April 25, 2022

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

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

On behalf of the West Health Policy Center, I am pleased to respond to the Federal Trade Commission's (FTC's) solicitation for public comments regarding Pharmacy Benefit Managers (PBMs). West Health is a non-profit, non-partisan family of organizations dedicated to reducing the cost of healthcare to enable successful aging, and reducing the cost of prescription drugs is one of our key areas of focus.

Our comments focus on the important role PBMs play in reducing net drug prices for patients, employers, and federal payers. Specifically, given the monopoly and oligopoly composition of the market for branded pharmaceuticals, we believe PBMs play a critical role in reducing net drug spending across all payers. While the FTC's request for comment rightly highlights concerning aspects of the PBM business model relative to contracts with employers and limits on patient access, we encourage the FTC to remain cognizant of the possibility that, given the unique nature of the pharmaceutical market, reduced PBM market concentration may result in higher total drug spending. Notably, the pharmaceutical market is currently bifurcated into two markets, brokered by PBMs: first, a market between drug manufacturers and PBMs, and second, a market between PBMs and payers, which include both employers and individual patients as well as government programs like Medicare Part D. This second market, between PBMs and payers, has two different regulatory regimes: one for Medicare Part D insurance plans and one for non-federal insurance plans, which is mostly comprised of employer-sponsored insurance. Given this structure, we highlight the importance of PBM consolidation in achieving price reductions from drug manufacturers in the first market while noting differences in PBM practices in the secondary Medicare Part D and commercial insurance markets that can result in difference net prices for payers. Finally, we describe how extending regulatory practices from the Part D market to the commercial market can promote competition and lower spending on pharmaceuticals for all patients.

Bilateral Oligopoly Markets – Pharmaceutical Manufacturers and PBMs

In the branded pharmaceutical market, there are few therapeutic areas with a significant number of complementary therapies and even fewer with truly substitutable therapies, ensuring that each therapeutic market is either a monopoly or oligopoly. In these markets, the profit incentives tend toward tacit collusion between the limited producers. As the Department of Justice (DOJ) notes, there are two market equilibria in these market types – either 1) producers all coalesce around publicly-listed prices that reflect the marginal cost of production, or 2) producers all coalesce around the monopoly public price and negotiate non-public discounts.[1] The reason the latter equilibria occurs stems from the

[1] https://www.justice.gov/sites/default/files/atr/legacy/2007/09/28/221873.pdf

relative attractiveness of each producer as a negotiating partner with buyers – buyers prefer to negotiate with the producer with the highest public list price, as they can always default to the producer with the lower public list price if discount negotiations with the first producer do not yield a lower price. Because this favors initial negotiations with the highest-priced producer, all producers have an incentive to match the highest price and attempt to shift buyer negotiations to their product. Therefore, the incentive for manufacturers to increase list prices exists regardless of PBM concentration so long as any buyer, including federal purchasers, is permitted to negotiate discounts from the posted price.

This second equilibria is more likely than the first so long as buyers have differing levels of negotiating opportunities and associated transaction costs, as not all buyers will be able to negotiate to the marginal cost of production and therefore producers will be able to capture surplus. As succinctly put by the DOJ: "Buyers without bargaining opportunities transact at posted price, while buyers with bargaining opportunities pay a discounted price and enjoy more surplus. Surplus is then lower for every buyer and supplier profits are higher (positive) as compared with the equilibrium in which suppliers post price at marginal cost." The pharmaceutical market clearly reflects this trend – buyers without bargaining opportunities, namely the uninsured and smaller purchasers, transact at the posted list prices, while larger organizations with more bargaining opportunities effect lower prices. The magnitude of these discounts, though, largely depends on the relative bargaining power between the monopoly/oligopoly producer(s) and the buyer. When producers are able to increase supply (i.e., the drug is not in shortage), larger buyers are able to negotiate larger discounts through volume commitments. If the buyer market is more fragmented, however, buyer discounts will be lower, as committable volume is lower. Under these precepts, a consolidated PBM market will be more effective in negotiating lower prices from consolidated pharmaceutical manufacturers than a diffuse PBM market. This bilateral oligopoly competition is more efficient that a unilateral oligopoly that extracts near-monopoly prices.

