Prepared Statement of
the Federal Trade Commission

Before the
United States House of Representatives
Committee on the Judiciary
Subcommittee on Intellectual Property, Competition, and the Internet

Concerning
H.R. 1946
"Preserving Our Hometown Independent Pharmacies Act of 2011"

Washington, D.C.
March 29, 2012

Introduction

Chairman Goodlatte, Ranking Member Watt, and Members of the Subcommittee, thank you for the opportunity to appear before you today. I am Richard Feinstein, Director of the Bureau of Competition of the Federal Trade Commission, and I appreciate the opportunity to present the Commission's views on H.R. 1946, "Preserving Our Hometown Independent Pharmacies Act of 2011."[1] This bill would create an exemption from the antitrust laws to allow pharmacies to engage in collective bargaining to secure higher fees and more favorable contract terms from health plans.

The Commission is mindful of the challenges and economic pressures faced by local independent pharmacies that serve the needs of patients in their communities, and understands that the bill's proponents are concerned with the quality of patient care. Although the Commission is sympathetic to the difficulties community pharmacies face, the proposed exemption threatens to raise prices to consumers for much-needed medicine, which would have an especially dire impact on seniors. It also threatens to increase costs to employers who provide health care insurance to employees and retirees, which may cause those employers to reduce or eliminate benefits. And there is no assurance that the proposed exemption would produce any offsetting higher quality care. For these reasons, the Commission opposes the legislation.

At various times since the advent of active antitrust enforcement in health care in the 1970s, health care providers have sought antitrust exemptions. The Commission has provided testimony on several such proposals, which would have insulated health care professionals and organizations, including independent pharmacies, from the competitive forces that we count on to help us rein in health care costs and provide incentives to improve the quality of health care

[1] The written statement represents the views of the Federal Trade Commission. My oral presentation and responses to questions are my own and do not necessarily reflect the views of the Commission or of any Commissioner.

throughout the system.[2] Although these bills have differed in their scope or details, they all have sought some form of antitrust immunity for anticompetitive conduct that would tend to raise the prices, and reduce the availability, of health care products or services. Recognizing that many American consumers already face difficult health care choices in the market, Congress wisely has declined to adopt such exemption proposals.

In 2007, the Antitrust Modernization Commission (AMC)—the bipartisan private body created by Congress to evaluate the application of our nation's antitrust laws—urged Congress to exercise caution with respect to the creation of exemptions from those laws. The AMC noted that antitrust exemptions typically "create economic benefits that flow to small, concentrated interest groups, while the costs of the exemptions are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation."[3] The Commission agrees with the AMC recommendation that statutory immunities be granted rarely and only where proponents have made a clear case that exempting otherwise unlawful conduct is "necessary to satisfy a specific societal goal that trumps the benefit of a free market to consumers and the U.S. economy in general."[4]

H.R. 1946 Would Result in Higher Health Care Costs

The Commission's analysis of H.R. 1946 is informed by a broad range of law enforcement activity, research, and regulatory analysis that it has undertaken as part of its

[2] *See, e.g.*, Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Subcomm. On Courts and Competition Policy, On "Antitrust Enforcement in the Health Care Industry," Dec. 1, 2010; Prepared Statement of the Fed. Trade Comm'n Before the Subcomm. On Consumer Protection, Product Safety, and Insurance, Comm. on Commerce, Science & Transportation, On "The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care," July 16, 2009 (all testimonies available at http://wwwftc.gov/ocr/testimony/index.shtml).

[3] ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS (April 2007) at 335, *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[4] *Id.*

mission to protect competition and consumers in the pharmaceutical sector as well as in most other sectors of the economy. The FTC has conducted numerous law enforcement investigations, some resulting in challenges, involving drug manufacturers,[5] wholesalers, and retailers.[6] In addition, Commission staff has done empirical studies and economic analyses of the pharmaceutical industry,[7] and, jointly with Department of Justice, the Commission examined competition in the pharmaceutical sector among other health care sectors in public hearings in 2003 and an ensuing report in 2004. Commission staff has also analyzed competitive issues raised by a wide variety of proposed state and federal regulations affecting the industry including the likely effects of antitrust exemptions for collective negotiations by health care providers.[8]

The collective negotiations authorized by H.R. 1946 can be expected to result in health plans paying more to pharmacies. In prior law enforcement actions involving collective negotiations by competing pharmacies, the Commission found that the pharmacies sought, and ultimately obtained, higher rates.[9] H.R. 1946 would permit privately-held pharmacies to engage

[5] For FTC enforcement actions involving pharmaceutical manufacturers, see the Bureau of Competition's Competition Enforcement database at http://www.ftc.gov/bc/caselist/industry/cases/healthcare/HealthCarePrescriptions.pdf.

