May 23, 2022

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

RE: Solicitation for Public Comments on the Business Practices of Pharmacy Benefit Managers and Their Impact on Independent Pharmacies and Consumers (ID#)

Dear Chair Khan,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to address PBM practices that impact independent pharmacies and their patients. Founded in 1898, NCPA is the voice for the community pharmacist, representing nearly 19,400 pharmacies that employ 215,000 individuals nationwide. Community pharmacists are small business owners rooted in the communities where they are located and are among America's most accessible health care providers. Almost half of all community pharmacies provide long-term care (LTC) 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 $67 billion healthcare marketplace and provide an expanding set of healthcare services to millions of patients every day.

What has become apparent during the increase of control and authority of PBMs in the prescription drug market, is that when PBM activity negatively impacts independent pharmacies, it also negatively impacts consumers. The PBM market is highly consolidated. The three largest PBMs, CVS Caremark, Express Scripts, and OptumRx are vertically integrated upstream with the three largest insurance providers, Aetna, Cigna, and UnitedHealthcare, respectively, and downstream with mail order, specialty, and retail pharmacies that compete directly with independent pharmacies. The three largest PBMs control at least 80% of the health plan pharmacy benefit market,[1] and control, through PBM-affiliated pharmacies, more than 65% of total prescription revenues ($122.2 billion in 2021) from pharmacy-dispensed specialty drugs.[2] This consolidation leads to worse outcomes for patients, pharmacies, and payers.

PBMs protect profits at the expense of competition and consumer welfare. In addressing each of the topics outlined by the FTC, our comments demonstrate the staggering scope of such practices. PBMs use market dominance to effectuate anticompetitive practices and harm consumers. NCPA believes the FTC could correct many of these harms by focusing its immediate attention on adhesion contracts between PBMs and independent community pharmacies, patient steering to PBM-affiliated pharmacies, and discriminatory reimbursement. The FTC should undertake studies and rulemaking to address each of these issues.

[1] Fein, A. (2022). *DCI's Top 15 Specialty Pharmacies of 2021—And Three Factors That Will Reshape 2022*. Drugchannels.net. Retrieved 5 May 2022, from https://www.drugchannels.net/2022/05/dcis-top-15-specialty-pharmacies-of.html.
[2] AllianceRx Walgreens Prime/Walgreens Stores have a 10% share and competitors split the remaining 25%. Fein, A. (2022). *DCI's Top 15 Specialty Pharmacies of 2021—And Three Factors That Will Reshape 2022*. Drugchannels.net. Retrieved 5 May 2022, from https://www.drugchannels.net/2022/05/dcis-top-15-specialty-pharmacies-of.html.

FTC Topic: The impact of PBM rebates and fees on net drug prices to patients, employers, and other payers.

NCPA has sought reforms on rebates and fees for over the past decade to address ballooning expenses for patients. PBMs use pharmacy direct and indirect remuneration (DIR) fees in ways never envisioned. NCPA is hopeful the Centers for Medicare and Medicaid Services'(CMS') attempt to bring transparency to pharmacy DIR fees through the recently issued final rule[3] is a step in the right direction. With vertical integration up and downstream, there is a need to level the playing field between independent pharmacies and PBM-affiliated pharmacies, to protect patients from paying too much at the counter. We invite the FTC to view NCPA's comments to CMS.[4] NCPA believes it is incumbent on the FTC and the DOJ, as part of President Biden's whole of government approach to competition policy,[5] to engage with CMS to address PBM market power exacerbated by rebates and claw back fees. The vertical integration of PBMs into monoliths with an affiliated upstream insurance provider and downstream pharmacies has only increased the incentives for PBMs to disfavor independent pharmacies. The FTC and DOJ cannot tackle the competition issues created by the incentives of the current rebate and fee structure without CMS's engagement. The current CMS fee and rebate structure creates incentives for PBMs to disfavor competing independent pharmacies, resulting in pharmacy deserts and increased patient costs. The final CMS rulemaking, however, also illustrates that CMS is not equipped to address the issues without the assistance of the FTC and DOJ. Already, PBMs are citing the rule to impose new predatory contract terms on independent pharmacies in 2023, as will be discussed below.