Unilateral Oligopoly Markets – PBMs and Employers

Though consolidated buyers are more efficient in negotiating with oligopoly manufacturers, in the prescription drug market, these consolidated buyers are not themselves the final purchaser of the drug. This yields a second market where PBMs are now the oligopoly sellers, faced with diffuse buyers – a mix of insurance plans and employers who contract with insurers to administer plan benefits. Here the dynamics are reversed, and the consolidation of PBMs creates an imbalance of market power. Yet two separate equilibria have been achieved: in the Medicare Part D market, regulation has resulted in nearly 100 percent rebate pass-through for consumers,[2] while in the commercial insurance market, PBMs retain a significant portion of the savings they negotiated with pharmaceutical manufacturers.[3] This demonstrates that under an appropriate regulatory framework, PBM market consolidation can benefit consumers, suggesting avenues for policy reform in the commercial market.

The Medicare Part D program requires plans to estimate their total costs in advance and uses this estimation to establish premiums, which are publicly known to Medicare beneficiaries as they shop for their plans. Medicare beneficiaries have a strong preference for lower premiums, creating a market with intense price competition; indeed, annual average premiums fell from 2017-2020 in Medicare Part D[4]

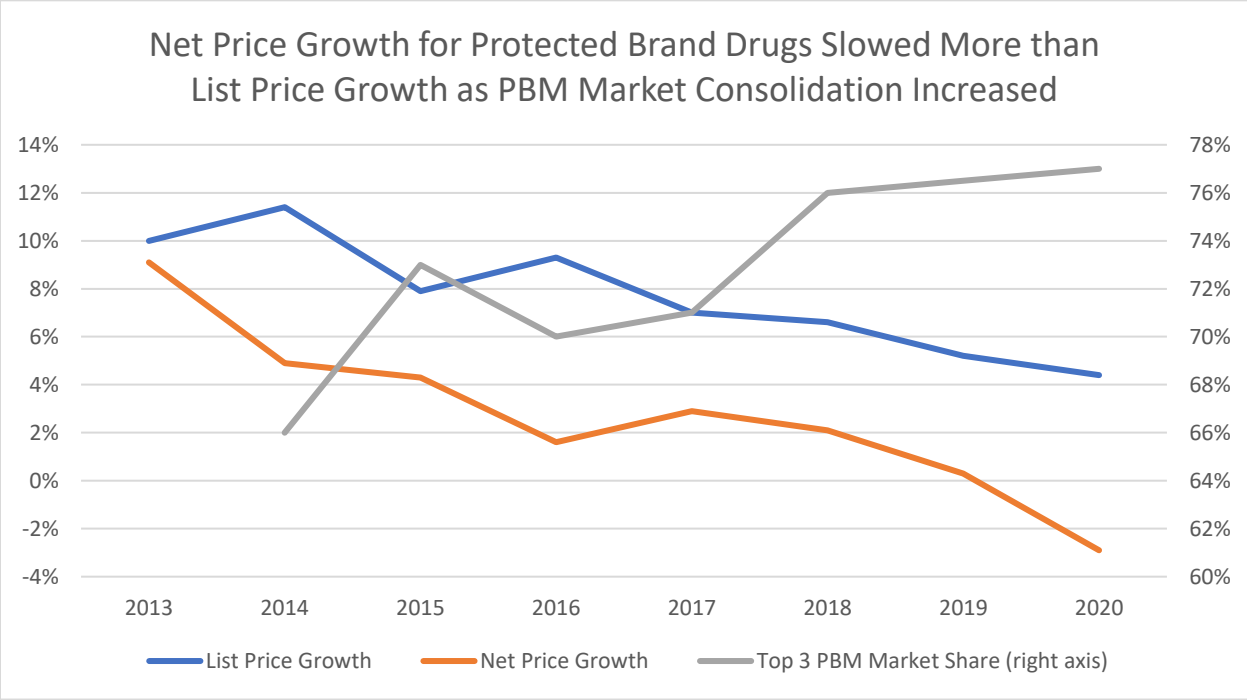
[2] https://www.gao.gov/assets/gao-19-498.pdf
[3] *Id.*
[4] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data

while commercial market premiums (which also include medical benefits) increased by 12% over this period.[5] The Part D premium estimation process is highly-regulated, including a requirement that all PBM rebates be included in estimating total costs; indeed, multiple studies by the Government Accountability Office and the Department of Health and Human Services Office of Inspector General have found that PBMs pass through over 99 percent of rebates to plans.[6] This requirement, coupled with the clear transparency around premium costs, demonstrates that a consolidated PBM market can generate substantial reductions in total drug spending.

