IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; LECH'S PHARMACY; PJL PHARMACY, INC.; MJR, LTD.; MJRRX, INC.; DAVID M. SMITH RPH, INC.; ANBAR, INC.; SELLERSVILLE PHARMACY, INC.; TEP, INC.; VALUE DRUG COMPANY; and VALUE SPECIALTY PHARMACY LLC,

Plaintiffs,

v.

Civil Action No. 2:12-cv-00395
Judge Cathy Bissoon

EXPRESS SCRIPTS, INC. and MEDCO HEALTH SOLUTIONS, INC.

Defendants.

AMENDED COMPLAINT

1. The National Community Pharmacists Association ("NCPA"); Lech's Pharmacy, PJL Pharmacy, Inc., MJR, Ltd., MJRRx, Inc. (collectively "LPG"); David M. Smith RPh, Inc. ("Means Lauf"); Anbar, Inc. ("Skippack"), Sellersville Pharmacy, Inc. ("Sellersville"); TEP, Inc. ("Brighton"); Value Drug Company ("Value Drug"), and Value Specialty Pharmacy LLC ("Value Specialty") (collectively the "Plaintiffs"), by and through their undersigned counsel, bring this civil action to unwind the merger between Defendants Express Scripts, Inc. ("ESI") and Defendant Medco Health Solutions, Inc. ("Medco") (collectively "Defendants"). The Plaintiffs allege as follows:

I. INTRODUCTION

2. This is an antitrust case concerning the merger of Medco and ESI. Defendants agreed to combine two of the three largest pharmacy benefits management companies ("PBMs") in the United States leaving only two significant competitors in a highly concentrated industry. Mergers in highly concentrated markets that dramatically increase market concentration, as this merger does, are presumptively illegal under U.S. antitrust laws. This merger creates a dominant entity with anticompetitive effects in the relevant markets for (a) the purchase of retail community pharmacy services and (b) the provision of Clinical Specialty Drugs.

3. By exercising its substantial market power post-merger, this unrestrained PBM will be able to reduce the quality of prescription drug care provided to tens of millions of patients by reducing its prescription drug reimbursement to retail community "brick-and-mortar" pharmacies to well below competitive levels and by forcing patients to use PBMs' proprietary mail-order and specialty pharmacies. As a result, Plaintiffs—retail community pharmacies throughout the United States that provide critical services to millions of patients—are threatened with substantial, imminent and irreparable harm as a result of this merger. This harm stems directly from the agreement between ESI and Medco to merge and their ultimate consummation of that merger; thus, the harm results from their coordinated action.

4. The loss of competition in the relevant markets will (a) reduce the quality and diminish the output of pharmacy services provided to patients and (b) raise patient's healthcare costs by increasing PBM fees and prices for prescription drugs. These anticompetitive effects violate the antitrust laws and require that the merger be unwound, that ESI divest assets acquired from Medco to protect pharmacies and consumers or that the Court take such action as it sees fit to protect those pharmacies and consumers.

II. BACKGROUND

5. Plaintiffs—which include a pharmacy association that represents thousands of retail community pharmacies in the United States as well as individual retail community pharmacies, a specialty pharmacy, and a pharmacy wholesaler—have brought this case to preserve competition and to protect pharmacies from serious and irreparable injury that will result from the anticompetitive effects of the merger.

6. For nearly two centuries, local pharmacies have been an essential part of the fabric of America—fabric that will be irreparably torn asunder by the continued combination of ESI and Medco. The corner drugstore is a quintessential American institution. The roots of American pharmacy date back to at least the 1820s with the founding of the Philadelphia College of Pharmacy (1821) and the Massachusetts College of Pharmacy (1823). Between 1820 and 1860 the traditional multipurpose drugstore became a ubiquitous feature of American cities and towns. Early drugstores typically featured general use articles, such as glass, paints, varnishes and oils, as well as apothecaries—the antecedents to pharmacies. During the early 20th Century, the practice of pharmacy became a regulated profession as states imposed mandatory training and licensing requirements on pharmacists. By the 1950s, pharmacies expanded their roles from dispensing drugs to counseling and disseminating public health information. Education and training for pharmacists was greatly expanded in the 1990s to address the growing role of pharmacists as patient-centered healthcare providers. Indeed, pharmacists now complete a doctoral Pharm.D. degree that includes extensive didactic clinical preparation and a full year of hands-on practice experience.

7. Pharmacies remain an integral part of most Americans' everyday lives. The modern retail community pharmacy and its highly trained pharmacists focus on dispensing

medication and counseling patients regarding those medications (hereinafter "community pharmacy services"). Pharmacists are indispensable resources in the otherwise complicated and murky world of health and medication information. Indeed, their clinical expertise and presence in cities and towns across America make them invaluable to patients and to our healthcare system generally. As the nation's shortage of primary care physicians grows, which particularly affects access to care for patients in poor rural and urban areas, pharmacists in all 50 states are now authorized to provide patients with vital immunizations.[1] Retail community pharmacies are the most accessible healthcare providers in the nation, providing vital care in underserved inner city and rural areas and placing pharmacists on the frontline of healthcare.

8. Pharmacists at community pharmacies provide an important human safeguard against computer limitations in identifying dangerous drug interactions. In more complicated situations, such as post-hospitalization where patients often have multiple medication changes, computer-based intervention alone can be particularly insufficient. Indeed, pharmacists in community pharmacies are uniquely able to provide extensive patient education and follow-up. As a result, consumers have an extraordinarily high regard for their local pharmacist and rank the profession second only to nurses as the most trusted and ethical profession in America.[2]

9. Older consumers rely on their retail community pharmacies even more than the rest of America. Elderly populations present medication management challenges uniquely suited to the skills of pharmacists accessible in retail community pharmacies. Medicare beneficiaries

[1] Health Resources and Services Administration, *Health Professional Shortage Areas & Medically Underserved Areas/Populations 2011*, available at http://bhpr.hrsa.gov/shortage/; *see also* National Conference of State Legislatures**,** *States Implementing Health Reform: Primary Care Workforce Webinar 2011*, available at http://www.ncsl.org/Portals/1/documents/health/PrimaryCarewebinar111.pdf.

