AMERICAN ECONOMIC LIBERTIES PROJECT

May 24, 2022

Federal Trade Commission
600 Pennsylvania Avenue NW
Washington, DC 20580

Re: Solicitation for Public Comments on the Impact of Prescription Benefit Managers' Business Practices

Dear Chair Khan, Commissioner Slaughter, Commissioner Bedoya, Commissioner Phillips, and Commissioner Wilson:

Thank you for the opportunity to submit comments on the impact of pharmacy benefit manager (PBM) practices on patients, independent pharmacies, and drug costs. By way of background, the American Economic Liberties Project is a non-profit advocacy and research organization committed to understanding and addressing the problem of concentrated economic power in America.

A 6(b) study on the PBM industry is desperately needed. As we detail below, PBMs operate in a highly concentrated industry with pervasive conflicts of interests. Patients face dangerously unreliable delivery of essential medication through poor customer service from PBMs. Overall drug costs and out-of-pocket costs to patients are greatly inflated through self-dealing PBM practices like rebates and DIR claw-backs. Independent pharmacies are under constant pressure and threat of bankruptcy through the self-privileging practices of PBMs and their unfair methods of competition.

Our comment first covers the history of the PBM industry and its gradual consolidation over time. Second, we detail the structural issues with the PBM industry, notably the large market shares of its dominant players and their vertical integration into major health insurers and pharmacies. Finally, we catalog and describe PBM-related harms to various PBM business partners and groups of consumers. To emphasize the frequency of PBM abuse, self-dealing, and their harms, an index of consumer complaints related to PBMs from the Better Business Bureau and two Facebook groups is appended to the end of this comment.

Section I: The History of the Pharmacy Benefit Manager Industry

PBMs are a little-known middleman in the pharmaceutical space. They are corporations that manage pharmaceutical benefits for Medicare Part D, Medicaid, and other insurance plans. As a service for their clients, PBMs develop and maintain lists of drugs that a health insurer will cover called "formularies," and track which drugs are being prescribed to plan patients by physicians.

The 1960s, 70s and 80s: PBMs Rise to Prominence

Up until the late 1960s, health insurers would process claims for medications themselves. As insurers started to expand coverage for prescriptions, their administrative costs to insurers began to balloon. To solve this problem, third-party, HMO-affiliated companies called Pharmacy Benefit Managers were created to save insurers time and money. The first PBM, Pharmaceutical Card System, or PCS, invented the plastic benefit card for beneficiaries, and negotiated with manufacturers on behalf of health plans to lower drug costs for patients. Patients with cards could walk into one of the many community chain and independent pharmacies in PCS's network,[1] pay a small copay to their pharmacist, and the pharmacist would be reimbursed by PCS for the balance of their medication.[2] PCS was bought by drug distributer McKesson in October 1972,[3] where it remained until it was sold to Eli Lilly in 1994.

The first PBM to grow out of an HMO was Diversified Pharmaceutical Systems, or DPS. DPS was created by United HealthCare Group in the 1980s and was the first PBM to utilize clinical information in generating cost savings for the HMO. The first PBM to pioneer mail-order drug delivery was Medco Containment Services, founded in 1983.[4]

From the 1960s through the late 1980s, PBMs focused mainly on their administrative role, eliminating the need for patients to file claims for prescriptions on their own, improving access through pharmacy networks, and adding efficiency and cost savings to what was quickly becoming a large, increasingly expensive, and complicated drug supply chain.[5] The leading three PBMs provided differentiated services from one another, competed with each other for business, and dealt fairly with their networks of community and independent chain pharmacies. Over the next three decades, however, PBMs became increasingly consolidated and vertically integrated, helping drive the opacity and self-dealing for which the industry is now known.

The 1990s: Drug Companies Use PBMs to Self-Deal Through Formularies

Prior to the 1990s, PBMs remained largely as separate companies from the drug manufacturers they bargained with, and the pharmacies that they reimbursed. This began to change when, in November 1993, drug manufacturer Merck acquired the PBM Medco, setting off a trend of

[1] Robert Navarro, "Managed Care Pharmacy Practice," Jones and Bartlett Learning, 2009, https://books.google.com/books?id=dJi3eNgrunUC&q=united+healthcare+creates+pharmacy+benefit+manager+dps&pg=PA225#v=snippet&q=united%20healthcare%20creates%20pharmacy%20benefit%20manager%20dps&f=false

[2] Peter Fox, Chris O'Flinn, Terry Latanich, Phonzie Brown, "The ABCs of PBMs," National Health Policy Forum, October 27, 1997, https://www.ncbi.nlm.nih.gov/books/NBK559746/pdf/Bookshelf_NBK559746.pdf

[3] "In Memoriam: L. Earl Melby," Airzona Republic, January 20, 2002, https://www.newspapers.com/clip/19453296/arizona-republic/

[4] Robert Navarro, "Managed Care Pharmacy Practice," Jones and Bartlett Learning, 2009, https://books.google.com/books?id=dJi3eNgrunUC&q=united+healthcare+creates+pharmacy+benefit+manager+dps&pg=PA225#v=snippet&q=united%20healthcare%20creates%20pharmacy%20benefit%20manager%20dps&f=false

[5] Peter Fox, Chris O'Flinn, Terry Latanich, Phonzie Brown, "The ABCs of PBMs," National Health Policy Forum, October 27, 1997, https://www.ncbi.nlm.nih.gov/books/NBK559746/pdf/Bookshelf_NBK559746.pdf

pharmaceutical companies acquiring PBMs. Shortly after that move, in May 1994 pharmaceutical manufacturer SmithKline Beecham bought the PBM Diversified Pharmaceutical Systems. Then in July of that year, another pharmaceutical manufacturer, Eli Lilly, bought PCS Health Systems, another PBM.

This vertical integration very quickly led to self-dealing. Though the FTC did not challenge the Merck-Medco merger,[6] in 1994 the agency noticed that Merck had immediately started using the formulary from its newly acquired Medco's formulary to give its own drugs favorable placement over competitors, using control of the PBM to rig the market for drugs.

