601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
C 202.450.8218
ahip.org

Matthew Eyles
President & Chief Executive Officer

May 25, 2022

Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Submitted via regulations.gov

Re: **Solicitation for Public Comments on the Business Practices of Pharmacy Benefit Managers and Their Impact on Independent Pharmacies and Consumers**

Dear FTC Chair Khan, FTC Commissioners, and FTC Staff:

Everyone should be able to get the medications they need at a cost they can afford. When drug prices are out of control, hardworking families feel the consequences every day. Health insurance providers and pharmacy benefit managers (PBMs) are Americans' bargaining power, negotiating savings for millions of patients every day. Because of our strong commitment to making prescription drugs more affordable for every American, AHIP[1] appreciates this opportunity to comment on the Federal Trade Commission (FTC) staff's Request for Information (RFI) on the Business Practices of Pharmacy Benefit Managers and their Impact on Independent Pharmacies and Consumers.

Rising costs associated with prescription drugs represent the largest segment of health care spending, accounting for more than 21.5% of commercial premiums[2] and 12% of all Medicare costs from Part D alone,[3] with Medicare prescription drug spending increasing by 3% over the previous year.[4] It is through the concerted efforts of health insurance providers, their PBMs, and other partners – e.g., to harness competition where it exists – that these costs are not even higher, as will be discussed more thoroughly in these comments. It is clear drug prices are out of control, and the problem is the price that Big Pharma, and Big Pharma alone, controls. While Big Pharma can choose to lower those prices for every American, they instead continue to raise prices year after year – even several times a year – which makes health care less affordable and accessible for everyone.

---

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and to help create a space where coverage is more affordable and accessible for everyone.
[2] https://www.ahip.org/resources/where-does-your-health-care-dollar-go. November 12, 2020.
[3] Report to the Congress: Medicare Payment Policy. MedPAC. March 2021. Available at https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch13_sec.pdf
[4] National Health Expenditures 2020 Highlights. Centers for Medicare & Medicaid Services. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

Health insurance providers are on the side of patients, negotiating lower prices to ensure access to the lifesaving medications they need. Many health insurance providers choose to contract with PBMs to add insight and leverage to their ability to negotiate with drug manufacturers who often hold monopoly power over these vital medicines and have little to no incentive to negotiate otherwise.

Through PBMs, health insurance providers gain specialized expertise on prescription drug pricing and clinical issues that they do not have themselves. They use PBM technology-based tools and programs to drive value, efficiency, and effectiveness that ensure patient access; as well as operational assistance in administering prescription drug benefits as efficiently and effectively as possible. Specific services that health insurance providers and other payer customers (such as private employers, state and municipal governments, and state Medicaid agencies) receive from PBMs in whole or in part include:

- Prescription drug claims adjudication and processing through the plan's drug benefit.
- Negotiation of pharmacy payments and manufacturer discounts, including through value-based arrangements that tie payments and discounts to clinical quality outcomes.
- Assistance with the development of formulary designs, including consultation with their own pharmacy and therapeutics (P&T) committee or in collaboration with those of their client health plans, to help enrollees obtain safe and effective medications at the best value.
- Development of pharmacy networks that drive value to patients and plan sponsors by incorporating clinical performance standards and metrics, while also negotiating contracts directly with pharmacies (including retail, specialty, and mail-order pharmacies).
- Design and implementation of consumer-driven and data-supported medication management and other innovative pharmacy programs to prevent medication errors, increase adherence, and incentivize the use of the high-value and clinically appropriate therapeutic options.
- Enrollee education services around the drug benefit and prescription drugs generally, including the availability of safe, effective, and potentially more affordable generic and/or biosimilar drugs where applicable.

Before addressing some of the specific questions posed in the RFI, we offer several overarching health insurance provider perspectives on PBMs for the FTC staff to consider:

Health insurance providers use PBMs because PBMs achieve positive results for consumers and plan sponsor clients (like employers and state governments). For example, research suggests PBMs in partnership with health insurance providers will save health plan sponsors and

consumers more than $1 trillion between 2020 and 2029 alone.[5] Other research shows PBMs help generate savings of nearly $1,000 per enrollee per year and reduce costs by $6 for every $1 spent on their services.[6]

PBMs obtain these savings by using practices that the FTC itself has indicated are pro-competitive. The FTC has recognized that "competitive forces encourage PBMs to offer their best price and service combinations to health plan sponsors in order to gain access to subscribers…including but not limited to the magnitude of any rebates the PBMs might receive, the circumstances under which those rebates will be paid, and how those rebates will be shared between PBMs and group health plan sponsors."[7] As the FTC has noted, "competition for [client] accounts is intense, has driven down prices, and has resulted in declining PBM profit margins—particularly in the large customer segment."[8] The FTC has also observed that smaller PBMs have won significant employer business "by emphasizing a transparent pricing model, providing more individualized account management support, and offering customized PBM offerings."[9] In fact, the FTC has evaluated the PBM marketplace numerous times over the years, and their findings have been consistent: PBM competition exists and it is driving down costs.[10]

Prescription drug list prices in the United States are skyrocketing, but the RFI fails to reference the stakeholders most responsible for high drug price increases – the drug manufacturers themselves. This is particularly true for those selling single-source prescription medications for which generic or biosimilar products are not yet available to create direct, clinically interchangeable competition. Manufacturers alone set their prices, which determine how much wholesalers and pharmacies pay for their drugs.

Health insurance providers and other payers, including their contracted (or integrated) PBMs, have been able to negotiate discounts or other reductions with manufacturers and the pharmacies to achieve lower net costs through various means discussed elsewhere in this response. However, despite these efforts:

- Spending on retail prescription drugs was just under $350 billion in 2020.[11]

---

[5] Pharmacy Benefit Managers (PBMS): Generating Savings for Plan Sponsors and Consumers. PCMA, Visante. February 2020. Available at https://www.pcmanet.org/wp-content/uploads/2020/02/Pharmacy-Benefit-Managers-Generating-Savings-for-Plan-Sponsors-and-Consumers-2020-1.pdf
[6] The Return on Investment (ROI) of PBM Services. Visante on behalf of PCMA. November 2016.
[7] FTC Letter to Assembly Member Greg Aghazarian, California State Assembly. September 7, 2004.
[8] Statement of the FTC Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc. April 2, 2012.
[9] *Id.*
[10] FTC Comment Before the ERISA Advisory Council of the U.S. Department of Labor Regarding PBM Compensation and Fee Disclosure. August 19, 2014.
[11] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

- As noted previously, prescription drugs represent the largest segment of health care spending, accounting for more than 21.5% of commercial premiums.[12]
- According to an analysis by the Medicare Payment Advisory Commission (MedPAC) of Medicare Part D data, prices for brand name prescription drugs net of rebates more than doubled between 2010 and 2020, with the net prices for single-source brand name drugs increasing by more than 10% annually.[13] MedPAC also found that high-priced drugs (those costing at least $700) saw net cost increases of around 25% annually during that period – well above the average rate of inflation, without changes to the products warranting such increases.
- A Congressional Budget Office (CBO) report[14] recently found that nationwide per capita spending on prescription drugs net of rebates and discounts increased from $140 in 1980 to $1,073 in 2018.

