

## **Testimony of David Balto**

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Chairman Buehrer, Vice Chair Faber and Ranking Member Schiavoni, thank you for the opportunity to testify today in support of Senator Patton's bill, Senate Bill 154. My testimony today documents the tremendous need for legislation to address the increasing problem of the ownership of pharmacy benefit managers, PBMs, by pharmacy chains and the need for regulation to stop these relationships which lead to less competition, greater fraud and deception, and harm to health plans, employers and unions, and consumers.

I am a Senior Fellow at the Center for American Progress Action Fund and have practiced antitrust law for over 25 years, both in the government and in private practice. Prior to entering private practice, I was at the Federal Trade Commission as the policy director of the Office of Policy and Evaluation for the Bureau of Competition of the Federal Trade Commission and attorney advisor to Chairman Robert Pitofsky. At the FTC, I helped direct the first antitrust cases against pharmacy benefit managers ("PBMs"). I have counseled health plans, PBMs, pharmacies, and consumers on PBM competition and consumer protection issues. My comments are based on those decades of enforcement and real world experience.

S.B. 154 is an innovative and important piece of legislation. The business of pharmacy benefit managers is enormously complex: PBMs play a central role in financial transactions involving plan sponsors, drug manufacturers, and pharmacies. For this system to work effectively PBMs must be independent—what plans are fundamentally purchasing is the services of an "honest broker" trying to seek the lowest prices and best services from pharmaceutical manufacturers and pharmacies. When the PBM is owned by the entity it is supposed to bargain with there is an inherent conflict of interest, which can lead to fraud, deception, anticompetitive conduct, and higher prices. That is why, when pharmaceutical manufacturers obtained PBMs in the 1990's, the FTC acted to eliminate those conflicts of interest. Then it challenged the acquisition of PCS by Lilly and Medco by Merck, because of the concern that having a manufacturer own a PBM would be giving the "fox the keys to the hen house door"—and would lead to higher prices for consumers.

In recent years, the major PBMs—including those with a clear conflict of interest in their cross-ownership with pharmacies—have engaged in a variety of anticompetitive

and anticonsumer practices. S.B. 154 appropriately addresses these practices, and I urge the committee to enact it.

### **PBMs: An anticompetitive market**

Although PBMs offer a great deal of promise in terms of the potential to control pharmaceutical costs, there is a pattern of conflicts of interest, self-dealing, and anticompetitive conduct, all of which ultimately means that Ohio consumers pay far more for drugs than necessary. The dominant PBMs (Merck, Caremark, and Express Scripts) have been plagued with opaque business practices, limited market competition, and widespread allegations of fraud. The facts are clear: while PBMs may well prove a necessary expedient in lowering the cost of healthcare, measures must be taken to ensure that they operate as they are supposed to.

I have a simple and vital message for this committee: there is a tremendous need for reform in the PBM market. The fundamental elements for a competitive market are transparency, choice, and a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access, there are agency relationships, and securing adequate information may be difficult.

Why are choice, transparency, and a lack of conflicts of interest important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire.

When dealing with intermediaries, it is particularly critical that there are no conflicts of interest. An intermediary such as a health insurer or PBM is fundamentally acting as a fiduciary to the plan it serves. In the PBM market, the service a PBM provides is that of being an “honest broker” bargaining to secure the lowest price for drugs and drug dispensing services. When a PBM has a relationship with either a drug company or a pharmacy chain, or has its own pharmacy dispensing operations, it is effectively serving two masters.

Only where these three elements—choice, transparency, and lack of conflicts of interest—are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice.

Unfortunately, in all three respects, PBM markets do not function as effectively as they could. **Few markets are as concentrated, opaque and complex, and subject to rampant anticompetitive and deceptive conduct as PBM markets. Regulation is necessary to ensure that PBMs cannot exploit consumers, health plans, employers and the state.**

## **Increasing conflicts of interest**

Today the committee will hear testimony of the problematic conduct CVS has engaged in after acquiring Caremark. This combination of the largest pharmacy chain with the largest PBM poses significant competitive concerns.

