PBMS: THE MIDDLEMEN WHO DRIVE UP DRUG COSTS

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Ensuring effective competition in healthcare markets is a critical priority for antitrust enforcers. Traditionally enforcement has focused on manufacturers and providers but far too little attention has been given to intermediaries such as Pharmacy Benefit Managers ("PBMs"). A lack of attention and enforcement has permitted a highly concentrated PBM market to evolve in which PBMs prevent transparency and exploit conflicts of interest to raise costs and deny necessary low-cost drugs and services to consumers. This article outlines how these problems have arisen and how the FTC can conduct a comprehensive study to spotlight the market failures and need for enforcement and regulation.

I. INTRODUCTION

In the past two decades, the Federal Trade Commission has taken a lax approach to Pharmacy Benefit Managers ("PBMs"), the middlemen in prescription drug markets. This has led to tremendous concentration, significantly higher prices, restricted consumer access, and a variety of abusive practices. PBMs transformed from "honest brokers" supposedly negotiating with drug companies to obtain lower costs for insurers and patients into oligopolists using the rebates they extract from drug manufacturers and pharmacies to enrich themselves.

The FTC is now considering conducting a study of PBM practices under Section 6(b) of the FTC Act. This study, which is long overdue, can provide the public with greater insight into PBMs' drug pricing practices, anticompetitive behavior, rebate contracts with drug manufacturers, and onerous contracts with independent pharmacies.

The PBM industry has avoided antitrust scrutiny for far too long. In sum:

- Lax antitrust enforcement has allowed the three largest PBMs to become vertically integrated and form a tight oligopoly.[2] As a result, the PBM market lacks the essential elements for a competitive market: (1) choice, (2) transparency, and (3) a lack of conflicts of interest. PBMs leverage this lack of competition to further their own interests at the expense of patients, payors, employers, unions, and pharmacists.[3]

- The PBM rebate system turns competition on its head with PBMs seeking higher, not lower, drug prices to maximize rebates and profits. **In the past decade, PBM profits have more than doubled and increased to $28 billion annually**.[4] PBMs are supposed to control costs, but because of the perverse incentives the rebate system creates, they frequently deny access to lower cost drugs to maximize rebates available from higher cost drugs.[5] That is why major consumer and patient groups and unions supported the past administration's efforts to eliminate the anti-kickback safe harbor for PBM rebates.[6]

- These middlemen increasingly stifle competition from this country's most accessible and trusted health care professionals – community pharmacists. PBMs create endless schemes to reduce reimbursement, claw back funds, restrict networks, and effectively force pharmacies to provide drugs below cost. **In 2020 alone, PBMs took $9,535,197,775[7] from independent pharmacies who serve Medicare Part D participants**. Community pharmacies are crucial for patients in underserved low-income and rural neighborhoods. These unfair and coercive tactics by PBMs result in inferior health care, less choice, and higher costs.

For the PBM market to function properly for patients, employers, unions, and other stakeholders, we need greater antitrust and consumer protection enforcement. This article elaborates on these harms and concludes with some recommendations to the FTC on how to design its 6(b) study.

II. THE PBM MARKET IS BROKEN

PBMs represent themselves as "honest brokers" or intermediaries between drug manufacturers, health insurers, plan sponsors, and providers. Although PBMs, in theory, have great potential to control prescription drug costs, over time their role has evolved, and they now engage in self-dealing and anticompetitive behavior. Two of the three largest PBMs are in the Fortune 10 and all three in the Fortune 15.[8]

2 *Reforming Biopharmaceutical Pricing at Home and Abroad*, The Council of Economic Advisors, White Paper, February 2018, https://trumpwhitehouse.archives.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf.

3 *How PBMs Make Drug Pricing Problem Worse*, David Balto, August 31, 2016, The Hill, https://thehill.com/blogs/pundits-blog/healthcare/294025-how-pbms-make-the-drug-price-problem-worse/.

4 PBM Accountability Project, *Understanding the Evolving Business and Revenue Models of PBMs*, 2021, https://www.pbmaccountability.org/_files/ugd/b11210_264612f6b98e47b3a8502054f66bb2a1.pdf?index=true.