[2] Gallup, *Honesty/Ethics in Professions 2011*, available at http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx.

with multiple chronic illnesses see an average of 13 different physicians, fill 50 different prescriptions per year, account for 76 percent of all hospital admissions, and are 100 times more likely to have a preventable hospitalization than those with no chronic conditions. Serving these patients requires analysis beyond merely identifying direct drug conflicts—oftentimes calling for nuanced adjustments to drug regimens based on a particularized knowledge of the patient, a task for which computers are ill-suited.

10. In addition, most patients prefer pharmacy services from brick-and-mortar retail community pharmacies over less personal mail-order delivery of drugs. Even patients who are amenable to mail-order delivery do not want to be *forced* to fill prescriptions through the mail. As J.D. Power and Associates recently reported, customers forced by PBMs to use mail-order services "aren't loyal customers. They're hostages, and they don't like it."[3] Similarly, a recent poll found that 82.5 percent of respondents disapproved of requiring patients to fill their prescriptions through out-of-state mail-order facilities.[4]

11. When pharmacy benefits are restricted so as to eliminate patient choice for community pharmacies versus mail-order, patient convenience and medication adherence are adversely affected.[5] Forcing patients to use mandatory mail-order pharmacies and denying them access to their local community pharmacist even causes some patients to discontinue their prescription drug therapy prematurely,[6] and patients who fill maintenance prescriptions at a

[3] J.D. Power and Associates, *Drug Topics article* (Mar. 2010).

[4] Rosetta Stone Communications, 2012 poll of voters in Georgia (Feb. 2012).

[5] Journal of the American Pharmacists Association, *Revealed Preference for Community And Mail Service Pharmacy* (Jan/Feb 2011).

[6] The American Journal of Managed Care, *Adherence to Medication Under Mandatory and Voluntary Mail Benefit Designs* (July 2011).

community pharmacy see a statistically significant increase in medication adherence rates when compared to mail-order patients.[7]

12. Community pharmacy patients receive face-to-face medication therapy management services from pharmacists, in collaboration with prescribers, which not only improves clinical outcomes, but also lowers total health expenditures.[8] Medication therapy management from community pharmacists has even been shown to decrease drug costs for Medicare Part D patients, while patients receiving medication from a mail-order pharmacy saw unchanged drug costs.[9]

13. Forcing patients to use the PBMs' proprietary mail-order and specialty pharmacies can also directly raise the costs of pharmacy services. PBMs negotiate payments from brand drug manufacturers in the form of "rebates" to promote branded drugs through mail-order and specialty channels. These branded drugs typically are more expensive than generic medications favored by retail community pharmacies. Because community retail pharmacies have a much higher generic dispensing rate than mail-order pharmacies, they also help control and reduce costs.

14. While individual consumers were traditionally the primary buyers of pharmacy services, in recent years PBMs have become the primary buyers of pharmacy services (on behalf of plan sponsors and patients).

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[7] The American Journal of Managed Care, *Medication Adherence for 90-Day Quantities of Medication Dispensed Through Retail and Mail Order Pharmacies* (November 2011).

[8] Journal of the American Pharmacists Association, *Clinical and Economic Outcomes of Medication Therapy Management Services: The Minnesota Experience* (Mar/Apr 2008).

[9] Journal of the American Pharmacists Association, *Impact on Drug Cost and Use of Medicare Part D of Medication Therapy Management Services Delivered in 2007* (Nov/Dec 2009).

15. PBMs administer prescription drug benefit programs for individual plan sponsors, such as HMO plans, self-insured employers, indemnity plans, labor union plans, and plans covering public employees. PBMs are responsible for processing prescription drug claims, maintaining drug formularies, contracting with pharmacies for pharmacy services, and reimbursing retail community pharmacies for dispensing prescription drugs and providing related professional services to patients. PBMs also sell drugs to plan sponsors through PBM-owned mail-order and specialty pharmacies. In addition, PBMs obtain payments (in the form of rebates and other compensation) from drug manufacturers in exchange for promoting the use of more expensive brand-name drugs.

16. Defendants ESI and Medco were two of what were previously known as the "Big Three" PBMs. They, along with CVS Caremark, Inc., collectively covered approximately 72 percent of privately insured lives in the United States.

17. The Big Three were the only companies with sufficient scale and breadth of service to serve the vast majority of large national pharmacy benefit plans. They were also the largest purchasers of pharmacy services by a wide margin.

18. As Medco's former CEO, David Snow publicly admitted, smaller competitors do not effectively compete with the Big Three:

> Q…just to follow up on the pricing question. I think, obviously, **everyone's always focused on your two primary competitors**. Are you seeing any behavioral changes from the smaller PBMs out there potentially getting more aggressive or has that behavior been kind of consistent as well? A. (Snow)...For the most part, I would tell you that …**I'm not seeing a lot of secondary PBMs in the mix at all. I'm really not.** You may see a name pop up here and there, but that's not really common at all.[10]

[10] Bloomberg Transcript, Medco Q2 2010 Earnings Call, at 12 (July 22, 2010) (emphasis added).

19. A basic tenet of antitrust law and economics is that high market concentration weakens competitors' incentives to compete. Indeed, ESI's chairman, George Paz, publicly admitted that limited competition in this highly concentrated industry *already* permits ESI to grow profits without "getting crazy" (in other words, competing vigorously):

> I think we can continue to grow EBITDA. **We can continue to grow our profits without getting crazy in the marketplace by just competing on the clients that make sense**.[11]

20. Medco's former CEO has also publicly admitted that limited competition in the industry has not forced Medco to price "irresponsibly" (in other words, price aggressively):

> **There are many reasons why you should believe that the pricing environment will be responsible and stable**, and because there's no reward for irresponsibility on the pricing side, investors will hammer a company that is irresponsible relative to its pricing. You cannot win in a marketplace by pricing yourself out of profitability…. Have there been one-off examples of wow, that was aggressive? Sure, but there were strategic reasons to do so on a one-off basis, but when you in aggregate look at the volume of transactions that are occurring, it's been a very responsible industry and a very responsible environment each and every year. And I would say, there's no reason to believe that will change going forward.[12]

21. Even smaller PBMs, such as Catalyst Rx, agree that the industry is highly concentrated, and that the largest companies have significant advantages over smaller rivals:

> **The industry is highly consolidated and dominated by a few large, profitable, well established companies with significant financial and marketing resources, purchasing power and other competitive advantages that we do not have.** Scale is a particularly important factor in negotiating prices with pharmacies and drug manufacturers.[13]

22. "[G]etting crazy in the marketplace" is precisely what competitors do in a highly competitive market. Even before the merger, ESI did not believe that such vigorous competition

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[11] Final Transcript, ESRX- Q3 2010 Express Scripts, Inc. Earnings Conference Call, at 5 (Oct. 28, 2010) (emphasis added).