[6] For FTC enforcement actions involving drug wholesalers and retail pharmacies, see the Bureau of Competition's Competition Enforcement database at http://www.ftc.gov/bc/caselist/industry/cases/healthcare/HealthCareRetail.pdf.

[7] *See, e.g,* FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (Jun. 2009); FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005); FED. TRADE COMM'N AND DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (Jul. 2004) (all reports available at: http://www.ftc.gov/reports/index.shtm).

[8] *See, e.g.,* FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011); FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009); FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008); FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008) (all advocacies available at: http://wwwftc.gov/opp/advocacydate.shtm).

[9] For example, an association of approximately 125 pharmacies in northern Puerto Rico demanded a 22 percent increase in fees and threatened that its members would collectively refuse to participate in Puerto Rico's indigent care program unless its demands were met, thereby succeeding in securing the higher prices it sought. *Asociacion*

in price-fixing and boycotts to raise fees,[10] without fear of antitrust challenge. If this bill were enacted, some groups of pharmacies likely would seek higher fees in their negotiations with health plans. Absent a sufficient number of alternative pharmacies acceptable to the health plan and its consumer members, a health plan would have no choice but to accede to such fee demands, or it would not have a marketable pharmacy network to offer. This will likely undermine the plans' ability to control drug costs, which could ultimately lead to higher premiums, or changes in coverage such as increased deductibles or higher co-pays, to offset their higher costs.

Higher payments to independent pharmacies would likely increase health care costs for consumers, employers (both public and private), and government benefit programs. It appears that H.R. 1946 seeks to protect the federal government from higher costs, by providing that the antitrust immunity conferred by the bill would not extend to negotiations pertaining to benefits provided under Medicare and various other federal programs. But despite this exclusion, the federal government could still bear significant additional costs from the anticompetitive conduct that the bill would allow. That is because the agreements and sharing of competitively sensitive information the bill would permit in the context of negotiations relating to private drug benefit plans would provide independent pharmacies with information they could use to more easily coordinate their prices and other competitive behavior with respect to federal programs— even

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de Farmacias Region de Arecibo, 127 F.T.C. 266 (1999) (consent order). *See also Institutional Pharmacy Network*, 126 F.T.C. 138 (1998) (consent order; conduct targeted state Medicaid program). For other price fixing and boycotts actions involving pharmacies, *see* FTC Bureau of Competition, Overview of FTC Antitrust Actions in Pharmaceutical Services and Products, 19 – 24, *available at* http://www.ftc.gov/bc/healthcare/antitrust/rxupdate.pdf.

[10] Section 2(e), entitled "Limitations on Exemption," states that the bill would not immunize any "agreement or otherwise unlawful conspiracy that . . . (1) would have the effect of boycotting any independent pharmacy or group of independent pharmacies, or would exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by, any independent pharmacy or group of pharmacies with respect to the performance of services that are within their scope of practice as defined or permitted by relevant law or regulation." While it is unclear exactly what this provision is intended to carve out, it does not appear to limit pharmacies' immunity for boycotts of purchasers or payers in order to force price concessions.

without an actual agreement that could create antitrust liability. Thus, there is reason to expect that the bill would lead to higher spending for Medicare and other federal programs. In 2007, the Congressional Budget Office evaluated a previous bill to immunize collective bargaining by pharmacists and concluded that, despite a carve-out of certain federal programs (not including Medicare), the bill would increase direct federal spending for these programs.[11]

State and local governments likely would incur higher costs from H.R. 1946 as well, both in drug benefits for their employees and in public assistance programs. Such plans have been victims of coercive boycotts in the past.[12] Finally, if prescription drug coverage becomes more costly, some individuals might have to do without needed drugs. Fewer employers may offer health plans incorporating prescription drug coverage and some presently covered individuals may have to forgo certain prescription purchases, with potentially detrimental effects on their health.

The Market Share Provisions Are Unlikely to Mitigate Harm

H.R. 1946 contains provisions that limit the application of the bill's antitrust exemption, but it is unlikely that these provisions will be effective in protecting health care consumers. First, the "independent pharmacy" to which the bill applies is defined as a pharmacy that has less than a 10 percent "market share" in any Medicare Part D prescription drug plan (PDP) region and less than 1 percent nationally. Second, the bill caps the overall size of the group that may engage in immunized price-fixing or boycotts at 25 percent of the total number of pharmacy

[11] Congressional Budget Office Cost Estimate on H.R. 971, "Community Pharmacy Fairness Act of 2007" (Sept. 26, 2008) at 4-5, *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/98xx/doc9824/hr971.pdf. The Commission also opposed H.R. 971.