5 Charlie Grant, *Hidden Profits in the Prescription Drug Supply Chain*, February 24, 2018, Wall Street Journal.

6 Comments of Consumer Action, Consumer Federation of America, Consumer Reports, NETWORK Lobby for Catholic Social Justice, and Public Research Interest Group PIRG in Support of Department of Health and Human Services Office of Inspector General's ("HHS") proposed new rules to eliminate the safe harbor for rebates in Medicare Part D plans, April 8, 2019, https://docs.wixstatic.com/ugd/1859d0_c7d2ccf1d47d4f65a8965e9bbaed989d.pdf.

7 Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency, CMS 4192-F, https://public-inspection.federalregister.gov/2022-09375.pdf.

8 Fortune Rankings, https://fortune.com/fortune500/2021/search/.

Patients pay higher prices for drugs than they should because PBMs are not fulfilling their cost-control function. Unreasonably high out-of-pocket costs force some patients to stop or delay treatment, which hurts patients individually and society as a whole.[9,10]

The PBM market is broken because it lacks the essential elements for a competitive market, namely: (1) choice, (2) transparency and (3) a lack of conflicts of interest.[11]

First, a lack of choice. According to the Council of Economic Advisors ("CEA"), three PBMs – CVS Caremark, Optum Rx, and Express Scripts – control over 80 percent of the market, "which allows them to exercise undue market power against manufacturers and against health plans and beneficiaries."[12] **Indeed, the three largest PBMs have a higher gross margin than any other players involved in the drug supply chain,[13] and in recent years, more of the increase in spending on brand medicines has gone to payers, including PBMs and health plans, than to drug manufacturers**.[14] It is hard to see what value these middlemen have added to our healthcare system in return for their skyrocketing profits.[15]

Second, a lack of transparency. PBM operations are cloaked in secrecy, and they fight tooth and nail against efforts to require transparency. Consider "gag clauses," which PBMs have long used to prevent pharmacists from telling consumers about available lower-cost alternative medications. While Congress finally prohibited PBMs from imposing such clauses, there was simply no pro-consumer reason to deny consumers the necessary information to receive drugs at a lower cost.[16] None.

Even sophisticated buyers are unable to secure specific drug-by-drug rebate information. PBMs prevent payors from auditing rebate information. As the Council of Economic Advisors observed, the PBM market lacks transparency as "[t]he size of manufacturer rebates and the percentage of the rebate passed on to health plans and patients are secret."[17] Without adequate transparency, plan sponsors cannot determine if the PBMs are fully passing on any savings, or whether their formulary choices really benefit the plan and subscribers.

Third, numerous conflicts of interest. PBM rebate schemes create a clear conflict between the PBM, the payor, and patients. All else equal, payors and patients generally prefer the lowest cost drug. But according to a recent Senate Finance Committee Report, "PBMs have an incentive for manufacturers to keep list prices high, since the rebates, discounts, and fees PBMs negotiate are based on a percentage of a drug's list price – and PBMs may retain at least a portion of what they negotiate."[18] PBMs have gone so far as to require additional payments in the event of any reduction in manufacturer list prices.[19,20]

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9 Press Release, Kaiser Family Foundation, *Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age* (Mar. 1, 2019), https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/.

10 Leigh Purvis & Stephen W. Schondelmeyer, *Brand Name Drug Prices Increase More Than Twice As Fast As Inflation in 2018*. AARP Public Policy Institute, November 2019, https://press.aarp.org/Brand-Name-Drug-Price-Increases-2018-Rx-Price-Watch?intcmp=AE-POL-TOENG-TOGL.

11 "*Protecting Consumers and Promoting Health Insurance Competition*," Testimony of David Balto, Before House Judiciary Committee, Subcommittee on Courts and Competition Policy, October 8, 2009, at http://www.dcantitrustlaw.com/assets/content/documents/CAP/protecting%20consumers.pdf.

12 CEA White Paper, *supra* note 2. The Top Pharmacy Managers of 2021, the big get even bigger, Drug Channels, April 2022, https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html.

13 Charley Grant, *Hidden Profits in the Prescription Drug Supply Chain*, February 24, 2018, Wall Street Journal, https://www.wsj.com/articles/hidden-profits-in-the-prescription-drug-supply-chain-1519484401#:~:text=Drug%20distributors%20converted%2046%25%20of,benefit%20from%20higher%20drug%20prices.