CMS estimates that the 10-year prospective impact of requiring PBMs to apply all pharmacy price concessions to the negotiated price (in other words, eliminating the billions in inflated prices used to calculate a Medicare Part D Participant's copay) will result in $33.1 billion in savings to beneficiaries.[6] When a PBM claws back any portion of what a patient paid at the counter, then the patient paid an inflated price. NCPA members report:

- Semglee (an interchangeable biosimilar to Lantus, an insulin medication) became Express Scripts' preferred formulary product as of 1/1/22. Coinciding with that formulary placement was a price jump from $137-$141/box of pens to $381-$393/box of pens, and from $94 to $262 for vials.
- A patient may have a 25% copay for insulin medications.

[3] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency, CMS 4192-F, Public-inspection.federalregister.gov. (2022). Retrieved 5 May 2022, from https://public-inspection.federalregister.gov/2022-09375.pdf.

[4] Transparency, definition clarity, closing the coverage gap loophole, addressing arbitrary performance measures, and addressing contract issues are at the heart of NCPA's suggestions to CMS. Houser, R. (2022). *Untitled*. NCPA.org. Retrieved 5 May 2022, from https://ncpa.org/sites/default/files/2022-03/ncpa-comment-cms-part-d-proposed-rule.pdf.

[5] "The [Executive] Order not only calls on the traditional antitrust agencies—the DOJ and the FTC—to enforce existing laws vigorously … it also directs all agencies and departments to use their detailed knowledge and expertise to ensure that their work clearly supports competition in the markets they regulate …" Boushey, H., & Knudsen, H. (2022). *The Importance of Competition for the American Economy | The White House*. The White House. Retrieved 5 May 2022, from https://www.whitehouse.gov/cea/written-materials/2021/07/09/the-importance-of-competition-for-the-american-economy/.

[6] *Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs*. Federal Register. (2022). Retrieved 5 May 2022, from https://www.federalregister.gov/d/2022-00117/p-1052.

- Due to the formulary change, that patient now has close to a $100 copay, instead of around $35.00.

PBMs calculate reimbursement using list price rather than cost of product. This creates an incentive to put drugs with higher list prices on formulary, or in more preferred formulary positions. Doing so inflates the patient copay and enables the PBM to assess a higher pharmacy DIR fee, while not increasing the plan sponsor's costs because there is no direct relationship between the list price and the drug cost. The PBM walks away with a larger total of the difference after offsetting what it shares with the plan sponsor. For the PBM administering the insulin patient's prescription benefit, the difference could be an amount between $0-$300.[7] The claw back creates a situation where the independent pharmacy has no ability to know the amount the PBM will reimburse it for dispensing the drug. In addition to harming consumers, this practice harms competition between independent pharmacies and PBM-affiliated pharmacies. Unlike independent pharmacies, PBM-affiliated pharmacies either do not pay pharmacy DIR fees or if they do, they have transparency into the fees and can financially plan for them.

FTC Topic: The impact of PBM rebates and fees on formulary design and patients' ability to access prescribed medications without endangering their health, creating unnecessary delay, or imposing administrative burdens for patients or prescribers.

Due to contractual obligations with PBMs, our members frequently must explain to their patients that due to "utilization management" (e.g., prior authorization and step therapy) and formulary exclusions, patients are unable to get access to their prescribed medication. While described as "payer controls," used to "control costs," PBMs, through their offshore group purchasing organizations Ascent Health Services (Cigna/Express Scripts), Zinc Health Services (Aetna/CVS Caremark) and Emisar Pharma Services (United Healthcare/Optum), use these cost controls to direct utilization to the drug with the best manufacturer rebate, which is often not the best drug for the patient, while also using the GPOs to hide rebates from plan sponsors.[8] PBMs also use these "cost controls" to control manufacturer access to the market, creating a "pay-to-play" game to get new drugs to the marketplace. In a recent analysis by IQVIA, two-thirds of patients who want to start a new prescribed drug were unable to do so because of these controls, and the largest PBMs are blocking about 450 products.[9]

"Aberrant" drug lists highlight the impact of pay-to-play on patients.[10] Aberrant drug lists are not what they sound like. Originally used to identify drugs susceptible to patient misuse or substance use disorder, aberrant drug lists helped pharmacists identify drugs that required more careful screening. Now, PBMs use aberrant drug lists to restrict pharmacy prescriptions for specialty drugs, or more expensive drugs, and steer that business to PBM-affiliated pharmacies.

