The Judge, Jury and Hangman

Submitted By: Mike Schwab

On Behalf of the Pharmacy Profession and Patients We Serve

I am going to provide you with the following observations as a consumer of prescription drugs as well as an employee of a pharmacy association. I have spent well over 10 years investigating and examining the PBM market place and the vertical integration that has already taken place in the PBM market. I have been basically examining the PBM market since the roll out of Medicare Part D in 2006 and the CVS/Caremark merger of 2007. It is my understanding the FTC has done little to nothing in terms of a review of PBM practices since that time. In my opinion, it is long overdue. There are many concerns and I feel personally that we have an industry shrouded in secret dealings, contracts of adhesion, anticompetitive practices and restraint of trade practices that are running rampant. ND has lead the way in legislative and policy PBM reform on multiple occasions.

I will try my best to be brief and to not write a novel which could easily happen regarding the topic of PBMs and pharmacies. First, I must ask a few questions of the FTC.

Would the FTC find it anticompetitive if U.S. Bank was able to set the reimbursement rates for all their competing banks or fees other banks could charge their customers? This is what happens in the PBM market, where the PBM gets to set the level of service a pharmacy can provide as well as what prescriptions s a competing pharmacy can dispense. In addition, the PBM gets to set the rates or knows what their competing pharmacies are going to be paid through contracts of adhesion and the contracts can change at the SOLE DISCRETION of the PBM AT ANY TIME. This has become standard in the PBM market place. The PBM has the right to change any pharmacy contract at any time with very little or no recourse by the pharmacy. Please explain to me how this is a fair business practice. If you don't sign the contract, you could be out of business in a hurry. In ND, we have roughly 3 main players and if you don't sign one of the major PBM contracts, you could lose 30% or more percent of your customers and revenue. The PBMs know this and use it to their advantage because all PBMs are now in the business of pharmacy! The fact that the PBM is also allowed to be in the business of pharmacy determining the rules for their competitors is clearly the fox watching the hen house.

Would the FTC find it anticompetitive if U.S. Bank had access to all the customer information of their competing banks? This is what happens in the PBM market. The PBM has access to their competitor's customer information. Guess what happens, customers are solicited to switch to the PBM's owned pharmacies. This practice happens weekly.

Would the FTC find it anticompetitive if U.S. Bank was allowed to design the "benefits" for all their competing banks and through the "benefit design" charged the customer a higher price if the customer uses a competing bank but offers a lower price if the customer uses U.S. Banks services? This is what happens in the PBM market. The PBM gets to create or sells a certain benefit design which incentivizes (or penalizes depending on how you look at it) customers to use the PBM's owned pharmacies but penalizes the customer if they use one of the PBMs competing pharmacies. Basically, they market to

customers…"Save money by using our mail order pharmacy but if you use one of our competing pharmacy's you have to pay a high price". Keep in mind, most of the time, the PBM sets the price and mail order clearly is not always the cheapest. Let's now forget the documented "waste" associated with mail order pharmacies. Even in instances where the competing pharmacy is offering to accept the same or less reimbursement, the PBM will not allow the pharmacy access to the customer. They hold customers hostage from using their competitors. On its face, it might not seem like customer allocation, but when the PBM holds all the cards and can put their competitors at a disadvantage that is exactly what is taking place. The pharmacies just want a chance to compete for the customer's business but are not given the opportunity to compete because the PBM truly doesn't want to compete with other pharmacies now that they are all in the business of pharmacy.