In light of these concerns, later that year it opened an investigation into Merck's and SmithKline's acquisitions,[7] and placed restrictions on Lilly's merger with PCS.[8] In 1995, Merck and SmithKline agreed to consent orders where they would make their PBMs maintain "open formularies,"[9] determined by an independent third party.[10] In 1998, the FTC closed its investigation into the Merck-Medco acquisition. Merck settled charges that its self-preferencing was leading to higher drug prices and reduced quality, and Merck agreed to a consent order to maintain an open formulary.[11]

Presumably at least in part as a response to these enforcement actions and thus unable to preference their own drugs, manufacturers sold their stake in their newly-acquired PBMs. In 1998, Eli Lilly sold its PBM, PCS, to the major pharmacy Rite Aid.[12] The following year, Merck spun off Medco into its own independent unit,[13] and SmithKline Beecham sold its PBM, Diversified Pharmaceutical Systems, to another PBM, Express Scripts.[14]

The Late 1980s-Today: Exemption from Anti-Kickback Statute

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[6] Times Staff, "FTC Approves Merck's Purchase of Medco," L.A. Times, November 9, 1993 https://www.latimes.com/archives/la-xpm-1993-11-09-fi-54911-story.html

[7] "Business Digest," Washington Post, November 11, 1994, https://www.washingtonpost.com/archive/business/1994/11/16/digest/fce99015-1d23-4d6c-a1b8-285c3f3738f9/

[8] "FTC Gives Final Approval to Lilly Order," Federal Trade Commission, July 31, 1995, https://www.ftc.gov/news-events/news/press-releases/1995/07/ftc-gives-final-approval-lilly-order-pledges-continued-monitoring-anticompetitive-practices

[9] "Merck Settles FTC Charges that Its Acquisition of Medco Could Cause Higher Prices and Reduced Quality for Prescription Drugs," Federal Trade Commission, August 27, 1998, https://www.ftc.gov/news-events/news/press-releases/1998/08/merck-settles-ftc-charges-its-acquisition-medco-could-cause-higher-prices-reduced-quality

[10] "In the Matter of Eli Lilly and Company, Docket No. C-3594, ORDER REOPENING AND SET ASIDE ORDER," May 1999, https://www.ftc.gov/sites/default/files/documents/cases/1999/05/elililly.htm

[11] Elyse Tanouye, "Merck Agrees to Settle FTC Inquiry Of Its Prescription-Management Unit," Wall Street Journal, August 27, 1998, https://www.wsj.com/articles/SB904173604889278000

[12] Kristine Henry, "Rite Aid to buy Lilly's PCS unit $1.5 billion deal grows chain as pharmacy benefit manager; Pharmaceuticals," Baltimore Sun, November 18, 1998, https://www.baltimoresun.com/news/bs-xpm-1998-11-18-1998322097-story.html

[13] Milt Freudenheim, With Ties Lingering, Medco Leaves Merck, New York Times, August 20, 2003, https://www.nytimes.com/2003/08/20/business/with-ties-lingering-medco-leaves-merck.html

[14] Steven Lipin and Robert Langreth, "SmithKline Beecham to Sell Twi Units for Nearly $2 Billion," Wall Street Journal, February 9, 1999, https://www.wsj.com/articles/SB91851814495292500

Since the 1990s, PBMs have been responsible for negotiating retrospective discounts on branded drugs with manufacturers in the form of rebates, or payments that flow from the drug maker to the PBM, and then to the contracting insurance company *after* the initial point-of-sale transaction – that is, after a patient has bought a drug from a pharmacy. The current rebate system has its roots in several events dating back to the late 1980s, culminating in a regulatory change that took place in 1999. Prior to this, drug makers would offer discounts to buyers up front, before the point-of-sale transaction, in exchange for volume purchases or favorable formulary placement, and in some cases offered them to all buyers.[15]

In 1987, President Reagan signed a bill allowing the Department of Health and Human Services (HHS) to issue safe harbors to the Medicare Anti-Kickback statute (AKS). The Anti-Kickback Statute "provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business reimbursed under the Medicare or State health care programs. The offense is classified as a felony, and is punishable by fines of up to $25,000 and imprisonment for up to 5 years."[16]

In 1996, hundreds of retail pharmacies settled a lawsuit against several major brand drug manufacturers and drug wholesalers under the Robinson-Patman act. The pharmacies alleged that the wholesalers and manufacturers were refusing to offer pharmacies the same rebates they were offering to purchasers like hospitals and health insurance plans. As a part of the settlement, brand manufacturers agreed not to provide discounts based solely on the status of the drug buyer and agreed that retail pharmacies that were able to demonstrate similar market share to managed care organizations like certain hospitals and insurers were entitled to the same discounts.[17]

Finally, in 1999, the HHS Inspector General revised the 1987 safe harbor rule to exempt all rebates that took place after the initial point of sale of a drug from the AKS. As a result, we today have the system of post-point-of-sale rebates that apply only to buyers of branded drugs with a certain market share. As discussed later in this comment, our current system of retroactive rebates incentivizes drug makers to compete, not to lower prices and gain market share, but to offer PBMs a higher rebate in return for higher formulary placement. As rebates climb higher each year, the overall cost of certain drugs has been shown to have increased. In 2019, the HHS Inspector General

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[15] Thomas R. Barker, Ross Margulies, "The History of Rebates in the Drug Supply Chain and HHS' Proposed Rule to Change Safe Harbor Protection for Manufacturer Rebates," Foley Hoag LLP, April 2019, https://foleyhoag.com/-/media/files/foley%20hoag/publications/ebooks%20and%20whitepapers/2019/foley%20hoag%20whitepaper%20-%20the%20history%20of%20rebates%20in%20the%20drug%20supply%20chain%20and%20hhs%20proposed%20rule%20to%20change%20safe%20harbor%20protection%20for%20manufacturer%20rebates%20-%20april%202019.ashx

[16] Office of Inspector General, "Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions," Department of Health and Human Services, July 29, 1991, https://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm

[17] Thomas R. Barker, Ross Margulies, "The History of Rebates in the Drug Supply Chain and HHS' Proposed Rule to Change Safe Harbor Protection for Manufacturer Rebates," Foley Hoag LLP, April 2019, https://foleyhoag.com/-/media/files/foley%20hoag/publications/ebooks%20and%20whitepapers/2019/foley%20hoag%20whitepaper%20-%20the%20history%20of%20rebates%20in%20the%20drug%20supply%20chain%20and%20hhs%20proposed%20rule%20to%20change%20safe%20harbor%20protection%20for%20manufacturer%20rebates%20-%20april%202019.ashx

proposed a rule that would do away with the safe harbor provision. While the implementation of that rule has been delayed, it is scheduled to be implemented at the beginning of 2023.[18]

