Pharmaceutical Care Management Association
Testimony to the ERISA Advisory Council
Presented by William J. Kilberg; Gibson, Dunn & Crutcher LLP
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We thank you for the opportunity to testify regarding whether mandatory disclosure requirements should be imposed on pharmacy benefit managers ("PBMs") pursuant to section 408(b)(2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). For the reasons we outline below, imposing mandatory disclosure rules on PBMs would be counterproductive, increasing health plans' costs of providing prescription drug benefits to participants and beneficiaries with no offsetting benefits.

The PCMA and the Role of PBMs

The Pharmaceutical Care Management Association ("PCMA") is the national association representing America's PBMs, which administer prescription drug programs for more than 220 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D. PBMs typically organize retail pharmacies into networks and bargain with the network pharmacies to set the rate at which the PBM will reimburse the pharmacy for each prescription that the pharmacy fills as a network provider. Some PBMs also operate, directly or through affiliates, their own mail-order, specialty drug and retail pharmacies, and negotiate directly with pharmaceutical manufacturers to purchase prescription drugs, which they use to fill prescriptions through these outlets. In many cases, those pharmacies are included in the client's pharmacy network pursuant to the client's agreement with the PBM.

PBMs are a key driver of reduced medical costs and improved medical outcomes. As outlined in the attached report from Visante (Exhibit A), PBMs were projected to save health plans and other consumers almost $2 trillion in prescription drug costs from 2012-2021. The report also found that another $550 billion could be saved if the tools PBMs use to drive down prescription drug costs for consumers were universally adopted. PBMs improve medical outcomes and provide cost savings in several ways:

- *Negotiating Discounts from Drugstores and Drug Manufacturers*. Retail pharmacies provide discounts to be included in a health plan's pharmacy network. The more selective the network, the greater the discount, since each participating pharmacy will gain business. In addition, PBMs negotiate rebates from manufacturers of brand drugs that compete with therapeutically similar brands and generics. Manufacturers typically provide a rebate if their product is "preferred," which means it is assigned a copay lower than competing products.
- *Home Delivery of Medicines*. PBMs' mail-service and specialty pharmacy channels typically give plan sponsors deeper discounts than retail pharmacies. These channels also help encourage the use of preferred products for additional savings.
- *Encouraging Use of Generics and Less Expensive Brands*. PBMs use several tools to encourage the use of generic drugs and preferred brands. These include formularies and tiered cost sharing, prior authorization and step therapy protocols, generic incentives, consumer education, and physician outreach. As PBMs and plan sponsors strive for greater savings, the right drug mix becomes even more important.

- *Using Cutting-Edge Tools to Improve Adherence*. PBMs use drug utilization review to reduce waste such as polypharmacy (*i.e.*, the use of multiple medications, most often by an older adult) and implement patient adherence programs to help patients stick to their prescription regimens. Both programs improve clinical outcomes and reduce prescription volume and expenditures.
- *Improving Quality and Safety*. PBMs promote the use of technology to improve quality and safety by preventing drug duplication and dangerous drug-to-drug interactions.

Because PBMs are the best tool to control prescription drug costs and maximize patient outcomes for self-insured health plans, governmental entities, insurance companies and others, they are utilized by nearly all such entities either directly or through an intermediary. The alternatives -- pharmacy benefit administrators and administrative services-only contracts – typically do no more than process claims and simply lack the tools to control ever-increasing costs and the need to provide drug safety.

How PBMs Operate

By contract with the PBMs, the PBMs' clients, and, more specifically, the individuals covered by the clients' prescription drug programs, obtain access to the retail pharmacy networks and mail-order and specialty drug pharmacies established by PBMs. The design of these arrangements, and the services provided by a PBM to a particular plan, are selected by the plan sponsor.

Retail pharmacies in the PBM's network fill prescriptions with drugs they have purchased on their own directly from wholesalers and manufacturers. A PBM does not handle or take possession of drugs, except for prescriptions filled through the PBM's mail-order or specialty pharmacy. When a plan participant or other consumer goes to the pharmacy to fill a prescription, the pharmacy will check with the PBM for coverage and copayment information. After the prescription is filled, the PBM reimburses the pharmacy at a contractually-agreed, negotiated rate minus the copay collected by the pharmacy. The PBM then separately bills the client at the rate contractually negotiated with it.

