a Final Monograph.

** New OTC NDA - Not previously Rx

*** New OTC indication, product previously OTC
Source: Consumer Healthcare Products Association, www.chpa-indy.org

Front-end sales differ markedly by type of store. All types of chain pharmacies carry health and beauty aids and OTC medicines, but the top categories are different by type of store. These differences are illustrated in Table 26. As always, the subcategories with the highest growth rate tend to have low dollar volume with plenty of room for growth.

Table 26. Top HBA/OTC Categories, by Type of Store, 2010

Traditional Drugstore		Supermarket		Mass Merchant	
Category	Sales (millions)	Category	Sales (millions)	Category	Sales (millions)
1 Cold remedies - adult	\$1,426	Nutritional supplements	\$1,084	Shampoo-aerosol/liquid/ lotion/ powder	\$976
2 Nutritional supplements	\$1,323	Pain remedies - headache	\$801	Tooth cleaners	\$889
3 Pain remedies - headache	\$968	Cold remedies - adult	\$723	Face cleansers & creams & lotions	\$847
4 Face cleansers & creams & lotions	\$689	Tooth cleaners	\$641	Deodorant-stick/ solid	\$837
5 Antacids	\$645	Shampoo-aerosol/liquid/ lotion/ powder	\$606	Cold remedies - adult	\$788
6 Laxatives	\$495	Antacids	\$483	Pain remedies - headache	\$786
7 Hair coloring - women's	\$459	Deodorant-stick/ solid	\$403	Nutritional supplements	\$762
8 Cough syrups & tablets	\$417	Sanitary napkins	\$393	Hair coloring - women's	\$664
9 Shampoo-aerosol/liquid/ lotion/ powder	\$407	Complete nutritional products	\$352	Baby accessory	\$657
10 Hand & body lotions	\$390	Oral rinse and antiseptic	\$323	Crepe rinses & conditioners	\$646

Source: ACNielsen Strategic Planner Data 2010 and NACDS Economics Department

For each type of store, we are able to assess growth by department. Tables 27 through 29 show growth by department. For traditional drug stores, the top growth departments are all traditional grocery departments.

Table 27. Growth by Department for Traditional Drug Stores, 2010

	Dollar Sales (000)	Growth Rate
Fresh Produce	\$7,721	89.6%
Fresh Meat	\$1,651	23.0%
Packaged Meat	\$38,497	7.9%
Delicatessen	\$49,005	4.8%
Non-Food Grocery	\$7,436,591	3.7%
Frozen Foods	\$425,003	3.4%
Alcoholic Beverages	\$2,493,635	3.0%
Dairy	\$573,337	2.0%
Health and Beauty Aids	\$21,908,385	1.1%
Dry Grocery	\$7,950,750	0.8%
General Merchandise	\$3,101,305	-9.8%

Source: ACNielsen Strategic Planner Data, 2010

Table 28. Growth by Department for Supermarkets, 2010

	Dollar Sales (000)	Growth Rate
Fresh Meat	\$1,830,461	5.0%
Fresh Produce	\$14,521,375	3.8%
Alcoholic Beverages	\$17,882,955	3.1%
Delicatessen	\$5,871,525	2.9%
Packaged Meat	\$10,645,401	2.2%
Dairy	\$38,846,559	0.4%
Dry Grocery	\$132,873,158	0.0%
Health and Beauty Aids	\$13,840,073	-0.1%
Frozen Foods	\$29,962,535	-0.4%
General Merchandise	\$5,738,869	-2.4%
Non-Food Grocery	\$26,300,167	-2.8%

Source: ACNielsen Strategic Planner Data, 2010

Table 29. Growth by Department for Mass Merchants and Superstores, 2010

	Dollar Sales (000)	Growth Rate
Dairy	\$10,617,297	6.9%
Alcoholic Beverages	\$2,618,386	5.7%
Fresh Produce	\$2,870,955	3.5%
Packaged Meat	\$3,658,546	2.6%
Frozen Foods	\$9,913,424	-1.3%
Dry Grocery	\$55,240,316	-1.5%
Health and Beauty Aids	\$26,972,327	-2.2%
Delicatessen	\$1,852,359	-6.1%
Non-Food Grocery	\$24,998,307	-7.2%
General Merchandise	\$25,615,881	-7.9%
Fresh Meat	\$1,383,373	-9.0%

Source: ACNielsen Strategic Planner Data, 2010

When we look deeper at the subcategory level, there appears to be a trend toward increasing consumption of fruit and fruit juices. Irish and Canadian whiskey have continued their growth from last year.

Shopping trips per month continue to decline overall. Grocery continues to lead in trips per month, followed by supercenters and mass merchants.

The front end will continue to be a vital part of community retail pharmacy, providing an adjunct avenue in which to impact the lives of customers. Community pharmacy front-end products can contribute to a healthy lifestyle as well as make customers' lives more convenient.

Table 30. Top Growth Subcategories for Traditional Drug Stores, 2010

Rank		Dollar Sales (000)	Growth Rate	Rank		Dollar Sales (000)	Growth Rate
1	Printers	\$1,498	6129.4%	16	Canned Green Beans	\$1,724	35.7%
2	Delicatessen Fruit/ Fruit Salad	\$1,214	204.2%	17	Frozen Hors D'Oeuvres/Snacks	\$6,685	34.1%
3	Canned Fruit Cocktail	\$1,846	104.8%	18	Canned Seafood	\$2,647	32.8%
4	Refrigerated Spreads	\$1,420	94.1%	19	Liquid Salad Dressings	\$4,079	32.7%
5	Frozen Breakfasts	\$6,141	91.4%	20	Fresh Rolls	\$1,502	32.1%
6	Baking Mixes	\$1,626	90.5%	21	Dry Mexican Foods	\$2,180	31.7%
7	Fresh Produce	\$7,721	89.6%	22	Canned Corn	\$1,926	31.5%
8	Dessert Mixes	\$1,015	86.6%	23	All Purpose Flour	\$2,420	30.7%
9	Processed Cheese	\$1,800	68.8%	24	Irish Whiskey	\$6,330	30.5%
10	Unshelled Nuts	\$2,397	64.9%	25	Honey	\$10,116	29.3%
11	Pancake Mixes	\$1,143	52.9%	26	Dehydrated Potatoes	\$1,351	27.7%
12	Canned Fruit	\$1,450	51.3%	27	Rice Cakes	\$1,941	26.4%
13	Canned Peaches	\$3,657	46.1%	28	Flavored/ Refreshment Wine	\$18,748	26.2%
14	Oriental Frozen Entrees	\$6,370	38.7%	29	Dog & Cat Treats	\$55,348	25.9%
15	Oral Hygiene Travel Packs	\$4,665	36.0%	30	Detergents	\$1,577	24.8%

Source: ACNielsen Strategic Planner Data, 2010

Table 31. Top Growth Subcategories for Supermarkets, 2010

Rank		Dollar Sales (000)	Growth Rate	Rank		Dollar Sales (000)	Growth Rate
1	Refrigerated Grape Juice	\$2,794	105.1%	16	Nail Care Cosmetics	\$63,292	11.0%
2	Breath Fresheners	\$1,441	32.3%	17	Dry Mixes	\$70,167	10.8%
3	Refrigerated Spreads	\$399,349	25.6%	18	Kitchen Appliances	\$178,758	10.7%
4	Cosmetics	\$37,732	21.4%	19	Delicatessen Fruit/ Fruit Salad	\$524,986	10.5%
5	Telephone and Accessories	\$29,126	21.3%	20	Whole Nuts	\$960,907	10.4%
6	Irish Whiskey	\$26,359	19.2%	21	Frozen Fish	\$820,997	10.4%
7	Computer Discs	\$12,963	16.8%	22	Nutritional Supplements	\$1,197,299	10.4%
8	Vitamins	\$171,353	15.0%	23	Dates	\$34,522	9.9%
9	Strained Baby Food	\$396,176	14.4%	24	Powdered Sugar	\$86,193	9.5%
10	Ale and Stout	\$767,373	13.0%	25	Remaining Snacks	\$2,688,696	9.1%
11	Shelf Stable Vegetable Juices	\$611,744	12.5%	26	Oriental Frozen Entrees	\$588,924	9.0%
12	Frozen Breaded Vegetables	\$321,081	12.2%	27	Canned Onions	\$105,756	8.8%
13	Laundry Supplies	\$156,496	12.0%	28	Refrigerated Eggnog	\$626,339	8.7%
14	Fresh Rolls	\$1,075,627	11.9%	29	Non Alcoholic Wine	\$93,640	8.7%
15	Flavored/ Refreshment Wine	\$212,067	11.1%	30	Dietetic Candy	\$83,762	8.6%

Source: ACNielsen Strategic Planner Data, 2010

Table 32. Top Growth Subcategories for Mass Merchants and Superstores, 2010

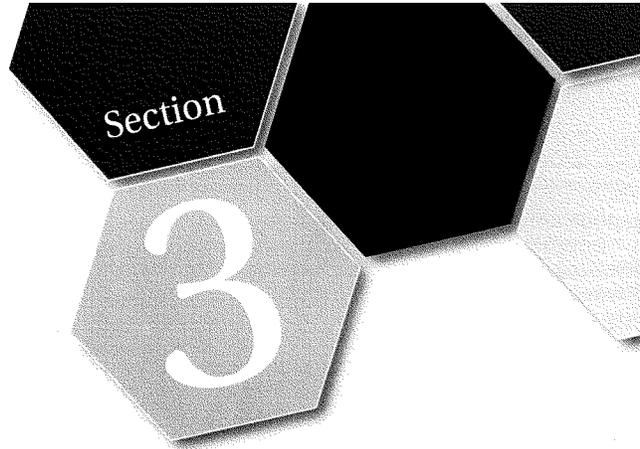
Rank		Dollar Sales (000)	Growth Rate	Rank		Dollar Sales (000)	Growth Rate
1	Remaining Liquor	\$8,438	83.8%	16	Fresh Rolls	\$308,604	28.8%
2	Frozen Fruit Drinks and Mixes	\$56,959	81.4%	17	Refrigerated Grapefruit Juice	\$12,081	27.8%
3	Refrigerated Spreads	\$52,414	80.0%	18	Deli Sauerkraut	\$4,628	27.6%
4	Irish Whiskey	\$1,985	69.0%	19	Cocktails	\$9,287	27.5%
5	Refrigerated Grape Juice	\$4,233	59.3%	20	Oral Care Treatment Combinations and Programs	\$20,895	26.1%
6	Shelf Stable Meal Starters	\$21,374	52.9%	21	Desserts/Syrups	\$3,631	25.9%
7	Bourbon	\$19,138	52.8%	22	Nuts in Jars	\$83,511	25.9%
8	Dessert Wine	\$1,767	48.8%	23	Men's Gift Sets & Travel Kits	\$122,434	24.9%
9	Shelf Stable Cider	\$12,740	46.1%	24	Pre-Shave Cosmetics	\$8,603	24.7%
10	Freezing Supplies	\$34,322	44.5%	25	Frozen Carrots	\$4,145	24.7%
11	Butter	\$366,725	36.1%	26	Canned Sardines	\$18,715	23.9%
12	Canadian Whiskey	\$12,407	32.5%	27	Frozen Breaded Vegetables	\$127,339	23.5%
13	Non Carbonated Soft Drinks	\$145,376	32.2%	28	Prunes	\$17,678	23.1%
14	Rum	\$25,406	30.3%	29	Dry Mixes	\$6,187	21.9%
15	Ale/Stout	\$36,068	29.3%	30	Wine	\$4,883	21.3%

Source: ACNielsen Strategic Planner Data, 2010

Table 33. Average Shopping Trips per Month and Dollars per Trip by Type of Store, 2010

	Trips	% Change vs. 2009	Dollars per Trip	% Change vs. 2009
Grocery	4.75	-3.1%	\$41.91	1.1%
Supercenter	2.10	-4.1%	\$63.25	-0.7%
Mass	1.08	-5.3%	\$48.21	0.1%
Drug	1.16	0.9%	\$24.50	2.3%
Dollar	1.05	-0.9%	\$14.51	3.0%
Club	0.96	1.1%	\$97.74	-0.5%

Source: ACNielsen



The Pharmacy

Americans Trust Community Pharmacists

Table 34 illustrates that pharmacists are widely considered one of the most trusted healthcare resources available. These figures reflect a 2010 Gallup poll on professional honesty and ethics in which pharmacists ranked second – behind nurses – as the most trusted professionals. Pharmacists have ranked in the top three in each of the past eight years. The Gallup survey measures perceptions across diverse professions – including but not limited to those in healthcare.

Pharmacist Employment Figures

All states and the District of Columbia require a license to practice pharmacy. Estimates of the current number of pharmacists vary. Pharmacists may be licensed and practice in multiple states, and therefore, the number of pharmacist licenses overestimates the actual number of pharmacists.

The Bureau of the Census estimates that there were 171,164 total pharmacist jobs in retail pharmacy – both chain and independent pharmacies – in 2010.

Table 34. Honesty and Ethical Ratings of People in Different Professions, 2010 Gallup Poll

	% Very high/High	% Average	% Low/very low
Nurses	81	16	1
Military officers	73	23	3
Druggists or pharmacists	71	25	4
Grade school teachers	67	24	6
Medical doctors	66	28	5
Police officers	57	33	10
Clergy	53	35	8
Day care providers	47	41	7
Judges	47	37	14
Auto mechanics	28	55	16
Nursing home operators	26	48	24
Banks	23	48	28
TV reporters	23	47	29
Newspaper reporters	22	49	27
Local officeholders	20	55	24
Lawyers	17	47	35
Business executives	15	52	32
State officeholders	12	49	37
Advertising practitioners	11	48	37
Members of Congress	9	32	57
Car salespeople	7	42	49
Lobbyists	7	29	61

Source: Gallup Poll, Honesty/Ethics in Professions, <http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx>

Using data from the Bureau of Labor Statistics' Occupational Employment Survey and the Current Population Survey (CPS), we projected the number of pharmacists currently employed in each state using total employment in the drug store industry and a pharmacist-to-total employment ratio. We assume that nearly all employee pharmacists work in chain companies, and that all or nearly all self-employed (proprietors) pharmacists work in independent pharmacies.

The National Association of Boards of Pharmacy (NABP) reports pharmacists licensed by states, pharmacists with in-state licenses, and occasionally the number of pharmacists employed in community pharmacy. We have included the number of licensed pharmacists by state for comparison purposes.

Table 35 shows the estimated number of licensed pharmacists overall, by state, as well as the estimated number of licensed pharmacists working in chain drug stores and independent drug stores, by state. California, Texas, Florida, New York, and Pennsylvania have the largest number of licensed pharmacists working in community retail pharmacy. These states also have the highest number of pharmacists working in chain pharmacies, with the substitution of Ohio in 5th place. New York has the largest number of licensed pharmacists working in independent drug stores, followed by California.

Alaska is the state with the smallest number of licensed pharmacists working in community retail pharmacy overall. Alaska also has the fewest pharmacists working in chain pharmacies, while Delaware has the fewest pharmacists working in independent drug stores.

Table 35. Licensed Pharmacists and Pharmacist Jobs, by State, 2010

State	2010 Estimated Licensed	Chain Community Pharmacy Pharmacist Jobs	Independent Drug Store Jobs	2010 Estimated Pharmacist Jobs in Community Pharmacy
Alabama	6,823	2,197	776	2,973
Alaska	847	217	56	273
Arizona	9,075	2,825	161	2,986
Arkansas	4,510	1,255	539	1,794
California	38,440	11,357	3,564	14,921
Colorado	6,435	2,494	282	2,776
Connecticut	5,183	1,624	208	1,832
DC	1,624	368	44	412
Delaware	1,660	340	12	352
Florida	27,565	9,218	1,609	10,827
Georgia	13,363	4,195	863	5,058
Hawaii	2,066	425	152	577
Idaho	1,937	660	164	824
Illinois	16,237	5,283	896	6,179
Indiana	9,482	4,085	352	4,437
Iowa	5,669	1,517	429	1,946
Kansas	4,333	1,390	531	1,921
Kentucky	6,996	2,004	702	2,706
Louisiana	6,958	1,946	716	2,662
Maine	1,546	688	79	767
Maryland	8,643	3,086	255	3,341
Massachusetts	11,223	3,265	297	3,562
Michigan	13,274	4,679	1,114	5,793
Minnesota	7,356	3,035	552	3,587
Mississippi	4,134	1,072	405	1,477
Missouri	8,303	2,828	784	3,612
Montana	1,801	423	198	621
Nebraska	3,622	977	392	1,369
Nevada	8,396	1,249	101	1,350
New Hampshire	2,343	1,106	89	1,195
New Jersey	14,354	4,374	950	5,324
New Mexico	2,338	770	155	925
New York	21,859	7,722	2,836	10,560
North Carolina	12,526	4,422	782	5,204
North Dakota	2,209	239	287	526
Ohio	16,911	6,222	915	7,137
Oklahoma	5,452	1,432	609	2,041
Oregon	5,122	1,989	299	2,288
Pennsylvania	21,015	6,034	1,229	7,263
Rhode Island	1,995	590	44	634
South Carolina	N/A	2,391	544	2,935
South Dakota	1,712	418	184	602
Tennessee	8,972	3,393	771	4,164
Texas	25,891	10,338	2,542	12,880
Utah	2,712	1,155	379	1,534
Vermont	949	266	57	323
Virginia	10,937	4,651	274	4,925
Washington	8,609	3,085	490	3,575
West Virginia	3,185	1,050	224	1,274
Wisconsin	5,376	2,724	552	3,276
Wyoming	1,086	243	68	311
Guam	66	2	30	32
Puerto Rico	5,340	369	969	1,338
Total	418,460	139,687	31,514	171,201

Source: Occupational Employment Survey, May 2010 and NACDS Economics Department

Table 36. Employment of Pharmacists by Practice Setting, Mean and Median Hourly Wage, 2010

Industry	Total Employment	Percent of Pharmacists	Mean Hourly Wage	Median Hourly Wage
Professional and Commercial Equipment and Supplies Merchant Wholesalers	220	0.1%	\$50.93	\$52.09
Drugs and Druggists' Sundries Merchant Wholesalers	3,040	1.1%	\$51.07	\$51.70
Wholesale Electronic Markets and Agents and Brokers	530	0.2%	\$53.73	\$53.43
Grocery Stores	22,520	8.4%	\$51.70	\$54.46
Health and Personal Care Stores	117,850	44.2%	\$53.37	\$53.75
Department Stores	17,620	6.6%	\$51.32	\$54.22
Other General Merchandise Stores	14,010	5.3%	\$54.26	\$56.03
Electronic Shopping and Mail-Order Houses	2,950	1.1%	\$49.85	\$50.71
Management, Scientific, and Technical Consulting Services	370	0.1%	\$58.19	\$52.76
Management of Companies and Enterprises	2,510	0.9%	\$52.93	\$54.76
Colleges, Universities, and Professional Schools	1,470	0.6%	\$48.44	\$50.23
Offices of Physicians	2,620	1.0%	\$54.54	\$53.51
Outpatient Care Centers	2,450	0.9%	\$53.99	\$55.55
Home Health Care Services	1,410	0.5%	\$51.22	\$51.38
General Medical and Surgical Hospitals	58,680	22.0%	\$52.13	\$53.25
Psychiatric and Substance Abuse Hospitals	1,070	0.4%	\$47.53	\$48.21
Specialty (except Psychiatric and Substance Abuse) Hospitals	2,310	0.9%	\$52.06	\$52.67
Nursing Care Facilities	430	0.2%	\$51.57	\$51.15
Community Care Facilities for the Elderly	80	0.0%	\$45.08	\$48.45
Federal Executive Branch (OES Designation)	7,050	2.6%	\$49.89	\$52.37
State Government (OES designation)	1,370	0.5%	\$46.78	\$46.43
Local Government (OES designation)	1,070	0.4%	\$50.41	\$52.01
Other Practice Settings	4,880	1.8%	**	**
Total	266,510			
In Community Retail Pharmacy	172,000	64.5%		

Source: Occupational Employment Survey, May 2010

**Unknown.

Pharmacists Employment by Practice Setting

Using the occupational employment survey data from 2010, Table 36 was developed to show the numbers of pharmacists working in different practice settings. This table shows total employment figures and the percentage of employed pharmacists in different practice settings, along with the median and mean hourly wage at each setting. Wages do not include overtime, holiday pay, severance, or other special categories such as merchandise discounts. In retail settings, the median wage is highest at grocery stores, followed by mass merchants and traditional chain drug stores. To some extent, this ranking may depend on the geographical distribution of the stores.

Retail Pharmacy Sales and Prescriptions

While front-end sales constitute a significant portion of sales for traditional chain drug stores, the pharmacy remains the core part of their business. Table 37 shows retail pharmacy sales and estimated prescriptions by type of store since 2000. Pharmacy sales for traditional chain drug stores remained strong in a recessionary economy, accounting for \$106.6 billion in total sales in 2010. Of the nearly 3.7 billion prescriptions dispensed in 2010, more than 2.6 billion – or nearly 73% – were dispensed by chain pharmacies of all types.

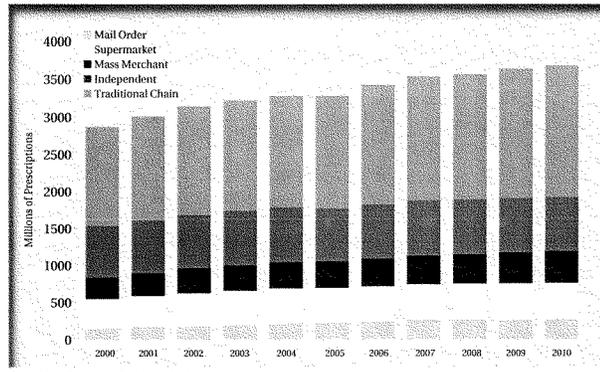
Figures 7 and 8 show the trends in both retail pharmacy sales and prescriptions by type of store, from 2000 through 2010.

Table 37. Pharmacy Sales and Prescriptions, by Type of Store, 2000-2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<i>Pharmacy Sales (millions)</i>											
Total	\$145,570	\$161,291	\$182,658	\$204,176	\$216,737	\$226,062	\$243,230	\$249,185	\$249,193	\$261,644	\$266,395
Drug Stores	\$92,537	\$101,525	\$113,723	\$127,799	\$130,902	\$136,135	\$142,658	\$145,811	\$144,488	\$148,880	\$151,279
Chain	\$59,102	\$65,299	\$75,735	\$86,557	\$86,721	\$90,706	\$95,978	\$100,548	\$101,172	\$105,260	\$106,582
Independent	\$33,434	\$36,226	\$37,988	\$41,242	\$44,181	\$45,429	\$46,680	\$45,263	\$43,316	\$43,620	\$44,696
Mass Merchant	\$13,542	\$15,192	\$15,593	\$16,111	\$16,751	\$17,497	\$21,627	\$23,596	\$24,160	\$25,622	\$26,553
Supermarket	\$17,362	\$19,818	\$23,111	\$25,221	\$26,397	\$26,887	\$28,063	\$27,291	\$25,172	\$25,857	\$25,944
Mail Order	\$22,129	\$24,756	\$30,232	\$35,045	\$42,687	\$45,543	\$50,882	\$52,487	\$55,373	\$61,284	\$62,619
<i>Prescriptions (millions)</i>											
Total	2,865	3,009	3,139	3,215	3,274	3,279	3,419	3,530	3,559	3,633	3,676
Drug Stores	2,033	2,118	2,181	2,219	2,238	2,232	2,337	2,405	2,416	2,461	2,489
Chain	1,335	1,408	1,462	1,480	1,494	1,513	1,599	1,652	1,677	1,731	1,760
Independent	698	710	719	740	744	719	738	753	739	730	729
Mass Merchant	293	311	339	345	353	359	375	390	400	423	433
Supermarket	394	418	444	462	470	465	476	478	481	488	490
Mail Order	146	161	174	189	214	223	232	257	262	261	264

Source: IMS HEALTH and NACDS Economics Department.

Figure 7. Prescriptions, by Type of Store, 2000-2010 (in millions)



Source: IMS HEALTH and NACDS Economics Department.

