



INTERNATIONAL

ISSUE BRIEF

Prepared For:

Pharmaceutical Care Management Association

601 Pennsylvania Avenue, Suite 740

Washington, DC 20004

Potential Effects of Proposed Changes to the Definition of Medicare Part D Negotiated Prices

Prepared By:

Peter J. Rankin, Archan H. Ruparel, and Eleanor C. Joseph

CRA International

1201 F Street, NW

Washington, DC 20004

Date: 15 July 2008

CRA Project No. D13373-00

DISCLAIMER

CRA International and its authors make no representation or warranty as to the accuracy or completeness of the material contained in this document and shall have, and accept, no liability for any statements, opinions, information or matters (expressed or implied) arising out of, contained in or derived from this document or any omissions from this document, or any other written or oral communication transmitted or made available to any other party in relation to the subject matter of this document.

1. EXECUTIVE SUMMARY

Operating at the nexus of contracts that define the pharmaceutical benefits reimbursement system, pharmacy benefit managers (“PBMs”) deliver value by providing efficient management services to health insurers, employers, unions, and other plan sponsors. In passing the Medicare Prescription Drug Improvement and Modernization Act of 2003, Congress modeled the new Medicare Prescription Drug program (“Part D”) on commercial market practices. This allowed PBMs to bring their expertise in the provision of management services to the Medicare population both as part D plan sponsors and as contractors to other entities sponsoring Medicare Prescription Drug Plans (“PDPs”).

The Centers for Medicare & Medicaid Services (“CMS”) recently offered a proposed rule that would alter the definitions used to determine beneficiary cost-sharing obligations for prescriptions covered by Medicare Part D. The proposed rule would require that patient cost-sharing be determined by the amount charged by a pharmacy for a prescription and not the price negotiated between the pharmacy and a PBM.

In the proposed rule, CMS suggests narrowing the range of competitive business models that PBMs can use to manage the Part D drug benefit. CMS has proposed similar rules in the past but did not finalize them in order to allow consideration of the potential impact. Even now, the impact of the proposed changes remains elusive as even CMS recognizes that “we have no reliable basis for estimating the effects of these proposals.”¹ In fact, consideration of the proposed rule raises a number of potential concerns, including the chance of affecting beneficiary confusion, participation in the retiree drug subsidy program, Part D costs, and the costs of commercial health plans. Until these risks are better understood, adopting the proposed rule entails considerable cost and access risks.

2. PERFORMANCE OF COMPETITIVE MODELS USED BY MEDICARE PRESCRIPTION DRUG PLANS (PDPs)

When Congress passed the Medicare Prescription Drug Improvement and Modernization Act of 2003 (known as the Medicare Modernization Act, or “MMA”), it created the Medicare Prescription Drug program (“Part D”), a federal program that explicitly relies on competitive privately-administered plans rather than direct government control in order to provide seniors an array of prescription drug benefit options. The design of Medicare Part D was intended to foster competition between plans, lower costs for beneficiaries, and reduce the burden on the federal government. Within a framework that allows for a broad range of competitive models, savings achieved by Medicare prescription drug plans (“PDPs”) have been higher than

¹ 73 FR 28589.

originally assumed by the Congressional Budget Office (“CBO”), contributing to lower-than-expected federal costs and beneficiary premiums. The Centers for Medicare & Medicaid Services (“CMS”) originally assumed that plans would achieve about 15 percent in savings in 2006 but subsequently increased its assumed savings to 27 percent.² Likewise, average monthly premiums charged to beneficiaries were originally estimated to be \$35, but the actual average premium was \$25.³

3. RULE CHANGES PROPOSED BY CMS WOULD NARROW THE RANGE OF COMPETITIVE PDP MODELS

CMS recently offered proposed rule that would alter the definitions used to determine beneficiary cost-sharing obligations for prescriptions covered by Part D.⁴ In particular, the proposed rule would require that patient cost-sharing be determined by the amount charged by a pharmacy for the prescription (the “pass-through” price) and not the price negotiated between the pharmacy and a PBM (the “lock-in” price).⁵

While the proposed rule purports only to clarify definitions, in reality it would substantially narrow the array of competitive business models used by PDPs to achieve savings for Medicare beneficiaries and the federal government.

