

Sept. 22, 2021

Chair Lina Khan
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Request for Public Comment Regarding Contract Terms That May Harm Fair Competition
(FTC-2021-0036-0022)

Dear Chair Khan:

The National Community Pharmacists Association appreciates the opportunity to submit this comment for the record on the solicitation for public comment opened by the Federal Trade Commission on contract terms which inhibit fair competition.

NCPA represents America's community pharmacists, including more than 21,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and LTC settings. Together, our members represent a \$74 billion health care marketplace, employ approximately 250,000 individuals, and provide an expanding set of health care services to millions of patients every day. Our members are small business owners who are among America's most accessible health care providers, often serving as the only pharmacy or the only medical provider of any kind, in many rural and urban medically underserved areas. NCPA is uniquely positioned to identify and explain the anticompetitive effects of the contract terms imposed on independent community pharmacies by vertically integrated Fortune 100 health care companies.

NCPA's members and their patients are directly impacted by the wave of consolidation that is transforming the U.S. health care system. A particularly pernicious example of consolidation that has resulted in substantial actual harm to competition is the vertical combination of health insurance plans with pharmacy benefit managers with retail and mail order pharmacies. Pharmacy benefit managers handle pharmacy services for the insurance plans. Created decades ago, PBMs negotiate with pharmaceutical companies for rebates in exchange for preferred formulary placement. They also manage pharmacy prescription reimbursement through contractual arrangements with pharmacies that participate in the health plan's provider network. The United States is the only developed country in the world that inserts an intermediary into the prescription drug chain. Originally intended to ease the filing of prescription claims for the insured, PBMs have evolved into the choke point controlling the flow of data and dollars between prescription drug channels – as prescription drug cost increases continue to outpace inflation¹. This fact undermines arguments that the actions of PBMs identified within this comment are in any way pro-competitive or efficiency-enhancing, or anything other than unlawful, exclusionary entities that monopolize

¹ <https://www.aarp.org/politics-society/advocacy/info-2021/prescription-price-increase-report.html>

the various retail and mail-order pharmacy markets to the detriment of consumers and small businesses.

The joining together of the major commercial health plans with PBMs and with consumer pharmacy operations created vertical entities wielding multi-market power unlike any since the railroad and oil monopolies that spawned antitrust laws.² Each entity has the ability and the incentive to engage in anticompetitive, exclusionary contracting practices against competing pharmacies³, many of which are small businesses like our members. The result is that our member pharmacies are forced out of the market, leaving patient populations without access to prescription medications except through mail order. Often, after thrashing small business pharmacies via low and below-cost reimbursement, the health plan-PBM-retail pharmacy conglomerate will offer to buy out and shutter the harmed pharmacy,⁴ adding to their portfolio of corporate owned pharmacies, which further consolidates the health care marketplace.

We offer these comments in response to the request for public comment to further encourage the FTC to review the anticompetitive contracting practices of the PBMs and to seek to level the playing field in the market for independently owned pharmacies.

PBMs impose one sided, take-it-or-leave-it contracts

PBM contracts with pharmacies are almost always adhesion contracts. The three largest PBMs control 77 percent of the health plan pharmacy benefit market.⁵ A PBM, as part of a vertically integrated entity with a health plan and mail-order/specialty/retail pharmacies, has market power in the majority of markets in which community pharmacies try to compete.⁶ Consequently, community pharmacies are unable to negotiate contract terms and are forced to sign these take-it-or-leave-it contracts in order to have access to the health plan subscribers.

Without a contract to be “in-network,” a pharmacy will be foreclosed from competing in the market for the prescriptions of that PBM’s related health plan’s patients. In many markets, one health plan is dominant. In other markets, there are just two health plans. If an independent pharmacy rejects the terms offered by the market-dominant health plan/PBM, it will lose access to a significant percentage of its potential customers. Those customers will lose the ability to choose where to obtain their prescriptions and will lose the benefits of innovation that comes from competition. PBMs have the incentive, as part of vertically integrated businesses, to foreclose pharmacy competitors and steer patients to their affiliated retail or mail-order pharmacies. “PBM-affiliated

² <http://www.ncpa.co/pdf/PBM-Storybook-12pg.pdf>.

³ There are only four national health insurers. Their affiliated PBMs are the four largest PBMs.

⁴ <https://ncpa.org/sites/default/files/2021-05/cvs-purchase-offer-letter.pdf>, (Letter from CVS to redacted community pharmacist owner).

⁵ Fein, Adam. “The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation.” Drug Channels. April 6, 2021. <https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html>

⁶ <https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf>, see e.g., Table 1 (in 92% of markets, at least one insurer with PBM has 30% market share; in 50% of the MSAs, one insurer has at least 50% market share).

pharmacies” are those brick and mortar or mail-order pharmacies that the PBM owns outright or has an economic interest in steering patients toward.