Figure 8. Retail Prescription Dollar Sales, by Type of Store, 2000-2010

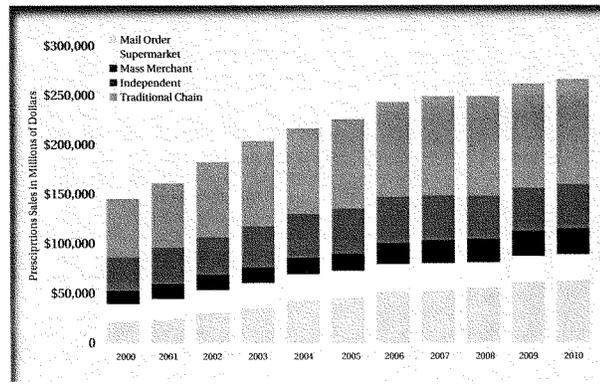


Table 38. Average Price per Prescription, by State and Source of Payment, 2010*

	Cash		Third Party		Medicaid		Overall					
	Dollars	Prescriptions	Average Price	Dollars	Prescriptions	Average Price	Dollars	Prescriptions	Average Price			
Alabama	\$350,226,665	9,821,258	\$35.66	\$4,699,889,880	65,117,956	\$72.18	\$483,092,158	7,578,700	\$63.74	\$533,308,743	82,518,144	\$67.05
Alaska	\$32,878,945	599,613	\$54.83	\$391,334,725	5,656,124	\$167.04	\$55,342,244	552,906	\$100.09	\$479,555,913	4,808,643	\$99.73
Arizona	\$440,185,075	7,975,429	\$55.19	\$5,092,277,736	58,692,769	\$86.89	\$38,687,678	440,141	\$87.90	\$5,571,150,489	67,018,321	\$83.13
Arkansas	\$289,244,665	7,203,064	\$33.21	\$2,448,907,205	33,852,277	\$72.34	\$301,031,234	4,081,831	\$73.75	\$2,989,183,094	45,137,172	\$66.22
California	\$1,843,852,426	30,839,679	\$59.79	\$72,132,987,000	274,693,390	\$86.60	\$1,891,587,625	20,360,309	\$92.91	\$25,868,427,052	325,803,278	\$79.40
Colorado	\$298,724,945	6,084,027	\$49.10	\$3,106,255,238	34,585,280	\$90.02	\$294,390,310	3,188,500	\$92.30	\$3,699,370,493	43,778,807	\$84.50
Connecticut	\$231,845,957	3,384,948	\$68.67	\$3,011,583,334	31,620,661	\$95.24	\$667,140,037	6,530,038	\$102.16	\$3,910,489,318	41,735,647	\$93.70
Delaware	\$58,686,624	954,390	\$61.48	\$862,023,477	7,647,806	\$112.71	\$189,044,111	1,820,183	\$104.11	\$1,194,754,211	10,422,629	\$106.00
District of Columbia	\$52,963,024	739,595	\$71.61	\$697,573,716	6,958,319	\$100.25	\$102,564,379	793,332	\$138.73	\$883,101,119	8,437,246	\$104.11
Florida	\$1,816,136,859	31,230,391	\$58.15	\$16,917,145,010	193,360,409	\$87.49	\$1,337,297,614	14,623,104	\$91.45	\$20,070,579,483	239,213,904	\$83.90
Georgia	\$655,213,911	16,498,569	\$39.64	\$7,570,302,212	102,522,309	\$73.94	\$408,799,702	5,946,814	\$70.98	\$8,626,313,852	125,127,692	\$68.94
Hawaii	\$34,440,680	721,262	\$47.73	\$903,352,659	11,588,646	\$80.22	\$38,765,338	424,609	\$91.99	\$973,120,678	12,414,217	\$78.29
Idaho	\$96,434,693	2,231,691	\$43.17	\$1,099,656,298	13,812,235	\$86.48	\$166,047,113	1,863,310	\$89.59	\$1,262,130,464	17,110,236	\$73.62
Illinois	\$893,398,125	15,327,235	\$58.42	\$10,251,383,428	108,781,156	\$94.24	\$1,477,602,046	20,493,169	\$78.49	\$12,822,574,599	144,660,699	\$87.29
Indiana	\$377,297,151	8,576,140	\$44.27	\$4,950,952,406	63,629,914	\$77.81	\$733,930,285	9,753,216	\$75.23	\$6,062,169,842	82,311,270	\$73.63
Iowa	\$219,590,442	4,786,882	\$45.87	\$2,399,389,889	23,163,379	\$77.60	\$400,105,276	5,652,941	\$70.78	\$3,019,085,207	42,693,202	\$70.87
Kansas	\$383,868,331	4,636,089	\$82.97	\$2,486,678,464	29,822,291	\$83.10	\$390,043,115	2,217,192	\$92.93	\$2,896,587,309	36,775,482	\$78.76
Kentucky	\$357,185,065	9,930,761	\$35.97	\$4,443,889,043	57,455,431	\$77.34	\$596,258,180	8,612,271	\$69.26	\$5,397,690,287	75,988,463	\$71.02
Louisiana	\$387,181,731	8,911,903	\$43.45	\$4,379,214,049	56,697,804	\$77.24	\$767,918,638	8,800,803	\$87.15	\$5,533,414,418	74,410,570	\$74.36
Maine	\$123,173,615	2,460,247	\$50.07	\$1,028,801,298	12,480,751	\$82.43	\$210,744,042	3,060,162	\$68.87	\$1,362,722,165	18,001,160	\$75.70
Maryland	\$281,659,784	5,249,729	\$55.56	\$4,823,111,556	50,557,329	\$96.40	\$397,213,243	2,548,880	\$116.61	\$5,411,984,584	58,355,838	\$92.74
Massachusetts	\$321,500,122	6,049,822	\$53.09	\$4,986,317,668	68,933,344	\$72.34	\$684,182,741	5,311,404	\$73.48	\$5,991,700,532	84,294,570	\$71.08
Michigan	\$614,507,513	12,653,375	\$48.56	\$6,281,259,313	106,859,193	\$82.11	\$664,641,237	6,908,802	\$102.11	\$8,560,498,063	120,021,370	\$70.96
Minnesota	\$334,448,871	3,271,989	\$102.44	\$4,829,275,503	47,351,092	\$101.99	\$359,618,060	3,831,759	\$93.80	\$5,223,143,434	56,454,836	\$92.83
Mississippi	\$223,407,138	6,733,323	\$33.18	\$2,569,374,457	35,282,969	\$73.12	\$296,968,096	4,398,662	\$67.95	\$3,031,649,691	46,414,954	\$65.32
Missouri	\$478,972,282	10,763,960	\$44.50	\$5,173,153,907	59,439,244	\$86.45	\$677,918,829	10,173,824	\$86.29	\$6,500,043,026	80,777,028	\$80.84
Montana	\$57,665,196	1,469,443	\$39.24	\$642,303,426	8,727,947	\$73.59	\$70,279,202	970,051	\$78.63	\$776,247,824	11,167,441	\$69.51
Nebraska	\$125,588,881	2,539,095	\$49.46	\$1,736,140,212	18,731,503	\$92.69	\$289,898,691	3,444,624	\$82.90	\$2,147,625,706	24,719,222	\$86.98
Nevada	\$151,426,763	3,141,190	\$48.21	\$1,878,279,985	23,325,290	\$80.53	\$107,347,511	1,008,290	\$106.58	\$2,172,254,079	27,535,760	\$77.82
New Hampshire	\$82,089,277	2,086,363	\$44.51	\$991,017,270	11,594,267	\$77.45	\$118,239,427	1,261,185	\$93.40	\$1,099,880,974	14,963,715	\$73.59
New Jersey	\$110,411,294	8,211,349	\$82.16	\$7,983,585,213	81,816,290	\$96.52	\$1,174,779,623	9,535,403	\$123.20	\$9,648,778,101	98,792,042	\$97.90
New Mexico	\$118,016,394	2,487,816	\$47.44	\$1,489,071,636	16,786,872	\$88.75	\$23,657,594	357,516	\$66.17	\$1,530,739,443	19,862,094	\$77.30
New York	\$936,227,959	16,312,153	\$57.40	\$16,396,967,222	172,886,250	\$94.84	\$3,326,233,779	46,572,964	\$94.17	\$22,664,458,960	245,766,369	\$92.20
North Carolina	\$562,351,367	14,215,161	\$41.67	\$7,773,202,780	99,917,717	\$77.80	\$1,015,044,544	11,995,429	\$84.67	\$9,301,158,612	126,128,307	\$74.38
North Dakota	\$38,899,898	919,344	\$42.27	\$557,898,532	7,585,917	\$73.54	\$69,994,779	724,608	\$70.38	\$647,753,209	9,229,869	\$70.18
Ohio	\$738,813,446	18,146,045	\$40.71	\$8,432,070,607	111,508,794	\$75.62	\$1,455,468,903	20,358,353	\$71.49	\$10,626,352,956	150,013,162	\$70.84
Oklahoma	\$310,798,580	7,476,123	\$41.57	\$2,936,601,215	33,306,275	\$88.17	\$370,312,094	4,667,876	\$79.33	\$3,617,711,803	45,450,274	\$79.60
Oregon	\$290,687,522	5,032,410	\$57.76	\$2,642,834,156	35,808,099	\$73.78	\$147,906,964	1,574,910	\$93.91	\$3,010,627,642	42,415,419	\$70.98
Pennsylvania	\$628,794,825	14,523,462	\$43.29	\$10,990,133,362	148,593,681	\$73.96	\$543,433,681	7,531,539	\$72.15	\$12,162,321,068	170,648,682	\$71.27
Puerto Rico	\$5,375,606	122,537	\$43.87	\$43,727,759	873,962	\$76.23	\$6,990,491	101,017	\$69.20	\$56,093,765	797,216	\$70.36
Rhode Island	\$63,336,320	1,272,181	\$49.73	\$994,369,673	14,827,448	\$67.06	\$47,260,842	545,681	\$86.50	\$1,094,996,835	16,645,310	\$65.78
South Carolina	\$284,882,653	7,227,911	\$39.41	\$3,743,322,632	51,589,697	\$72.68	\$243,867,342	3,294,119	\$74.03	\$4,278,072,027	52,111,727	\$68.88
South Dakota	\$51,248,007	1,270,634	\$40.39	\$586,880,133	6,039,001	\$73.01	\$75,618,941	995,764	\$75.94	\$711,825,081	10,306,389	\$69.27
Tennessee	\$574,704,381	13,769,758	\$41.74	\$7,139,497,162	85,024,930	\$83.97	\$752,508,090	9,737,645	\$77.28	\$8,466,619,633	108,532,333	\$78.01
Texas	\$1,960,999,435	39,811,015	\$49.82	\$18,103,664,735	204,834,477	\$88.38	\$2,368,475,770	27,077,585	\$88.58	\$22,485,707,856	271,723,077	\$82.75
Utah	\$180,099,435	3,720,420	\$48.41	\$1,894,493,262	22,064,954	\$86.31	\$153,765,813	1,886,515	\$81.51	\$2,249,398,511	27,671,869	\$80.89
Vermont	\$29,508,054	591,755	\$49.87	\$434,141,871	5,576,382	\$77.85	\$112,410,541	1,234,226	\$91.82	\$576,121,066	7,382,543	\$77.93
Virginia	\$416,029,569	9,629,939	\$43.20	\$6,055,897,944	78,962,233	\$76.69	\$288,360,970	3,079,320	\$77.41	\$6,719,203,483	91,671,492	\$79.20
Washington	\$353,415,740	7,312,995	\$48.33	\$4,531,916,796	55,240,775	\$80.29	\$482,265,129	6,265,094	\$76.97	\$5,867,597,665	68,888,174	\$78.52
West Virginia	\$115,044,286	3,328,471	\$34.58	\$1,756,750,456	25,318,942	\$69.41	\$388,702,368	5,124,746	\$75.86	\$2,240,467,069	33,793,259	\$66.30
Wisconsin	\$311,811,223	5,632,046	\$55.22	\$4,610,495,446	49,759,879	\$92.55	\$977,200,305	10,377,828	\$94.12	\$5,998,880,974	65,760,753	\$89.69
Wyoming	\$35,125,547	792,871	\$44.30	\$354,195,689	4,882,591	\$75.97	\$23,047,884	343,948	\$67.19	\$412,369,120	5,398,510	\$76.12
Overall	\$19,882,544,861	411,884,037	\$48.08	\$213,801,093,063	2,936,865,942	\$83.04	\$30,185,881,272	353,417,194	\$85.41	\$229,879,518,287	3,782,167,173	\$76.94

Source: Wilentz Klover Health Pharmaceutical Audit Suite, data accessed 6/22/11.
Local market conditions will determine average prices for prescriptions, the same as for any other product.



Average Prescription Prices

The average sales price per prescription continues to climb. Average prescription prices in 2010 by state and source of payment are listed in Table 38. The average overall price for a prescription in 2010 was \$79.43, up from \$75.21 in 2009.

Delaware had the highest average cash price at \$71.61, while Mississippi had the lowest at \$33.18. Delaware also had the highest average price for a prescription paid by a third-party program at \$112.71, while Rhode Island had the lowest at \$67.06. The overall average price paid by a third party was \$85.41 per prescription.

Prescription Drug Prices and Brand/Generic Mix

Generic drug utilization has increased in recent years, and will likely continue to do so due to the implementation of the Medicare Part D drug benefit and the loss of patent protection for some blockbuster drugs. This increase continues to slow the overall growth of prescription drug prices, but is counteracted by increasing demand driven by the aging of the population. Average prescription prices increased 5.6% in 2010. Table 39 shows the prices for brand-name drugs and generic drugs since 1990 as well as the mix of utilization. As the table illustrates, generic drugs accounted for over 70% of prescriptions in 2010 and have reached a share unimaginable just ten years ago.

Inflation

The rate of inflation in prescription drug prices at the manufacturer level increased to 4.3%, up substantially from the previous two years. As a general rule, pharmaceutical manufacturers' prices for brand-name drugs tend to outpace general inflation.

Figure 9 shows the increase in Consumer Price Index for all items (CPI-U), Consumer Price Index for Prescription Drugs, and increase in retail prescription drug expenditures from 1992-2010.

Revenue From a Prescription

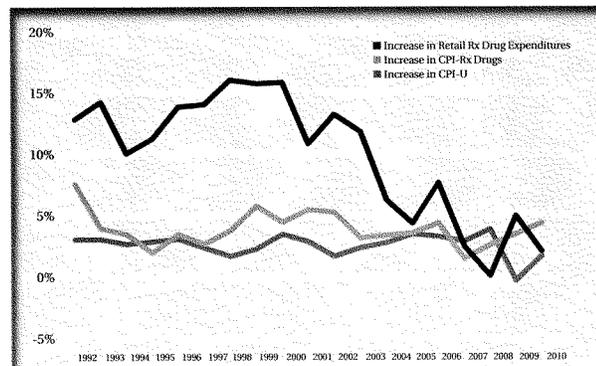
The average community retail pharmacy reimbursement across all payers in 2010 was \$79.39 per prescription. Of this amount, about 80% (\$63.57) represents the amount that the pharmacy pays to the manufacturer or a wholesaler to purchase the drug. The remaining 20% (\$15.82) is used by the pharmacy to pay for operating and overhead costs such as salaries, rent, utilities, computer systems, services of wholesalers, complying with state and federal regulations, and other expenses. From this amount, pharmacy retains a net profit of less than 2% (\$1.09) per prescription.

Table 39. Prescription Drug Prices and Brand/Generic Mix, 1990-2010

Year	Brand	All Rx's	Generic	Percent Brand	Percent Generic
1990	\$27.16	\$22.06	\$10.29	69.8%	30.2%
1991	\$30.11	\$23.87	\$10.85	67.6%	32.4%
1992	\$33.68	\$26.33	\$11.78	66.4%	33.6%
1993	\$35.28	\$26.99	\$12.82	63.1%	36.9%
1994	\$37.37	\$28.37	\$14.18	61.2%	38.8%
1995	\$40.22	\$30.01	\$14.84	59.8%	40.2%
1996	\$45.11	\$32.86	\$15.71	58.3%	41.7%
1997	\$49.55	\$35.72	\$16.95	57.6%	42.4%
1998	\$53.51	\$38.43	\$17.33	58.3%	41.7%
1999	\$60.66	\$42.42	\$18.16	57.1%	42.9%
2000	\$65.29	\$45.79	\$19.33	57.6%	42.4%
2001	\$69.75	\$50.06	\$21.72	59.0%	41.0%
2002	\$77.49	\$55.37	\$24.89	57.9%	42.1%
2003	\$85.57	\$59.52	\$27.69	55.0%	45.0%
2004	\$91.80	\$62.64	\$28.23	54.1%	45.9%
2005	\$97.65	\$63.87	\$29.21	50.6%	49.4%
2006	\$112.24	\$66.97	\$30.17	44.8%	55.2%
2007	\$121.29	\$68.49	\$32.59	40.5%	59.5%
2008	\$138.02	\$71.27	\$35.21	35.1%	64.9%
2009	\$151.12	\$75.21	\$39.25	32.2%	67.8%
2010	\$166.68	\$79.43	\$44.14	28.8%	71.2%

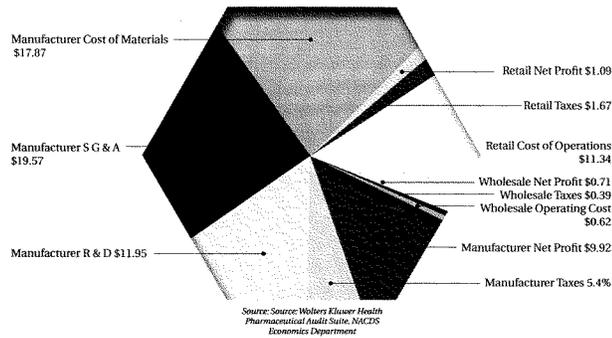
Source: IMS HEALTH, Wolters Kluwer Health, and NACDS Economics Department
Excludes mail order prescriptions.

Figure 9. Prescription Drug Consumer Price Index vs. Consumer Price Index for all Items



Source: U.S. Bureau of the Census, Bureau of Labor Statistics, and IMS HEALTH.

Figure 10. Where Revenue From a Prescription Goes, 2010



Profile of the Pharmacy Consumer

While it is interesting to see how consumers have their prescriptions filled, it is also interesting to see what types of consumers are filling their prescriptions at certain types of pharmacy outlets. Table 40 shows the profile of a pharmacy consumer by the type of pharmacy used most often.

Affluent homeowners are most likely to use online/mail pharmacies. Employed individuals fill their prescriptions at traditional chain drug stores most often, while those claiming to be in excellent health are more likely to fill their prescriptions at supermarkets. Finally, the percent of cash customers is significantly higher at mass merchants.

Source of Payment

Just as the method consumers use to fill and refill prescriptions varies, so too does the source of payment for those prescriptions, which are increasingly being made by third parties. Table 41 shows that the percentage of prescriptions paid for with cash has dropped from 63% in 1990 down to approximately 10% in 2010. However, cash prescription share increased in 2008 through 2010, reversing a consistent decline for the previous twenty years. This may be attributable to discount generic programs in the retail sector. The share of Medicaid prescriptions dropped precipitously in 2006 with the implementation of the Medicare Part D prescription drug benefit, as dual eligibles were shifted to Medicare. This share has grown substantially since 2006 and is now back up to about 10% of all prescriptions.

Table 40. Profile of the Pharmacy Consumer, 2010

By Type of Pharmacy Used Most Often	Chain	Food	Mass	Mail/Online	Independent	Clinic/Other
Average Age	51	54	53	60	55	56
65+	15	23	20	39	23	19
55-64	29	31	28	37	30	43
45-54	24	24	25	14	26	21
35-44	18	14	16	7	15	10
25-34	12	6	8	2	5	5
18-24	2	2	2	*	1	2
<i>Gender</i>						
Male	34%	34%	31%	43%	35%	49%
Female	66%	66%	69%	57%	65%	51%
<i>Household Size</i>						
5+	10	7	10	4	7	5
4	16	15	13	6	11	15
3	19	16	17	11	16	12
2	38	40	44	59	40	44
1	17	22	16	20	26	24
<i>Ethnicity</i>						
White	84%	88%	87%	92%	92%	85%
Black	8%	4%	6%	3%	3%	6%
Other	8%	8%	7%	5%	5%	9%
<i>Education</i>						
Master's Degree	14%	13%	9%	15%	10%	13%
Some Grad School	5%	6%	4%	6%	4%	5%
Bachelor's Degree	20%	17%	17%	19%	12%	23%
Some College/Associate Degree	40%	41%	41%	40%	46%	44%
High School Graduate	19%	21%	26%	19%	26%	14%
Some High School or less	2%	2%	3%	1%	2%	1%
<i>Employment</i>						
Full Time	37%	31%	30%	24%	28%	29%
Part Time	9%	9%	9%	9%	10%	7%
Self Employed	5%	5%	5%	3%	5%	4%
Homemaker	10%	9%	11%	5%	8%	12%
Student	2%	1%	2%	1%	1%	1%
On Disability	8%	10%	7%	5%	14%	9%
Retired	21%	27%	25%	48%	26%	29%
Unemployed	7%	7%	10%	4%	6%	7%
Other	1%	1%	1%	1%	2%	2%
<i>Average Household Income</i>						
\$100,000+	13%	10%	6%	12%	6%	11%
\$75,000 - <\$100,000	13%	11%	10%	15%	11%	12%
\$45,000 - <\$75,000	26%	25%	26%	30%	18%	28%
\$25,000 - <\$45,000	22%	25%	27%	23%	26%	21%
Less than \$25,000	18%	22%	23%	12%	31%	18%
Refused/No Answer	8%	7%	8%	8%	8%	10%
No prescription insurance (%)	10%	12%	26%	8%	13%	17%
With prescription drug coverage	90%	88%	74%	92%	87%	83%

Source: Pharmacy Satisfaction™ Pulse 2011 Household Study. Copyright © Boehringer Ingelheim Pharmaceuticals, Inc. All rights reserved. (3/2011) M990756TR

Table 41. Retail Prescriptions by Source of Payment, 1990-2010

	Medicaid	Other Third Party	Medicare Part D		Medicaid	Other Third Party	Medicare Part D
1990	10.7%	26.1%	63.10%	2001	11.0%	73.0%	16.00%
1991	12.8%	28.0%	59.20%	2002	11.1%	74.5%	14.40%
1992	14.3%	30.1%	55.60%	2003	11.7%	74.7%	13.70%
1993	14.9%	34.7%	50.50%	2004	12.8%	73.8%	13.30%
1994	13.3%	42.0%	44.70%	2005	12.9%	75.1%	12.00%
1995	12.7%	49.1%	38.20%	2006	7.1%	82.7%	10.20%
1996	11.6%	55.0%	33.40%	2007	6.4%	83.4%	10.20%
1997	11.1%	59.8%	29.10%	2008	6.6%	83.0%	10.40%
1998	10.5%	64.8%	24.70%	2009	7.0%	82.3%	10.70%
1999	10.8%	68.2%	21.00%	2010	10.9%	59.4%	10.50%
2000	11.1%	70.4%	18.50%				

Source: IMS HEALTH through 2001, Wolters Kluwer Pharmaceutical Audit Suite for 2002-2010. Beginning in 2010, Medicaid includes Managed Medicaid prescriptions.

Top Prescription Products

Tables 42 and 43 list the top prescription products by the number of prescriptions dispensed and by dollar volume at community retail pharmacies. Tables 44 and 45 show the top products for mail-order pharmacies. Seven of the top 10 mail-order products were generic in 2010, as compared to all of the top 10 for community retail pharmacy. This reflects the fact there is a higher use of chronic medications within the mail-order population, which tend to consist of brand-name products.

In terms of spending, brands account for the majority of the top products. In fact, of the top 20 products by spending in 2010, only seven were generic drugs. Seven of the top 10 products by spending for community retail pharmacy and eight of the top 10 products by spending for mail-order pharmacy were brands.

E-Prescribing

According to data from Surescripts, approximately 25 percent of eligible prescriptions were prescribed electronically at the end of 2010 compared to just 4 percent in 2009. Prescriptions routed electronically grew 72% from 191 million in 2009 to 326 million in 2010. The number of prescribers routing prescriptions electronically grew from 156,000 at the end of 2009 to 234,000 by the end of 2010 – representing about 34 percent of all office-based prescribers.

Experts have long viewed e-prescribing as a means of raising awareness of non-adherence when it occurs so that appropriate steps can be taken to help patients. According to studies cited in a recent report by the National Council on Patient Information and Education (NCPIE), only about 50% of American patients typically take their medicines as prescribed. According to data from the AHRQ Medical Expenditure Panel Survey (1997-2007) and an analysis of that data

Table 42. Top 100 Prescription Products, 2010, by Number of Prescriptions Dispensed

Rank	Product	Brand/Generic Status	Rank	Product	Brand/Generic Status
1	Hydrocodone-Acetaminophen	G	51	Naproxen	G
2	Lisinopril	G	52	Potassium Chloride	G
3	Simvastatin	G	53	Ventolin HFA	B
4	Levothyroxine Sodium	G	54	Fexofenadine HCl	G
5	Amoxicillin Trihydrate	G	55	Fluconazole	G
6	Amlodipine Besylate	G	56	Lovastatin	G
7	Azithromycin	G	57	Cymbalta	B
8	Metformin HCl	G	58	Diovan	B
9	Hydrochlorothiazide	G	59	Propoxyphene-Acetaminophen	G
10	Alprazolam	G	60	Diazepam	G
11	Omeprazole	G	61	Methylprednisolone	G
12	Furosemide	G	62	Ranitidine HCl	G
13	Zolpidem Tartrate	G	63	Amitriptyline HCl	G
14	Lipitor	B	64	Doxycycline Hyclate	G
15	Metoprolol Tartrate	G	65	Allopurinol	G
16	Atenolol	G	66	Acetaminophen with Codeine	G
17	Ibuprofen	G	67	Oxycodone HCl	G
18	Sertraline HCl	G	68	Promethazine HCl	G
19	Citalopram HBr	G	69	Clonidine HCl	G
20	Metoprolol Succinate	G	70	Albuterol Sulfate	G
21	Oxycodone HCl-Acetaminophen	G	71	Triamterene with HCTZ	G
22	Prednisone	G	72	Enalapril Maleate	G
23	Lisinopril-Hydrochlorothiazide	G	73	Carisoprodol	G
24	Tramadol HCl	G	74	Pantoprazole Sodium	G
25	Gabapentin	G	75	Diovan HCl	B
26	Singulair	B	76	Actos	B
27	Plavix	B	77	Loratadine	G
28	Warfarin Sodium	G	78	Seroquel	B
29	Clonazepam	G	79	Glimepiride	G
30	Fluticasone Propionate	G	80	Triamcinolone Acetonide	G
31	Nexium	B	81	Nasonex	B
32	Fluoxetine HCl	G	82	Folic Acid	G
33	Ciprofloxacin HCl	G	83	Spirolactone	G
34	Cyclobenzaprine HCl	G	84	Levaquin	B
35	Lorazepam	G	85	Tamsulosin HCl	G
36	Cephalexin Monohydrate	G	86	Bupropion HCl	G
37	Sulfamethoxazole-Trimethoprim	G	87	Latuda	B
38	Pravastatin Sodium	G	88	Cefdinir	G
39	Lexapro	B	89	Viagra	B
40	Amoxicillin Trihydrate- Potassium Clavulanate	G	90	Metronidazole	G
41	Crestor	B	91	Metformin HCl	G
42	Proair HFA	B	92	Celebrex	B
43	Synthroid	B	93	Amlodipine Besylate-Benazepril	G
44	Trazodone HCl	G	94	Premarin	B
45	Carvedilol	G	95	Glipizide	G
46	Advair Diskus	B	96	Digoxin	G
47	Meloxicam	G	97	Lyrica	B
48	Alendronate Sodium	G	98	Amphetamine Salt Combination	G
49	Vitamin D2	G	99	Lamotrigine	G
50	Paroxetine HCl	G	100	Benazepril HCl	G

Source: Wolters Kluwer Health Source: Pharmaceutical Audit Suite, data drawn 6/22/10.