In one provider manual, such a list obligates pharmacies not to dispense beyond a 25% threshold (by dollar amount or number of claims for that PBM) of so-called aberrant drugs. If a patient presents with a prescription for a drug on the aberrant drug list, the pharmacist must guess whether that drug puts the pharmacy over the dollar or number of claims threshold. If the

[7] PBMs share some of the DIR with plan sponsors, but with the larger pool of DIR, it can also pocket a greater proportional share.

[8] PBMs claim that they no longer retain rebates but that is because the rebates have shifted to their offshore GPOs.

[9] Greenwalt, L. (2022). *Payer Controls: Goodbye, Old Assumptions for Access and Uptake*. Iqvia.com. Retrieved 5 May 2022, from https://www.iqvia.com/locations/united-states/blogs/2021/09/payer-controls-assumptions-for-access-and-uptake.

[10] To find aberrant drug language, look at PBM annual provider manuals or network contract education documents.

prescription gets the pharmacy close to this threshold, the pharmacy must choose between filling it or "walking" the patient to another pharmacy, which is most likely affiliated with a PBM.[11] If the pharmacy chooses to fill the prescription and it places the pharmacy beyond the arbitrary 25% threshold, per the manual, the pharmacy could face a punitive audit, claim chargeback (i.e., no payment), or PBM-unilaterally-enforced "remedies" including contract termination. With those kinds of obstacles, patients are either steered to a different pharmacy, offered an alternative drug (if available and authorized by the prescriber), or in the worst-case scenario, left without access to any drug. PBMs undertake this kind of activity because drugs on their aberrant lists tend to be the higher reimbursed drugs, and the PBMs want to foreclose independent pharmacies from accessing the market for higher reimbursed drugs.

One PBM arbitrarily prohibited independent pharmacies from purchasing more than a 30-day supply of drugs, without first asking for permission.[12] The PBM justified this bulk purchase restriction on grounds of fraud prevention. For pharmacies in remote locations, however, the harm the restriction caused to patients, who likely had to go without necessary prescriptions if there was any disruption in the supply chain, outweighed any fraud concern. PBMs enforce restrictions like this through invoice audits during which the PBM will check "quantity in" against the claims billed, or "quantity out." That means if a remote pharmacy invested in three months' worth of inventory to protect their patients' access to drugs and that purchase was beyond 30 days prior to the billed claim, the PBMs could deem the claim out of compliance with the policy and the PBM can recoup payment. A pharmacy could obtain an exception to this rule but would have had to submit a request (akin to asking for permission) for each exception via U.S. Mail.

In addition to the potentially devastating effect on patients, purchasing only 30-day supplies increases the wholesale costs to independent pharmacies. There are less restrictive and more effective ways that PBMs can protect against fraud. But this method is effective in driving up costs for independent pharmacies, so PBMs use it.

FTC Topic: Whether patients are being forced to substitute different prescription drugs to maximize PBM rebates and fees.

PBMs operating in the commercial, Medicare Part D, and Medicaid spaces alike contribute to artificially inflating drug costs using expensive name brand medications when less expensive generic alternatives are available. For example, PBMs continue to require the use of the more expensive brand asthma inhaler Symbicort over the generic budesonide; Symbicort costs over $150 per month more. One PBM mandated a state Medicaid program use Lamictal, at over $16.50 a tablet, which is significantly more expensive than its generic counterpart that costs less than $0.10 a tablet. PBMs similarly give wasteful, preferential treatment to other brand medications like Advair, Concerta, Colcrys, Ventolin, Adderall XR, and Focalin XR. Common sense would dictate where you have a choice between two equivalents, you take the less expensive one, unless there is a compelling reason not to.

Insulin is the most notable case of PBMs steering patients to use different drugs to maximize their profits. As mentioned above, Express Scripts identified Semglee (an interchangeable biosimilar to Lantus) as a preferred formulary drug for 2022. However, coinciding with that formulary

[11] The Newsletter of Pharmacy Audit Assistance Services (PAAS) National. (February 2022). Newsline: Caremark® Expands "Aberrant" Language & Restricts Bulk Purchases.