Without the efforts of health insurance providers, including through PBMs, these staggering costs would have been even greater.

PBMs' negotiations for discounts are limited most by the pricing practices of drug manufacturers – which in turn limits the savings that can be delivered to American consumers and businesses. If manufacturers were to reduce their prices for downstream stakeholders, it would reduce net drug costs and make drugs more affordable for consumers. But instead, manufacturers keep their prices high to maximize their profits at the expense of patients. In fact, drug manufacturers are currently making record profits through their record high prices – not through launching innovative new medicines, but by raising the list prices of existing products. Among the 25 biggest manufacturers, average profit margins ranged from 15-20%, according to a study by the U.S. Government Accountability Office (GAO).[15] Compare that to the 500 largest non-drug companies, which ranged from just 4-9% in that same time period.[16]

Moreover, in the latest of what is a regular bi-annual action, drug companies increased prices[17] on 785 brand-name drugs[18] in January 2022, with an average price increase of nearly 5%. We welcome future FTC scrutiny of drug manufacturers that have implemented pricing practices that are the key driver of drug costs. Their actions have been consistently shown to limit competition

---

[12] https://www.ahip.org/resources/where-does-your-health-care-dollar-go. November 12, 2020.
[13] MedPAC analysis presented at April 7, 2022 public meeting. Available at https://www.medpac.gov/wp-content/uploads/2021/10/MedPAC-DIR-data-slides-April-2022.pdf
[14] CBO: Prescription Drugs: Spending, Use, and Prices. January 2022. Available at https://www.cbo.gov/publication/57772
[15] Drug Industry: Profits, Research and Development Spending, and Merger and Acquisition Deals. Nov 17, 2017. Available at GAO-18-40
[16] *Id.*
[17] https://www.csrxp.org/csrxp-big-pharmas-business-as-usual-approach-to-january-price-hikes-underscores-urgency-for-rx-solutions/
[18] https://www.goodrx.com/blog/january-drug-price-hikes-2021/

by, among other things, engaging in so-called "shadow pricing" increases that are closely timed with price increases made by competitors, and manipulating the patent system to exclude competitors, thereby harming consumers, employers, and taxpayers in the process.[19]

Many assertions about PBMs are thinly veiled efforts by others in the supply chain to distract from their roles in increased health care costs and extract higher reimbursement and more revenue for themselves. While the FTC has repeatedly noted the pro-competitive practices of PBMs in the drug space, drug manufacturers continue to hold up PBMs as a distraction. By attempting to limit PBMs' negotiating ability, manufacturers and others in the drug distribution supply chain – including wholesalers, pharmacies, hospitals,[20] and physicians who use "buy and bill" approaches for physician-administered drugs – would have fewer checks against these abuses and far more leverage in negotiations with payers, ultimately raising costs for patients. The FTC should not give a free pass to drug manufacturers and others looking to scapegoat PBMs. Instead, the Commission should examine the entire drug distribution supply chain, including drug manufacturers, to better understand why drug prices are out of control.

FTC question on the impact of PBM rebates and fees on net drug prices to patients, employers, and other payers:

Despite the manufacturer practices referenced above, health insurance providers are committed to reducing prescription drug costs as much as possible for the enrollees they serve. And the record shows that, in partnership with PBMs and pharmacies, health plans are achieving this goal despite brand drug makers' best efforts to extract more from patients and payers.

PBM-negotiated rebates and other discounts with manufacturers and pharmacies have played a key role in helping to make prescription drugs accessible. As a business practice, rebates and discounts that buyers obtain from sellers are obviously not unique to the drug benefit industry. Negotiation of rebates between plans/PBMs and drug makers became the primary means of securing discounts for these products due to settlement of class-action litigation in 1996.[21] This action was brought by hundreds of retail pharmacies against drug manufacturers and wholesalers alleging violations of both the Sherman Antitrust and Robinson-Patman Acts.[22] To address the plaintiffs' claims and implement the terms of the settlement, drug makers, wholesalers, and

[19] Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug, Staff Report of Senate Finance Committee. Available at https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf

[20] Xiao R, Ross JS, Gross CP, et al. Hospital-Administered Cancer Therapy Prices for Patients With Private Health Insurance. JAMA Intern Med. April 18, 2022. Available at https://jamanetwork.com/journals/jama/fullarticle/10.1001/jamainternmed.2022.1022?utm_campaign=articlePDF%26utm_medium=articlePDFlink%26utm_source=articlePDF%26utm_content=jamainternmed.2022.1022

[21] See generally, In re Brand Name Prescription Drugs Antitrust Litig., No. 94-C-897, 1996 Dist. WL 167350, at *10 (N.D. Ill. Apr. 4, 1996), opinion modified on reconsideration, No. 94 C 897, 1996 WL 351178 (N.D. Ill. June 24, 1996), and rev'd, 123 F.3d 599 (7th Cir. 1997).

[22] *Id.*

others in the supply chain adopted retrospective rebating arrangements to negotiate discounts and both protect competition while avoiding the practices claimed to be Robinson-Patman violations in the case.

Drug manufacturers most commonly agree to offer rebates for certain high-cost, brand-name prescription drugs in competitive therapeutic classes where substitutions or alternative treatments are available.[23] In return for these price concessions, the manufacturers may obtain preferred formulary placement and/or limitations on the use of certain formulary tools (discussed in more detail below). As for pharmacy discounts, since PBMs and payers do not control how and from whom pharmacies (whether chain or independent) purchase their supply of drugs for dispensing at their retail settings, PBMs typically seek to negotiate contracts with pharmacies that include incentives to purchase drugs from wholesalers at the lowest acquisition prices available in their respective locations. Without pressure from PBMs to have pharmacies purchase from wholesalers at the lowest acquisition price possible, acquisition prices would otherwise be much higher, leading to higher costs throughout the system. If pharmacies were simply reimbursed for their products at their cost of acquisition, net costs to payers for providing coverage would increase significantly and be borne ultimately by enrollees, states, and taxpayers through increases in cost sharing, premiums, and subsidies, or through reductions in other benefits, depending on what a plan sponsor can afford.

