April 25, 2022

Honorable Lina Khan, Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580


Dear Chair Khan,

On behalf of OCHIN, I appreciate the opportunity to provide comments on the Impact of Prescription Benefit Managers’ Business Practices on patients served by community clinics in underserved communities. OCHIN is a national nonprofit health IT innovation and research network that supports members with more than 1,000 locally controlled community health care sites, reaching more than 6 million patients in 45 states and 21,000 providers. OCHIN strongly urges the Federal Trade Commission (FTC) to regulate the anti-competitive practices of pharmaceutical benefit managers (PBMs) that adversely impact patients served by safety-net providers. In brief, current PBM practices undermine the sustainability of federally qualified health centers (FQHCs) and other safety-net providers serving patients facing significant structural inequality that are further exacerbated by PBM practices. These actions are worsening conditions faced by all patients in underserved communities, but the strain has been magnified in rural communities.

The OCHIN network is comprised of federally qualified health centers (FQHCs) and other community health centers, local public health departments, school-based clinics, correctional facilities, behavioral health providers, Tribal community providers, and critical access hospitals. Fifty percent of our members’ patients are covered by Medicaid, one out of three prefer care in language other than English, and three out of five network patients have chronic conditions.¹

### 340B AFFORDABLE PRESCRIPTION DRUG PROGRAM AND ACCESS TO CARE

The 340B affordable prescription drug discount program (340B program) ensures patients have access to affordable medication and has served as a vital source of funding for community health clinics in underserved communities since 1992 as intended by Congress. However, congressional intent and the structure of the 340B program currently is being undermined by the unfair and anti-competitive PBM practices. Eligible OCHIN members actively participate in the savings available through this 340B program and utilize the savings to provide care to underinsured or uninsured patients, who may otherwise not have access to medically necessary medication and medical services.

¹ OCHIN Epic patients only.
OCHIN members operate community health clinics that provide needed, affordable medication and health care services to underserved populations. The level of 340B funding is significant, making the difference between operating at a net gain or loss for the majority of OCHIN members. OCHIN conducted an analysis of the financial role that the 340B program plays in community clinic sustainability. OCHIN found for 60% of sampled OCHIN members examined, net revenue from 340B program participation was critical to their bottom line, making the difference between an annual gain or loss in net assets. Twenty-four percent of sampled members operated at losses and would have seen larger losses without the net revenue received from 340B program participation. If the FTC or Congress is unable to stop the anti-competitive practices of the PBMs, patients will either lose access or the cost of medication and health care services will be shifted from the 340B program to American taxpayers. The continued pick-pocketing and other practices by PBM that reduce 340B net revenue, could further destabilize many of the nation’s community health clinics with devastating impact on patient access to affordable medication and health care services.

**PBM MARKET CONCENTRATION AND ANTI-COMPETITIVE PRACTICES**

The national market for PBM services is highly concentrated with 80 percent of the PBM national market controlled by three suppliers. The high market concentration has hampered market competition and resulted in increasingly draconian anti-competitive practices. Furthermore, the consolidation of the PBM market, combined with opaque pricing, is one significant cause for higher pharmaceutical prices.

Currently, PBMs impose contract terms on community-based providers that reduce all, or part, of the federal 340B Program savings that eligible entities are qualified to receive. Congress intended that these savings were to be used by community health clinics to provide affordable medication and other health related services to patients facing persistent structural inequality and health disparities. According to the PBMs this high market concentration produces overall improved affordability of prescription drugs for everyone, yet it is well documented with the consolidation of PBMs the opposite has occurred. Instead, this market consolidation has allowed for-profit PBMs to misuse their market share to divert funds away from patients in underserved communities.

Due to market consolidations, large health plans, and their PBMs typically are the only option for small, community-based providers participating in the 340B Program. As a result of the foregoing, OCHIN members have no alternative to (1) accepting a reduced amount of the 340B program savings; (2) acquiescing to limited coverage of drugs purchased under the 340B Program; (3) paying higher administrative service fees relative to the rate charged to other providers; and/or (4) agreeing to administrative fee as a percentage of the provider’s 340B savings. All of these are terms that community health clinics must accept as a result of market consolidation which is pervasive in across the nation. We urge the FTC to take immediate steps to bring an end to these practices.

