Statement of the National Community Pharmacists Association (NCPA) to the United States Senate Committee on Commerce, Science, and Transportation Subcommittee on Consumer Protection, Product Safety, and Insurance Hearing on "Competition in the Health Care Marketplace"

July 16, 2009

Chairman Pryor, Ranking Member Wicker, and members of the Consumer Protection, Product Safety, and Insurance Subcommittee of the Senate Commerce, Science, and Transportation Committee. The National Community Pharmacists Association (NCPA) and I appreciate you conducting this hearing on "Competition in the Health Care Marketplace", and for giving me this opportunity to testify on behalf of independent community pharmacists. My name is Mark Riley. I have been an independent pharmacist for over thirty years, and I currently serve as national treasurer of NCPA. From my perspective, in order to increase the quality of care and the number of people receiving care, there must be transparency and the elimination of self-dealing, so that competition is fair and ensures that both private and public health care expenditures are used efficiently.

NCPA was founded in 1898 as the National Association of Retail Druggists (NARD) to promote pharmacy as a profession and the role of independent community pharmacy in delivering quality prescription and related health care to their patients. NCPA represents the 55,000 pharmacists, pharmacist owners, managers and 300,000 employees of more than 23,000 independent community pharmacies across the United States. Independent pharmacists provide prescription drug and related health care services to millions of patients, many of them in underserved areas.

In addition to my duties as a national officer for NCPA, I have owned East End Pharmacy in a small town outside of Little Rock, Arkansas for the last 26 years. I currently serve as the executive vice president of the Arkansas Pharmacists Association, where I have been for the last 6 years.

I have spent my career serving patients in the independent community pharmacy marketplace and advocating for a level playing field throughout the pharmacy industry. I've also worked as a pharmacy consultant for ten years within the Pharmacy Benefit Manager (PBM) industry. During that time as a PBM consultant, I saw the industry change from a claims processing industry, to an industry veiled in secrets that often deceives its own clients for the sake of corporate profits. In addition, they have created an environment of anti-competitiveness where self-dealing is the norm. Simply put, the unregulated, anticompetitive practices of the PBMs are costing our healthcare system so much money that I absolutely do not believe it is possible to control costs in the prescription drug sector without exposing their egregious business tactics.

Mr. Chairman, NCPA proposes reforms that will make their PBM operations transparent, thus ensuring that PBMs can no longer keep these excessive profits from patients and the government. Second, I will discuss the need for the correct "class of trade" pricing to ensure that the appropriate sectors of the pharmacy market are measured according to the same terms. These discussions naturally lead to a third issue, the FTC's unbalanced study of mail order pharmacy operations. I will present the drawbacks of the study and mail order. Finally, I will close with a discussion of the anti-competitive merger of CVS, the nation's largest chain pharmacy, and Caremark, one of the nation's three largest PBMs. The non-transparency and the self-dealing aspects of these areas skew the health care market and prevent the implementation of level competition, to the detriment of the health care system, patients and taxpayers.

Mr. Chairman, the result of the current system is that powerful competitors (chain pharmacies aligned with large PBMs) know the prices at which we buy pharmaceuticals, they know to whom we sell our prescription drugs, and they know the prices at which we sell them. I can think of no other industry – health care or otherwise – in which there is such a gross imbalance of power that skews the market, to the detriment of most of the stakeholders in it and those people and entities affected by it.

I. The Need for PBM Reforms

A. The Problems and Proposed Reforms

Through its purely administrative actions, a PBM plays a critical role in both gathering patient eligibility information from the payer and providing this information to the pharmacy to allow for online processing of prescriptions claims. As part of these transactions, the PBM often makes critical decisions about the patient's health care including determining the benefit plan design, and determining the amount the patient is responsible for paying, commonly referred to as the copay.

Besides these key functions, PBMs also fix pricing for the retail pharmacies who participate in their networks. This creates a huge conflict of interest because the PBMs also own mail-order pharmacies that compete directly with the retail pharmacies with whom they are contracted. This leads to the PBM being able to collect not only pricing information from the retail pharmacy, but also to collect patient specific data. PBMs have become increasingly aggressive with the large amount of data that they have and they are using this data to steer patients away from the community-based pharmacy into a mail-order pharmacy that the PBM owns.

This type of self-dealing is becoming more and more prevalent in the marketplace and is at its heart anticompetitive. In the Medicare Part A & B worlds, this type of physician self-dealing would be illegal. PBMs simply call it part of their everyday business plan. Due to the large volume of

prescriptions that are managed by PBMs, transparency of these intermediaries is much needed to shed light on the many deceiving acts that add unneeded expense to our healthcare system. This transparency will provide substantial savings to patients and plan sponsors.