Several key facts about rebates and discounts need to be considered:

1. ***Manufacturer rebates and pharmacy discounts lower the net costs to a payer, which, depending on the type of plan and sponsor, can be passed on to plan enrollees in the form of lower premiums and/or reduced out-of-pocket costs.*** By lowering net costs of subsidizing the purchase of drugs by their enrollees, rebates and pharmacy discounts allow a payer to offer coverage at lower premiums and/or to offer a richer benefit through reduced cost sharing to the enrollee. Payers (health insurance providers or plan sponsors) have the choice of how to apply those cost reductions (e.g., toward premiums, out-of-pocket, or other costs) to best meet the needs and preferences of their clients and consumers. In addition, payers and PBMs determine through contractual negotiation to what extent (if any) the PBM retains rebates and discounts as payment for services in lieu of other compensation, such as administrative fees. In this regard, we note that two of the largest PBMs (CVS Caremark and Express Scripts) previously reported that they return up to 98% and 95% of rebates, respectively, to those they serve in the commercial market.[24] In some cases, state and/or federal laws can affect these choices.

[23] A Primer on Prescription Drug Rebates: Insights into why Rebates are a Target for Reducing Prices. Milliman. May 2018. Available at A primer on prescription drug rebates: Insights into why rebates are a target for reducing prices (milliman.com)
[24] Rebate Rule Would Increase Drug Prices, Premiums, and Costs to Taxpayers. AHIP. March 2019. Available at https://www.ahip.org/documents/1P_RebateRule-v3.pdf

2. ***Rebates are a response to, not a cause of, increasing drug costs.*** Recent MedPAC research regarding rebates and discounts in the Part D program indicates that ***prices for brand name prescription drugs have far outpaced rebates, with the net prices (that is, prices after the manufacturer's rebates are subtracted) more than doubling between 2010 and 2020.***[25] Moreover, a 2019 U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) report[26] found that the rebates insurance providers and PBMs secure for seniors in Part D in fact lead to lower costs. The report included data showing, for example, that ***drug prices increased faster than rebates*** and ***many drugs actually saw declines in rebates at the same time prices rose.*** While drug manufacturers have asserted that "higher rebates mean higher prices," these ***analyses show in fact that manufacturer drug prices, rather than rebates, are the key driver of net costs.*** A report from the U.S. House of Representatives' Committee on Government Oversight and Reform further found, after conducting a thorough review of drug makers' own data on pricing, their claims that rebates increase drug prices were not supported by their own evidence.[27]

3. ***Despite the outsize focus that drug manufacturers place on rebates, most drugs do not generate rebates.*** For example, MedPAC found that in Part D, higher priced drugs in 2020 had fewer and proportionately smaller rebates than other drugs. It noted that "[p]roducers of brand-name drugs with no therapeutic substitutes or drugs that are required to be on formulary might provide no rebates or small rebates."[28] For example, significant rebates that reduced net costs for hepatitis C antivirals occurred only when competitors appeared in the marketplace.[29] Further, the MedPAC report noted that certain Part D policies such as the mandate that plan sponsors cover all (or substantially all) drugs in six protected therapeutic classes, effectively removed any incentive for manufacturers of those drugs affected to offer rebates: "… of 124 brand name drugs in protected classes, only 16 received rebates, and among those drugs, rebates averaged 14 percent of point-of-sale prices compared with 30 percent for all brand-name drugs."[30]

---

[25] MedPAC analysis presented at April 7, 2022 public meeting. Available at https://www.medpac.gov/wp-content/uploads/2021/10/MedPAC-DIR-data-slides-April-2022.pdf

[26] Rebates for Brand-Name Drugs in Part D Substantially Reduced the Growth in Spending from 2011 to 2015. HHS OIG. September 2019. Available at Rebates for Brand Name Drugs in Part D Substantially Reduced the Growth in Spending from 2011 to 2015 (OEI-03-19-00010; 09/19) (hhs.gov)

[27] Drug Pricing Investigation, Majority Staff Report, House Committee on Government Oversight and Reform. December 2021. Available at https://oversight.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf

[28] Report to the Congress, Ch. 13, The Medicare prescription drug program (Part D): Status report. MedPAC. March 2022. Available at https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch13_SEC.pdf

[29] PBMs Use Competition to Negotiate Lower Net Costs for Hepatitis C Treatments. June 2021. Available at https://www.pcmanet.org/wp-content/uploads/2021/06/hcvdrugs_Infographic.pdf

[30] *Id.*

In discussing the impact of rebates on net drug prices, the FTC should heed its own prior warnings about how widespread sharing of rebate data would effectively allow drug manufacturers to set forth price floors for their products and reduce the rebates they would otherwise be willing to pay. Efforts to require disclosure of rebate data would increase premiums and other costs borne by consumers. The FTC, which has previously analyzed this dynamic, repeatedly found that requiring these types of disclosures could lead to higher rather than lower drug prices, less aggressive pricing negotiations, and even tacit collusion among manufacturers.[31] The FTC has also noted that "**the sharing of information relating to price, output, costs, or strategic planning is more likely to raise competitive concern than the sharing of information relating to less competitively sensitive variables**."[32] (Emphasis added.) In other words, public disclosure for its own sake is not always pro-competitive – it also can be anti-competitive.

