

**Statement of the National Community Pharmacists Association (NCPA)
ERISA Advisory Council Hearing on PBM Compensation and Fee Disclosure
August 20, 2014**

Good Morning—my name is Susan Pilch and I am appearing today on behalf of the National Community Pharmacists Association (NCPA). NCPA represents the interests of pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. Together they employ over 300,000 full-time employees and dispense nearly half of the nation’s retail prescription medicines.

NCPA is pleased to be here today to discuss the important topic of PBM compensation and fee disclosure. As pharmacists, our members serve on the front lines of patient care and on a daily basis field questions from patients about the costs of their prescription medications. Most, if not all patients seem to assume that we, as pharmacists, determine the cost of prescription medications to patients. Very few, if any, patients are aware of the role that Pharmacy Benefit Managers (PBMs) play in determining virtually all aspects of their prescription drug benefit. In addition, most health plan sponsors and fiduciaries have very little knowledge of the breadth of PBM revenue streams and the ins- and- outs of PBM contracting and auditing. We feel that knowledge of this type is critical for plan sponsors and fiduciaries that are responsible for safeguarding the assets of a plan and protecting the rights of the beneficiaries.

PBMs serve as the “middleman” in virtually all prescription drug transactions in the United States. They are able to leverage the number of beneficiaries in a particular plan in order to negotiate lucrative rebates from pharmaceutical manufacturers. They also formulate pharmacy provider networks that will supply or dispense these drugs to the plans’ beneficiaries and in turn charge the plan sponsor for these products. What most consumers and plan sponsors alike do not know is that PBMs extract “spread” profits from both of these activities. Unless a plan has negotiated a “pass through” contract with its PBM --and typically only the largest and most sophisticated plans are able to do so-- the PBM will keep a significant percentage of the rebate dollars that they have obtained by virtue of the number of plan beneficiaries for themselves. Second, the amount that the PBM pays the pharmacy for dispensing the drug to the plan beneficiary is rarely the same amount that the PBM “charges” the plan for the same drug. Typically, the PBM “marks up” the cost of the drug, charging the plan more than the pharmacy is reimbursed, keeping the difference as profit for the PBM.

It is precisely these hidden spread amounts that need to be disclosed in some way to plan sponsors or plan fiduciaries. This type of information—about the vast sums of money that PBMs are making by virtue of the drug

spend of a particular plan—should be readily available to a plan. If plan sponsors or fiduciaries have a clearer picture about the amount of money that is being made by their vendor by virtue of handling the plan’s business—this may provide them with a greater ability to negotiate competitive contracts with these vendors in the first place.

NCPA testified on a closely related topic in December of 2010—when we spoke in favor of extending proposed regulations that would require fee disclosures for vendors of ERISA pension plans to vendors of ERISA welfare benefit plans (and specifically PBMs). In 2010, we also advocated for the disclosure of all “direct and indirect compensation” in light of the fact that much, if not the majority of, the compensation that PBMs receive is in the form of indirect compensation—typically in the form of manufacturer rebates, discounts, credits, fees, grants and chargebacks. Over the past decade, a number of government agencies and third party payors have filed numerous high profile lawsuits against major PBMs alleging a variety of inappropriate business schemes, including fraud, kickbacks, overcharges and breach of fiduciary duty to plan sponsors. Several of these lawsuits have since resulted in hundreds of millions of dollars in fines and settlements being paid by some of the largest for-profit PBMs.¹

There is a growing recognition of the value of transparency in healthcare—specifically PBM transparency. Federal law now dictates that PBMs that serve any of the state insurance exchanges and Part D plans disclose certain aggregated information to the Secretary of HHS and to the plan sponsors. Under the Medicare Modernization Act (MMA), Part D plans are already required to disclose to the Secretary the manufacturer rebates and price concessions for the purposes of determining whether the plans are passing through the direct and indirect price concessions that they negotiate. CMS had to revise the definition of “negotiated prices” to require that Part D sponsors base beneficiary cost sharing and price reporting to CMS on the price ultimately received by the pharmacy or other dispensing provider, commonly referred to as “pass-through” pricing. This was after they noted that sponsors were reporting the price they paid the PBM, which is higher than the price the PBM negotiates with pharmacies.