Under one model (commonly referred to as the "spread" model), the PBM pays the pharmacy the pre-negotiated rate, and bills the plan at the client's separate pre-negotiated rate (which may be lower or higher than the rate paid by the PBM to the pharmacy). This model provides the client with more cost certainty and generally requires lower administrative fees. Under another model (commonly referred to as the "pass-through" model), the PBM simply "passes through" the cost of the prescription (less any copay) directly to the client, so the client pays whatever rate was negotiated with the pharmacy that filled the prescription. This model generally requires more complex administrative systems, and therefore higher administrative costs.

Under either model, the PBM's obligations to pay the retail pharmacies are not contingent on its receipt of payments from its clients. With respect to mail-order and specialty pharmacy prescriptions, the plan's payment obligation for drugs dispensed is determined under the PBM contract, and the PBM directly provides the healthcare (*i.e.*, prescription drugs).

PBM administrative services may include general recordkeeping, data management and information reporting, formulary management, health care utilization review, claims adjudication, participant communications, and other benefit and plan enhancement services. How PBMs charge for services varies significantly from PBM to PBM and contract to contract. For example, one contract may provide a flat fee for administrative services, while another may include variable fees for some services and no fee for other services.

When the client is an employee benefit plan, the products and services provided by PBMs may be paid for through employer contributions, employee contributions, or a combination of both. In some cases, those payments may come from plan assets (*e.g.*, when a "VEBA" is the contracting party), but more typically, they are paid from the plan sponsor's general assets. However, the basic model used by, and the prices charged by, the PBM generally is not affected by the funding arrangement for the plan.

The PBM Contracting Process

PBMs compete for business from ERISA plans or their sponsors by submitting bids through a Request for Proposal ("RFP") process initiated by the plan sponsor. The RFP bidding process allows a plan sponsor to leverage its negotiating ability and purchasing power by creating intense competition among PBMs. The plan sponsors often utilize the services of sophisticated consultants with a deep knowledge of the PBM industry. In other cases, they work in tandem with brokers, third party administrators and others intimately familiar with how PBMs work. Most PBM contracts are only for a one, two, or three-year period, so plan sponsors have the opportunity to quickly switch PBMs if they are dissatisfied with a PBM's performance or pricing.

The RFPs often request proposals under both the "spread" and "pass-through" pricing models, with various other iterations. The spread model is most often selected by the client, because it provides the PBM a very strong incentive to drive hard bargains with the downstream pharmacies (since the PBMs make money based on the difference between what they pay the pharmacies and what the client pays them, commonly referred to as the "spread") and therefore results in larger cost savings for the client. It also provides more cost certainty to the client.

The contracting process is highly transparent. The RFP, usually developed by highly experienced consultants or other professionals, includes questions developed to ensure that the plan receives the best possible deal. The data requirements will include all information deemed relevant by the consultant, including information on rebates and other matters. If the PBM wants to participate in the RFP process, it must answer these questions. Thus, significant disclosures typically are agreed to between the PBM and the client, subject to negotiated confidentiality obligations (and, in general, the stronger the confidentiality protections, the more information may be disclosed). In addition, the financial provisions of PBM contracts are heavily negotiated. For example, under many contracts the PBM shares some or all of the rebates it receives from pharmaceutical manufacturers with the client. In fact, many contracts have minimum rebate guarantees, under which the PBM must pay additional amounts out of its own pocket to the client if the client's share of rebates falls below the agreed-to amount. A recent national survey of plans that elected a rebate-sharing model concluded that the median rebates received by the plans were 80% to 93% of manufacturer rebates on prescriptions filled at retail pharmacies.[1]

PBM-client contracts typically include significant audit rights for the client, and clients frequently take advantage of these rights to confirm that the arrangement is being operated in accordance with the contract. Audits may examine claims processing, rebate sharing, and other aspects of the contractual relationship. Many professional firms, including the largest accounting firms, provide PBM auditing services at a reasonable cost. PBM contracts typically have an annual audit right covering at least two years of data at the PBM's cost.

[1] Pharmacy Benefit Management Institute, *2013-2014 Prescription Drug Benefit Cost and Design Report*.

In addition, service providers offer software programs to manage and analyze PBM bills on a "real-time" basis and also offer processes to manage RFPs, either directly or through consultants and brokers.[2] These programs are becoming increasingly popular with plan sponsors and other purchasers of PBM services.