The FTC has consistently reinforced this perspective, as demonstrated by the following statements:

- "…the amount of transparency in the plan design is one dimension upon which PBMs compete for accounts" and "mandatory disclosure requirements may hinder the ability of plans to negotiate an efficient level of disclosure with PBMs."[33] The FTC has also opined that, although sometimes mandatory disclosures of price and quality information can improve how markets function, the market for PBM services is not such a market.[34]
- In most other markets, purchasers of consumer goods or services don't have this level of information about underlying costs, nor are there regulations premised on the belief that they should have this data. "Similarly, consumers of PBM services do not need to know anything about PBMs' costs to ensure they are paying a competitive price. When health plan sponsors contract with PBMs, they know the price of the services they are obtaining and can simply compare prices among competing PBMs."[35]
- "…[I]mposing unneeded and unwanted disclosures will increase heath care costs…the scope of coverage consumers receive under such plans, or the number of consumers who have access to such coverage."[36]

---

[31] FTC Comment Before the ERISA Advisory Council of the U.S. Department of Labor Regarding PBM Compensation and Fee Disclosure. August 19, 2014; and FTC Letter to Senator James L. Seward, New York Senate. March 31, 2009.
[32] Antitrust Guidelines for Collaborations Among Competitors. The Federal Trade Commission and Department of Justice. 2000.
[33] https://www.ftc.gov/sites/default/files/documents/reports/pharmacy-benefit-managers-ownership-mail-order-pharmacies-federal-trade-commission-report/050906pharmbenefitrpt_0.pdf
[34] FTC Letter to Senator James L. Seward, New York Senate. March 31, 2009.
[35] Written Testimony of Joanna Shepherd, Ph.D for the ERISA Advisory Council Hearing on PBM Compensation and Fee Disclosure. June 19, 2014.
[36] FTC Letter to Senator James L. Seward, New York Senate. March 31, 2009.

Similarly, the CBO found that PBMs obligated to provide specific pricing and rebate information to government regulators "**would find it more difficult to obtain significant price concessions and rebates from drug manufacturers**, who would be concerned that the terms of those favorable deals could be determined by competitors or other purchasers."[37] (Emphasis added.)

Lastly, when CMS explored removing the Anti-Kickback Safe Harbor for prescription drug rebates in the Medicare program and developing an alternative "chargeback" system, the agency's own Office of the Actuary estimated that a portion of negotiated discounts would essentially disappear, resulting in higher premiums along with other effects (such as increases in Medicare spending and drug manufacturer revenues).[38]

The FTC should carefully consider if PBM "reform" efforts that eliminate payer flexibility in choosing how to apply drug rebates could result in increased net costs to plan sponsors and enrollees. Currently, such flexibility allows a payer to choose based on the payer's varying payment methods, either individually or in combination, when contracting with PBMs. This allows each payer to determine the approach that fits best with its products, markets, and needs. For example, they can pay administrative fees for each service provided by a PBM (i.e., per claim adjudicated, per member per month, monthly service charge, or other fee-based service charge). Alternatively, they can use a practice often referred to as "spread pricing." In the pharmacy services payment context, this arrangement involves allowing a PBM to retain the difference between the price for a drug charged to a payer and any lower reimbursement price the PBM negotiates with a pharmacy, with the spread retained in lieu of receiving per claim fees.[39] Note that spread pricing may be prohibited or limited under state or federal law; for example, spread pricing is prohibited in Medicare Part D in determining negotiated prices and other purposes.

Payers and PBMs can also negotiate shared savings arrangements, under which a PBM may retain part of the rebates/discounts that are negotiated with brand drug manufacturers or agree to other value-based and/or pay-for-performance designs. Such innovative arrangements are being developed as data analytics advance and allow new insights into managing prescription drug benefits to drive value and reduce waste. For example, data-driven insights based on prescription drug claims, demographic factors, and applied behavioral economics tools have enabled PBMs to offer commercial plan sponsors opportunities to more tightly manage enrollees' chronic diseases, such as diabetes, inflammatory conditions, and cancer (among others) by extracting greater discounts from manufacturers of these drugs in exchange for a PBM guaranteeing maintenance of a certain percentage of medication adherence for these populations. In addition to generating

---

[37] Cost Estimate for H.R. 1 and S. 1. Congressional Budget Office. July 22, 2003.
[38] Proposed Safe Harbor Regulation Impact. CMS Office of the Actuary. August 30, 2018. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/ProposedSafeHarborRegulationImpact.pdf
[39] https://www.pcmanet.org/wp-content/uploads/2019/05/FINAL_Visante-46brooklyn-MCO-Spread-Analysis.pdf

savings on drug costs, the ability to help manage these conditions more effectively should help improve the outcomes and health of these enrollees.

In addition, focusing only on the amount of rebates passed on to clients is a myopic approach, as it provides no information about the PBM's performance on other metrics of importance to payers. And of course, it fails to assess why drug costs are so high in the first place.

The key is that health insurance providers and other payers have choices as to whether to employ PBMs to manage their drug benefits, implement innovative value-based payment programs, and determine how to pay for these services. Health insurance providers and plan sponsors are able to select among competing PBMs offering differing approaches to managing complex drug benefits to determine what arrangement best meets the needs of their enrollees.[40] They are sophisticated purchasers of PBM services and typically hire a host of independent, expert drug benefit consultants to assist in making these determinations. And conversely, PBMs must respond to client demands on behalf of their consumers – whether that means additional transparency, greater innovation, and/or improved value – or face the potential for significant loss of business.

Accordingly, eliminating the choice of payers to use spread pricing would reduce competitive options. It can ultimately lead to higher net costs under substitute payment arrangements (e.g., through higher administrative fees) that can harm plan sponsors' ability to stretch their health care dollars to offer more generous benefits for their enrollees.[41]

Efforts to constrain how payments from PBMs to pharmacies are calculated or that mandate a minimum level would also increase net costs, resulting in higher premiums or reduced benefits. Some states require that PBMs "guarantee" full reimbursement at cost for pharmacies, with proponents using certain benchmarks, such as Average Wholesale Price (AWP) or National Average Drug Acquisition Cost (NADAC) to determine cost. Moreover, even if such benchmarks might be reliable cost indicators for brand-name drugs[42], they do not accurately reflect actual acquisition costs for generic drugs by retail pharmacies.[43] In fact, some selected drugs have extreme differences between AWP and pharmacy acquisition costs.[44] Such approaches ignore the fact that plans must already ensure payments are sufficient to incent sufficient participation by pharmacies or risk failure of providing clients and enrollees an adequate pharmacy provider network. Interfering with the ability of plans and their contracted PBMs to determine payments that most cost effectively provide access to drugs without a means

[40] The PBM Marketplace is Highly Competitive. PCMA. Available at https://www.pcmanet.org/wp-content/uploads/2019/04/Competitive-PBM-Marketplace.pdf
[41] *Id.*
[42] However, some data sets in fact do raise reliability issues. For example, concerns are consistently raised around the response rate and variability in NADAC data.
[43] *Id.*
[44] *Id.*

to incent more price-sensitive product acquisitions by pharmacies would add significant costs that would be passed through to consumers.