CVS's ownership of Caremark distorts Caremark's incentive and ability to be an honest broker. There is a clear conflict of interest and an ability to manipulate the relationship to harm CVS's rivals (other pharmacies) and consumers. Moreover, controlling health care costs is dependent on a PBM seeking the lowest costs from all entities it deals with. Caremark, because it is a CVS subsidiary, is unlikely to demand the lowest costs from its parent when negotiating for the cost of drug dispensing. Nor is it likely to aggressively audit its parent. I will discuss these problems further throughout my testimony.

## **Ongoing fraudulent and deceptive conduct**

No other segment of the health care market has such an egregious record of consumer protection violations as the PBM market. Between 2004 and 2008, the three major PBMs have been the subject of six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. **These cases listed below, resulted in over \$371.9 million in damages to states, plans, and patients so far.**

- *United States v. Merck & Co., Inc., et.al*—\$184.1 million in damages for government fraud, secret rebates, drug switching, and failure to meet state quality of care standards.
- *United States v. AdvancePCS* (now part of CVS/Caremark)—\$137.5 million in damages for kickbacks, submission of false claims, and other rebate issues.
- *United States v. Caremark, Inc.*—pending suit alleging submission of reverse false claims to government-funded programs.
- *State Attorneys General v. Caremark, Inc.*—\$41 million in damages for deceptive trade practices, drug switching, and repackaging.
- *State Attorneys General v. Express Scripts*—\$9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans.

Caremark and its predecessor, AdvancePCS, paid nearly half of these damages.

The state of Ohio played a key role in uncovering problematic conduct by PBMs back in 2003, when the state sued Medco, one of the “Big Three” PBMs, for a number of fraudulent practices. The state alleged that Medco overcharged the State Teachers Retirement System tens of millions of dollars for dispensing fees, improperly dispensed drugs, and steered patients, pharmacists and physicians to choose higher-cost drugs rather than seeking the least expensive drug for the plan. In 2005, after trial, Medco was found

liable and paid \$7.8 million in damages. Here, we have a clear example of how, without transparency, PBMS can take advantage of the system at an enormous cost to plan sponsors and consumers. By passing S.B. 154, the state of Ohio could continue to protect consumers by preventing a host of anticompetitive and deceptive practices.

### **The PBM-pharmacy model hurts consumers and plan sponsors**

A PBM pursues various goals: to reduce costs for plan sponsors; to ensure that plan members are satisfied with their pharmacy benefit; and to earn profits, something which should be a function of how well it performs the first two tasks. Unlike other major PBMs, a PBM that is owned by a pharmacy chain, like CVS Caremark, has another priority that's entirely at odds with the services it provides to plan sponsors and plan members, and one that fundamentally disrupts the ability of a PBM to act as an honest broker.

CVS Caremark is the largest PBM owned by a pharmacy, and when the two entities merged in 2007, there was widespread concern that the company would exploit its relationships with consumers to drive market share, leading to increased prices and diminished quality. Many of these concerns have materialized in the company's practices, which have aroused outcry from consumer groups and pharmacists, leading the FTC to open a formal investigation of the company.

CVS Caremark, as a PBM-pharmacy, is concerned first and foremost with getting customers into its retail pharmacies. This is why CVS Caremark has instituted the "Maintenance Choice" program, which requires many plans' members to use a CVS retail or mail-order pharmacy for a drug after its second fill. The term "choice" is an interesting one—CVS is giving the consumers who have chosen their pharmacy because it offers the best combination of service and price the so-called "choice" of having to move their prescriptions to CVS. It does not sound like much of a choice to me, and that's why scores of consumers and public interest groups have been complaining about Maintenance Choice to the FTC and Congress.