An immediate economic implication of the proposed rule is the likely change to competition among plan sponsors. A change in program rules that would not affect all Part D providers similarly will affect competition for provision of Part D plans. This is not unintentional: CMS suggests that there may be competitive imbalances under the current program definitions where plan sponsors using lock-in pricing might gain advantage relative to those using pass-through pricing.⁶ Proscribing specific pricing models, however, moves the Part D program away from emulating private-market competitive dynamics.

² “Medicare Part D: An Assessment of Plan Performance and Potential Savings,” PriceWaterhouseCoopers, prepared for PCMA, January 2007, available at [http://pcmanet.org/assets/2008-03-25_Research_PwC%20Medicare%20Savings%20and%20Generics%20Report%202006%20\(Jan%202007\).pdf](http://pcmanet.org/assets/2008-03-25_Research_PwC%20Medicare%20Savings%20and%20Generics%20Report%202006%20(Jan%202007).pdf)

³ “Prescription Drug Benefit Under Medicare: Background Brief”, Kaiser Family Foundation, http://www.kaiseredu.org/topics_im.asp?id=131&imID=1&parentID=66.

⁴ 73 FR 28562. CMS has proposed, but not finalized, similar definition changes. See 72 FR 29403.

⁵ Under lock-in pricing, PBMs are at risk for any difference between their agreed rate with the pharmacy and what they receive from a health insurer or a plan sponsor. If the lock-in rate is lower than the amount received, then the PBM earns revenue; if not, the PBM loses revenue.

⁶ 73 FR 28566.

3.1. THE PART D PROGRAM IS MOTIVATED BY MARKET-BASED BENEFIT DELIVERY

In commercial market operations, the competitive provision of PBM services has led to widespread use of PBM contracting. PBMs provide services for more than 210 million Americans. The types and levels of PBM services used for any particular prescription can vary significantly, and depend on contracts between plan sponsors and PBMs.⁷ Those contracts typically result from a competitive bidding system that determines the range, prices, and types of PBM services provided to commercial clients.

A plan sponsor issues a Request for Proposals (“RFP”) when considering the use of an external PBM to manage its drug benefit.⁸ The RFP seeks quotes for services and charges, including any particular provisions desired by the sponsor (e.g., pass-through pricing).⁹ Large plan sponsors are sophisticated buyers of PBM services; many engage in several rounds of evaluating and selecting PBM vendors and services, often using a multi-disciplinary team and independent benefit consultants to help design the RFP, evaluate responses, and winnow candidates through successive proposal rounds.¹⁰

PBM responses to a RFP can vary widely, referencing a number of services and pricing elements.¹¹ The same PBM often submits multiple proposals that vary in the types and pricing of the services provided in response to the same RFP. Plan sponsors often engage in multiple RFP rounds, narrowing the services to be provided, adapting the requests based on submitted proposals, and winnowing bids to benefit from the competition from potential PBM vendors.

Of particular relevance for considering the proposed rule changes for Medicare Part D, PBMs often provide proposals that allow plan sponsors to choose either lock-in or pass-through

⁷ In some situations, PBMs might provide full management of plans designed by sponsors, while in others PBMs might provide administrative services only.

⁸ In some cases, PBMs contract with plan sponsors directly. In other cases, PBMs contract with the managed care organizations (“MCOs”) used by plan sponsors to manage the health plan. For the purposes of this Issue Brief, MCOs are included in the phrase “plan sponsors.”

⁹ Terms addressed in RFPs often include the following: pharmacy reimbursement rates, generic and mail-order utilization guarantees, administrative fees, rebate pass-through amounts, formulary management, implementation allowances, data exchanges, drug utilization review, and disease management, among others.

¹⁰ The team typically consists of a mix of clinical, financial, systems, and operations personnel, who evaluate the many aspects of PBM proposals. Mercer and Towers Perrin are two examples of independent benefit consultancies.