There are two markets for prescription drug pricing. The first market is where the PBM and the plan sponsor negotiate regarding how much the plan sponsor will pay the PBM for prescriptions dispensed to patients covered under that plan. The second market is between the PBM and the pharmacy network, where the PBMs are able to set the rates at which community pharmacies will be reimbursed for dispensing medications to the patient under that health plan. Due to inadequate transparency regarding PBMs, they are able to engage in "spread pricing" where they charge the plan sponsor a rate substantially higher than what is paid to the pharmacy for services rendered. These spreads can vary dramatically on individual prescription drugs, and represent a substantial additional cost to plan sponsors, yet provide no added value to the health of patients. It has also been argued by many experts that PBMs use vague and inadequate language when defining what constitutes a "brand" and a "generic" prescription drug, allowing these intermediaries to maximize their revenue by charging the brand name while artificially increasing their reported generic utilization rate.[1]

Lack of transparency and inadequate auditing also allows these PBM's to keep payments from pharmaceutical manufacturers, rather than passing these rebates on to plan sponsors. For example, an audit was performed for the Federal Employees Health benefits Program (FEHBP) Retail Pharmacy Drug Program, for the years 2000 through 2005. It found that the PBM administering that program had collected over $13 million in administrative fees, which should have been considered drug rebates and hence subsequently returned the FEHBP Program.[2] Such audits are difficult to administer, due to a severe lack of transparency.[3]

I also want to bring to your attention an article published by the Creighton University Medical Center, titled "Spread Pricing in the Prescription Benefit."[4] This document provides examples from actual claims data for four different employers, detailing the spreads charged by PBMs for a sample of prescription drugs. As an example, looking at atenolol, a blood pressure drug, the PBM charged the plan sponsor $80, but paid the pharmacy only $7, creating a spread of $73, equal to 91% of the entire

[1] Learner, N. "PBMs Allegedly Manipulate Definitions of 'Brand' and 'Generic' Rx at Payers' Expense. 2008; http://www.aishealth.com/DrugCosts/DBN_PBMs_Generic_Brand.html.
[2] Testimony for Susan A Hayes for the Committee on Oversight and Government Reform, Subcommittee on Federal Workforce. June 24, 2009.
[3] Drug Benefit News. "PBM Auditing Increasing as Rx Costs Rise, But Critics Allege PBMs Are Foiling Audits." September 5, 2009.
[4] Garis RI, Mohammad A. "Mail-order prescription pricing: a critical examination." Creighton University Medical Center School of Pharmacy and Health Professions. http://www.pbdsuite.com/documents/SPREAD_BROCHURE.pdf.

cost that the PBM charged the plan sponsor. In another example, the PBM charged the plan sponsor $104 for propoxyphene, a pain medicine, but only paid the pharmacy $40, creating a spread of $64, equal to 62% of the entire cost.

It is important to note that the plan sponsor is not made aware of the spread and is charged an administrative fee by the PBM on top of that. One expert has argued that the spread retained by PBMs is responsible for as much as 5% of prescription drug spending, and is done with little knowledge of the plan sponsor due to inadequate transparency.[5] These serve as but two examples of the wide variability that can exist when analyzing spread pricing. There are, however, multiple peer-reviewed studies and commentaries from many experts demonstrating this same wide range in spread prices, thus indicating the need for transparency.

To provide an example from my home state of Arkansas, the Arkansas Pharmacists Association had an opportunity to review 103 claims for a small self-insured business in central Arkansas. This company was paying a per claim administrative fee to the PBM for the PBM's "services." What we found was shocking. After comparing the employer's PBM invoice with the pharmacy's payments, we found that the employer was being charged, on average, $45.50 per generic prescription. The pharmacies were only paid, on average, $22.95 per generic prescription. In this example, the PBM was blindly charging this small, self-insured business, on average $22.55 **more** than the prescription actually cost. In essence, the PBM added $22.55 per prescription in worthless healthcare expenses. Attached is a two-page PowerPoint power that outlines these dramatic differences.