Prohibiting Home Delivery and Mailing of Prescriptions by PBM Competitors:

Would the FTC find it anticompetitive or a restraint of trade if a PBM prohibited their competitors from being able to offer certain services such as a reasonable accommodation like providing home delivery or mailing of prescription drugs? This is what is happening currently in the PBM market. The PBMs have taken it upon themselves to prohibit pharmacies from providing home delivery or the mailing of prescription drugs to any of the PBMs customers. The customer can only have those services provided by the PBM owned pharmacies. In ND, pharmacies have been providing home deliveries and mail order services for over 125 years (prior to ND even being a state) and now all of a sudden, pharmacies are prohibited from providing that service or apparently are no longer good enough to provide such a service to customers. If PBMs were not in the business of pharmacy, I highly suspect we wouldn't even see these kinds of restraints of trade take place. This policy clearly forecloses a competitor from achieving the sales needed to compete effectively and denies a pharmacy from being able to compete with the PBM owned mail order pharmacies. In addition, I have serious questions if it is legal for the PBM to require such contractually of a pharmacy. For example, if you look at the Americans with Disabilities Act, if a customer is requesting a reasonable accommodation for the pharmacy to home deliver the medications, in my opinion the pharmacy needs to adhere to doing such unless it is a financial burden. However, the PBMs send threating letters to the pharmacy telling them if they mail or provide home deliveries they will be kicked out of the PBMs network.

When a PBM only allows their own pharmacy into a network or has mail order prohibitions in place for their competitors, they are clearly assigning certain customers to themselves. They are clearly assigning market share through customer allocation or put another way, they are knowingly assigning a certain percent of customers to their own business segments while locking out the competition. Again, if I am U.S Bank and I get to set the rates and the rules my competitors have to honor but then set my rates lower than all my competitors, how is that not anticompetitive? Pretty sweet deal if I am the PBM.

Generic Drug Reimbursement - aka. MAC Pricing:

Generic drug pricing is another black hole. To start, did you know that a pharmacy has to sign a PBM contract that DOES NOT tell the pharmacy how much they will be paid from the PBM (a direct competitor of the pharmacy)? I am not joking, in every contract the PBM will tell the pharmacy how

much they are going to be paid for branded prescriptions, but when it comes to generic drugs the PBM contract simply states "whatever we want to pay you and we will pay you below cost sometimes as well". Seriously, the contract DOES NOT tell a pharmacy what they will be paid for 80%+ of the pharmacy's business volume. The pharmacy is at the mercy of their direct competitor who gets to set the generic reimbursement rates off of what is called a Maximum Allowable Cost (MAC) List. Guess who controls and determines the generic MAC lists and what rates will be paid? You guessed it, the PBM. Common theme developing isn't it? Multiple times throughout the day a pharmacy is paid below the cost of procuring the drug and because the PBM contract states a pharmacy cannot deny service to a covered beneficiary, the pharmacy has to counsel and dispense the drug to the customer while taking a loss on that claim as determined by their competitor. Through this practice, a PBM can effectively run their competition out of business. Only in pharmacy do you find your competitor determining what they are going to pay you regardless of what it cost you to buy the product. The PBMs will tell you that overall the pharmacy makes money. In the infamous words of one PBM "you win some and you lose some". That would be ok, if I as the business owner got to determine when I won some and lose some not my direct competitor telling me when I lose some and win some!

Specialty Pharmacy:

Specialty Pharmacy is quite possibly the biggest black hole of them all. In most cases, there is nothing special about the drug. We have seen the supposed specialty list grow extremely fast in the past couple of years. We are starting to see drugs that have been around for years added to the specialty list. PBMs have officially found a way to capture the fastest growing and most lucrative area of the pharmacy industry. In the vast majority of instances, PBMs are able and very successful at locking pharmacies out of the PBMs specialty network. PBMs constantly are promoting mandatory mail order specialty pharmacy services through their own specialty network. Even if a pharmacy jumps through all the hoops and pays tens of thousands ($30,000-50,000) on average to become "accredited" because the PBMs determined pharmacies need to be accredited, the PBM still gets to set the reimbursement rate to their competing specialty pharmacies. In an ever increasing number, the pharmacies that go through all the work of trying to get into the PBMs network are left locked out of the market still because of the mandated mail order specialty pharmacy contracts PBMs sell to plan sponsors. Once again, who gets to create the supposed specialty lists? The PBMs do! Again, who gets to determine the reimbursement for their competitors? The PBMs do! And finally, who gets to determine the plan design that ultimately benefits the PBM, even when the PBM owes someone else a fiduciary duty? The PBMs do!