Ultimately, the plan sponsor chooses the arrangement that best suits its needs. With the vigorous competition in the industry to obtain and retain clients (as discussed in detail below) and the significant voluntary, mutually agreed-to disclosures that provide for significant transparency, clients can ensure that they are paying competitive rates for the services the PBMs provide and the health care their covered members receive.[3]

Pricing of Drugs – MAC and AWP

The two most common methodologies for paying pharmacies for dispensed prescription drugs are maximum allowable cost ("MAC") for generics and, for brands, applying a negotiated percentage discount to a marketplace price benchmark such as average wholesale price ("AWP").

MAC is a common cost management tool specifying the reimbursement limit for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. MAC price lists are widely used by health plans and private-sector clients and by most states for Medicaid and other programs. They are calculated based on aggregate data that shows what pharmacies pay on average for generic drugs.

The reason MAC lists are used is that generic drugs often have a huge range of manufacturer list prices, and the MAC prices reconcile the differences between an inflated list price and the price the pharmacy actually pays for the drug. Each manufacturer has its own price for a particular strength and dosage of a generic drug, and these prices can vary widely by manufacturer. A MAC list standardizes the reimbursement amount for identical products, regardless of each manufacturer's list price. It prevents pharmacies from earning extraordinary profits from dispensing generics. Without the MAC list, pharmacies could negotiate to acquire the drugs at a substantial discount from a manufacturer's list price but be reimbursed at the manufacturer-published price. With the MAC lists, the pharmacies are always motivated to seek and purchase generic drugs at the lowest price in the marketplace. Thus, MAC lists are intended to prohibit pharmacies from "gaming the system" and inflating drug prices.

Because manufacturer list prices for generics change frequently, the MAC lists need to be updated frequently. How often this happens is determined by the contracts between the PBM and its client and the PBM and the pharmacy. Typically, prices for generics fall over time, so MAC prices are updated to reflect the falling prices and ensure that consumers are not overpaying for generics. They are also adjusted when manufacturers raise prices so that pharmacies are fairly paid.[4]

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[2] *See, e.g.*, www.truveris.com.

[3] Some parties with interests adverse to plan participants, such as pharmacies, allege that PBM compensation arrangements create conflicts of interest, such as being incentivized to structure formularies to encourage the use of brand name drugs with higher rebates or spread. This argument is a red herring. To the extent there were any such conflicts at one time, they arose when pharmaceutical manufacturers owned PBMs. Those PBMs have since been sold to third parties with no such conflict. In addition, the FTC Report (discussed below) concluded that there are no problematic conflicts of interest.

[4] Medicare Part D MAC lists must be updated no less frequently than every seven days.

Pharmacies will typically have a separate MAC list for each PBM with which they contract. In addition, contracts between PBMs and plan sponsors may require use of a specific MAC list for the affected plan, so a pharmacy may have multiple MAC lists with a single PBM as well.

PBMs operate in a highly-competitive environment with other PBMs, and it is essential to ensure that pharmacies compete with each other to get the lowest prices possible from the manufacturers. If MAC information were publicized, it would have an anti-competitive effect on plans and insurers, as well as PBMs. Competing PBMs would have access to other PBMs' drug payment calculations, allowing price fixing and higher costs for consumers. In addition, if a pharmacy could discover a PBM's MAC pricing methodology, that would allow it to purchase drugs in a way to maximize prices and profits at the expense of consumers by dispensing the generic drug made by a manufacturer with the highest list price (from which it would negotiate substantial discounts, resulting in a higher overall margin to the pharmacy). These are the key reasons why the FTC has consistently opposed state laws that could allow MAC-related data to be made public.

PBMs have no role in setting AWP for brand-name prescription drugs. It is calculated by third parties such as Medi-Span based on marketplace averages.

Amounts Received by PBMs

There is substantial transparency regarding the manner of PBM compensation. In December 2008, URAC (formerly known as the Utilization Review Accreditation Commission) and the National Business Coalition on Health released *PBM Purchasers Guide: A Quality Management Toolkit* (the "Toolkit") (Exhibit B). The Toolkit provides advice on negotiating a contract with a PBM, and includes voluntary transparency programs that members of the PBM industry follow. It also lists the services PBMs typically provide and the ways in which PBMs are compensated for the goods and services they provide.