¹¹ Responding bids, however, typically provide a variety of price points in four categories: (a) pharmacy charges, (b) per claim processing fees, (c) administrative fees for other services, and (d) percentage of manufacturer rebates passed through to the plan sponsor or MCO.

pharmacy reimbursement terms as part of the RFP process.¹² Several major PBMs report that the majority of their commercial accounts elect lock-in reimbursement terms.¹³

When electing the lock-in model, the plan sponsor agrees to reimburse the PBM based on a fixed or “locked-in” discount relative to an agreed upon price benchmark for all prescription claims generated by their enrollees, regardless of which network pharmacies their enrollees patronize. This generally provides the plan sponsor with stable and predictable pharmacy costs for the duration of the contract with the PBM and may allow the PBM to reduce per-claim administrative fees.¹⁴

In a pass-through arrangement, PBMs simply pass through to clients whatever prices have been negotiated with various pharmacies. Because there is no difference between what the plan sponsor reimburses the PBM and what the PBM reimburses the pharmacy, actual costs are dependent on where enrollees fill prescriptions. In addition, per claim administrative fees typically become the primary method of PBM reimbursement.

Due to the competitive nature of the commercial sector RFP process, either business model selected by plan sponsors is likely to result in substantial savings relative to unmanaged expenditures:

Since PBMs reflect aggregate purchases representing all individuals within a drug coverage program, their reimbursement formulas are established to extract volume purchase discounts from pharmacies. Levels of prices paid by PBMs generally are the lowest or some of the lowest accepted by pharmacies for any types of customers. Prices paid by cash paying customers and even Medicaid programs in many states are higher than what a PBM would pay. Thus, the PBM pricing approach can be considered a negotiated price, volume discount strategy targeted at pharmacy providers.¹⁵

12 Based on structured interviews with PBM officials.

13 Based on structured interviews with PBM officials.

14 These factors describe why plan sponsors engage in contracts that allow PBMs to retain the difference between the amount they receive from plan sponsors for pharmacy costs and the reimbursements that PBMs negotiate with pharmacies. This difference is sometimes called the “spread” or “risk premium.”

15 See David Kreling, Cost Control for Prescription Drug Programs: Pharmacy Benefit Manager PBM Efforts, Effects, and Implications, Prepared for the Department of Health and Human Services' Conference on Pharmaceutical Pricing Practices, Utilization and Costs, August 8-9, 2000, pdf p. 2. Similarly, in 2005, the FTC evaluated proposed legislation in North Dakota that would limit PBMs' abilities to engage in selective contracting. The FTC noted that the proposed legislation (H.B. 1332) would “prevent covered entities from designing benefit plans to encourage participants to use network pharmacies that provide drugs to the plan at a lower cost than other network pharmacies.” FTC Office of Policy Planning, Letter to Senator Richard L. Brown, North Dakota Senate, March 8, 2005.

Until this point in time, CMS has allowed PDPs to use either lock-in or pass-through pricing as the basis for the Part D “negotiated prices” used to calculate beneficiary cost sharing, reporting costs to CMS for reinsurance and risk sharing purposes, and determining the actuarial equivalence of plan bids to CMS. Enabling PDPs to use either pricing model has allowed Part D plans to compete and innovate in a way that mirrors the private sector RFP process and achieve higher-than-expected savings. Similarly, Part D beneficiaries enjoy a wide choice of actuarially equivalent plans offering a variety of options substantially different from the “standard” PDP plan as defined by CMS. Options such as reduced premiums, lower deductibles, and coverage for generics in the “doughnut hole” have proven particularly attractive to beneficiaries.¹⁶

3.2. PART D DEMONSTRATES COMPETITION AMONG PLANS

While CMS cites competitive balance among commercial and Part D plans as a concern, the proposed rule does not demonstrate competitive imbalance in the provision of Part D plans, nor does it describe whether the economic consequences of the proposed rule would be beneficial or detrimental. In fact, with respect to anticipated benefits from the proposed rule, CMS recognizes that it has “no reliable basis for estimating the effects of the proposals.”¹⁷ The current existence of multiple types of arrangements and plan sponsors demonstrates a diversity of options and approaches. This diversity provides options for Medicare beneficiaries, and will persist if those options provide value to beneficiaries.

If, alternatively, beneficiary preferences create demand patterns emphasizing certain types or levels of benefits, the competition among Part D plan sponsors will respond. Plan D sponsors are capable of providing services directly or by contracting those services from PBMs. In particular, if Medicare beneficiaries demonstrate a preference for plans that use lock-in pricing, plan sponsors not currently using that approach can do so directly or via contracts with PBMs that provide lock-in pricing. The level of competition among PBM vendors ensures that the contracting rates for these services would be efficient, providing any contracting plan sponsor with the means to compete.

