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**Responses to Questions for the Record from Senator Grassley**

1. It is certainly possible that the consolidation of the insurance and PBM functions may facilitate controlling health care expenses by reducing the costs of gathering information needed to evaluate tradeoffs between pharmaceuticals and medical treatments. However, whether those cost reductions are significant and whether the information can be obtained by other means are important considerations in assessing whether such purported efficiencies outweigh harms to competition.
2. I do not have access empirical evidence to answer this question. However, as indicated in the answer to the following questions, there is ample reason to conclude that consolidation in the PBM and insurance sectors has enabled firms to engage in pricing and contracting practices that significantly raise health care costs. The evidence of excessive costs resulting from “spread pricing” by PBMs serving the Ohio Medicaid program and other government payors suggests that state and federal payment programs are susceptible to harms from anticompetitive conduct and concentrated market structures.
3.
  - a. No. The PBM sector exhibits all the characteristics of a market unconstrained by competitive forces: high prices; lack of price transparency; extraordinary concentration; consumer dissatisfaction; conflicts of interest; and entry barriers.
  - b. Hardly. When competition is absent, consumers suffer along three dimensions: price, quality, and access. Although high prices attract the most attention, it is important to remember that impaired competition reduces incentives to innovate and causes patients to forego needed care and pharmaceuticals. As FDA Commissioner Gottlieb pointed out, the pharmaceutical manufacturing and middleman oligopoly operate hand in hand to extract huge sums that result in higher prices, reduced innovation and less access.
  - c. Yes. Entry is difficult because of the need to have a large number of beneficiaries in order to obtain significant discounts from pharmaceutical manufacturers. In addition the vertical stacking of health insurance companies with PBMs creates a need for two-level entry, which is costly and carries higher risk than single level entry.
4. As I indicated in my testimony, vertical merger law is in need of clarification: there are few recent precedents; government guidance is outdated; and enforcers are reluctant to tackle cases in important industry sectors like health care. Vertical merger guidelines would be a good first step, but they are no substitute for litigation that will establish workable standards. The FTC might also consider using its Section 5 authority to establish sound and administrable presumptions and rules of thumb.
5. As indicated in my responses to Questions 2 and 3, PBMs have failed to serve the role of “trusted agents.” Market concentration has enabled PBMs to operate free of incentives to

vigorously pursue discounts or to pass them along to their clients. Furthermore, the absence of regulatory oversight has enabled the practices undertaken by PBMs to persist.

6. The manner in which PBMs handle rebates and the fees they extract are obvious problems. For one legislative option, the Lower Health Care Costs Act (S. 1895) tackles a number of the key problems head on. First it promotes disclosures by requiring PBMs to reveal direct and indirect payments including fees, rebates and other remuneration and the total amounts paid by patients. It also would ban spread pricing and require a full pass through of rebates from PBMs to health plans. Notably, this bill (and others) tackle some of the broader issues that underlie the pharmaceutical cost problem. It addresses longstanding and largely ignored problems of abuse of citizen petitions to delay entry, surprise billing, contractual provisions that limit patient choice and deter effective bargaining, competition-blocking tactics of brand drugs to deter or delay generic competition, and the need to speed up generic drug and biosimilar approvals.

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**Responses to Questions for the Record from Senator Booker**

1. Merger retrospectives can provide concrete examples of harms arising from vertical mergers. Such studies can serve to correct assumptions found in some legal precedents that vertical combinations are almost always procompetitive. Studies of this kind undertaken by the FTC in the 1990s served the purpose of showing that horizontal hospital mergers were likely to raise prices and that geographic markets were smaller than courts had previously determined. Armed with such studies, enforcers are more likely to abandon laissez-faire policies and closely examine and challenge problematic vertical mergers.
2. Guidance specific to health care markets would be helpful. Attorneys counselling clients are currently operating in the dark as to legal standards and the likelihood of government challenge. The peculiar economics of health care require special attention. As I suggested in the articles cited in my testimony, health care provider and payor markets present laboratory conditions for potential consumer harm: high levels of concentration, durable barriers to entry, regulations that encourage consolidation, trends toward increasing consolidation, etc.
3. Adequate staffing is important. FTC merger reviews can be time-consuming, and litigating even a few cases can deplete staff resources. The FTC should also be encouraged to use its powers under Section 5 to establish workable presumptions regarding vertical mergers. To reaffirm the long-standing central goals of merger law, legislation providing that courts should apply presumptions of *U.S. v. Philadelphia National Bank* and the incipency standard of *Brown Shoe Co. v. U.S.* is needed.
4. Independent pharmacies face serious risks of becoming victims of foreclosure and raising rivals cost strategies by a vertically-integrated CVS/Aetna. Persuasive testimony by Professor Sood and Dr. Moss in the Tunney Act hearing in *U.S. v. CVS Health Corporation and Aetna* explains that post-merger the firm will have the ability and strong incentives to engage in such anticompetitive behavior. Specifically, CVS could harm rival pharmacies by any or all of the following tactics:
  - Entering into exclusive contracts that require patients to use CVS pharmacies
  - Implementing forced conversions to mail order for Aetna subscribers
  - Driving down dispensing fees
  - Delaying reimbursements to independent pharmacies
  - Charging higher co-pays at non-CVS pharmacies for specific drugs