**Testimony of David Balto**
**Antitrust Attorney**
**Former Policy Director, Federal Trade Commission**
**on behalf of Community Catalyst, Consumer Federation of America, Consumers Union and the National Legislative Association on Prescription Drug Prices[1]**

**Regarding "Public hearing on Pharmacy Benefit Legislation"**
**Pennsylvania House Committee on Health**
**October 8, 2013**

## Introduction

Mr. Chairman Baker, Chairman Fabrizio, and other distinguished members of the House Health Committee, I want to thank you for giving me the opportunity to testify today on the need for legislation to regulate Pharmacy Benefit Managers ("PBMs"). My testimony today documents the compelling need for legislation to protect consumers and regulate PBMs in Pennsylvania. As I explain in my testimony the proposed legislation includes many policies that are a sound approach to providing a regulatory framework to protect consumers and provide a more competitive marketplace.

My comments in this testimony are based on my 20 plus years of experience as a private sector antitrust attorney and an antitrust enforcer for both the Department of Justice and the Federal Trade Commission ("FTC"). From 1995 to 2001, I served as the Policy Director for the FTC's Bureau of Competition and the attorney advisor to Chairman Robert Pitofsky. Currently, I work as a public interest antitrust attorney in Washington, DC. I have represented consumer groups, health plans, unions, employers, and even PBMs on PBM regulatory and competitive issues.[2] I have testified before Congress and eleven state legislatures on PBM regulation, and was an expert witness for the State of Maine on its PBM legislation.

My testimony explains why the proposed legislation is necessary to protect consumers and competition:

- PBMs are one of the least regulated sectors of the healthcare system. Other than the Anti-mandatory Mail Order Act, Pennsylvania does not regulate the conduct of PBMs.

[1] Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system.
Consumer Federation of America is a non-profit association of nearly 300 consumer groups that was established in 1968 to advance the consumer interest through research, advocacy, and education.
Consumers Union is the policy and action division of Consumer Reports. It works with their million plus activists to pass consumer protection laws in states and in Congress.
The National Legislative Association on Prescription Drug Prices ("NLARx") is a national nonprofit, nonpartisan organization of state legislators who support policies to reduce prescription drug prices and expand access to affordable medicines.

[2] I have testified in the past on PBM issues for several consumer groups including Consumers Union, Consumer Federation of America, USPIRG, Community Catalyst, and others. I operate a website www.pbmwatch.com which provides resources on PBM issues.

- PBMs engage in fraudulent and deceptive practices that are harmful to consumers. Further, the market is lacking the essential elements for a competitive market: (1) transparency, (2) choice and (3) a lack of conflicts of interest.
- The proposed legislation properly gives regulatory oversight to the Board of Pharmacy. The Board however needs an enforcement and complaint mechanism. The Board has the experience and expertise necessary to fulfill the consumer protection provisions contained in the proposed legislation.
- The legislation is not preempted by ERISA.
- Consumers need to be protected from restrictive PBM networks that deny them choice and access. The proposed legislation will help to protect patient choice while also ensuring that PBMs do not alter physicians' treatment plans in favor of purchasing drugs that provide the PBM with higher profits. In addition, the proposed legislation helps eliminate some of the conflicts of interest in the market by prohibiting PBMs from issuing mandates to their customers that they must use a specific pharmacy when the PBM has an ownership interest in the pharmacy.
- The legislation can be strengthened through transparency provisions. More transparency increases savings to consumers. However, the proposed legislation should include more disclosure requirements, which will help address PBMs "playing the spread" and profiting at the expense of consumers. In addition, the legislation needs additional transparency on generic drug reimbursement for pharmacies.

## I. Background

PBMs increasingly engage in anticompetitive, deceptive or egregious conduct that harms consumers, health plans, and pharmacies alike. In a nutshell, consumers and pharmacies alike suffer as consumers are increasingly denied a choice in their level of pharmacy service by PBMs. PBMs exercise their power to restrict consumers to the PBM's own captive mail order and specialty pharmacy operations, reducing choice and quality for many. Consumers and their health plans also suffer when health plans are denied the benefits of the PBMs services as an honest broker, which drives up drug costs, and ultimately leaves consumers footing the bill for higher premiums.