One source of revenue for PBMs is rebates from pharmaceutical manufacturers. These rebate arrangements are negotiated with the manufacturers and vary greatly. They are applicable only to brand-name drugs, and not generics. Generally, a PBM rebate is a discount paid to the PBM by the pharmaceutical manufacturer on the prescription drug sold through the PBM product offering in coordination with the dispensing of the drug (*i.e.*, providing healthcare) to a patient at the retail pharmacy or a mail-order pharmacy. The terms of the rebate are negotiated independently by the PBM and the pharmaceutical manufacturer. The rebate is a valuable tool for the PBM to reduce its supply chain costs associated with the procurement and delivery of the prescription drug to the patient. Whether, and to what extent, a rebate is passed through to the client is negotiated based on the particular PBM package desired by the client. As noted above, the vast majority of these rebates are, in fact, shared with clients, and it is not uncommon for 100% of rebates to be passed through to a particular client (*e.g.*, through per-prescription guarantees, a share of the rebate from each prescription, generic dispensing rate guarantees, etc.). PBMs often have contractual agreements to share minimum rebate levels with clients.

Rebates (and discounts) are not properly classified as compensation for services. Rather, they effectively are reductions in the cost of goods sold of products (*i.e.*, prescription drugs) provided to participants and beneficiaries and paid for by their health plans. *See* 72 Fed. Reg. 64731, 64739 (Nov. 16, 2007) ("As was noted in the July 2006 Proposal, Schedule C was intended to capture information on compensation received by persons providing services, and not information on benefit payments to participants and beneficiaries."). In addition, the preamble to the initially-proposed section 408(b)(2)

regulations in 2006 stated that a doctor providing medical services to a participant as part of an HMO network that has a contract with the plan is not a service provider subject to the proposed regulations. Similarly, a retail pharmacy owned by a PBM would not be a service provider just because it fills prescriptions of plan participants.

As described above, PBMs provide numerous services to clients in addition to the provision of healthcare, and the URAC report summarizes those services. Some types of compensation for services that PBMs may receive (and which are fully disclosed to clients) include:

- *Dispensing Fees*. A dispensing fee typically is charged by the PBM to a client for each prescription filled by its mail-order pharmacy, specialty pharmacy or a pharmacy that is a member of the PBM's retail network.

- *Administrative Fees*. These are amounts intended to compensate the PBM for the services it provides to its clients in processing prescriptions. (In some cases, a PBM and a client may agree that no amount is designated as an administrative fee. In that case, the administrative fee typically is reflected as part of the dispensing fee.)

- *Ancillary Services*. PBMs often provide ancillary administrative services to clients, such as recordkeeping, data management and information reporting, formulary management, participant health desk, benefit education, health care utilization review, claims adjudication, participant communications, reporting services, website services, prior authorization, client-adopted clinical programs, card production, pharmacy audits and other services, which are reflected in the client's contract with the PBM. Clients typically pay fees for these services directly to the PBM (and such payments are reportable on Schedule C of Form 5500 as direct compensation if paid from plan assets).

PBM Disclosure Requirements Under the Affordable Care Act and State Laws

Section 6005 of the Affordable Care Act imposes limited disclosure requirements on PBMs. Specifically, the ACA requires entities that provide PBM services to a prescription drug plan or a "qualified health plan" offered through a state exchange to provide certain information to the Secretary of the Department of Health and Human Services. The information must be aggregated, with de-identified data, so that the PBM and plan names are not disclosed to anyone other than the Secretary. The information that must be disclosed to the Secretary is limited to:

- Percentage of prescriptions provided through retail and mail pharmacies;
- Generic dispensing rates by type of pharmacy;
- Aggregate amount and type of rebates, discounts or price concessions attributable to patient use under the plan;
- Aggregate amount of rebates, discounts or price concessions passed through to plan sponsors;
- Aggregate amount of the difference between what a plan pays the PBM and what the PBM pays pharmacies; and
- Total number of prescriptions dispensed.