These expenses did not improve outcomes, they did not help manage chronic diseases, they did not help to provide additional medications to the patients. Instead these added expenses went solely to pad the corporate profits of the PBMs. The most egregious example from this employer was the drug Simvastatin, a medication commonly used to lower cholesterol. The pharmacy was paid $14.40 for this drug, while the PBM charged the small, sell-insured employer $126.72. That's an 880% overcharging of the employer. And remember, no added benefit was provided to the healthcare system in this example, just corporate profits run rampant at the expense of our healthcare system. And perhaps the single most disgusting aspect of this business practice is that the PBM leads the small, self-insured employer to believe that the local pharmacy was actually paid the full $126.72.

To address this spread pricing issue and other key PBM issues, NCPA proposes the following four reforms, the third of which would eliminate these inflated costs by mandating that the PBM cannot reimburse the pharmacy less than what they are billing the payor for covered medications. Each reform requires that a group health plan, and a health insurance issuer providing health

[5] Testimony for Susan A Hayes for the Committee on Oversight and Government Reform, Subcommittee on Federal Workforce. June 24, 2009.

insurance coverage in connection with a group health plan, cannot enter into a contract with any pharmacy benefit manager (PBM) to manage the prescription drug coverage provided under such plan or insurance coverage, unless the PBM satisfies the following requirements:

1) The group health plan provides to the patient an explanation of benefits (EOB) statement;

2) The PBM uses equal payment bases and disclosure of reimbursement amounts for mail order and retail in order to avoid unfair steering to mail order.

3) The PBM can not engage in spread pricing, which occurs when a PBM charges the group health plan or health insurance issuer a higher price for a drug than the amount the PBM pays the pharmacy for the same drug.

4) The PBM must identify and pass along in the form of lower copays or premiums any cost savings it negotiates with a manufacturer.

Plan sponsors will also realize additional health care savings by mandating that PBMs keep a verifiable and transparent account of all rebates received from pharmaceutical manufacturers. Due to inadequate transparency, it is difficult to know the amount of revenue collected by PBMs from pharmaceutical manufacturers, making it difficult to ensure that these payments are passed on to the plan sponsor. As an example, according to Winkelman Management Consulting, in 2004 Medco collected over $3 billion in revenue from pharmaceutical manufacturers through prescription drug rebates, but failed to pass along $1.3 billion (44%) of this revenue to their plan sponsors.[6] One expert has testified that as much as 50% of drug manufacturer rebate payments are kept by the PBM and never paid to the plan sponsor.[7] Also, one-sided PBM/client contracts give PBMs undue influence on audits in many cases. PBMs generally restrict the number of rebate agreements that can be audited.

PBMs should therefore be required to meet the following fiduciary duties to health plans:

1) The PBM must annually provide to the group health plan or health insurance issuer all financial and utilization information requested by them, and must annually provide all financial terms and arrangements for remuneration between it and a drug manufacturer;

2) PBMs must also disclose, before signing an agreement with a prospective client plan, its methodology of soliciting and receiving payment from drug manufacturers; and

3) PBMs owned by a retail pharmacy are prohibited from sharing with that pharmacy any patient identifiable data that may be sent to the PBM by competing pharmacists to process prescription drug claims for enrollees.

[6] Winkelman Management Consulting. April 2005.

[7] Testimony for Susan A Hayes for the Committee on Oversight and Government Reform, Subcommittee on Federal Workforce. June 24, 2009.

NCPA is not alone in seeing the need to address these concerns. PBMs have been subject to a remarkable number of enforcement actions by state attorneys generals and the Justice Department. There are over 6 key pending and settled government enforcement actions brought against the three major PBMs. Many of these cases have been brought by a coalition of over 30 state attorneys generals securing monetary penalties of over $370 million. As the National Legislative Association on Prescription Drug Prices (NLARx), a bipartisan alliance of state legislators, has observed "we know of no other market in which there has been such a significant number of prominent enforcement actions and investigations, *especially a market with such a significant impact on taxpayers*."[8] The enforcement actions address:

(1) conflicts of interest because PBMs both manage drug benefits and dispense drugs;

(2) improper prescription drug switching to a higher priced drug without medical justification and without the authorization of the prescribing physician; and

(3) failing to disclose and pass on the full extent of rebates and other incentives received from drug manufacturers, and failing to pass through such discounts to pharmacies and consumers.

The tremendous amount of litigation by employers, insurers, consumer groups and others demonstrate the chronic conflicts of interest and the lack of transparency. Regulation to create some sort of market transparency is crucial to the proper functioning of this market. The First Circuit Court of Appeals that upheld Maine's regulatory statute noted that PBMs "introduce a layer of fog to the market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs." Over the past four years, more than twenty states either have passed or are considering regulation of PBMs to address these problems.