The 2000s: FTC Approves PBM consolidation

However, just a few years later, the FTC began to approve a series of mergers and acquisitions in the PBM space, a trend that continued through the 2010s to the point where now there are only three major PBMs. The FTC's review of these mergers reveals that the agency paid little attention to the clear conflicts of interest, incentives to self-deal, and anticompetitive threats from consolidation that now pervade the industry. Guided by the belief that PBMs had enhanced efficiency and lowered drug spending, and would continue to do so if more consolidated, the Federal Trade Commission approved a series of mergers from 2004-2015 that drove this consolidation.[19]

Caremark-AdvancePCS

In 2004, the FTC approved the merger of the two largest PBMs in the country, Caremark and AdvancePCS. In its statement outlining the merger approval, the FTC acknowledged issues with previous pharmaceutical-PBM mergers, but noted that horizontal, PBM-to-PBM merger did not present the same concerns. Despite acknowledging that the newly merged PBM could stifle competition in the pharmacy benefits industry for the typical reasons that horizontal mergers are often held suspect, the FTC wrote that "dozens of small, often regionally-oriented PBMs provide sufficient service offerings to smaller employers (and will continue to do so post-acquisition)." The FTC continued, writing that "significant additional competition from several health plans and several retail pharmacy chains offering PBM services should suffice to prevent this acquisition from giving rise to a potentially anticompetitive price increase. The FTC ended its statement by acknowledging that the merger could lead to a reduction in dispensing fees paid to pharmacies, but that the agency was allowing the merger because "a reduction in dispensing fees following the merger could benefit consumers." [20]

CVS-Caremark

In 2007, the FTC approved the merger of Caremark and drugstore chain CVS, without even issuing a second request for information.[21] Two years later, a coalition of labor unions, House and Senate

[18] Ryan Pate, "Future of discount safe harbor for prescription drugs remains uncertain," Health Industry Washington Watch, December 23, 2021, https://www.healthindustrywashingtonwatch.com/2021/12/articles/regulatory-developments/hhs-developments/future-of-discount-safe-harbor-for-prescription-drugs-remains-uncertain/
[19] Stacy Mitchell and Zach Freed, "How the FTC Protected the Market Power of Pharmacy Benefit Managers," ProMarket, February 19, 2021, https://promarket.org/2021/02/19/ftc-market-power-pharmacy-benefit-managers/
[20] "Statement of the Federal Trade Commission: In the Matter of Caremark Rx., Inc./AdvancePCS, File No. 031 0239," Federal Trade Commission, February 2004, https://www.ftc.gov/sites/default/files/documents/cases/2004/02/040211ftcstatement0310239.pdf
[21] "FTC Closes Antitrust and Unfair Competition Investigation of CVS," Akin Gump, January 19, 2012, https://www.akingump.com/en/news-insights/ftc-closes-antitrust-and-unfair-competition-investigation-of-cvs-caremark-post-merger.html#_ftn5

members, independent pharmacists and patients urged the agency to investigate allegations that CVS Caremark was forcing patients to fill prescriptions exclusively at CVS pharmacies and otherwise steering patients to CVS.[22] After a group of eight House Representatives wrote to the Commission, "We are troubled that these are unfair and deceptive business practices. We strongly encourage the FTC to reopen the CVS Caremark merger investigation and determine if the acquisition poses a threat of reducing competition or whether CVS is engaging in any unfair or deceptive practices."[23] In response, the FTC opened an investigation into the merger, completed in 2012. While the FTC did find that CVS Caremark had violated patient privacy and HIPAA in certain cases,[24] the agency found no evidence of anti-competitive behavior or antitrust violations.[25]

Express Scripts-Medco

That same year, the FTC approved the merger of Caremark's two largest competitors, Express Scripts and Medco, following an eight-month investigation. The FTC's investigation sought to assess whether the merger would reduce competition in the PBM market, unduly increase Express-Medco's power in bargaining with pharmacies, and harm patients with chronic conditions who relied on specialty pharmaceuticals. While the FTC voted to approve the merger, it was split 3-1, with Commissioner Julie Brill dissenting. In her dissent, Commissioner Brill called the acquisition a "merger to duopoly with few efficiencies in a market with high entry barriers – something no court has ever approved." She concluded her statement by writing: "while I sincerely hope that I am wrong about the effects of this merger, I believe – with deep sadness and concern – that will not prove to be the case."[26]

CVS-Omnicare

In 2015, the FTC allowed CVS Caremark to acquire Omnicare, which was the largest long-term pharmacy care provider at the time, controlling 45% of the market. In 2012, Omnicare had tried to acquire another long-term pharmacy care provider, and the FTC blocked the transaction because Omnicare had a track record of "threaten[ing] to terminate its participation in the Part D sponsor's LTC Pharmacy network if the sponsor refuses its demand for higher rates."[27] As one lawyer wrote

[22] Reuters Staff, "Eight Lawmakers ask FTC to reopen CVS merger," Reuters, September 15, 2009, https://www.reuters.com/article/cvs-antitrust/eight-lawmakers-ask-ftc-to-reopen-cvs-merger-idUSN156908820090915
[23] Ibid.
[24] "CVS Caremark Settles FTC Charges:Failed to Protect Medical and Financial Privacy of Customers and Employees;CVS Pharmacy Also Pays $2.25 Million to Settle Allegations of HIPAA Violations," FTC, February 18, 2009, https://www.ftc.gov/news-events/news/press-releases/2009/02/cvs-caremark-settles-ftc-chargesfailed-protect-medical-financial-privacy-customers-employeescvs
[25] "FTC Ends Investigation of CVS Caremark," PR Newswire, January 12, 2012, https://www.prnewswire.com/news-releases/ftc-ends-investigation-of-cvs-caremark-137183688.html
[26] Julie Brill, "Dissenting statement of Commissioner Julie Brill concerning the proposed acquisition of Medco Health Solutions Inc. (Medco) by Express Scripts, Inc. (ESI)," FTC, April 2, 2012, https://www.ftc.gov/sites/default/files/documents/public_statements/dissenting-statement-commissioner-julie-brill/120402medcobrillstatement.pdf
[27] David Balto, "FTC must carefully investigate the CVS Health Omnicare acquisition," The Hill, July 30, 2015, https://thehill.com/blogs/congress-blog/healthcare/249664-ftc-must-carefully-investigate-the-cvs-health-omnicare/

at the time, CVS post-merger could "simply adopt the same kinds of exclusionary practices to limit the choices of Part D plans and reinforce Omnicare's dominant position."[28]

The 2010s: DOJ Approves PBM-Insurance Mergers

While this comment is addressed to the FTC, the Department of Justice played a significant role in allowing PBMs to become vertically integrated with the largest health insurers in the country.