These adhesion contracts contain language that minimizes the ability of the pharmacy to advocate for better terms or provide better service to patients. The PBM contracts offered to our members contain overly broad confidentiality and audit language, non-disparagement clauses, data ownership conveyance, and vague requirements surrounding participation and information sharing related to certain drug pricing programs such as 340B. The binding terms are often embedded in lengthy provider manuals and ill-defined enforcement protocols and compliance criteria. PBMs unilaterally change substantial terms of the agreements and their provider manuals. While pharmacies are held responsible for the changed terms, PBMs are not obligated to notify the pharmacies of the updates or even to provide clarification for compliance purposes. For example, one PBM included the following language in its contract:

Unilateral: It shall be the Provider’s responsibility to check for any updates to the Provider Manual to ensure that Provider has the most recent version of such Provider Manual; . . . The Provider Manual may be revised from time to time by [PBM] in its sole discretion.

PBMs often limit which types of prescriptions non-affiliated pharmacies in their network are allowed to fill. The PBMs regularly design plans that require, coerce, or incentivize patients to use a PBM-affiliated pharmacy option for high-cost specialty drugs. These plans force community pharmacists when presented with a prescription for a PBM-deemed “specialty” drug to direct the patient to a competing PBM-affiliated pharmacy – endangering the prospect of that patient returning to the community pharmacy in the future. In order for the patient to use the patient’s prescription drug benefit, the patient must use the pharmacy dictated to the patient by the PBM. Furthermore, if the original pharmacy does not re-direct the patient to its competitor, it risks breaching its contract terms, and among other penalties, expulsion, without recourse, from the plan’s network.

PBM contracts often require the pharmacy, or the member pharmacies, in the case of a Pharmacy Services Administration Organization,⁷ to relinquish ownership to all data and information sent from the pharmacy to the PBM. The data and information transmitted represent essentially the entire record of the dispensing event and claim(s) for coverage and reimbursement. Pharmacies that are members of PSAOs may be completely unaware that such a provision exists in the contract with the PBMs because PBMs often restrict the PSAO from allowing the member pharmacies to have copies of such contracts. Furthermore, health plans and PBMs may incorporate restrictions on use of data by network pharmacies in network provider manuals, which are often incorporated by reference into pharmacy network agreements and remain subject to revision at any time by the health plan or PBM in its sole discretion. The conveyance of data ownership is important because it not only allows access to a pharmacy’s competitively sensitive information, it all but guarantees the PBM will utilize the information to manipulate reimbursements and fees and steer patients to PBM-affiliated pharmacies.

⁷ PSAOs manage health plan and PBM relationships on behalf of pharmacies that choose to engage their services. Among other things, PSAOs contract on behalf of the pharmacies with the PBMs and field questions about claims, reimbursement, and audits.

In addition, PBMs include broad confidentiality language that prohibits pharmacists from discussing their own drug costs, services, business practices, or the undefined term “other information” contained in the contract or provider manuals with third parties. Some PBMs include provisions that at the very least chill if not prohibit pharmacist communication with policymakers and elected officials. For example, some of the largest PBMs have included the following provisions in their contracts and provider manuals:

Confidentiality: Any information or data obtained from, or provided by, [PBM] or any Benefit Sponsor to the Participating Pharmacy is confidential. This includes, but is not limited to, products, programs, services, business practices, procedures, MAC lists or other information acquired from the contents of the Pharmacy Participation Agreement, Provider Manual and related Exhibits or other [PBM] documents.

While this provision, on its face, does not appear particularly outrageous, the limitation on maximum allowable cost lists allows PBMs to use a lower MAC price to reimburse pharmacies while charging plan sponsors higher MAC prices, thereby increasing the “spread” retained by the PBMs to the detriment of plan sponsors and consumers. Ohio and Kentucky, for example, found spread pricing cost \$225 million⁸ and \$123.5 million,⁹ respectively, in a one-year period.

Contacting Sponsors or Media: Provider hereby agrees (and shall cause its affiliates, employees, independent contractors, shareholders, members, officers, directors and agents to agree) that it shall not engage in any conduct or communications, including, but not limited to, contacting any media or any Sponsor and/or Sponsor’s Members or other party without the prior consent of [PBM].

These broad provisions contribute to PBM efforts to maintain an opaque distribution scheme and effectively stifle any ability of individual pharmacies from advocating for fair and equitable pricing and reimbursement. Violation of any of these provisions may lead the PBM to terminate the contract with the pharmacy and remove the pharmacy from the PBM’s networks, which it can do at its own discretion and with only minimal notice to pharmacy providers within the plan.