[12] *See supra* note 9*; see also Baltimore Pharm. Ass'n, Inc. and Maryland Pharmacists Ass'n*, 117 F.T.C. 95 (1994) (consent order); *Southeast Colorado Pharmacal Ass'n*, 116 F.T.C. 51 (1993); *Peterson Drug Co. of North Chili, New York, Inc.*, 115 F.T.C. 492 (1992) (opinion and order); *Chain Pharmacy Ass'n of NY State, Inc.*, 114 F.T.C. 327 (1991) (consent order); *Empire State Pharm. Soc'y, Inc.*, 114 F.T.C. 152 (1991) (consent order); *Pharmaceutical Soc'y of the State of New York, Inc.*, 113 F.T.C. 661 (1990) (consent order).

licenses issued to all retail pharmacies in a PDP region. However, these market share screens will do little to prevent potentially widespread harm from the collective bargaining contemplated by H.R. 1946.

First, these market share provisions do not reflect antitrust markets from either a legal or economic perspective. PDP regions are established by the Centers for Medicare and Medicaid Services to determine a health plan's or pharmacy benefits manager's eligibility to offer Medicare Part D prescription drug plans. Each PDP is at least as large as an entire state and some are as large as three.[13] Competition among retail pharmacies, however, is frequently local in nature, with consumers using pharmacies within a few miles of their homes.[14] As a result, the bill would permit price-fixing by pharmacies that, although constituting less than 25 percent of a PDP, have a much larger share of economically meaningful markets. Second, it is unclear what products or services provided by pharmacies should be used to calculate the market share limits contained in the bill.[15] Due to this uncertainty, the bill would be difficult to implement in practice.

[13] Of the 34 PDP regions established by the Centers for Medicare and Medicaid services, 25 encompass one state, while six cover two states and the other three cover three or more states. *See 2012 Medicare Part D Prescription Drug Plans: Overview by CMS Region, available at* http://www.q1medicare.com/PartD-Medicare-PartD-Overview-byRegion.php.

[14] *See, e.g., Rite Aid Corp. and The Jean Coutu Group (PJC) Inc.*, Dkt. C-4191 ¶16,015 (CCH) (Sept. 17, 2007) (consent order) (order requiring divestiture of retail pharmacies in 23 local markets to prevent anticompetitive effects of proposed merger); *J.C. Penney and Thrift Drug, Inc.*, 123 F.T.C. 778 (Feb. 28, 1997) (geographic markets were state of North Carolina and four Metropolitan Statistical Areas within North Carolina).

[15] In reviewing proposed mergers among pharmacies, the Commission has considered the likely competitive effects in different product markets. *See, e.g., Rite Aid, supra* note 14 (retail sale of pharmacy services to cash customers); *CVS Corp. and Revco, Inc.*, 124 F.T.C. 161 (Aug. 1997) (consent order) (retail sale of pharmacy services to third-party payors); *J.C. Penney and Thrift Drug, Inc., supra* note 14 (same); FTC News Release, *FTC Will Seek to Block Rite Aid/Revco Merger*, (Apr. 17, 1996), *available at* http://www.ftc.gov/opa/1996/04/riterevc.shtm (sales of prescription drugs sold in retail pharmacy outlets) (merger abandoned).

No Compelling Need Has Been Shown for the Proposed Exemption

Although the purpose of H.R. 1946 is "[t]o ensure and foster continued safety and quality of care and a competitive marketplace," the Commission is concerned that the proposed exemption would not further those goals. Nothing in the bill requires that the collective bargaining it authorizes, or the higher reimbursement rates that it will likely cause, be directed at improving patient safety or quality. On the contrary, antitrust immunity not only would grant competing sellers a powerful weapon to obstruct innovative arrangements for the delivery and financing of pharmaceuticals, but also would dull competitive pressures that drive pharmacies to improve quality and efficiency in order to compete more effectively.

Some joint conduct by health care providers can benefit consumers, create efficiencies, and be pro-competitive, without running afoul of the antitrust laws. In their joint *Statements of Antitrust Enforcement Policy in Health Care*, the antitrust agencies have expressly recognized that there are a variety of lawful ways – short of price fixing and coercive boycotts – that health care providers can collectively express to health plans their concerns about both price and quality issues.[16] In addition, joint ventures among pharmacists to provide medication counseling and disease management programs for patients with chronic illnesses such as asthma, diabetes, and heart disease have the potential to improve care and reduce overall costs. Commission staff has issued advisory opinions to groups of pharmacies that planned to develop such programs and jointly negotiate the fees for such services with third-party payers, finding that the antitrust laws presented no barrier to their proposed arrangements.[17] Similarly, independent pharmacies often

[16] *See* U.S. Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (August 1996) at Statements 4 and 5, *available at* http://www.ftc.gov/reports/hlth3s.pdf.