Table 43. Top 100 Prescription Products, 2010, by Dollar Spending

Rank	Product	Brand/Generic Status	Rank	Product	Brand/Generic Status
1	Simvastatin	G	51	Truvada	B
2	Lipitor	B	52	Amoxicillin Trihydrate-Potassium Clavanulate	G
3	Nexium	B	53	Fentanyl	G
4	Plavix	B	54	Dextroamphetamine-Amphetamine	G
5	Advair Diskus	B	55	Fluticasone Propionate	G
6	Abilify	B	56	Suboxone	B
7	Omeprazole	G	57	Risperidone	G
8	Singulair	B	58	Tricor	B
9	Seroquel	B	59	Lidoderm	B
10	Zolpidem Tartrate	G	60	Bupropion XL	G
11	Crestor	B	61	Humalog	B
12	Oxycontin	B	62	Nasonex	B
13	Actos	B	63	Lantus Solostar	B
14	Cymbalta	B	64	Viagra	B
15	Hydrocodone-Acetaminophen	G	65	Geodon	B
16	Lexapro	B	66	Ciprofloxacin HCl	G
17	Zyprexa	B	67	Provigil	B
18	Pravastatin Sodium	G	68	Zetia	B
19	Amlodipine Besylate	G	69	Oxycodone HCl-Acetaminophen	G
20	Ondansetron HCl	G	70	Lovenox	B
21	Gabapentin	G	71	Vytorin	B
22	Sertraline HCl	G	72	Vyvanse	B
23	Lisinopril	G	73	Valacyclovir HCl	G
24	Lamotrigine	G	74	Lansoprazole	G
25	Metformin HCl	G	75	Aciphex	B
26	Fluoxetine HCl	G	76	Proair HFA	B
27	Aticept	B	77	Tramadol HCl	G
28	Lantus	B	78	Venlafaxine HCl ER	G
29	Spiriva	B	79	Alendronate Sodium	G
30	Topiramate	G	80	Lovastatin	G
31	Meloxicam	G	81	Sumatriptan Succinate	G
32	Lyrca	B	82	Tamsulosin HCl	G
33	Diovan	B	83	Solodyn	B
34	Azithromycin	G	84	Niaspan	B
35	Citalopram HBr	G	85	Lunesta	B
36	Celebrex	B	86	Symbicort	B
37	Atripla	B	87	Ambien CR	B
38	Levaquin	B	88	Ondansetron ODT	G
39	Carvedilol	G	89	Adderall XR	B
40	Effexor XR	B	90	Paroxetine HCl	G
41	Oxycodone HCl	G	91	Namenda	B
42	Pantoprazole Sodium	G	92	Amlodipine Besylate-Benazepril	G
43	Concerta	B	93	Levothyroxine Sodium	G
44	Januvia	B	94	Ranitidine HCl	G
45	Diovan HCT	B	95	Lovaza	B
46	Metoprolol Succinate	G	96	Flovent HFA	B
47	Alprazolam	G	97	Fexofenadine HCl	G
48	Enbrel	B	98	Cialis	B
49	Novolog	B	99	Seroquel XR	B
50	Humira	B	100	Androgel	B

Source: Wolters Kluwer Health Pharmaceutical Audit Suite, data drawn 6/22/11

Table 44. Top 10 Products Filled by Mail Order, 2010, by Number of Prescriptions Dispensed

Rank	Product	Brand/Generic	Rank	Product	Brand/Generic
1	Simvastatin	G	6	Omeprazole	G
2	Lipitor	B	7	Hydrochlorothiazide	G
3	Lisinopril	G	8	Nexium	B
4	Synthroid	B	9	Metformin HCl	G
5	Amlodipine Besylate	G	10	Atenolol	G

Source: Wolters Kluwer Health Pharmaceutical Audit Suite, data drawn 6/22/11.

Table 45. Top 10 Products Filled by Mail Order, 2010, by Dollars Spent

Rank	Product	Brand/Generic	Rank	Product	Brand/Generic
1	Lipitor	B	6	Omeprazole	G
2	Simvastatin	G	7	Copaxone	B
3	Nexium	B	8	Plavix	B
4	Enbrel	B	9	Crestor	B
5	Humira	B	10	Actos	B

Source: Wolters Kluwer Health Pharmaceutical Audit Suite, data drawn 6/22/11.

by the NACDS Economics Department, an average of 20% of prescriptions written go unfilled. For those office visits generating a prescription, approximately 20% have no filled prescriptions associated with them. This relationship has consistently held for several years.

Estimated Total Prescriptions Written –	4.60 billion
Estimated Unfilled Prescriptions –	919 million
Prescriptions Dispensed –	3.68 billion
New and Renewal Prescriptions –	1.93 billion
New Prescriptions –	960 million
Renewal Prescriptions –	973 million
Refill Prescriptions –	1.74 billion

Source: Medical Expenditure Panel Survey and NACDS Economics Department; Verigan Vector One National Audit database, data drawn 5/15/08.

Table 46 shows the top 20 therapeutic drug classes by prescriptions. In 2010, the top therapeutic drug class ranked by the number of prescriptions dispensed was vascular agents, which includes ACE inhibitors and calcium channel blockers. Psychotherapeutics, including anti-psychotics and antidepressants, ranked second.

Table 46. Top Therapeutic Classes, 2010, by Number of Prescriptions

Rank	Therapeutic Class	Total Prescriptions	Prescription Dollars
1	Vascular Agents	551,975,224	\$29,238,572,149
2	Psychotherapeutic Drugs	438,842,277	\$47,856,204,567
3	Analgesics, Ethical	308,498,808	\$19,662,138,402
4	Anti-Infectives, Systemic	271,757,857	\$12,413,297,335
5	Antihyperlipidemic Agents	263,109,905	\$35,303,922,538
6	Respiratory Therapy	185,416,306	\$23,696,509,591
7	Diabetes Therapy	175,402,466	\$21,861,617,353
8	Gastrointestinal	159,836,769	\$23,718,550,227
9	Neurological Disorders, Misc.	141,858,550	\$20,662,011,352
10	Hormones	138,981,480	\$8,307,390,631
11	Diuretics and Aquaretics	129,208,232	\$1,469,962,091
12	Antiarrhythmics	118,348,424	\$12,686,342,767
13	Thyroid Therapy	111,640,178	\$1,988,592,892
14	Contraceptives	93,781,066	\$5,414,205,890
15	Musculoskeletal	89,189,240	\$6,666,681,318
16	Hemostatic Modifiers	65,223,335	\$9,572,495,597
17	Ophthalmic Preparations	63,849,168	\$5,564,750,316
18	Sedatives, Ethical	61,485,254	\$5,974,378,138
19	Allergy/Cold Preparations	57,595,480	\$3,148,706,169
20	Genitourinary	56,146,107	\$6,323,064,345

Source: Wolters Kluwer Health Pharmaceutical Audit Suite, data drawn 6/22/2011.

Direct-to-Consumer Advertising

Manufacturer spending on direct-to-consumer (DTC) advertising continues to rise and continues to influence decisions regarding prescription drug use, as well as the overall spending on prescription drugs. According to research conducted for the FDA (www.fda.gov/cder/ddmac/P1Slaughter/), consumers aware of DTC ads spoke to their doctor about 30% of the time about the prescription medication. Of these consumers, 30% asked the doctor to prescribe the medication, and 79% of those consumers received the requested medication.

Table 47 shows the 10 leading drugs in terms of DTC spending in 2010 and their share of total 2010 retail drug sales. The top 10 drugs account for over \$1.4 billion in spending on DTC advertising and 12.0% of total retail drug spending in 2010.

Table 47. Ten Leading Drugs in Terms of Direct to Consumer Advertising, 2010

Name of Drug	2010 U.S. Sales (\$ millions)	Share of Total 2010 U.S. Retail Drug Sales	Spending on DTC Advertising, 2010 (\$ millions)	Spending on DTC Advertising, 2009 (\$ millions)
Lipitor	\$7,923.5	3.0%	\$249.9	\$237.4
Cymbalta	\$3,407.8	1.3%	\$190.8	\$130.5
Cialis	\$887.4	0.3%	\$178.9	\$148.5
Ablify	\$4,318.8	1.6%	\$131.5	\$171.8
Plavix	\$6,328.6	2.4%	\$127.8	\$151.0
Pristiq	\$546.7	0.2%	\$122.2	\$104.2
Advair Diskus 250/50	\$4,967.7	1.9%	\$105.9	\$50.9
Viagra	\$1,214.2	0.5%	\$103.7	\$127.2
Chantix	\$476.2	0.2%	\$99.4	\$93.4
Lyrica	\$1,803.8	0.7%	\$99.2	\$136.9
Total Above	\$31,874.7	12.0%	\$1,409.3	\$1,351.8
Total all drugs	\$266,394.9			

Source: Med Ad News, May 2011; Wolters Kluwer Health Pharmaceutical Audit Suite; IMS HEALTH; NACDS Economics Dept.

Demographics and Prescription Utilization

Identifying which patient groups have the highest prescription drug utilization is important for many reasons. It helps manufacturers project prescription volume for particular drugs and also helps them identify specific marketing opportunities. Lastly, knowing which demographic uses which types of drugs helps insurers assess contracts, especially risk contracts.

The National Ambulatory Medical Care Survey (NAMCS) collects this information on an annual basis and publishes data relating to prescriptions written as a result of physician visits. Since these data are released two years after they are collected, the most recent information is from 2008.

Table 48 compares prescriptions mentioned at outpatient visits by age and sex in 2008. Females continue to get more prescriptions than males in almost every age group measured. Females account for nearly 60% of all drug mentions at physician visits. Overall, on an annual basis, an average female discusses 6.9 prescriptions with her physician and an average male discusses 4.9 prescriptions. Individuals age 75 and older discuss 22.3 prescriptions per year, more than double the number of those between the ages of 55 and 64.

Table 49 compares the average number of prescriptions mentioned at physician visits by age and race.

Table 48. Prescriptions Mentioned at Outpatient Physician Visits, by Age and Sex, 2008

Age Group	Female	Male	Overall
<5	4.47	4.91	4.69
5-14	1.64	1.78	1.71
15-24	2.08	1.07	1.57
25-34	3.26	1.44	2.35
35-44	4.53	2.50	3.53
45-54	7.10	4.47	5.81
55-64	11.29	8.32	9.86
65-74	17.30	14.91	16.20
75+	22.30	22.33	22.31
Overall Prescription Mentions	6.93	4.87	6.42
			12.34
Total Physician Visits	572,697,202	383,271,616	955,968,818
Total Prescription Mentions	1,056,136,824	712,098,388	1,768,235,212
Percent	59.73%	40.27%	

Source: National Ambulatory Medical Care Survey, 2008; NACDS Economics Dept.

Table 49. Prescriptions Mentions by Age and Race, 2008 at Outpatient Physician Office Visits

Age Group	White	Black*	Other
<5	4.72	5.65	3.07
5-14	1.76	1.65	1.36
15-24	1.89	1.32	0.87
25-34	2.55	1.91	1.23
35-44	3.64	3.87	1.97
45-54	5.99	5.80	3.61
55-64	10.11	9.83	6.35
65-74	16.24	18.85	10.88
75+	22.15	25.46	19.97
Total Physician Visits	802,361,913	104,001,501	49,605,404
Total Prescription Mentions	1,496,037,926	198,398,106	234,607,230
Percent	77.6%	10.3%	12.2%
Total Prescription Mentions	1,056,136,824	712,098,388	1,768,235,212
Percent	59.73%	40.27%	

Source: National Ambulatory Medical Care Survey, 2008.

*Survey respondents were asked to identify themselves as white, black, Asian/Pacific Islander, or American Indian/Alaskan/Aleut

The remaining utilization information provides indications about methods of payment. The number of prescription mentions from patients with private insurance rose from 46.4% in 2007 to 49.9% in 2008.

A frequently asked question is the percentage of prescriptions written for chronic versus acute conditions. Table 51 shows that approximately 40% of prescription discussions are for routine chronic conditions. Non-illness care – which includes routine pre-natal care, well-baby exams, and physical examinations – accounts for more than 15% of prescription mentions in physician visits.

Table 50. Number of Prescription Mentions per Doctor Visit, by Type of Payment, 2008

Age Group	Private Insurance, HMO	Medicare	Medicaid	Worker's Compensation	Self-Pay	Other	Total
<5	1.31	1.65	1.53		0.00		
5-14	1.09	1.17	1.46		0.71		
15-24	0.74	1.39	1.33	1.00	0.34		
25-34	0.82	1.98	1.83	2.50	1.10		
35-44	1.01	2.53	2.57	0.33	0.25		
45-54	1.63	3.19	3.21	0.53	1.88		
55-64	1.89	3.13	3.44	1.41	1.72		
65-74	2.71	3.01	2.89	0.00	2.01		
75+	3.56	3.15	3.24	0.00	0.00		
Total Physician Visits	29,082,327	8,420,592	6,604,234	663,498	1,013,094	3,999,490	49,783,235
Total Prescription Mentions	41,401,632	20,303,382	9,862,419	467,551	1,304,819	9,634,546	82,974,349
Percent	49.9%	24.5%	11.9%	0.6%	1.6%	11.6%	100.0%

Source: National Ambulatory Medical Care Survey, 2008.

Table 51. Number of Prescription Mentions per Doctor Visit, by Major Reason for Visit, 2008

	Acute Problem	Chronic Problem, Routine	Chronic Problem, Flare-Up	Pre- or Post-Surgery or Illness	Non-Illness Care	Other
Prescriptions per Visit	1.35	2.63	2.23	1.34	1.21	1.91
Physician Visits	19,684,844	11,918,259	2,301,707	2,817,203	12,037,730	845,661
Prescriptions	23,534,776	28,648,783	4,745,607	3,164,150	12,593,878	1,111,986
Percentage	31.9%	38.8%	6.4%	4.3%	17.1%	1.5%

Source: National Ambulatory Medical Care Survey, 2008.

An additional source of information about prescription utilization is the Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Healthcare Research and Quality. Data from MEPS are several years old, but it is the most comprehensive source of information on healthcare expenditures currently available. Unlike the NAMCS data, which focus on discussion of medicines during office visits, MEPS data focus on prescriptions actually filled (as opposed to those discussed or written). These data confirm the patterns found in NAMCS data.

Using MEPS data, it can be shown that users of chronic medications (defined as filled three or more times per year) account for a disproportionate number of total prescriptions filled. In fact, only 6.9% of the U.S. population – those filling prescriptions for six or more chronic medications each year – accounts for 47.2% of total prescriptions.

Table 52. Percent of Population and Prescriptions Accounted for by People Taking Chronic Medications

<i>Chronic Medications Only</i>						
Number of Chronic Medications	Population	Prescriptions	Population Share	Prescriptions per Year	Prescriptions per Month	Prescription Share
6+	21,060,061	1,230,317,090	6.9%	58.4	4.9	40.8%
5+	28,130,767	1,447,243,120	9.4%	51.4	4.3	48.0%
4+	37,812,274	1,680,863,279	12.5%	44.5	3.7	55.8%
3+	51,521,609	1,928,147,483	17.1%	37.4	3.1	64.0%
2+	73,003,437	2,173,807,398	23.8%	29.8	2.5	72.1%
1+	108,249,786	2,375,285,092	35.7%	21.9	1.8	78.8%
<i>All Medications Filled by Population</i>						
6+	22,512,032	1,421,410,424	6.9%	63.1	5.3	47.2%
5+	29,852,529	1,668,676,820	9.4%	55.9	4.7	55.4%
4+	39,704,056	1,937,427,113	12.5%	48.8	4.1	64.3%
3+	53,629,656	2,227,676,486	17.1%	41.5	3.5	73.9%
2+	75,165,444	2,527,904,920	23.8%	33.6	2.8	83.9%
1+	110,092,497	2,807,914,098	35.7%	25.5	2.1	93.1%
Total	304,375,942	3,014,547,281		9.9	0.8	

Source: Medical Expenditure Panel Survey, Prescribed Medicines File, 2008, and NACDS Economics Department.
Chronic medications are defined as those filled more than three times per year.

Table 53 shows the frequency of prescription mentions by physician specialty. The vast majority of new prescriptions are written by physicians in family practice or internal medicine.

Table 54 shows the number of prescriptions filled by the specialty of the writing physician. This table includes refills and renewals as well as new prescriptions and, in conjunction with physician specialty data from the American Medical Association, is used to estimate the total number of prescriptions per physician per year by specialty, as well as the estimated price. Family practice and internal medicine account for nearly two-thirds of all prescriptions filled.

Table 53. Prescription Mentions, Physician Visits, and Prescription Mentions per Visit by Physician Specialty, 2008

<i>at Outpatient Physician Offices</i>			
Physician Specialty	Physician Visits	Prescription Mentions	Prescription Mentions per Visit
General/Family Practice	224,443,174	471,636,255	2.10
Internal Medicine	152,909,045	412,955,798	2.70
Pediatrics	119,796,601	147,013,184	1.23
General Surgery	15,750,752	14,485,561	0.92
Obstetrics and Gynecology	81,927,917	59,583,387	0.73
Orthopedic Surgery	51,322,072	39,928,680	0.78
Cardiovascular Diseases	39,251,565	158,236,468	4.03
Dermatology	34,482,994	41,453,964	1.20
Urology	24,786,123	35,493,375	1.43
Psychiatry	22,990,400	45,213,485	1.97
Neurology	12,099,149	26,956,872	2.23
Ophthalmology	65,598,838	95,132,805	1.45
Otolaryngology	18,169,022	22,105,502	1.22
Other Specialties	92,441,166	198,039,876	2.14
Total	1,011,362,956	1,911,388,789	1.89

Source: National Ambulatory Medical Care Survey, 2008.

Table 54. Number of Prescriptions Filled, by Specialty of Writing Physician, 2010

Specialty Group	Total Prescriptions	New Prescriptions	Total Dollars	Average Price	Physicians (2009)	Estimated Prescriptions per Physician
Family Practice/General Practice	680,124,573	1,360,245,993	\$103,054,454,573.99	\$151.52	95,981	7,086
Internal Medicine	473,423,283	1,062,507,458	\$104,256,251,468.67	\$220.22	186,352	2,540
Psychiatry	102,009,959	168,346,823	\$24,801,427,446.54	\$243.13	48,054	2,123
Pediatrics	132,277,823	167,660,652	\$13,060,349,343.48	\$98.73	76,095	1,738
Cardiology	53,532,902	161,609,350	\$13,804,086,126.31	\$257.86	24,801	2,158
Obstetrics & Gynecology	78,684,149	160,573,105	\$10,901,342,045.91	\$138.55	42,855	1,836
Emergency Medicine	85,619,317	106,775,940	\$4,981,623,090.07	\$58.18	32,442	2,639
Neurology	25,470,694	58,472,045	\$12,446,270,001.14	\$488.65	15,479	1,645
Dentist	50,792,933	57,512,856	\$1,263,752,444.56	\$24.88		
Dermatology	32,829,054	49,052,485	\$7,958,300,981.13	\$242.42	11,201	2,931
Surgery	36,114,507	48,327,191	\$2,715,353,364.48	\$75.19	44,016	820
Endocrinology, Diabetes, & Metabolism	15,687,619	44,319,474	\$5,491,962,897.08	\$350.08		
Orthopedics	31,828,253	40,437,812	\$2,265,781,996.81	\$71.19	25,027	1,272
Ophthalmology	20,750,617	39,183,311	\$3,797,022,794.90	\$182.98	18,305	1,134
Urology	16,585,042	32,464,142	\$3,370,922,170.98	\$203.25	8,636	1,916
Anesthesiology	22,978,514	30,438,070	\$3,709,859,849.41	\$161.45	42,672	538
Geriatrics	12,761,593	26,467,461	\$2,308,189,636.79	\$180.87		
Medical Oncology	13,888,352	25,888,976	\$6,645,715,883.49	\$478.51		
Otolaryngology	16,715,370	23,931,169	\$1,808,624,494.65	\$108.20	10,264	1,629
Allergy & Immunology	11,784,763	22,232,885	\$2,753,961,618.85	\$233.69	4,316	2,730
Physical Medicine & Rehabilitation	15,205,011	20,839,710	\$2,372,276,603.58	\$156.02	8,799	1,728
Preventive Medicine	8,545,779	13,255,503	\$964,285,995.56	\$112.84	6,476	1,320
Optometrist	6,076,888	9,724,690	\$940,685,018.55	\$154.80		
Neurological Surgery	4,860,244	6,495,942	\$404,035,309.93	\$83.13	5,633	863
Plastic Surgery	4,878,928	5,734,902	\$261,864,464.95	\$53.67	7,298	669
Radiology	3,180,596	4,983,080	\$416,181,961.95	\$130.85	19,801	161
Midwives	1,253,438	2,433,826	\$140,367,120.97	\$111.99		
Pathology	1,358,155	2,232,630	\$182,267,766.68	\$134.20		

Source: Wolters Kluwer Health Pharmaceutical Audit Suite, and AMA, Physician Characteristics and Distribution in the U.S., 2009.

Table 55. Prescription Utilization by Age and Sex, 2008

Prescriptions Filled at Retail Pharmacies

Age Group	Male	Female	Overall
<5	2.37	2.93	2.63
5-14	2.71	1.88	2.30
15-24	2.04	3.97	2.96
25-34	2.31	6.08	4.22
35-44	5.61	8.76	7.22
45-54	11.45	14.50	13.02
55-64	18.19	21.96	20.12
65-74	24.71	29.62	27.33
75+	27.25	34.48	31.62
Overall Retail Prescriptions	8.51	12.12	10.35
Total Prescriptions	1,270,735,523	1,879,178,440	3,149,914,963
Percent	40.34%	59.66%	

Source: Medical Expenditure Panel Survey, 2008; NACDS Economics Dept.

More detailed analysis of MEPS data shows that prescription utilization increases with age and appears to decline with increases in income. For example, as shown in Table 56, in older age groups there is a relatively consistent decline in the number of prescriptions per year as income increases.

Table 56. Prescription Utilization by Age and Income Group, 2008, Prescriptions Filled at Retail Pharmacies

Age Group	Income Group								
	<\$5,000	>=\$5,000 <\$10,000	>=\$10,000 <\$15,000	>=\$15,000 <\$20,000	>=\$20,000 <\$30,000	>=\$30,000 <\$40,000	>=\$40,000 <\$50,000	>=\$50,000 <\$75,000	>=\$75,000
<5	1.9	3.0	8.7	*	*	*	*	*	*
5-14	2.2	7.1	*	*	*	*	*	*	*
15-24	2.8	3.1	3.4	3.4	3.0	3.3	4.1	*	*
25-34	9.3	12.0	9.0	7.9	7.4	8.8	7.5	7.2	6.9
35-44	15.7	23.7	16.5	11.1	11.7	10.2	9.6	9.8	8.8
45-54	25.6	34.5	26.3	20.4	16.6	15.8	16.1	15.7	12.6
55-64	32.9	37.7	30.3	22.9	17.0	23.3	20.2	20.7	17.3
65-74	33.0	41.6	35.2	31.8	32.0	27.6	26.3	26.4	23.5
75+	39.1	35.0	37.4	34.2	30.4	30.6	35.2	31.1	*

Source: Medical Expenditure Panel Survey, 2008, NACDS Economics Dept.
* Cell size not large enough to report.

Source of payment is also important. Table 57 shows the number of prescriptions per year by primary expected source of payment. Cash customers spend less and get fewer prescriptions than either Medicaid or other third-party payment customers. They also (on average) spend less per prescription.

Table 57. Prescription Utilization by Age and Primary Payment Type, 2008, Prescriptions Filled at Retail Pharmacies

Age Group	Prescriptions/Year			Dollars/Year			Dollars/Prescription		
	Cash Customers ¹	Medicaid ²	Other 3rd Party ³	Cash Customers	Medicaid	Other 3rd Party	Cash Customers	Medicaid	Other 3rd Party
<5	2.1	4.4	7.1	\$47.85	\$498.04	\$405.34	\$22.44	\$112.53	\$57.28
5-14	2.0	7.0	5.2	\$55.91	\$648.21	\$600.49	\$27.73	\$92.40	\$115.24
15-24	3.0	7.8	7.2	\$161.65	\$686.44	\$642.99	\$54.16	\$88.35	\$89.44
25-34	3.7	14.6	8.3	\$184.18	\$1,114.82	\$634.15	\$49.23	\$76.14	\$76.49
35-44	6.3	17.9	13.0	\$347.12	\$1,251.26	\$1,168.20	\$55.53	\$69.73	\$90.05
45-54	8.6	38.0	19.5	\$447.95	\$2,858.12	\$1,694.51	\$52.15	\$75.28	\$86.93
55-64	13.0	50.2	24.7	\$682.60	\$3,497.43	\$1,998.37	\$52.33	\$69.70	\$80.78
65-74	9.6	*	31.2	\$714.19	*	\$2,480.51	\$74.18	*	\$79.41
75+	16.1	*	33.8	\$1,319.07	*	\$2,267.28	\$82.04	*	\$67.14
Overall	6.2	13.8	19.3	\$342.74	\$1,093.19	\$1,540.43	\$55.16	\$79.13	\$79.88
Percent of Prescriptions	7.8%	8.4%	83.8%						
Percent of Prescription Dollars	5.5%	8.6%	85.9%						
Percent of Prescription Customers	20.2%	9.8%	70.0%						

Cash customers were defined as those paying 90 percent of total prescription spending out of pocket.
Medicaid customers were defined as those paying more than 50 percent from Medicaid sources.
Other 3rd party customers were the remaining group.
Source: Medical Expenditure Panel Survey and NACDS Economics Department.