Why do consumers care about restricted access to pharmacies? Because the community pharmacists are the most accessible health care professionals; and in many markets, such as rural markets, they may be the only accessible professional. Because retail pharmacies provide consumers with valuable clinical services and counseling, often free of charge. Because some pharmacies, especially supermarket pharmacies, offer drugs at lower prices than the PBMs. Egregious PBM conduct jeopardizes these types of programs that consumers highly value. As retail pharmacies are already economically efficient and operate on very minimal margins, reduced consumer access to these pharmacies would, in the end, likely result in harm to other consumers who rely on these community pharmacies.

This is especially true for specialty pharmacies. Specialty pharmacies manage the highly-expensive and very complex treatments for the most intricate and serious illnesses. The service they provide is both distinct and significant from other retail pharmacies. Beyond merely dispensing drugs, specialty pharmacies help administer complex treatments, assist physicians in

monitoring patient therapy, and play an important role in medication compliance and improved health outcomes. Specialty pharmacies educate patients on effective utilization, monitor side effects, and partner with physicians to identify ineffective medications and recommend treatment changes. Specialty pharmacies play an active role in providing continuity of patient care to ensure that costs are minimized and health outcomes improve. And there is clear evidence that patients needing specialty medications have better health outcomes when they have the services of a community pharmacy rather than being forced into a PBM-owned mail order operation.

This Committee's attention to PBM regulation is extremely timely. PBMs are one of the least regulated sectors of the healthcare system. Because there is very limited federal regulation – basically a single provision in the Affordable Care Act – State regulation has increased. Fortunately the Pennsylvania legislature took the lead in sound regulation by passing Act 207 the Anti-mandatory Mail Order Act, which preserves patient choice by preventing PBMs from forcing consumers into mail order. While Act 207 was a good start, it did not create the necessary tools to enforce the statute or protecting against other egregious conduct. That is why the proposed legislation is so necessary.

Similarly, consumers also care about rising health care costs, including out-of-pocket costs for prescription drugs. PBMs have a profound impact upon drug costs. If PBMs are unregulated they can continue to engage in conduct that is deceptive, anticompetitive, egregious, and sometimes shown to be illegal. For this system to work effectively PBMs must be independent, and free of financial conflicts of interest. What health plans and employers are fundamentally purchasing is the services of an "honest broker" to secure the lowest prices and best services from both pharmaceutical manufacturers and from pharmacies. When the PBM is owned by the entity it is supposed to bargain with or has its own mail order operations there is an inherent conflict of interest, which can lead to fraud, deception, anticompetitive conduct, and higher prices. The two major PBMs – ESI/Medco and CVS Caremark clearly face that conflict since they own mail order operations, specialty pharmacies, and in the case of CVS Caremark – retail pharmacies.

Conflicts of interest raise severe concerns in the health care system. Where a payor is also a provider they can manipulate the relationship to raise health care costs. That is why, when pharmaceutical manufacturers obtained PBMs in the 1990's, the FTC acted to eliminate those conflicts of interest. The FTC challenged the acquisition of PCS by Lilly and Medco by Merck, because of the concern that having a manufacturer own a PBM would be giving the "fox the keys to the hen house door"—and would lead to higher prices for consumers.

In recent years, the major PBMs—including those with a clear conflict of interest in their cross-ownership with pharmacies—have engaged in a variety of anticompetitive and anticonsumer practices. The proposed legislation appropriately addresses many of these practices, and I urge the committee to enact it. However, in many respects the legislation does not go far enough to regulate many of the anticompetitive practices of PBMs and we highlight the need to address transparency and MAC pricing in the legislation.

## II. Chronic Anticompetitive and Consumer Protection Problems in the PBM Market

PBMs are like other healthcare intermediaries that manage transactions by forming networks and transferring information and money. As a former antitrust enforcer I know that there are three essential elements for a competitive market: (1) transparency, (2) choice and (3) a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access, there are agency relationships and securing adequate information may be difficult.

Why are choice, transparency, and a lack of conflicts of interest important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering fair prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. In both of these respects the PBM market is fragile at best. There is certainly a lack of choice especially for those plans that are dependent on the top tier big two PBMs (Medco/ Express Scripts and CVS Caremark). And PBM operations are very obscure and a lack of transparency makes it difficult for plans including government buyers to make sure they are getting the benefits they deserve.