FTC question on the impact of PBM rebates and fees on formulary design and patients' ability to access prescribed medications:

Prescription formularies are lists of drugs covered by a health plan. For a small percentage of prescription drugs, formularies may include utilization management tools to protect patients by saving costs, promoting safety, and preventing waste. Such tools may include quantity limits, step therapy, and prior authorization criteria, and often include "tiered" designs that apply different levels of enrollee cost-sharing for drugs in each tier.

Payers maintain responsibility for choosing formularies for their enrollees that are adequate and meet any state or federal requirements. They often work with PBMs in developing the design and operation of formularies to optimize benefits, while always retaining the final decision on their form and use.

Multiple layers of protections ensure that formulary design and utilization management processes are clinically appropriate and that enrollees are able to access the medications they need. These practices are heavily regulated by state and federal laws such as utilization management (UM) licensure requirements in most states, along with extensive auditing and other requirements by plans and/or client sponsors, including the Medicare and Medicaid programs. For example, Medicare Part D requires formularies to include at least two drugs within each therapeutic category and class (if at least two such products are available) and requires substantially all drugs to be covered in six classes of clinical concern. In addition, most PBMs also undergo rigorous independent accreditation from national accrediting bodies to ensure these services are offered at the highest quality.

Subject to applicable statutory and regulatory restrictions, formularies are typically developed and reviewed by a P&T committee which may be provided by the payer itself or by the PBM. While all P&T committees may function slightly differently and can also be subject to specific state or federal requirements, generally most are composed of clinical experts from different medical specialties. They focus on reviewing (i) clinical evidence in determining if certain drugs (whether new, or newly approved by the Food and Drug Administration (FDA) to treat different conditions other than those under the terms of its original drug application) are appropriate for inclusion in a plan formulary, and (ii) clinical appropriateness of practices and policies of formulary management activities. P&T committees make formulary decisions based on scientific evidence and clinical standards of practice. In Medicare Part D, CMS also allows P&T committees to take into account studies related to pharmacoeconomic considerations that achieve appropriate, safe, and cost-effective drug therapy.

For therapeutic drug classes that have multiple drugs with comparable clinical effectiveness as determined by the P&T committee, such as generic versions of brand drugs or multiple brand drugs (such as statins for treating high cholesterol), health insurance providers (often through their contracted PBMs) can use tiering and other formulary tools to offer a comprehensive benefit that provides access to safe and effective medication at the lowest possible cost based on list prices and potential discounts that PBMs are able to negotiate with drug manufacturers. For example, most Medicare Part D plans use a five-tier formulary with differential cost sharing between preferred and non-preferred drugs, and a specialty tier for high-cost drugs.

It is in this context that PBM-negotiated rebates with drug makers can affect formulary design. Negotiated rebates encourage competition among manufacturers offering therapeutic alternatives, providing favorable coverage for the drug that is lowest net cost based on determinations of clinical appropriateness by P&T committees. Thus, manufacturer rebates play a critical role in the formulary placement for certain drugs (generally brand drugs with therapeutic alternatives) by reducing plan costs. However:

- *The net cost and not the availability of rebates is the key driver.* Even for brand drugs that generate rebates, in most cases available generics will have a preferred formulary position. This is because in most cases there are many competing generic drugs with prices substantially lower than the brand drug makers' net costs (even though the generics do not generate rebates). Due to the intense competition among generic drug makers, plans and PBMs have almost always preferred them over rebated brand drugs in their formularies. Accordingly, this is the main reason why the generic fill rate among all health plans in the United States is 90%, at only 20% of the cost of brand name equivalents.[45]
- *Rebates do not impact clinical assessments made by P&T committees regarding appropriate coverage and management tools.* Formulary designs must be clinically appropriate and ensure access to drugs that meet patient needs. Most P&T committees are expressly forbidden from taking drug costs into consideration when making formulary recommendations. Plans and PBMs then ultimately make their decisions taking costs into account where competing treatment options allow for this consideration.
- *Enrollees who have clinical needs that can only be met by off-formulary drugs or those on a high-cost-sharing tier have the ability to obtain exceptions that enable them to get coverage at the more favorable cost-sharing amount*. While the exact processes may vary between Medicare, Medicaid, and commercial health plans, formularies provide pricing incentives to choose the most cost-effective and clinically appropriate therapies. Enrollees are never "forced" by formularies to substitute drugs. The ability of a pharmacy to substitute one drug for another prescribed by a clinician depends on state pharmacy

[45] 2020 Generic Drug & Biosimilars Access and Savings in the U.S. Report. Association for Accessible Medicines. Available at https://accessiblemeds.org/resources/reports/2020-generic-drug-biosimilars-access-and-savings-us-report#:~:text=At%20a%20time%20when%20access,only%2020%25%20of%20the%20cost

laws. Generally, unless substitutions involve therapeutically equivalent generic drugs, any changes could require clinician authorization, and in any case, patients ultimately have the choice of whether to receive a substitute. Moreover, processes for enrollees to request formulary exceptions are also available if they seek to use a brand drug over a generic or other alternative, provided their prescribers provide clinical reasons for the need.

In summary, PBM negotiated rebates and discounts are often critical to enhancing enrollee access to drugs. They allow plans to develop formularies that offer lower premiums and out-of-pocket costs and improve patient safety. At the same time, state and federal laws around formulary development and appeals processes ensure formularies have adequate breadth, are based on clinical evidence, and provide exceptions when necessary.

FTC question on PBMs' policies and practices related to specialty drugs and pharmacies:

Criteria for designating specialty drugs. Specialty drugs do not have a federal, standardized regulatory definition universally applicable to all publicly or privately sponsored health insurance products.[46] This is because it would be inappropriate to attempt to shoehorn such a diverse – and ever-evolving – line of prescription drug products into a simple categorization. Such limitations would likely inhibit access for existing specialty drugs and could hamper efforts to rein in the costs of products yet to be introduced to market through manufacturer gaming of such definitions, or their safe dispensing to patients.