In contrast, transparency about both prospective and net drug costs is limited in the commercial insurance market, particularly for employers who self-fund insurance and contract with insurers and PBMs to administer benefits. PBMs have confirmed in interviews with federal investigators that, in the commercial market, they retain a portion of rebates negotiated from manufacturers due to the discrepancy in negotiating power between employers and PBMs.[7] Moreover, in employer-funded coverage, there is little consequence to inaccurate prospective estimation of total pharmaceutical spending over the coming year, as the PBM is not at financial risk for mis-estimating premiums when claims are paid by the employer. In these markets, the relative consolidation of PBMs without any regulation that requires them to disclose their net costs means there is less open competition on premium costs – a substantial difference from the Part D market.

This does not mean, however, that total drug spending is higher in the commercial market than it would be absent PBMs. The chart below shows that net price growth for protected brand prescription drugs has slowed as PBM consolidation has increased. While this declining growth is in the net price realized by the manufacturer and not necessarily the net price realized by employers and beneficiaries, it demonstrates the success of large PBMs in negotiating discounts with manufacturers. Policies that reduce PBMs' ability to negotiate with manufacturers could reverse this trend, increasing spending on prescription drugs at a faster rate.

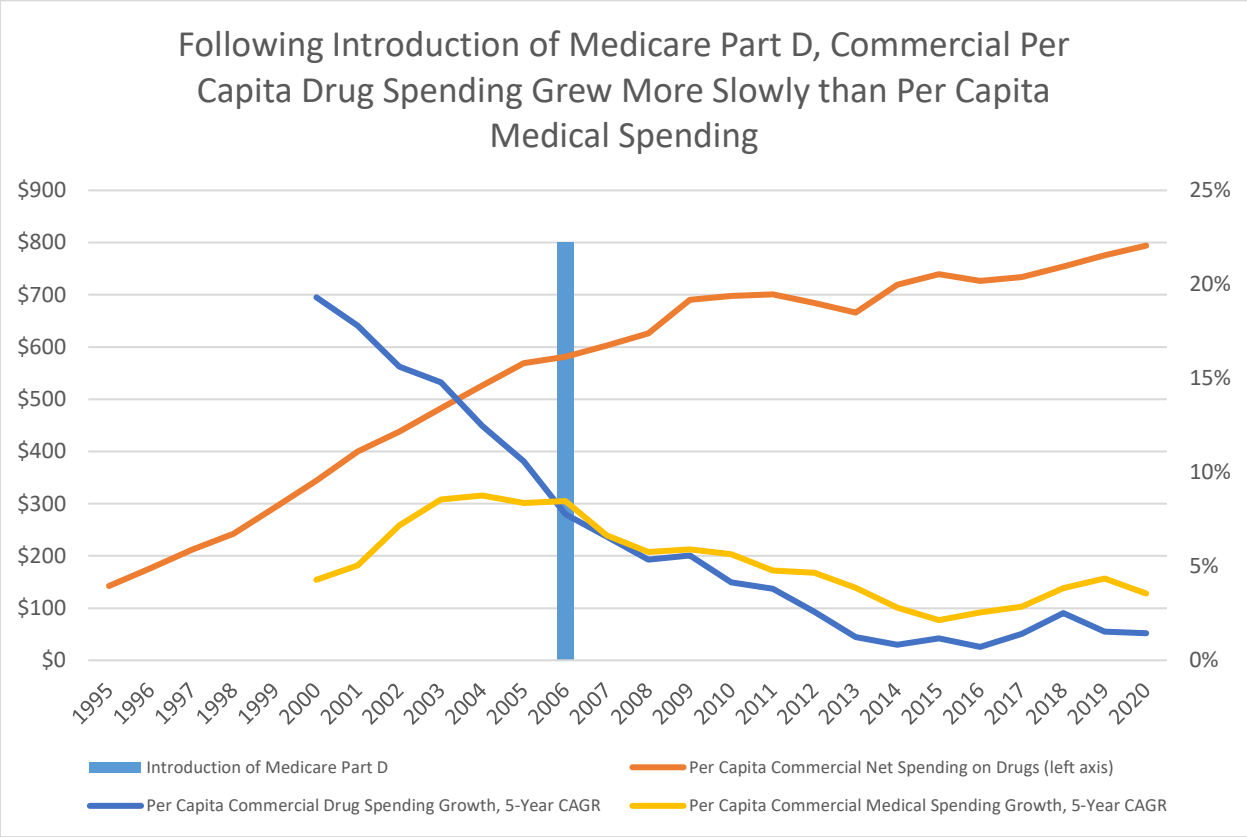
[5] https://www.kff.org/report-section/ehbs-2021-section-1-cost-of-health-insurance/
[6] *Id.*, https://oig.hhs.gov/oas/reports/region3/31800007.pdf; https://oig.hhs.gov/oas/reports/region3/31800006.pdf
[7] https://www.gao.gov/assets/gao-19-498.pdf