CVS-Aetna

In October 2018, the DOJ allowed CVS to acquire health insurer Aetna.[1] The American Medical Association urged the Antitrust Division to block the deal outright, writing that the merger "would likely substantially lessen competition in many health care markets, to the detriment of patients."[29] In analysis cited by the AMA, the organization noted that Aetna performed many of the functions of a PBM, including formulary design, rebate contracting, and pharmacy policy, making Aetna the closest competitor to the Big Three PBMs. The AMA was not alone in opposing the merger. Several national consumer groups submitted a letter to the DOJ urging them to block the deal outright, rather than allow the merger to go through with a number of behavioral and structural conditions. "Even structural remedies such as divestitures," wrote the groups, "are inherently risky and inadequate."

The Department of Justice ended up allowing the merger to go through with conditions, including divestitures. In an unusual move, Federal Judge Richard Leon ordered a series of evidentiary hearings on the merger's settlement terms after the DOJ allowed the deal, although Judge Leon eventually also gave the merger and settlement a green light.[30]

Cigna-Express Scripts

While CVS' $69 billion purchase of Aetna generated controversy and press coverage, Cigna's $67 billion acquisition of Express Scripts that same year generated much less scrutiny, both from the Department of Justice and from consumer watchdogs.[31] With that said, the National Community Pharmacists' Association did voice opposition, writing that "we're seeing the growing balkanization of the health care industry – a world in which patients may be forced into a health

[28] Ibid.
[29] "RE: The Acquisition of Aetna, Inc. by CVS Health Corporation," American Medical Association, August 7, 2018, https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-8-7-Letter-to-Delrahim-CVS-Aetna-Merger.pdf
[30] Shelby Livingston, "
Federal judge signs off on CVS-Aetna merger after post-deal review," Modern Healthcare, September 4, 2019, https://www.modernhealthcare.com/mergers-acquisitions/federal-judge-signs-cvs-aetna-merger-after-post-deal-review
[31] Evan Sweeny, "Cigna closes $67B Express Scripts acquisition, promising affordability and choice," Fierce Healthcare, December 20, 2018, https://www.fiercehealthcare.com/payer/cigna-closes-67b-express-scripts-acquisition

care kingdom – the CVS-Aetna kingdom, the Cigna-Express Scripts kingdom, the UnitedHealth-OptumRx kingdom, et cetera – where the borders aren't porous, and patients are stuck with what they get."[32] As the rest of this comment details, NCPA's concern was prescient.

Section II: The PBM Business Model

Market Structure and Concentration

Because of two decades of frequent mergers approved by the agencies, three PBMs—CVS Caremark, Express Scripts, and OptumRx—now manage almost 80% of all U.S. prescription claims.[33] So unfortunately as drug spending has increased and PBMs have become more important to the health care system overall, they are now highly concentrated. Because the "big three" have cornered so much of the market, independent pharmacists are left with little recourse when facing unfair conduct by PBMs, such as DIR claw-backs, under-reimbursement, and unfair audits. The market share of the big three also gives them leverage to charge independent pharmacies excessive fees for network access.

Vertical Integration

All three PBMs are "vertically integrated" into the largest health insurers in the country, Aetna (CVS), Cigna (Express Scripts), and UnitedHealth (OptumRx). All three PBMs operate their own mail-order and specialty pharmacies, which compete with the independent pharmacies they reimburse on behalf of health insurance plans. CVS also operates the largest chain of brick-and-mortar drug stores in the country. The big three insurers/PBMs also operate the three largest Medicare Part D plans in the country, covering roughly 6 out of every 10 enrollees.[34] Because the big three sit at the middle of so many transactions—simultaneously as the PBM, the private and Medicare Part D insurer, and its own pharmacy—granting them access to patient and pricing data that their business partners do not, they have the leverage and an enormous incentive to self-deal at multiple points. When negotiating with drug companies, when reimbursing pharmacies, when dealing with patients, and when contracting with Medicare and state governments, they can self-preference and self-deal in many troubling and harmful ways.

PBMs are tasked with reimbursing independent pharmacies for prescriptions, but also compete with those pharmacies. PBMs are supposed to bargain with drug companies for lower costs, but are able to extract kickbacks from those companies as a part of the bargaining process, pushing costs higher. Because PBMs pocket rebates and the "spread" from pharmacy reimbursement, state governments and Medicare are also victims of PBM self-dealing. PBMs are supposed to help

[32] "NCPA's Statement on Cigna's Bid to Buy Express Scripts," PR Newswire, March 8, 2018, https://www.prnewswire.com/news-releases/ncpa-statement-on-cignas-bid-to-acquire-express-scripts-300611032.html
[33] "Pharmacy Benefit Managers: Market Landscape and Strategic Imperatives," HIRC, 2022, https://www.hirc.com/PBM-market-landscape-and-imperatives
[34] Juliette Cubanski, "Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2021," Kaiser Family Foundation, June 8, 2021, https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2021/

patients manage medication adherence but are incentivized to steer patients toward less convenient and more unreliable pharmacy care systems owned by the PBM.

Section III: Harms

A number of different parties have raised their own concerns, and experienced specific harms, with various aspects of the vertically integrated PBM business model and the way PBMs leverage their market power. Pharmacists have complained of burnout, poor working conditions, and pressure to fill prescriptions at an unsafe pace due to PBM policies. Medicare Part D patients have noted that their out-of-pocket costs are exploding because PBMs push for ever-larger rebates but obscure the actual cost of the drugs they need. Independent pharmacists have taken issue with DIR fees, audit practices, and under-reimbursement by PBMs. Patients have complained of poor service when dealing with PBM-owned specialty and mail-order pharmacies. And finally, state managed care programs across the country have collected evidence of PBMs overcharging taxpayers for administering drug benefits.

Patient Complaints with PBM-owned Specialty Pharmacies:

In the FTC's 6(b) study of the pharmacy benefit manager industry, it should take care to review consumer complaints regarding PBM-owned specialty and mail-order pharmacies.

