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.
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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

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

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

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 w

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.

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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

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.