When dealing with intermediaries, it is particularly critical that there are no conflicts of interest. A PBM is fundamentally acting as a fiduciary to the plan it serves. The service a PBM provides is that of being an "honest broker" bargaining to secure the lowest price for drugs and drug dispensing services. When a PBM has an ownership interest in a drug company or has its own mail order or specialty pharmacy dispensing operations, it is effectively serving two masters and may no longer be an "honest broker."

Finally, where these factors – choice, transparency and lack of conflicts of interest are absent – often regulation is necessary to fill the gap. And Congress has enacted some regulation that provides a degree of transparency under the Affordable Care Act. But unlike other aspects of the healthcare delivery system, PBMs remain basically unregulated.

Competition and choice are crucial for a market to work effectively. Currently consumers in Pennsylvania make a choice in how they value pharmacy services. Some choose community pharmacies, others who value one-stop shopping choose their local supermarkets, and others choose chains. This choice is important because competitors have to respond to this choice by improving services and lowering prices.

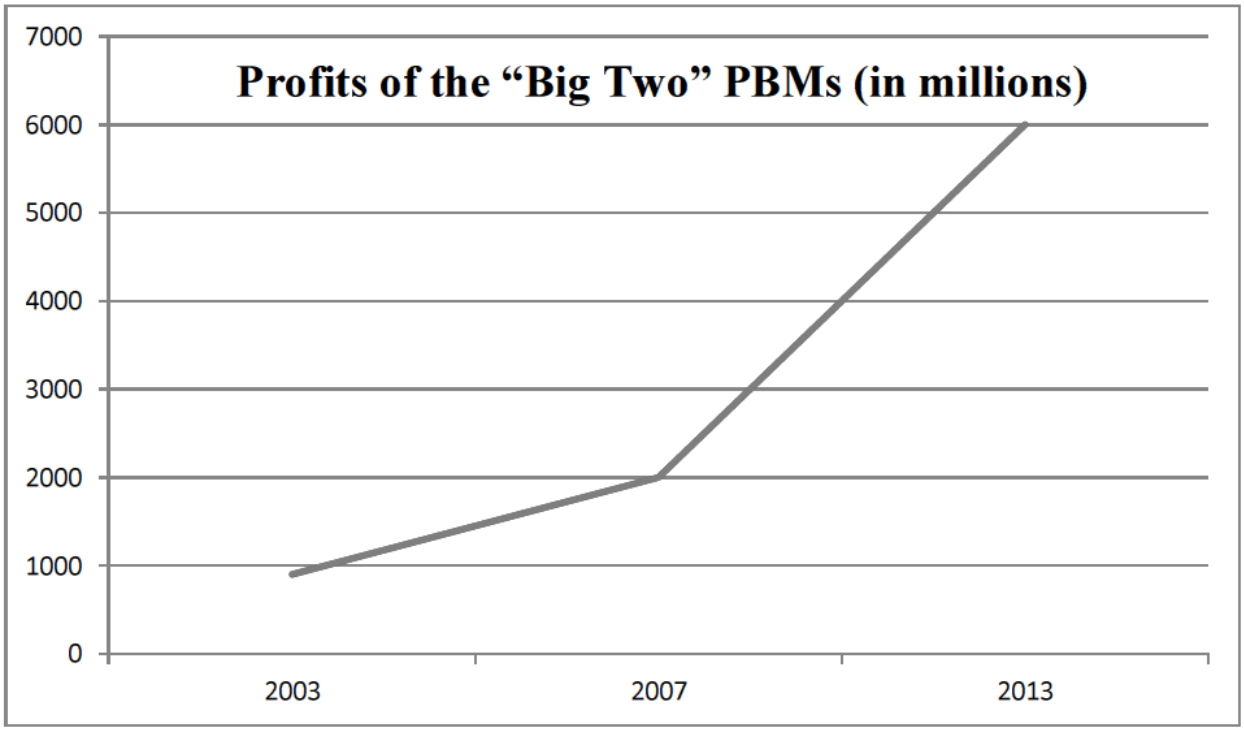
One important aspect of pharmacy services is the service pharmacists provide in assisting consumers in dealing with insurance companies and PBMs. In fact the pharmacist, because of this assistance is effectively the face of the pharmacy benefit. From the countless conversations I have had with consumers and consumer advocates, one thing is clear: PBMs create barriers for consumers, and patients typically seek help from their pharmacist to navigate their pharmacy benefit. The majority of consumers never directly interact with their PBM or insurance company, and pharmacists are their only connection to the vast array of complex rules and agreements that determine their prescription drug benefit. For these consumers, pharmacists act as an advocate, providing information on what limitations the PBM may be imposing on the patient, the co-pay the PBM has determined the patient will pay, and a host of other PBM policies affecting the