[17] Letter to Paul E. Levenson regarding *Northeast Pharmacy Service Corporation* (July 27, 2000) (network of independent pharmacies in Massachusetts and Connecticut offering package of medication-related patient care services to physician groups) *available at* http://www.ftc.gov/bc/adops/neletfi5.htm; Letter to John A. Cronin, Pharm. D., J.D. regarding *Orange Pharmacy Equitable Network* (May 19, 1999) (network of retail pharmacies and

participate in joint purchasing groups that allow them to lower costs and compete more effectively.[18] The proposed exemption would reduce incentives for pharmacies to undertake such lawful, pro-competitive, but perhaps more difficult, collaborations to improve service and compete more effectively in the marketplace.

Those who seek antitrust immunity for collective negotiations by pharmacies argue that health plans and pharmacy benefits managers (PBMs) have superior bargaining power when contracting with independent pharmacies. Thus, some suggest an antitrust exemption will "level the playing field" by enabling pharmacies to exercise countervailing power. According to proponents, allowing pharmacies to exercise leverage to obtain more favorable contracts will help ensure the survival of small pharmacies, and thereby promote high quality and accessible health care.

This type of rationale has been used to request special treatment for a host of situations and participants throughout our economy, both within and outside the health care sector. Antitrust law, and the enforcement agencies, recognize the risks of undue power on the part of buyers. Excessive buying power, known as "monopsony," enables buyers to depress prices below competitive levels. In response, sellers may reduce sales or stop selling altogether, ultimately leading to higher consumer prices, lower quality, or substitution of less efficient alternative products. If there were evidence of this type of consumer harm, antitrust enforcement

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pharmacists offering drug product distribution and disease management services) *available at* http://www.ftc.gov/bc/adops/openadop.htm**;** Letter to Allen Nichol, Pharm. D. regarding *New Jersey Pharmacists Association* (Aug. 12, 1997) (pharmacist network offering health education and monitoring services to diabetes and asthma patients) *available at* http://www.ftc.gov/os/1997/08/newjerad.htm.

[18] For example, the Independent Pharmacy Cooperative (IPC), which describes itself as "the nation's largest group purchasing organization for independent pharmacies," is a member-owned cooperative that has been in operation since 1984. IPC claims to represent 4500 pharmacy members. *See* http://www.ipcrx.com/public/About_IPC/MOC.aspx. Another independent pharmacy purchasing cooperative, EPIC Pharmacies, Inc., was formed in 1982, and describes itself as "a not-for-profit buying group of hundreds of independently owned pharmacies across the country." *See* http://www.epicrx.com/about/index.aspx.

might be necessary to combat an exercise of monopsony power. It is important, however, to distinguish between this type of buyer power, which can harm competition and consumers, and disparities in bargaining power, which are common throughout the economy and can result in lower input costs and lower prices for consumers.

Lawmakers are understandably concerned that some independent pharmacies may be unable to survive in the current environment, and especially about the prospect that some rural communities might be left without a local pharmacy. But these concerns do not justify a broad antitrust exemption that would apply to diverse businesses in markets throughout the country. To the extent that certain local concerns may warrant attention, targeted efforts to address particular issues in the distribution of pharmaceuticals and pharmacy services (perhaps looking to strategies used for medically under-served areas) may be a better way to address problems of access to prescription drugs, while avoiding the concerns that are raised by an antitrust exemption.

The Commission's opposition to this particular antitrust exemption proposal is not based on any policy preference for any particular type of pharmacy, or disregard for the strong sense of responsibility that individual pharmacists feel for the welfare of their patients. Rather, our opposition is based on the Commission's experience investigating the harm to consumers of numerous instances of collective bargaining by independent health care providers, including pharmacies.

Conclusion

Antitrust enforcement in the health care sector has helped ensure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. It has helped to restrain the upward-spiral of health care costs. Although health care markets have changed dramatically over time, and continue to

evolve, collective action by health care providers to obstruct new models for providing or paying for care, or to interfere with cost-conscious purchasing, remains a significant threat to consumers. Policymakers have been exploring ways to address widespread concerns about our health care system, including ways to stem spiraling costs and improve quality. Giving health care providers – whether pharmacies, physicians, or others – a license to engage in price fixing and group boycotts aimed at extracting higher payments from third-party payers would be a costly step backward, not forward, on the path to a better health care system.

Thank you for this opportunity to share the Commission's views on this proposed legislation. The Commission looks forward to continuing to work with the Subcommittee to ensure that our antitrust laws and policies are sound and that they benefit consumers without unduly burdening businesses.