[12] Final Transcript, "Goldman Sachs Healthcare CEO Unscripted Conference," at 2, Jan. 6, 2011.

[13] Catalyst SEC Form 10-K for the fiscal year ended December 31, 2010 at 20 (emphasis added).

was necessary. ESI's merger with Medco has lessened competition and will reduce pricing pressure by effectively creating a duopsony in the purchasing of retail community pharmacy services.

23. The merger of ESI and Medco will have dire consequences for retail community pharmacies and their patients. For community pharmacies, a duopsony means that they will be forced to sell their services to ESI-Medco regardless of the terms offered by the merged entity, which will have the power to (a) reduce reimbursements to community pharmacies, (b) drive consumers to their own mail-order and specialty pharmacies, (c) reduce output of community pharmacy services, (d) reduce competition between community pharmacies and PBMs in the dispensing of certain drugs for which PBMs and community pharmacies are direct competitors, and (e) ultimately raise prices and reduce quality of services and choice for patients.

24. For patients, the merger means that plan sponsors will have very few competitive options. This will allow ESI-Medco to divert patients away from the face-to-face pharmacy services that patients prefer and receive from retail community pharmacies (and that improve their health outcomes and reduce overall healthcare costs) to ESI-Medco's proprietary mail-order facilities. Similarly, the lack of competition in the provision of PBM services will allow ESI-Medco to force patients to accept drug formularies weighted towards brand name drugs and expensive "specialty drugs" only offered by ESI-Medco's specialty pharmacies. These harms to patients also injure pharmacies that stand to lose business diverted from them to PBM-owned mail-order facilities and specialty pharmacies.

25. The merger will also exacerbate barriers to entry and expansion into the top tier of the PBM market and increase the likelihood that the remaining "Big Two" PBMs could substantially reduce competition through successful coordination. The history of attempted,

unsuccessful entry demonstrates the high barriers to entry in the relevant markets. For instance, both Aetna and Walgreens founded PBMs but ultimately divested these businesses. With its increased market power ESI will be able to raise barriers to entry, for example, through exclusivity arrangements over expensive specialty drugs.

26. Prior to the merger, ESI and Medco competed in the markets (among others) for the purchase of retail community pharmacy services and the provision of specialty pharmacy services. Absent the merger, ESI and Medco would have continued to compete.

27. For these reasons, as set forth and detailed below, the merger violates Section 7 of the Clayton Act, 15 U.S.C. § 18, and Section 1 of the Sherman Act, 15 U.S.C. § 1. The Plaintiffs, therefore, seek injunctive relief unwinding the merger or at a minimum forcing ESI to divest assets acquired from Medco to remedy the anticompetitive effects of the merger or taking such other measures as this Court sees fit to remedy those anticompetitive effects.

III. THE PARTIES

28. The National Community Pharmacists Association is a trade association organized and existing under the laws of the Commonwealth of Virginia, having its principal place of business at 100 Daingerfield Road, Alexandria, VA 22314. NCPA represents the pharmacist owners, managers, and employees of more than 23,000 independent community pharmacies across the United States. In Pennsylvania, NCPA represents more than 1,000 independent retail community pharmacies and has 597 NCPA members. As stated in its bylaws, the core mission of NCPA is "[t]o promote pharmacy as a profession and the role of the independent community pharmacy and pharmacist in the American concept of free enterprise by maintaining freedom of choice of pharmacy to all citizens of the nation."

29. NCPA's members include thousands of retail community pharmacies nationwide.

30. NCPA's members routinely contract with Defendants to provide a range of pharmacy services to Defendants' clients and their beneficiaries. The Big Three PBMs are the largest purchasers of retail pharmacy services from NCPA members.

31. Plaintiffs and members of NCPA also compete with Defendants' mail-order and specialty pharmacies in two ways. First, Plaintiffs and NCPA's members compete by offering through their retail community pharmacies many of the same drugs that the PBMs provide through their mail and specialty pharmacies. Second, Value Specialty and NCPA's members compete by offering mail service/home delivery, and they own (or subcontract with) specialty pharmacies.

32. NCPA serves as plaintiff on behalf of its members and in furtherance of the aforementioned goals and purposes of the organization. NCPA has been authorized to bring this suit in accordance with its bylaws.

33. Members of NCPA will be irreparably harmed by the merger in their capacity as sellers of pharmacy services to Defendants and as competitors against Defendants' mail-order and specialty pharmacies. NCPA's members would otherwise have standing to sue in their own right; the interests at stake are germane to the purposes of NCPA; and neither the claims asserted nor the relief requested requires the participation of individual members in the lawsuit.

34. Brighton is an independent pharmacy in New Brighton, Pennsylvania serving patients from the cities of New Brighton, Beaver Falls, Rochester, and Freedom. Brighton annually reaches an average of 30,000 patients and fills approximately 115,000 prescriptions. In addition to filling prescriptions, Brighton also offers other vital pharmacy services that its patients have come to rely upon, including immunizations, counseling, and medication therapy management ("MTM").

35. The combined ESI-Medco controls 56 percent of Brighton's prescriptions. This is such a significant portion of prescriptions that if the combined firm adopted non-competitive, or even below-cost, prices for retail pharmacy services, Brighton would be forced to sign the contract anyway.

36. Further reductions in reimbursement rates resulting from the merger likely would force Brighton to reduce pharmacy hours; reduce or cut patient programs, including medication and wellness counseling; and possibly even close altogether. Thus, Brighton and its customers will be immediately and irreparably harmed by the merger.