patient. When a particular policy is problematic, the pharmacist will often work through it with the patient, providing explanation and even advocating on behalf of the patient with the PBM—going far beyond the tasks for which the pharmacist is paid.

In effect, pharmacists provide a necessary check on the complex system of PBMs. That is another reason why this legislation is so necessary

## III. Ongoing fraudulent and deceptive conduct

What is the result of this dysfunctional market? PBMs entered the health care market as "honest brokers" or intermediaries between heath care entities. However, the role of the PBM has evolved over time and increasingly PBMs are able to — "play the spread" – by not fully sharing the savings they secure. As a result PBM profits have skyrocketed over the past decade. Since 2003, the two largest PBMs—Express Scripts/Medco and CVS Caremark— have seen their profits increase by almost 600% from $900 million to almost $6 billion.




The PBMs' skyrocketing profits suggests that the market is not competitive and that plans and consumers are paying more than they otherwise would. That is why regulation is so necessary.

Facing weak transparency standards, the largest PBMs frequently engage in a wide range of deceptive and anticompetitive conduct that ultimately harms and denies benefits to consumers. Some PBMs secure rebates and kickbacks in exchange for exclusivity arrangements that may keep lower priced drugs off the market. PBMs may switch patients from prescribed drugs to an often more expensive drug to take advantage of rebates that the PBM receives from drug

manufacturers. In addition, PBMs derive enormous profits from the ability to "play the spread" between pharmaceutical manufacturers, pharmacies and health care plans.

More recently PBMs are finding new revenue sources through egregious conduct. Some PBMs are using audits not just as a means of combating fraud but as a mechanism to secure greater revenue. PBMs engage in a variety of audit tactics such as "extrapolating" errors to inflate recoveries.[3] Other PBMs are manipulating generic drug reimbursement rates, known as MAC pricing, as a method of increasing profits. Often these generic rates force pharmacies to dispense below cost.

No other segment of the health care market has such an egregious record of consumer protection violations as the PBM market. Between 2004 and 2008, the three major PBMs have been the subject of six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases listed below, resulted in over $371.9 million in damages to states, plans, and patients so far.

- *United States v. Merck & Co., Inc., et.al*—$184.1 million in damages for government fraud, secret rebates, drug switching, and failure to meet state quality of care standards.
- *United States v. AdvancePCS* (now part of CVS/Caremark)—$137.5 million in damages for kickbacks, submission of false claims, and other rebate issues.
- *United States v. Caremark, Inc.*—pending suit alleging submission of reverse false claims to government-funded programs.
- *State Attorneys General v. Caremark, Inc.*—$41 million in damages for deceptive trade practices, drug switching, and repacking.
- *State Attorneys General v. Express Scripts*—$9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans.

It is important to note that the regulatory provisions of many of these settlements have already expired while others will expire within the next 10 years, making state action regulating this industry all the more vital to ensuring that the market functions with transparency, consumer choice, and free of conflicts of interest. [4]

There are three very important lessons here: (1) the fundamental elements of a well functioning market are absent; (2) plans and consumers have already suffered substantial harm from deception, fraud and other egregious practices: and (3) there is a tremendous need for comprehensive regulation of PBMs.

[3] The Pennsylvania legislature currently is considering fair audit legislation in S.B. 461.

[4] For a more detailed analysis of the federal and state cases against the PBMs, *see* David A. Balto, *Federal and State Litigation Regarding Pharmacy Benefit Managers*, January 2011 http://www.dcantitrustlaw.com/assets/content/documents/PBM/PBM%20Litigation%20Updated%20Outline%20-%201-2011.pdf.

