June 15, 2018

The Honorable Hank Vaupel
Michigan House of Representatives
N-896 House Office Building
PO Box 30014
Lansing MI 48909

RE: Drug Price Transparency Workgroup Draft Bills

Dear Representative Vaupel:

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing you to provide feedback on the drug price transparency workgroup draft bills discussed at the June 5 workgroup. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through large and small employers, health plans, labor unions, state and federal employee-benefit plans, and government programs.

PCMA appreciates the opportunity to be part of the discussion on the rising costs of prescription drugs. PBMs' primary focus is creating solutions for payers to improve the quality and continuity of care patients receive while managing ever-growing costs. Over the next ten years, PBMs and specialty pharmacies will save payers and patients an estimated total of $650 billion nationally when compared to expenditures with limited use of PBM tools.[1]

At the outset it is important to note that it is always the drug manufacturer who decides what the price of a given drug will be. PBMs do not set drug prices—rather, PBMs evolved as a means to lower the cost of drug benefits by negotiating price concessions with manufacturers and pharmacies on behalf of plan sponsors. In addition, PBMs lower costs by encouraging use of generics, offering specialty pharmacy services, and helping patients with drug adherence. Payers would not choose to use PBMs if PBMs did not bring down costs. Quite simply, the easiest and most effective way to decrease the price of drugs is for manufacturers to reduce the prices they set for drugs.

We understand that Michigan policymakers want deeply to be part of the solution to the problem of rising drug costs, and we share this concern. However, some provisions in the draft PBM bill threaten to have the opposite effect, creating an environment where tacit collusion among manufacturers can take place, which as the Federal Trade Commission has highlighted multiple times, could result in *higher* prescription drug prices, and thus negatively impact consumers.

[1] Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante, (February 2016), available at https://www.pcmanet.org/pbms-generating-savings-for-plan-sponsors-and-consumers/.

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However, one important, consumer-focused transparency concept incorporated in this draft is the provision that prohibits so-called "gag clauses" in PBM–pharmacy contracts. PCMA supports the patient paying the lower of the cash price or the copay, and believes that pharmacists should have the ability to discuss lower cost alternatives with patients, even if they are outside of the health plan benefit. This is the type of common sense transparency that both benefits consumers and encourages important pharmacist-patient discussions.

The concerning provisions in the draft are those that would threaten to publicly expose the amount of rebates that PBMs collect and share with payers. Rebates are used as a tool to help reduce the cost to third party payers who are arranging patient access, and indirectly patients, through lower premiums and copays. Drug price negotiations operate like sealed-bid auctions where bidders (in this case, the manufacturers) offer the lowest price they can in hopes of winning business. If rebates were made public, the companies giving the biggest rebates would likely stop giving them and costs would rise. Though the draft refers to the rebate reporting as in the "aggregate," the definition of "aggregate retained rebate percentage" appears to establish a formula where drug-specific rebates could be calculated. Without any protections from backing into drug-specific rebate amounts, if this information were to be in the public sphere, using basic enrollment and coverage market information, manufacturers could easily figure out what price concessions their competitors are providing.

It is with this concern that the FTC has said, ""[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors … then tacit collusion among manufacturers is more feasible … Whenever competitors know the actual prices charged by other firms, tacit collusion—and thus higher prices—may be more likely."[2] The FTC has also warned several states that legislation requiring PBM disclosure of negotiated terms could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[3] Additionally, the Department of Justice and the FTC issued a report noting that "states should consider the potential costs and benefits of regulating pharmacy benefit transparency" while pointing out that "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."[4]

This draft bill requires an unprecedented level of disclosure of confidential pricing information that exists between private businesses. Rebate sharing arrangements are simply an element in pricing a contract between a payer and PBM, and PBMs are transparent to clients on rebates in accordance with contractual requirements. Nearly half of employer plan sponsors negotiating to receive manufacturer rebates elect to receive 100% of the rebate amounts[5] and pay administrative fees to the PBM. Other payers negotiate for their PBMs to receive a portion of the rebates. Payers may also negotiate to put drug inflation risk on the PBM by locking in a specific

[2] U.S. Federal Trade Commission and the U.S. Department of Justice, Improving Health Care: A Dose of Competition (July 2004).
[3] Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004).
[4] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004
[5] Pharmacy Benefit Management Institute, "PBMI Research Report: Trends in Drug Benefit Design," 2016.

rate for their drugs. Plan sponsors may negotiate any combination of these payment methods and other provisions, and always have the right to audit their PBMs' performance under their contracts. On average, PBMs pass back 90 percent of negotiated rebates from drug manufacturers, which payers use to lower enrollees' and their own health spending.[6] Because of the variety of types of payer-PBM contracting and rebate sharing arrangements, the information reported would be out of context and would have no value to the state. However, the potential *cost* of public disclosure of those private contracts on payers and health care consumers would be great.

In addition, PCMA believes the disclosure requirements in the draft PBM bill would be preempted by the federal Employee Retirement Income Security Act (ERISA), to the extent those disclosures contain information on rebates collected for employer-provided coverage. Michiganders who work for private sector employers (whether large or small) are for the most part enrolled in ERISA plans. Many of those plans choose PBMs directly to serve as administrators to those plans, or work with health plans that choose PBMs as administrators.

ERISA provides a "comprehensive system for the federal regulation of employee benefit plans."[7] As the Supreme Court recently noted, there must be a "single uniform national scheme for the administration of ERISA plans without interference from the laws of several states."[8] No state mandate can directly or indirectly interfere with key matters of plan administration, such as interfering with PBM contracts with their clients by requiring reporting to state entities.

As the Supreme Court noted in Gobeille v. Liberty Mutual, "ERISA's reporting, disclosure, and recording requirements for welfare benefit plans are extensive," and states cannot impose differing or parallel regulations on administrators like PBMs. Only one entity—the U.S. Department of Labor—has the authority to require such reporting and disclosures. For these reasons, we believe the PBM reporting provisions in the draft bill are preempted by ERISA as they relate to employer-provided coverage, and would be struck down by a federal court if challenged.

On the PBM registration provisions in the draft, PCMA has no comment. As was discussed in the workgroup meeting, PBMs already register as TPAs with the Department of Insurance and Financial Services (DIFS) and provide business and financial information to the state in accordance with those requirements. We believe these long-standing protections are sufficient.

We appreciate the opportunity to provide comments on the drafts and look forward to future discussions. Thank you for your consideration.

[6] Written Testimony of Joanna Shepherd, Ph.D, Emory University for the ERISA Advisory Council Hearing on PBM Compensation and Fee Disclosure, June 19, 2014, Citing J. P. Morgan, "Pharmacy Benefit Management, Takeaways from Our Proprietary PBM Survey," May 21, 2014.
[7] District of Columbia v. Greater Was. Bd. Of Trade, 606 U.S. 125, 127 (1992).
[8] Gobeille v. Liberty Mutual Ins. Co., 577 U.S. ___ (2016).

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Sincerely,

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cc: Ms. Cindy Denby, Legislative Aide

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