Congress expressly did not permit the disclosure of PBM-specific information to the states or any other party. The disclosure requirements do not apply to ERISA plans, insurance policies sold through the exchanges, or other arrangements other than the two types of arrangements listed in the statute. In addition, the Secretary may only disclose the information she received if (i) it is in a form that does not

disclose the identity of the PBM, the plan or the prices charged for drugs, and (ii) the disclosure is either necessary to carry out the requirements of the ACA or Medicare Part D, for review by the Comptroller General, for review by the Congressional Budget Office, or to enable states to carry out the health exchange provisions of the ACA. The limited nature and strong confidentiality protections for these disclosures was an intentional decision of Congress, following input from the FTC, because of the negative impact such disclosures would have on the marketplace.

Even with the limited disclosure obligations and confidentiality provisions under the Affordable Care Act, there are concerns that there could be anticompetitive effects. For example, Professor Shepherd stated in a *Cornell Law Review* article that: "it is unclear whether these provisions will be sufficient to prevent the competitively sensitive information from leaking to other participants in the prescription drug market."[5] Given that the Affordable Care Act disclosure obligations recently came into effect, it is much too early to determine their potential effect on the prescription drug market.

A handful of states have laws "requiring" certain PBM disclosures (District of Columbia, Maryland, Mississippi, South Dakota, Vermont). However, these laws are limited to generic information (*e.g.*, aggregate rebates) and only upon request of the client. They also generally exclude proprietary information. As described in detail below, the FTC has consistently opposed mandatory disclosure regimes for PBMs. Even with the limited disclosure obligations and statutory confidentiality protections, Professor Shepherd and other commentators have raised serious concerns regarding the potential anticompetitive impact of these laws.[6]

Requiring PBMs to disclose information under section 408(b)(2) of ERISA is much more problematic, even if the Department attempted to include confidentiality requirements. First, there is a concern about how practical and enforceable a purported confidentiality obligation would be, given the ability to obtain plan-related information in discovery and through ERISA's disclosure regime. Second, the number of recipients of this information would increase exponentially, making information leaks out to the market much more likely. This may be good for the profits of pharmacies and drug manufacturers, but not for ERISA plans and other health care consumers that rely on PBMs to control their costs.

The Highly Competitive Market for PBM Services

The Federal Trade Commission has thoroughly examined the PBM industry, and it has concluded that market forces are operating to provide the transparency sufficient to allow consumers of PBM services, like ERISA-covered health plans, to make informed decisions regarding the selection of a PBM provider. These market forces have driven increased transparency because it is demanded by clients, as outlined in the description of the RFP process above.

In 2004, the FTC and the U.S. Department of Justice completed a joint two-year project examining the role of competition in the health care industry.[7] The findings of this study were reached after 27 days of joint hearings, including testimony from 250 panelists, which produced a transcript of almost 6,000 pages. With respect to PBMs, the joint FTC/DOJ Report stated that, "[i]n general, vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency

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[5] Joanna Shepherd, *Is More Information Always Better? Mandatory Disclosure Regulations in the Prescription Drug Market*, 99 Cornell Law Review Online 1, 13.

[6] *Id.* at 11-13.

[7] U.S. Federal Trade Commission and the U.S. Department of Justice, Improving Health Care: A Dose of Competition (July 2004) ("FTC/DOJ Report") (Exhibit C).

than regulation. Just as competitive forces encourage PBMs to offer their best price and service combination to health plan sponsors to gain access to subscribers, competition should also encourage disclosure of the information health plan sponsors require to decide with which PBM to contract." FTC/DOJ Report at Executive Summary, p. 28.

While collecting information with respect to the joint FTC/DOJ Report, the FTC was also conducting a separate study of the PBM industry pursuant to a congressional request that it investigate "differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers."[8] The resulting report, released in 2005, concluded that PBMs were not engaging in self-dealing by both administering a health plan's pharmacy benefits program and directly selling prescription drugs to plan participants via the PBM's own mail-order pharmacy. FTC Report at vi. ("The actual data from study participants on the business practices Congress requested the FTC to study revealed that these allegations are without merit.").

