Federal Trade Commission

PREPARED REMARKS OF COMMISSIONER JANET D. STEIGER

FEDERAL TRADE COMMISSION

BEFORE THE

NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

LOEWS L'ENFANT PLAZA
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* The views expressed are those of the Commissioner and do not necessarily reflect the views of the Federal Trade Commission or any other Commissioner.

Introduction

I don't need to tell you how much things are changing in the pharmaceutical industry and in the healthcare industry overall. It seems that newspapers every day report some new development, such as an acquisition, a strategic alliance, a technological advance, or some government decision. Given all of these changes, I think it would be most useful for me to talk about how the antitrust laws apply to this everchanging marketplace. First, I will discuss some specific cases where the Commission has charged pharmacies and pharmacy associations with violating the antitrust laws, including the Commission's recent RxCare consent accepted for public comment this past January. Second, I will touch on vertical integration in the pharmaceutical industry and the Commission's *Lilly/PCS* consent, issued last year. And finally, I will discuss price discrimination under the Robinson-Patman Act, a subject I know is of interest to you. As usual, the views I express here are my own. They are not necessarily those of the Commission or any other Commissioner.

Before I get started, let me give a brief word about the Rite Aid/Revco matter. You are all probably aware that last Wednesday the Commission voted unanimously to authorize staff to seek a preliminary injunction in federal district court to prevent Rite Aid Corporation from going ahead with its acquisition of Revco. This morning the parties announced publicly that the cash tender offer has been extended to April 26th. As a result, a complaint has not been filed and there is very little I can add on this matter this afternoon.

In response to skyrocketing healthcare costs, there has been increased movement on the part of managed care firms to control costs. As you well know, in recent years, managed care firms have begun to focus their cost control efforts on the prescription drug

business, resulting in reduced reimbursements to pharmacies and decreased dispensing fees. Managed care firms have also obtained rebates from manufacturers on drug purchases. Pharmacies have reacted to this changing environment in a variety of ways.

Before I get into some of the antitrust obstacles to the various forms of collective action pharmacies may wish to take in this changing competitive environment, I want to point out that there are a number of ways for pharmacies to collaborate without infringing the antitrust laws. For example, in many circumstances pharmacies may be able to form joint buying arrangements, pharmacy-owned PBM joint ventures and pharmacy preferred provider organizations (also known as PPOs). Such joint activity is generally procompetitive if it allows pharmacies to compete more effectively or introduces new competition into the market place.

Except for naked agreements such as price fixing or boycotts, the Commission would likely evaluate such joint activity by looking at a variety of factors, such as whether the network members collectively have market power, whether the network generates efficiencies (such as the ability to offer a product that none of the participants could provide on their own), and whether there are anticompetitive effects that outweigh the efficiencies. The Commission would evaluate such evidence on a case-by-case basis.

Now let me give you a few examples where the Commission has taken enforcement action against collective activity by pharmacies and pharmacy associations. The first two cases I am going to discuss, the *Maryland Pharmaceutical Association* matter and the *Chain Pharmacy Association of New York* matter, involved alleged boycotts of third party prescription drug plans. The law on this type of conduct is very clear. Competitors may not

get together and agree not to do business with others, or to do business with them only on certain terms or conditions. Such activity is termed a "group boycott" and is generally *per se* illegal under the antitrust laws.[1]

Maryland Pharmaceutical Association

The Commission's 1994 consent agreement in the *Maryland Pharmaceutical Association* matter settled charges that the members of the Maryland Pharmacists Association and the Baltimore Metropolitan Pharmaceutical Association illegally conspired to boycott a plan for Baltimore City government employees.[2] The Commission's complaint charged that the associations, in response to a reimbursement reduction by the Baltimore City health plan, orchestrated a group boycott by their member pharmacies, in order to restore the plan's original reimbursement rate. Specifically, the Commission alleged that the associations held meetings at which members discussed the reimbursement reduction and possible responses to it; exhorted pharmacist members that operated within the City to stop participating in the plan; requested pharmacists to notify the associations if their pharmacies intended to stop participating in the plan; kept a list identifying those pharmacies that intended to stop participating in the plan; and communicated this information to their members. The respondents agreed to cease and desist from such conduct through a consent agreement with the Commission.

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[1] *See FTC v. Superior Court Trial Lawyers Association*, 493 U.S. 411, 431-36 (1990).

[2] *Baltimore Metropolitan Pharmaceutical Association, Inc. et al.*, 59 Federal Register 15733 (Consent Order, April 4, 1994).