According to the trade group National Association of Specialty Pharmacy (NASP), "specialty pharmacies connect patients who are severely ill with the medications that are prescribed for their conditions, provide the patient care services that are required for these medications, and support patients who are facing reimbursement challenges for these life-changing and often times life-saving, but also frequently costly medications."[35] Although the specialty pharmacy patients make up less than 2% of the population in the US, specialty medications make up 52% of US drug spending, up from 24% in 2010, and 37% in 2015.[36] CVS Health, Express Scripts, OptumRx, and Walgreens Boots Alliance/Prime Therapeutics own the four largest specialty pharmacies in the country.[37]

While the FTC has not published research on PBM ownership of specialty pharmacies, it has studied PBM ownership of mail-order pharmacies extensively in the past. In 2005, the Commission published a report entitled "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies." The commission's report aimed to assess whether conflicts of interest arise when a PBM handles pharmacy benefits for a client and dispenses drugs to the same client's members via its mail-order pharmacy. "The concern," wrote the FTC, "is that a vertically integrated PBM will steer plan sponsors' members to drugs on which the PBM's mail-

[35] "What is Specialty Pharmacy?," National Association of Specialty Pharmacy, August 2019, https://naspnet.org/wp-content/uploads/2019/08/What-Is-Specialty-Pharmacy-090718.pdf
[36] Ibid.
[37] Adam J. Fein, "PBM-Owned Specialty Pharmacies Expand Their Role In—and Profits From—the 340B Program," Drug Channels Institute, July 21, 2020, https://www.drugchannels.net/2020/07/pbm-owned-specialty-pharmacies-expand.html

order pharmacy will make a greater profit, regardless of costs to the PBM's plan sponsor client." The report found that there were no significant price differences between PBM-owned mail-order pharmacies and non-PBM-owned mail-order pharmacies. "Potential conflicts of interest should be rare," the report declared, "if competition among PBMs provides plan sponsors with alternative choices."[38] FTC staff cited this study in two letters to state legislatures discouraging state-level regulation of PBMs.[39]

The American Society of Clinical Oncology (ASCO), an organization that represents oncologists whose patients rely especially on specialty medications, has written that "timely access to therapies may be harmed by PBM-imposed network restrictions. Some PBMs require that patients use only their proprietary specialty pharmacy for certain drugs, despite the possibility that the patient could access the drug more cheaply and quickly from a different pharmacy."[40] Furthermore, as ASCO has written, "PBMs regularly place cancer drugs on the highest tier of their formularies, requiring the largest amount of cost-sharing from patients."[41]

These issues are reflected in Better Business Bureau complaints involving PBM-owned specialty pharmacies. A sampling of those complaints is below. The cataloged posts from two Facebook groups, "DOWN WITH Express Scripts and Accredo!" and "OptumRx Sucks!," can also be found in the Index at the end of this comment. Patients consistently complain of being charged for refills they didn't need, botched deliveries of delicate and temperature-sensitive medications, terrible customer service, surprise price increases on medications, and overruling doctors' recommendations for prescriptions. As one patient wrote in a Facebook group, "who would have thought that getting medication refilled without new torture from express scripts would feel like winning a big prize."

Caremark Specialty Pharmacy BBB Complaints[42]

- Caremark Specialty Pharmacy has received 1,603 complaints with the Better Business Bureau in the past three years.

[38] "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacy," FTC, August 2005, https://www.ftc.gov/sites/default/files/documents/reports/pharmacy-benefit-managers-ownership-mail-order-pharmacies-federal-trade-commission-report/050906pharmbenefitrpt_0.pdf

[39] Maureen Ohlhausen, Michael A. Salinger, Jeffrey Schmidt, "Staff Comment to VA Delegate Terry Kilgore," FTC, October 2, 2006, https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.terry-g.kilgore-concerning-virginia-house-bill-no.945-regulate-contractual-relationship-between-pharmacy-benefit-managers-and-both-health-benefit/v060018.pdf; Maureen Ohlhausen, Michael A. Salinger, Jeffrey Schmidt, "Staff Comment to Assemblywoman Nellie Pou," FTC, April 17, 2007, https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.nelie-pou-concerning-new-jersey.b.310-regulate-contractual-relationships-between-pharmacy-benefit-managers-and-health-benefit-plans/v060019.pdf

[40] "American Society of Clinical Oncology Position Statement:
Pharmacy Benefit Managers and Their Impact on Cancer Care," ASCO, 2020, https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2018-ASCO-PBM-Statement.pdf

[41] Ibid.

[42] "Better Business Bureau Customer Complaints for Caremark Specialty Pharmacy," Accessed May 5, 2022, https://www.bbb.org/us/md/columbia/profile/pharmacy/caremark-specialty-pharmacy-0011-90170595.

- Of those, there have been 1,278 complaints regarding problem with a product or service, and 118 complaints regarding billing and collections.
- Caremark Specialty Pharmacy has an "F" rating from the Better Business Bureau, and its average customer rating is 1.08/5 stars.

1. "CVS/***** has increased my copay for ********** (brand name ******) by 500% without any explanation. As this medication is vitally important for me, and I would have a seriously reduced quality of life without this medication, I do not understand why my copay was increased from $90 every 3 months to $450 every 3 months. I have asked for an explanation from the company, but I am getting the run around. The insurance company is requesting that I speak to the pharmacy, but it is the same company! They merged in 2017. I am frustrated and I can't get any answers from them. I would appreciate your help. Thank you." (04/15/2021)[43]

2. "Every month I unfortunately rely on CVS Specialty to deliver medication for my son. They was assigned a rep ********** to take care of my sons hemophilia meds. Ever since Ive been dealing with this pharm for some reason they always wait until last min to deliver meds. To the point where when the snow storm occurred earlier this year my son was out of meds. Situation that couldve been avoided if rep ******* been responsible enough to deliver meds a few days early. After this incident where my son was out of his meds (let me point out I DO NOT PLAY with this as hes a 4 year old with special needs whom almost died bc of his chemo) I asked to speak to a mgmt bc I wanted to switch to rep who is more responsible and was on top of the job/deliver on time. Bc of this incident, every time I call conversations are EXTREMELY RUDE and asking a question is an offense. I've called several times to switch rep w no resp whatsoever." (10/04/2021)[44]

3. "I am a transplant recipient and CVS Caremark refuses to send my life saving medication in a timely manner. I was told today that a med I was supposed to get a week ago will not arrive for another 3 days. I was given the option to have it sent to my local Rite Aid but that would take 3 days. The fact that they thought that was a viable solution shows they do not have qualified staff. Common sense is totally absent during every interaction I have with them. They also continue to say that my local pharmacy has to call them which is simply wrong and cannot be done.The ONLY reason I use them is because my prescription co pays are not applied to my deductible from any other pharmacy. This is due to a deal made between them and my insurance. I've also asked repeatedly for easy open caps for all of my prescriptions and they just send me caps and they don't fit half the bottles I need easy open caps for.Their customer service is beyond unacceptable." (08/29/2021)[45]

[43] Ibid.
[44] Ibid.
[45] Ibid.