## IV. The Proposed Legislation Represents a Sound Approach to Creating a Regulatory Structure for PBMS

### A. Regulatory Authority Should be Vested with the Board of Pharmacy

At the outset we must recognize that the Commonwealth has no regulatory body vested with the authority to regulate PBMs. The lack of a regulatory body is critical. As much as the Commonwealth needs PBM regulation there must be an agency with jurisdiction to regulate. And that agency must be given the resources to fulfill its enforcement mandate.

The proposed legislation appropriately vests regulation of PBMs with the state Board of Pharmacy. The principal role of a state board of pharmacy or any professional licensing board in any state is that of consumer protection. The Board has the experience and expertise to fulfill the consumer protection provisions in the proposed legislation. Its members have significant expertise in drug dispensing and protecting privacy. It is responsible to ensure that all Pennsylvania consumers receive the highest level of service for drug dispensing.

Some may raise concerns about a Board of Pharmacy regulating PBMs because the Board includes pharmacists who may compete with the PBM. Those concerns are misplaced. There is no evidence that the Board of Pharmacy or any other state professional regulatory board has ever acted inconsistent with their duty to the public. Moreover, there are representatives of the public on the Board of Pharmacy including a representative from the Attorney General's office. The proposed legislation addresses this concern by incorporating a confidentiality provision. Further, State boards of pharmacy deal on a daily basis with sensitive practitioner and consumer health information which they hold in strict confidence. Moreover, if a Board member were found to be inappropriately using any of these data, that individual would be subject to significant legal consequences.

Consumers need a strong regulator of PBMs and that authority is best vested with the Board of Pharmacy. However, we believe the legislation should go further and provide an enforcement mechanism. Without an adequate enforcement mechanism, the Board of Pharmacy will be unable to reign in on abusive practices. The proposed legislation should contain a provision permitting individuals to remedy alleged violations of this legislation. This complaint process should involve an internal review and investigation as well as an appeals process to the Board.

### B. It is Important to Protect Patient Choice and Eliminate Conflicts of Interest

As consumers and patients we all understand the critical importance of patient choice. Only where consumers have the full range of choices does the competitive market thrive. Unfortunately, because PBMs have their own retail operations – through retail stores, mail order, or specialty pharmacy – they are increasingly engaging in conduct that restricts patient choice and leads to higher costs and worse health care.

The proposed legislation helps preserve patient choice though two provisions. First it prevents PBMs from mandating that a patient uses "a specific retail pharmacy, mail order pharmacy, specialty pharmacy or other pharmacy if the PBM has an ownership interest in the pharmacy." Second, it prevents a PBM from intervening in the "delivery or transmission of prescriptions from the prescriber to the pharmacist or pharmacy for the purpose of: influencing the prescriber's choice of therapy; or altering the prescription information, including but not limited to, switching the prescribed drug without the express authorization of the prescriber."

Both of these provisions can play a crucial role in preserving patient choice. Additionally, the proposed legislation could help to prevent fraud and abuse by requiring that PBMs disclose to covered entities the cost of both drugs and any benefit or payment directly or indirectly accruing to the PBMs if they make a substitution in which the substitute drug costs more than the prescribed drug.

The major PBMs make a large portion of their profits by forcing Pennsylvania consumers to use out of state mail order. The major PBMs often restrict network options to drive consumers to their operations. Mail-order may be more costly, may result in significant waste, and fails to provide the level of convenience and counseling that many consumers require. Consumers may have existing relationships with a community pharmacy and may not wish to leave the pharmacist they know and trust to be served by a mail order robot. Others simply enjoy the ability to one-stop-shop and prefer the convenience of their supermarket pharmacy. The bottom line is that consumers are left worse-off when they are unable to choose the level of pharmacy care they desire. The Commonwealth already recognized that fact when it enacted the anti-mandatory mail order legislation.