Chain Pharmacy Association of New York State

In the *Chain Pharmacy Association of New York State* matter,[3] in 1990 and 1991 the Commission charged numerous retail pharmacy chains, their trade associations, independent pharmacy trade associations and two individuals with illegally agreeing to boycott New York State's Employee Prescription Plan. The complaints alleged that the purpose of the boycott was to force the state plan to increase its reimbursement rate for prescriptions. The Commission litigated against one respondent, Peterson Drug Company ("Peterson"). An FTC Administrative Law Judge issued an initial decision finding that Peterson illegally agreed to boycott the plan. When Peterson declined to pursue the litigation, the Commission adopted the Administrative Law Judge's initial decision. The other respondents in the matter agreed to settle with the Commission through cease and desist orders. According to the Administrative Law Judge, the alleged agreements which the Commission took enforcement action against may have cost consumers up to $7 million.[4]

As these two cases demonstrate, the Commission will not hesitate to challenge collective action among pharmacies that seeks to forestall efforts to lower prices. But I should add here that pharmacies can collaborate to petition a governmental body under the *Noerr-Pennington* doctrine, which provides First Amendment protection for petitioning the

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[3] *Peterson Drug Company of North Chili, New York, Inc.*, CCH Trade Reg. Rep., Complaints and Orders 1987-93 Para. 23,189; *Orange County Pharmaceutical Society, Inc.*, C-3292 (July 9, 1990); *Westchester County Pharmaceutical Society, Inc.*, C-3293 (July 9, 1990); *Pharmaceutical Society of the State of New York, Inc.*, C-3294 (July 9, 1990); *Long Island Pharmaceutical Society, Inc.*, C-3295 (July 9, 1990); *Empire State Pharmaceutical Society, Inc.*, D. 9238 (February 22, 1991); *Capital Area Pharmaceutical Society, Inc.*, D. 9239 (February 22, 1991).

[4] *Peterson Drug Company of North Chili, New York, Inc.* at 22,883.

Government and seeking redress through the judicial process.[5] All of the orders involved in the two matters I just mentioned contain safe harbors for *Noerr-Pennington* protected activity. I mention this because I know the primary purpose of today's gathering is for NARD members to talk about legislative issues, and I think it is a good idea to do so.

RxCare

Let me now turn to another matter involving a joint venture that on its face was not a sham created to forestall efforts to lower prices. In January, the Commission accepted for public comment a consent agreement in the *RxCare* matter, which involved a pharmacy network's use of a most favored nations, or "MFN" clause, to restrict price competition.[6] The public comment period closed on March 29, and the Commission has not yet issued a final order. If it becomes final, it will be the Commission's first order directed against the use of a MFN clause.

RxCare is a pharmacy network, that is, a group of pharmacies that offer their services to payers and to pharmacy benefit managers or PBMs. The Tennessee Pharmacists Association owns RxCare. RxCare is the leading pharmacy network in Tennessee, serving as the pharmacy network for approximately 2.4 million residents of Tennessee, who

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[5] *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961; *United Mine Workers v. Pennington*, 381 U.S. 657 (1965). There is a sham exception to the *Noerr-Pennington* doctrine. The Supreme Court has stated that where one uses "the governmental process -- as opposed to the outcome of that process -- as an anticompetitive weapon," the protection of the *Noerr-Pennington* doctrine may not apply. *Professional Real Estate Investors, Inc. v. Columbia Pictures Indus. Inc.*, 113 S. Ct. 1920, 1928 (1993)(quoting *Columbia v. Omni Outdoor Advertising, Inc.*, 111 S. Ct. 1344, 1354 (1991)).

[6] *RxCare of Tennessee, Inc.*, File No. 951 0059 (consent agreement accepted for public comment January 18, 1996).

represent well over half of Tennessee citizens with third-party pharmacy benefits. Because the RxCare network is the largest source of their third-party business, Tennessee pharmacies as a practical matter must participate in the RxCare network and virtually all do participate.