Generally speaking, several criteria help identify "specialty drugs," though all do not need to be present for a medication to receive that designation. Among these characteristics are:

- They typically cannot be dispensed at a retail (i.e., "brick and mortar") pharmacy due to sophisticated storage and handling needs for the product, such as super-cold chain temperature maintenance, non-exposure to light, or prevention of excessive shaking/handling. Such requirements may be imposed by the manufacturer and/or FDA, and compliance with them involves capital-intensive facilities and resources, i.e., specialty pharmacies, that specialize in meeting such conditions.
- Specialized dispensing and/or administration needs along with clinical care monitoring above and beyond the prescriber's obligations are often necessary – and may even be required by federal regulation. These include providing patient support and collecting clinical data necessary for compliance with FDA-imposed Risk Evaluation and Mitigation Strategies (REMS) programs that may also require significant post-marketing

[46] The term is sometimes confused with drugs that are available on a "specialty tier," which is typically determined based on drug cost (Medicare typically sets an annually adjusted threshold based solely on drugs whose cost is $670 or more per 30-day supply). While many specialty drugs are high cost and are placed on specialty tiers, many other specialty tier drugs do not require special handling or other requirements, and thus are not specialty drugs.

surveillance for efficacy and/or adverse events. Alternatively, given the cost and storage/handling requirements necessary for a particular drug, a manufacturer may simply decide it is in its best interests to limit distribution of their product to specialty pharmacy providers they have determined are best capable of dispensing them safely.

- Manufacturers also sometimes choose to enter into exclusive distribution arrangements with a specialty pharmacy. In such a case, shipment from that provider can be the only way to obtain the drug and competing specialty pharmacies may have to purchase those products from industry rivals.
- Specialty drugs are typically among the most expensive medications available. Preventing compromise/loss of these products are critical objectives for both the specialty pharmacy and manufacturer.

Coverage. P&T committees use clinical evidence to determine coverage of specialty drugs, subject to any additional requirements or limits imposed by law. Once covered, many are likely placed on specialty tiers since typically they are high-cost drugs. Utilization management tools such as prior authorization or step therapy may be applied based on clinical appropriateness. At the same time, most specialty drugs face little, if any, competition from alternatives in their same therapeutic class. Accordingly, rebates are not typically available to reduce net costs or influence formulary design.

The use of specialty pharmacies is a pro-competitive, innovative response to a lack of competition among manufacturers and rising drug prices that also improves the quality and safety of pharmacy care services provided to patients. PBMs and specialty pharmacies voluntarily undergo accreditation at great expense and with significant dedication of resources with multiple nationally recognized accreditation bodies. This is because the market demands they meet the highest quality and safety standards to patients, in addition to helping plans, states, and the Federal government afford to care for the nation's most vulnerable individuals. PBMs and plans similarly require specialty pharmacies and their mail order/home delivery pharmacies to maintain their respective pharmacy accreditations regardless of any ownership relationship.

As noted, most specialty drugs lack comparably effective, competitive drugs in their respective therapeutic classes and thus manufacturers have no incentive to offer rebates. Most are also biologics. While biosimilar product approvals offer the hope of greater competition – and eventually, rebates/discounts – current biosimilar products approved in the U.S. market generally lack interchangeability status with the originator product (which can only be granted by FDA). This has inhibited the potential for achieving substantially greater savings for biologic drugs. Moreover, drug manufacturers continue to abuse the patent system through patent extensions/evergreening, product hopping, pay-for-delay of market competitors, and other anti-competitive drug manufacturer practices. AHIP urges the FTC to continue its efforts to prevent such manipulative practices that only delay patient access to these potentially miraculous, novel treatments due to high prices.

Within this environment, specialty pharmacies introduce pro-competition elements in several respects. For example, specialty pharmacies can receive volume discounts on purchases of products in bulk. While such discounts may be modest, they can help payers and consumers by making the drugs more affordable and therefore accessible to greater numbers of patients.

More significantly, just as mail order/home delivery pharmacies (whether owned by PBMs/other vertically integrated entities or not) have introduced competition for pharmacy services with traditional retail pharmacies that have given consumers added convenience and cost savings for filling their regularly taken medications, specialty pharmacies also provide an alternative channel for patients and payers to disrupt traditional dispensing of physician-administered (specialty) medications through "buying and billing" practices. By way of background, for physician-administered drugs (i.e., those which a patient may not be able to self-administer such as infusion or other injectable medications), the long-standing payment practice has been for a prescriber to purchase and store these products at their practice/clinic/hospital pharmacy and then bill the insurance provider for both the drug and the service of administering it to the patient. This practice is known as "buying and billing," and is typically much more expensive than dispensing through specialty pharmacies.

Under this buy and bill system, Medicare reimburses the physician the full average sales price (ASP) of the drug being administered, and then pays an additional 6% of that drug's price as compensation for storing, dispensing, and administering it to the patient. For example, if the average sales price for specialty drug is $1,000 per dose, then the full Medicare payment to the clinician is $1,060 including the service fee. Other health insurance providers commonly have similar systems of pricing based on a specific benchmark plus administrative services.

The buy and bill payment methodology raises significant concerns because prescribers administering these medications are fully reimbursed for their drug acquisition cost and are therefore insensitive to purchasing these products at the lowest available prices. Further, since payment for their services is based on a percentage of the drug acquisition cost, the higher that medication's price, the more they are paid for their administration services to the patient. This could provide incentives for some physicians to prescribe more expensive drugs than are needed in order to obtain higher service fees.

Moreover, various studies have documented hospital/physician drug pricing markup abuses under the buy and bill system, including:

- JAMA Internal Medicine (2021): The median negotiated prices for the 10 drugs studied ranged from **169% to 344% of the Medicare payment limit.**[47] The largest variation in markup came from Remicade, an IV drug that treats a range of autoimmune conditions – the median rate paid by commercial insurers at Mayo Clinic's hospital in Phoenix was more than 800% of the Medicare rate.
- Bernstein (2021): This analysis found that some hospitals mark up prices on more than two dozen medicines by **an average of 250%.**[48] For example, hospitals were found to charge up to **five times the purchase price** for Epogen, which is used to treat anemia caused by chronic kidney disease for patients on dialysis, and **4.6 times the price** for Remicade, a rheumatoid arthritis medication. According to the analysis, administering treatments to commercially insured patients is **20 times more profitable** than administering the same drugs to Medicare patients. The analysis also showed hospitals have been slow to begin using biosimilars, which are nearly identical to brand-name biologic treatments and produce the same health outcome, but at a much lower cost.
- Health Affairs (2021): This study examined the 2019 prices paid for by Blue Cross Blue Shield plans for certain drugs administered in hospital clinics versus provider offices. The study found the prices paid for hospital outpatient departments were **double** those paid in physician offices for biologics, chemotherapies, and other infused cancer drugs (99-104% higher) and for infused hormonal therapies (68% higher). Blue Cross Blue Shield plans would have saved **$1.28 billion, or 26 percent of what they actually paid**, if the insurance provider had all patients receive their infusions in a provider's office instead of hospital clinics.[49]
- AHIP (2022): This analysis comparing drug claims data for drugs in specialty pharmacies, physician offices and hospitals found that costs per single treatment for drugs administered in hospitals (2018-2020) were an average of $7,000 more than those purchased through pharmacies. Drugs administered in physician offices had costs on average $1,400 higher than those from pharmacies.[50]

Markups on the price of the drug noted above are **in addition to** the amounts hospitals separately bill insurance providers for the professional services required to administer the drugs.