CVS has also used various incentive programs to entice or force other plans' members to use CVS pharmacies. I have learned from consumers and pharmacists around the country that CVS Caremark is more concerned with getting potential customers into their pharmacies than ensuring the patient has access to their drugs when they are needed. For example, when plans require patients to use a restricted network or mail order, patients might need the occasional emergency refill at their local pharmacy. Pharmacists have told me that CVS Caremark is less likely to allow emergency refills, even if it means the patient needs to drive 50 miles to the nearest CVS in order to obtain their drugs in time.

This certainly does not demonstrate a concern with patient safety and health. For the many patients across the country who are required to use a CVS pharmacy, where they are highly unlikely to get the personalized care that a community pharmacist or a

pharmacy with which they have a long-term relationship offers, this disregard for patient care is stark.

Over the course of the past year, my office has been working with pharmacy groups and consumer groups that have raised concerns about the anticompetitive and deceptive conduct of CVS Caremark. Some of the problematic practices reported include:

- Using aggressive marketing tactics to steer patients to CVS pharmacies.
- Cutting off patients' access to affordable drugs to force them to use a CVS pharmacy, even if it means the patient must wait for a mail order delivery or drive a long distance.
- Charging patients and plan sponsors more for prescription drugs when the patient uses a CVS pharmacy.
- Taking advantage of access to independent pharmacies' claims data in order to target their customers and steer them to CVS pharmacies.

While individual consumers are the direct targets of CVS Caremark's deceptive practices, plan sponsors, including public and private entities, have also found that CVS Caremark does not have their best interest in mind. Cutting plan sponsors' costs certainly conflicts with CVS Caremark's intent to earn the highest profits through its own pharmacy operations. Typically, PBMs and pharmacies negotiate for the reimbursement rate the plan sponsor will ultimately pay for individual drug fills. This reimbursement rate is based upon the enormously complex nationwide system of drug pricing. Plan sponsors expect their PBM to play hardball with each retail or mail order pharmacy in their members' network to seek low reimbursement rates. CVS Caremark, however, has no reason to bargain with itself for lower reimbursement rates when it would benefit from higher reimbursements, which are paid for entirely by the plan sponsor.

When dealing with any other PBM, a sophisticated plan sponsor with audit rights can determine whether or not the PBM is "playing the spread." With CVS Caremark, however, there's no need to "play the spread" since the PBM and pharmacy are one and the same. Not only is there no need to "play the spread," but there's also no way for a plan sponsor to know what CVS Caremark's real costs are. This makes it much more difficult for a plan sponsor to decide whether or not they are getting a good deal by doing business with CVS Caremark.

### **Eliminating a crucial check on the system**

Competition and choice are crucial for a market to work effectively. Currently consumers in Ohio make a choice in how they value pharmacy services. Some choose community pharmacies, others who value one-stop shopping choose their local supermarkets, and others choose chains. This choice is important because competitors have to respond to this choice by improving services and lowering prices. One important aspect of pharmacy services is the service pharmacists provide in assisting consumers in dealing with insurance companies and PBMs. In fact the pharmacist, because of this assistance is effectively the face of the pharmacy benefit. From the

countless conversations I have had with pharmacists, one thing is clear: PBMs are enormously complex, and patients typically seek help from their pharmacist to navigate their pharmacy benefit. The majority of consumers never directly interact with their PBM or insurance company, and pharmacists are their only connection to the vast array of rules and agreements that determine their prescription drug benefit. For these consumers, pharmacists act as an advocate, providing information on what limitations the PBM may be imposing on the patient, the co-pay the PBM has determined the patient will pay, et cetera. When a particular policy is problematic for the patient, the pharmacist will often work through it with the patient, providing explanation and even advocating on behalf of the patient with the PBM—going far beyond the tasks for which the pharmacist is paid.

In effect, pharmacists provide a necessary check on the complex system of PBMs. That is another reason why this legislation is so necessary.

### **Conclusion**

PBMs can play an important role in controlling health care costs, but this depends on a competitive market supported by choice, transparency, and a lack of conflict of interest. Where these are absent, legislation is appropriate to protect the market and competition. Preventing these conflicts of interest arising from pharmacy chain ownership of PBMs is important to protect plans and consumers.