CMS concerns regarding lock-in pricing suggest that plans using this approach might have higher cost-sharing obligations for patients (as the difference between lock-in and pass-through price is included in the base used for determining the cost-sharing obligation) and lower premiums (resulting from the difference in Part D coverage for drug and administrative costs). Under this assumption, beneficiaries would face a range of Part D options that allow tradeoffs between higher premiums and higher cost-sharing. Again, patients would

¹⁶ The term “donut hole” refers to a coverage gap within the defined standard benefit under Part D. There is a gap between the initial coverage limit (\$2,400 in 2007) and the catastrophic coverage threshold (over \$5,100 in 2007). If total drug spend is in this range, all costs are patient out-of-pocket costs, ranging in this case from \$750 to \$3,850.

¹⁷ 73 FR 28589.

demonstrate preferences based on their expected utilization patterns and associated costs; if demand for plans moves toward or away from plans using lock-in pricing, then sufficient options are available to allow plan sponsors to adjust their plans.¹⁸

If beneficiaries demonstrated a preference for plans that used pass-through pricing, then there would be no need for the proposed rule. Alternatively, a demonstrated preference for lock-in pricing would indicate that beneficiary interests would be adversely affected by the proposed rule change. By continuing to allow both lock-in and pass-through models to be used in Part D, CMS would ensure that the program continues to mirror the competitive dynamics in the private sector that have proven to substantially lower prescription costs relative to unmanaged drug expenditures.

4. PRICE VARIABILITY AND ADMINISTRATIVE FEES UNDER THE PROPOSED RULE

In proposing changes to the definition of Part D negotiated prices, CMS recognizes that requiring PBMs to pass-through the price charged by the pharmacy for reimbursement will eliminate a risk management technique that shelters plan sponsors from pharmacy “price variability.”¹⁹ In the pass-through model, PBMs typically manage pharmacy networks for administration fees and do not assume risk for variations in pharmacy costs. While the MMA looked to commercial market operations that managed costs by managing risks, dictating that only pass-through pricing be used in Part D could reduce the dimensions in which PBMs can manage risk for plan sponsors.

CMS expects that if the lock-in terms were not allowed, that any increase in administrative fees would be less than the difference between lock-in and pass-through prices. This conclusion does not appear to be consistent with the economic operation of PBMs. If Part D plans were competitive before the rule change, then the rule change will need to be revenue neutral (i.e., fees will change in the amount of lost risk premiums), lost revenue will be passed on, or the willingness to participate in the Part D program will be affected. Efforts to recapture revenue might affect patients, either through increased premiums or reduced benefits.

¹⁸ CMS also expresses concerns that Part D beneficiaries might be adversely affected based on their expected utilization. Since the beneficiary cost-sharing obligation changes during a year based on total expenditures, patients anticipating high utilization know that their cost-sharing obligations will change and can include this consideration when selecting a plan. If the expected utilization (or another characteristic affecting plan choice) results in a segment of beneficiaries selecting a type of plan that becomes unviable as other beneficiaries demonstrate different demand patterns, CMS will need to consider whether the maintenance of both types of plan is justified and evaluate the potential efficiency costs resulting from provisions of a second-best option for all beneficiary types.

¹⁹ 73 FR 28564.

5. POTENTIAL IMPACT OF GREATER PRICE VARIATION

Under lock-in pricing, pharmacy prices are generally predictable for all network pharmacies. Under pass-through pricing, the variation in pricing terms for network pharmacies is passed on to the plan sponsors.²⁰ Consequently, the proposed rule could result in situations where the same beneficiary may see different prices for the same drug at different network pharmacies.²¹

Greater pharmacy price variation could affect the complexity of price information presented on the Medicare Prescription Drug Plan Finder (“MPDPF”), which currently allows beneficiaries to compare premiums and cost-sharing obligations on any set of drugs before choosing a plan. Any increased variation in network pharmacy drug prices would increase the range of prices that a beneficiary might see on the MPDPF, but the range of prices might not be well represented by the lowest drug price. In this case, Medicare beneficiaries might choose Part D plans based on drug prices at the cheapest pharmacy, not necessarily a representative pharmacy.