In short, we urge an end to unilateral PBM contracts and amendments (on rates, network contract education – i.e., aberrant product list restrictions) and discriminatory reimbursement and unfair contracting terms. We strongly urge the FTC to require data and transparency from PBMs to shine a light

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2 “Pro Market Blog of the Stigler Center at the University of Chicago Booth School of Business, Craig Garthwait Associate Professor of Strategy and the Director of Kellogg School of Management’s Health Enterprise Management Program (HEMA) at Northwestern University and Fiona M. Scott-Morton, Theodore Nierenberg Professor of Economics at the Yale University School of Management.

3 Id.
on how manufacturer rebates are calculated and impact the cost of drugs for patients.

OCHIN community-based providers are facing extraordinary resource challenges and need their existing sources of funding to maintain their immediate- and longer-term sustainability. We urge the FTC to regulate PBMs and curtail rampant anticompetitive practices which negatively impact pharmacy reimbursement and patient access to affordable medications. Please contact me at stollj@ochin.org to discuss how OCHIN can support your efforts moving forward.

Sincerely,

Jennifer Stoll
Executive Vice President
External Affairs
OCHIN urges the Federal Trade Commission (FTC) to carefully consider the following:

1. Health centers need more federal protection from pharmacy benefit managers’ anticompetitive practices which negatively impact pharmacy reimbursement and patient access to affordable medications. Because there is de facto PBM monopolies, OCHIN members are forced to accept—without legitimate negotiation— their contracts, amendments (on rates, network contract education – i.e., aberrant product list restrictions), and provider manuals to get access to patients in network in their area.

1. Pharmacy benefit managers discriminate against health centers for participating in the 340B program and force in-house and contract pharmacies to accept lower reimbursement and unfair contracting terms.
   a. PBMs intentionally reimburse 340B pharmacies at lower rates than non-340B pharmacies for prescription drugs simply because health centers receive a 340B discount. This practice is known as “pickpocketing,” because PBMs are picking the 340B savings out of the health center’s pockets.
   b. Health centers have very little negotiating power to fight against PBMs’ discriminatory contracts, as they cannot afford to be excluded from the PBM’s network nor the associated health insurer’s network for medical and mental health services.
   c. As the Health Resources & Services Administration oversees the 340B program, it does not have authority over the business practices related to operating a 340B program. Health centers need the FTC to issue regulations and increase oversight over PBMs’ discriminatory and anti-competitive business practices against 340B covered entities.
   d. Health centers utilize contract pharmacies to increase access for uninsured and underinsured patients to receive discounted medications in their communities. PBMs’ greedy business practices to generate higher manufacturer rebates are negatively impacting health centers’ ability to receive 340B priced drugs at contract pharmacies. Since July 2020, over 16 drug manufacturers have restricted shipments to 340B contract pharmacies until health centers provide claims level pharmacy data to help manufacturers limit PBM rebates.
   e. PBMs have also mandated that pharmacies comply with onerous prescription claims identification requirements. These requirements typically force the safety-net provider’s in-house or contracted pharmacy to devote exorbitant time and resources to entering codes for each claim filled with a drug purchased under a federal discount program. For many safety net providers, their in-house or contracted pharmacies are unable or unwilling to apply the requisite claims modifiers.
   f. Without federal protection against these discriminatory practices, health centers and our patients are at the mercy of manufacturers and PBMs.
   g. (INSERT LOCATION EXAMPLE OF 340B RELATED CONCERNS OR IMPACT OF 340B SAVINGS FOR YOUR PATIENTS)
2. **(INSERT ORGANIZATION)** requests more data and transparency from pharmacy benefit managers to understand how manufacturer rebates are calculated and impact the cost of drugs for patients.
   
   a. Health centers and patients deserve to have access and insight into the process and the data used to calculate PBM rebates from manufacturers. PBMs should disclose information related to fee arrangements with drug manufacturers.
   
   b. PBMs are responsible for reimbursing the pharmacy for dispensing the patient’s medication. The pharmacy, who has already incurred a cost for stocking and dispensing the medication, has no control over any aspect of the medication’s sale. It is the PBM who determines the patient’s copay and the PBM who determines in advance how much it will reimburse pharmacies for each medication covered under the drug plan.
   
   c. Health centers receive information at the point-of-sale and have little control over how PBMs change drug prices and reimbursement rates based on PBMs rebates.
   
   d. PBMs often receive rebates that are calculated as a percentage of the manufacturer’s list price and receive larger rebates for more expensive drugs. This creates an incentive for PBMs to make formulary decisions based on higher rebates than efficiency and value to the patient.