[12] See The Newsletter of Pharmacy Audit Assistance Services (PAAS) National, 2022.

placement price jump, the PBM removed the brand referenced biologic drug, Lantus, from the formulary altogether. Mylan Pharmaceuticals discontinued the cheaper Semglee National Drug Code (NDC) and issued a new NDC. The PMB listed the new NDC for Semglee at the new-found, higher price. To offset this change, the PBM introduced insulin glargine, which is an unbranded biosimilar equivalent to Lantus, at the same time with a new NDC at the same price as the original Semglee -- $141 per box of pens. Unfortunately, the PBM did not place insulin glargine on the formulary. So, for a patient to get access to the less expensive insulin glargine, a patient would have to pay out of pocket and not have it count toward their annual deductible.

In these cases, PBMs claim that they secure large rebates from the manufacturer to bring the net cost of the product down to below the cost of the generic. Even if this was true (which would require complete transparency and 100% pass through of all monies that flow from a pharmaceutical manufacturer to a PBM), it does not negate the consumer harm that exists to patients when they are in the deductible phase and paying 100% of their medication costs. PBMs will also blame these formulary placements on plan sponsors, but plan sponsors, like others in this industry are at the mercy of PBMs and their constant threats of rate hikes.

FTC Topic: PBMs' use of potentially unfair, deceptive, or anticompetitive contract terms and all related practices when calculating pharmacy reimbursements and disbursements, including the use of Average Wholesale Price, Wholesale Acquisition Cost, Maximum Allowable Cost, and Usual and Customary Pricing as well all types of claw backs, fees, discounts, and performance metrics, such as Direct and Indirect Renumeration, Generic Effective Rate, Brand Effective Rate, Dispense Fee Effective Rate and all other similar provisions.

In response to CMS's rule, NCPA members have received contract amendments that appear predatory. One PBM offered an anticompetitive contract amendment that would compensate independent pharmacies 10% below their wholesale acquisition cost, provides no dispensing fee,[13] and assesses a per transaction performance pool fee. The intended effect of such an amendment and discriminatory pricing can only be to force independent pharmacies to opt out of the Medicare Part D networks or stay in them only to face financial ruin. The end-result is the strengthening of PBM-affiliated mail order pharmacies at the expense of independent pharmacies.

In September 2021, NCPA submitted comments in response to FTC-2021-0036-0022, a request for information concerning contract terms that may harm competition. While there has been no change in the PBMs' practices since, it is important to understand the lengths to which PBMs go to obfuscate how they price and reimburse drugs. Such distortion begins with terminology: An Average Wholesale Price (AWP) is generally a mark-up (typically 20%) of the Wholesale Acquisition Cost (WAC) and can be thought of as the manufacturer's list price.[14] It is generally accepted that WAC is the amount paid by the wholesaler to the manufacturer.

The Maximum Allowable Cost (MAC) is the amount set by the PBM and is the amount the PBM will reimburse a pharmacy for generic drugs ("Pharmacy MAC"). MAC is also the amount it will charge a plan sponsor for a drug ("Plan Sponsor MAC"). The Pharmacy MACs and Plan Sponsor MACs can change by the hour or even minute. The price difference between the Pharmacy MAC

[13] Stoller, M. (2022). *The Red Wedding for Rural Pharmacies*. Mattstoller.substack.com. Retrieved 5 May 2022, from https://mattstoller.substack.com/p/the-red-wedding-for-rural-pharmacies?s=r.

[14] Anderson, L. (2022). *Average Wholesale Price (AWP) as a Pricing Benchmark*. www.drugs.com. Retrieved 5 May 2022, from https://www.drugs.com/article/average-wholesale-price-awp.html.

and the Plan Sponsor MAC is the "spread." Many understand that the spread is a revenue stream retained by the PBMs. As an example of the amount of money generated by this arbitrage, spread pricing cost the state of Ohio $225 million in 2018.[15]