Finally, beneficiaries may substantially increase their demands for pharmacists’ time under the proposed rule. If beneficiaries experience drug price variation between network pharmacies, some might increase their travel to patronize lower-cost pharmacies while others might seek more time with pharmacists in seeking to understand drug prices. While this might foster beneficiary confusion, it might also provide incentives for narrower divergence in contracted pharmacy rates in order to allay beneficiary concerns.

6. THE PROPOSED RULE MIGHT AFFECT PARTICIPATION IN THE RDS PROGRAM

Under MMA, many Medicare beneficiaries could keep the drug coverage they had from an alternative source, such as an employer, union, or the Department of Veterans Affairs (“VA”), provided it was “creditable”—that is, at least as generous as standard Part D coverage. Employer and union run plans became eligible for a Retiree Drug Subsidy (“RDS”) for

²⁰ Requiring pass-through provides another concern for CMS, which expressed concern that lock-in pricing was “discriminatory” to patients with high utilization rates. (73 FR 28565). CMS expects if pass-through pricing reveals higher drug costs for small, independent pharmacies, those pharmacies will need to remain in the network to meet pharmacy access standards. (73 FR 28567). If that supposition is accurate, then pass-through pricing will result in systematically higher costs for beneficiaries whose only local options are small, independent pharmacies (i.e., rural beneficiaries).

²¹ CMS recognizes that the variation in pharmacy costs will increase under pass-through pricing, but believes that there is “no value” to beneficiaries from uniform pricing across pharmacies under lock-in pricing. 73 FR 28565.

Medicare-eligible beneficiaries they covered, again subject to coverage being creditable.²² The RDS was established to provide previous sources of pharmacy benefit coverage to maintain that coverage for retired employees. The RDS program is an attractive element of the MMA, as it has lower costs relative to Part D.²³

The proposed rule would redefine drug costs to exclude lock-in pricing from the RDS program. As noted by CMS, the proposed rule would increase administrative costs (e.g., administration fees) and lower the subsidy amounts (since the lock-in would not contribute to subsidy determination). As a result, RDS providers could receive lower subsidies for their members. Rather than go through the extra burden for the entire plan when they receive subsidies for only a portion of enrollees, it is possible that employer-based plans would re-evaluate their continued participation in the RDS program.²⁴

7. MEDICARE POLICIES AFFECT COMMERCIAL OPERATIONS

While the proposed changes apply only to the Part D reimbursement system, it is likely that the effects of the proposed rule will spill over into commercial insurance operations. With rare exceptions, plan sponsors find it efficient to operate commercial and government accounts using the same reimbursement method, thereby reducing administrative costs associated with administering plans that utilize different pricing models.²⁵ As a result, plan sponsors forced to adopt pass-through pricing for Part D plans will likely use the same method for commercial plans as well.

Some plan sponsors are anticipating that CMS's proposed changes will take effect and are considering pass-through pricing for Part D plans in an attempt to save themselves later administrative turmoil. For example, some plan sponsors are preempting CMS's proposal by asking that three-year PBM contracts use lock-in pricing for the first two years and then switch to pass-through in the third.²⁶ However, plan sponsors are concerned about the costs of administering plans and transition costs, so the changes motivated by the anticipated proposed rule for Part D are already leading to changes in commercial contracts with PBMs.

²² CMS, "Medicare Prescription Drug Coverage – An Introduction for Employers and Unions," CMS Pub. No. 11145.

²³ Based on comparison of percent of subsidized drug costs. See CBO, "Retiree Health Benefits: Majority of Sponsors Continued to Offer Prescription Drug Coverage and Chose the Retiree Drug Subsidy," May 2007.

²⁴ CMS, "Overview of Retiree Drug Subsidy Option," November 2, 2005.

²⁵ Based on structured interviews with PBM officials.

²⁶ Based on structured interviews with PBM officials.

The financial consequences of limiting competition and innovation by effectively compelling the use of a particular contracting model in the private market could be significant.