Express Scripts BBB Complaints[46]

- Express Scripts has received 671 complaints with the Better Business Bureau in the past three years.
- Of those, there have been 130 complaints regarding delivery issues, and 276 complaints regarding a problem with a product or service
- Express Scripts has an "F" rating from the Better Business Bureau, and its average customer rating is 1.03/5 stars
- "Better Business Bureau is advising consumers to use caution when considering doing business with Express Scripts. BBB has received a pattern of consumer complaints alleging delays or failure to ship correct prescriptions or medications, failure to accept returns or medications which were shipped in error, failure to issue refunds, debiting credit or debit cards for prescriptions not shipped, and poor customer service."[47]

1. "I want my medication Skyrazi to be delivered to my home address. In December, 2021 I ordered the medication. It shipped to a Fedex pick up point….I received no notification that the medication shipped. I attempted to pick up the medication on January 6th, 2021. The medication was not refrigerated. Through out the month of January and February of 2022 I made several contacts to Accredo to request a replacement medication. I was told there was a delay in shipment. But I could expect it in late February, 2022 and the replacement was approved. I contacted Accredo yet again in late February, 2022 and was told the pharmacy was unable to fill my order because they did not have a physician's order on file and so I contacted my physicians office to have a replacement. I later filled another prescription and checked on the Skyrazi and was advised that the Medication shipped on February 23rd, 2022. I received no notice the medication shipped and it returned to Accredo. I am trying to get this medication replaced." (03/04/2022)[48]

2. "I called Accerdo on February 22,2022 for them to deliver my Tremfya injection that I take every 8 weeks. My next dose is due February 28, 2022 my injection was scheduled to be delivered on February 25, 2022 which it wasn't. I called them on February 25, 2022 to let them know that I didn't receive them. So they apologized for the inconvenience said I should expect them on February 28, 2022. On February 28, 2022 I called them again and spend almost 2 hours on the phone with them trying to figure out why they didn't delivered the med, and once again they came up with the same excuse that they need a prior authorization. Mind you they spoke to me 3 different time they never mention it until I called the 3rd time. I go through this everytime I need to take my injection. Accredo is very irresponsible to there patient. I am very disappointed and overwhelmed with there services. This is an on going situation. Thank you advance, ******* *********" (03/01/2022)[49]

[46] "Better Business Bureau Complaints for Express Scripts," Accessed May 5, 2022, https://www.bbb.org/us/mo/saint-louis/profile/health/express-scripts-0734-110132662
[47] Ibid.
[48] Ibid.
[49] Ibid.

3. "Express Scripts is our pharmacy insurance provider and we are also forced to use them after 2 refills at the local pharmacy for mail order prescriptions. Not once have they delivered the meds on time and without problems. Most recently, the date of refill for my son was a month off and I was told it was fixed twice, but I still have to get an emergency refill at the local pharmacy. One of my son's meds is a controlled substance and he cannot miss a day without major side effects. When I tell Express Scripts that he will run out before we receive their shipment, they ask me if I want to talk to a pharmacist about possible side effects. NO - I want his medicine in time to not have to deal with any side effects. It seems like a complete racket that this company is the insurance provider and we also have no choice but to use them to fill prescriptions. They also do not cover two of my prescriptions that have always been covered in the recent past. I have called 2/23, 2/24, & 2/25 and am always promised that the issue with this delayed script is dealt with, then get a message the next day that it is cancelled or delayed. The guy I talked to today refused to let me talk to anyone else about how to get this issue resolved and receive ALL our prescriptions on time and without issue. Since this is through our employer's health insurance plan, we are also going to go through HR and ****** ********** to get this provision that we have to use Express Scripts for mail order removed and be able to use a local pharmacy for every medication." (02/25/2022)[50]

4. "I am a disabled Tricare for Life veteran who underwent prostate surgery at ****** **** ******* ****** in 2004. Following the surgery, my urologist prescribed several different medications to facilitate urine flow, none of which was completely effective except brand name Flowmax. This has been well documented in my health records over the past 18 years. I normally receive all of my medications through the clinic pharmacy at Naval Air Station Corpus Christi but when I turned 65, I was told they could no longer provide name brand medications such as Flomax. At this point, I took my prescription for Flomax to the local HEB pharmacy but was told that the Tricare Express Scripts office would not approve the prescription as written but were authorized to substitute the generic version called Tamsulosin. In July of 2021, I went to my current urologist, Dr Robert ******** to obtain a new prescription for Flomax which he submitted to Express Scripts. Express Scripts initially disapproved the Brand over Generic Prior Authorization Request Form (****) as submitted and authorized HEB to dispense the generic substitute. Dr ******** immediately filed an appeal and was told he would have to submit additional justification to get approval for the name brand Flomax which he did. After several months of back and forth, Express Scripts eventually approved the request and I was able to obtain the name brand from my local HEB pharmacy with a modest co-pay. I was told by an Express Scripts Customer Service Rep in November that I would begin receiving the name brand Flomax via USPS in December or January. Bottom Line: After almost 8 months, I still have not received the Flomax as promised but instead received a single bottle of generic Tamsulosin with a dosage different than prescribed by my urologist. Since July of 2021, I have spoken with 7 different customer service reps, 2 different supervisors, and a registered pharmacist at Express Scripts. Still no resolution." (02/22/2022)[51]

[50] Ibid.
[51] Ibid.

5. "I have called countless times on behalf of my mother and myself. I was told that it takes two days for my medicine to get here, but its been past two days and still no medicine (called on a Monday, four days later and nothing) and my mothers medicine is still "being approved" or "on its way". Also, I have not gotten any tracking details to begin with for either one. I'd like to add that for my medicine I'm being told that I have to pay money which I never had to before because I'm a dependent and on Medicaid. I demand to know what is going on because I get told different things everytime. I literally just want and need my medicine WHICH KEEPS ME ALIVE, and also my mother's." (2/18/2022)[52]

OptumRx BBB Complaints[53]

- OptumRx complaints are grouped with the rest of UnitedHealth Group complaints, making impossible an exact accounting of complaints against the specialty pharmacy in particular as opposed to other parts of the UnitedHealth.