Patients with high blood pressure spend the most per year, more than any other patients with other given diagnoses. Table 58 lists annual prescription drug spending per person, for a given diagnosis. Patients with high blood pressure (essential hypertension) spent an average of \$2,289 in 2008. Patients with high cholesterol (diseases of lipid metabolism) spent an average of \$2,545 in 2008. These numbers could vary from year to year, however, depending on the number of generic therapeutic equivalents that are on the market for a given diagnosis.

Table 58. Average Annual Prescription Drug Spending by Patients with Given Diagnosis, 2008

Sorted by Total Dollar Spending on Prescription Drugs

Diagnosis	Annual Prescription Dollars per Person	Annual Prescriptions per Person	Dollars per Prescription	Total Prescription Spending By Individuals with Diagnosis (millions)
Essential Hypertension	\$2,289	33.0	\$69.39	\$131,564
Diseases of Lipid Metabolism	\$2,545	32.9	\$77.26	\$124,750
Diabetes Mellitus	\$3,304	42.9	\$76.99	\$69,985
Depressive Disorders	\$2,930	34.5	\$84.87	\$56,636
General Symptoms	\$3,634	44.1	\$82.46	\$56,100
Diseases of Esophagus	\$3,151	35.8	\$87.99	\$52,095
Joint Disorder	\$2,012	26.6	\$75.57	\$45,948
Chronic Ischemic Heart Disease	\$3,532	50.1	\$70.46	\$41,581
Neurotic Disorders	\$2,703	34.9	\$77.47	\$40,496
Arthropathies	\$2,679	36.5	\$73.42	\$40,018
Asthma	\$2,165	25.8	\$83.99	\$38,612
Back Disorders	\$2,050	26.6	\$76.95	\$27,798
Intestinal Infection	\$1,019	13.2	\$77.34	\$27,078
Other Soft Tissue Disorder	\$3,109	37.5	\$82.86	\$26,039
Acute Nasopharyngitis	\$881	11.3	\$77.96	\$24,121
Acute Myocardial Infarction	\$3,565	51.1	\$69.75	\$20,121
Fluid/Electrolyte Disorder	\$4,325	60.7	\$71.30	\$19,507
Acquired Hypothyroidism	\$2,281	32.8	\$69.60	\$17,852
Chronic Sinusitis	\$1,281	17.1	\$75.09	\$17,555
Chronic Bronchitis	\$3,074	41.3	\$74.39	\$17,512
Other Inflammatory Polyarthropathy	\$3,094	39.9	\$75.35	\$16,969
Stomach Function Disorder	\$2,417	29.2	\$82.77	\$15,673
Angina Pectoris	\$3,812	53.3	\$71.56	\$15,602
Other Thyroid Disorders	\$2,276	34.1	\$66.67	\$15,506
Cataract	\$2,716	33.5	\$81.01	\$13,861
Other Bone and Cartilage Disorder	\$2,912	33.5	\$86.97	\$13,377
Emphysema	\$3,847	52.8	\$72.92	\$13,350
Stroke (CVA)	\$3,279	43.4	\$75.49	\$13,267

Source: Medical Expenditure Panel Survey, 2008 and NACDS Economics Department.

Many of the top diagnoses are what are termed comorbid conditions – that is, the patient has more than one condition. To illustrate this, we show the top products for patients with the top four diagnoses in terms of spending. All of the top diagnoses have drugs that are used to treat other conditions in the top 10 by prescriptions.

Table 59. Top Products Taken by Patients with Top Diagnoses, 2008

Product	Total Spend (millions)	Total Prescriptions (millions)	Dollars per Person	Used to Treat
<i>Essential Hypertension</i>				
Hydrochlorothiazide Tablets 25 mg	\$240	42	\$22.70	high blood pressure
Lisinopril Tablet 20 mg	\$4,281	32	\$55.08	high blood pressure
Lisinopril Tablet 10 mg	\$2,898	25	\$47.82	high blood pressure
Plavix Tablet 75 mg	\$1,886	24	\$845.64	prevent blood clots
Metformin Tablet 500 mg	\$1,703	22	\$100.84	diabetes
Furosemide Tablet 40 mg	\$1,621	20	\$27.56	high blood pressure
Metoprolol Tartrate Tablet 50 mg	\$1,616	19	\$49.72	high blood pressure
Omeprazole Capsule 20 mg DR	\$1,563	19	\$158.29	heartburn and acid reflux disease
Lisinopril Tablet 40 mg	\$1,464	17	\$86.55	high blood pressure
Lipitor Tablet 20 mg	\$1,355	17	\$882.64	high cholesterol
<i>Diseases of Lipid Metabolism</i>				
Hydrochlorothiazide Tablets 25 mg	\$136	\$24	\$21.24	high blood pressure
Lipitor Tablets 20 mg	\$3,939	\$23	\$839.27	high cholesterol
Lipitor Tablets 10 mg	\$2,702	\$23	\$388.40	high cholesterol
Plavix Tablets 75 mg	\$4,094	\$23	\$829.83	prevent blood clots
Lisinopril Tablets 20 mg	\$333	\$23	\$57.53	high blood pressure
Metformin Tablets 500 mg	\$482	\$21	\$100.83	diabetes
Metformin Tablets 1000 mg	\$475	\$18	\$133.42	diabetes
Furosemide Tablets 40 mg	\$109	\$18	\$29.61	high blood pressure
Lisinopril Tablets 10 mg	\$217	\$17	\$51.73	high blood pressure
Simvastatin Tablets 20 mg	\$1,796	\$17	\$349.59	high cholesterol
<i>Diabetes Mellitus</i>				
Metformin Tablets 500 mg	\$655	29	\$100.06	diabetes
Metformin Tablets 1000 mg	\$578	22	\$123.68	diabetes
Furosemide Tablets 40 mg	\$79	13	\$30.49	high blood pressure
Glyburide Tablets 5 mg	\$247	12	\$95.23	diabetes
Lisinopril Tablets 20 mg	\$177	12	\$57.76	high blood pressure
Lantus Subcutaneous Solution 100 unit/ml	\$1,956	11	\$1,109.39	diabetes
Plavix Tablets 75 mg	\$1,812	10	\$902.77	prevent blood clots
Lisinopril Tablets 10 mg	\$116	10	\$47.85	high blood pressure
Hydrochlorothiazide Tablets 25 mg	\$54	10	\$22.61	high blood pressure
Actos Tablets 45 mg	\$2,219	8	\$1,234.02	diabetes
<i>Depressive Disorders</i>				
Fluoxetine Capsules 20 mg	\$198	7	\$111.96	depression
Lexapro Tablets 20 mg	\$794	7	\$562.67	depression
Lexapro Tablets 10 mg	\$733	7	\$182.72	depression
Cymbalta Capsules 60 mg	\$1,049	7	\$18.79	depression
Sertraline Tablets 100 mg	\$177	6	\$76.85	depression
Omeprazole Capsules 20 mg	\$294	6	\$950.59	heartburn and acid reflux disease
Nexium Capsules 40 mg	\$1,686	6	\$104.26	heartburn and acid reflux disease
Lisinopril Tablets 20 mg	\$88	6	\$166.30	high blood pressure
Citalopram Hydrobromide Tablets 20 mg	\$224	6	\$238.29	depression
Hydrochlorothiazide Tablets 25 mg	\$31	6	\$816.58	high blood pressure

Source: Medical Expenditure Panel Survey, 2008, and NACDS Economics Department.

Specialty Pharmacy

Specialty pharmaceuticals are generally defined as products used to treat chronic, high-cost, or rare diseases and can be injectable, infusible, oral, or inhaled medications. Specialty pharmaceuticals tend to be more complex to maintain, administer, and monitor than traditional drugs, therefore, they require closer supervision and monitoring of a patient's overall therapy.

Specialty pharmacy is defined as the service created to manage the handling and service requirements of specialty pharmaceuticals, including dispensing, distribution, reimbursement, case management, and other services specific to patients with rare and/or chronic diseases.

Estimates of the size of the specialty pharmacy market depend on the definition and continue to vary dramatically based on the source. However, it is generally accepted that the percentage of people on specialty medications is about 3-5% of total. Current spending on specialty pharmaceutical products is estimated at over \$25 billion in retail pharmacies.

The following is a list of some of the large, higher-volume specialty pharmacy providers:

- Aetna Specialty Pharmacy
- BioScrip
- CIGNA Pharmacy Management
- Coram Specialty Infusion Services
- Diplomat Specialty Pharmacy
- Medco Health Solutions
- New Century Infusion Solutions
- Prescription Solutions
- Walgreens - Option Care

Retail Clinics

Recently healthcare has begun expanding out of traditional doctor's offices and HMOs or public health clinics into retail clinics – open to the public and frequently affiliated with or located in a community retail pharmacy chain. The number of these is expected to increase dramatically in the near future. Clinic companies and their affiliations with retail pharmacy are shown in Table 60.

Table 60. Retail Clinics and Their Affiliations, 2010

				Retailer
In-Store Clinic ?	Health System Association of			Apple Discount Drug Alabama International Airport Aurora Baylor Medical Clinics Charlotte Douglas International Airport Creighton Center Drug Diana Beale Food City Fry's H-E-B Jaffa Drug Center Kaiser's Kroger Mettis Marshland Pharmacy Munroe Pharmacy Munroe Pharmacy Philadelphia International Airport Publix Rite Aid Shopee Walgreens Walgreens West Markets
Health System Association of				
Health Plan Coverage				
Aetna, Blue Cross and Blue Shield of Georgia/WellPoint, Choice Care/Humana PPO, CIGNA, Cofinity, Coventry National, Delinny Health, Forecare-Medicare, First Health, FISERV, Fortified Provider Network, Galaxy Health Network, Golden Rule, Great West Life, Healthlink, Humana PPO, Humana Choice PPO, McDonald's Healthplan, MedAvant NPPN, Medicare, Medical Mutual Ohio/Supermed, Medicare Private Fee For Service Plans, Multiplan (including PMS), Beechtree/Viant/Multiplan), OneNet PPO, Oxford Healthplan, Pacificare PPO, Prime Health Services, Secure Horizons, SuperMed, Three Rivers, TriCare-Standard, Unitedcare PPO, United Medical Resources, United Healthcare				
Little Clinic	None listed		See more insurance carriers here	
Medpoint Express	Memorial Health System (IN)	Accepts Most Insurance		
Minute Clinic	CVS-owned	Accepts "Most Insurance"		
Pikeville Medical Center Clinic At Walmart	Pikeville Medical Center (KY)			
Redcliff (TX)	Memorial Hermann HealthCare System, Methodist Healthcare System, St. David's Healthcare (TX)	Humana, Great West HealthCare, BlueCross BlueShield of Texas, Aetna, Assurant, United Healthcare, Cigna, Great West HealthCare, Humana.	Source	
Stillwater Medical Group Clinic at Walmart	Stillwater Medical Group (MN, WI)			
Sutter Health Expresscare	Sutter Health (CA)	Aetna, Blue Cross of CA, Blue Shield of CA, Cigna, Great West, Health Net, Medicare PFS, PacifiCare, Sutter Select, United Healthcare	See more insurance carriers here	
Take Care Clinics	Take Care Health Systems	Accepts most major insurance carriers and networks. Coverage depends on the geographic area.	See more insurance carriers here	
Target Clinic	Target Corporation (FL, MN, MD, IL)	Accepts most insurance plans		

Insurance

A major factor in determining whether a patient will fill a prescription is whether they have insurance coverage. The uninsured population fell for the first time in 10 years in 1999, but rose again in each successive year. The current insurance status of the U.S. population is shown in Table 61.

Table 61. Nonelderly Americans with Selected Sources of Health Insurance Coverage, 1987-2009

Source of Coverage	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2002	2003	2004	2005	2006	2007	2008	2009		
Total Population	214.4	216.6	218.5	220.6	222.9	225.6	228.0	229.9	231.9	234.0	236.2	238.6	240.7	245.1	247.5	250.4	252.7	255.1	257.4	260.0	261.4	262.8	264.7	
Employment-based	150.3	151.2	151.7	149.6	149.5	147.7	146.7	148.1	148.7	151.7	152.9	150.4	154.7	157.5	166.1	164.9	162.9	161	161.3	161.7	162.5	160.6	156.1	
Own Coverage	73.5	74.5	75.1	74.1	74.1	72.7	76.0	76.3	76.9	76.0	76.5	80.2	80.6	84.1	82.5	81.5	81.7	82.3	82.9	83.9	82.5	79.1	79.1	
Dependent Coverage	76.8	76.7	76.6	75.5	75.4	75.0	76.7	71.9	72.8	73.7	76.4	80.2	82.4	82.9	82.4	81.5	79.4	79.0	78.8	78.5	78.1	77	77	
Individually Purchased	15.0	14.3	15.2	15.1	14.3	15.3	17.5	17.3	16.8	16.8	17.1	16.5	16.4	16	16.6	16.7	18.0	17.9	17.7	17.9	16.7	16.7	16.7	
Total Public	30.3	30.5	30.6	34.1	36.6	38.4	40.8	39.4	38.8	37.8	35.3	34.6	34.8	35.8	37.9	40.0	42.5	45.1	45.5	45.5	47.7	51.0	58	
Medicare	3.1	3.2	3.2	3.5	3.5	4	3.7	3.7	4.1	4.6	4.7	4.8	4.9	5.4	5.9	5.8	6.2	6.3	6.4	6.5	7.1	7.7	7.3	
Medicaid	18.6	19.1	19.5	22.7	25.2	28.9	28.4	29.1	28.4	28.6	26.4	25.2	25.5	26.2	28.3	29.9	32.4	34.6	34.7	34.9	36.3	39.2	44.1	
Ticare/CHIP/PA*	8.6	8.2	7.9	7.9	7.9	7.5	7.5	8.7	7.5	6.9	6.6	6.6	6.6	6.6	6.6	6.6	6.9	7.4	7.7	7.1	7.5	7.8	8.3	
No Health Insurance	29.5	31.1	31.7	32.9	33.6	35.4	36.4	36.5	37.3	38.3	39.9	39.4	38.5	38.2	39.5	41.8	43.1	43.0	44.4	46.5	45.0	45.7	50	
Total Population	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Total Private	77.1%	76.4%	76.4%	74.7%	73.5%	72.8%	72.0%	71.9%	71.8%	72.0%	73.7%	74.1%	73.2%	74.9%	73.6%	72.4%	71.1%	70.2%	69.6%	69.0%	67.5%	65.3%	65.3%	
Employment-based Coverage	70.1%	69.8%	69.4%	67.8%	67.1%	65.5%	64.3%	64.4%	64.6%	64.8%	64.4%	64.4%	64.4%	64.4%	64.4%	64.4%	64.4%	64.4%	64.4%	64.4%	62.2%	62.2%	61.1%	59.0%
Individually Purchased	7.0%	6.6%	7.0%	6.8%	6.4%	6.8%	7.2%	7.2%	7.2%	6.9%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%	
Total Public	14.1%	14.1%	14.0%	15.5%	16.4%	17.0%	17.8%	17.1%	16.7%	16.2%	14.9%	14.5%	14.6%	15.3%	15.9%	16.8%	17.7%	17.7%	17.5%	18.2%	18.4%	21.2%	21.2%	
Medicare	1.4%	1.5%	1.5%	1.6%	1.6%	1.6%	1.8%	1.8%	2.0%	2.0%	2.0%	2.2%	2.3%	2.3%	2.3%	2.5%	2.5%	2.5%	2.5%	2.7%	2.9%	2.9%	2.9%	
Medicaid	8.7%	8.6%	8.9%	10.3%	11.3%	11.9%	12.7%	12.7%	12.7%	12.2%	11.2%	10.8%	10.6%	10.7%	11.0%	11.9%	12.8%	13.0%	13.4%	13.9%	14.6%	16.7%	16.7%	
Ticare/CHIP/PA*	4.0%	3.8%	3.6%	3.6%	3.5%	3.3%	3.9%	3.2%	2.9%	2.8%	2.9%	2.7%	2.8%	2.7%	2.8%	2.7%	2.8%	2.7%	2.6%	2.6%	2.6%	2.6%	2.6%	
Total Uninsured	13.8%	14.4%	14.5%	14.9%	15.1%	15.7%	16.0%	15.9%	16.1%	16.4%	16.9%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	16.6%	

Note: Details may not add to totals because individuals may receive coverage from more than one source.



What the Customer Wants

Although the service offerings and products offered by retail pharmacies have changed over time, customers continue to value convenience. Table 62 shows many of the dimensions over which customers evaluate retail pharmacies.

Table 62. Reasons for Using a Specific Pharmacy

Service Issues	Very Important	Important	Not Very Important	Not Important at All
Pharmacists' ability to address questions and concerns	73%	23%	3%	1%
Pharmacists and pharmacy staff	65%	36%	4%	1%
Pharmacists coordinate care with doctor/others	60%	31%	7%	2%
Items for purchase other than medications	34%	33%	20%	13%
<i>Convenience Issues</i>				
Ability to call ahead to have Rx ready for me	76%	20%	4%	1%
Overall convenience	75%	24%	1%	0%
Pharmacy is conveniently located/accessible	73%	24%	2%	1%
Pharmacy hours are convenient for me	70%	27%	2%	1%
Wait times to pick up prescriptions	68%	29%	3%	1%
Pharmacy provides reminders to refill prescriptions	39%	28%	22%	10%
<i>Cost Issues</i>				
Pharmacy accepts my insurance card	91%	7%	1%	1%
Cost at primary pharmacy	74%	18%	2%	1%
\$4 or less generic program	58%	26%	11%	6%

Source: Pharmacy Satisfaction™ Pulse 2011 Household Study. Copyright © Boehringer Ingelheim Pharmaceuticals, Inc. All rights reserved. (3/2011) M190756TR

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December 13, 2011

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

Dear Chairman Kohl:

Re: Correcting the Record

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

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

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

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

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

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

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

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

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

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

Moreover, PBMs receive significant revenue from drug manufacturers that they define as other types of revenue besides rebates, and thus can avoid disclosing such revenue to health plans and employers and still claim to be "100% transparent" about rebates. This unreported revenue is often characterized as: "cost effectiveness rebates," "grants," "loans," "therapeutic switching fees," or "data selling."¹ "Transparency" should mean that a health plan or employer has a right to review rebates and that no unreported monies are retained by the PBM. Unfortunately, this is not the definition by which most PBMs abide².

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

Mr. Paz, referencing a report from the GAO, testified that PBMs have had tremendous success in driving down prescription drug costs. Upon a closer reading, it appears that this success may have been overstated. Mr. Paz cited the GAO report in testifying that PBMs receive "discounts from negotiating with drug makers, which average 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs and 53 percent below the retail cash price for generic drugs." The discounts cited by Mr. Paz do not accurately reflect the findings of the GAO report. The report identified these percentages of discounts when comparing the prices paid by PBM participants for

¹ See: <http://www.pharmacybenefitsacademy.com/documents/HayesBootCamp.pdf>.

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

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

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

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

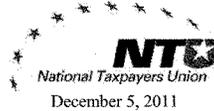
Finally, Mr. Chairman, we respectfully request for these reasons and those expressed during the hearing, that you write to the FTC and oppose the merger.

Sincerely,



Steven C. Anderson, IOM, CAE
President and CEO

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



December 5, 2011

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

Dear Senator Kohl:

On behalf of American taxpayers, I write to urge you and your colleagues on the Subcommittee to consider fully supporting the Express Scripts-Medco Health Solutions merger. This merger will permit these industry leaders to pursue greater savings on prescription medicines for patients, employers, and taxpayers.

As you may know, NTU's mission on behalf of fiscal responsibility and economic freedom has long included advocating for sensible federal regulatory policies toward mergers and competition, in sectors ranging from software to telecommunications to health care. Our experience tells us that an Express Scripts-Medco Health Solutions merger would result in benefits to consumers and the economy.

It is clear that cost issues surrounding prescription drugs can only be addressed through an open and competitive marketplace, despite the intentions of ongoing government-directed efforts to impact their prices. Uniquely in the health care industry, pharmacy benefit managers (PBMs) lower prescription drug costs and improve safety by managing drug benefits for many private and taxpayer-funded health insurance plans.

PBMs help control drug spending by leveraging purchasing power when negotiating with drug manufacturers – both brand and generic – and pharmacies for the fairest prices for their clients. Also, by evaluating incoming patient prescriptions for adverse drug interactions, availability of less-costly, medically-appropriate generic medications, and through the use of other clinical and economic tools, PBMs safely reduce drug-related spending for their clients. These efforts have had a tremendously positive impact on our health care system overall – 50 percent of which is supported by taxpayer dollars.

Government interventions, whether through imposition of unnecessary regulations or interruption of industry evolution, would severely compromise the ability of PBMs to introduce more efficiency and safety in the provision of prescription drugs to millions of employer-sponsored insurance beneficiaries. Especially during this time of major economic and fiscal uncertainty, we cannot afford to unnecessarily pay more for prescription drugs.

Because the PBM industry is so competitive, market participants have developed distinct tools and methods for achieving savings and providing quality care for clients and their beneficiaries. The proposed merger between Express Scripts and Medco Health Solutions would then combine the best practices of each company to further empower patients with greater and safer prescription choices and savings.

Impeding the merger of two companies that have been hugely successful in lowering costs sends a message to the health care industry that government leaders continue to believe they know best how to address the problems facing our health care system. I hope you and your Subcommittee colleagues will consider supporting real health care reform – represented in the form of this merger – that wouldn't cost taxpayers one cent to enact.

Sincerely,

Duane Parde, President

Cc: Ranking Member Lee and Members of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights

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AMERICANS FOR TAX REFORM

December 1, 2011

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

Dear Senator Kohl,

I write to encourage you and your committee members to consider free-market solutions to the rising costs of health care. In particular, the ballooning cost of pharmaceuticals is a problem that can only be addressed through an open and competitive marketplace. Pharmacy benefit managers (PBMs) play a critical role in lowering prescription drug costs by reviewing and managing medications covered under health care plans. Any government intervention intended to impede growth and evolution in this industry would undoubtedly compromise efficiency and taxpayer savings in the health care system.

PBMs play a critical role in lowering prescription drug costs by reviewing and managing the medications covered under health care plans. This incentivizes manufacturers to provide the best product for the best price to compete for placement in a plan. In effect, PBMs address the preeminent concerns facing the health care system today—safety and cost-effectiveness—without compromising either.

PBMs work to understand and address problems that cost the health care industry billions, such as patient compliance and harmful medication interactions. These losses are mitigated and could ultimately be prevented by the efforts made by PBMs to promote greater patient understanding.

The competitive nature of PBMs has allowed companies to develop diverse methods for controlling costs and providing safe medications. Thus, the proposed merger between pharmacy benefit managers (PBMs) Express Scripts and Medco Health Solutions would empower patients with greater prescription choice and broader pharmaceutical information. These companies have recovered preventable costs in the health care system without government mandate or management—to intervene as companies start to build on their successes would reverse significant pro-patient reform.

Discouraging the collaboration of two companies that have been tremendously successful in lowering costs and increasing safety would indicate lawmakers are not serious about addressing long-term sustainability in the American health care system. I encourage you to consider these points as the discussion on PBM mergers continues and urge you to refrain from any action that would allow this effective health care reform to move forward.

Sincerely,

Grover Norquist
 President
 Americans for Tax Reform

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Written Testimony of

George Paz

Chairman and Chief Executive Officer

Express Scripts Inc.

Before the

Senate Judiciary Committee

Subcommittee on Antitrust, Competition Policy and Consumer Rights

Hearing on The Proposed Merger between Express Scripts and Medco

December 6, 2011

1

Introduction

Chairman Kohl, Ranking Member Lee, and Members of the Subcommittee, my name is George Paz and I am the Chairman and Chief Executive Officer of Express Scripts, Inc. Express Scripts is headquartered in St. Louis, Missouri and has more than 13,000 employees located in 13 states.

I wish to thank the subcommittee for the privilege to testify and share my perspective on why and how the proposed merger of Express Scripts and Medco Health Solutions will be a win/win for the nation's patients and its public and private purchasers. Conversely, it is my hope that today's hearing will also make clear why failure to finalize and approve the merger will eliminate one of the best prospects we know to secure safer, better and more affordable pharmaceutical coverage and care for tens of millions of Americans.

Express Scripts is one of more than 40 pharmacy benefit managers, or PBMs, operating in the United States. Every year, Express Scripts is hired by thousands of small businesses, Fortune 500 employers, Taft-Hartley funds, managed care plans, and state and local governments to manage the pharmacy benefits for more than 50 million patients. Last year, our patients reported a 95% satisfaction rating.

Clients appreciate what we do to help them provide cost-saving, medically appropriate prescription drug coverage for American workers and families. Failure to produce savings and value for our customers means they turn to our competitors or attempt to manage the costs themselves. We are quite proud, however, that almost all of our clients "re-elect" us. Several of our more widely known clients such as, Blue Cross Blue Shield of Northeast Pennsylvania, Blue Cross Blue Shield of Massachusetts, MetLife and Lowes have contracted with Express Scripts for more than a decade.

Express Scripts is a genuine American success story. We have grown rapidly over our 25-year history, bringing innovation to the marketplace, driving out unnecessary or expensive spending in the pharmacy benefit and making medicines safer and more affordable. Since being founded in 1986, much has changed in the world. One overriding principle that forms the bedrock of our company never wavered: our goals will always fully align with our clients' needs. We are successful when our clients save money.