8. LACK OF ECONOMIC SUPPORT FOR CMS'S PROPOSED RULE

In the proposed rule, CMS notes that: "we estimate that while there could be economic benefits associated with these proposals, they are difficult to gauge at this time."²⁷ As any potential gains from the proposed rule are uncertain and require further empirical investigation, the magnitude of the proposed rule raises serious concerns.

First, CMS has not given due consideration as to why many commercial sector plan sponsors have a revealed preference for lock-in pricing terms and the impact that the absence of such terms would have on the competitive market. Today, plan sponsors are sophisticated purchasers, making repeated purchases of PBM services from competitive bidders, often with the guidance of benefit consultants. Under these conditions, plan sponsors learn from the repeated negotiation experiences with PBMs. The result of these negotiations is the persistence of lock-in pricing as a widespread contracting option. CMS attributes the existence of lock-in pricing to "asymmetric information," where plan sponsors are unaware of PBM management efforts generating the risk premium.²⁸ Not only is this inconsistent with the competitive bidding process noted above, however, but it also fails to recognize that many plan sponsors who opt for lock-in pricing arrangements do so after thoroughly considering the relative merits of pass-through contract terms.

Second, in considering the cost implications of the proposed rule, CMS expects that cost-sharing obligations would decrease and premiums increase as plans convert from lock-in to pass-through prices.²⁹ CMS consideration of these changes does not apparently include the potential utilization effects that could result from changing contractual pricing models. For example, assuming that CMS's expected changes in cost obligations comes about under the proposed rule, beneficiaries could face higher premiums (i.e., fixed cost), while their cost-sharing obligations fall. Such a scenario might encourage increased drug utilization.

Third, the long-term effects on investment in drug utilization management under a pass-through price only system warrant consideration. CMS suggests that administrative fees would likely be higher under a pass-through only system, but notes that competition could

²⁷ 73 FR 28589. Note that "the proposals" include changes to other Medicare operations as well as the proposed definition changes addressed in this Issue Brief.

²⁸ 73 FR 28566.

²⁹ 73 FR 28565-28566.

encourage the subsequent reduction of such fees.³⁰ If the primary basis of competition between plans focuses on the reduction of administrative fees, resources available to the PDP to undertake programs to encourage more cost-effective drug utilization could be limited. Therefore, the impact of a pass-through only system on long-term costs is unclear.

Fourth, CMS's "Regulatory Impact Analysis" estimates that the costs from implementing the proposed definition changes for Part D are slightly higher than the expected cost savings from the RDS program. This CMS cost estimate could underestimate the potential consequences of the proposed rule to Part D if competition to reduce administrative fees in a pass-through only system led to less drug utilization management. In addition, the purported gains from the RDS program, do not consider the effect that the proposed rule might have on employer (or other plan sponsor) participation in the program. The CMS analysis considers the benefits to RDS beneficiaries under the proposed rule, but does not consider whether the altered payments expected under the changes will affect employer willingness to participate.³¹ Even without the proposed rule changes, plan sponsor participation in the RDS program is not assured: administrative costs are dissuading participation, and a survey from late 2006 indicated that plan sponsors expected to decrease participation by 2010.³² If the sponsor participation rate for the RDS is affected by the proposed rule, not only will costs be affected by affected beneficiaries seeking other forms of Part D coverage, but the CMS estimates of savings would need to be corrected.

Finally, CMS's proposed rule frequently refers to expected gains from increased transparency.³³ A significant body of economic literature and regulatory opinion notes the inflationary effect of certain kinds of transparency. Economic literature recognizes at least two reasons that transparency can result in higher prices. First, price concessions are more likely to be granted to one purchaser when other purchasers are unaware of the concessions. If a seller (e.g., PBM, insurer, drug manufacturer) were forced to disclose the average amount of price concessions broadly, then the incentives to provide such concessions would be reduced—the cost of providing a price concession to one buyer is increased if that

30 73 FR 28566.

31 73 FR 28591.

32 John Abell, "Life After the Retiree Drug Subsidy, What are the Other Options?" HR Management, July 2007. Kaiser Family Foundation, "Retiree Health Benefits Examined, Findings from the Kaiser/Hewitt 2006 Survey of Retiree Health Benefits," December 2006. Joanne Wojcik, "Gaps in Data Slow Retiree Rx Subsidies," Business Insurance, January 28, 2008.