---

[47] Feldman WB, Rome BN, Brown BL, Kesselheim AS. Payer-Specific Negotiated Prices for Prescription Drugs at Top-Performing US Hospitals. JAMA Intern Med. 2022. Available at https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2785833

[48] How much? Hospitals mark up some medicines by 250% on average. Silverman; STAT. Jan. 20, 2021. Available at https://www.statnews.com/pharmalot/2021/01/20/hospitals-biosimilars-drug-prices/

[49] James C. Robinson, Christopher M. Whaley, and Timothy T. Brown. Price Differences To Insurers For Infused Cancer Drugs In Hospital Outpatient Departments And Physician Offices. Health Affairs. September 2021. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00211

[50] Hospital Price Hikes: Markups for Drugs Cost Patients Thousands of Dollars. AHIP Research. February 16, 2022. Available at https://www.ahip.org/resources/-2

Specialty pharmacies have disrupted these egregious buy and bill practices. They directly ship these drugs, where clinically appropriate and safe to do so, that are to be administered to the patient by the clinician to the provider's location shortly before the day of administration. This approach, often referred to as "white bagging" or "alternative sourcing," disrupts the buy and bill process by allowing health insurance providers and plan sponsors to remove the drug's purchasing cost from the reimbursement arrangement and focuses payment on the quality of care provided by the physician in administering the drug. Patients and payers have saved substantially on the cost of obtaining these critically important medications and services, but hospital and physician associations have launched legislative initiatives in numerous states attempting to prohibit such practices.

In sum, the conditions of the specialty pharmacy market are not anti-competitive, and indeed are the most competitive element in the movement of these goods from (often monopolist) manufacturers to (often price-insensitive) providers. In fact, innovations in delivery by specialty pharmacies have introduced competition to dispensing these drugs that result in substantial savings for patients and payers.

FTC question on potential conflicts of interest and anticompetitive effects arising from horizontal and vertical consolidation of PBMs with insurance companies, specialty pharmacies, and providers:

As noted previously in this comment letter, the FTC and Department of Justice (DOJ) have recognized the competitive forces affecting the PBM industry, including the intense competition for clients and the way such competition has driven down costs.
The DOJ also recently assessed potential anticompetitive effects relating to horizontal and vertical PBM consolidation in the context of several specific mergers. In those cases, they noted various factors that indicated why such consolidations did not have anticompetitive effects. For example:

- In addressing concerns in one proposed merger,[51] the DOJ found that "Because insurance companies and customers have PBM and pharmacy options, the consolidated entity in the proposed merger cannot dictate unfavorable terms without risk of losing a substantial number of customers." Key insights from the DOJ's analysis included the following:
    - The DOJ explained that insurance providers (not PBMs) set out-of-pocket costs for enrollees, and insurance providers (not PBMs) set benefit designs. The DOJ concluded: "These are important facts that bear on [a vertically integrated insurance provider's] ability to foreclose rival insurers…"

[51] United States Supplemental Brief in Support of Entry of the Proposed Final Judgment, U.S. et al. v. CVS Health Corp., et al., 1:18-cv-02340 (D.D.C. June 21, 2019). Available at https://www.justice.gov/atr/case-document/file/1131901/download

  - The DOJ noted that "while the PBM market may be unfamiliar to consumers, it is not 'opaque' to insurance companies such that they cannot determine the pricing of terms in their PBM services contracts."
  - The DOJ further observed that the insurance provider at issue "would not have an incentive to foreclose [a rival insurance provider] because [the insurance provider] would lose a profitable PBM customer and would not be able to offset the lost profits by capturing additional health insurance customers."
  - In addressing concerns about PBM/pharmacy consolidation in that same proposed merger, the DOJ noted that the level of competition in the pharmacy and PBM industry would give other clients of a PBM alternative options to use if a vertically consolidated PBM did not offer competitive pricing.

- In another proposed merger, the Department of Justice Antitrust Division determined that a proposed insurance provider/PBM consolidation "is unlikely to result in harm to competition or consumers."[52] In particular, the DOJ noted that merger is unlikely to enable the insurance provider to increase costs to rivals "due to competition from vertically-integrated and other PBMs." Instead, the DOJ observed that an increase in PBM prices to rivals "likely would result in the merged company losing PBM customers and not result in [the insurance provider's] gaining a sufficient volume of additional health insurance business to offset the loss of PBM customers."[53]

In addition, in past decisions not to oppose mergers of PBMs, integration with retail and specialty pharmacies, and even health insurance providers, the FTC and/or DOJ has recognized how such consolidations provide opportunities to integrate disparate services efficiently to increase the value proposition of health insurance and leverage the resources of the constituent companies into a new entity.[54,55] Again, vertical consolidation is not, in and of itself, problematic. Integration has allowed, among other things, enhancement of disease management and care coordination programs health insurance providers have demanded and various Congresses and multiple administrations have also championed. For example, integrated organizations may be able to more effectively share data involving medical and/or prescription drug claims and demographic information to help detect trends such as hospitalizations caused by potentially wasteful prescribing/drug administration practices; better coordinate post-acute

[52] Statement of the Department of Justice Antitrust Division on the Closing of Its Investigation of the Cigna–Express Scripts Merger. September 17, 2018. Available at https://www.justice.gov/atr/closing-statement
[53] *Id.*
[54] The Proposed Acquisition of Medco Health Solutions, Inc., by Express Scripts, Inc. FTC. April 2, 2012. Available at https://www.ftc.gov/legal-library/browse/cases-proceedings/closing-letters/proposed-acquisition-medco-health-solutions-inc-express-scripts-inc
[55] Cigna Corporation; Express Scripts Holding Company. FTC. September 17, 2018. Available at https://www.ftc.gov/legal-library/browse/early-termination-notices/20180981

care and ease transitions across patient settings (e.g., post-operative procedure to in-home care/recovery); and otherwise improve management of health care and improve quality.[56,57] DOJ examined the transactions that created these vertically integrated entities and deemed their creation to be "unlikely to result in harm to competition or consumers."[58] In addition, in at least one of those transactions, DOJ specifically considered the types of conflict-of-interest issues raised in the FTC's question here. DOJ concluded that some entities already had in place sufficient measures to mitigate such risks with existing internal businesses (e.g., by using/installing "firewalls" between client accounts and operations) accordingly, and that no additional conflict mitigation requirements were necessary – or imposed – as a condition of allowing the combination to proceed.[59]

In summary, health insurance providers, PBMs, and other industry stakeholders need to respond to their clients' demands for capabilities to help defray health care costs, stretch their benefit dollars, and improve patient outcomes. If leveraging such vital resources under a "single roof" achieves those objectives, it reflects a pro-competition response to competitive dynamics in a complex, evolving set of markets.