37. LPG is an independent pharmacy group with five locations in Wyoming, Sullivan and Bradford counties, Pennsylvania. LPG annually reaches tens of thousands of patients and fills over 213,000 prescriptions. In addition to filling prescriptions, LPG also offers other vital pharmacy services that its patients have come to rely upon, including, but not limited to, home delivery of prescriptions and durable medical equipment, prescription management systems that ease the burden of medication administration and face-to-face direct consultation by a pharmacist.

38. A combined ESI-Medco will control 28 percent of LPG's prescriptions. While LPG retained *some* negotiating power in its dealings with the Big Three before the merger, ESI-Medco now control such a significant portion of LPG's prescriptions that if the combined firm adopted non-competitive, or even below-cost, prices for retail pharmacy services, LPG would be forced to sign the contract anyway.

39. A combined ESI-Medco will significantly and immediately impact the quantity, quality, and range of pharmacy services LPG is able to provide to patients, thereby undermining hard-won goodwill among its customers and communities.

40. Further reductions in reimbursement rates as a result of this merger likely will force LPG to reduce hours of operation (thereby diminishing access in three counties and five communities in rural northeast Pennsylvania), and also reduce staff (affecting salary and benefits of employees along with tax base consequences). The merger will lead to the distinct possibility that LPG will be forced to close pharmacies. Thus, LPG and its customers will be immediately and irreparably harmed by the merger.

41. Means Lauf is an independent pharmacy in Brookville, Pennsylvania. Means Lauf fills over 85,000 prescriptions a year. In addition to filling prescriptions, Means Lauf also offers other vital pharmacy services that its patients have come to rely upon, including delivery service, immunizations and medication therapy management.

42. A combined ESI-Medco will control 51.1 percent of Means Lauf's prescriptions. This is such a significant portion of prescriptions that if the combined firm adopted non-competitive, or even below-cost, prices for retail pharmacy services, Means Lauf would be forced to sign the contract anyway.

43. A combined ESI-Medco will significantly and immediately impact the quantity, quality, and range of pharmacy services Means Lauf is able to provide to patients, thereby undermining hard-won goodwill among its customers and communities.

44. Further reductions in reimbursement rates as a result of this merger likely will force Means Lauf to reduce pharmacy hours and reduce or cut patient programs, including medication and wellness counseling. However, even if Means Lauf cut services such as delivery or reduced store hours and staffing, it likely will not be able to withstand the merger of ESI and Medco. Thus, Means Lauf and its customers will be immediately and irreparably harmed by the merger.

45. Skippack and Sellersville are independent pharmacies located in Skippack and Sellersville, Pennsylvania, respectively. The two pharmacies share common ownership. Together, Skippack and Sellersville annually reach 6,000 patients and fill over 160,000 prescriptions. In addition to filling prescriptions, Skippack and Sellersville also offer other vital pharmacy services that its patients have come to rely upon, including patient counseling, compliance packaging for both the vision and memory impaired, home delivery of medications, medication therapy management ("MTM"), vaccinations, and medication adherence programs.

46. A combined ESI-Medco controls approximately 40 percent of Skippack's and Sellersville's prescriptions. This is such a significant portion of prescriptions that if the combined firm adopted non-competitive, or even below-cost, prices for retail pharmacy services, the pharmacies would be forced to sign the contract anyway.

47. A combined ESI-Medco will significantly impact the quantity, quality, and range of pharmacy services Skippack and Sellersville are able to provide to patients, thereby undermining hard-won goodwill among their customers and communities.

48. Further reductions in reimbursement rates as a result of this merger likely will force Skippack and Sellersville to reduce pharmacy hours; reduce or cut patient programs, including medication and wellness counseling; and possibly close altogether. Thus, the two pharmacies and their customers will be immediately and irreparably harmed by the merger.

49. Value Drug is the parent of Value Specialty. Value Specialty serves a patient base in seven states in support of nearly 600 independent community pharmacies. In addition to filling prescriptions, Value Specialty also offers vital services that its patients have come to rely upon, including patient reimbursement assistance, clinical services, patient adherence and compliance activities, and patient reimbursement assistance.

50. Value Specialty dispenses Clinical Specialty Drugs which are drugs that require specialized storage, control and security, handling, administration, and patient monitoring to achieve successful clinical outcomes.

51. A combined ESI-Medco controls approximately 50 percent of Value Specialty's prescriptions. This is such a significant portion of prescriptions that if the combined firm adopted non-competitive, or even below-cost, prices for specialty pharmacy services, Value Specialty would be forced to sign the contract anyway.

52. A combined ESI-Medco will also significantly impact the quantity, quality, and range of pharmacy services Value Specialty is able to provide to patients, thereby undermining hard-won goodwill among its customers and communities.

53. Further reductions in reimbursement rates as a result of the merger likely would force Value Specialty to reduce pharmacy hours; reduce or cut patient programs, including medication and wellness counseling; and possibly even close altogether. Thus, Value Specialty, its parent Value Drug, and its customers will be immediately and irreparably harmed by the merger.

54. Value Drug is also a purchasing cooperative of more than 550 independent drugstores that provides wholesale pharmaceutical distribution services to its members, primarily in the central Pennsylvania area. These drugs are resold to Value Drug's members. Value Drug will be injured in its capacity as a seller of pharmaceutical distribution services to its members, who will be injured by the merger's effect on the sale of retail pharmacy services. Thus, Value Drug will be irreparably harmed by the merger in its capacity as a wholesaler.

55. Defendant Express Scripts, Inc. is a corporation organized and existing under the laws of Delaware, having its principal place of business at One Express Way, St. Louis, MO

63121. In 2011, ESI reported revenues of over $46 billion. As of the third quarter of 2011, ESI covered approximately 60 million lives and controlled 656.1 million prescriptions, many of which were filled by Plaintiffs' pharmacies. ESI also owns and operates CuraScript, the third largest specialty pharmacy in the U.S., as well as the largest mail-order pharmacy business.

