Statement of National Community Pharmacists Association (NCPA)
Public Hearing on Reasonable Contracts or Arrangements for Welfare Benefit Plans Under Section 408(b)(2)—Welfare Plan Fee Disclosure of ERISA

December 7, 2010

Good Morning—My name is Zachary French and I am appearing today on behalf of the National Community Pharmacists Association (NCPA). NCPA represents the interests of America's community pharmacists, including the owners of more than 23,000 independent community pharmacies, pharmacy franchises, and chains. Together, they have more than 315,000 employees, including 62,400 pharmacists, and dispense over 41% of all retail prescriptions.

NCPA feels strongly that the proposed regulation should apply to contracts or arrangements involving the provision of administrative services to employee welfare benefit plans, specifically Pharmacy Benefit Management (PBM) service contracts. PBMs should be required to disclose critical information about their primary revenue sources and potential conflicts of interest. This will give plan fiduciaries the necessary tools in order to assess the reasonableness of a PBM's compensation and any conflicts of interest that may affect the service providers' performance. In other words, plans need to know where all the money is buried so they can make determinations of whether the compensation they are paying is reasonable.

Over the past few years, due in large part to a proliferation of mergers, the PBM marketplace has become extremely concentrated. The "Big Three" PBMs, (Medco, ExpressScripts, and CVS Caremark) manage the drug benefit for approximately 95% of Americans with employer-based health coverage. From 2003 to 2007, these three PBMs saw their profits climb nearly threefold, from over $900 million to over 2.7 billion. In a truly competitive market, these dramatic profit increases would never occur. In spite of these facts, the PBMs are minimally regulated at the state and federal level, in large part due to extremely aggressive lobbying efforts. In the states that have managed to enact some form of PBM regulation, the PBMs have been very successful in claiming that such state legislation is not applicable to PBMs serving ERISA plans.

One of the PBM's primary profit streams is derived from rebates provided by drug manufacturers for driving brand drug market share on drugs purchased on behalf of PBM clients. PBMs retain all or a very large percentage of these rebates, even though they are generated by the welfare benefit plans' pharmacy "spend." This is a clear conflict of interest on the part of the PBM serving in its role as a service provider to a welfare benefit plan. But there are other sources of direct and indirect revenues earned by the PBM as well, whose names keep changing as the PBMs try new and innovative ways to hide these revenue streams from the plan sponsors. These include indirect remuneration such as educational sponsorship, data management payments, and others.

The DOL held a hearing on this very same issue in 2008. Testimony was provided at that time (WellPoint and ExpressScripts) to the effect that there was no evidence of any problems in the PBM industry. To the contrary, between 2004 and 2008, substantial enforcement actions instituted against each of the major PBMs indicating fraudulent and deceptive conduct have resulted in over $370 million in damages. These cases also shed light on some of the questionable widespread practices in the PBM industry, including the misuse of rebates, kickbacks, submission of false claims and drug switching.

During the 2008 proceedings on this issue, the PBM industry relied heavily on the fact that, in 2003, the Congressional Budget Office (CBO) estimated that a proposed amendment to the Medicare Modernization Act that would have required some level of transparency by PBMs involved in Part D would cost the taxpayers $40 billion over 10 years. In addition, it was suggested that PBM transparency would in some way "enable tacit collusion among drug manufacturers." In contrast, the recently enacted health care reform legislation now mandates a certain degree of PBM transparency in the form of aggregated required disclosures of all of the PBMs that will serve any of the state insurance exchange health plans, as well as in Medicare Part D. This federal mandate was scored by CBO as cost neutral and, due to the fact that the federal legislation provides for confidentiality between the PBM and the plan sponsor, there is no risk that such data will become public information and in any way impair the PBM's ability to negotiate with drug manufacturers. Likewise, a similar confidentiality provision could be applied to the disclosures under debate today.

Some large employers with the requisite amount of negotiating power have been able to demand certain measures of transparency from their PBM—and the PBMs are likely to argue that because of these contractual arrangements, the mandatory disclosures proposed by EBSA are unnecessary. However, the smaller ERISA plans do not have the negotiating power or knowledge base to demand the same disclosures and for this reason, it is critical that all the regulations under discussion today should apply to all PBMs serving ERISA plans—in order to establish a baseline or minimal level of required disclosures.

There is a growing recognition of the value of transparency in healthcare—specifically PBM transparency. Federal law now dictates that PBMs that will serve any of the to-be created state insurance exchanges and Part D plans disclose certain aggregated information to the Secretary of HHS and to the plan sponsors. Under the MMA, PBMs that serve 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 they negotiate. A few large employers—with sufficient negotiating power-- are now requiring various disclosures. However, as encouraging as these provisions are, these inroads are simply a starting point and the PBMs serving ERISA plans have a long history of using their status as ERISA plans to evade regulation.

Conclusion:

In conclusion, the totality of the circumstances—the extremely concentrated PBM marketplace, the minimal amount of state and federal regulation, and the lack of any verifiable harm to the PBMs by requiring transparency considered together with the potential benefits to plan fiduciaries --- clearly indicate that the proposed regulation should apply to service providers to welfare benefit plans—and specifically to Pharmacy Benefits Management contracts. Disclosure will allow plan fiduciaries to confirm that the PBM is providing the service it was hired to do—to secure low drug costs. Without transparency, the plan fiduciary has no way to verify that the PBM is sharing manufacturer rebates or that the PBM is negotiating the lowest possible cost for specific drugs.