1. "This company goes out of its way to not fill prescriptions. because they push the customer to choose mail order, I did so with a pre authorized prescription from my physician, with approved refills, after waiting for well over to weeks for my order, an after contacting OptumRx why I had not received it, I was informed that they were unable to contact my physician in a reasonable time. I immediately contacted my Physician who told mr that OptumRx had absolutely made NO Effort what so ever to contact her. This is nothing short of fraud, and deliberately endangering peoples lives for profit." (02/27/2020) [54]

2. "OptumRX is stalling on a medication that my wife needs to survive as a type one diabetic. For those who don't know, insurance companies now require prior authorization forms to be filled out for necessary medication that a doctor prescribes for any disease. The idea is to try to get people discouraged from ordering an expensive medication that insurance doesn't want to pay for, but says they will when you get the insurance. Bait and switch. Her prior authorization for Dexcom G6 supplies which controls her blood sugar has been denied two times. They blame her doctor for not checking a box on the form. Now going on almost 30 days she is out of her prescription and when calling optum rx they don't seem to care. They just say there is nothing they can do about it. And that is after being on hold for at least an hour every time she calls. We've tried to get answers and they won't tell us anything, and a letter came in the mail saying it was denied because she "is not motivated and knowledgeable about the use of continuous glucose monitoring". She has been a diabetic on continuous glucose monitors for years! Also her insulin pump doesn't work without this continuous glucose monitor. The past 24 hours she has already had two diabetic emergencies due to this. Thank you Optum RX for making paperwork so challenging that an MD can't figure out how to fill it out. You guys might get to save some money and not have to pay for a life saving medication! Great job protecting your

[52] Ibid.
[53] "Better Business Bureau Complaints for UnitedHealth Group," Accessed May 5, 2022, https://www.bbb.org/us/mn/minnetonka/profile/health-insurance/unitedhealth-group-0704-21000358
[54] Ibid.

shareholder profits while my wife suffers. Also for the love of god staff your call center with people who care. You are in healthcare. If your people don't care, they don't belong there." (09/28/2020) [55]

3. "Optum RX has filled my medication for years with $0 copay. Recently a generic equivalent was released. Instead of offering the new generic that would have been $0 they sent me the brand name at a cost of over $400 in February. When I realized this, I called to find out why the cost was so high and was informed due to it being brand now that a generic was available. I offered to return the unopened pack so it could be switched to generic. I was advised that wasn't needed, I would be refunded the cost but should keep the 3 month supply and next refill would be generic. The refund never happened. I have made numerous calls and been given different answers each time. My most recent call was to check on the refund only to be informed I would need to return the medication. I was set to begin the medication the very next day and could not risk not taking it. I was then informed it would be escalated as the representative recognized it was a mistake on their end. It has now been almost 3 months with no refund or resolution even though I have now been told by 3 different representatives that my refund would be processed and to give it more time" (05/13/2020) [56]

4. "Optum RX denied my claim for tier cost exception for a doctor prescribed use of brand name Zoloft anti-depressant. However, they rejected my claim indicating I did not meet the criteria, yet the doctors form submitted clearly stated that I tried two generic equivalents and had a poor response, which meets the required criteria. I spent approx 6 hours on the phone with Optum RX (a division of UHC) and my doctor made multiple calls and faxes, all were denied or ignored. I ended up going without my medicine for several days, then paid $240 for a 30 day prescription that should have cost $109 for 90 days! Also, this request was simply an annual renewal since I had previously been granted this approval (Prior Authoriation expired 2/22/2020). How can an insurance company deny a doctors prescribed medicine?!" (04/13/2020) [57]

5. "I have been getting my Repatha and Humira from OptumRX Specialty Pharmacy (OSP) (Tel:###-###-####) for a while. I called yesterday, January 9th at 9:04 pm, to place a a refill order, as I have in the past. I was told by the associate that Repatha would no longer be covered by them and that I would need to talk to HDP, which I found out later was Home Delivery Pharmacy, and the number I was told to call was ###-###-####. So I continued to place my order with OSP for Humira, with my regular Co-pay of $5, which I authorized. My delivery date was set for the Tuesday the 14th. This call lasted 22min and 9 sec. Then I proceeded to call HDP at 9:27pm to find out how I can get my Repatha refilled. The associate told me that my prescription had already been filled and I argued with them, based on the conversation I just had with OSP. Apparently, not only had my Humira been ordered with my co-pay of $5 but an order had been placed for the Repatha

[55] Ibid.
[56] Ibid.
[57] Ibid.

> as well, with a co-pay of $275.40. I was furious, as you might expect. So I gathered more information and found out that this was getting shipped to me on Saturday, the 11th. Again, not authorized by me. I attempted to immediately stop the shipment and kept getting bounced around between HDP and OSP until they finally told me I can speak to a supervisor, and once transferred, it was a dead end. I called my bank immediately and placed a stop payment on the $275.40 and followed up this morning with a dispute. In the mean time, I got notification from my bank that I was placed into overdraft by $28.21- via text. I contacted the company again this morning (10th), and now I have to make sure I ship back the medication, because they apparently cannot cancel the order, and I have to sit and wait for my refund after they investigate the call and they receive the medication back. So who is going to pay for my time and energy spent to rectify their mistake. Also, what is the penalty for unauthorized use of my credit card?" (01/10/2020)[58]

PBM Rebates and Drug Pricing

For a drug manufacturer, a drug's position on a PBM's formulary is the difference between success and failure, because patients will have trouble accessing a drug if it is lower on the PBM's formulary.[59] To get a more favorable formulary placement, manufacturers will offer discounts to PBMs in the form of rebates. These rebates flow from the manufacturer to the PBM and then to the insurance company. PBMs take a cut of the rebate, so the larger a rebate is, the more the PBM can profit.

This is all exacerbated because PBMs operate under safe harbor from the Medicare Anti-Kickback Statute. Because of this exemption from what is otherwise a felony offense, rather than compete against each other to provide and lower price for the patient, drug companies compete against each other to offer higher and higher rebates to the PBM, driving up a drug's list price.