A few very large employers—with significant negotiating power—are now requiring similar “pass through” contracts and disclosures. However, as encouraging as these provisions are, these inroads are simply a starting point and the majority of plans do not have the industry knowledge or the negotiating power to exact similar results. There is no legitimate reason to limit the ability to obtain transparency to only government programs

¹ Benjamin, RG. Point: a case for state regulation of PBMs. *Managed Healthcare Executive*. May 17, 2007.

and the largest and most sophisticated plans. All plan beneficiaries should be able to reap the benefits of similar fiduciary protections, regardless of the size of their plan sponsor.

The Pharmaceutical Care Management Association (PCMA) has testified in the past about concerns that that if any disclosures are required, such transparency would somehow encourage “tacit collusion” on the part of the pharmaceutical manufacturers. However, in order for an ERISA plan fiduciary to make the most informed purchasing decisions in a free market environment, more – and not less information – is essential. Such specious arguments about collusion are simply a red herring. The PBM disclosures required of those PBMs that serve state exchanges and Part D are accompanied by a confidentiality provision—and require confidentiality on the part of HHS and of the plans themselves--something that could easily be added to any disclosure requirement contemplated for PBMs serving ERISA plans.

There are several different PBM reporting requirement options that the ERISA Advisory Council may consider that would provide ERISA plan fiduciaries with an additional tool with which to evaluate the PBM that they have chosen to serve their beneficiaries.

1. The first option would simply be to follow through on the contemplated course of action from 2010—and extend the disclosure requirements under 408(b)(2)—that are currently applicable to ERISA pension plan vendors—also applicable to ERISA welfare plan vendors (namely, PBMs). NCPA would recommend the addition of the following clarification of “indirect compensation” specific to pharmacy benefit managers to the existing definition of “indirect compensation” that appears in 408(b)(2).

“Indirect compensation is compensation received from any source other than the plan, the covered service provider, an affiliate or subcontractor.” (**Specific to pharmacy benefit managers or PBMS, indirect compensation shall include all financial benefits the PBM receives, including but not limited to all: rebates, discounts, credits, fees, grants, chargebacks, or other payments or financial benefits of any kind.**

A disclosure requirement of this type should be accompanied by a confidentiality requirement on the part of the ERISA plan/fiduciary. Any violation of this confidentiality provision could be subject to sanction by the Secretary of Labor pursuant to his or her powers under ERISA. It should also be noted that the final regulations under 408(b)(2) specifically allow both direct and indirect compensation amounts to be provided “either in the

aggregate or by the service that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services provided.” Allowing the information to be reported in the aggregate in combination with a confidentiality provision should be more than sufficient to allay the fears of the PBM industry. In addition, the final 408(b)(2) regulations also include a category for “incentive compensation” that is designed to capture compensation that is based on a “transaction basis (e.g., commissions, soft dollars, finder’s fees or other similar incentive compensation). It would seem that this category could also easily be used to account for certain types of PBM compensation-- such as the rebate dollars based on a plan’s drug spend.

2. A second option would require PBMs to disclose to plan fiduciaries the same aggregated information that is currently required of PBMs that serve state health insurance exchanges or Part D, also accompanied by a confidentiality provision. This would provide ERISA plans with the same disclosures that are already required under federal law for exchange plans and Part D.

The PBM industry may point to the fact that many PBMs hold certain voluntary third-party PBM accreditations or certifications and because of that fact, they should not be subject to any further requirements. However, it must be emphasized that these are not sufficient and do not address transparency to plan sponsors. URAC accreditation for example, evaluates five practice areas of a PBM that have nothing to do with financial disclosures, potential conflicts of interest or audit rights. URAC accreditation focuses is limited to five areas including organizational integrity (staff qualifications, quality improvement); customer service; distribution channels; drug use management; and therapeutic uses.

In addition to requiring a “baseline” level of disclosure, it is critical that plan sponsors and ERISA fiduciaries are able to conduct a valid and effective audit of their PBM. The best contract terms and PBM disclosures are of no practical use if there is no accountability on the part of the PBM. Strong audit rights are essential for the ERISA plan to meet its fiduciary responsibilities and ensure to the plan and its beneficiaries. In fact, if the plan fiduciaries do not ensure that they have effective audit rights over the PBM (or any plan vendor), they could be vulnerable to causes of action from plan beneficiaries who could assert that plan assets are not being adequately protected and safeguarded.