Simply and most accurately put, we and our competitors in the PBM industry are successful when our clients save money through lower employer and employee health premiums and/or reduced out-of-pocket costs while at the same time enhancing safety and more positive medical outcomes. To the extent we fail to deliver on that promise, we fail to retain and sustain our client base and business model.

PBMs Lower Prescription Drug Costs for Consumers & Payers

At Express Scripts, we work hard on behalf of our clients to rein in high drug costs, improve patient outcomes, advance the practice of pharmacy, and assist law enforcement in critical efforts to stop fraud, waste and prescription drug abuse. With nearly four *billion* prescriptions filled in

the United States last year alone¹, pharmacy is the most frequently used part of health care and demands the sophisticated tools and expertise only PBMs can bring to bear.

Express Scripts' fundamental mission is to make medicines safer, more affordable and more accessible. PBMs make prescription drugs more affordable for clients by creating old-fashioned American competition among brand-name and generic drug manufacturers as well as among more than 60,000 chain drugstores, mass merchandisers, independent pharmacies, and grocery pharmacies. We "ride the same horse" with our clients, helping them benefit directly from our bargaining know-how and world-class clinical initiatives.

At a time when many Americans struggle to afford their medications, sometimes having to choose between a rent check and the prescription to keep their diabetes under control, our role has real meaning in the lives of so many. When a patient visits a pharmacy, she leaves with both peace of mind and the right medication to improve her health and well-being. Whether a patient realizes it or not, through our rapid and robust high-tech adjudication process, more than 100 safety checks occurred *before* she left the pharmacy. These safety checks avoid costly drug interactions, contraindications, and other harmful medication errors. PBMs save lives and deliver real value for millions of Americans every day.

PBM-Generated Competition Lowers Drug Prices

PBMs have had tremendous success in driving down prescription drug costs for patients and payers. In doing so, PBMs have relied upon a wide range of tools and techniques, including expanded access to less costly, medically appropriate generic drugs, step therapy programs, and home delivery pharmacy. According to our data, Express Scripts members utilizing our full complement of tools enjoy an additional annual average savings of over 11 percent per year. These savings are in addition to the discounts from negotiating with drug makers, which average 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs and 53 percent below the retail cash price for generic drugs.²

The decisions we make and the innovations we bring forward are rooted in the best clinical data available anywhere in the world. A key tool PBMs rely upon to increase competition in the prescription drug supply chain begins with a Pharmacy and Therapeutics (P&T) Committee. Comprised of an independent group of highly-trained physicians and pharmacists, these panels review every marketed prescription medication to ensure safety, clinical appropriateness, and establish coverage parameters to guide formulary (the list of covered medications) development. These P&T Committees are focused solely on the clinical benefit of these medicines and are not involved in negotiations with pharmaceutical manufacturers, contracting with network pharmacies, or any other aspect of a PBM's business. The P&T Committee develops independent, science-based clinical parameters consistent with best medical practices, which

¹ IMS Health. "Channel Distribution by Prescriptions." 7 Apr. 2011. Accessed 15 Nov. 2011. Available at: http://www.imshealth.com/deployedfiles/ims/Global/Content/Corporate/Press%20Room/Top-line%20Market%20Data/2010%20Top-line%20Market%20Data/2010_Distribution_Channel_by_RX.pdf.

² US GAO. "Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees and Pharmacies" Jan. 2003. GAO-03-196.

PBMs use to build innovative programs and negotiate with drug makers to compete at the lowest price.

Perhaps a P&T Committee's role can be best explained through the example of a class of medications that treat high blood cholesterol (hyperlipidemia). Payers, whether health plans, employers or the federal government, spend more on prescription medications in this class than any other group of medications. Within this therapeutic class, there are dozens of available treatments. Looking just at statins, a sub-class that lowers LDL cholesterol, there are seven different medications available. As the P&T Committee reviews this class, clinicians examine all the available data, weed out the "me-too" drugs from truly novel therapies, and determine that a clinically comprehensive formulary should include generic medications and only one high-potency statin. With only one high-potency statin needed on the formulary, the manufacturers of these products blindly bid at the lowest possible price in an effort to ensure placement on the formulary. Price variation in this class is significant, with the monthly treatment costs varying from \$11 to more than \$200³.

In 2010, brand drug makers increased prices on statins by an average of 9.3 percent. Yet because of Express Scripts' sophisticated negotiating tools, our clients' exposure to this increase was limited to 6.3 percent – which translates to a 32 percent discount for clients. Our business model is a winning formula for patients, payers, and the entire health care system. Each of our clients makes their own choice about how to use these savings. Some use the savings to offset premium increases. Others offer these savings to patients through reduced copayments, coinsurance, or through copayment waivers altogether. Interestingly, the number of patients receiving treatment for high-blood cholesterol actually increased last year, addressing a public health concern well documented by the Centers for Disease Control and Prevention (CDC)⁴.

PBMs are creating competition in the drug supply chain. If a dozen different prescription medications treating the same condition were all covered by a health plan at identical levels, drug makers would be incentivized to maximize prescription drug prices to whatever level the market would bear. Instead, the use of independent P&T Committees creates a market dynamic where the manufacturers of these products must compete with one another for placement on the plan formulary. The result – patients and plan sponsors save money and have better health outcomes.

PBMs Have Driven Dramatic Decline in Drug Trend in the Past Decade

The emergence of PBMs correlates directly with the reduction in the rate of growth in prescription drug costs. In the late 1990s, the rate of growth in the cost of pharmaceuticals was growing at an all-time high annual rate of 18 percent. This growth rate was simply unsustainable. Employers seeking to rein in costs were desperate for help and began turning to PBMs in earnest for solutions. Throughout the 2000s, the annual rate of growth was reduced

³ Consumer Reports. "Evaluating Statin Drugs to Treat High Cholesterol and Heart Disease." June 2010.

⁴ Kuklina EV, Shaw KM, Hong Y. "Vital Signs: Prevalence, Treatment, and Control of High Levels of Low-Density Lipoprotein Cholesterol – United States, 1999–2002 and 2005–2008. Morbidity and Mortality Weekly Report." 2011;60(4):109–114. Available at: <http://www.cdc.gov/mmwr/pdf/wk/mm6004.pdf> Accessed February 4, 2011.

gradually to just 5 percent in 2009.⁵ This historic decline in drug trend is attributed to a variety of factors, including the expanded use of cost-effective generic alternatives. Trend management tools that promote the use of generic drugs are the single most potent tool to lower drug spending. Largely because of the leadership from companies like mine, the use of generic drugs has saved American patients and payers \$824 *billion* in the last decade alone⁶.

Medicare Part D: Working as Congress Intended to Lower Seniors' Drug Costs

Medicare and more than 40 million older Americans and people with disabilities have also benefitted from PBMs' tool and techniques. Prior to the advent of Medicare Part D in 2006, about one in three Medicare beneficiaries lacked prescription drug coverage. Without comprehensive drug coverage provided through PBMs, millions of seniors every-month faced agonizing choices that either meant forgoing needed medications or diverting scarce resources away from rent or food to pay for their prescriptions. Working together on a bipartisan basis, Congress passed historic legislation in 2003 modernizing Medicare by adding a much-needed prescription drug benefit.

Despite dire predictions by some of high costs and low participation, Medicare Part D has exceeded expectations. Beneficiary satisfaction is very high, with seniors enjoying broad access to a wide range of medicines. Plan participation is robust, with dozens of health plans and PBMs acting as prescription drug plan (PDPs) sponsors or Part D sub-contractors. Premiums are far lower than originally forecast and the program has come in under budget. In fact, the Center for Medicare and Medicaid Services announced in early August that 2012 Medicare Part D premiums will actually *go down* for the first time in the program's six year history. This is due to competition amongst Medicare Part D plans (administered by PBMs) and increased generic utilization.⁷ While there are important distinctions between Medicare Part D and how PBMs operate in the commercial marketplace – particularly how Part D's design protects drug makers from competition for certain classes of drugs -- Part D nonetheless builds on many of PBMs' core business functions.

Improving Patient Care through Prescription-Drug Adherence Programs

While Express Scripts and Medco have built very different capabilities to serve their patients, we have a shared mission to protect working families and small businesses from high prescription drug costs. Express Scripts has advanced this goal by applying behavioral sciences to healthcare to understand the reasons why patients may not always adhere to their medications. More than half of all patients fail to engage in behaviors consistent with their intentions. This disconnect between patient intent and reality results in the wasting of more than \$18 million of pharmacy

⁵ Centers for Medicare and Medicaid Services. National Health Expenditure Data. Available at: <https://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf> Accessed September 14, 2011.

⁶ IMS Health. "Savings: An Economic Analysis of Generic Drug Use in the U.S." Sept 2011. Available at: <http://www.gphaonline.org/about-gpha/about-generics/case/generics-providing-savings-americans>

⁷ US Department of Health and Human Services. "Medicare prescription drug premiums will not increase, more seniors receiving free preventive care, discounts in the donut hole." 4 Aug 2011. Available at: <http://www.hhs.gov/news/press/2011pres/08/20110804a.html>

benefits *each and every day*. Imagine if our system could recoup even a modest portion of this waste? These resources could be allocated much more effectively in other parts of the system.

Express Scripts helps close this intent-behavior gap and improve patient outcomes through the application of behavioral sciences. Inherently, we all want to use the least costly medicine, delivered safely as possible. Any number of barriers can come along that trip us up—leading to non-adherence, financial waste and poor outcomes. We cut through the noise and create simple to execute programs allowing people to act on their best intentions. While Express Scripts has focused on improving compliance, Medco has made a key priority of managing chronic illness through Therapeutic Resource Centers (TRCs). TRCs focus on patients diagnosed with different chronic diseases and employ an array of specially trained clinicians to optimize therapy effectiveness, maximize health outcomes by improving adherence, and help patients avoid adverse drug interactions. While our clinical capabilities are very different, we share the same goal that these capabilities will be a powerful complement to one another when the merger receives regulatory approval and is finalized.

Let me leave you with another example of how this combination will improve healthcare. You recall the excitement around the mapping of the human genome. We were promised a golden era of medicines. By and large, that promise has not been fulfilled. By bringing together our companies' complementary expertise in behavioral sciences and pharmacogenomics, we have the potential to truly deliver on the real promise of personalized medicine: ensuring that patients get the right treatment at the right time for the best outcome.

Reducing Pharmacy Fraud, Waste and Abuse

Another shared goal of Express Scripts' and Medco's business is driving waste out in the pharmacy benefit, deterring fraud, and reducing prescription drug abuse. In 2010, Americans unnecessarily spent more than \$400 billion on their health care, and risked their lives and health, by choosing the wrong medication, pharmacy or through simple but all-too-frequent non-adherence to their doctors' instructions⁸. Beyond wasteful prescription drug spending, these costs include unnecessary hospitalizations, testing and treatment in costly emergency rooms. These are very real problems with costs across the entire health system and PBMs are the most advanced partners to provide common-sense solutions.

As much as 1 percent of prescription drug costs result from fraud, waste, and abuse⁹. With Americans spending \$307 billion just on prescription drugs in 2010, this amounts to several billions of dollars in unnecessary costs to our system. Our clients already rely on us to help detect and prevent fraud, waste and abuse. Through advanced high-tech programs and processing systems, we save clients millions of dollars in wasteful pharmacy spending. Beyond saving money for our clients and patients by preventing this wasteful, and in some cases criminal behavior, our merger can bring new resources to bear for law enforcement to address America's other drug problem – prescription drug abuse.

⁸ Express Scripts. *2010 Drug Trend Report*. Apr 2011.

⁹ Pharmaceutical Care Management Association. White paper on Fraud, Waste and Abuse. July 2011.

Examples of fraud in the pharmacy marketplace are plentiful. A few years ago, six pharmacists, a doctor, and five drug dealers in Texas were convicted for conspiracy to divert more than 1.7 million tablets of prescription pain killers for illicit sale and use. The \$30 million scheme involved pharmacists repeatedly refilling fraudulent prescriptions that were dispensed to drug dealers. These criminal enterprises have become so wide-spread, several states have enacted anti-“pill mill” legislation to detect and end this kind of prescription drug abuse.

The combination of Express Scripts and Medco’s systems will create a new tool for law enforcement when investigating potentially criminal prescribing or dispensing patterns. With data from more than 65,000 pharmacies across the country, doctor-shopping, polypharmacy, and other instances of fraud can be stopped like never before.

Expanded Clinical Offerings

Express Scripts and Medco both have significant clinical capabilities to serve all of our patient groups. By combining these offerings, we can pioneer new drug safety systems, create new resources for public health, and continue to advance evidence-based medicine to better serve our patients.

Express Scripts has been on the cutting edge of improving patient safety. Through a combination of our P&T committee expertise, our vast database of prescription drug utilization, and post-marketing surveillance, Express Scripts identified serious safety concerns with Vioxx® more than six months before the FDA withdrew market approval. By combining with Medco, we will have even more clinical data that can create the largest and best real-time early warning drug safety system in the world.

This combined clinical data is also useful to public health. As various government agencies monitor epidemiology, or track supply chain disruptions in the United States, our resources will provide comprehensive data that have never before existed. The FDA, CDC, DEA and FEMA could all benefit from the comprehensive warehouse of supply chain data to track, distribute and respond to public health emergencies.

We also intend to continue our focus on evidence-based medicine that improves the safety and cost-effectiveness of prescription drugs. The growing availability of generic alternatives has already created enormous opportunities to better manage prescription drug spending.

Advancing Specialty Pharmacy Services

An Express Scripts-Medco merger will facilitate the advancement of specialty pharmacy services for patients facing the challenges of diseases like cancer, MS, leukemia, and hepatitis C among others. Express Scripts is very proud of our specialty pharmacy capabilities. We are at the forefront of providing specialized care to patients with chronic, complex diseases with medications that can cost tens or even hundreds of thousands of dollars per year. Our specialty pharmacy programs keep patients adherent to injectable and infusible therapies, avoid more costly treatment settings, and improve the livelihood of our patients. Our specialty pharmacies also partner with drug makers, the Food and Drug Administration, and the Drug Enforcement

Agency because of the need for post-marketing surveillance. Narrow distribution channels are necessary for drugs that are sometimes schedule III controlled substances. Specialty pharmacy is a complex business with competition both inside and outside of the pharmacy benefit, including retail pharmacies across the nation.

We Will Protect American Families from the Rising Cost of Prescription Medicines

A combined Express Scripts and Medco will be well-positioned to protect American families from the rising cost of prescription medicines. The Federal Trade Commission, the country's only regulatory agency tasked with both consumer protection and competition, is reviewing the competitive effects of our merger. After its thorough review, the FTC will make its determination as to whether the proposed transaction passes muster under the antitrust laws.

The PBM marketplace is highly competitive and dozens of PBMs compete for business in various payer streams providing coverage to roughly 260 million Americans, including the commercial marketplace serving large group, small group, and individual insurance markets, Taft-Hartley union plans, and an array of separate public programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, state employee benefit plans, and the federal employees' program (FEP). Multitudes of different PBMs service the Fortune 500 employers and the advent of the Medicare Part D program has dramatically increased the number of prescription drug benefit offerors.

While a focus on historical market shares ignores the highly complex and dynamic nature of the marketplace and how PBM business is bid and won, by our estimates, the combined historical shares of the companies would be less than 30 percent. This range falls well inside the parameters of mergers which have passed antitrust regulatory review.

The benefits of this merger are numerous and will accrue to patients, employers, clinicians, and payers alike by:

- Generating greater cost savings for patients and plan sponsors;
- Closing gaps in care and achieving greater adherence through behavioral approach and clinical strengths;
- Providing leadership and resources required to drive out waste and improve health outcomes;
- Utilizing shared expertise to better manage the cost and care associated with specialty drugs – the biggest driver of costs in the drug supply chain; and
- Responding to the national call for a more affordable and accountable healthcare system.

In conclusion, our health care system is at a crossroads. Consumers want the protection that comes from comprehensive coverage providing high-quality, affordable care, including

pharmacy benefits. Employers, already struggling in a difficult economy, are seeking greater value for their health care spending and are looking for a calm port amidst the storm of rising costs and middling outcomes. Policymakers are combing through our nation's accounting ledgers and finding Medicare and Medicaid awash in red ink.

The proposed merger of Express Scripts and Medco will not resolve all of the challenges facing our health care system, but it is an affirmative step in the right direction. The merger of Express Scripts and Medco will help make prescription drugs more affordable for seniors, people with disabilities and working families. It will also help small businesses and large employers better compete in a global economy by helping to rein in their medical costs. Finally, a combined Express Scripts and Medco will help deliver real savings to Medicare and Medicaid beneficiaries and put our nation's fiscal footing on a stronger foundation.

Thank you for the opportunity to testify today and to explain the consumer benefits and enhanced competition that will arise with a merged Express Scripts-Medco.

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David B. Snow, Jr.

Chairman and Chief Executive Officer

Medco Health Solutions, Inc.

December 6, 2011

Senate Committee on the Judiciary,

Subcommittee on Antitrust, Competition Policy and Consumer Rights

Hearing on the Proposed Merger between Express Scripts and Medco

I. INTRODUCTION

Chairman Kohl, Ranking Member Lee, and Members of the Committee, thank you for this opportunity to discuss the proposed merger of Medco Health Solutions and Express Scripts. My name is David Snow, and I am the Chairman and CEO of Medco Health Solutions. Medco is a leading health care company that has pioneered the world's most advanced pharmacy. We employ thousands of medical professionals, including more than 3,000 pharmacists and more than 1,000 nurses. We are an industry leader in developing innovative, clinically-driven pharmacy services that deliver unique value for a broad range of clients—private and public employers, health plans, labor unions and government agencies of all sizes—as well as individuals served by Medicare Part D Drug Plans. When we became a public company in 2003, our goal was to enhance the way health care is delivered in our country—to improve patient outcomes and lower costs. Passion to achieve that goal is what has driven our people and fueled our growth.

Medco's strategies are designed to help address one of the most pressing issues facing America today—the unsustainable, ever-increasing cost of health care. In 2010, U.S. spending for prescription drugs alone was more than \$300 billion and is expected to reach more than \$450 billion by 2019.^{1,2} As the health care industry necessarily focuses on reducing costs; as Congress seeks to find health care savings without compromising patient care; and as all participants in the system are faced with the prospect of doing more with less, we must make

¹HMS Institute for Healthcare Informatics' study, "The Use of Medicines in the United States: Review of 2010," April 2011.

²Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2010.

our health care dollars work more effectively. We believe that the services that Express Scripts and Medco, working together, will provide are critical to achieving this goal.

Across every level of health care, organizations are evaluating their strategies to prepare for a new era that will be defined by greater efficiency, tighter coordination of care and an imperative to create value and deliver proven results. They are restructuring their enterprises and combining with strong and complementary partners to meet the higher expectations of payors and consumers, and to effectively operate in a new environment of accountable care. Doctors' offices, hospitals, health insurance providers and pharmaceutical manufacturers are all engaged in combinations to accelerate innovation, improve their productiveness and reduce their costs. With the combined expertise and capabilities of Medco and Express Scripts, we will be able to speed the pace of delivering value-added solutions that address the pressing need to reduce overall costs and raise the standard for quality care.

II. MEDCO BACKGROUND

Medco has distinguished itself as one of America's most trustworthy, innovative and admired companies. This year, Medco captured the No. 1 position in the Health Care: Pharmacy and Other Services sector on Fortune's World's Most Admired Companies List for the fourth consecutive year.

Through our innovative solutions, we drive drug costs down for our clients and patients in service to our more than 65 million members across America. Our clients include private and public employers, health plans, labor unions and government agencies of all sizes. We also

serve individuals under our Medicare Part D Prescription Drug Plan, which in 2010 received the first and only five-star rating for a national plan from the Centers for Medicare & Medicaid Services (CMS).

Both Medco and Express Scripts' models require that we establish a collaborative environment that aligns interests across payors, retail pharmacies, physicians, pharmaceutical manufacturers, and CMS for Medicare programs and state agencies for Medicaid. We provide our services through a nationwide network of retail pharmacies, both independents pharmacies and chains, our own mail order pharmacies, and specialty pharmacies that we and others operate across the country.

Medco's success in this collaboration is well-documented. In the last eight years, revenues have more than doubled, and we have nearly doubled our employee base, which is overwhelmingly in the U.S., to more than 23,000 people—despite one of the most challenging economic environments in generations. This is in large part because the clients we've gained recognize the value that we create and patients benefit from the advanced clinical services we provide. Since 2003, our clients and patients have saved more than \$20 billion from increased utilization of generics alone, and Medco expects to deliver another \$6.5 billion in savings in 2012.

Medco's success is also driven by innovation. Since 2003, Medco has invested nearly \$1.8 billion in capital expenditures alone. These are investments on U.S. soil and have been directed toward delivering new clinical programs and higher levels of service to clients and members. We have designed and developed sophisticated automated mail-order pharmacies

that are widely considered the world's most advanced and most accurate. For chronic medicines, which patients often take for a protracted period of time to address conditions such as high blood pressure or high cholesterol, our mail order pharmacies dispense a 90-day supply of drugs efficiently and accurately. This efficiency translates to lower costs for clients and savings for consumers through more competitive pricing.

But there is much more to the Medco equation than our ability to deliver medicine for a lower cost. The clinical programs designed by our pharmacists and nurses ensure that we deliver the right medicine, in the right dose, to address the right conditions, and then that those medicines are taken as prescribed by the patient's physician. We call this "closing gaps in care," or eliminating omissions in care, where patients are either not taking their medicine properly or not being treated effectively for a known condition.

Our advanced clinical model is focused specifically on meeting the needs of patients with chronic and complex conditions. While representing only 50 percent of the population, these patients account for an estimated 96 percent of all prescription drug spending and more than 75 percent of all health care costs. Optimizing the pharmacy care of these patients is a proven means to deliver the greatest overall impact on improving their health and reducing overall costs. Our model is centered on what we call Medco Therapeutic Resource Centers (TRCs), which are staffed with pharmacists who are deeply trained in specific disease categories and their associated medicines and co-morbidities.

A good example of how the model works is to consider its impact on a patient under treatment for diabetes. In a situation where a diabetes patient is not taking their medications

as prescribed, not testing for cholesterol and heart disease, and not monitoring their blood sugar properly, drug costs would be saved through such non-compliance. However, catastrophic and costly outcomes would ultimately be highly likely—ranging from renal failure, blindness and amputations to stroke and premature death. Diabetes is one of the most prevalent conditions, but with consistent treatment, it is also one of the most manageable. Our TRC for diabetes provides a new level of insight and care for these patients—significantly improving therapy adherence levels, averting the tragic human consequences of a progressive illness and lowering overall health care costs. With diabetes reaching near-epidemic proportions in our society, this level of care is increasingly important.

In short, Medco's clinical solutions keep patients healthier, out of the hospital, and on the job—and ensure affordable care is more accessible for all. Combining these capabilities with Express Scripts' focus on improving patient compliance to medications will allow the collective impact we make to enhance the quality of life for millions of patients and reduce overall costs in our health care system.

III. DYNAMIC MARKETPLACE

To fully appreciate the value that is created by the merger of our two companies, it is critical to recognize the dynamic marketplace in which we operate. The business of pharmacy benefit managers is characterized by robust competition, with more than 40 PBMs aggressively competing to provide differentiated value propositions for public and private payors of all sizes. Today, no fewer than 10 PBMs serve Fortune 50 companies, seven PBMs each process more than 150 million prescriptions annually, 12 PBMs serve more than 5 million members each, and

at least nine PBMs serve large state accounts. Additionally, nine Fortune 500 companies operate PBMs directly for their employees.

All PBMs are not alike. Some are integrated with pharmacies, some with managed care organizations and others are entirely independent. Non-PBM participants such as Wal-Mart and Target offer low-price generic prescriptions, as do other retail pharmacies that are providing steep discounts on 90-day prescriptions. Retail chain pharmacies remain powerful—for every single prescription filled by mail order, eight are filled by large chain stores.³

The core services that we and other PBMs offer are similar, regardless of the size and nature of a client's business; this enables competing PBMs readily to reposition from one group to another. At the same time, the PBM services that customers choose to purchase may vary. Some customers choose to assemble their own network of retail pharmacies to fill the prescriptions of their members or employees, and contract separately with those retailers. Other customers design their own formulary, which determines which prescription drugs are covered by a customer's plan.

PBM customers themselves differ as well, including in important dimensions such as the demographics of their members or employees. An entire industry of consultants exists to assist the buyers of PBM services (those employers, health plans, labor unions and government

³Adam J. Fein, "2010-11 Economic Report on Retail and Specialty Pharmacies," Pembroke Consulting, December 2010 and US Census 2009 Annual Retail Trade Report, Gross Margin, March 31, 2011.

agencies that comprise our client base) in designing a prescription drug plan best suited to the customer's needs, and pit PBMs against each other to provide the required services at the lowest possible cost. This is not a one-size-fits-all business. Instead, it is a business where PBMs constantly change to better meet the evolving needs of our customers. With that change comes opportunity, for existing PBMs and new PBMs alike, to win new accounts and expand their business.

Our competitors often are major industry participants with household names that include Aetna, Cigna and CVS/Caremark. Other competitors may not be as well-known but continue to make major investments to grow and are intent on taking advantage of the opportunity created by change to better serve their current and potential new customers.

For example, the PBM Catalyst acquired Walgreens' PBM in June, more than doubling its business in terms of number of members and prescriptions. This strategic transaction builds on Catalyst's 2010 acquisition of Future Scripts, the PBM arm of Independence Blue Cross, and its 2008 acquisition of Immediate Pharmaceutical Services, a mail order pharmacy. In a recent earnings call, Catalyst's COO highlighted the company's recent success in winning large, national employers during this selling season—and that was even prior to the Walgreens' acquisition. Several of Catalyst's recent Fortune 500 new-client wins were previously served by Medco and Express Scripts. These wins added large companies such as Ford Motor Company, MGM Mirage International, Whirlpool and Waste Management to its growing roster of Fortune 500 customers—a list that already included companies ranging from Nike and Sprint to Southwest Airlines and Lear Corporation.