In addition, on April 2, 2012, the FTC issued a closing statement in connection with the acquisition of Medco Health Solutions, Inc. by Express Scripts, Inc., two of the largest PBMs in the United States.[9]

The FTC conducted an intensive eight-month investigation of the transaction:

> The evidence we examined was the product of a comprehensive investigation. Our staff interviewed over 200 market participants, including customers, other PBMs, retail and specialty pharmacies, pharmacy trade groups, pharmaceutical manufacturers, and healthcare benefit consulting firms. Millions of documents produced by the merging parties and numerous market participants were reviewed. Staff economists performed detailed analyses of historical sales, cost, and bid data obtained from the parties and other industry participants. We also considered numerous advocacy letters and white papers submitted by a variety of consumer organizations. Our investigation was conducted in cooperation with, and the assistance of, a working group of 32 state attorneys general.

The FTC concluded as follows:

> Our investigation revealed a competitive market for PBM services characterized by numerous, vigorous competitors who are expanding and winning business from traditional market leaders. The acquisition of Medco by Express Scripts will likely not change these dynamics: the merging parties are not particularly close competitors, the market today is not conducive to coordinated interaction, and there is little risk of the merged company exercising monopsony power. Under these circumstances, we lack a reason to believe that a violation of Section 7 of the Clayton Act has occurred or is likely to occur by means of Express Scripts' acquisition of Medco.

In addition, the FTC has consistently opposed efforts to mandate disclosures by PBMs. For example, in September 2004, the FTC objected to a proposed California law that would have required PBMs to make specific disclosures to their health plan clients regarding revenue (including rebates from drug manufacturers), administrative fees, and arrangements to encourage formulary compliance or manage

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[8] U.S. Federal Trade Commission, Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies (Aug. 2005) ("FTC Report") (Exhibit D).

[9] U.S. Federal Trade Commission, Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc. (the "Medco/Express Scripts Report").

benefits. Among other things, the FTC observed that the proposed legislation might well have an anticompetitive effect:

> [F]inancial information disclosed by PBMs to [health plans] may become public and a knowledgeable pharmaceutical manufacturer might well be able to use this information to calculate the rebate a competitor was offering. If pharmaceutical manufacturers learn the exact amount of the rebates offered by competitors . . . then tacit collusion among manufacturers is more feasible. Consequently, the required disclosures may lead to higher prices for PBM services and pharmaceuticals.

Although acknowledging that "[i]t is possible that [the bill] may provide some additional information to these plan sponsors about the revenue streams obtained by PBMs," the FTC emphasized that "it does not necessarily follow that this would make the PBMs compete more aggressively to do business with this plan sponsor. Indeed, to the extent [the bill] makes tacit collusion more likely, these plan sponsors may end up with 'worse' contractual terms."

The FTC also found that "[t]here do not appear to be any significant barriers to negotiation between health plan sponsors and PBMs over all the terms of their agreement, including how PBMs are to be paid for their services and the disposition of any rebates." Indeed, the FTC observed that:

> [V]igorous competition in the marketplace for PBMs is more likely to arrive at an economically efficient level of transparency than regulation of those terms. Just as competitive forces encourage PBMs to offer their best price and service combinations to health plan sponsors in order to gain access to subscribers, competition also encourages disclosure of the information group health plan sponsors require to decide which PBM to contract with. . . .

Then, in a July 15, 2005 letter[10] regarding a North Carolina bill that would have mandated certain financial disclosures by PBMs—including with respect to "rebates, discounts, disbursements, or any other similar financial program or arrangement relating to income or consideration received, directly or indirectly, with any pharmaceutical company"—the FTC concluded that, while "[c]onsumers need accurate information on price and quality to make informed purchasing decisions," "there is no theoretical or empirical reason to assume that consumers require a producer's underlying cost information for markets to achieve competitive outcomes." In other words, there is no need for health benefit plans to know what it costs PBMs to purchase drugs from manufacturers in order to achieve a competitive price for the PBM's service. Indeed, because most health benefit plans select PBMs via a sealed bidding process, there is "no indication that clients of PBMs lack accurate information on the price and quality of the service that they intend to purchase." The FTC did not agree that "requiring PBMs to reveal information related to rebates received from pharmaceutical companies would improve market outcomes." On the contrary, it was the agency's view that "increased disclosure of financially sensitive information may pose a risk to healthy competition between pharmaceutical manufacturers" by increasing the risk of tacit collusion.