PBMs harm consumers by using their market power to reduce compensation to pharmacies. As noted below the PBM market is highly concentrated and that enables them to exercise "monopsony" or buyer power to reduce compensation to the pharmacies that provide dispensing services. Although a reduction in compensation may appear attractive from the perspective of a buyer of PBM services, that attraction is misleading. The savings from reducing compensation is not passed on to buyers in lower prices because of the market power of PBMs. Moreover, ultimately the consumer of drugs is harmed because there are fewer pharmacies available because of reduced reimbursement rates, or other forms of pharmacy services diminish.[9] Leaving the PBM scheme unfettered and without oversight to ensure true open competition, along with leaving matters to litigation, is unworkable.

[8] Letter from Senator Mark Montigny, on behalf of NLARx, to Deborah Platt Majoras, FTC Chair, May 11, 2005.
[9] This monopsony power that PBMs enjoy is similar to that of health insurers, which have the ability to impose take-it-or-leave it contracts on physicians.

B. FTC Study

The FTC has spoken today about its report, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies" August 2005. (*The Study*).[10] As part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which became law in November, 2003, Congress requested that the Federal Trade Commission determine whether PBMs that own a mail-order pharmacy act in a manner that maximizes competition and results in lower prescription drug prices for its plan sponsor members. The FTC acknowledged that "in theory they (PBMs) could have incentives to increase costs and generate additional profits through mail-order pharmacies. However, the FTC concludes that, in 2002 and 2003, PBM's ownership of mail-order pharmacies generally did not disadvantage plan sponsors." (*The Study*, Executive Summary, p. ii).

The Study, however, contained many methodological structural flaws, including (but not limited to) its methods of assessing costs and Generic Dispensing Rates (GDRs) for owned-mail order, non-owned (independent) mail order and retail pharmacy and by therapeutic class between mail order and retail, in comparing Generic Substitution Rates (GSRs); in assessing brand-to-brand therapeutic interchange; in failing to fairly determine conflicts of interests and in simply mischaracterizing its analyses. (An Assessment of the Federal Trade Commission Conflict of Interest Study, John N. Demos and Stewart Stewart, April 2006, particularly pages ii – iv of the executive summary, found at: http://www.ncpanet.org/pdf/ftcassessment-exsum.pdf). *(An Assessment***).**

More specifically, I would highlight that:

1) In assessing payments and their plans for drugs dispensed by mail order operations which are owned by PBMs, compared to mail-order operations not owned by PBMs and retail pharmacies, costs may be lower at retail pharmacies. In addition, mail order cannot accomplish the face-to-face counseling and medication management, which are especially important for elderly patients taking multiple drugs, which is featured at retail community pharmacies."[11]

2) In response to the question of whether plans are acting in a manner that maximizes competition and results in lower prescription drug prices for enrollees, PBMs suffer from a conflict of interest created, to a large extent, by retention of pharmaceutical manufacturer payments.[12]

3) Mail-order pharmacies that are owned by PBMs (or by entities that own PBMs) dispense "significantly fewer" generic drugs compared with mail-order pharmacies that are not owned

[10] http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf.
[11] *An Assessment* at vii.
[12] Id. At vii, viii.

by PBMs."The FTC's assessment of PBM spreads at mail-order is erroneous in that it looks at spreads on average rather than assessing specific transactions."[13]

4) Therapeutic interchange is a prevalent practice at PBM mail-order pharmacies, which helps explain the lower generic dispensing rates at these facilities.[14]

5) If PBMs pursue their interest in mail-order, "it will have a substantial impact on the national cost of drug benefits and the burden on the taxpayer."[15]

II. The Need for Uniform Application of Class of Trade Pricing

A reoccurring issue for community pharmacy is that there are increasingly harmful, illogical inclusions of various pharmacy pricing structures where a well-defined retail pharmacy class of trade should be used. A "retail pharmacy class of trade" has traditionally been defined to mean any independent pharmacy, independent pharmacy franchise, independent chains, independent compounding pharmacy, traditional chain pharmacy – including each traditional chain pharmacy location, mass merchant pharmacy and supermarket pharmacy.

Unfortunately, government programs are increasingly expanding the class of trade to include areas such as low cost drug pricing under the 340B program. Congress created the program to provide low cost drugs to low income and uninsured individuals. Lack of a strong regulatory structure has created situations, however, where the low cost drugs are provided by 340B (health care) entities, such as 340B hospitals, to their own employees, many or perhaps all of whom are not the type of individuals for which the program was designed to assist. If different pricing structures, such as the 340B program, mail order drug operations, and various hospital price programs, are included in different drug programs, then market forces will not work correctly, as there will be differently priced products "competing" for purchase within the same program. Lumping together differently priced drugs runs counter to the purposes of each individual program/pricing structure, and inappropriately mixes the types of patients each is designed to reach.