PBMs leverage market position to force contractual provisions that harm competition in pharmacy markets

A pharmacy agrees to receive lower patient copays in exchange for being in a PBM’s preferred pharmacy network. PBMs, however, can and do remove pharmacies from preferred networks without cause or prior notice – despite the existence of a contractual relationship. These changes detrimentally impact patients who are forced to seek out a different preferred pharmacy – often the PBM’s affiliated pharmacy – or pay higher copays for their prescriptions at the now-removed pharmacy. PBMs leverage their “gatekeeper” position in favor of their affiliated downstream pharmacies. Necessarily, this action adversely affects competition – it reduces patient choice, stifles innovation, and may lead to increased prices.

⁸ <https://ohioauditor.gov/news/pressreleases/Details/5042>

⁹ <https://kentucky.gov/Pages/Activity-stream.aspx?n=AttorneyGeneral&prId=739> (many more states have found similar results).

The PBM contract terms subject independent pharmacies to “audits” of their business practices. While requiring an audit is not necessarily anticompetitive on its face, the practice allows a PBM (that likely owns or is affiliated with a competing mail or retail pharmacy) to punish direct competitors with time-consuming and costly fishing expeditions. For example, one particular provider manual provides for “random basis” audits where “advance notice may not be provided at [PBM’s] discretion.” This allows a PBM to tie up a competitor with burdensome document and information requests under the threat of termination of the pharmacy’s agreement, and keep it from effectively servicing its customers, potentially causing access problems for patients. In addition to the cost of complying with these audits, independent pharmacies are often saddled with unfounded allegations of substantially underpaying certain fees to PBMs, necessitating a lengthy and costly appeals process. The end result is an independent pharmacy driven out of business by compliance costs. Even if the pharmacy survives the assault of overreaching audits, it finds itself economically exhausted from exonerating itself and constantly having to dig itself out of the PBM-created hole, or worse, it is the recipient of a buyout letter from the same PBM that put it in that hole.¹⁰

Additionally, NCPA is concerned about the selective enforcement of provisions of the contract as it relates to PBM-affiliated pharmacies. Our membership is forced to comply with complex and vague compliance requirements while PBM-affiliated pharmacies are excused from those same compliance costs. For example, PBM contracts contain provisions that prohibit, under threat of expulsion from the network, any in-network pharmacy from employing or affiliating with any person that was affiliated with a pharmacy that was audited. Notably, PBMs do not enforce this “guilt by association” provision on PBM-affiliated pharmacies. It’s already been evidenced PBMs offer higher reimbursement rates to their own pharmacies¹¹, and there is no existing regulatory scheme which governs these instances of self-dealing.

Conclusion

NCPA appreciates the diligent work of the FTC to examine the contracting practices of PBMs. After learning of this opportunity, we have encouraged our membership to respond directly to this request with specific examples of contractual language. NCPA hopes our member examples provide the FTC with the perspective of small business community pharmacies and compel the commission to use its subpoena power to investigate anticompetitive PBM contracting and related patient steering practices, undertake rulemaking to address these activities, and initiate enforcement actions where appropriate.

To assist the FTC in its rulemaking process, NCPA submits the following proposed language for a Rule to address the anticompetitive contracting practices of PBMs. While this language specifically addresses PBMs, it can likely be used to address other anticompetitive practices and unfair methods of competition.

¹⁰ <https://www.dispatch.com/news/20180415/three-cvs-actions-raise-concerns-for-some-pharmacies-consumers>.

¹¹ Arkansas Department of Insurance Limited Scope Examination of Pharmacy Benefit Manager (July 27.2020), <https://ncpa.org/sites/default/files/2020-10/ark-doi-pbm-mmc-examination.pdf>.

It shall be an unfair method of competition for any PBM to:

- **require a pharmacy not otherwise affiliated with the PBM to fill a prescription under terms not equivalent to the terms under which a PBM-affiliated pharmacy fills a prescription;**
- **engage in any act or practice that a reasonable person would view as favoring an affiliated pharmacy over a non-affiliated pharmacy, whether an actual effect can be shown.**

NCPA greatly appreciates the opportunity to share our views with the FTC. NCPA is committed to working with the FTC and other stakeholders to resolve these issues in a manner which promotes competition and ensures the best health care marketplace for consumers and small business pharmacies. Please do not hesitate to contact me at (703) 838-2648 or doug.hoey@ncpa.org or Matthew Seiler, NCPA's Vice President and General Counsel, at (703) 600-1221 or matt.seiler@ncpa.org to further discuss how NCPA can be of assistance to the FTC.

Sincerely,

A handwritten signature in black ink, appearing to read "B. Douglas Hoey". The signature is fluid and cursive, with the first name "B." and last name "Hoey" clearly visible.

B. Douglas Hoey, RPh, MBA
CEO, National Community Pharmacists Association