56. Defendant Medco Health Solutions, Inc. is a corporation organized and existing under the laws of Delaware, having its principal place of business at 100 Parsons Pond Dr., Franklin Lakes, NJ 07417. In 2011, Medco reported revenues of over $70 billion. As of the third quarter of 2011, Medco covered approximately 65 million lives and controlled 740.1 million prescriptions, many of which were filled by Plaintiffs' pharmacies. Like ESI, Medco also owns and operates a proprietary mail-order pharmacy business, as well as Accredo, the second-largest specialty pharmacy.

IV. THE MERGER

57. On July 20, 2011, ESI and Medco entered into an Agreement and Plan of Merger, pursuant to which ESI acquired Medco for 0.81 shares of ESI and $28.80 in cash per Medco share, for a total of approximately $29 billion.

58. On April 2, 2012, ESI and Medco consummated their Agreement and Plan of Merger.

59. The merger resulted in the largest PBM in the United States, controlling and limiting access to prescription medications for 125 million people, more than 1/3 of all Americans and more than 1/2 of all insured Americans.

V. JURISDICTION AND VENUE

60. This action is filed by Plaintiffs under Section 16 of the Clayton Antitrust Act, 15 U.S.C. § 26, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18.

61. This Court has subject matter jurisdiction of the federal antitrust claims asserted in this action under Section 16 of the Clayton Act, 15 U.S.C. § 26, and 28 U.S.C. §§ 1331 and 1337.

62. Defendants purchase retail pharmacy services, sell prescription drugs via mail order, and sell specialty prescription drugs in the flow of interstate commerce in the United States. Their activities substantially affect interstate commerce. This Court has subject matter jurisdiction over the federal antitrust claims asserted in this action under Section 16 of the Clayton Act, 15 U.S.C. § 26, and 28 U.S.C. §§ 1331 and 1337.

63. Defendant ESI ships goods, promotes, purchases and sells goods and services, and otherwise transacts business of a substantial character in Pennsylvania. Defendant Medco ships goods, promotes, purchases and sells goods and services, and otherwise transacts business of a substantial character in Pennsylvania. Venue and personal jurisdiction over Defendants are proper under Section 12 of the Clayton Act, 15 U.S.C. § 22 and 28 U.S.C. § 1391.

VI. THE RELEVANT MARKETS

64. There are multiple relevant markets in which competition will be substantially lessened by the agreement between ESI and Medco to merge, including: (a) the purchase of retail community pharmacy services in fifty-one geographic markets each consisting of a single state or the District of Columbia and/or a geographic market consisting of the United States and (b) the provision of Clinical Specialty Drugs in the United States.

A. The Purchase of Retail Community Pharmacy Services in State Markets

65. Many health care plan sponsors rely on PBMs to administer prescription drug benefit plans and manage drug utilization. PBMs contract with retail community pharmacies to purchase retail community pharmacy services, including the dispensing of prescription drugs, as part of the PBM's administration of prescription drug benefits. Retail community pharmacies provide critical services to patients under PBM plans, including dispensing prescription drugs, educating patients about drug side effects, and counseling patients about drug interactions. Retail community pharmacies also provide a range of other health and wellness services to PBM plan beneficiaries, including health screenings, immunizations, nutrition counseling, and medication adherence counseling.

66. From a retail community pharmacy's perspective as a seller, there are no substitutes for the purchase of retail pharmacy services. A retail community pharmacy either contracts with a purchaser of retail pharmacy services for the sale of its retail pharmacy services or the pharmacy's labor and capital investments in those services will be wasted. Similarly, from the retail community pharmacy's perspective as a seller, the purchase of other goods and services (by potential customers of a retail community pharmacy) is not reasonably interchangeable with the purchase of retail pharmacy services, as pharmacy services and its inputs are specialized and not saleable to buyers not seeking these specific services.

67. A small but significant decrease by a hypothetical monopsonist (created by a merger or agreement between the parties) in the price paid to pharmacies for retail pharmacy services would not cause pharmacies to seek other purchasers of their services or to otherwise change their activities sufficiently to make such a price reduction unprofitable to the hypothetical monopsonist. Therefore, cross-elasticity of supply between the purchase of retail pharmacy

services and any potential alternatives is low or zero. This is demonstrated by the fact that PBMs have successfully implemented reimbursement reductions in the past without driving sellers of retail pharmacy services to alternative purchasers.

68. Numerous states require PBMs to obtain licenses or certificates of registration, or otherwise to submit to state-specific regulatory requirements to operate within a state, including Connecticut (CONN. GEN. STAT. § 38a-479aaa (2011)), Georgia (GA. CODE ANN. § 26-4-110.1 (2011); GA. CODE ANN. §§ 33-64-1 - 33-64-7 (2011)), Iowa (IOWA CODE §§ 510B.1 – 510B.1 (2011)), Kansas (KAN. STAT. ANN. § 40-3821 (2011)), Maryland (MD. INSURANCE CODE ANN. § 15-10B-20 (2012)), Mississippi (MISS. CODE ANN. §§ 73- 21-151 – 73-21-159), North Dakota (N.D. CENT. CODE § 26.1-27.1-1 – 26.1-27.1-11 (2011)), Rhode Island (R.I. GEN. LAWS § 27-29.1 (2011)), South Dakota (S.D. CODIFIED LAWS § 58-29E-1 – 58-29E-11(2011)); and Vermont (VT. STAT. ANN tit. 18 § 942).

69. Retail community pharmacies in a given state cannot sell pharmacy services to PBMs that are not permitted by statute or regulation to operate within that state. Retail community pharmacies in a given state also cannot sell pharmacy services to PBMs that do not have customers who fill prescriptions within that state. Therefore, for a retail community pharmacy operating in a given state, that state is the area in which a seller of retail community pharmacy services may rationally look for a buyer of those services.

70. If a hypothetical monopsonist (created by a merger or agreement between the parties) of PBM purchasing pharmacy services in a given state were to reduce reimbursement rates by a small, but significant amount for a non-transitory period of time, retail community pharmacies could not reasonably sell pharmacy services to PBMs operating exclusively in other

states. Thus, such a reimbursement decrease would be profitable to the hypothetical monopsonist.

