The pharmacy benefit managers (PBMs) lobbying group has paid for yet another report containing dubious claims that proposals to increase prescription drug transparency will increase drug benefit costs. The report was written by Visante, a firm with a well-documented history of biased research methods.[1] By examining the report's claims, it is clear they do not hold up to scrutiny.

PBM Disclosure Mandates

The claim: Mandates requiring PBMs to disclose price concessions from drug manufacturers and pharmacies would reduce savings from manufacturer rebates and pharmacy network discounts.

The truth: There is a growing recognition of the value of PBM transparency in healthcare. Federal law dictates that PBMs that serve any of the state insurance exchanges and Part D plans disclose certain aggregated information, such as manufacturer rebates and price concessions, to the Secretary of Health and Human Services and to the plan sponsors. There has been no evidence of a reduction in savings as a result of these disclosures. In fact, the United States Department of Health and Human Services recently asserted in a proposed rebate rule released in early February, that PBM rebates in programs like Medicare Part D and Medicaid, may contribute to drug prices increasing at a faster rate, encouraging PBMs to favor higher-cost drugs over lower cost drugs, and discourage the adoption of lower-cost brand drugs and biosimilars.

The claim: Disclosure requirements could lead to tacit collusion, allowing firms to observe the prices charged by their rivals, which could lead to reduced competition.

The truth: The report fails to consider to whom the disclosures are made. Disclosures are required to be made to plan sponsors and government agencies, not PBM or drug manufacturer rivals. In order for a plan sponsor to make the most informed purchasing decisions in a free market environment, more information is essential, not less. Such specious arguments about collusion are simply a red herring. Those states that have passed rebate disclosure requirements have included provisions expressly stating that the disclosed information is confidential.[2]

The claim: Contract negotiations between PBMs, manufacturers, and pharmacies are like sealed-bid auctions: manufacturers and pharmacies are encouraged to offer aggressive price concessions since they don't know what's being offered by their competitors.

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[1] *See* Marty Schladen, *CVS makes dubious case for rebates' impact on drug prices*, THE COLUMBUS DISPATCH (Jan. 14, 2019), *available at* https://www.dispatch.com/news/20190114/analysis-cvs-makes-dubious-case-for-rebates-impact-on-drug-prices.

[2] Ct. H.B. 5384 (2018); La. S.B. 283 (2018); Or. H.B. 4005 (2018). *See also* National Academy for State Health Policy, "A Model Act Relating to Pharmacy Benefit Managers," https://nashp.org/wp-content/uploads/2018/08/PBM-Model-Act-FINAL-8_9_2018.pdf.

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

The truth: During contract "negotiations," pharmacies and their Pharmacy Services Administration Organizations (PSAOs) are offered take-it-or-leave-it contracts. In 2013, the Government Accounting Office (GAO) conducted a study on the role and ownership of PSAOs and stated that "over half of the PSAOs we spoke with reported having little success in modifying certain contract terms as a result of negotiations. This may be due to PBMs' use of standard contract terms and the dominant market share of the largest PBMs. Many PBM contracts contain standard terms and conditions that are largely non-negotiable."[3]

PBM Fiduciary Mandates

The claim: Federal courts have struck down state PBM fiduciary mandates as being preempted by the Employee Retirement Income Security Act (ERISA).

The truth: Federal courts have **upheld** fiduciary mandates because they **are not preempted** by ERISA.[4]

The claim: Imposition of a fiduciary mandate would create a conflict between PBMs' contractual obligations to their clients and the fiduciary duty to act "solely in the interest of plan participants."

The truth: The report confuses the issue. Those states with fiduciary mandates require that PBMs have a fiduciary duty to their clients, not the undefined concept of a "plan participant."[5] Therefore, no conflict would exist.

Any Willing Specialty Pharmacy Requirements

The claim: Any willing specialty pharmacy legislation would bring in specialty pharmacies that do not have specialized resources and expertise and are not coordinated with PBM programs.

The truth: Any Willing Pharmacy (AWP) laws do not require PBMs to accept any pharmacy, nor do they prohibit PBMs from establishing the terms and conditions to be included in a specialty network. PBMs are free to establish terms to ensure quality and safety. They must accept any pharmacy that is willing and able to meet those terms and conditions. Therefore, AWP laws ensure PBMs and plan sponsors have the authority to allow only qualified pharmacies into their networks. Realizing that AWP laws increase both access to pharmacy services and competition among pharmacies, many states and the Medicare Part D program have implemented AWP rules.[6]

The claim: Health plans and PBMs typically contract to include only selected specialty pharmacies in their pharmacy networks to ensure high-quality services for consumers, avoid waste, and ensure appropriate use of high-cost specialty medications. Specialty pharmacies must meet payers' terms and conditions to be included in preferred pharmacy networks.

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[3] GAO-13-176.

[4] *First Circuit Upholds Maine Pharmacy Benefits Law,* AHLA (Dec. 2005) https://www.healthlawyers.org/News/Health%20Law%20Digest/Pages/First_Circuit_Upholds_Maine_Pharmacy_Benefits_Law.aspx

[5] Nv. S.B. 539 (2017). *See also* NASHP, "A Model Act Relating to Pharmacy Benefit Managers."

[6] *See* "Any Willing Provider Laws," PBM WATCH http://www.pbmwatch.com/any-willing-provider-laws.html.

The truth: PBMs use specialty pharmacy networks to steer patients to PBM-owned specialty pharmacies. In 2017, the top four specialty pharmacies were all owned or co-owned by a PBM.[7] In 2017, specialty drugs accounted for one-third of total prescription dispensing revenues, and that number will increase to 47% by 2022.[8] It is therefore unsurprising that PBMs want that money remaining with PBM-owned pharmacies.

[7] Adam J. Fein, *The Top 15 Specialty Pharmacies of 2017: PBMs and Payers Still Dominate,* DRUG CHANNELS (Mar. 13, 2018) https://www.drugchannels.net/2018/03/the-top-15-specialty-pharmacies-of-2017.html.
[8] *Id.*