The ownership of specialty pharmacies exacerbates the conflict of interest problem. Restrictive networks raise significant concerns for the over 57 million Americans that rely on specialty drugs.[5] Specialty drugs are typically expensive treatments that require special handling or administration. These drugs provide treatment for our nation's most vulnerable patient populations who suffer from chronic, complex conditions such as hemophilia, Crohn's Disease, Hepatitis C, HIV/AIDS, and many forms of cancer. The leading PBMs – Express Scripts and CVS Caremark own their own specialty pharmacies and increasingly force consumers to use their specialty pharmacy. Specialty drugs are expected to be the single greatest cost-driver in pharmaceutical spending over the next decade. The cost of specialty drugs is rising rapidly, increasing by 28.7 percent in 2012 and expected to reach as high as 50 percent by 2018.[6] Meanwhile, by 2016, 8 of the top 10 prescription drugs are expected to be specialty.[7]

The dominant PBMs are able to force consumers to use their own specialty pharmacies through restrictive networks. These networks can be higher cost and can also disrupt the continuum of care degrading health outcomes and increasing healthcare costs. [8] Patients on

---

[5] *Rising Health Costs, Medical Debt and Chronic Conditions*, Issue Brief, Center for Studying Health System Change (Sept. 2004).

[6] Prime Therapeutics. *2013 Drug Trends Insights*. (2013).

[7] Medco Health Solutions. *2011 Drug Trend Report*. (2011).

[8] The vital service-related role of independent specialty pharmacies was described in my testimony before the United State Senate Judiciary Antitrust subcommittee concerning the Express Scripts-Medco merger. *See* David Balto, Testimony regarding "The Express Scripts/Medco Merger: Cost Savings for Consumers or More Profits for

specialty drugs often require regular contact and counseling from their pharmacist (who is often assisted by a nurse). For many disease states, the pharmacist and nurse regularly contact the patient to make sure the drug is properly administered, taken on time, and the drug is working effectively. Disrupting this patient-provider relationship in complex and expensive treatment of very sensitive health conditions imposes significant harm to both the consumer and the health plan. We all know there is a profound difference between the personal treatment of an independent pharmacy and dealing with the automated telephone approach of the large PBMs.

Moreover, restrictive networks and steering practices rob consumers of the choice to use their preferred pharmacy and method of distribution; and—with this important rivalry gone—consumers also miss out on the benefits of vigorous competition, including lower prices and improved service. These restrictive networks deny patients a choice in provider and, given the high-touch nature of services in this area, this choice is highly valued by many consumers. The PBMs' ability to impose restrictive networks harms consumers that depend on the high-cost products and services that are of great, and even life-altering, significance to these vulnerable patients.

Finally, these PBMs have used their market clout to extract exclusivity arrangements from manufacturers significantly increasing the price of drugs. Take the case of H.P. Acthar Gel, a drug for severe epilepsy whose price jumped from $1,600 a vial to $23,000 after Express Scripts was named the sole distributor.[9] These PBMs have also created exclusive specialty networks to prevent retail pharmacies in their network from dispensing specialty drugs. Express Scripts and Medco in particular steer plan participants towards their captive specialty pharmacy (which in turn forces the plan participants to use the PBM's captive mail order facility). That is why this provision is so essential for the thousands of Pennsylvania consumers who need specialty drugs.

### C. Preserving Patient Privacy is Necessary

Patients have tremendous concerns about the privacy of all their health care information, especially the drugs they take. The proposed legislation provides that a PBM cannot sell claims data without the permission of the plan sponsor. These provisions are necessary because consumers have a right to protect their private patient information. In addition, the legislation also provides that PBMs shall "[n]otify a plan sponsor if such PBM intends to sell utilization or claims data" and also "[n]ot sell such data unless the sale complies with all Federal and State laws." A PBM is also prohibited from "transmit[ing] any personally identifiable utilization of claims data to a pharmacy owned by the PBM if the patient has not voluntarily elected to share such data." All of these provisions are necessary to ensure a patient's vital right to have their privacy protected.

---

the Middlemen?" before the U.S. Senate Subcommittee for Antitrust, Competition Policy and Consumer Rights, December 6, 2011, available at http://dcantitrustlaw.com/assets/content/documents/testimony/SenateJudiciary.ESIMedci.Balto.pdf.

[9] Freudenheim, Milt. "The Middleman's Markup." The New York Times (April 19, 2008).