These analyses correctly highlight that the specific facts and competitive dynamics in the PBM, insurance and pharmacy industries all need to be carefully considered – both separately and in combination – to assess the impacts of specific proposed consolidations. The analyses referenced appropriately recognized how assessments of the cost, quality, and performance of services provided by PBMs, the desired level of transparency offered regarding both the operation of the drug benefit and compensation structure, along with whether enrollee care and outcomes achieve promised goals, are all components of a highly complex and dynamic market structure that provides incentives for parties – whether consolidated or not – to obtain the combination of high-quality and low-cost services that best meet their competitive needs.

With regard to market dynamics, it is also important to highlight one specific industry that has repeatedly raised concerns about PBMs: independent pharmacies. Undoubtedly, there have been changes in the distribution chain from manufacturer to consumers that involve far more significant influences and factors than actions taken by PBMs to drive value in that part of the

---

[56] Cigna And Express Scripts Deal: Virtues Of Vertical Integration. Joshua Cohen; Forbes. Oct 3, 2018. Available at https://www.forbes.com/sites/joshuacohen/2018/10/03/cigna-and-express-scripts-deal-virtues-of-vertical-integration/?sh=c46a236a0b98

[57] Cigna Customers with Connected Pharmacy and Medical Benefits Are More Active in Improving Their Health, Leading to Lower Medical Costs. Cigna Corporation. November 20, 2017. Available at https://www.businesswire.com/news/home/20171120005579/en/Cigna-Customers-Connected-Pharmacy-Medical-Benefits-Active

[58] Statement of the Department of Justice Antitrust Division on the Closing of Its Investigation of the Cigna–Express Scripts Merger. September 17, 2018. Available at https://www.justice.gov/atr/closing-statement

[59] United States Supplemental Brief in Support of Entry of the Proposed Final Judgment, U.S. et al. v. CVS Health Corp., et al., 1:18-cv-02340 (D.D.C. June 21, 2019). Available at: https://www.justice.gov/atr/case-document/file/1131901/download

patient care space. Regional retail pharmacy chains have become national retail pharmacy providers; and "big box" stores, grocery chains, and online sellers have also entered the space and have substantially altered the traditional retail pharmacy industry.[60,61] These developments reflect a healthy expansion of competitive options for consumers that increase the quality of care provided to patients while also reducing patient costs. Even so, there are tens of thousands of independent pharmacies.

Despite those changes and other market developments, recent research by the National Community Pharmacy Association (NCPA), a trade association representing independent pharmacies, shows that both their members' prescription and overall pharmacy profit margins remain stable at roughly 21%.[62] Further, independent pharmacies represent 34% of all retail pharmacies in the U.S. as of 2021, maintaining that 1/3 proportion of recent years. These data completely undermine claims that PBM practices are "putting them [i.e., independent pharmacies] out of business."[63,64] Ultimately, these observations and acknowledgments by critics of PBMs only reinforce instead why the FTC should consider the myriad of factors influencing drug prices and look beyond the efforts of one self-interested stakeholder to enhance their clients' bargaining position within it at a substantial cost to plan sponsors and patients.

Simply put, the robust market for the provision of PBM services to health insurance providers continues to function well, and health insurance providers have the option of purchasing from a variety of PBMs – some of which share ownership with an insurance provider and some of which do not. Health insurance providers have, for years, provided consumers with the benefit of competing models. Many markets offer the options of plans with integrated delivery systems, plans with some owned providers and some contracted providers, and plans with only contracted providers. The variety of relationships between health insurance providers and PBMs reflects the same trend. Health insurance providers will continue to compete to offer the best products to consumers. Such competition includes a variety of approaches, including pro-competitive vertical integration focused on reducing overall healthcare costs. Consumers have, and will continue to, benefit from such variety, innovation, and competition.

******

[60] Competition, Consolidation, and Evolution in the Pharmacy Market. Elizabeth Seeley, Surya Singh. The Commonwealth Fund. August 12, 2021. Available at https://www.commonwealthfund.org/publications/issue-briefs/2021/aug/competition-consolidation-evolution-pharmacy-market
[61] CVS Pharmacy Downsizes: 10 Industry Trends Driving the Retail Shakeout. Adam Fein; Drug Channels Blog. December 1, 2021. Available at https://www.drugchannels.net/2021/12/cvs-pharmacy-downsizes-10-industry.html
[62] Five Things to Know About the State of Independent Pharmacy Economics. Adam Fein; Drug Channels Blog. February 15, 2022. Available at https://www.drugchannels.net/2022/02/five-things-to-know-about-state-of.html
[63] NCPA Releases 2021 Digest Report. NCPA. October 11, 2021. Available at https://ncpa.org/newsroom/news-releases/2021/10/11/ncpa-releases-2021-digest-report
[64] NCPA Releases 2020 Digest Report. NCPA. October 19, 2020. Available at https://ncpa.org/newsroom/news-releases/2020/10/19/ncpa-releases-2020-digest-report

In closing, AHIP urges the FTC to be as transparent as practicable in terms of releasing the full findings, including underlying analyses, from this study upon its completion. To do so will help lawmakers and consumers better understand the issues in their totality, including areas of disagreement or uncertainty. Again, AHIP is grateful for this opportunity from the FTC to weigh in on the positive, critical impact that the use of PBMs by health insurance providers has had in helping patients afford their needed medications. Please contact Sergio Santiviago at ssantiviago@ahip.org if you have additional questions, and we are eager to assist you further as you consider how to proceed on evaluating these issues further.

Sincerely,

Matthew Eyles
President & Chief Executive Officer