The MFN clause at issue required an RxCare pharmacy that accepted a reimbursement rate lower than the RxCare rate to accept the lower reimbursement rate for all its RxCare business. The Commission's complaint in this matter alleges that because RxCare's business is such a large percentage of the pharmacies' third-party business, the clause made it very expensive for pharmacies to discount their reimbursement rates to other payers and, quite naturally, they rarely did so. In effect, the MFN clause created a price floor for pharmaceutical reimbursements in Tennessee. RxCare vigorously enforced the MFN clause. As a result, in the words of the complaint, RxCare and TPA acted as "combination of competing pharmacies . . . to maintain reimbursement levels for pharmacy services. Their use of the MFN clause and other activities have restrained rivalry . . . among Tennessee pharmacies and thereby harmed consumers by limiting price competition and entry into pharmacy network services."[7]

Several factors explain the Commission's challenge to the RxCare MFN clause, even though such clauses may often be procompetitive. First, although RxCare nominally operated as a purchaser of pharmacy services as well as a seller, it was composed of virtually all the pharmacies in the state and therefore lacked the same incentive as a "pure" purchaser to use the MFN clause as a device to lower prices. Indeed, the evidence showed that RxCare sought to use the MFN clause to stabilize, rather than lower, prices. The

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[7] *RxCare* Draft Complaint ¶ 8.

evidence also indicated that RxCare discouraged pharmacies from participating in rival networks seeking to offer prices below the RxCare level, by urging them to refrain from such participation and warning that acceptance of such rates might trigger the MFN clause and result in lower reimbursement.

Second, RxCare possessed significant market power. We traditionally use market shares to assess the level of market power and in this case virtually every pharmacy was a member of the RxCare network and thus subject to the MFN clause. But most pharmacies were also part of rival networks offered by other payers and pharmacy benefit managers. What made RxCare's structure problematic was the evidence of its control over so many covered lives -- its clients included the major providers to Tennessee's Medicaid program. With so much business flowing through RxCare, pharmacies found it essential to be part of the RxCare network and adhere to the MFN clause.

Third, there was ample evidence of actual anticompetitive effects. Third-party payers frequently had to give Tennessee pharmacies the RxCare reimbursement rate rather than the lower rates routinely given to pharmacies in other states. The MFN clause thus injured consumers by effectively establishing the RxCare network rate as a price floor and by inhibiting the entry of firms wishing to establish lower priced pharmacy networks or prescription drug benefit plans in Tennessee.

Finally, there was no evidence that the MFN clause helped consumers. To be sure, the clause may have reduced reimbursements to some RxCare clients. But for the other clients, the RxCare price was above the competitive level and it was unlikely that the reductions left even these clients paying a competitive rate. For these and other reasons, we

believed, on balance, that the demonstrated anticompetitive effects of the MFN clause far outweighed any possible benefits.

Before moving on, I want to emphasize that a great deal of what RxCare was doing appeared procompetitive for both Tennessee pharmacies and consumers. As I previously explained, joint ventures by retail pharmacists can be procompetitive by creating new products and creating efficiencies. RxCare in particular was taking steps to enhance quality and control costs by, for example, educating pharmacists. The Commission had no quarrel with these efforts. For this reason, the Commission's order accepted for public comment is very narrow, prohibiting only the use of the MFN clause, the only RxCare activity that allegedly harmed consumers. The Commission has taken no action to dismantle or eliminate RxCare itself.

Let me add a word about the speed of our investigation. We opened it late in March 1995 and began consent negotiations in September. Thus our investigation took approximately six months, which I believe was very expeditious for an investigation conducted under a rule of reason analysis. Given the complexity of the fact situation, the quantity of evidence our staff collected, and the novelty of the practice, I think we are justifiably proud of our effort.

Lilly/PCS

Now let me turn to the Commission's *Lilly/PCS* consent, where the Commission addressed vertical integration in the pharmaceutical industry. As you know, in the past few years, pharmaceutical manufacturers have been acquiring some of the largest PBMs -- Medco/PAID, PCS and DPS. These acquisitions raise a number of important issues.

When Eli Lilly, in July 1994, sought to acquire PCS Health Systems, the Pharmacy Benefit Management arm of McKesson Corp., the Commission commenced an investigation that resulted in a final consent order, settling allegations that the acquisition raised competitive concerns about manufacturer foreclosure and the facilitation of coordinated firm conduct.[8] The complaint alleges that Eli Lilly's acquisition of McKesson Corporation's pharmacy benefit management arm, PCS Health Systems, would harm competition in several markets, including pharmaceutical markets and the national full-service PBM market. The complaint also alleges that as a result of the acquisition, products of drug manufacturers other than Lilly would likely be foreclosed from PCS' formulary, and that PCS would be eliminated as an independent negotiator of pharmaceutical prices with drug manufacturers.