In the United States, pharmaceuticals are sold by the pharmaceutical manufacturers at different prices to different entities, such as retail pharmacies, hospital pharmacies, long-term care pharmacies, and mail-order pharmacies. Historically, the differences in pricing have not substantially affected retail pharmacies because retail pharmacies are not competing for patients in hospitals or long term care facilities. However, mail order pharmacies pose a different threat to retail pharmacies because mail order pharmacies are competing for the same patients as retail pharmacies, and mail order pharmacies are doing so using preferentially priced prescription medications. This results in

[13] Id. At x, xi.
[14] Id. At xiv.
[15] Id. At xv - xvii.

mail order pharmacies buying prescription medications at prices that retail pharmacies cannot access and this is why we are concerned with mail order pricing being included in the calculation of Average Manufacturer Price (AMP). This discrepancy in pricing in fundamentally unfair and does not promote true competition.

In sum, Retail Class of Trade should focus on the class of patients being served, and not on who is sending the pharmaceutical product. Medicaid AMP is a situation where putting mail order in the same class of trade as retail pharmacy class of trade makes no sense, as there are differentials in the pricing structure of each category.

The problem of mixing pricing structures is also highlighted by the self-dealing that is inherent in the merger of CVS and Caremark.

III. Problems of the CVS-Caremark Merger

The merger of CVS, the nation's largest retail pharmacy, and Caremark, the nation's largest pharmacy benefits manager (PBM), has produced a prescription services giant. The resulting company operates more than 6,800 pharmacies, affects 134 million consumers and fills or manages 1.2 billion prescriptions annually—controlling or influencing the prescription benefit of an estimated 1 out of 3 Americans. With $9 billion in incremental earnings last year and a nearly $50 billion market cap, CVS/Caremark has created a virtual monopoly limiting consumer options.

PBMs do have a role to play through their "pharmacy benefit administer" role. When a giant PBM is owned by a pharmacy, however, there is the ability and incentive for the pharmacy to misuse this relationship to diminish competition among non-CVS pharmacies. With the substantial market share CVS possesses in numerous markets, such conduct may raise significant competitive concerns.

On May 13, 2009, the Federal Trade Commission (FTC) met with more than 80 independent community pharmacists and several patients to discuss the negative impact of the March 2007 CVS/Caremark merger and to urge the FTC to re-examine it. At the meeting, NCPA members explained how their patients experienced higher costs, fewer choices and less privacy since the merger took effect. NCPA therefore urged the FTC to take a number of steps, including investigating allegations of anticompetitive and deceptive conduct by CVS/Caremark; requiring CVS/Caremark to treat all pharmacies in a nondiscriminatory fashion; and ensuring that the company creates an ironclad barrier between CVS and Caremark so that competitively sensitive Caremark information cannot be used by its retail operations.

Some of the recent conduct by CVS/Caremark that raises these concerns includes the following activities and examples which were discussed at the May 13 meeting. Due to the potential for retaliation by CVS/Caremark through excluding pharmacies from their network, the patient and pharmacy names have been withheld.

- CVS/Caremark has significantly increased the copay for members when they seek to fill prescriptions at non-CVS pharmacies. This clearly raises the costs for members for using non-CVS pharmacies;

    - In New England, Pharmacist D. was appalled when his patient's co-pay on a monthly refill suddenly increased from approximately $5 to $50. When D. asked her if she knew why, he learned she had been receiving letters that said she would have to either pay a "penalty co-pay" or transfer her prescriptions to CVS retail or Caremark mail order. CVS/Caremark was also requiring her to get a 3-month supply of a liquid drug which was much too heavy for the 94-year-old patient to lift. Instead, D. offered her the drug at cash price—less than half the price CVS/Caremark wanted her to pay.

- CVS/Caremark has adopted a program to attempt to steer consumers to CVS pharmacies. When a Caremark member fills a prescription at a CVS pharmacy, the CVS pharmacist is informed through the Caremark electronic system of whether the recipient uses another non-CVS pharmacy. In those situations, the CVS pharmacist is instructed to inform the consumer of the dangers of using multiple pharmacies. Obviously the only way the CVS pharmacists knows the consumer uses multiple pharmacies is through the misuse of consumer information possessed by Caremark; and

    - A longtime patient of Pharmacist R. in Louisiana was shocked when her monthly refill was denied and the system claimed the drugs had already been processed—at a CVS/pharmacy two towns over. When R. called to ask why the drugs had been filled at a different pharmacy without the patient's request, the CVS pharmacy refused to comment and only said, "We'll back them out [reverse the prescription claims]."