71. On information and belief, many PBMs lack a national or multiregional presence.

72. Accordingly, a relevant product market within the meaning of Section 7 of the Clayton Act, 15 U.S.C. § 18 and Section 1 of the Sherman Act, 15 U.S.C. § 1, is the purchase of retail community pharmacy services, and relevant geographic markets within the meaning of Section 7 of the Clayton Act, 15 U.S.C. § 18, are each of the fifty states in the United States and the District of Columbia.

73. In the alternative, a relevant geographic market within the meaning of Section 7 of the Clayton Act, 15 U.S.C. § 18 and Section 1 of the Sherman Act, 15 U.S.C. § 1, is the United States, because pharmacies in the United States cannot sell retail community pharmacy services to PBMs operating exclusively in other countries. Therefore, to the extent that the area in which a seller of retail community pharmacy services may rationally look for a buyer of those services is broader than a state, that area is limited to the United States.

B. The Provision of Clinical Specialty Drugs in the United States

74. There are two distinct categories of drugs that are commonly called "specialty drugs." First, Defendants maintain formularies of drugs (i.e., lists of drugs for which a PBM provides reimbursement under its administered pharmacy benefit plan) with certain drugs designated by Defendants as "specialty drugs." Defendants unilaterally can and do change their formularies to designate new and existing drugs as "specialty drugs" (hereinafter "Designated Specialty Drugs"). The second category of drugs that are commonly called "specialty drugs" are drugs that should be dispensed and managed through a specialty pharmacy because they require specialized storage, control and security, handling, administration, and patient monitoring to

achieve successful clinical outcomes (hereinafter "Clinical Specialty Drugs"). Most traditional retail community pharmacies cannot dispense Clinical Specialty Drugs without operating as or contracting with "specialty pharmacies," which are pharmacies that specialize in the provision of specialty drugs.

75. Once a drug is designated as a "specialty drug" by a given PBM (e.g., becomes a "Designated Specialty Drug"), the PBM typically prohibits retail community pharmacies, including pharmacies that are licensed to offer specialty drugs and pharmacies with separate specialty drug operations, from seeking reimbursement for sale of this drug to persons under a plan administered by the PBM. Normally, only the PBM's proprietary "specialty pharmacies" or other specialty pharmacies in the PBM's network may dispense and obtain reimbursement for such sales. Thus, the PBM's designation of a drug as "specialty" effectively excludes retail community pharmacies from competing for the provision of Designated Specialty drugs.

76. The classification of Designated Specialty Drugs is often performed by PBMs to advance the financial interests of the PBMs' specialty pharmacy subsidiaries, and is not based on a widely-accepted clinical definition of "specialty drugs" or on the clinical needs of patients. In fact, re-classifying a drug as "specialty" makes it much more likely that the patient will be forced to receive the drug through the mail without the face-to-face clinical services provided by retail community pharmacies.

77. Absent the restrictive reimbursement policies implemented by PBMs, retail community pharmacies are fully capable of competing for the provision of many Designated Specialty Drugs. In fact, many Designated Specialty Drugs can be, and have been, appropriately dispensed by retail community pharmacies. Moreover, many Designated Specialty drugs should be dispensed with continual interaction among the pharmacist, the physician, and the patient.

When retail community pharmacy services are properly utilized, the pharmacist, as part of the healthcare delivery team, makes sure that the drugs are being properly administered and carefully monitors the effectiveness of the treatment and any interactions with other medications. Quickly switching a patient off an ineffective treatment can save the plan and the patient significant resources, reduce harmful drug interactions and result in better outcomes.

78. PBMs provide Clinical Specialty Drugs, as well as Designated Specialty Drugs, through their proprietary "specialty pharmacies," which are facilities that specialize in the provision of specialty drugs. PBM-owned subsidiaries often provide Clinical Specialty Drugs and Designated Specialty drugs by mail throughout the United States.

79. Some of NCPA's members own or contract with specialized facilities to dispense Clinical Specialty Drugs. These members compete directly with Defendants' specialty pharmacies for the provision of Clinical Specialty Drugs.

80. Plaintiff Value Drug, through its subsidiary Value Specialty, competes directly with Defendants' specialty pharmacies for the provision of Clinical Specialty Drugs.

81. PBMs' clients (plan sponsors) and their patient beneficiaries cannot substitute the provision of non-Clinical Specialty Drugs for the provision of Clinical Specialty Drugs due to the complexity of storing, controlling, securing, handling, administering, and monitoring the usage of these drugs. Therefore, the provision of non-Clinical Specialty Drugs is not reasonably interchangeable with the provision of Clinical Specialty Drugs.

82. If a hypothetical monopolist of the provision of Clinical Specialty Drugs were to increase prices on the provision of those drugs by a small, but significant amount for a non-transitory period of time, PBMs' clients (plan sponsors) and their patient beneficiaries would not turn to alternative drug provision services such that this price increase would be unprofitable to

the hypothetical monopolist. Therefore, cross-elasticity of demand between the provision of Clinical Specialty Drugs and any potential alternatives is low or zero.

83. There are substantial barriers to entry and expansion in the market for Clinical Specialty Drugs. The ability of a PBM proprietary specialty pharmacy to secure exclusive distribution agreements with manufacturers of Clinical Specialty Drugs constitutes a significant competitive advantage over other specialty pharmacies. Indeed, drug manufacturers typically award exclusive agreements to firms with access to more lives. Large PBMs with proprietary specialty pharmacies are in a position to leverage their dominance in the PBM market to drive patients to their specialty pharmacies by using their negotiating power with pharmaceutical drug manufacturers to secure exclusive deals on Clinical Specialty Drugs. Furthermore, the large PBMs are able to use the claims adjudication process (e.g., prior authorization) to effectively block competitors from filling prescriptions. Thus, retail community pharmacies and specialty pharmacies that are not a subsidiary of a major PBM will have difficulty entering the specialty pharmacy market or expanding their current operations because they lack this built-in preferred access to a large pool of lives and the ability to determine where patients with PBM-administered plans can fill their prescriptions.

84. United States laws, including 28 U.S.C. § 301 et seq. and 28 U.S.C. § 952, prohibit the importation of many Clinical Specialty Drugs or other drugs into the United States by customers.

85. The United States is the area in which a buyer of Clinical Specialty drug services may rationally look for those services.