A Generic Effective Rate (GER) represents a reimbursement baseline calculated as a percentage discount (e.g., 86%) off the Average Wholesale Price (AWP) of a generic drug. A PBM will calculate across all generic drugs dispensed for a specified period (e.g., 1 year) either at an individual pharmacy level or often across all the pharmacies represented by a Pharmacy Services Administrative Organization (PSAO). However, PBMs reimburse generic claims at varying MAC, WAC, or discounts off AWP, not at the GER. So, at the end of the specified evaluation period, PBMs reduce the AWP of all the individual generic drugs dispensed by the GER discount (e.g., 86%) and that number is compared to the actual reimbursement originally paid to a pharmacy. The PBM will then reconcile the total dollar difference. If, after the PBM completes the calculations, and it determines a pharmacy has received excess reimbursement, the PBM will claw back the money. Given the vast differences between generic reimbursements based on MAC, WAC, and discounts of AWP, it is particularly difficult for pharmacies to know where they stand in comparison to the contracted generic effective rates. Notably, PBMs do not refund claw backs to patients; the PBMs retain the claw backs for themselves. Brand Effective Rates (BER) work the same, except the PBMs use them for brand drugs.

The effective rate contracting/payment method allows PBMs to play games with individual drug reimbursements to the detriment of patients, pharmacies, and employers. Effective rate contracts allow a PBM, at its sole discretion, to initially reimburse a pharmacy artificially high or low at any time, knowing the PBM will reconcile the pharmacy reimbursements dollars at the end of the evaluation period to the contracted effective rate, as described above. For patients who have a percentage-based cost share, when a pharmacy dispenses a drug at a higher price artificially inflated by the PBM, based on the point-of-sale adjudication, the patient will pay a higher copayment. The patient will not receive the benefit of the end of the year reconciliation – the PBM will keep that money.

FTC Topic: PBMs' use of other potentially unfair, deceptive, or anticompetitive practices, including audit provisions; pharmacy network design and exclusions; use of gag clauses, confidentiality clauses, and non-disparagement clauses; and other potentially unfair provisions.

PBMs control market access, and they use that control to force unconscionable contract terms. PBM adhesion contracts include random basis audits, aberrant drug list compliance, inventory management limitations, specialty drug limitations, complicated performance metrics, complex pricing schemes, "flexible contracting," which means unilateral no notice contract changes, and other such provisions. The PBM can base an audit off any of those unconscionable contract terms. It is common for a single pharmacy to face several PBM audits a month. One of the most common audits is an invoice audit. Invoice audits require the pharmacy to prove that it bought the drugs it billed to the PBM. While that sounds reasonable, it is the frequency with which the PBM conducts such audits and the penalties that are not reasonable. A PBM audit is an existential threat to an independent pharmacy's business. If a PBM finds even a minor discrepancy, the pharmacy faces substantial financial penalties, and potentially even termination of the network agreement.

[15] *Ohio Auditor of State*. Ohioauditor.gov. (2022). Retrieved 5 May 2022, from https://ohioauditor.gov/news/pressreleases/Details/5042.

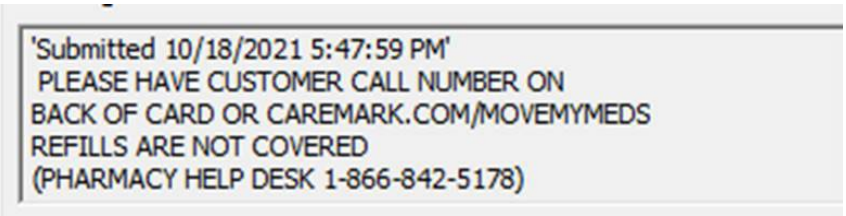
Termination of the network agreement can be fatal. In 92% of Metro Statistical Areas, at least one insurer with a PBM has a 30% market share, and in 50% of MSAs, one insurer has at least 50% market share.[16] With PBMs controlling access to the upstream insurer networks, it is able to control the downstream pharmacy market, and conflicts of interest abound.

PBMs incorporate confidentiality and non-disparagement clauses into their contract to limit scrutiny. PBMs prohibit pharmacies from sharing with third parties, including the FTC, any portion of a contract, including its unconscionable, unilateral terms. For example, prior to the open meeting on February 7, a pharmacy submitted a comment to the FTC and included de-identified data supplied to it by its PSAO. A PBM examined the now-public document and calculated that its data had been shared. It suggested that the pharmacy breached its confidentiality obligations and made a veiled threat to the PSAO and pharmacy that its contract prohibited sharing such information.

FTC Topic: PBMs' use of methods to steer patients away from unaffiliated pharmacies and methods of distribution and toward PBM-affiliated specialty, mail-order, and retail pharmacies.

PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. PBMs create arbitrary lists, such as specialty and aberrant drug lists to limit independent pharmacies' access to patients. These lists require patients to obtain certain drugs from a PBM-affiliated pharmacy.[17] The PBMs use contract provisions that require independent pharmacies to "walk" their patients to "specialty pharmacies," a term PBMs arbitrarily define. Potentially, any independent pharmacy can be a specialty pharmacy, however, the PBMs make the sole determination of whether they meet the opaque "criteria." If the PBMs do not determine the independent pharmacy meets PBM-established specialty pharmacy accreditation requirements, then the pharmacy cannot be part of the specialty pharmacy network. Such a process begs the question: when would a PBM with a downstream affiliated specialty pharmacy ever determine an independent pharmacy is worthy of such designation?

Other methods include refill walk requirements. Below is a screenshot from an independent pharmacy's pharmacy management system. As you will see, the PBM requires the independent pharmacy to inform its patient that the patient must seek an alternative way of filling the patient's refills. The alternative way is through the PBM-affiliated pharmacy.



Failure to follow these exclusionary procedures often leads to audits and threats of termination of the pharmacy's network agreement. At the very least, PBMs force pharmacies to choose between

[16] *COMPETITION in HEALTH INSURANCE A comprehensive study of U.S. markets*. Ama-assn.org. (2022). Retrieved 5 May 2022, from https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf.

[17] Fein, A. (2022). *Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?*. Drugchannels.net. Retrieved 5 May 2022, from https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

filling the refill free of charge (real-time claims adjudication would prevent the independent pharmacy from submitting a claim) or let the patient go untreated until they find a PBM-affiliated alternative.

FTC Topic: PBMs' policies and practices related to specialty drugs and pharmacies, including criteria for designating specialty drugs, reimbursements to specialty pharmacies, practices for encouraging the use of PBM-affiliated specialty pharmacies, and practices relating to dispensing high-cost specialty drugs over alternatives.

On behalf of PBMs, sPCMA, a division of PCMA representing the specialty pharmacy industry, released a white paper to defend PBM specialty drug practices.[18] In it, sPCMA admits that the definition of specialty drug continues to evolve. It lists a number of attributes that on the one hand applies to many non-specialty drugs, and on the other hand begs the question: If specialty drugs are used to treat complex or chronic medical conditions that require lab monitoring, additional patient education, adherence, and support, and administration technique training -- beyond traditional dispensing activities, then why would a PBM want to send specialty drugs through its affiliated mail order pharmacy that uses the mail? sPCMA provides the answer – money -- stating that a specialty drug "[h]as a high monthly cost"[19] and "[i]n 2020, nine of the ten best-selling drugs by revenue will be specialty drugs."[20]

Other criteria cited in this document reveals the lack of differentiation between most designated specialty drugs and more widely used drugs. In fact, sPCMA notes that patients use specialty drugs for a wide range of conditions. When addressing why specialty drugs have limited distribution, sPCMA cites criteria that is relevant with all non-specialty designated drugs too: drug inventory tracking, supply chain integrity, and dosing and lab monitoring. Therefore, the criteria PBMs use is nebulous at best.

Another way PBMs control access to the specialty drug market is through controlling relationships some specialty pharmacies have with manufacturers. Citing efforts to curb favoring brands over generics, PBMs moved against several specialty pharmacies that had ties with manufacturers and shut down their access to their networks. The PBMs, less concerned with favoring brands over generics, take these actions against independent specialty pharmacies while controlling two-thirds of the specialty market through their own mail-order operations.[21]

The impact on patients is clear. PBMs cut off patients who often have complex or chronic medical conditions from specialty options and force them into mail order at significant risk to their health.[22] The PBM practices prevent patients from accessing prompt access, patient education, injection training, adherence, and related support that only an in-person pharmacist can provide. Additionally, this practice is hurting consumers because when a mail order drug fails to arrive at a patient's home, this failure forces patients to fill their specialty drugs at a pharmacy that is out of network, or not authorized to distribute specialty drugs.