Prime Therapeutics recently won from Medco the Blue Cross and Blue Shield of North Carolina account with more than a billion dollars in drug spend. Prime originally was formed as a joint venture among selected Blue Cross Blue Shield health plans across the country. Today Prime includes twelve different Blue Cross Blue Shield plans as equity owners. In addition to serving as the private-label PBM inside those plans, Prime has expanded to a major PBM competing nationwide for both health plan and employer accounts of all sizes and now covering 17 million lives.

A few months ago, SXC Health Solutions, No. 1 on Fortune's 100 Fastest-Growing Companies list, agreed to acquire PBM PTRx and mail order pharmacy provider SaveDirectRx, providing another dramatic illustration of the constantly evolving nature of PBM competition. At one time SXC was thought of as more of a data processor for PBMs and other health organizations. But they evolved with the marketplace and now offer a full-service PBM that competes effectively. SXC's recent addition of Bravo Health Plan to its roster of clients captured more than \$1 billion in additional drug spend. And just last month, SXC announced its agreement to acquire the HealthTrans PBM, which will increase SXC's covered lives from 8.3 million to 23.6 million.

Perhaps nothing more clearly demonstrates the dynamic character of the PBM business than the evolution of our Medco customer, UnitedHealth Group, now the largest single health carrier in the U.S. In 2005, as part of the PacifiCare acquisition, UnitedHealth acquired Prescription Solutions, a significant stand-alone PBM now rebranded as OptumRx. UnitedHealth has steadily built OptumRx to the point that it now covers 12.7 million lives. This

summer it was announced that UnitedHealth's contract with Medco would not be renewed and that the 14 million lives currently served by Medco would be added to OptumRx. With over 26 million covered lives and billions of dollars in revenue, OptumRx immediately becomes a major competitor in the marketplace, one that is widely regarded to be a significant force going forward.

UnitedHealth has publicly highlighted its increased investment in OptumRx and its intention to aggressively engage the marketplace to serve accounts of all sizes. As a senior UnitedHealth executive noted on a recent earnings call: *"We've been working on improving OptumRx consistently over the last 3 or 4 years and believe that we, actually, are quite competitive right now, and we'll continue to be even more competitive. We're hearing from consultants that OptumRx is well positioned, has a rising profile in the national accounts market in particular and is increasingly seen as a thoughtful alternative to the big PBMs."*⁴

As is evident from these few examples, competition across the PBM business is both intense and diverse. We compete against a wide range of firms, generating a number of wins, as well as some significant losses. To further demonstrate the dynamic and fluid nature of our business—and to underscore the fierce competition—Medco won more than \$10 billion in new business in 2009, and lost more than \$10 billion in 2012. As mentioned above, we will also lose UnitedHealth as a customer, currently representing annual revenues of approximately \$11

⁴ Jacqueline B. Kosecoff from transcript of UnitedHealth Group's Earnings Call Discussion of Q3 2011 Results, October 2011

billion. This \$21 billion in lost business is substantial, considering Medco's 2011 revenues are estimated at \$68 billion.

And, as Former Sen. Tom Daschle (D-S.D.) noted in a recent opinion piece, the passage of the Affordable Care Act (ACA) is prompting change: *"We are seeing today a natural first wave of adjustments in response to the ACA. Those organizations and companies that deliver better quality at lower cost will thrive in this new environment. Those that don't will suffer. But the result will be a healthcare system that truly starts to look like a system that is much more integrated and delivers better patient care. And that will be a benefit to us all, now, and in the future."*⁵

Taken together, these recent activities demonstrate the dynamic, competitive nature of the PBM marketplace and belie the notion that the combination of Medco and Express Scripts represents a threat to client choice. The reality is that the PBM business is extremely competitive today and that competition will only be enhanced —not diminished -- by the Express Scripts-Medco merger.

IV. BENEFITS OF THE COMBINATION

It is within the context of this competitive marketplace that the merger of our two companies was conceived and ultimately approved by our respective executive management teams and boards of directors. To succeed, a PBM must lower drug prices and improve the quality of care for its clients and patients. The Congressional Budget Office has estimated that

⁵Tom Daschle, "Sharing Information to Improve Healthcare," The Hill, December 2011.

PBMs reduce drug costs by as much as 30 percent.⁶ And as validated in a recently released study, Medco and Express Scripts will save their clients and members up to \$87 billion per year in total drug spending, compared to what would have been spent in an unmanaged environment.⁷

The combination of Medco and Express Scripts makes strategic sense for our clients and patients. Each company employs a fundamentally different business model, and combining the best attributes of both will create an enhanced capability to lower prices and improve quality care for patients. We will accomplish this in a number of ways, including the following:

First, the merger of Medco and Express Scripts will result in immediate savings to our clients and, ultimately, to consumers. This is because our combined entity will achieve even greater purchasing volume discounts from drug manufacturers and other suppliers. Under the terms of our existing contracts alone, we project that at least \$1 billion in savings from the merger will be passed back to our clients annually starting immediately. These savings are part of our contractual requirements, certifiable by us and independently auditable by our clients.

Second, the merger will allow the companies to streamline operations and implement each other's best practices. Our ability to drive higher volumes through a combined network with fixed overhead also will create efficiencies to reduce the unit cost of medications for our patients and customers. Savings from these synergies are estimated at \$1 billion.

⁶ Congressional Budget Office, "Issues in Designing a Prescription Drug Benefit for Medicare," October 2002, Table 6 at 40.
⁷ Jonathan Orszag, "The Economic Benefits of Pharmacy Benefits Managers," December 2011

Third, the merger will allow us to apply our advanced technology platforms across all elements of the expanded company to seamlessly integrate prescription management at both mail order and retail with our client and member services, and facilitate collaboration with physicians to deliver the benefits of new science more quickly to patients. The combined entity will advance the transition to wired health care—building on our strong foundation to improve communications among patients, physicians and pharmacists, enabling real-time secure access to vital patient information, enhancing drug interaction screening and furthering the cause of evidence-based medical practice.

Fourth, Medco and Express Scripts will effectively join forces to combat fraud, waste and abuse, which is estimated at about 1 percent of all prescription spending, or \$3 billion a year.⁸ The merger will allow us to enhance our ability to help state and federal law enforcement in their efforts to shut down so-called “pill mills” that fraudulently bill the health care system by more effectively monitoring claims data to detect patterns of potential fraud and abuse.

Finally, and perhaps most significantly, the Express Scripts–Medco combination will empower the two companies to use their collective and complementary expertise to close gaps in care—attacking the estimated \$290 billion in avoidable medical spending annually, resulting

⁸Pharmaceutical Care Management Association, “Fraud, Waste, and Abuse Detection in Retail Pharmacy: The Drugstore Lobby vs. Employers,” July 2011.

from patients' non-adherence to their prescribed medications and representing about 13 percent of all health expenditures.⁹

Medco's TRCs house more than 1,000 specially-trained Medco pharmacists, who use evidence-based clinical protocols to ensure patients are taking the right medicines and overcome barriers to adherence. Our pharmacists are available around the clock to consult with physicians and counsel patients. Medco's investment in its TRC model has served our patients well—we closed 2.3 million gaps in care in 2010 alone, with a projected savings of approximately \$900 million by reducing hospitalizations, ER visits, and other medical expenses across a range of chronic and complex conditions.¹⁰ At the same time, through its Consumerology initiative, Express Scripts has applied advanced behavioral science to identify and change common behaviors that prevent patients from adhering to their prescription medications. Their research has also helped to increase generic substitution and increase use of the most efficient and safest delivery channels. Express Scripts has documented this increased adherence and its associated cost savings, which are significant.¹¹

Combined, we can amplify our impact to reduce overall costs by improving the quality of patient care. This will make American business more competitive—creating a healthier, more productive workforce, preserving existing jobs, and creating new jobs in the future.¹² This will

⁹ New England Health Care Institute, "Thinking Outside the Pillbox: A System-wide Approach to Improving patient medication Adherence for Chronic Disease," August 12, 2009 and Jonathan Orszag, "The Economic Benefits of Pharmacy Benefit Managers," December 2011.

¹⁰ Medco 2010 Annual Report

¹¹ ESI 2010 Drug Trend Report

¹² David Cutler and Neeraj Sood, "New Jobs Through Better Health Care," Center for American Progress, January 2010.

also drive greater savings in the Medicare and Medicaid programs without the need to reduce benefits.

V. INDEPENDENT PHARMACIES

We recognize that some have voiced concern about the effect of an Express Scripts-Medco merger on retail pharmacies—particularly on independent community pharmacies. The facts are that more than 85 percent of prescriptions filled for Medco customers are filled through our networks of more than 60,000 retail pharmacies representing about 95 percent of all retail pharmacies nationwide. Even as our companies seek to drive efficiency in the health care system, retail pharmacies of all sizes will continue to play a crucial, complementary role to the mail order pharmacies operated by PBMs.

Today, PBMs provide services that help independent pharmacies better care for their patients, increasing adherence and reducing adverse drug interactions. The Express Scripts-Medco combination will create additional partnership opportunities that can help independent pharmacies better serve their customers and create new sources of value.

As PBMs have become increasingly important participants in the health care system, independent pharmacies have also thrived. Between 2009 and 2010, the number of independent community pharmacies grew by almost 400, to more than 23,000, representing a \$93 billion industry. Last year, they filled nearly three times more prescriptions than were filled through mail order delivery services. Additionally, in a challenging economy, independent retail

pharmacy profits have doubled since 1999, with average profits per pharmacy of close to \$1 million.¹³

In short, PBMs and independent pharmacies both benefit from a growing demand for more and better prescription care. It is our expectation that a successful Express Scripts-Medco—far from being a threat to independent pharmacies—will actually be a driver of improved care for our mutual customers and improved economics for their businesses.

VI. CONCLUSION

Our testimony confirms what our market experience has long told us: the health care system is at its best when there is competition, innovation and collaboration. We stand ready to serve as a leader for experimentation and progress, resulting in continuous improvements, and even breakthrough solutions.

We all know the future of health care belongs to those who deliver more for less. The merger of Express Scripts and Medco is part of that transformation of America's health care system. Together, we will build a strong, competitive company that helps millions of people to live longer, healthier lives, while supporting the nation's goal of a sustainable, affordable health care system.

¹³Drug Channels, "Owning a Pharmacy: Still Pretty Profitable", January 25, 2011 (Analysis of 2010 NCPA Digest Data)

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**Written Testimony of
Scott E. Streator**

**Associate Vice President Business Development,
The Ohio State University Medical Center
Former CEO of The Ohio State University Health Plan, Inc.**

Columbus, Ohio

**Before the
United States Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer
Rights**

December 6, 2011

1

Introduction

Chairman Kohl, Ranking Member Lee and Members of the Subcommittee, my name is Scott Streater and I am pleased to have been invited by you to testify on the Express Scripts-Medco merger. I will provide a multi-faceted perspective on the issue at hand: "Cost Savings for Consumer or More Profits for the Middlemen"?

My testimony will reflect over twenty years of experience in healthcare and pharmacy benefit management, from each angle: Payer, Provider and Plan. Each of these perspectives of course represents the ultimate customer, our patients. This testimony is my own, and does not represent an official position of The Ohio State University.

By way of background, I began my professional career as a clinical pharmacist at Johns Hopkins Hospital, provided medication management consulting in various health delivery channels and have spent the majority of my career working in health benefit management to innovate, implement and promote cost containment strategies.

My employer, The Ohio State University Medical Center is future-focused and driven by a mission to improve people's lives through innovation in research, education and patient care. The Medical Center, with 17,000 employees, serves more than 1 million patients each year at its main medical campus in Columbus, Ohio and a network of additional sites around Central Ohio. Research funding has surpassed \$291 million and over 2,000 research studies are ongoing in virtually every medical specialty. Ohio State's College of Medicine educates more than 800 medical students each year and 1,600 students in the allied medical professions. Today, 13,500 College of Medicine MD and residency program graduates practice in all 50 states and in more than 50 countries around the world.

Recently, I served as the CEO of The Ohio State University Health Plan, managing the medical and pharmacy benefit for our 56,000 health plan members with a focus on health promotion and clinical integration. The OSU Health Plan is also privileged to serve as the administrator of the Rx Ohio Collaborative, a partnership amongst Ohio-based plan sponsors who competitively contract with a single PBM, currently ESI, in a transparent manner. This public-private sector partnership provides services to our member organizations in the areas of benefit consulting, data analysis from our OSU College of Pharmacy and pooled purchasing of benefits to approximately 80 different Ohio-based employers representing 540,000 members and over \$1B in pharmaceutical expenditures annually. This business model allows deep

discounts and consultative services to all employer groups so that the financial benefits are realized for any size employer from the small to the large.

Each individual plan sponsor in the Rx Ohio Collaborative is self-insured and therefore has autonomy and financial responsibility for their respective benefit designs. Therefore no provider, nor PBM, mandates how payers in the Collaborative design their benefit structure. Each plan sponsor is responsible for funding and providing benefits to meet their respective organizational requirements. This is an important distinction to make, as community pharmacy providers may assume benefit design decisions rest with the PBM or health plans instead of the individual payer or plan sponsor such as self-insured employers.

Key Position

As one who has been engaged in this industry as a payer, plan administrator and provider, it is clear to me the Express Scripts-Medco merger will further spawn competition from existing pharmacy benefit managers, health plans and emerging business models that can lead to lower overall pharmaceutical therapy costs for payers and consumers. Therefore, I am in favor of this merger.

Greater Competition from Health Plan/Insurers as a result of PPACA

From a payer and health plan perspective, the business context is important before explaining how market forces, competitors and the Patient Protection and Affordable Care Act (PPACA) may alter the PBM industry landscape.

The Pharmacy Benefit Manager (PBM) serves as the claim administrator function in the ERISA self-funded plan sponsor environment. The PBM will administer the plan design according to the rules identified and established by the plan sponsor, or end payer. Areas where the PBM has considerable influence are in the development of the formulary, or list of preferred medications, and in negotiating prices and rebates with pharmaceutical manufacturers. The PBM also negotiates reimbursement rates with the community pharmacy provider network. The PBM can provide these types of services for private sector employers, health plans or governmental agencies.

Historically, self-funded government and private sector purchasers generally contract for pharmacy benefit management services directly from a PBM or a health plan/insurance carrier. Health plan/insurance carriers thus have the option to "carve-in" or "carve-out" the pharmacy benefit. If carved-in, the health plan operates the internal PBM function that allows a plan sponsor to contract for medical and pharmacy benefits. If carved out,

essentially the health plan out-sources a range of functions to a PBM for a given fully insured or self-insured population.

While the market share of health plan-owned PBMs has fluctuated over the years, in today's new PPACA environment, insurance carriers may increasingly decide to carve in, or in-source, this benefit management function as evidenced by United Healthcare's decision to in-source the pharmacy benefit beginning in 2013. In terms of competition, not only has this significantly reduced Medco's market presence, but United's PBM (OptumRx) represents another competitive market entrant with the combined UHC/Optum Rx membership in excess of 20M. Thus insurance carriers can now offer a more competitive alternative to stand alone PBMs by using their own in-house PBM.

As another example, Humana, with approximately 6M members and \$12B in drug spend is an "in sourced" PBMs offering. Like other insurance carriers/health plans, Humana competes for Medicare Advantage, PDP members and direct employer contracts. Similarly, Cigna (Cigna Pharmacy Services) and many of the Blue Cross/Blue Shield insurance carriers such as Prime Therapeutics also offer an in-sourced PBM option.

With the likelihood of insurance exchanges emerging for the individual and small group market, the in-sourced PBM offering coupled with the health insurer may be an attractive offering for health plans that do not yet effectively integrate clinical, data and core operational functions across the pharmacy and medical benefit.

Greater Competition from Pharmacy Benefit Managers

I remain optimistic the proposed merger of Express Scripts and Medco will further generate competition with innovative business models that could produce lower costs; some of which will be shared with the payers and consumers of healthcare. More and more, employers are willing to consider innovative solutions to reduce costs and are open to new pharmacy benefit management strategies they may not have considered before.

In terms of PBM organizations competing directly to employers in a "carve out" program, there are a growing number of attractive options to payers, including members of the Rx Ohio Collaborative and other coalitions. While three PBMs have had the majority of market share in the past, there are several companies that have evolved recently with strategic acquisitions to develop a robust infrastructure that can now accommodate large employer needs on all levels. As a result they are gaining market share. For instance Catalyst, SXCI, Navitus, MedImpact, OptumRx, Envision, CVS-Caremark, and Welldyne are several options available in today's PBM marketplace depending on individual or purchasing group needs.

Further, as the barriers to entry in the PBM market have decreased, new PBM entrants will emerge such as retail-only PBM models.

Meanwhile, irrespective of the size of the PBM, end payers can develop innovative partnerships with their PBMs to increase the purchasing value available to them, and to reduce costs. For example, at Ohio State University, we realized savings synergy in our pharmacy benefit when we combined our lives with other large, sophisticated purchasers. We leveraged local public-private expertise, conducted a thorough due diligence bidding process and then selected a PBM that could deliver savings, transparency, service and innovation.

As a result, Ohio State University has saved approximately \$10M or 9% for the first three-year term and is on track to continue these savings. Last year, when brand drug makers increased prices by 4.2%, OSU's current per capita ("drug trend") pharmacy benefit expenses have decreased by 0.4%, while our generic dispensing rate increased 3.4%.

For government and private sector employers, these cost containment initiatives are imperative and can help preserve jobs or provide benefit dollars to invest in health promotion and wellness programs for employees. Moreover, other plan sponsors have realized significant savings from clinical programs available from the PBM platform that is not dependent on size of the PBM.

ESI-Medco

The proportion of savings realized to plan sponsors from a PBM is largely dependent on how effectively plan sponsors leverage their purchasing power with competitive, transparent contracting; utilization of clinical programs; and actively manage their benefit. While competition is escalating to provide the best value and lowest costs to payers, current customers of ESI and Medco are also hoping to financially benefit from the combined ESI-Medco platform.

While the Food and Drug Administration works diligently to ensure safety and efficacy, there is no "comparative effectiveness" requirement on prescription drugs as in other developed countries. The merger of ESI and Medco, along with other PBMs, will continue to provide the market pressure on cost containment of pharmaceutical manufacturers. Payers expect the PBM to leverage their book of business to obtain the best value for their expenditures from pharmaceutical manufacturers. Until comparative effectiveness research matures, PBMs and health plans provide drug coverage determination, formulary management and negotiate rebates with pharmaceutical manufacturers on behalf of plan sponsors. Larger PBMs could leverage size in reducing the net cost of various prescription drugs with pharmaceutical

manufacturers; however, the ability to drive market share of the lowest net cost can be done irrespective of the PBM's size.

At the same time, as a result of blockbuster brand drug patent expirations, over 75 of every 100 prescriptions are now filled with generic medications that save over \$150 per prescription for our beneficiaries. This wave of patent expirations will limit ESI-Medco, or any PBM's ability to generate increased rebates in a number of therapy classes.

The proliferating "specialty" drug classes, or biologics, have been managed by the PBMs due to unique distribution requirements, monitoring, and patient education requirements in this small subset of the pharmaceutical marketplace. The Express Scripts-Medco merger will provide a sizeable purchasing and clinical platform to benefit payers. While some believe the combined specialty market share approach 50% with this proposed merger; it is important to note that half of specialty drugs and many new biologics anticipated to receive approval by the FDA in coming years, can only be distributed and administered at physician offices or outpatient settings. This shift to infused or physician administered products will effectively reduce this perceived market share. Regardless, at costs that can exceed more than \$10,000 per month, the combined purchasing power of larger PBMs should underscore the need for an accelerated bio-generics or bio-similar approval pathway as there is *little if any competition for various biologics or specialty products*.

While there are certain scale advantages of large PBMs, it is important to note flexibility can be a tradeoff. It is well established clinical programs can yield tremendous savings that far exceed simple drug discounts for plan sponsors. For example, when Prilosec OTC was introduced several years ago, PBMs that swiftly changed formularies, distribution strategies and implemented customized plan design changes produced tangible savings far exceeding discounts of leading brand-name prescription products for their payer customers. Smaller PBMs and health plans can be more agile in implementing customized programs to meet local health market characteristics and plan sponsor requirements.

An important competitive consideration with this proposed merger is the affect on community pharmacists and their role as network providers. Plan sponsors and consumers should be given choice of their preferred drug distribution channel. With the growing Medicare Advantage/PDP, the 90 day retail supply provides competition to the ESI-Medco mail pharmacy distribution channel. For the Rx Ohio Collaborative there is no "preferred channel" of distribution as each employer plan sponsor is responsible for their own unique plan design.

While reimbursement to community pharmacy needs to be competitive; true savings sought by pension systems, government, and private sector employers will be a result of

coordinating care, improving compliance, safety, and quality of health care. Thus, PBMs and health plans need to integrate with community physicians and pharmacists to ensure patients are on the proper medications, and medications therapies are appropriately managed as part of a coordinated care process for improved outcomes.

Emerging Models

This leads me to my final point; there is an over-emphasis in the payer and provider community by equating value with “discounts,” whether the discount is in the form of physician’s “fee for service” charge or a discount off the pharmaceutical’s ingredient cost and dispensing fee. Regardless of what ultimately happens with PPACA, it is clear the current fee for service reimbursement model in physician and hospital sectors is evolving from “payment for volume” to “payment for value.” In the future, due to the passage of the PPACA and payer financial pressures, the insurance risk will increasingly shift from payers to the physician/hospital delivery channel as evidenced by greater financial risk for hospital readmissions and bundling of payments for episodes of care. These may indeed replace the current discounted fee for service reimbursement schedules.

How will new financial models alter the PBM and community pharmacy industry? Since reimbursement of pharmaceuticals is also largely based on discounts off the ingredient cost, it is unclear how new health financing models will modify the current reimbursement model. As the Patient Centered Medical Home and Accountable Care type of organizations emerge, coordination of care and outcomes will be valued versus the current “compartmentalization” of pharmaceutical expenses. In these emerging reimbursement models where the risk shifts to the health delivery system; managing costs of pharmaceuticals in a “silo” while important, will be de-emphasized versus improving the overall effectiveness of managing medication therapies across the entire care continuum.

For example, in the November 24, 2011 New England Journal of Medicine article “Emergency Hospitalizations for Adverse Drug Events in Older Americans” an estimated 37% of emergency department visits required hospitalization for adverse drug events. With economic risk shifting from insurers/payers to providers, integrating the management of pharmaceuticals to prevent hospital admissions (and readmissions) by both physicians and pharmacists will be necessary and financially incentivized to prevent these needless occurrences.

Thus both community pharmacy and PBMs can play a vital role supporting the physician by reviewing and recommending therapies in a given population.

Conclusion

Greater competition from PBMs and health plans is emerging, and will continue to advance as a result of the proposed ESI-Medco merger. Lower costs can be generated with greater competition and thus I support the proposed merger. Moreover, the impact of the Patient Protection and Affordable Care Act and health exchanges will provide new opportunities for current and emerging business models. New reimbursement models will be shifting greater financial risk from insurers to the physician and hospital level. Thus the PBM landscape will be altered so that the size of the PBM may be less important as the ability to manage and coordinate care at the individual and population level.



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**United States Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy
and Consumer Rights
Hearing on the Proposed Merger between
Express Scripts and Medco
Testimony of Sue Sutter, Independent Pharmacist and Member of the
National Community Pharmacists Association
December 6, 2011**

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

Thank you for conducting this hearing and for providing me the opportunity to share my views regarding the proposed Express Scripts-Medco merger. My name is Sue Sutter of Horicon, Wisconsin. I am the co-owner of three independent pharmacies in the rural area of Dodge County, Wisconsin and I have been a practicing pharmacist for 33 years. I am representing the National Community Pharmacists Association, which represents the pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. These pharmacies provide about 40 percent of all community-based prescriptions.

Today, I join with consumer groups and other small business groups to oppose the proposed merger. In sum, if the FTC allows this merger, it will make an already bad situation even worse for small community pharmacies and the patients that we serve. The PBM marketplace today is already extremely concentrated with the "Big Three" PBMs dominating the large employer market. A recent Morgan Stanley Report revealed that Medco alone controlled 50% of the top ten employer groups.

Allowing the merger of two of the "big three" PBMs would result in unparalleled market concentration in the PBM industry with the merged entity controlling at anywhere from 1/3 to 2/3 of all prescriptions filled in community pharmacies. This market dominance and significant reduction in competition will result in reduced choices for federal and state programs and third party payers, decreased patient access to pharmacy services and ultimately lead to higher prescription drug costs paid by plan sponsors and consumers. This includes Medicare Part D, FEHBP, TRICARE and state employee and retiree programs.

Why are we so concerned? Small community pharmacies are faced with "take it or leave it" contracts from the PBMs. PBMs directly set the ever-shrinking reimbursement rates for community pharmacies. These are the same pharmacies that stand in direct competition to the PBM-owned mail order pharmacies. Therefore, it is no surprise then when these PBMs try to shift patients to their own mail order pharmacies, many against their wishes. There is no negotiating. And we are not crying wolf.

THE VOICE OF THE COMMUNITY PHARMACIST

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If Walgreens, the largest pharmacy in the country with 7,000 pharmacies, had to drop out of the Express Scripts network because they couldn't negotiate fair terms, how can a one or two store independent pharmacy have any chance against these corporate giants?

Right now we have no negotiating leverage with the three large PBMs. From a business standpoint, we cannot merely walk away from these contracts - because we would lose a significant amount of our prescription revenues if we did. From a patient care and consumer services standpoint, if we drop a contract, we drop our patients. Independent community pharmacies across this country have been built on a philosophy of community service. However, if we continue to take these contracts we are selling our profession and patients short by being forced to provide pharmacy services at unsustainable rates. We are in a no-win situation.