86. Accordingly, a relevant product market within the meaning of Section 7 of the Clayton Act, 15 U.S.C. § 18, and Section 1 of the Sherman Act, 15 U.S.C. § 1, is the provision of

Clinical Specialty Drugs, and a relevant geographic market within the meaning of Section 7 of the Clayton Act, 15 U.S.C. § 18, and Section 1 of the Sherman Act, 15 U.S.C. § 1, is the United States.

VII. MARKET CONCENTRATION

87. The relevant markets are highly concentrated and have become significantly more concentrated as a result of the merger.

88. The *Horizontal Merger Guidelines* issued by the Department of Justice and FTC rely on the Herfindahl-Hirschman Index ("HHI") as a measure of market concentration. Market concentration provides a structural indicator of the strength of competition in a given market and the likelihood of coordination between competitors. Markets in which the HHI is between 1,500 and 2,500 points are considered moderately concentrated, and markets in which the HHI is in excess of 2,500 points are considered highly concentrated. Transactions that increase the HHI by more than 200 points in a highly concentrated market are presumed likely to enhance market power.

89. In state markets for the purchase of retail pharmacy services, data show that ESI and Medco often collectively control over a 50 percent share of individual pharmacy prescriptions. In these markets, HHI after the merger will be over 3,000 points, with a change of over 1000 points resulting from the merger. In a geographic market consisting of the United States, data show that ESI and Medco collectively control over one third of individual pharmacy prescriptions.

90. In the market for the provision of Clinical Specialty pharmacy services, analysis done by Pembroke Consultants based on publicly available data show that Medco (Accredo Health) and ESI (CuraScript) collectively dispense approximately 31 percent of "specialty"

pharmacy prescriptions, and CVS Caremark dispenses approximately 25 percent. On information and belief, this analysis relies on a flawed definition of specialty pharmacy drugs that deflates Defendants' market share and ignores clinical considerations in favor of PBMs self-designations. Nonetheless, even using this flawed definition of "specialty" drugs, HHI after the merger will be over 2,600, with a change of approximately 400 to 1,000 points resulting from the merger.

VIII. ANTICOMPETITIVE EFFECTS

A. The Merger Eliminates Head-to-Head Competition Between ESI and Medco and Promotes Anticompetitive Coordination Between Competitors in the Purchase of Retail Community Pharmacy Services.

91. An agreement between two parties to merge and the ultimate consummation of that merger is coordinated action and not unilateral behavior. Therefore harm stemming from the merger is harm resulting from coordinated action.

92. The merger combines two of the three largest purchasers of retail pharmacy services in the United States and in local markets.

93. Many retail community pharmacies, including NCPA's members and Plaintiff pharmacies, will be forced to deal with a combined ESI-Medco regardless of its purchase terms because refusing to accept ESI-Medco's terms would foreclose a high percentage of retail prescriptions and access to ESI-Medco's current retail customers such that many of the pharmacies would become unviable.

94. The merger between ESI and Medco gives ESI-Medco's market power in the market for the purchase of retail community pharmacy services and will harm Plaintiffs and competition in at least two ways. First, the agreement between the two defendants and the resulting merger allows the merged firm to profitably and unilaterally reduce reimbursement for

the purchase of retail community pharmacy services below competitive levels and will promote potential coordination among the remaining two of the Big Three on reimbursement rates. This reduction in reimbursement rates will, in turn, reduce output in markets for the sale of retail pharmacy services. Second, the agreement between the two defendants and the resulting merger permits ESI-Medco to together force retail community pharmacies to accept contractual terms and business behavior detrimental to the pharmacies and competition, including restrictions on pharmacies' abilities to offer mail-order and specialty services, and the merger will also promote potential coordination among the remaining two of the Big Three on contractual terms and business behavior.

95. Defendants would not be able to reduce reimbursement rates and depress output as independent companies. But for the merger, the aforementioned harms resulting from Defendants' enhanced market power and concentration in this market would not occur.

96. The resulting effects will irreparably harm the goodwill and customer relations of retail community pharmacies, including Plaintiffs and NCPA's members, and in many cases cause them to reduce services or exit the market. The harm to employers, plans and patients as a result of less competition will be increased costs, few choices, less services (lower output), and less value.

97. The structure of the market for the purchase of retail pharmacy services is conducive to coordination. Many reimbursement terms and other competitive purchasing terms are publicly available. Additionally, both Defendants already transact business with the other largest PBM in its capacity as a retail pharmacy. Therefore, pricing and other purchasing terms in this market are very transparent among the Big Three. Furthermore, Defendants purchase retail pharmacy services from tens of thousands of retail community pharmacies, including

Plaintiffs and NCPA's members, in small quantities. Markets characterized by large numbers of small transactions are vulnerable to coordination because incentives to "cheat" on a tacitly agreed-upon pricing by reducing prices on any given transaction will not result in a sizable enough benefit to the cheater.

98. Reduced reimbursement rates to retail community pharmacies, including Plaintiffs and NCPA's members, will ultimately reduce the quality and output of retail community pharmacy services by forcing retail community pharmacies, including Plaintiffs and NCPA's members, to reduce hours and limit other services for patients. Furthermore, reduced reimbursement rates likely will not be passed to plan sponsors or patients. PBMs typically charge more to plan sponsors than they reimburse to pharmacy service providers, retaining the difference as profit.

99. Forcing retail community pharmacies, including Plaintiffs and NCPA's members, to accept restrictions on mail-order and specialty pharmacy business will harm competition between pharmacies and Defendants, and further reduce the viability of retail pharmacies by diverting profitable business away from Plaintiffs. Reducing the quality and output of pharmacy services offered by retail community pharmacies, including Plaintiffs and NCPA's members, and reducing their ability to compete for mail-order and specialty business will cause irreparable harm to the goodwill of the Plaintiffs and threaten their patients' health.

100. Compared to the typical monopsony or duopsony case, Defendants will have an unusually strong incentive to purchase sub-optimal levels of Plaintiffs' services and to set sub-optimal prices because reduced output and reduced quality in retail community pharmacy services resulting from sub-optimal reimbursement rates would force or encourage patients to

use Defendants' proprietary mail-order and specialty services, thereby increasing the value adjusted price for patients and reducing choice and value for patients.