33 See, for example, 73 FR 28563, 73 FR 28566, and 73 FR 28591.

concession has to be shared with all buyers.³⁴ As a result, greater transparency could be expected to lead to greater reluctance to offer price concessions, which would lead to an increase in the costs, not a decrease.

Another economic concern relates to the amount of information that one seller (e.g., PBM, insurer, drug manufacturer) has about other sellers. In a competitive marketplace, sellers do not know their rivals' costs and must bid competitively and at risk to win or retain buyers. Greater transparency reveals additional information to other sellers as well as other buyers, creating situations where sellers would be able to identify situations where discounts are not necessary to win or retain buyers.

While CMS does not consider the inflationary aspects of transparency, other government agencies have considered transparency in the healthcare marketplace and determined that it would increase, not decrease, costs. The CBO, for example, released an Issue Brief on transparency in healthcare markets last month. While the CBO noted that competing factors make the ultimate effect of transparency unclear, it also found that:

The markets for some health care services are highly concentrated, so increasing transparency in such markets could lead to higher, rather than lower, prices because higher prices are easier to maintain when the prices charged by each provider involved can be observed by all of the others.³⁵

This consideration follows CBO's consideration of transparency legislation that would have required PDPs to report "information on negotiated price discounts, rebates, and other price concessions that they obtained from drug manufacturers."³⁶ In this letter to legislators, CBO found that disclosure requirements would reduce the range of price concessions to PDP plans and would increase the risk of tacit collusion among manufacturers.

Similarly, the Federal Trade Commission ("FTC") has also found that increased transparency risks cost inflation. In evaluating proposed legislation in California (A.B. 1960) that would have required increased disclosure of certain financial information by PBMs, the FTC noted that the proposed legislation was likely to increase prices and costs of pharmaceuticals.³⁷

34 A common example is the Medicaid rebate program: when regulations required the "best prices" from commercial customers of pharmaceutical manufacturers be shared with the Medicaid program, the result was a swift decrease in the discounts granted to commercial purchasers. See CBO, "How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry," January 1996.

35 CBO, "Increasing Transparency in the Pricing of Health Care Services and Pharmaceuticals," Economic and Budget Issue Brief, June 5, 2008.

36 CBO, "Potential Effects of Disclosing Price Rebates on the Medicare Drug Benefit," March 12, 2007.

37 FTC, "FTC Staff: California Bill May Raise Prices for Pharmaceuticals," September 10, 2004.

Many plan sponsors also recognize that transparency that results in the public disclosure of contract terms is not helpful. As one health insurer noted at a public hearing conducted by the FTC and the Department of Justice, “We believe that price competition can best be achieved when negotiated prices and rebates are kept confidential. Widespread public disclosure of prices is unnecessary to assure that the ultimate payer receives most of the benefit of drug rebate arrangements.”³⁸

In summary, the justification for CMS efforts to mandate one type of contractual model in order to achieve lower costs through “transparency” alone is questionable. In fact, the FTC and DOJ issued a joint report in which they recognized that “Vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms... Just as competitive forces encourage PBMs to offer their best price and service combination to health plan sponsors to gain access to subscribers, competition also encourages disclosure of the information health plan sponsors require to decide on the PBM with which to contract.”³⁹

9. CONCLUSION

PBMs deliver value by vigorously competing to provide plan sponsors and their beneficiaries the highest possible quality prescription drug benefit management at the lowest possible cost. Various contractual models, including both lock-in and pass-through pricing, facilitate the development of diverse and highly competitive plan options that have resulted in enhanced access, choice, and reduced drug costs for Medicare enrollees. By effectively eliminating the use of a widespread contracting model, the proposed rule could lead to beneficiary confusion, lower participation in the RDS program, while showing no evidence that it would reduce costs for either beneficiaries or Medicare Part D. Until these risks are better understood, adopting the proposed rule entails considerable cost and access risks.

³⁸ Testimony of Anthony Barrueta, Senior Counsel for the Kaiser Foundation Health Plan, FTC/DOJ Joint Hearings, Health Care and Competition Law and Policy, Pharmacy Benefit Management Companies, June 26, 2003.

³⁹ FTC and DOJ, “Improving Health Care: A Dose of Competition,” July 2004, Chapter 7, p. 17.