## V. The Legislation is not Preempted by ERISA

Some may raise concerns that any proposed legislation is preempted by the Employee Retirement Income Security Act ("ERISA"). Those concerns are misplaced.

ERISA covers certain employee benefit plans, including some health plans, and provides detailed standards under the goal of providing uniformity to protect employee pension plans from fraud and mismanagement.[10] As a result, generally ERISA can preempt state laws that "relate to any employee benefit plan."[11] ERISA, however, has a savings clause that saves from preemption state laws governing the "business of insurance" so long as the State's law is "limited to entities within the insurance industry."[12] This is precisely what the proposed legislation does. Moreover, federal courts have narrowed the broad interpretation of ERISA preemption of state laws and have expressed reluctance to find state laws preempted by ERISA.[13]

The PBM industry has invested a great deal of time and money into defeating state legislative and regulatory proposals that would require their oversight. PBMs have a long history of using their status or connection to an ERISA plan to evade attempts at state regulation. Over twenty states have been able to regulate PBMs without raising ERISA concerns.

## VI. The Legislation Can Be Strengthened by Requiring Transparency and Requiring Standards on MAC Pricing

### A. Transparency Provisions are Necessary to Protect Plan Sponsors and Consumers

The proposed legislation is a sound beginning but it can be significantly strengthened through a provision requiring transparency. It is essential to provide transparency for consumers, which will help them to adequately evaluate products carefully, to make informed choices, and to secure the full range of services they desire. In these respects the PBM market is fragile at best. PBM operations are very obscure and a lack of transparency makes it difficult for payors to make sure they are getting the benefits they deserve.

Responding to the numerous enforcement actions, both a handful of states and Congress have taken measures to enact transparency provisions by requiring some degree of disclosure of rebates and other revenue. In addition, in the multistate enforcement action against CVS Caremark, 30 state attorneys generals required rebate disclosure. Finally, some large sophisticated health plans have negotiated for greater transparency.

---

[10] 29 U.S.C. § 1001, *et seq*. For a more detailed discussion of why state legislation will not be preempted by ERISA see letter of David Balto to Hawaii State Legislature April 12, 2013, available at http://www.dcantitrustlaw.com/assets/content/documents/House%20Bill%2065_Baker_Belatti.pdf.
[11] 29 U.S.C. § 1144(a).
[12] 29 U.S.C. § 1144(b)(2)(A).
[13] *See, e.g.*, *N.Y. State Conf. of Blue Cross and Blue Shield Plans v. Travelers Inc. Co.*, 514 U.S. 645 (1995).

Although settlements from litigation and negotiations have helped to address some issues, without legislation a lack of transparency allows PBMs to "play the spread," leading to higher costs for plan sponsors and patients. PBMs earn enormous profits by negotiating rebates and discounts with drug manufacturers in exchange for promoting certain drugs on their preferred formulary or engaging in drug substitution programs. PBMs also negotiate contracts with pharmacies to determine how much the pharmacists will be paid for dispensing medication and providing services. By paying a lower reimbursement rate to pharmacies, but failing to adequately disclose reimbursement rates PBMs can generate more revenue. In both respects, PBMs can play the spread by failing to disclose these forms of indirect compensation. The failure to disclose these payments denies purchasers important information that impacts their buying decisions. As a result, this lack of information often results in higher costs for consumers, health plans, employers, and other plan sponsors.

PBMs are free to "play the spread" between manufacturers, pharmacists and plans because of a lack of disclosure. Unclear and inadequate disclosure of rebates and discounts undermine the ability of plan sponsors to compare competing proposals. Because rebates, discounts, and other fee structures remain undisclosed, plan sponsors cannot clearly identify and choose PBMs offering the highest value services. PBMs' promise of controlling pharmaceutical costs has been undercut by a pattern of conflicts of interest, self-dealing, deception, and anticompetitive conduct. The dominant PBMs have been characterized by opaque business practices, limited market competition, and widespread allegations of fraud.

Increased disclosures by PBMs have resulted in price decreases and significant savings for health plans. Increasingly larger health plans are negotiating for transparency and securing significant savings. Large plan sponsors, such as universities, states, and federal programs have recently learned that they can achieve substantial cost savings by requiring transparency – i.e. requiring PBMs to disclose their negotiations and financial interactions with drug manufacturers.