Continuing with specialty drugs, I would like to add the following. In the profession of pharmacy we have seen self-injectable drugs broadly added to the specialty drug lists. For 10 years, it was ok for a pharmacist to counsel and dispense the medication but now all of a sudden the pharmacist is not good enough to counsel and dispense the drug. PBMs will tell you it is safer for a patient to get the specialty drug from one of their mail order pharmacies because they have a 24 hour help line a patient can call. It is laughable that the PBM would rather have my grandma call them on their 24 hour help line so they can walk her through how to properly self-inject the drug. Are you kidding me? Guess what happens, most of the customers end up going to their local pharmacy after they get the self-injectable drug in the mail and ask the pharmacist to show them how to properly self-inject the drug. This happens constantly.

Another important factor to consider is that "these drugs are so special they will just show up in your mail box". In ND, they bake in the mail box in the summer and freeze in the mail box or on the customers door step in the winter. We have numerous reports of customers of mail order pharmacies calling their local pharmacy asking them if they should still take the drug because they found it frozen in their mail box. Thank God the customer called their local pharmacist…which is not always the case. I could go on and on about how the PBMs are effectively capturing the fastest growing and most lucrative area of the pharmacy market virtually unabated. One last point, to prove an ever growing number of these drugs are NOT special, we as a profession are starting to see the PBM deem the "capsule or tablet" form of drug as a specialty drug but the PBM will leave the self-injectable form of the same drug off the specialty list. The only driver is price and price alone and everyone knows it! In the process though, PBMs are able to carve out a segment of the pharmacy market for themselves and are effectively locking out pharmacies that would gladly compete in the space or had been competing in the space for years. All of a sudden the pharmacy is not qualified to do so even if they meet all state and federal requirements to operate a pharmacy, the PBM says sorry but you are not qualified or are not following the rules we determine. This is crazy ladies and gentleman and only going to get worse because all the PBMs are not only in the business of pharmacy but are aggressively in control of specialty pharmacy now!

Spread Pricing:

I assume you are familiar with spread pricing. While it is not illegal, it is highly suspect and secretive. This is where the PBM pays the pharmacy one price but turns around and bills the employer a different price. In numerous instances, the PBM bills the employer a higher price than they paid the pharmacy and this is the "spread" the PBM retains. Here is my issue with the "spread". First, it drives up the premiums for employers and their employees. There is no market check or balance in terms of who gets to determine if the "spread" is too much. The PBM gets to decide and gets to technically bill whatever they want to employers. Yes, I know, the PBM will tell you the employers are learned purchasers of their benefits. I cry foul! Maybe some of the large Fortune 500 companies are and I stress maybe some of them. By far, the vast majority of the employers have more questions than answers when it comes to the complicated PBM market as well as the complicated 30+ page contracts the PBMs use. In ND, I have sat in on multiple employer meetings as they review PBM contracts and potential renewal of PBM contracts. I would love you show you a PBM contract that our Public Employees Retirement System was basically clueless on and their own attorney stated they did not understand a vast majority of what was in the contract. I provided them a quick review and found 15 areas of the contract that basically let the PBM do whatever they wanted to with the prescription benefit design once the employer signed the contract.

The biggest concern or legal question I have when it comes to spread pricing is the following. The PBM creates a spread price on multiple drugs. Bills the employer based off of whatever spread the PBM determines. The employer never knows the spread even exists or never knows what the pharmacy is actually paid, how can the employer make an informed contracting decision or how do they know if they are getting a fair deal? On top of that, as I sit in on employer board meetings to discuss PBM prescription drug coverage or renewal of existing coverage, the PBM will state something like the following "Overall pharmacy spend was up 10% this year, we are doing the best we can to control

prescription drug prices. We have aggressively negotiated with our network pharmacies. We have done the best we can to help keep drug spend down for you". At no point does the PBM tell the employer that the TRUE PHARMACY SPEND was up only 2% but the PBM created an 8% spread price on the book of business back to the employer. The employer is under the impression or is being misled, to believe the pharmacy spend increased due to the pharmacies when in fact the majority of the increase is actually directly attributed to the PBM using spread pricing. At a minimum the PBM should be required in the aggregate to show what the network of pharmacies was paid and then show what the PBM charged in spread pricing. If I look at deceptive business practices, this one comes right to the top.