Now here comes the ESI Medco mega merger. This entity could single-handedly put pharmacies out of business, reducing competition and choice for consumers. And these companies have already said that this is exactly what they are going to do. Unlike some chains and mass merchandise pharmacies, unless I can turn a small profit on prescriptions, I can't stay in business. My focus is serving my patients and my business is based upon dispensing prescriptions not over the counter, non-health related items. What sort of competitive balance would be created in the market by creating a monolithic entity of this size? None.

Express Scripts and Medco have claimed that the combination of these two companies would create an entity with the negotiating leverage that will enable it to create greater "efficiencies" in the pharmaceutical supply chain that it could in turn pass along to plans and consumers. They have claimed they can do this by squeezing manufacturers and pharmacies. I can tell you there is nothing left to squeeze. Our pharmacies operate at 2 to 3% net profit margin before taxes. In fact, the number of independent pharmacies operating at a loss is now 25%. Despite the PBMs false claims to the contrary, I am not making "millions" of dollars in margin.

In fact, we have estimated that the merger, if approved, will cost the state of Wisconsin \$68 million in sales and tax revenues annually and approximately 1,350 jobs and will send these precious resources to an out of state mail order pharmacy. The loss of pharmacies in rural communities could mean the end of primary health care for millions of individuals. Also, appended to this statement you will find an economic impact analysis detailing the potential effect that this merger-- and a corresponding shift to mandatory mail order pharmacy for state employees-- would have on each of the eight states represented by the members of this Subcommittee.

Even if greater "efficiencies" in the market were to be created, there are no assurances whatsoever that such savings will be passed along to plans and consumers. Keep in mind that the PBM industry is virtually unregulated at either the federal or state level and has a long track record of enforcement actions alleging fraudulent and deceptive conduct.

Rural Patients, Medicaid Patients, Medicare Patients Rely on the Community Pharmacist

I am extremely concerned about the negative impact that this merger would have on independent community pharmacies and in turn on consumer access to health care services, prescription drugs and face-to-face interaction with their community pharmacist. Overly restrictive PBM plan designs and rules already make it more difficult for my patients to have access to the medications that they need, and adversely affect their choice of pharmacy. It is important to recognize the critical services that community pharmacists provide that cannot be duplicated or replaced by access to a PBM-owned mail order pharmacy. We hope that the FTC takes this into account when reviewing this merger.

Community pharmacies represent the most accessible point in patient centered health care. Consumers do not need an appointment to talk with a pharmacist about prescription medication, over-the-counter products or any other health-related concern. In this way, community pharmacies also serve as safety net health care providers on the frontlines not only when a natural disaster, such as a tornado, hurricane or flooding occurs, but every day when consumers need help with their medications. Community pharmacists provide expert medication counseling and other cost-saving services that help mitigate the \$290 billion annual cost of treating patients that do not adhere to their medication regimen.

Merged Entity Would "Corner the Market" on Mail Order and Specialty Drugs

Believe it or not, the merged ESI Medco PBM can and will start dictating to employer sponsors the plan design they have to choose. Not the other way around. And why not? For large plans, including the Federal Medicare Part D program, TRICARE and FEHBP, there are currently really only three choices. If the merger is approved, there will only be two, one of which will be a vertically-integrated PBM that owns 7,000 of its own pharmacies. Why is this of concern? Because employers will have less choice over their plan design - which means less choice for consumers.

For example, if the merger is approved, it is likely that plan designs will include more mandatory mail order. And who loses with that? Consumers, pharmacies and plan sponsors. Who wins? The PBMs. The proposed merger would create the largest mail-order pharmacy in the United States, accounting for close to 60% of all mail-order prescriptions processed.¹ ESI will shift as many patients to its mail order facility as possible – for its own benefit. One misconception frequently cited by the merging parties is that mail order is less expensive than the use of a community pharmacy. However, evidence demonstrates that mail order pharmacies consistently dispense more costly brand-name drugs and fewer generics than community pharmacies. For example, the generic dispensing rate at the ESI mail facility is 60% and 62% at the Medco facility.² The PBMs collect lucrative manufacturer rebates from the large quantities of expensive drugs they push out to consumers, which they may or may not pass through to the plan sponsors, including the Federal government.

¹ AIS Annualized Through Q2-2011

² Big Three PBMs GDR by Channel. SEC Filings and Company Reports. 2007-2010.

In comparison, community pharmacies dispense generics 72% of the time. The enhanced generic dispensing rates of community pharmacies is particularly significant when one considers that for every one percent increase in generic utilization, health plans can expect to save 2.5%.³ Mail order pharmacies also play games with pricing benchmarks that are designed to fool payers into thinking that they are getting a better deal.

Finally, mail order pharmacy is simply not appropriate for certain patient populations--such as the elderly-- or for medications designed to treat acute conditions or are temperature sensitive. Waste in mail order pharmacy is rampant, and it's not anecdotal as the PBMs claim. Attached to this statement is example upon example of mail order waste collected from community pharmacy patients. I can tell you story upon story of patients who come in and bring boxes and bags of drugs they received from a mail order pharmacy.

This proposed merger would allow the merged entity to "corner the market" on specialty drugs. Specialty drugs are high cost medications that treat chronic, complex illnesses and are the wave of the future. It is estimated that eight of the top ten drugs in 2016 will be specialty drugs—compared with only five in 2008 and just one in 2000. Currently, the top PBMs already dominate this market due to the fact that many times they prevent community pharmacies from filling these prescriptions and direct these highly lucrative prescriptions to their own mail order pharmacies. The proposed merger would create an entity that would immediately own 52% of the market share for specialty drugs.⁴ There is no reason community pharmacists cannot dispense specialty medications, other than that the PBM's design their plans so we can't. This is just the newest form of anticompetitive behavior we've been dealt by the PBM industry.

We Need Human, Face-to-Face Pharmacist Interactions, Not Mail Order Prescription Robots!

During the September 20th House Judiciary Subcommittee on Intellectual Property and the Internet hearing on the proposed Express Scripts-Medco merger, Medco Chairman and CEO David Snow, Jr. expressed his support for the continued existence of "strong, independent retail pharmacies", in an attempt to allay the concerns that the merged entity would simply use the increased market power to drive consumers to its own mail order pharmacy.

However, just two weeks later, Mr. Snow in a presentation at the Cleveland Clinic's Medical Innovation Summit, told attendees "I am not dissing retail [pharmacy] but....there's a fiction that a pharmacist comes out and dialogues with you. In reality, a high school student hands you a script from a shelf." In subsequent statements, Snow added that "Medco's robots are 'twenty-three times more accurate' than human pharmacists, in terms of dispensing prescriptions."

This is not what Consumer Reports shows year after year. Consumers highly value the interaction they receive from their pharmacist. It is also not what happens in our three pharmacies in Wisconsin. Our pharmacists speak with every patient, review every medication order, and work to assure that all of our patients are achieving their intended medication goals. PBM's, if they really managed the benefit, would be encouraging and rewarding such service, and they have not.

³ Prescription Drug Costs and Generic Dispensing Ratio. J.N. Lieberman, Ph.D, M. Christopher Robuck, MBA, Journal of Managed Care Pharmacy, Sept. 2010, ppg. 502-506, Vol. 16, no. 7.

⁴ Pembroke Consulting 2010- 2011 Economic Report on Retail and Specialty Pharmacies

I would like to share with you a few stories from my own pharmacies that highlight the fact that actual community pharmacists— not Mr. Snow’s robot prescription filling machines that reduce pharmacy care services to a one size fits all commodity— are truly making a difference in the quality of patient’s lives.

- Twice in the last couple of weeks, I’ve assisted transplant patients by contacting their physicians and dispensing a needed supply of their medications that had not arrived from the mail-order pharmacy. Now if the mail-order pharmacy is so committed to patient care, why wasn’t one of their pharmacists working to assure these patients got a supply from a community pharmacy? These patients were “on their own” and had to pay for the full cost of the medication, since payment by the PBM was not even authorized.
- Recent federal healthcare reform recognized the critical nature of and need for improvements in transitions of care. Transitions of care refers to the need for increased coordination between healthcare providers when patients transfer in or out of a particular care setting and typically includes medication reconciliation— or an accounting of all of the medications that the patient is currently prescribed. Our pharmacists, as do many community pharmacists, routinely assist with confirming patients’ current doses, directions and adherence to their medications when one of their patients is hospitalized. One of my pharmacists, with recent hospital experience, describes what a “nightmare” mail order was for doing “med rec” on admissions. “We simply never got responses from mail order pharmacies.”

At this time I would also like to submit for the record many examples just collected from community pharmacists from across the country about how they are not feeling this new-found “love” from ESI and Medco. Make no mistake; this publicly-professed new-found-love for community pharmacies by ESI and Medco is nothing but a thinly-veiled attempt to deceive policymakers at a time when these companies know that the proposed merger is suspect.

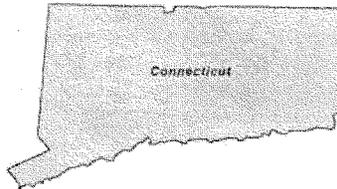
In conclusion, this proposed merger would:

- Reduce competition in the delivery of pharmacy benefits for consumers, employers and plan sponsors, including the Federal and state governments;
- Further threaten the existence of community pharmacies—safety net health care providers, especially in rural communities;
- Reduce patients’ choice and mandate that they use mail order pharmacy rather than their trusted community pharmacist.

I enjoy my role as a community pharmacist and I know my colleagues across the country and I, as a group, make a real difference in helping our patients manage their medical conditions and maintain their overall health. This proposed merger threatens the very existence of community pharmacies and the individualized care that we provide.

I appreciate the opportunity to address the Committee today and would be happy to address any questions that you may have. Thank you.

CONNECTICUT



Independent Community Pharmacy Impact Estimate

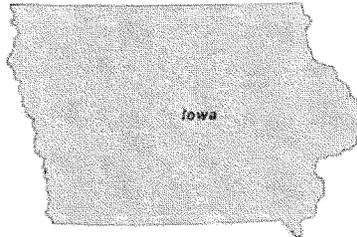
- There are 159 independent community pharmacies in the state of Connecticut
- Connecticut's independent community pharmacies generate \$639M in annual revenues
- Connecticut's independent community pharmacies support additional revenues to other state businesses in the amount of \$575M annually
- Combined, Connecticut's independent community pharmacies support \$1.21B in annual revenues (\$639M + \$575M)
- Connecticut's independent community pharmacies employ 1,685 full time individuals
- Connecticut's independent community pharmacies support additional full time employment to other businesses equal to 674 individuals
- Combined, Connecticut's independent community pharmacies support 2,359 full time employees (1,685 + 674)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

- Connecticut's Independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- Connecticut's independent community pharmacies will lose \$28.8M in annual revenue due to mandatory mail order
- Other businesses in Connecticut will lose \$25.5M in annual revenue due to forced mail order
- Combined, Connecticut will lose \$54.3M annually due to mandatory mail order
- Connecticut's independent community pharmacies will lay off 382 full time employees due to mandatory mail order
- Other businesses in Connecticut will lay off an additional 153 full time employees
- Combined, Connecticut will lose 535 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 110,000 employees, retirees, and their family members are part of the Connecticut State Health Plan.

Iowa



Independent Community Pharmacy Impact Estimate

- There are 339 independent community pharmacies in the state of Iowa
- Iowa's independent community pharmacies generate \$1.36B in annual revenues
- Iowa's independent community pharmacies support additional revenues to other state businesses in the amount of \$1.22B annually
- Combined, Iowa's independent community pharmacies support \$2.58B in annual revenues (\$1.36B + \$1.22B)
- Iowa's independent community pharmacies employ 3,593 full time individuals
- Iowa's independent community pharmacies support additional full time employment to other businesses equal to 1,437 individuals
- Combined, Iowa's independent community pharmacies support 5,030 full time employees (3,593 + 1,437)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

- Iowa's Independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- Iowa's independent community pharmacies will lose \$38.1M in annual revenue due to mandatory mail order
- Other businesses in Iowa will lose \$34.3M in annual revenue due to forced mail order
- Combined, Iowa will lose \$72.4M annually due to mandatory mail order
- Iowa's independent community pharmacies will lay off 813 full time employees due to mandatory mail order
- Other businesses in Iowa will lay off an additional 325 full time employees
- Combined, Iowa will lose 1,138 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 150,000 employees, retirees, and their family members are part of the Iowa State Health Plan.

Minnesota



Independent Community Pharmacy Impact Estimate

- There are 358 independent community pharmacies in the state of Minnesota
- Minnesota's independent community pharmacies generate \$1.44B in annual revenues
- Minnesota's independent community pharmacies support additional revenues to other state businesses in the amount of \$2.74B annually
- Combined, Minnesota's independent community pharmacies support \$4.18B in annual revenues (\$1.44B + \$2.74B)
- Minnesota's independent community pharmacies employ 3,795 full time individuals
- Minnesota's independent community pharmacies support additional full time employment to other businesses equal to 1,518 individuals
- Combined, Minnesota's independent community pharmacies support 5,313 full time employees (3,795 + 1,518)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

- Minnesota's Independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- Minnesota's independent community pharmacies will lose \$28.3M in annual revenue due to mandatory mail order
- Other businesses in Minnesota will lose \$25.5M in annual revenue due to forced mail order
- Combined, Minnesota will lose \$53.8M annually due to mandatory mail order
- Minnesota's independent community pharmacies will lay off 859 full time employees due to mandatory mail order
- Other businesses in Minnesota will lay off an additional 347 full time employees
- Combined, Minnesota will lose 1,202 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 120,000 employees, retirees, and their family members are part of the Minnesota State Health Plan

NEW YORK



Independent Community Pharmacy Impact Estimate

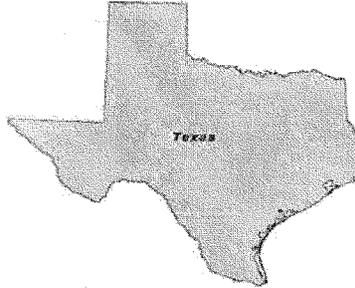
- There are 2,203 independent community pharmacies in the state of New York
- New York's independent community pharmacies generate \$8.6B in annual revenues
- New York's independent community pharmacies support additional revenues to other state businesses in the amount of \$7.97B annually
- Combined, New York's independent community pharmacies support \$16.57B in annual revenues (\$8.6B + \$7.97B)
- New York's independent community pharmacies employ 23,352 full time individuals
- New York's independent community pharmacies support additional full time employment to other businesses equal to 9,340 individuals
- Combined, New York's independent community pharmacies support 32,692 full time employees (23,352 + 9,340)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

- New York's Independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- New York's independent community pharmacies will lose \$266M in annual revenue due to mandatory mail order
- Other businesses in New York will lose \$240M in annual revenue due to forced mail order
- Combined, New York will lose \$506M annually due to mandatory mail order
- New York's independent community pharmacies will lay off 5,287 full time employees due to mandatory mail order
- Other businesses in New York will lay off an additional 2,114 full time employees
- Combined, New York will lose 7,401 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 1,000,000 employees, retirees, and their family members are part of the New York State Health Plan.

Texas



Independent Community Pharmacy Impact Estimate

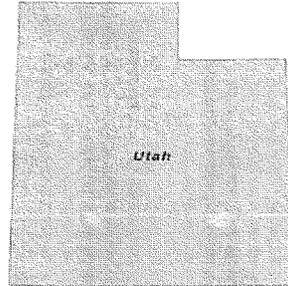
- There are 1,594 independent community pharmacies in the state of Texas
- Texas's independent community pharmacies generate \$6.4B in annual revenues
- Texas's independent community pharmacies support additional revenues to other state businesses in the amount of \$5.8B annually
- Combined, Texas's independent community pharmacies support \$12.2B in annual revenues (\$6.4B + \$5.8B)
- Texas's independent community pharmacies employ 16,896 full time individuals
- Texas's independent community pharmacies support additional full time employment to other businesses equal to 6,758 individuals
- Combined, Texas's independent community pharmacies support 23,654 full time employees (16,896+ + 6,758)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

- Texas's Independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- Texas's independent community pharmacies will lose \$173M in annual revenue due to mandatory mail order
- Other businesses in Texas will lose \$156M in annual revenue due to forced mail order
- Combined, Texas will lose \$329M annually due to mandatory mail order
- Texas's independent community pharmacies will lay off 3,825 full time employees due to mandatory mail order
- Other businesses in Texas will lay off an additional 1,530 full time employees
- Combined, Texas will lose 5,335 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 750,000 employees, retirees, and their family members are part of the Texas State Health Plan.

Utah



Independent Community Pharmacy Impact Estimate

- There are 204 independent community pharmacies in the state of Utah
- Utah's independent community pharmacies generate \$820M in annual revenues
- Utah's independent community pharmacies support additional revenues to other state businesses in the amount of \$738M annually
- Combined, Utah's independent community pharmacies support \$1.6BB in annual revenues (\$820M + \$738M)
- Utah's independent community pharmacies employ 2,162 full time individuals
- Utah's independent community pharmacies support additional full time employment to other businesses equal to 865 individuals
- Combined, Utah's independent community pharmacies support 3,027 full time employees (2,162 + 865)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

- Utah's independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- Utah's independent community pharmacies will lose \$31.8M in annual revenue due to mandatory mail order
- Other businesses in Utah will lose \$28.6M in annual revenue due to forced mail order
- Combined, Utah will lose \$60.4M annually due to mandatory mail order
- Utah's independent community pharmacies will lay off 490 full time employees due to mandatory mail order
- Other businesses in Utah will lay off an additional 196 full time employees
- Combined, Utah will lose 686 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 110,000 employees, retirees, and their family members are part of the Utah State Health Plan

Wisconsin



Independent Community Pharmacy Impact Estimate

- There are 404 independent community pharmacies in the state of Wisconsin
- Wisconsin's independent community pharmacies generate \$1.6B in annual revenues
- Wisconsin's independent community pharmacies support additional revenues to other state businesses in the amount of \$1.5B annually
- Combined, Wisconsin's independent community pharmacies support \$3.1B in annual revenues (\$1.6B + \$1.5B)
- Wisconsin's independent community pharmacies employ 4,282 full time individuals
- Wisconsin's independent community pharmacies support additional full time employment to other businesses equal to 1,713 individuals
- Combined, Wisconsin's independent community pharmacies support 5,995 full time employees (4,282+ 1,713)

Economic Impact Estimate: Mandatory Mail Order for State Employees¹

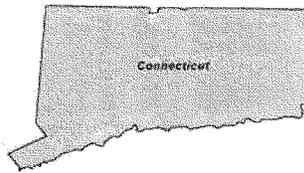
- Wisconsin's Independent community pharmacies will lose 30% of their prescription drug business due to mandatory mail order
- Wisconsin's independent community pharmacies will lose \$35.8M in annual revenue due to mandatory mail order
- Other businesses in Wisconsin will lose \$32.2M in annual revenue due to forced mail order
- Combined, Wisconsin will lose \$68M annually due to mandatory mail order
- Wisconsin's independent community pharmacies will lay off 970 full time employees due to mandatory mail order
- Other businesses in Wisconsin will lay off an additional 388 full time employees
- Combined, Wisconsin will lose 1,358 full time employees due to mandatory mail order

¹ Numbers are based on state employee health plan switching to mandatory mail order. Roughly 150,000 employees, retirees, and their family members are part of the Wisconsin State Health Plan.



**Independent Community Pharmacists to ESI-Medco:
"We are NOT Feeling the Love"**

Connecticut



November 2011

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Connecticut Pharmacy Comments

- We try to work with ESI & Medco to update them on manufacturer price increases in a timely manner. The in-house data base is not kept up to date especially with drugs that they MAC. The MAC committees have no time schedule to meet so price increases take up to 60-90 days while stores are expected to fill prescriptions, many times at a loss. The pricing guides show prices from manufacturers that have stopped manufacturing the product without showing the plans this information - so PBM's continue to use old pricing in their calculations. Shortages in active ingredients (which are nonsense) have caused drug prices to increase up to 1000%+, leaving us no option to service our patients, and still staying in business.
- On a weekly basis customers are telling our pharmacies that their mail order pharmacy keeps sending medications after the medication has been discontinued. Talk about waste! Have you ever thought about why medication take backs are so important now? It's because of the mail order waste. Years ago patients never had unused medications to throw away.

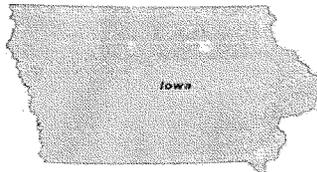
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**Independent Community Pharmacists to ESI-Medco:
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Iowa



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Iowa Pharmacy Comments

- Both Medco and ESI individually are threatening to independent pharmacies, and their merger one-ups the threatening nature of the CVS-Caremark merger which I didn't think it could get any worse. George Paz and David Snow's statements about independent pharmacies are beyond ignorant, their ridiculous margins do put us in the position where we could go out of business, and their mail-order pharmacies cause us to work for free as they are well aware their beneficiaries will eventually tire of talking to \$8.00/hour technicians if they're able to make it past their discouraging IVR system, and show up to the faithful pharmacist who has helped them so many times in the past. These organizations prey on the good nature of the community pharmacist, and because we are at an unfortunately powerless intersection of the healthcare industry, they know they can get away with it.....we'll see if my pharmacies are here in 10 years, what will my patients do then?
- No love from ESI or Medco. Both would like to see all business be funneled in to their own pockets through mail order service and leave community pharmacy to fill antibiotics and pain meds. That just doesn't pay the bills, especially when reimbursement is at an all time low, and continually going down. I don't think it's too much to ask from a company that pays their CEO \$3 million per year, and 31k shares of stock to pay us at least for our cost for the medications we dispense. Walgreens not signing Express's contract should speak VOLUMES to the customers of Express Scripts as to what type of payments are being offered to retail pharmacies. Walgreens and independent pharmacies are not greedy. We simply want to be paid a fair price for the drugs we dispense and the service we provide.

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**Independent Community Pharmacists to ESI-Medco:
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Minnesota



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Minnesota Pharmacy Comments

- I am in the process of trying to figure out why Express Scripts reversed and re-billed some eye drops for a patient of mine. Express Scripts did not tell me of any issue involving the script nor was there a reject or message when the scripts were initially filled. I did not receive any notification from them saying they were going to do the reversal/re-bill and, as of now, they have not returned a phone call to describe the reason after 2 + weeks of waiting. I have even called United Drugs to try and resolve the issue and Express has not returned that call either. This is a \$100 loss for me on one prescription for one patient for no reason. In another matter I was told by a patient of mine that just started taking Methotrexate injection that she HAD to get the medication through Express' mail order program. It would not be covered through my pharmacy. Period. I asked her how much Express was charging and she couldn't tell me for sure because of the billing confusion involved. She would try to find the price and get back to me. Plain and simple this whole process is undesirable. I don't understand why independent pharmacies can't combine our negotiating power because it would create a monopoly, and yet, with the proposed Express/Medco merger processing over 40% of prescriptions nationwide cannot be considered a monopoly.
- Please find listed below the latest example of an Express Scripts audit. As I state below, none of the pharmacists recall speaking with Express about the claims. 11-2-11 I talked to the 2 other pharmacists working here and they do not recall speaking to anyone at Express Scripts, or any other PBM, concerning a phone audit. Everything is done via fax or mail. If it wasn't documented on paper then it didn't happen. If we did talk to someone at a PBM we always document on the paperwork received what was asked and what was given. Does Express Scripts have documentation as to who they spoke with? If they can't produce documentation concerning this than they need to fess up and admit that they are in the wrong. I want, and deserve, documentation from Express Scripts concerning this "audit."
- A friend has had several experiences with Express Scripts mail order that indicate that the early refill limitations our patients struggle with in community pharmacy don't seem to apply to Express Scripts mail order. After an annual visit with his physician he received new prescriptions for all of his maintenance medications. He mailed all the prescriptions to Express Scripts thinking they would not fill them because he had as much as a 60-day supply remaining on all of them and all of them had been filled the last time by Express Scripts. Express Scripts filled all of them. When he called to inquire why, he was told that Express Scripts had no means to track when they had last filled his prescriptions or how much he had remaining. On his next physician visit, the physician prescribed an albuterol inhaler and accidentally transmitted the order to Express Scripts electronically. He requested another prescription and had it filled at a community pharmacy on his way home. Several days later, he received six albuterol inhalers in the mail from Express Scripts, apparently a 90-day supply. He

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called me asking how to dispose of them because he knew he would never use any of them because his need for the inhaler was only temporary.

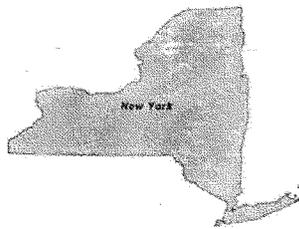
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**Independent Community Pharmacists to ESI-Medco:
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New York



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New York Pharmacy Comments

- The growing regularity and ferocity of the pharmacy audits done by predatory companies hired by ESI, MEDCO, and all other PBMs will eventually drive independent pharmacies out of business. These audits drastically increase pharmacy operating expenses and labor costs by having to deal with auditors while they are on site, as well as preparing our defenses to blunt the ridiculous take-backs they claim for frivolous claims of clerical errors that are easily solved using common sense, which they lack. These audits, combined with increasingly low reimbursement rates will indeed cause the demise of the independent pharmacy.
- Express Scripts is notorious for blocking prescriptions from being filled at my local pharmacy. This forces a devaluation of my business by taking my patients away. I know of no other business like this. Patients are peeled away after their choosing who they want to support. Then, we are held to these take it or leave it contracts.
- ESI and Medco don't value community pharmacies. Why would they if they have their own pharmacies they are trying to direct business to? In a rich country like USA, it is shame what low level of pharmacy care patients gets through big mail order pharmacies. Yes, robots are more accurate than humans in counting the pills yet there is so much more that community pharmacists provide to their patients. What about human factor, good advice for patient not to take two meds together because of interaction, (computer interactions are overlooked in big chains) or reducing the load of meds to better combo with same effect? Hepatitis C patient getting refill on Ribavirin but no Interferon? Robots will never picked up those things! AMERICANS DESERVE GOOD HEALTHCARE AND ACCESS TO PHARMACY OF THEIR CHOICE. Pharmacy business is not "selling candies!" Drugs are dangerous if they are not used properly and on the same token, drugs don't work if patient doesn't take them. How many ER visits are prevented just by community pharmacists staying on the top of the patient meds regimen? We pharmacists ask Congress members, if one of them tomorrow is in need of good healthcare - try to get that from ESI / MEDCO - you will be very sorry you ever let the healthcare reform take the turn for worse and not being able to have access to humane way of getting appropriate help.
- We have tried to communicate to Medco that they are "allowing" us to fill a 90-day supply at a retail level at a negative gross profit margin. When I called MEDCO they told us that was a "negotiated rate." I explained to them there were never any negotiated rates. Then they told us "take it or leave it." I wish there was something to take! This is blatant abuse and Medco continues to get away with it. ESI does the same. This is exactly how they will do away with small business.