[18] https://www.spcma.org/wp-content/uploads/2016/06/sPCMA_The_Management_of_Specialty_Drugs.pdf.
[19] Id at 3.
[20] Id at 4.
[21] https://www.policymed.com/2016/01/pharmacy-benefit-managers-begin-to-cut-ties-with-specialty-pharmacies.html.
[22] https://www.npr.org/sections/health-shots/2019/01/07/673806506/extreme-temperatures-may-pose-risks-to-some-mail-order-meds.

FTC Topic: Potential conflicts of interest and anticompetitive effects arising from horizontal and vertical consolidation of PBMs with insurance companies, specialty pharmacies, and providers.

In 2018, the Auditor of the State of Ohio produced a State Report on Ohio's Medicaid Managed Care Pharmacy Services that spoke to PBM conflicts of interest.[23] In it, the Auditor found discriminatory reimbursement because PBMs compensated their affiliated pharmacies at a higher rate than independent pharmacies. This discriminatory reimbursement occurs nationwide, based on evidence reviewed from Arkansas, Florida,[24] and Oklahoma. In fact, in February 2018, the Arkansas Pharmacists Association, joined by Arkansas Lt. Gov. Tim Griffin and almost half of the General Assembly, held a press conference unveiling data demonstrating that PBMs pay their own affiliate pharmacies more than independent pharmacies.[25] The Arkansas data contained over 200 examples of discriminatory reimbursement. Of the top generic drug prescriptions, Arkansas found that the PBMs were paying themselves, on average, over $60 more per prescription than they were paying independent pharmacies. The PBM was steering patients to its wholly owned affiliate so that it could pay itself more. Such anti-competitive behavior results in increased costs and harm to patients.

In 2019, Express Scripts and Prime Therapeutics announced a "collaboration" whereby ESI would jointly contract with pharmacies and pharmaceutical manufacturers on behalf of the two PBMs combined members. While described as a collaboration, in practice this agreement functions akin to a horizontal merger without government approval or oversight. Prior to this collaboration, Express Scrips was already the second largest PBM in the country, and Prime managed pharmacy contracting on behalf of all the licensees of the Blue Cross Blue Shield Association (BCBSA), many of which are the dominate health insurer in their respective states. This "collaboration" is a collusive monopsony the PBMs use to enhance even further negotiating leverage.

The goal of this non-merger merger was to create collusive buying power to enable anticipative behavior. As depicted in their own words:

> Prime Owner BCBS of North Carolina: "The collaboration between ESI and Prime **improves their ability to negotiate** lower costs. By **leveraging combined economies of scale**, Prime can provide us with the **best pricing possible**. . . ."[26]
>
> Cigna's 10-K explained "**HOW WE WIN**" in its ESI PBM business:
> "**Leveraging purchasing volume** to deliver discounts . . . across the pharmaceutical supply chain."
>
> A news article similarly stated that the agreement will give ESI and Prime **"outsized leverage in negotiating drug prices with**

[23] https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.
[24] Milliman, *Florida Agency for Health Care Administration: Pharmacy Benefit Manager Pricing Practices in Statewide Medicaid Managed Care Program* (Dec. 2020).
[25] https://m.youtube.com/watch?v=CDnFSOMAazA.
[26] https://www.bluecrossnc.com/provider-news/express-scripts-and-prime-therapeutics-collaborate-deliver-more-affordable-care-more.

manufacturers and pharmacy networks. The move would greatly increase these entities' influence over drug prescribing."[27]

Conclusion

NCPA recognizes the limited resources the FTC has to devote to such complex and opaque companies and business practices. We therefore believe that there are a few practical areas the FTC (in conjunction with CMS and the DOJ) could focus on that would increase competition in pharmacy and savings to consumers. NCPA urges the FTC to:

- Undertake unfair methods of competition rulemaking to address patient steering and specialty drug limitations.
- Address discriminatory reimbursement and take-it-or-leave-it contracts by promulgating a rule that would recognize it is 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, and
    - 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.
- Study the effect of retroactive claw backs on consumer overpayment of copays.

By doing the above, FTC will demonstrate that it is dedicated to its mission of protecting consumer welfare and competition. Should you have any questions, please contact Matt Seiler, General Counsel, at matt.seiler@ncpa.org or (703) 600-1221.

Sincerely,

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

[27] https://www.physicianspractice.com/mergersacquisitions/integrations-consolidations-and-mergers-steps-toward-better-future.