List and net price data from IQVIA, PBM market share data from drugchannels.net. Net price is the price realized by the manufacturer and is inclusive of non-commercial discounts, including Medicaid rebates and 340B discounts. PBM market share data for 2019 was imputed based on 2018 and 2020 data.

These reductions in net prices appear to have benefited commercial insurance payers, as show in the chart below. Prior to 2006, net per-capita spending on pharmaceuticals in the commercial market was growing faster that spending on medical services, driven by the launch of blockbuster drugs in the 1990s. However, following the introduction of Medicare Part D in 2006, net spending on prescription drugs grew at a lower rate than medical spending. While this declining growth can be attributed in part to increased use of generics,[8] the creation of a robust PBM market under the Medicare Part D benefit appears to have had spillover effects in the commercial market, increasing PBMs' ability to negotiate lower drug prices and to encourage utilization of lower cost therapies (including generics). In recent years, as the PBM market has consolidated, net pharmaceutical spending growth has slowed further and maintained its lower growth rate compared to medical spending, suggesting that commercial payers are benefiting from PBM negotiations.

[8] https://www.cbo.gov/system/files/2022-01/57050-Rx-Spending.pdf



Spending data from National Health Expenditures; per capita amounts estimated using number of individuals under 65 with commercial insurance from National Health Interview Survey.

Recommendations

The Solicitation for Comments highlights many areas of concern in PBM-payer relationships, including anticompetitive contracting practices and vertical integration with pharmacies, that deserve attention. However, any reforms that weaken PBMs' negotiating power with pharmaceutical manufacturers may result in overall drug spending increases that outweigh savings from reforms. Specifically, we recommend:

- Policies that maintain or increase PBMs' negotiating power with pharmaceutical manufacturers
- Reforms that strengthen employers' negotiation power with PBMs
- Extending transparency requirements on PBM rebate and fee data in Part D to the commercial market
- Promoting generic utilization to ensure a robust generic marketplace that can generate greater price reductions over time

To that end, reforms which strengthen employers' negotiating relationship with PBMs will help ensure that a larger portion of drug price reductions flows to patients and employers rather than to PBMs, reducing overall drug spending. Reforms that promote the transparency around rebates, fees, and net estimated drug costs – akin to those in Medicare Part D – can encourage greater competition between PBMs for employers' business, lowering spending. And reforms that ensure generic products can fairly

compete with brand products for formulary placement will generate greater price competition in the long run through a healthy generic marketplace, outweighing short-term savings from brand manufacturers increasing rebates in the face of generic competition to drive out lower-cost options. But these reforms will have only minimal impact if PBMs' negotiating position with manufacturers is significantly weakened, as manufacturers will continue to wield monopoly and oligopoly prices that increase spending.

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West Health appreciates the opportunity to comment on this solicitation. We strongly support reforms that reduce spending on prescription drugs and commend the FTC for its attention to the role of PBMs in prescription drug pricing. We hope that our comments are helpful as you consider these questions. If we can provide any technical assistance or support, please contact Sean Dickson at sdickson@westhealth.org.

Sean Dickson, JD MPH
Director, Health Policy
West Health Policy Center
sdickson@westhealth.com