Historically, PBMs have resisted effective plan audits and have been relatively successful in inserting certain “roadblocks” or phrases that thwart plans from conducting a meaningful audit. PBMs typically cite confidentiality concerns or competitive trade secrets as their rationale for their reticence to disclose information

in an audit. However, it is unacceptable to have to depend on your own PBM to let you know how they are doing! Plan sponsors and fiduciaries have a right and an obligation, on the part of their plan and its members to validate and verify their PBM's performance. The following are several of the phrases that PBMs will typically try to insert into contracts to limit the ability of the plan sponsor to conduct a meaningful audit:

- Giving the PBM the ability to select or "co-select" the auditor: PBMs usually want to include language that gives them veto power over any auditor. NCPA believes that if an auditor has demonstrated appropriate expertise and professional experience, adequate insurance and a willingness to abide by a reasonable confidentiality agreement, then auditor selection should be at the sole discretion of the plan sponsor.
- Limiting what information the auditor can review. Many PBMs consider certain information and data to be "proprietary" and will not allow the plan sponsor or its auditor to access this information even to simply verify contractual obligations. This is in spite of the fact that the plan sponsor arguably "owns" much of the information that is considered proprietary (like claims data) because it is about its plan and plan members!
- Restricting the auditor from sharing their findings or pertinent information from the plan sponsor. Again, this is information about the prescription drug spend of plan beneficiaries themselves and should belong to the plan!
- Prohibiting the auditor from copying any information or data that would be necessary for the plan sponsor to review. Many times, PBMs will only allow auditors to "take notes" from official documents and records rather than allow them to be copied. This allows them to also claim that auditors must have made mistakes in their "notetaking," if red flags are raised.
- Preventing the recovery of funds that are due the plan sponsor. PBMs routinely conduct pharmacy audits and recoup funds from prescriptions that were mistakenly or inaccurately filled. These amounts should always be returned to plan sponsors.

Plan fiduciaries need to ensure that the above issues are dealt with in a satisfactory way in any future PBM contracts. As outlined in a 2008 article published in American Health and Drug Benefits, plan sponsors should build contract language that: (1) allows full audit rights to all PBM network pharmacy contracts, claims data,

manufacturer rebate and administrative fee contracts, mail service purchasing invoices, clinical coverage criteria and formulary-making records; (2) includes contract clauses that identify all documents and data to be made available to auditors; and (3) includes contract terms that prohibit the PBM from limiting who may perform such audits, at what times and under what circumstances.² The right to conduct a thorough audit of an ERISA plan's PBM contract is essential to ensuring that the assets of the plan are being adequately safeguarded and the rights of beneficiaries are being fulfilled.

Conclusion

In conclusion, NCPA recommends that the ERISA Advisory Council extend the disclosure requirements of Section 408 (b)(2) that currently apply to vendors of employee pension benefit plans to vendors of employee welfare plans (and specifically PBMs). In addition, under this option, NCPA would also recommend further clarification of what is meant by "indirect compensation" to ensure that all of the collateral arrangements that the PBMs have negotiated in connection to a plan's drug utilization are adequately covered. Alternatively, the ERISA Advisory Council could require the same disclosures for PBMs serving ERISA plans that currently are required for those serving state insurance exchange plans and Part D. In addition to requiring a certain baseline disclosures, it is critical that plan sponsors and fiduciaries have the unfettered ability to conduct a thorough and meaningful audit of their plan's PBM and making sure that these rights are adequately protected in any future PBM contracts. This could be accomplished by the publication of a PBM audit "best practices" guide or other education campaign on the topic for ERISA fiduciaries or the imposition of possible penalties for PBMs who thwart meaningful audits.

In closing, NCPA would like to thank the ERISA Advisory Council for holding these hearings on such an important topic and allowing us to present our views. I would be happy to answer any questions that you may have.

² Calabrese, David. Comparing Pharmacy Benefit Managers: Moving Well Beyond the Simple Spreadsheet Analysis. *AHDB*. 2008;1(5):9-19.