Susan L. Sutter
Co-Owner
Marshland Pharmacies
Horicon, Wisconsin
U.S. Senate Committee on the Judiciary
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.

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

- 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 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.wbcbaltimore.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 Streator 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. Streator 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.

Lee1

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.wbcbaltimore.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.

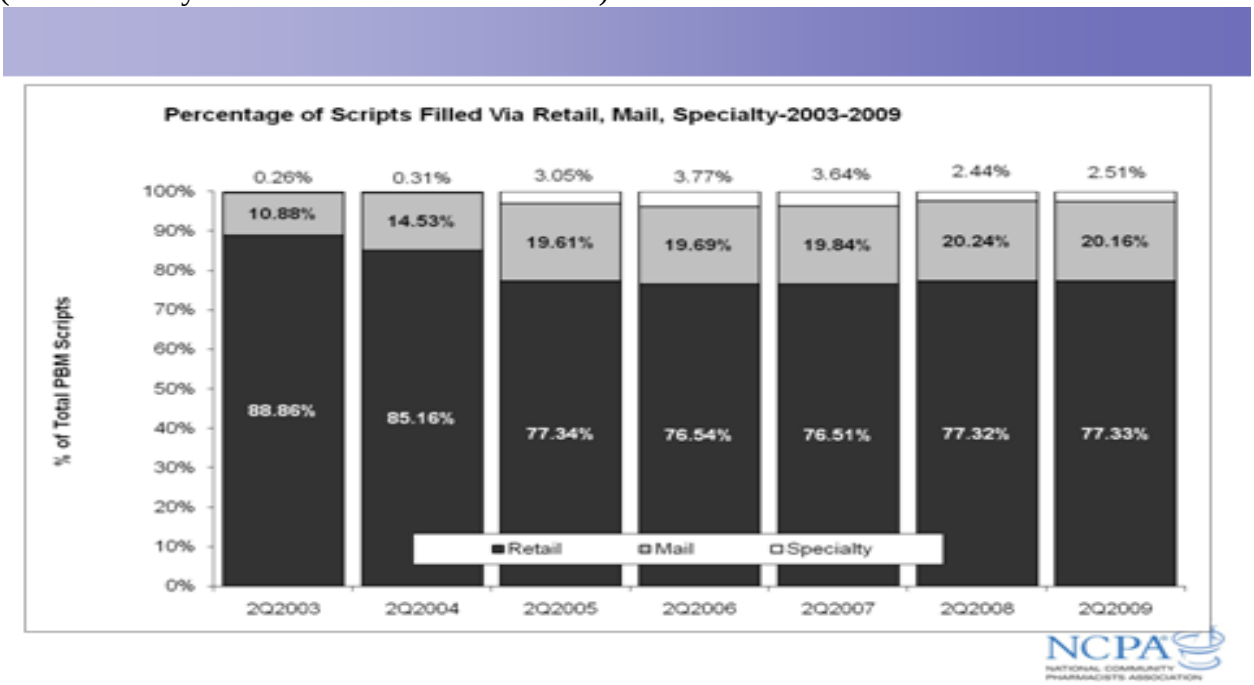
While the large PBM-owned mail order pharmacies like to tout that they have corporate pharmacists that mail order patients can call, patients are likely to get a different pharmacist via the 1-800 number (assuming they get through to a human in a reasonable amount of time and do not forgo the call altogether). 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; Niteesh 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, Siracuse 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).