14 Brownlee A., *The Pharmaceutical Supply Chain*, 2013-2020, Berkeley Research Group, January 2022, https://www.thinkbrg.com/insihts/publications/pharmaceutical-supply-chain-2013-2020/; Van Nuys K, Ribero R, Ryan M., *Estimation of the Share of Net Expenditures on Insulin Captured by U.S. Manufacturers, Wholesalers, Pharmacy Benefit Managers, Pharmacies, and Health Plans from 2014 to 2018,* JAMA Health Forum, 2021, https://doi.org/10.1001/jamahealthforum.2021.3409.

15 PBM Accountability Project, Understanding the Evolving Business and Revenue Models of PBMs, 2021, https://www.pbmaccountability.org/_files/ugd/b11210_264612f6b98e47b3a8502054f66bb2a1.pdf?index=true.

16 On October 10, 2018, President Donald Trump signed into law the "Know the Lowest Price Act of 2018" and the "Patients' Right to Know Drug Prices Act of 2018".

17 CEA White Paper *supra* note 2.

18 Senate Finance Committee. *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, 2021, https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf.

19 Sagonowsky, E., UnitedHealthcare demands drug rebates even if pharma cuts list prices: analyst, February 2019, https://www.fiercepharma.com/pharma/letter-to-pharmas-unitedhealthcare-seeks-to-protect-drug-rebates-from-price-reductions.

20 Avalere. (July 20, 2021). "Some Part D Beneficiaries May Pay Full Price for Certain Generic Drugs." https://avalere.com/insights/some-part-dbeneficiaries-may-pay-full-price-for-certain-generic-drugs. In some instances, generic drugs and biosimilars are covered on brand-drug formulary tiers in Medicare Part D instead of a generic, which causes patients to pay for the full cost of their medicine and after learning of this, patients will then purchase more expensive branded drugs because their copays will be less.

Insured patients suffer because they pay the higher list price until they meet the deductible, and then pay co-insurance or co-pays based off the higher list prices. Uninsured patients must simply pay the higher list price.[21]

Conflicts of interest also abound because PBMs are vertically integrated with health insurers, mail order operations, specialty pharmacies, and in the case of CVS, the largest retail and specialty pharmacy chain, and the dominant long-term care pharmacy. All three PBMs own their own specialty pharmacies, which they favor, discriminating against rival pharmacies. These PBMs steer patients to their own pharmacies as a requirement for patients to access their full prescription benefit. And all three PBMs are owned by or affiliated with the three largest insurance companies – United, Aetna, and Cigna. How can they offer fair contracts to their clients when they have a vested interest in driving traffic to their own providers, pharmacies, and insurers? The fox is guarding the henhouse, and the FTC needs to ensure that patients are not paying the price in less choice, inferior service, and higher prices.

III. PBMS' DEMAND FOR REBATES RESULTS IN PATIENTS NOT HAVING ACCESS TO THE MOST EFFICACIOUS AND AFFORDABLE MEDICINES

In pursuit of higher rebates, PBMs routinely exclude certain drugs from their formularies or require prior authorization for drugs that may be best for a patient's condition, even in cases where a more efficacious medication is available. As Robin Feldman, a professor at UC Hastings College of Law, puts it, "the system contains odd and perverse incentives, with the result that higher-priced drugs can receive more favorable health-plan coverage, channeling patients toward more expensive drugs."[22] Uninsured patients face higher prices and insured patients pay higher coinsurance or pre-deductible out-of-pocket costs when list prices rise.[23]

IV. PBMS USE THEIR MARKET DOMINANCE TO HARM COMMUNITY PHARMACIES

PBMs engage in a long list of egregious, unfair, and abusive practices that harm community pharmacies. Consider direct and indirect remuneration ("DIR") fees, a term advanced by the Centers for Medicare & Medicaid Services ("CMS") to ensure that Medicare Part D sponsors and PBMs accurately report rebates and other "price concessions" from manufacturers or other third parties which could not be reasonably determined at the point-of-sale. Because the government is the ultimate payor of prescription drugs under Medicare Part D plans, it wants to know exactly how much Part D and Medicare Advantage drugs cost the plans so the government does not reimburse them too much.

