I'm writing today as a 27 year pharmacist and pharmacy owner for 5 years. Its disheartening to see such reduction in choice for our patients and an industry (PBMs) who has been able to get away with so much, yet continues to add to the cost of drug pricing in America.

This workshop was a very good start for the FTC to start to (re)look at where we are with prescription drug prices. It was good to see pharmacists represented on each of the panel discussions as it seems the entire pharmacy profession has been hijacked by major corporations trying to extract as much money out of the drug supply chain system they possibly can.

Prescription Rebates - PBMs

The particular focus on the prescription rebate system is something that the government needs to fully explore as it is admitted even by the PBMs that 50% (or more) of the prices of brand name medications - like insulins for example are used as bargaining, pay to play schemes for PBMs to make money that is supposed to help bring prices DOWN (ultimately) but have done the exact opposite. This is a practice that Medicaid expanded and has been looked at as being somewhat successful but its purpose at this point no doubt is working against the American people. CMS should factor this into Medicare Part D plans n(as well as state Medicaids) and work to discourage/disincentivize this structure. If not make it really illegal as it is the true definition of a "kick back". This kickback issue is something some entity, if not the FTC should certainly address.

The more this is touted as being successful, the more the PBM industry leverages this aspect for their own bottom line as all of the rebates are impossible to audit and are considered trade secrets. Do we really ever know how much rebates are given? (see attached news article on Express Scripts response to SEC's request for rebates to be broken out).

Managing a pharmacy network

PBMs due to size, scope and a monopolistic marketplace where almost 80% of all prescriptions are managed through one of 3 companies have the unique ability to financially exploit their network providers with virtually no recourse by the provider. In no other industry would a product/service be subsidized by the company providing a product or service for a customer - yet somehow through abuse practices by PBMs to their pharmacy network providers, pharmacies are somehow expected to do this. The term "negative reimbursement" is in itself an oxymoron as essentially pharmacies are NOT getting reimbursed but getting funds related towards those prescriptions based on pricing models that are false, change hourly, by plan, Also there is not a 2 way communication for pharmacies to obtain wholesale information regarding the availability of that prescription being available at less cost in the marketplace, when doing an appeal on this MAC (maximum allowable cost) pricing - the plan can simply state "plan refused to update MAC" when pharmacies send in invoices and other proof of what the product costs to purchase. MAC pricing has allowed PBMs to basically make up for any revenue shortfall internally by quickly reducing all MAC pricing and there is nothing that

pharmacies can do. And with that FORCING pharmacies to lose money while they pad their revenue streams.

Gag Clauses
If pharmacies share the fact that they are expected to lose $150 (yes that is a real number) on a prescription and refuses to fill the prescription, the patient can call and complain to the insurance company who simply calls that pharmacy and tells that as part of the "contract" they HAVE to fill all prescriptions presented as part of being in the network. The pharmacy is also reminded that sharing pricing information with patients (and payers) falls under the non-disclosure section of "trade secrets" in their contract.

Exploiting the providers is protected via contract language and there is nothing the pharmacy can do about it. Its not a good analogy but the only one that illustrates this practice is that this is a type of modern day slavery where the slave (pharmacists) are beholden to the master (PBM) who makes all the rules, can enact punishment and the master is profiting quite handsomely off of the work of the slave while the slave is barely sustaining, or in this case - sustaining to the extent that the master allows as the master controls everything.

There have been plenty of comparisons and illustrations of how the PBM industry operates - quite commonly the PBM's business model has best been explained as being mafia -like with a recent article comparing it to the popular tv show - Sopranos, and their business model. This is not an inaccurate comparison.

Gag clauses are particularly troublesome also as PBMs have revenue generators where patients could have paid LESS for the prescription if the pharmacy didn’t bill insurance, but we are specifically gagged from sharing that information with the patient and are mandated to run EVERY prescription through the drug plan.

Enclosed is an email thread attacking me (obtained by public records request) outlining to the extent that PBMs will go to keep pharmacists quiet, enact threats and justify their profits and also acknowledge they are aware that pharmacies lose money on prescriptions as if the (low) reimbursements on the positive claims more than make up for the losses - which is not the case.

Why independent pharmacies matter and why the merger/buyout flury in healthcare must be overseen/slowed down or even halted
An active "market" depends on plenty of players who compete on price and other factors. There is no such a market in prescriptions in America as 90% of the money being used to pay for these prescriptions comes via a third party, and thus via a PBM who controls the process AND pricing. Patients won't simply pay $300 for a drug to go to a pharmacy of their choice when they can go to one (steered by PBM) where they can use their benefit and get that same prescription for a nominal copay of for example $30.

Independent pharmacies are the last vocal advocate for American healthcare patients. While they are businesses, pharmacists have ethical standards of professional practice. There is no such ethical standard of the PBM business other than their ultimate goal of deriving profit for their shareholders. There is a true movement to make things so difficult for independent pharmacies that no one would want to own such a business controlled by outside entities that rob from you daily under the guise of "patient care" and somehow "saving money" for plans.

The past mergers have allowed all of this to get worse and to the extent today that its almost truly hard to believe. When 10-12% of your prescriptions you fill on a daily basis you LOSE money, its psychologically devastating and isn't serving our patients in the best manner. When a pharmacy owner or manager is spending 90% of their time filling/re-filling MAC appeals that just get ignored anyway, or trying to find a (non-existent wholesaler) to purchase a product at a price where you don't lose money, it's sad to think that time would have been better spent talking/counseling with patients on effective lifestyle choices and how to best manage their condition (with or withOUT medications)

The FTC does have the regulatory authority and power to do and then sometimes UNDO some major changes. I would ask that the FTC acknowledge that bigger hasn't shown to be better, nor has it reduced costs or expand patient choice. All of the red flags that were waved (interesting mostly by pharmacists who predicted what would occur - but what it truly happening now is worse than anyone would have even imagined), yet were minimized and thought to be non-issue have shown to be truly worse than possibly predicted. A sincere, thoughtful consideration to drastic measures should be taken not only to unwind the mergers and acquisitions but also to prevent the same mistakes in the future, especially in a sector of our society that is so highly important - healthcare.

I would ask the FTC to disallow PBMs from being allowed to steer any patients to their own facilities, or even to disallow that portion of vertical integration as it has only served as a mechanism for PBMs to ensure themselves customers/profits and (obviously) in the anti-competitive manner - take those customers/profits from other providers, most of which the patients would rather have worked with.

The vertical integration of entities needs to be carefully re(inspected) with what is known now with the data proven with these entities taking advantage of opaque pricing models, their size and scope on provider relationships,and schemes for self gain at the expense of patients, providers and tax payers and chart a different course for healthcare in our country.