Thank you Chair Kahn and Commissioners Phillips, Slaughter and Wilson for this opportunity to comment on the proposed Federal Trade Commission study of PBM relationships with affiliated and independent pharmacies, and their impact on prescription drug prices.

My name is Stewart Perry and I am board chair of the Diabetes Leadership Council. The Diabetes Leadership Council is a 501(c)(3) patient advocacy organization. Our experienced advocates all served in volunteer leadership roles with national diabetes organizations. We are united by our personal connections to diabetes and a shared commitment to drive policy solutions that improve the lives of all people impacted by the disease.

I have lived with type 2 diabetes for more than 33 years. I have helped care for a mother and father with type 1 diabetes, lost a son to type 1 diabetes, and lost a grandfather and uncle to type 2 diabetes. I am here today to speak on behalf of 37 million Americans with diabetes and urge the FTC to include within the scope of this proposed study a close examination of PBM practices that drive up consumer costs at the pharmacy counter. These practices include:

- Restrictive formularies for essential medicines like insulin;
- Retaining drug manufacturer rebates and discounts rather than passing them through to patients;
- Spread pricing, requiring pharmacies to charge consumers above-market prices for covered medicines; and
- Incentivized formulary coverage of medicines with high list prices and large rebates, thereby limiting access to lower priced alternatives including generics and biosimilars

Most people with diabetes are frequent visitors to their community pharmacy because managing this disease requires multiple prescribed medications, devices and related supplies. A long time ago PBMs inserted themselves between patients and providers to dictate which products should be prescribed. Continuity of care is critical for diabetes management, yet each year people with diabetes know to expect letters explaining that their plan now prefers a different product – even essential medicines like insulin and brand drugs with no generic alternative. The patient can either switch or gear up with their prescriber’s office to seek authorization to stay on medicines that are working.
This non-medical switching stems from PBM’s use of restrictive formularies to secure larger rebates from drug manufacturers. In this regard PBMs have actually helped to bring down the net cost of medicines including insulin, but you wouldn’t know that from the prices ringing up at the pharmacy counter. The PBMs’ drive for larger rebates instead of lower net cost has led to higher and higher list prices. Today a vial of analog insulin with a list price of $335 nets out at less than $80. Consumers could save even more money if they buy it outside their insurance plan – the cheapest price we found for that same vial is $30, but it won’t count toward a deductible or out-of-pocket maximum. For each insulin vial a consumer or their child needs to survive, they are required to pay an unconscionable $300 toll into an opaque system created by insurance companies and PBMs to financially benefit insurance companies and PBMs.

That isn’t competition. That is backdoor underwriting of people with diabetes and other serious chronic health conditions and it has largely gone unchecked as the marketplace has vertically integrated. PBMs now control which medicines we are prescribed, which pharmacy will fill our prescriptions, and our out-of-pocket share of the cost.

The Diabetes Leadership Council is encouraged to see states stepping up to regulate some of these conflicts of interest, but there is only so much states can do to protect consumers. This is a national problem that demands national answers. If the FTC votes to proceed with this study we urge you to include in its scope a close examination of PBM impact on consumers’ prescription drug costs and access.

Thank you.