



## AMERICAN BENEFITS COUNCIL

March 29, 2012

Representative Bob Goodlatte  
Chair  
House Committee on the Judiciary  
Subcommittee on Intellectual Property,  
Competition and the Internet  
House of Representatives  
Washington, DC 20515

Representative Mel Watt  
Ranking Member  
House Committee on the Judiciary  
Subcommittee on Intellectual Property,  
Competition and the Internet  
House of Representatives  
Washington, DC 20515

**Re: Opposition to H.R. 1946, Preserving Our Hometown Independent Pharmacies Act of 2011**

Dear Chairman Goodlatte and Ranking Member Watt:

The American Benefits Council (the "Council") appreciates the opportunity to provide comments to the House Judiciary Committee's Subcommittee on Intellectual Property, Competition and the Internet in opposition to H.R. 1946, denominated the Preserving Our Hometown Independent Pharmacies Act of 2011. ("H.R. 1946" or "the Act"). The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly, or provide services to, retirement and health plans that cover more than 100 million Americans. Our members bear the bulk of the costs of health care coverage for these covered individuals, the majority of enrollment in private health plans in the country.

We oppose H.R. 1946 because its principal impact is likely to be to increase costs to our employer members and their employees for prescription drug benefits. Indeed, permitting price fixing by pharmacies in their dealings with health plans appears to be the primary aim of H.R. 1946.

H.R. 1946 would create a broad antitrust exemption from both state and federal antitrust law for price fixing and other anticompetitive agreements by otherwise

competing pharmacies in their dealings with America's employee health benefit plans and the insurance carriers and administrators who serve those plans. The proposed legislation would do this by treating pharmacies as if they were fellow employees negotiating with a common employer, when they are in fact neither fellow employees and they do not have a common employer. H.R. 1946 would give pharmacies' joint price negotiation activities with health plans the full protections that labor unions enjoy with regard to collective actions of their employee members with regard to employers. This would apparently include the right to jointly withhold services, to pressure health plans with threats of boycotts and refusals to participate in health plans, and would do so without imposing any of the responsibilities or obligations that labor unions must bear.

While subsection 2(e) of H.R. 1946 contains certain purported limitations on the Act's scope, these limitations do not alter the fundamental thrust of the Act—which is to immunize price fixing by competing pharmacies in their negotiations with health plans. The Act excludes from the new antitrust immunity: (a) boycotts of independent pharmacies; (b) imposition of limits on the scope of services provided by pharmacies; (c) allocation of markets among competitors; (d) unlawful tying arrangements; and (e) monopolization or attempts to monopolize.

Thus, price fixing, effected through joint negotiations on price among competing pharmacies, would be immunized from both state and federal antitrust challenge. Subsection 2(h) of H.R. 1946 excludes from its scope price-fixing directed at Medicare, Medicaid and certain other government programs, but the Act remains squarely intended to immunize price fixing in connection with the employer sponsored health plans serving American citizens, including both private employer plans and government employee plans serving school districts and city and state governments across the country.

Subsection (f) of H.R. 1946 also puts a purported "market share" cap on the joint negotiations by independent pharmacies with a health plan that would receive the new antitrust exemption. The cap is 25 percent of the independent pharmacies operating within a "region". While this sounds as if it might provide protection against abuse and the exercise of market power to raise prices, the term "region" is defined in Section 2(i)(4) of the Act by cross reference to use of the term "region" in the Medicare Part D prescription drug program law. See §1860DD-11(a)(2) of the Social Security Act, 42 U.S.C. § 1395w-111(a)(2). Under Medicare Part D, the Centers for Medicare & Medicaid Services has established 34 "regions" covering the entire United States, and five more covering the U.S. territories. See <http://www.q1medicare.com/PartD-Medicare-PartD-Overview-byRegion.php>. Every region includes at least an entire state, and some contain as many as two, four or seven states.<sup>1</sup>

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<sup>1</sup> Region 25 includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming.

Since pharmacy services are typically provided at a local or community level, and the joint price negotiations protected by the Act could be undertaken on exactly such a local or community basis, a market share cap based on the number of pharmacies participating across a region that is the size of a whole state, or even larger, would not constrain the exercise of market power by these price-fixing combinations of pharmacies in communities across the country. For example, if all the independent pharmacies in Winchester, Virginia were to jointly negotiate prices with health plans, employers would have no other alternative than to pay higher prices, notwithstanding that the pharmacies in the scheme would be far fewer, of course, than 25 percent of the licensed pharmacies in the entire Commonwealth of Virginia. Tinkering with the Act's phrasing would not solve the problem – if the joint price setting would not alter the dynamics of the price negotiations so as to permit the pharmacies to achieve higher pricing that they would consider more desirable, it is not evident what purpose the legislation would serve in the first place.

Finally, the Act permits any “independent” pharmacy company to participate in the immunized price fixing, with independent status depending under section 2(i)(3) of the Act on whether the retail pharmacy company had less than 10 percent of the pharmacies in the entire region and less than 1 percent of the pharmacies in the whole country. This constraint would not, obviously, protect competition in local market areas throughout the country where a particular pharmacy could have a very high share, while being less than 10 percent statewide. And, of course, as noted above, multiple pharmacies that each have less than 10 percent of a region's pharmacies could freely engage in price fixing under the bill's terms so long as these combinations were separately organized around a state, so that the statewide caps on “region” market share were avoided.

Congress has consistently rejected similar efforts to provide antitrust immunity to price fixing by health care providers going back to the 1970s. Comments by the Federal Trade Commission in opposition to the very similar proposed Community Pharmacy Fairness Act of 2007 remain applicable today.<sup>2</sup> The Commission explained:

The bill would immunize price-fixing and boycotts to enforce fee and other contract demands, conduct that would otherwise amount to blatant antitrust violations. Experience teaches that such conduct can be expected to increase health care costs, both directly through higher fees paid to pharmacies, and less directly by collective obstruction of cost containment strategies of purchasers. These higher costs would fall on consumers, employers – both public and private – who purchase pharmaceuticals and other products on behalf of their employees . . . .

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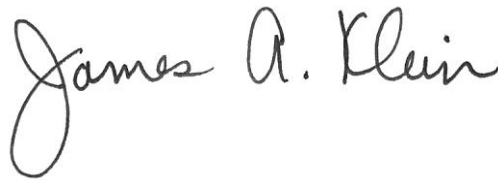
<sup>2</sup> See Prepared Statement of the Federal Trade Commission Before the Antitrust Task Force of the Committee on the Judiciary United States House of Representatives Concerning H.R. 971 “The Community Pharmacy Fairness Act of 2007,” October 18, 2007.

Giving health care providers – whether pharmacies, physicians, or others – a license to engage in price fixing and boycotts in order to extract higher payments from third-party payers would be a costly step backward, not forward. . . .<sup>3</sup>

Rising health care costs are a key public policy challenge for our country, and, in particular, for employer-sponsored health plans. Federal legislation providing an antitrust exemption for pharmacies to negotiate higher rates of payment with health plans would drive up health costs for employers and their employees and retirees, and limit, rather than enhance, choice for American consumers. We appreciate that community pharmacies face challenges in today’s marketplace, just as employers sponsoring health plans do. Creating an antitrust exemption for price fixing is not a fix for anything that ails us.

Thank you for this opportunity to share our views.

Sincerely,

A handwritten signature in black ink that reads "James A. Klein". The signature is written in a cursive style with a large, looping initial "J".

James A. Klein  
President  
American Benefits Council

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<sup>3</sup> Id. at pp. 4, 21.