PBMs use DIR fees to claw back money from pharmacies, sometimes more than a year after a medication has been dispensed. After accounting for these fees, some pharmacies are reimbursed for less than their acquisition cost of the drug, meaning that they actually lose money on filling that prescription. That, of course, is financially untenable. No pharmacy would sign on to this agreement unless it had no choice. The foundation for these fees is the inflated price points and unattainable performance established by PBMs. The fact that these fees skyrocketed from practically nothing to over $9 billion demonstrates the PBMs market dominance over pharmacies.

V. LAX ANTITRUST ENFORCEMENT OF THE PBM INDUSTRY HAS LED TO WIDESPREAD ANTI-COMPETITIVE CONDUCT

The U.S. antitrust agencies have effectively placed PBMs in a regulatory free zone. Past leadership at the Department of Justice Antitrust Division ("DOJ") and the FTC have failed to take any meaningful enforcement actions, while permitting massive consolidation and anti-consumer practices. The FTC knew that PBMs "gagged" pharmacists from telling consumers of lower-priced alternatives, yet the FTC did not act. As authors from the Institute for Local Self Reliance have observed:

21 Testimony of Robin Feldman, U.S. Senate Committee on Commerce, Science, & Transportation, Sub Committee on Consumer Protection, Product Safety, & Data Protection, "Ensuring Fairness & Transparency in the Market for Prescription Drugs, May 5, 2022, https://www.commerce.senate.gov/services/files/37DB7CA0-F3FA-4D99-84C0-9C2697F913E3.

22 Robin Feldman, *Why Prescription Drug Prices Have Skyrocketed?*, Washington Post, November 26, 2018, https://www.washingtonpost.com/outlook/2018/11/26/why-prescription-drug-prices-have-skyrocketed/.

23 *American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs*, U.S. Department of Health and Human Services ("HHS"), May 14, 2018, pg. 17.

> The FTC was designed to be a forward-thinking agency that would use its investigatory and rule-making authority to stamp out unfair methods of competition and protect the less powerful from fraud and abuse. But the FTC has been quick to dismiss concerns about the impact of concentration on small independent businesses. The agency has presided over an increasingly consolidated economy and has repeatedly embraced vertical integration despite evidence that such industry structures invite self-dealing and inflict harm on small businesses and the communities they serve.[24]

Ten years ago, the FTC faced a critical decision – whether to approve the merger of two of the three largest PBMs – Express Scripts and Medco. Despite strong opposition from employers, unions, pharmacists and consumer groups, and dozens of congresspersons who raised significant competitive concerns, the FTC approved the merger. The Commission statement is illustrative of its misguided views.[25] The Commission suggested that there were ten competitors in the market, yet by this point its list looks more like a list of fossils – a record of firms that have since been acquired or exited the market. The Commission also suggested the concerns of pharmacies were unfounded because they "negotiate" contracts with PBMs, but no one with any business sense would suggest those are anything more than take it or leave it arrangements. The merging parties suggested that the country would benefit from the larger, merged firm driving down drug prices. The real result was skyrocketing drug prices, rebates, and massive profit increases.

Unfortunately, the FTC decision to green light the *ESI-Medco* merger led to a flood of additional PBM mergers, as the major PBMs devoured their smaller rivals and specialty pharmacies. None of these transactions were challenged by the FTC, yet the underlying structural factors were far worse.

The lack of FTC merger enforcement is only one example of how the FTC failed to address PBM misconduct. When states recognized the rampant consumer protection concerns and proposed legislation to regulate deceptive and anti-consumer conduct of PBMs, FTC staff sided with the PBMs, suggesting that "economic theory" teaches that PBM-pharmacy and PBM-drug manufacturer relationships result in lower prices and that regulation would harm consumers.[26] For example, in the past, the FTC consistently opposed PBM transparency even though both Republican and Democratic administrations have advocated for healthcare transparency. In many cases, the FTC staff has relied on an outdated 2005 FTC mail order study, which Commissioner Julie Brill acknowledged was "antiquated."[27] Ultimately, many states rejected the FTC advocacy and adopted state regulations, but the broad statements in the FTC's own advocacy hamper the ability of states or federal regulators to engage in meaningful PBM regulation.

One of the reasons previous FTC advocacy and nonenforcement has missed the mark is that it has focused on the wrong set of consumers – payors rather than patients. With the vertical integration of the three largest PBMs with an insurer, lowering cost for insurers by sharing rebates does not directly equate to lower prices for patients taking prescription drugs. Under the current system, vulnerable patients are left to pay artificially high prices when their cost sharing is tied to the undiscounted list price of a medicine, rather than the lower net price the PBMs and insurers pay. And uninsured patients are in an even worse predicament. That is why consumer groups and unions supported reform of PBM rebates in the prior administration and continue to call for change.

