Pharmacists United for Truth & Transparency

January 9, 2023

**RE: Unfair or Deceptive Fees Trade Regulation Rule Commission Matter No. R207011**

To the Honorable Lina Khan & FTC Commissioners,

Pharmacy benefit managers (PBMs) are the middlemen of the pharmacy industry. They dictate prescription drug pricing and fees, and stand between patients and their medications. PBMs have been mostly unregulated and able to operate without scrutiny - and have developed a complicated prescription drug environment to allow themselves to go mostly unchecked and able to get away with many anticompetitive practices.

PBM deceptive pricing and fees in the pharmacy environment is a major problem. Excessive fees harm patients by artificially driving up prices. They harm small business pharmacies by reducing payments to the pharmacy and forcing pharmacies to endure unfair corporate business practices at the expense of their patients, who they are entrusted to serve.

**PBM Copay Clawbacks**

While there are many examples of unnecessary fees imposed by PBM middlemen plaguing the pharmacy industry, the practice of copayment clawbacks is a starkly clear example of fee abuse. It is also one of the easiest examples to see and understand.

The anatomy of a copay clawback:

A pharmacy customer picks up a filled prescription at the pharmacy. Before the prescription is dispensed to the patient, the pharmacy must adjudicate that prescription claim through a middleman (the PBM).

The pharmacy contract with the PBM dictates:

- the reimbursement the pharmacy will receive for dispensing that medication;
- the transaction fees that must be paid by the pharmacy to adjudicate that claim (although many of these transaction fees are not clearly defined and may be changed without negotiation by the pharmacy benefit manager- another area of hidden/unfair fees), and;
- that the pharmacy must collect the copayment passed through the pharmacy to the patient. The pharmacy contract with the pharmacy benefit manager is crystal clear that the copayment may not be waived or discounted. It must be collected in full.

The patient pays the full copayment at the point of sale, as their agreement states in their health plan contract and is spelled out in their benefit design. The patient's expectation is that the full

copayment (or their financial responsibility portion of the prescription transaction), is offsetting a portion of the total expense of the medication that their health plan is responsible for. There is no expectation nor disclosure to the patient that the copayment has been inflated, allowing the middleman (the PBM) to “claw back” a portion of the copayment.

The balance due to the pharmacy is paid at a later date by the pharmacy benefit manager. **The PBM then “claws back” or withholds from the pharmacy reimbursement adjudication a previously undisclosed amount, which in some cases is more than the copayment itself; resulting in a net loss to the pharmacy.**

This practice hurts small business pharmacies because the many hidden and unexpected additional reductions are taken from the reimbursement checks. Cash flow is stifled, and unexpected costs are pushed back onto the small pharmacy. Patients who learn of the clawback become angry with the pharmacy, not realizing the pharmacy could not deter the process.

Everyone loses - the patient, the health plan payer (usually the patient’s employer), the pharmacy - except the PBM, who neatly profits.

**DIR Fees and Clawbacks**
DIR (Direct and Indirect Remuneration) is a catch-all term that covers the monies a Medicare Part D plan and/ or its managing PBM may collect to offset member costs. Originally a performance metric designed to incentivize plan sponsors for improved health outcomes, DIRs are now involuntary “concessions” made by pharmacies that produce free-flowing revenue streams for PBMs.

DIR fees come in numerous forms, including penalties and other charges often unknown to the dispensing pharmacy. DIRs are assessed as a “clawback” - the pharmacy doesn’t “pay” the PBM, the PBM deducts these fees directly from the pharmacy’s bank account or by reducing future reimbursements without notice - weeks or months after the initial transaction. DIR fees can also take the form of service fees, network access fees, administrative fees, reconciliation fees, etc.

**By contrast, copay clawbacks occur when a patient’s copay is higher than the price of the medication, whether the patient is using a commercial or federally-funded plan.** The pharmacy collects the patient’s copay, and the PBM “claws back” the money over and above the contracted reimbursement, and keeps that money as profit.

If gag clauses - which are clearly anti-consumer - are illegal, why wouldn't DIR fees, which are both anti-consumer AND anti-taxpayer, also be illegal?

PBMs use arbitrary and opaque DIR fees to derive record profits at the expense of pharmacies, plan sponsors, and most importantly, patients. The lack of transparency surrounding DIR fees allows PBMs to clawback money from the pharmacies, without any indication to the pharmacy of related measures that would allow a pharmacy to plan accordingly.

Currently, DIR fees are not adjudicated at the point of sale, meaning the pharmacy lacks knowledge of if, when, and how much a DIR fee on a prescription may be. This lack of understanding inhibits pharmacists' ability to implement new patient care services as they do not know what their reimbursement will be and if they will be able to afford to provide new services.

**Transaction Fees Assessed on Pharmacies**
These types of hidden fees drive up the cost of prescriptions and offer no benefit in exchange.

PBMs charge “nickel and dime” transaction fees on standard practices necessary to the pharmacy’s operations - e.g. submitting claims for payment, appealing claims, etc. These fees can average as much as $30,000 per year or more for some pharmacies and are required as part of the PBM contract.

Transaction fees are paid to the “switch” - the ostensibly independent entity that routes the prescription from the pharmacy to the plan payer. Recently UnitedHealth purchased Change Healthcare, a “switch” company, and CVS and Express Scripts share ownership in Surescripts, another “switch” entity, meaning the 3 largest PBMs in the U.S. with an estimated 80% combined market share, now also have access to private information transmitted from pharmacies (see more about the issue of PBMs, health plans and firewalls below).

These fees work against all non-PBM owned/affiliated pharmacies, and often total as much annually as a pharmacy technician’s salary. Because these types of fees especially work against pharmacies with larger prescription volume, consuming revenue that could be used to fund additional staff or investment in pharmacy care services for patients means patients are at risk of losing the opportunity for improved quality of care and therapeutic outcomes.

If PBM practices including spread pricing (adding markup to a drug’s price in order to profit from the health plan payer), drug maker rebates and reimbursing pharmacies below drug acquisition cost are the “meat and potatoes” of PBM revenue, “transaction” fees (e.g. charging pharmacies to submit claims for reimbursement, appeals, check cost share or drug cost for patients etc), network certification / recertification, and other miscellaneous nickel-and-diming of providers are the “gravy money”.

**Network and “Recertification Fees”**
Finally, we recommend the FTC review monitor the certification / recertification fees and requirements PBMs place on network pharmacies, which are often more onerous than most states’ Board of Pharmacy would require. Because the largest PBMs own brick-and-mortar retail stores; mail order, infusion and other types of specialty pharmacies, it is in their interest to erect barriers to entry for community and grocery store pharmacies. High certification / recertification fees and demanding network entry paperwork or other requirements can be difficult for newer pharmacies to navigate, ultimately affecting patient access and their right to choose their pharmacy provider.

Pharmacists United for Truth & Transparency

**Conclusion**

We believe the FTC must use Section 18 of the FTC Act, 15 U.S.C. 57a, to stop this practice in pharmacy, and in the many examples offered in the background section of the proposed rulemaking request.

Respectfully submitted,

Deborah Keaveny, RPh
President
Pharmacists United for Truth and Transparency

Monique Whitney, MBA
Executive Director
Pharmacists United for Truth and Transparency