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 revenue[1].

[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	Estimated 2011 Prescription Revenues[1] (billions)	Share of 2011 Prescription Revenues	Primary Dispensing Format
CVS Caremark Corporation	CVS			
• Retail Pharmacy		$40.5	14.8%	Chain drugstore
• Pharmacy Services[2]		$16.1	5.9%	Mail-order pharmacy
Walgreen Company	WAG	$45.1	16.5%	Chain drugstore
Medco Health Solutions, Inc.	MHS	$25.8	9.5%	Mail-order pharmacy
Wal-Mart Stores, Inc.[3]	WMT	$17.4	6.4%	Mass merchant with pharmacy
Rite Aid Corporation	RAD	$17.1	6.3%	Chain drugstore
Express Scripts, Inc.	ESRX	$13.9	5.1%	Mail-order pharmacy
The Kroger Company	KR	$7.0	2.6%	Supermarket with pharmacy
Safeway, Inc.	SWY	$3.7	1.4%	Supermarket with pharmacy
Target Corporation	TGT	$3.0	1.1%	Mass merchant with pharmacy
Sears Holding Corporation[4]	SHLD	$2.4	0.9%	Mass merchant with pharmacy
Supervalu Inc.	SVU	$2.3	0.8%	Supermarket with pharmacy
All other chains	n/a	$33.3	12.2%	various
Independent Pharmacies	n/a	$45.8	16.7%	Independent drugstores
Total		$273.4	100.0%	

Totals 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 Kmart
Published in *The 2011-12 Economic Report on Retail and Specialty Pharmacies* (http://www.pembrokeconsulting.com/pharmacy.html)

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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 prescription[2].

(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 effect 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 costs[3][4][5] 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 PMBs 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?

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[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 Consulting[6], Express Scripts and Medco would have approximately 31% share of specialty pharmaceutical (as defined by Pembroke) revenues..

Pharmacy Revenues from Specialty Pharmaceuticals, by Company, 2010

Company	Estimated 2010 Specialty Revenues ($ billions)	Share of Specialty Revenues
CVS Caremark	$9.7	25%
Medco (Accredo)	$7.9	20%
Express Scripts (Curascript)	$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.

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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?

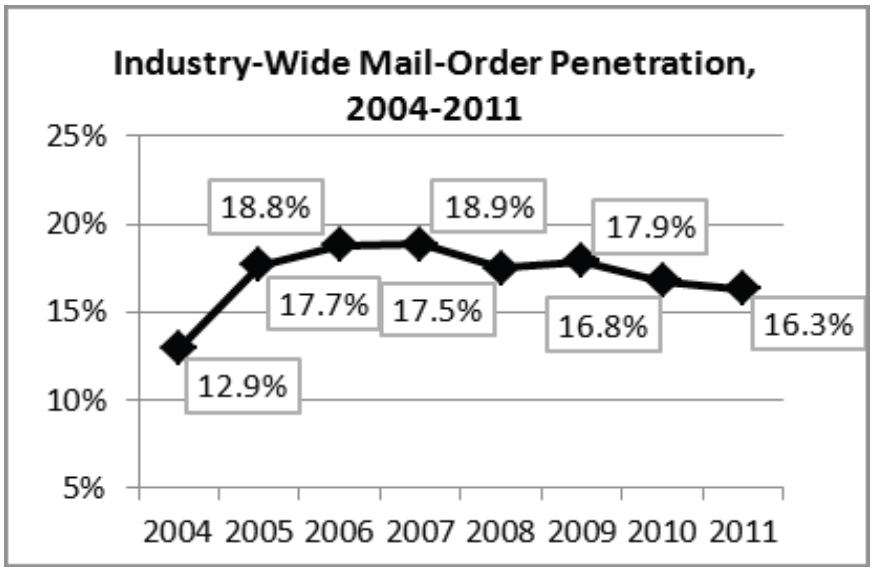
(b) What types of medications are disbursed via mail order?

(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 t*he 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 Consulting[7], 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