Furthermore, because PBMs are so concentrated, a drugmaker is effectively unable to lower their drug's list price in order to gain market share. A bipartisan Senate Finance Committee investigation from 2021 found that drug maker Novo Nordisk considered reducing the list price for its insulin by up to 50%, but decided not to because of "risk of backlash from PBMs." The same report found that insulin maker Sanofi gave a 56% rebate to PBMs in exchange for more favorable formulary placement, up from 2-4% in 2013.[60]

PBM Steering of Patients

PBMs will also self-deal by directly requiring patients to use their own specialty and mail-order pharmacies, rather than allowing them to use the pharmacy of their choice. They notify patients

[58] Ibid.
[59] Francis Ying, Julie Appelby, Stephanie Stapleton, "VIDEO: Little-Known Middlemen Save Money on Medicines – But Maybe Not For You" NPR, August 2, 2017," https://www.npr.org/sections/health-shots/2017/08/02/540918790/video-little-known-middlemen-save-money-on-medicines-but-maybe-not-for-you
[60] Lala Jackson, "Inside the Senate Report on Rising Insulin Prices," Beyond Type 1, February 6, 2021, https://beyondtype1.org/senate-insulin-report/

that they must sever their relationship with their current pharmacy and move to the PBM-owned pharmacy, sometimes giving as little as one month for a patient to switch. Allowing PBMs to self-deal in this way restricts patient choice, weakens the resiliency of pharmacy networks, and forces patients to cut off relationships with their existing pharmacy care provider. PBM anti-steering laws are in place in several states, including Louisiana, Georgia, Mississippi, and Maryland, but nationally this remains a problem.[61]

Predatory Conduct Towards Independent Pharmacies

PBMs have a well-documented history of under-reimbursing the independent pharmacies they compete with through their own in-house pharmacy, often to the point of bankruptcy.[62] CVS had a pattern of reducing payments to independent pharmacies until they were in dire financial condition, and then offer to buy them out.[63] Roughly 16% of rural independent pharmacies shuttered between 2003 and 2018,[64] likely due in part to extractive PBM business practices like this. PBMs conduct surprise "audits" of community pharmacies and will charge excessive fees if they find even small clerical errors.[65] Acting effectively as a private regulator for their own competitors, such practices reflect both a substantial abuse of power and a deep conflict of interest. PBMs and their corresponding Part D plans leverage their market dominance to force independent pharmacies into unfair take-it-or-leave-it contracts, exposing community pharmacies to under-reimbursement and excessive, unnecessary fees by PBMs. These types of fees fall under what CFPB Chair Rohit Chopra refers to as "junk fees."[66]

Since 2010, PBMs have been charging pharmacies ever-increasing pharmacy price concessions, known as direct and indirect remuneration (DIR) fees. These are post-point-of-sale adjustments to the negotiated price of a drug. Instead of taking money from pharmacies at point-of-sale, these fees can be levied months after a patient buys a drug at a pharmacy. That is, a patient can go to a pharmacy, and the pharmacist gets a copay from the patient and a reimbursement from a PBM. The copayment from the patient is usually based on the total price then charged. But then, months later, the PBM claws back a portion of the amount reimbursed to the pharmacy.

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[61] "Patient Steering Fact Sheet," California Pharmacists Association, August 2021, https://cpha.com/wp-content/uploads/2021/08/Patient-Steering-Fact-Sheet-_F.pdf
[62] "Side Effects: An Ongoing Investigation on the Rising Costs of Prescription Drugs," Columbus Dispatch, https://stories.usatodaynetwork.com/sideeffects/
[63] Marty Schladen and Lucas Sullivan, CVS Caremark Cut Payments to Pharmacies Amid $70 Billion Deal to Buy Aetna, Columbus Dispatch, June 24, 2018, https://stories.usatodaynetwork.com/sideeffects/cvs-caremark-cut-payments-pharmacies-amid-70-billion-deal-buy-aetna/
[64] Abiodun Salako, Fred Ullrich, Keith J. Mueller, "Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018," RUPRI Center for Health Policy Analysis, July 2018, https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf
[65] Zach Freed, "Reining In Pharmacy Middlemen," Institute for Local Self-Reliance, 2018, https://ilsr.org/rule/reining-in-pharmacy-middlemen/
[66] Rohit Chopra, "Prepared Remarks of CFPB Director Rohit Chopra on the Junk Fees RFI Press Call," Consumer Financial Protection Bureau, January 26, 2022, https://www.consumerfinance.gov/about-us/newsroom/prepared-remarks-of-cfpb-director-rohit-chopra-on-the-junk-fees-rfi-press-call/

Post-point-of-sale price concessions obfuscate and drive up the negotiated price of a drug, allowing PBMs and plans to skim money from both patients and independent pharmacists. According to CMS, the use of DIR fees increased by more than 90,000% from 2010 to 2019.[67] Pharmacies now pay hundreds of thousands of dollars a year in retroactive price concessions. 8 Because these fees are levied long after the sale, pharmacies are often caught by surprise and have little recourse. They fuel pharmacies going out of business.

Overcharging State Managed Care Programs

A number of states have found that PBMs have overcharged their Medicaid, workers comp, and other managed care programs by millions of dollars. A 2017 analysis by Ohio's state auditor found that PBMs were pocketing 31% more than they were reimbursing pharmacies for generic Medicaid prescriptions, a spread totaling $208 million for just one year from April 1, 2017 to March 31, 2018.[68] A report by Kentucky's state agency for health and family services also found that PBMs pocketed a spread of $124 million for generic prescriptions in 2018. In 2018, West Virginia found that it had saved $54 million after pharmacy services were carved out of the state's Medicaid managed care program. Most of these savings was from administrative costs.[69]

Conclusion

A comprehensive 6(b) study of the PBM industry is urgently needed. States, congressional committees, health care provider groups, and patient groups have gathered overwhelming evidence of unfair and predatory tactics by PBMs over the last two decades. PBMs drive up drug spending, weaken pharmacy networks and patient care, and cost taxpayers millions of dollars. We support Chair Khan's work to commence work on a new study and urge the FTC to begin work on one immediately.

Sincerely,

American Economic Liberties Project

[67] "Centers for Medicare and Medicaid Services FY22 Budget Justification," Department of Health and Human Services, https://www.cms.gov/files/document/fy2022-cms-congressional-justification-estimates-appropriations-committees.pdf
[68] Dave Yost, "Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period," Ohio Auditor of State, https://ohioauditor.gov/news/pressreleases/details/5042
[69] Marty Schladen, "Reports Show Pharmacy Middlemen Making Big Money in Other States," March 14, 2019, https://stories.usatodaynetwork.com/sideeffects/reports-shows-pharmacy-middlemen-making-big-money-states/