In October 2006, the FTC again submitted comments, regarding proposed legislation in Virginia that would have regulated the contractual relationship between PBMs and health benefit plans, including

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[10] Letter from Maureen K. Ohlhausen, Director, Office of Policy Planning, Michael A. Salinger, Director, Bureau of Economics, and Susan A. Creighton, Director, Bureau of Competition, U.S. Federal Trade Commission, to Patrick T. McHenry, U.S. House of Representatives (July 15, 2005). (Exhibit E).

mandatory disclosure of proprietary information.[11] Again the FTC opposed the legislation, reiterating the points raised in the letters above and further stating:

> [P]lan sponsors generally appear able to negotiate contract terms—including terms regarding information disclosure—to protect themselves from conflicts of interest. Press reports suggest that, as a result of competition to provide the best mix of price and quality, many PBMs offer contracts that provide both full disclosure and rebate sharing to their clients. Further, it is common for contracts to provide for audit rights, so that [health plans] can verify that pharmaceutical payments are being shared as per agreement. Thus, there is no reason to suppose that competition between PBMs is less likely than government regulation to produce efficient levels of information disclosure.

The FTC also opposed a New Jersey bill that would have required PBMs to disclose sensitive financial information to health benefit plans,[12] noting that "such disclosures may facilitate collusion, raise price, and harm the patients the bill is supposed to protect." The FTC reiterated its consistent concern with mandatory disclosure regimes:

> If pharmaceutical manufacturers know the precise details of rebate arrangement offered by their competitors, then tacit collusion among them may be more feasible. Absent such knowledge, manufacturers have powerful incentives to bid aggressively for formulary position, because preferential formulary treatment offers the prospect of substantially increased sales. Unprotected disclosures thus may raise the price that New Jersey consumers pay for pharmaceutical coverage by softening competition among pharmaceutical companies for preferred formulary treatment.

Then, in 2009, a proposed New York statute would have required PBMs to make substantial disclosures to health plans during contract negotiations and annually thereafter. Disclosures would have included extensive details of the PBM's cost structure and business strategies, and the bill also would have required PBMs to provide physicians with financial and clinical information upon request. The FTC strongly objected to the proposed bill,[13] noting that "health plans appear able to protect themselves . . . through arms-length contracts." The FTC concluded that "[a]llowing competition among PBMs is more likely to yield efficient levels of payment sharing, disclosure, and price than contract terms regulated by government regulation."

In short, the FTC's longstanding position with respect to each state's proposed PBM disclosure regime has been clear and consistent: mandated disclosures can lead to tacit collusion, which can lead to higher prices. Far from benefiting ERISA plans and consumers of prescription drugs, it is the consumers, including health plan participants and beneficiaries, who are the ultimate losers in such a scenario.

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[11] Letter from Maureen K. Ohlhausen, Director, Office of Policy Planning, Michael A. Salinger, Director, Bureau of Economics, and Jeffrey Schmidt, Director, Bureau of Competition, U.S. Federal Trade Commission, to Terry G. Kilgore, Member, Commonwealth of Virginia House of Delegates (Oct. 2, 2006). (Exhibit F).

[12] Letter from Maureen K. Ohlhausen, Director, Office of Policy Planning, Michael A. Salinger, Director, Bureau of Economics, and Jeffrey Schmidt, Director, Bureau of Competition, U.S. Federal Trade Commission, to Nellie Pou, Assemblywoman, New Jersey General Assembly (Apr. 17, 2007). (Exhibit G).

[13] Letter from James Cooper, Acting Director, Office of Policy Planning, Pauline M. Ippolito, Acting Director, Bureau of Economics, and David P. Wales, Acting Director, Bureau of Competition, U.S. Federal Trade Commission, to James L. Seward, New York Senate (March 31, 2009). (Exhibit H).

Conclusions

The PBM market is working well. The FTC has consistently opposed regulatory initiatives that would mandate PBMs to disclose their trade secrets and other proprietary information, such as their arrangements with pharmacies and pharmaceutical manufacturers. The PBM industry has saved, and if left alone will continue to save, billions of dollars for health plans, participants and beneficiaries, taxpayers and other stakeholders.

As the FTC has concluded, there is no reason to believe that mandatory disclosures of PBM-related information will help consumers. In fact, they almost certainly would have the unintended (but easily anticipated) effect of driving up prescription drug prices, further increasing the costs borne by ERISA health care plans. The risk of upsetting a well-functioning market is too great. Therefore, we strongly urge the Council not to recommend enhanced disclosure requirements for PBMs.