I have attended board meetings' where the PBM representative clearly takes on an act of misleading or likely to mislead the customer or in this case, the employer by stating overall pharmacy spend was up by X percent. The PBM will include the spread pricing into the overall pharmacy spend. The pharmacy never directly bills the employer. The pharmacy bills and is paid by the PBM. Then the PBM turns around and creates another invoice to the employer stating the pharmacy costs were whatever they want them to be because they get to create the spread as they see fit. I could actually find you examples of employer invoices where the invoices states the charge is coming from pharmacy X when in fact the pharmacy was never paid that amount by the PBM or never sent an invoice to the employer. If that isn't deceptive and misleading, I do not know what is then. Again, if spread pricing is going to be legal, at least require the PBM to disclose the practice to the employer and break out what portion the PBM is charging on top of paying the pharmacy so the employer can make an informed contracting decision. Why do I tell you all of this? Mainly because the PBM uses the "pharmacy spend" as a way to pitch their mail order pharmacies as being cheaper and encourage employers to use mandated mail order and lock out the other pharmacies. It works too. The employer sees the charges and it appears the retail pharmacies cost more than the PBM mail order pharmacy. However the employer never knows what the pharmacy is actually paid which is often times even below what the PBM will charge the employer for their own mail order pharmacies. Doesn't look that way on paper to the employer but in reality that is what is happening! I have seen it in practice and could find someone to gather information to verify such.

Drug Rebates:

I assume the FTC will receive plenty of comments on rebates and how rebates are one of the biggest drivers for increased costs. You know the game. The drug manufacturer is asked to pay a $500 million dollar rebate to the PBM in order to keep their drug as a covered drug under the PBM drug formulary list. You and I both know the drug manufacturer is not going to eat that cost so they just move the "list price" of the drug higher to get their money back. The PBM is happy with this arrangement because the PBM bases their prescription coverage to customers off of the list price. The higher the list price, the more the employer and customer have to pay for the drugs. A patients/customers cost share is based off of the list price not the negotiated price a PBM gets from the drug manufacturer. No one ever knows the negotiated price because it is secret between the PBM and the drug company. So, who really benefits from the rebate game? The PBM!

In addition, even though a PBM will tell an employer they will pass on 100% of the rebates, it is smoke and mirrors. Here is one example of how it is all smoke and mirrors while enriching the PBM. In the largest employer contract in ND, the PBM contract language as it relates to "rebates" is listed below. This is from a publically funded group so the contract language was available to the public. In addition, I was requested to help review it for the employer.

"Rebates: means retrospective (key word) formulary rebates that are paid to the PBM or its Affiliates, pursuant to the terms of a formulary rebate contract negotiated independently and attributed to the utilization of certain covered drugs ("certain" being a key word) by EGWP enrollees under the benefit. For clarity, Rebates do not include, for example, manufacturer administrative fees, product discounts, other financial incentives OR fees related to the procurement of prescription drug inventories by or on behalf of the PBM or its Affiliates owned and operated specialty or mail order pharmacies."

Keep in mind the contract language also states the PBM will charge the employer a "formulary rebate management fee". By the time the employer gets their supposed 100%of the rebate, there is basically nothing left!