- CVS/Caremark co-brands its prescription drug card in such a fashion to confuse consumers that the benefit card can only be used at CVS.

- From Pharmacist K. in Wisconsin: "Today we attempted to fill a medication for a customer who needed it to coincide with her chemotherapy. Her plan does cover the medication but when we attempted to fill she was told it had to come from their [CVS/ Caremark] mail-order service. This delay will affect her chemo cycles and possibly her whole recovery."

- One North Carolina patient on a Medicare Part D plan operated by CVS Caremark switched his and his wife's prescriptions to CVS pharmacy in March 2009, expecting lower costs, as advertised. Instead, he had an extra $302 billed to his plan in pharmacy reimbursements, in *addition* to $12 in extra co-pay. At the local pharmacy, the plan paid a total of $11.08 for seven of their drugs; at CVS, it paid $313.17. These actions raised the government's payments by **more than 2,800%,** pushing seniors to the donut hole coverage gap sooner.

NCPA hopes that these examples and the previous discussion of the vital need for PBM transparency reforms will spur the Subcommittee, the Committee, and Congress to call on the FTC to carefully re-examine the CVS-Caremark merger. For your reference, we are attaching a copy of the May 12, 2009 letter of NCPA President Holly Henry to FTC Chairman Jon Liebowitz in which she outlines how the merger and recent CVS/Caremark actions might diminish pharmacy competition, and also asks for specific relief.[16] We believe that CVS/Caremark's actions may be violations of Section 5 of the FTC Act, and the original acquisition may be a violation of Section 7 of the Clayton Act.

It is not too late for the FTC to investigate the merger and challenge any anticompetitive conduct. They have done so in the past on numerous occasions. In 1998, for example, the FTC investigated Merck's acquisition of the Medco PBM five years after its approval and found "the merger has made it possible for Medco to share with Merck sensitive pricing information it gets from Merck's competitors." The company signed a consent agreement to settle the FTC investigation, agreeing to refrain from sharing proprietary or other non-public information they receive from one another's competitors.

NCPA knows about some of CVS/Caremark's practices which, for profit making motives, migrate customers from low value behaviors to higher value behaviors. NCPA does not, however, have full knowledge of CVS/Caremark's operations, yet CVS/Caremark has full knowledge of the operations of independent community pharmacies. CVS/Caremark knows the prices at which we buy pharmaceutical products, who we are selling the product to, and at what prices we are selling. I respectfully submit that the Subcommittee should be extremely concerned about this concentration of power and the impact it has upon fair competition in the pharmaceutical industry. As I have tried to highlight by stating some "real life" examples, the problem is not an obscure accounting practice – it is that profits are kept from those providing services in this health care industry and grossly overly rewarding the PBM sector for merely providing administrative services. Instead, the manager of the transaction takes large profits at the expense of patient care.

Finally, I wish to highlight that CVS/Caremark's actions include breaches of privacy rights:

[16] http://www.ncpanet.org/pdf/needftcinvestigation.pdf.

- In October 2007, a Massachusetts judge condemned CVS for advising patients to switch drugs in a direct-to-consumer mailing that was secretly financed by manufacturers and by which CVS profited.[17]

- In June 2008, CVS/Caremark sent a letter to one doctor urging that physician to switch several patients – mentioned specifically by name, patient identification number, and date of birth – to Januvia, a Merck diabetes medication that costs between 5 and 11 times more than other comparable treatments.[18]

I thank you for the opportunity to speak before you today to provide this testimony and I want to submit to you one final statement. Independent retail pharmacists know how to save money and how to maximize healthcare expenses. We do it every day. We are quite literally the only providers in the entire healthcare system that understand both the therapeutics of the medications **and** their economics. When we have a chance to compete on a level playing field with all the huge companies, we save the healthcare system money.

I would be pleased to answer any questions.

[17] Change to Win report, "CVS Caremark: An Alarming Prescription." Page 16
[18] Marley Seaman, "Unions Accuse CVS Caremark of Pushing Merck Drug," Forbes 11/14/08, <http://www.forbes.com/feeds/ap/2008/11/14/ap5696569.html>