The consent order has two principal remedial provisions directed at Lilly's future behavior to address the Commission's concerns. The first requires Lilly to maintain an "open" drug formulary, one which does not give unwarranted preference to Lilly products. To accomplish this goal, Lilly is required to install an independent Pharmacy and Therapeutics Committee ("P&T Committee") with responsibility for maintaining this formulary in an objective manner. The second principal provision erects a so-called "firewall," precluding communications between Lilly and PCS concerning bids, proposals, prices or other information related to other drug manufacturers' products.

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[8] *Eli Lilly*, C-3594 (consent order issued July 28, 1995, Commissioner Azcuenaga dissenting).

The Commission is continuing to monitor this industry carefully.[9] While I cannot comment on whether the Commission may be investigating any particular transaction, the Commission publicly stated in the statement accompanying the July 1995 final consent order in Lilly/PCS that it remains concerned that vertical integration in these markets could lead to anticompetitive consequences requiring additional relief.[10]

Price Discrimination

Now I would like to turn to price discrimination under the Robinson-Patman Act.[11] The Robinson-Patman Act makes it unlawful, under certain circumstances and subject to various defenses, for a supplier to charge different prices to different purchasers of a product of like grade or quality where the price discrimination may substantially lessen competition. However, it is important to realize that charging a different price to a different purchaser, by itself, does not constitute a *per se* violation of the statute; it may be a reflection of vigorous

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[9] *See Eli Lilly*, C-3594, Statement of the Commission (consent order issued July 28, 1995, Commissioner Azcuenaga dissenting).

[10] The Commission's determination to continue to monitor the industry is supported by a recent study conducted by the United States General Accounting Office of mergers and alliances in the pharmaceutical marketplace. *See* Statement of John C. Hansen, Assistant Director Health Financing and Public Health Issues, Health Education, and Human Services Division, United States General Accounting Office, "Pharmacy Benefit Managers -- Early Results on Ventures with Drug Manufacturers," before the Committee on Insurance, California State Senate, February 7, 1996. The report states: "In summary, the results from our analysis of PBM formularies indicate that continued oversight of mergers and alliances between drug manufacturers and PBMs is warranted to ensure that the markets for their products and services remain competitive. For example, the changes in Medco's formulary that appear to favor Merck drugs do not necessarily demonstrate that Medco automatically gave preference to Merck drugs over those of competitors. However, the formulary changes support FTC's decision to continue monitoring the Merck/Medco merger and other such ventures." Statement at 2.

[11] 15 U.S.C. §§ 13a-13b (1976).

competition among sellers for the business of certain customers. The statute expressly provides that it is not a violation of the Robinson-Patman Act for a supplier to meet the competition of others in sales to a particular business. This defense is known as the "meeting competition" defense. The Robinson-Patman Act also contains a "cost-justification" defense. This defense allows sellers to charge prices that reflect cost differences of providing an item of like grade or quality to different purchasers. Sometimes these cost differences can be solely the product of high-volume purchasing that lowers a suppliers' cost by permitting scale economies or reductions in risk. In other instances, the Act permits purchasers to purchase products at lower prices if they offer suppliers services that other purchasers don't. This practice has been referred to as "functional discounting."[12] A common example of a functional discount could be the provision by purchasers of transportation. Suffice it to say that the Robinson-Patman Act is extremely complicated and there are many other technical requirements.

Let me dispel one myth about the Commission's views on differential pricing in the pharmaceutical industry. Some people have said that the Commission in the past has given implicit approval to differential pricing of prescription drugs based on class of trade differences. I would like to stress that the Commission does not have a specific policy concerning differential pricing in the pharmaceutical industry. In this industry, as in others, we examine all facts on a case-by-case basis to determine whether differential pricing may raise concerns under the Robinson-Patman Act, and if so, whether an applicable defense avoids enforcement action. The Commission is always ready to follow up on credible

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[12] *See Texaco, Inc. v. Hasbrouck*, 110 S. Ct. 2535, 2544 (1990).

allegations of price discrimination that may harm consumers or competition in the pharmaceutical market.

Conclusion

I think it's clear that the Commission will act against practices that harm consumers, such as conspiracies to boycott third-party plans, some most favored nations clauses, some vertical acquisitions, and price discrimination that lessens competition. At the same time, we want to be sure that we do not stand in the way of your efforts to enhance your efficiency and competitiveness, for a vigorously competitive pharmacy industry is in everyone's best interest. I hope that my comments will be of some value to you as you continue to compete in this changing marketplace. Thank you for inviting me. I would be happy to attempt to answer any questions you may have.