The lack of enforcement has harmed pharmacies, and this has a direct impact on patients. Patients place tremendous value on their access to community pharmacies. Community pharmacists are consistently ranked as our most trusted health care professionals. And community pharmacies are often the most accessible form of health care services in underserved rural or inner-city markets. Community pharmacies provide essential advice and healthcare monitoring especially for patients taking specialty drugs. Yet despite receiving hundreds of complaints from community pharmacies for the egregious and deceptive actions by PBMs, the FTC has never brought a single enforcement action.

And because antitrust agencies have allowed PBMs to vertically integrate with insurers, mail order operations, and pharmacies, PBMs have financial incentives and the necessary market power to steer patients to their affiliated services.[28] Since PBMs have their own pharmacies

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24 Stacey Mitchell & Zach Freed, *How the FTC Protected the Market Power of Pharmacy Benefit Managers*, February 19, 2021, Pro Market, https://www.promarket.org/2021/02/19/ftc-market-power-pharmacy-benefit-managers/.

25 Statement of Commission Concerning Proposed Acquisition Medco Health Solutions and Express Scripts, Inc., FTC File No. 111-0210, April 2, 2012, https://www.ftc.gov/sites/default/files/documents/public_statements/statement-commission-concerning-proposed-acquisition-medco-health-solutions-express-scripts-inc./120402expressmedcostatement.pdf.

26 FTC Press Release, *FTC Staff: Mississippi Bill That Would Give State Pharmacy Board Authority Over PBMS Likely Would Increase Prices*, March 22, 2011, https://www.ftc.gov/news-events/news/press-releases/2011/03/ftc-staff-mississippi-bill-would-give-state-pharmacy-board-authority-over-pbms-likely-increase.

27 See Commissioner Brill's Letter to the ERISA Advisory Council, August 19, 2014, available at https://www.ftc.gov/system/files/documents/public_statements/579031/140819erisaletter.pdf.

28 Vertical Integration Isn't Great for Health Care Consumers or Purchasers, PURCHASER BUSINESS GROUP ON HEALTH (Aug. 23, 2021) available at https://www.pbgh.org/despite-claims-vertical-integration-isnt-great-for-health-care-consumers-or-purchasers/.

(indeed the largest pharmacy chain, CVS, owns the second largest PBM) PBMs frequently access rival pharmacy patient data and provide it to their pharmacy affiliate in an effort to steer patients away from rivals. Patients may be forced into PBM-owned mail order or 1-800 specialty pharmacy operations that provide an inferior level of service to competing community pharmacies and specialized pharmacies like AIDS Healthcare Foundation pharmacies.[29] Or the PBMs may engage in egregious auditing practices to harm rival pharmacies.

PBMs "offer" independent pharmacies "take it or leave it" contracts, where a pharmacy must choose between accepting unfavorable reimbursement terms, or exclusion from the PBM's network (and patient population). In some cases, pharmacies are coerced into agreeing to below-cost reimbursement. This unsustainable choice has forced many pharmacies to close their doors.[30] This has caused what has been characterized as "pharmacy deserts" and has disproportionately harmed rural and urban African American and Hispanic populations that now lack pharmacies because PBMs have driven the independents out of business, but these PBMs do not put new pharmacies in these locations and instead they steer patients to mail order or long distance driving.[31] This is a significant problem for these vulnerable patients, because many times their community pharmacists were the most accessible providers.[32] The FTC has heard these concerns but has chosen not to take any action to prevent PBM predatory behavior designed to eliminate pharmacy competition.

VI. RECOMMENDATIONS TO THE FTC IN DESIGNING ITS 6(B) STUDY

In designing its 6(b) study, the FTC needs to take a broad approach, including qualitative evidence (as opposed to a narrow focus on market shares, for example), while keeping impact on patients front and center. We strongly encourage the following key steps:

First, the FTC needs to determine the impact of PBM practices on actual consumers, not just payors. Actual consumers are the patients. To this end, the study should account for patient cost, choice, convenience, and service. It is critical for the FTC to consider how PBM conduct harms patients.