For instance, New Jersey projects savings of $558.9 million over six years and Texas expects savings of $265 million by switching to a transparent PBM contract for their state employee health plans.

Other plans have been forced to take even more extreme steps to ensure transparency and honest brokering in the negotiations of prices and rebates – they have simply eliminated their PBM and managed their own pharmacy benefits directly. For example, TRICARE, the federal health plan for military personnel and their families, anticipates savings of $1.67 billion by negotiating its own drug prices, including rebates, rather than going through a PBM. The University of Michigan has saved nearly $55 million by administering its own plan for the past six years. Each of these examples demonstrates that increased transparency can improve competition and reduce costs to plans and consumers.

The proposed legislation would be significantly strengthened through transparency provisions requiring disclosure of rebates and discounts.

### B. The Legislation should address the abuse of MAC pricing[14]

Like many health care businesses PBMs must establish reimbursement rates for services and the dispensing of drugs. This system works best, for consumers, plans, and pharmacies when there is a transparent and consistent system for determining these reimbursement rates. When there is a transparent and consistent system all of the market participants can effectively plan, purchase goods and provide services. Where transparency and consistency are absent there is a significant opportunity for providers and ultimately consumers to be harmed by deceptive and unfair conduct.

Unfortunately, currently the reimbursement system for generic drugs often lacks these critical elements. Generic drug reimbursement is based on a so called "MAC" list, which sets the "Maximum Allowable Cost." MAC lists are PBM-generated list of products that includes the upper limit or maximum amount that a PBM will pay for generic drugs and brand name drugs that have generic versions available. There is no standard methodology for derivation of MAC lists or how the maximum prices are determined. Neither plan sponsors nor retail pharmacies are informed how products are added or removed from a MAC list or the methodology that determines how this so-called "maximum" cost is calculated or adjusted. Moreover, PBMs often change the "MAC" benchmark, or utilize multiple MAC lists to create a spread between what they charge a plan versus the amount they reimburse a pharmacy. This lack of transparency and prevalence of nonstandard MAC list and pricing derivation allows PBMs to utilize an aggressively low MAC price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients, plan sponsors. Essentially, the PBMs reimburse low and charge high with their MAC price lists, pocketing the significant spread between the two prices. Most plans are unaware that multiple MAC lists are being used and have no real concept of how much revenue the PBM retains.

This can be additionally problematic from a plan sponsor perspective. The lack of transparency surrounding MAC list derivation causes plans worry that they are paying more than they should for some multisource products. Without the knowledge of whether certain generics are included or excluded on MAC lists, a plan does not know whether a member's copay may increase due to drugs not being available on MAC lists. A member may complain that they cannot get access to a generic that should be available through their benefit and the plan is forced to pay a higher price to the PBM.

The proposed legislation should address these problems by, *inter alia*, requiring PBMs to disclose the specific market-based sources they use to determine and set MAC prices; ensuring that MAC prices are not set below costs (market-based sources available); setting specific requirements of drugs to be included on MAC lists; and requiring PBMs to disclose to plan sponsors whether the PBM is using an identical MAC list with respect to billing the plan sponsor and the network retail pharmacy. If a PBM is using multiple MAC lists, the proposed legislation should require that the PBM disclose to the plan sponsor any differences between the amount paid to any pharmacy and the amount charged to the plan sponsor. Where transparency and

[14] Recently, North Dakota enacted legislation to address the distortions created by use of MAC pricing by PBMs. *See* Letter to Sen. Judy Lee, Re: House Bill No. 1363 (March 25, 2013), available at.http://www.dcantitrustlaw.com/assets/content/documents/NDPHA%20letter%202013_Lee.pdf.

consistency are absent there is a significant opportunity for providers and ultimately consumers to be harmed by deceptive and unfair conduct. By requiring disclosure of MAC pricing, the legislature would help ensure Pennsylvania consumers, plans, and pharmacies do not pay more for generic drugs than they should.

## VII. Conclusion

Pennsylvania consumers need greater protection from the egregious practices of PBMs. That is why this legislation is so necessary.