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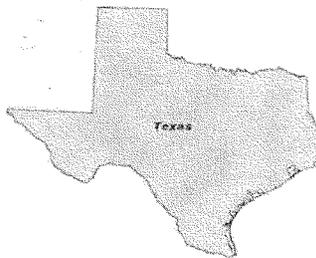
- Large PBMs drive business away from local pharmacies by using "saving money" as the biggest excuse. It's not really saving money for the consumer though. Sometimes, the co-pays for the consumer is less if they use mail order instead of a local pharmacy, which itself should be illegal, since they are practicing unfair pricing. But, that little saving for the consumer quickly erodes when they do not receive their drug on time or if the dosage changes midway thru therapy and the mail order pharmacy can't deliver meds right away. Also, the preferred formulary of drugs is not always the cheapest medicine in terms of cost. It is the preferred manufacturer giving rebates to the PBM for dispensing it irrespective of cost! And the consumer has barely any say it, since the PBM directly communicates with the doctor to change meds, in the middle of therapy to save them money, while advocating savings for the consumer. Please clear off all these false promises from PBMs and let the consumer choose whichever pharmacy they would like with equitable pricing. If some want mail order only then that's fine too. At least we would have a healthy competition, not unfair pricing and luring customers by threat and coercion.
- Independent pharmacies lose due to the mandatory mail order some patients are being forced to use. Medco states that patients have a choice. Truly is the choice of 100% co-pay at local level compared to three months co-pay at mail-order a choice?
- We do not get paid on time. I thought with the prompt payment laws in this state that was an agreement to which they had to adhere. What can I do to have them pay me promptly? They are at least 120 days behind.

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Texas Pharmacy Comments

- I have several patients whose companies chose an insurance plan about a year ago that uses ESI. With this particular plan, my patients are only allowed two fills of a medication before they must send the prescription to ESI mail order. When we try to run a maintenance medication claim we get a rejection that states "Refills not covered" and gives a number for the patient to call ESI. Some of these patients have called to try to get exemption from mandatory mail order and were told that mail order was NOT mandatory. The patient still had the choice to fill their prescription at the pharmacy of their choice, but insurance would only cover if filled by mail. What kind of choice is that? When these patients have drug questions, though, who do you think they call? I have often answered drug questions or identified tablets when the patient received a new manufacturer from mail order and were not sure they had received the right medication. They state when they try to call the ESI mail facility they cannot ever get through to a person.
- I am a community pharmacist in a small, rural community. My insurance is through my husband's work and is managed by Medco. I get letters about every quarter from Medco telling me how much money I could save by switching my maintenance medications to their mail order facility. I am certainly not going to join the many others that are leaving my pharmacy due to these coercive co-pays, though it is hard to fault my patients for leaving us to use mail order when they can get three months for the price of two in my pharmacy.
- The PBM model for drug distribution is a failed model! Health care expenditures across the spectrum have out-paced inflation at a rate proportionally to the market share of PBM's since their entry into the market. There is a huge disconnect between the PBM / Mail order and the patient. Check Consumer Report or talk to a few patients for confirmation. The PBM / mail order is motivated by the number of units shipped. Or check mail order waste. When I am doing MTM patient counseling and review the drug profile of a mail order patient it is apparent that mail order does not have the same refill rules that retail pharmacy have. Ninety day refills are shipped about every sixty days, patients are over-run with medication in addition to change orders or adverse effects of excessive medication. The retail pharmacist is motivated by patient outcomes. Why not compare the drug cost per 1,000 mail order patients vs. retail. I wager that if direct and indirect costs are factored in, the mail order distribution system represents a vastly more expensive model. Only the PBM's will win in a game with the PBM writing the rules and keeping score!

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- I became a pharmacist in order to help cure sick people or at least make them feel better. Having been a pharmacist since 1960, the good old days were when the doctor wrote the prescription, the patient took it to his/her PHARMACIST OF CHOICE, and the pharmacist and patient took care of the rest. Now with the PBM's, the doctor prescribes, the PBM decide whether or not to pay and how much to pay. In the mean time, the patient is left without the chosen medication and sometimes no medication at all because it is not on the PBM formulary. AFTER 51 YEARS, MY OPINION OF THE PBM'S IS VERY LOW AND THEY ONLY WANT TO MAKE MONEY AND THEY HAVE NOT A CARE ABOUT THE PATIENTS WELLBEING. We should go back to the 20/80 system where the patient pays for services whether MD or RPH and files claim with their insurance carrier for payment. This worked well!! We have seen good PBM's start and conduct themselves very well in regard to treating patient and caregivers fairly; however, the big PBM's want them out of the picture so they offer to purchase them for whatever the good guys ask. I am not calling ESI or MEDCO good guys, but the larger the PBM gets the less their actions show any real concern for the patients and caregivers. I could ramble on and on, but THERE HAS TO BE A BETTER SYSTEM than the PBMs. They are really Pharmacy Benefits MISMANAGERS rather than managers.
- It has been our experience to receive either by fax, mail, phone, email, etc. communication after communication from PBMs like Medco and ESI about how we have to fill out forms, take cuts in reimbursements, transmit via another processing format, re-enroll, sign contracts that continue to cut our reimbursements to the point it has become a nightmare to process insurance covered prescriptions. If I'm not mistaken, pharmacist and pharmacies have been on the top of the charts year after year as being one of the most trusted professions in America. Insurance companies and used car dealers are at the bottom of the trust chart. Why is the pharmacy profession the target of all the waste, fraud prevention legislation when the insurance companies are the ones that should be investigated? The pharmacy profession is having to jump through so many hoops now we can't do what we were trained to do and that is provide a needed product to a needy public at a reasonable price for profit. It is time that the insurance PBM's be held accountable for their practices of "saving money" for companies.
- We are a brand new independent pharmacy that opened October 19th. I started the application process with Medco in June 2011. In the last two weeks I have talked to about 10 different people, 10 different times, and each time we get a different answer as to if we are set up with Medco or not. ALL of our patients that have come with insurance are dependent on Medco. We have had a hard time even getting off the ground or knowing where to go in order to service these patients due to their inability to work with the independent pharmacy.

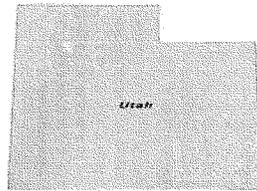
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Utah Pharmacy Comments

- Plainly stated, and consistent with the comments from David Snow, Medco has aggressively been trying to put community pharmacy out of business for a long time. Likewise, Express Scripts is our lowest paying PBM. We lose money on every script we fill for their patients, plus we do all the legwork making sure their patients are well taken care of. As noted by Mr. Snow, if he is suggesting the notion that "high-school" seems to be the standard in my practice and in all others like mine, name-calling is a poor and weak admission of someone who represents an organization that purposely places undue economic pressure on the very players who keep him in business. His comments are indicative of someone who takes pleasure in playing the bully.
- My patients are continually being harassed by Medco mail order pharmacy solicitors. They use any transmitted prescription information as a marketing tool to divert business from the community pharmacy to the mail order by calling the patient and telling them that they should fill any future prescriptions through mail. They use their whole retail network as a large marketing lead generator for their mail pharmacy. This year has seen many price increases and market shortages. The adjustments to MAC prices are deliberately slow. My guess is that ESI tracks increases in cost of goods (because of their mail order pharmacy acquisition costs) and immediately pass on price increases to the payer but are deliberately slow to pass any increase in MAC pricing to the pharmacy.
- All of us need to ask ourselves, who are our customers? In the case of PBMs, they are represented by their many members. In the case of community pharmacy, they are represented by the many patients who frequent their pharmacies. If put to the members/patients for a vote, I believe this merger would be met with a resounding "No!" When it comes to the business of health care, the level of touch is high, at least for those of us on the front lines. When our democracy has advanced to the point that the sound of the wallet carries more weight than the sound of the people, something is terribly wrong. This merger is bad for many reasons: a further disconnect with members, poorer service, inherently more problems for members, for providers and for pharmacies (the PBM mail order model is flawed, just ask the members). Oh and yes, it will not save a dime for anyone, but will only perpetuate less service at a higher cost. Having spent over thirty years in the health care industry, it is clear that managing costs has actually never occurred. The ever-changing system has only managed to re-direct profits to the chosen few who are least involved in patient care. Let's put an end to this nonsense and stop the merger of ESI and Medco. Their service to members is bad now, let alone what it will be later if this goes through.
- The PBMs continue to record profits and wield unprecedented power over the community pharmacists. Contracted reimbursement rates continue to decline and community pharmacists struggle to stay in business. A merger of ESI and Medco would only create a greater position of market dominance and produce even lower contracted rates which could potentially force many of the community pharmacies out of the network and drive more business to mail order. This would have a negative impact on overall patient care and in the long run add to the costs associated with delivering quality health care.

THE VOICE OF THE COMMUNITY PHARMACIST

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**Independent Community Pharmacists to ESI-Medco:
 "We are NOT Feeling the Love"**

Wisconsin



November 2011

Recent comments by the Chairman of ESI and Medco to a Congressional Committee would make it sound like independent community pharmacies are their new best friends.

- Under oath, ESI CEO George Paz said about independent pharmacies: *"They are a critical component of our offering. We do not want to see (them) go out of business, nor will we put (them) in that position ..."*
- Medco CEO David Snow said, *"Medco is dependent on the continued existence of strong independent retail pharmacies."*
- However, Snow also said "I'm not dissing retail [pharmacy], but...there's a fiction that a pharmacist comes out and dialogues with you. In reality, a high school student hands you a script from the shelf."

This survey provides examples to policymakers regarding the challenges that over 240 pharmacies say they confront when dealing with ESI and Medco. These pharmacies are not feeling the love from either company. Survey results suggest that PBM practices negatively affect pharmacies ability to care for patients or stay in business. This survey was conducted between October and November 2011.¹

¹ Responses may have been edited for clarity purposes only. NCPA has not independently verified the statements made by survey respondents



Wisconsin Pharmacy Comments

- I started one of my days this past week adjudicating six commonly used generics to these PBM companies. Four of the prescriptions came back with PBM pricing below acquisition cost on the U.S. market. These were commonly used antibiotics that had stable pricing for many months if not years. These behemoth PBM companies are systematically putting me out of business with corrupt practices which will ultimately require local residents to travel many miles in order to obtain commonly prescribed prescriptions. They absolutely need legislative oversight and regulation rather than considering a merger and making the problem even worse!
- My most recent example happened today, November 17, 2011. I own and operate a small town/rural pharmacy, where the nearest pharmacy is either 15 miles east, west or south of my business. Yes, mail order pharmacies share many of my patients. This particular patient has actually not been to my pharmacy in three years, as she moved 18 miles east of my business - allowing a more local pharmacy to take care of her medication needs when mail order fails her. Today this patient was in need of a Combivent inhaler. She was told by Medco that the soonest they could ship her med was Thursday, November 17, despite the fact that she requested the refill ten days ago. The very thought of not having ready access to a "fresh inhaler" caused this 80-something year old oxygen restricted woman to have what I will refer to as anxiety induced shortness of breath. She contacted her more local pharmacy to see if they would deliver one Combivent inhaler to her, to be told they had changed their policies, and she was now outside of their delivery area. When this woman was referred to my pharmacy, she was adamant that she needed a Combivent inhaler today. She was willing to pay the full price of the inhaler - plus a delivery fee - anything to have access to the new Combivent inhaler today. She openly admitted she believed the temporary worsening of her symptoms was anxiety induced. This understanding did not allow her shortness of breath to go away. I took the time to transfer the one time doctor authorized prescription from her more "local" pharmacy. We contacted Medco third party to get the override for her Medicare D coverage, and then delivered the med to her - free of charge. My pharmacy could do this "extra" because we are not bound by administrative "red tape." I know the chances of this woman needing this inhaler prior to the arrival of her mail order supply was minimal, but having the inhaler in her possession could certainly decrease the potential need for additional medical attention when she is already identifying worsening of her symptoms because she would not have a new inhaler! Simply put, big business does not allow for compassion or common sense when taking care of the patient. What good comes of a patient in this situation requiring emergency care because it was too soon for her mail order to send her inhalers two weeks ago? If they are so concerned about the possibility of misuse/waste, then only send ONE inhaler! When does the assault on patient care and compassion end? When do "those who know" finally wake up to realize if big mail order companies were the answer to less expensive health care, then we should be seeing results already? Thanks for being a sounding board.

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THE VOICE OF THE COMMUNITY PHARMACIST



NCPA[®]

the NATIONAL COMMUNITY
PHARMACISTS ASSOCIATION

THE VOICE OF COMMUNITY PHARMACY



Waste Not, Want Not

Examples of mail order pharmacy waste

*These are actual images sent by participating pharmacies in the Dispose My Meds Program. Patient information has been removed or obscured to comply with all applicable laws protecting personal health information.



Mail Order Waste – ESI



“Just one example of Express Scripts overutilization of the healthcare system. The patient has since deceased and his spouse opened up about how many times that she tried to get Express Scripts to stop sending items. That is over \$6,000 that Express Scripts charged the patients plan.”

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Mail Order Waste – ESI



Tricare patient

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Mail Order Waste – ESI



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Mail Order Waste – Medco



“Almost all were returned unopened” ~ \$2,300

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Mail Order Waste – Medco



“Just over \$17,000 worth of meds from Medco Mail order. I hate to see what this persons company paid for these meds and what it did to his company’s health premiums. Mail order facilities can shout from the rooftops about compliance all they want but just because you mail a person his/her meds, that doesn’t mean they are taking them.”

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Mail Order Waste – Medco

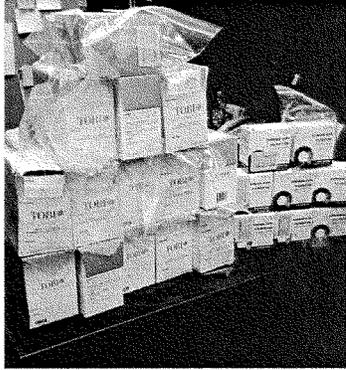


“One patient. Six months over supply due to 90-day rx filling and therapy changes.” Approximately \$4,000

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Mail Order Waste – Caremark



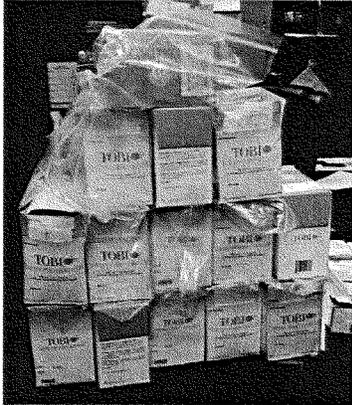
“This is all for ONE patient that passed away and the family brought it into us to see if we could dispose of it for them. The patient was a Cystic Fibrosis patient that was dealing with Caremark Specialty mail order.”

\$61,000

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Mail Order Waste – Caremark



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Mail Order Waste – Caremark



\$17,000

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Mail Order Waste – Caremark



Medicare Part D Patient

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Mail Order Waste – Caremark

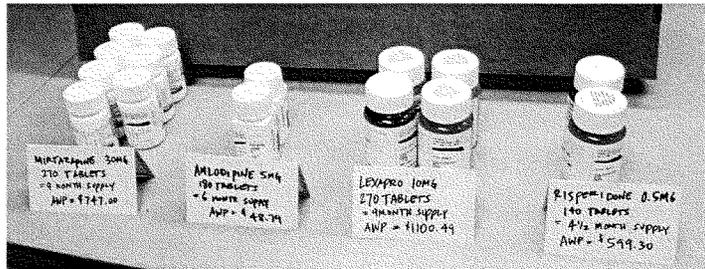


Medicare Part D Patient

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Mail Order Waste – Caremark



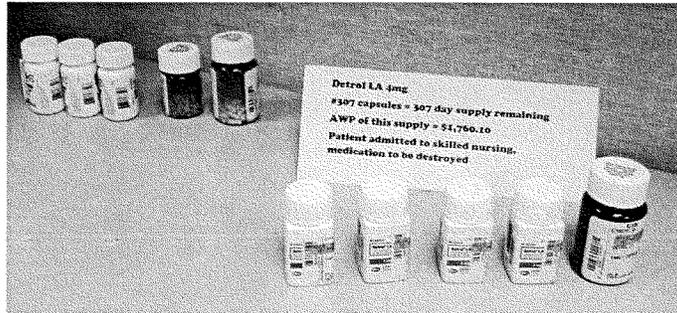
“This patient is cared for in a dementia unit so these are not missed doses, it is overfilling by mail order.”

\$2,500

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Mail Order Waste – Caremark

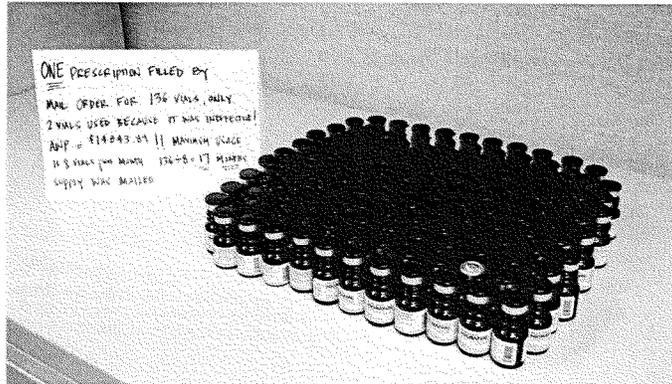


\$1,760

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Mail Order Waste – Caremark



\$14,844 = 17 month supply

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Mail Order Waste – Veteran's Affairs



\$6,800

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Mail Order Waste – Veteran's Affairs



\$3,500

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Mail Order Waste – Veteran’s Affairs



\$1,000

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Mail Order Waste – Veteran’s Affairs



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Mail Order Waste – Medicare



“These items were brought in by a customer for a family member who just entered a nursing home. They were not ordered, just automatically shipped regularly by Liberty Medical. I assume taxpayers paid for all this through Medicare.”

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Mail Order Waste – Medicare



Albuterol and Budesonide, 1201 doses from Liberty Medical, billed to Medicare Part B. The patient only brought in what was outdated and said she had 3 to 4 times that much at home still and they send more each month.

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Mail Order Waste – Medicare



Albuterol and Ipratropium, 1920 doses, billed to Medicare Part B. Patient had 6 times more still at home and called the mail order pharmacy to tell them they had overstocked. The pharmacy told the patient to hang on to the medicine because his insurance might stop covering these products. None of this medicine was outdated.

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Mail Order Waste – Medicare/Medicaid

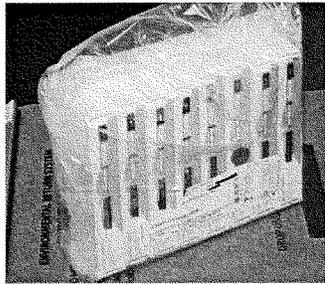


“Almost \$900 worth of insulin, still in date! We can’t recycle to anyone, clinic, or organization because there’s no guarantee that it has been stored appropriately (including us). What a travesty! This patient is a **Medicare patient, dual eligible.**”

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Mail Order Waste – Cigna



“A patient of ours was ‘forced’ to use mail order for her insulin. Cigna mail order signed her up for an auto ship program. She told us that she called them to alert them that she would be on vacation and to hold her insulin until she returned. They shipped about \$2,000 worth of insulin which sat on her front porch in the summer heat for over a week.”

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Mail Order Waste – Prescription Solutions



\$2,500

“Photos of insulin that one of our regular customers got from mail order - the patient has not been in good health for some time and passed away. The family brought in this unused insulin to see what to do with it. Unfortunately the only option was to tell them to dispose of it.”

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Mail Order Waste – Prime Therapeutics



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Mail Order Waste



\$3166.87

A customer brought in a sack full...her husband had passed away and wanted us to donate the medications for someone else to use. Unfortunately we couldn't.

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Mail Order Waste



\$7,000



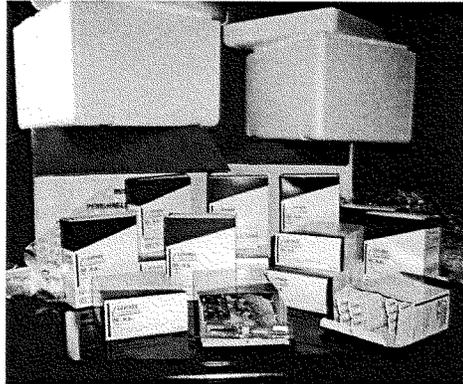
\$2,700

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Mail Order Waste

“Over \$10,000 of Lovenox mailed to a patient! She received 18 boxes of 180 syringes when typically a patient may only use a few syringes (certainly not 90 days worth) following a hospital procedure for certain medical conditions, surgeries, or risk factors for blood clots. The patient only used about \$170 worth of product, the rest was thrown away.”



Over \$10,000

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Mail Order Waste



\$2,800

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Mail Order Waste



"26 vials of Novolog and 84 vials of Lantus. About \$11,096 worth of waste in the mail order pharmacy system. Auto Shipped from Liberty Medical to the patient who accumulated beyond belief and now wants them wasted, since they are changing to the Insulin Pen. Adherence was not great for this patient. Do you think that Liberty Medical ever checked to see if the patient was compliant? Or do you think they just kept auto shipping, and auto shipping, and auto shipping."

\$11,096

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Mail Order Waste



"These testing supplies were brought in by a customer who had already called and asked the mail order company to stop sending her father's testing supplies since he already had more than he could ever use. There was over \$3500 in strips, another \$500 in lancets and another \$100 in testing solutions. 2 meters and 3 lancing devices. She said she had already thrown out several other boxes in the past to make room. We advised her to call the Medicare fraud waste and abuse hot line..... she has received two more shipments since that time."

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Mail Order Waste



"Liberty Mutual testing supplies. Wasteful! They send too much to the patient without them requesting it!"

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Mail Order Waste



"The picture represents my mother's diabetes medications that were auto shipped to her from Liberty mail order pharmacy during a 2 year period. The cost for these products represents \$442.50 per year of waste in the system that you and I as taxpayers paid for. Multiply this by the number of diabetic patients in this country, over 21 million, and the numbers are astronomical: **\$9.3 Billion** in potential waste and abuse in the diabetes community alone when provided by mail order companies."



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Congress of the United States
House of Representatives
Washington, DC 20515

November 28, 2011

The Honorable Jon Leibowitz
 Chairman
 Federal Trade Commission
 600 Pennsylvania Ave, NW
 Washington, DC 20580

Dear Chairman Leibowitz,

We are writing to urge an expeditious review of the proposed merger between Express Scripts and Medco. Experts have indicated that the combined company has the potential to foster greater competition among businesses and help to create new business models that will drive down the costs of health care, while enhancing access to critical drug therapies. Specifically, experts indicate that the combined Express Scripts and Medco could be better equipped to deliver value for patients nationwide by lowering prescription drug prices.

Today's Pharmaceutical Benefit Manager (PBM) market is defined by robust competition. Other competitors have already won large accounts and are aggressively pursuing additional clients. Against this backdrop, it is our understanding that businesses would have plenty of competitive choices post-merger, and the combined Express Scripts-Medco will be fully subject to competitive pressures that will help ensure value-based pricing and service.

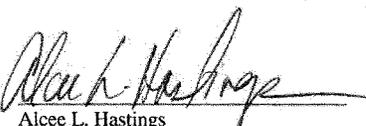
This robust competition is crucial because PBMs like Express Scripts and Medco play a key role in lowering the costs of prescription medications, an issue that is especially critical to our constituent communities. Experts indicate that the combined company will have the potential to reduce drug procurement costs and increase rebates and discounts negotiated from drug manufacturers, which could result in substantial cost savings passed on directly to consumers and employers.

Such cost savings would also have ramifications for our economy. At 12% of payroll, health care is the most costly benefit expense for employers. Reducing the cost of prescription medicines would make all American businesses more competitive – creating a healthier, more productive workforce, preserving existing jobs, and creating new jobs in the future.

We urge you to complete the review process for this merger with all deliberate speed, consistent with all applicable laws and regulations. We view the merger as consistent with a competitive marketplace, which could contribute meaningfully to achieving critical goals for our nation's health care system.

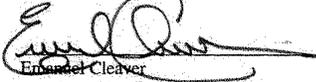
Sincerely,


 Edolphus "Ed" Towns
 Member of Congress

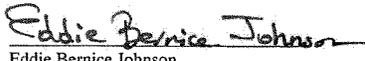

 Alcee L. Hastings
 Member of Congress


Wm. Lacy Clay
Member of Congress


Gregory W. Meeks
Member of Congress


Emanuel Cleaver
Member of Congress


Danny K. Davis
Member of Congress


Eddie Bernice Johnson
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