Second, the study should evaluate how PBMs have the power to steer patients to affiliated services and simply exclude independent pharmacies from their networks altogether, limiting patient access and choice. Indeed, after CVS and Caremark merged in 2007, there were allegations that CVS Caremark, the PBM arm, used its PBM business to steer patients to CVS retail pharmacies over independent pharmacies.[33]

Third, the FTC needs to study PBMs' rebate contracts with manufacturers. PBMs have a great deal of control in the construction of formularies, and manufacturers pay rebates for preferred position on the formularies. Not only does this practice lead to higher prices, but some branded drugs, generics, and biosimilars are excluded from formularies, which results in patients not being able to obtain more affordable and efficacious drugs.

Fourth, a broad study is necessary to capture allegations of widespread fraudulent and deceptive practices. PBMs are reducing reimbursements to independent pharmacies so much that independent pharmacies dispense prescription drugs to consumers below the independent pharmacies' cost of the drugs. PBM clawbacks of pharmacy revenue have been increasing year after year, causing significant financial strain on these small businesses.[34] The FTC should explore whether vertically integrated PBMs reimburse their own pharmacies at the same level as they reimburse independent pharmacies. Further, it should examine whether there are any other differences in how vertically integrated PBMs treat their own pharmacies versus independent pharmacies.

29 Dr. Michael Wohlfeiler of the AIDS Healthcare Foundation testified in the CVS-Aetna Tunney Act proceeding that the merger could endanger HIV and AIDS patients because the merged firm could steer its "patients to leave HIV and AIDS specific treatment providers for providers that are unequipped to treat those conditions." *United States v. CVS Health Corp.*, 407 F. Supp. 3d 45, 57 (D.D.C. 2019). AHF has created an extraordinarily successful model for delivery of care to HIV/AIDS patients, a one stop shop model in which AHF functions as a testing, linkage, specialist, health insurer, pharmacy, and price care facility. Patient steering to cookie-cutter models results in fragmentation of care, inferior quality of care, and severance of trusted provider relationships, which is very problematic for vulnerable patients with chronic conditions like HIV.

30 Markian Hawryluk, *The Last Drugstore: Rural America is Losing Its Pharmacies*, WASH. POST (Nov. 10, 2021), https://www.washingtonpost.com/business/2021/11/10/drugstore-shortage-rural-america/.

31 *Id.* Stacy Mitchell & Charlie Thaxton, *The Rebirth of Independent Pharmacies Could Cure Rural Ills*, The American Conservative, November 5, 2019, https://www.theamericanconservative.com/articles/the-rebirth-of-independent-pharmacies/.

32 See, Stacy Mitchell, *Small Pharmacies Beat Big Chains at Delivering Vaccines. Don't Look So Shocked*, Washington Post, February 5, 2021, https://www.washingtonpost.com/outlook/small-pharmacies-beat-big-chains-at-delivering-vaccines-dont-look-so-shocked/2021/02/05/6bb307ec-671b-11eb-886d-5264d4ceb46d_story.html.

33 Reed Abelson & Natasha Singer, *Pressure Grows to Unwind CVS Merger*, Henderson Times News, April 14, 2011, https://amp.blueridgenow.com/amp/28267825007.

34 *Id.*

Fifth, the study should examine whether PBMs' use of firewalls protect independent pharmacies' patient data.

Finally, as part of the study, the FTC needs to conduct a retrospective of the *Express Scripts/Medco* merger, which the FTC cleared in 2012.[35] Since then, concentration levels in the PBM industry have increased. Moreover, the FTC's *Express Scripts/Medco* merger review did not focus on the issue of the competitive effects of different PBM plan designs, or the competitive effects of state law requirements that mandate either transparent plan designs or the inclusion of proposals with transparent plan designs as a component of PBM bids to plan sponsors. The FTC needs to evaluate the competitive impact of different plan designs considering the significant changes in the PBM market and state laws.

35 Press Release, Fed. Trade Comm'n, *FTC Closes Eight-Month Investigation of Express Scripts, Inc.'s Proposed Acquisition of Pharmacy Benefits Manager Medco Health Solutions, Inc.*, Apr. 2, 2012, https://www.ftc.gov/news-events/press-releases/2012/04/ftc-closes-eight-month-investigation-express-scripts-incs.

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