Gag Clauses:

Did you know that pharmacies are being gaged by PBMs in multiple ways? One of the most egregious gags is when a customer comes to a pharmacy to buy a prescription the pharmacist is gaged or barred from telling the customer if there is a cheaper alternative available or if it would be cheaper if the customer would pay cash for the prescription. If the customer presents their insurance card, unless the customer flat out asks the pharmacist if there are cheaper options, the pharmacist is NOT supposed to say anything to customer or risk being terminated from the PBMs contract. Talk about driving up costs for customers. There are a number of states that have legislated against gag orders of this nature with ND being one of the first to do so. Below you will find a link to an NBC investigational report that recently aired regarding gag clauses imposed upon pharmacies by the PBMs.

https://www.nbcnews.com/health/health-care/could-your-health-insurance-be-costing-you-money-pharmacy-n811171

Direct and Indirect Remuneration Fees:

Here is a fairly new revenue stream for the PBMs. A DIR fee is a fee imposed upon a pharmacy after the point of sale (after the patient has left the pharmacy counter). The PBM will tell a pharmacy in a contract that the PBM retains the right to charge a post DIR fee upon the pharmacy. The PBM does not tell the pharmacy when the fee will be imposed, which drugs it will imposed upon, how often the fee will be taken and all fees will be automatically redacted from future payments to the pharmacy by the PBM. These fees have already gotten out of hand and some pharmacies are being charged thousands of dollars after the point of sale on a retroactive monthly basis. My first question is if a customer comes in and pays $100 copayment for a drug, then after the customer leaves the pharmacy, on the following months remittance the PBM automatically takes $60 back from the pharmacy, isn't this "misrepresentation to the customer". Should their copayment have been $40 because if the PBM is

taking $60 of the $100 in a DIR fee, why was the patients copayment $100 when they were at the pharmacy?

CMS has stated that DIR fees cost taxpayers more money, pushes them into the catastrophic coverage phase sooner and the federal government has to pay 80% of the charges then. By utilizing DIR fees, it also reducing the plans (PBMs) liability and shifts the liability to the government. ND was one of the first states to pass legislation that states all DIR fees must be present at the point of sale and not done after the point of sale. Once again, we have the PBM being deceptive to the customer, employer/government and taxpayers.

There is also a federal piece of legislation attempting to address the DIR fees. Due to numerous states starting to address these DIR fees through their local legislature, the PBMs have already started to change the contract language in an attempt to side skirt state legislation and potential federal legislation. PBMs have changed the language and are now calling these fees a "patient administrative fee" or "patient participation fee" and the fee is to be collected by the pharmacy and will be automatically redacted on a future remittance of the pharmacy. Once again, they are trying to gag the pharmacist from disclosing this built in fee to the customer/patient. When the pharmacist or pharmacy asks the PBM if the pharmacy can disclose this built in fee to the customer, the PBM responds by saying "no, it cannot be disclosed to the customer or the pharmacy could be terminated from the network contract." We know of a pharmacy that has a PBMs response in writing stating the pharmacy is prohibited from disclosing the fee to the patient or anyone else for that matter.

Conclusion:

I could go on and on regarding the market failures that currently exist in the PBM market but will refrain from continuing. If you would like verification or additional information regarding any of the comments above, please let me know. It is clear that most of these unfair business practice and deceptive business practices would not even take place if the PBM industry was prohibited from being in the business of pharmacy in addition to being a PBM. Again, the PBMs are clearly involved with deception business practices, reduce competition by picking winners and losers, most of their practices lead to higher prices, customer allocation takes place under their model and they implore exclusionary exclusive dealings and contracts.

They need to be broken up. They need to decide are they a PBM or are they in the business of pharmacy. Not both! The CVS and Aetna merger will only make these market failures grow and quickly due to both of their market size. How can anyone expect a business that gets to determine the terms and condition including reimbursement rates for their competitors to be fair and just? Again, I feel the FTC needs to take a very serious look at prohibiting the PBMs from also being in the business of pharmacy. The FTC broke up the Merck/Medco (a drug company and PBM) merger over 15 years ago and it is time they consider doing the same thing with the PBM and pharmacy models that are running rampant with little to no oversight along the way. We feel the FTC should at a minimum implement certain restrictions or market conditions upon the PBMs to help stop this runaway train to the benefit of patients, pharmacies, employers and taxpayers.

Thank you for your time and attention to this very important matter. Time is of the essence.

Respectfully Submitted,

Mike Schwab