101. Industry analysts recognize that increasing concentration in the market for the purchase of retail pharmacy services has already increased Defendant ESI's purchasing power. For instance, in analyzing ESI's 2010 acquisition of WellPoint's NextRX PBM , JP Morgan concluded:

> Given the size, we view the $4.7 billion acquisition of WellPoint's NextRx PBM business as a transformational deal for Express Scripts. We note that the addition of the NextRx scripts puts the company on relatively equal footing with its two large peers, and the larger size translates into greater purchasing leverage with manufacturers and retail pharmacies.[14]

B. The Merger Eliminates Head-to-Head Competition Between ESI and Medco in the Provision of Clinical Specialty Pharmacy Services.

102. ESI's merger with Medco combines the second- and third- largest specialty pharmacies in the U.S. and the largest specialty pharmacies in various local markets.

103. ESI-Medco's enhanced market power in the market for the purchase of Clinical Specialty Pharmacy Services will harm Plaintiffs and competition in at least two ways. First, the merger allows the combined company to unilaterally raise prices on Clinical Specialty Pharmacy Services and will promote potential coordination on pricing among the few remaining competitors in this market. Second, the merger provides ESI-Medco even greater power to exclude competing specialty pharmacies by securing exclusive contracts with manufacturers of Clinical Specialty Drugs. As noted, large PBMs with proprietary specialty pharmacies are in a position to exploit their negotiating power with drug manufacturers to secure exclusive deals on drugs. Drug manufacturers tend to favor specialty pharmacies with access to the most lives. In

[14] J.P. Morgan, *Gill's Guide to the Rx Channel – An Investor Handbook*, at 216, 217 (May 10, 2011).

turn, plan sponsors and patients favor specialty pharmacies that have access to more drugs. Furthermore, Defendants are able to exploit the claims adjudication process (e.g., prior authorization) to effectively block competitors from filling prescriptions. Thus, specialty pharmacies that are not subsidiaries of Defendants will have difficulty competing in the specialty pharmacy market because they lack this built-in preferred access to a large pool of lives and the ability to determine where patients with PBM-administered plans can fill their prescriptions. The merger will exacerbate this problem by giving the combined entity additional leverage in negotiations with Clinical Specialty drug manufacturers and by enhancing Defendants' ability to divert business away from Plaintiffs through claims adjudication.

104. Value Specialty and NCPA's members that operate specialty pharmacies will also be injured in their capacities as competitors in this market due to their likely exclusion resulting from exclusive dealing contracts between Defendants and drug manufacturers and from Defendants' ability to divert business away from Value Specialty and NCPA's members that operate specialty pharmacies through claims adjudication. Additionally, Value Specialty and NCPA's members that operate specialty pharmacies will be injured when ESI-Medco uses its market power to force plan sponsors to accept exclusive specialty networks consisting only of CuraSript and Accredo.

105. The exclusion of Value Specialty and NCPA's members that operate specialty pharmacies from the specialty pharmacy market through drug dispensing limitations (due to Defendants' exclusive contracts and claims adjudication) as well as their resulting inability to serve their patients, will cause irreparable harm to the goodwill of Value Specialty, Value Drug and NCPA's members as well as the pharmacy services provided to their patients.

106. In many cases, Value Specialty and NCPA's members that operate specialty pharmacies will be forced to reduce their services and to close their businesses due to financial losses resulting from reduced contracting opportunities and increased prices on Clinical Specialty Drug services.

107. Injuries resulting from the likely loss of contracting opportunities and increased Clinical Specialty pharmacy prices are independent antitrust injuries and inextricably intertwined with the antitrust injury to patients and sponsors caused by eliminating head-to-head competition between ESI and Medco and reducing the breadth of their services.

108. The resulting effects will irreparably harm the goodwill and customer relations of Value Specialty, Value Drug and NCPA's members that operate specialty pharmacies and in many cases cause them to reduce services or exit the market. The harm to consumers as a result of this lessened competition will be increased costs, fewer choices, less services, and less value.

IX. VIOLATION ALLEGED

VIOLATIONS OF SECTION 7 OF THE CLAYTON ACT, 15 U.S.C. § 18 AND SECTION 1 OF THE SHERMAN ACT, 15 U.S.C. § 1

109. Plaintiffs re-allege and incorporate paragraphs 1 through 108 as if set forth fully herein.

110. Defendants' agreement and ESI's resulting merger with Medco lessens competition in the markets described above in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18 and Section 1 of the Sherman Act, 15 U.S.C. § 1. The merger has had the following effects, among others[15]:

[15] The merger agreement between Defendants and subsequent merger by ESI and Medco is the source of Plaintiffs' claims. The likelihood of anticompetitive effects arising because of the merger renders this agreement illegal.

a. Head-to-head competition between Defendants has been eliminated in the purchase of retail pharmacy services and the provision of Clinical Specialty pharmacy services.

b. Competition generally has been reduced and the likelihood of anticompetitive coordinated interactions between the remaining competitors has been increased in the purchase of retail pharmacy services and the provision of Clinical Specialty pharmacy services.

c. Prices are likely to increase in the provision of clinical specialty pharmacy services.

d. The quality, breadth, and output of services will decline in the provision of retail community pharmacy services and the provision of Clinical Specialty pharmacy services.

e. Reimbursement rates will decline and output will accordingly decline in the purchase of retail community pharmacy services, and the quality of pharmacy services will likewise decline.

f. Plaintiffs will be irreparably harmed by the reduction in competition in the purchase of retail community pharmacy services and the provision of Clinical Specialty pharmacy services.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs request:

a. that the merger be adjudged to violate Section 7 of the Clayton Antitrust Act, 15 U.S.C. § 18 and Section 1 of the Sherman Act, 15 U.S.C. § 1;

b. that ESI and Medco be required to unwind their merger or alternatively that ESI be required to divest assets acquired from Medco pursuant to Defendants' merger;

c. that Plaintiffs be awarded the cost of this action; and

d. that Plaintiffs be awarded such other relief as the Court may deem just and proper.

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Respectfully submitted,

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