

IS MORE INFORMATION ALWAYS BETTER? MANDATORY DISCLOSURE REGULATIONS IN THE PRESCRIPTION DRUG MARKET

Joanna Shepherd[†]

Pharmacy benefit managers (PBMs) save Americans billions of dollars each year by lowering the prices of prescription drugs and the costs of prescription drug coverage. However, as I explain in this Article, mandatory disclosure regulations recently enacted in several states and at the federal level under the Affordable Care Act threaten to disrupt the cost savings that PBMs currently produce for consumers. These regulations require PBMs to disclose competitively sensitive financial information to various participants in the prescription drug market. Although mandatory disclosure regulations are premised on the idea that PBM clients can only ensure that they are paying a competitive price for a PBM's services if they know the specifics of the PBM's financial arrangements with pharmaceutical manufacturers and pharmacies, there is no theoretical or empirical reason to believe mandated disclosure of this information is necessary. Not only are these regulations unnecessary to achieve competitive outcomes, they also impose significant costs on PBMs. The additional disclosure increases both direct costs and litigation costs for PBMs. More importantly, the regulations foster tacit collusion and reduce PBMs' ability to negotiate discounts with pharmacies and rebates with drug manufacturers. By disrupting competition in the prescription drug market, mandatory disclosure regulations will ultimately increase the prices that consumers pay for prescription drugs.

INTRODUCTION.....	1
I. BACKGROUND OF PHARMACY BENEFIT MANAGEMENT	4
A. PBM Industry Structure	5
B. PBM Business Model and Prescription Drug Spending	6
II. MANDATORY DISCLOSURE REGULATIONS	11
A. State Regulations	11
B. Regulations Under the Affordable Care Act.....	13
III. ARE MANDATORY DISCLOSURE REGULATIONS NECESSARY?	14
IV. COSTS OF MANDATORY DISCLOSURE REGULATIONS	17
A. Direct Costs of Disclosure	17
B. Litigation Costs	18
C. Competitive Harms.....	18
CONCLUSION.....	21

INTRODUCTION

The prescription drug market has changed dramatically over the last few decades. Whereas consumers once paid for prescription

[†] Associate Professor of Law, Emory University School of Law.

drugs out of pocket, now most Americans have prescription drug coverage requiring a third party—such as an employer or Health Maintenance Organization—to pay for prescription medication. These third parties typically hire pharmacy benefit managers (PBMs) to manage the prescription drug benefits for their members. In fact, 95 percent of insured Americans have prescription drug coverage that is managed by a PBM.¹ PBMs act as the intermediaries among consumers with prescription drug coverage, pharmacies, drug manufacturers, and third party payers.² They influence the prices that consumers pay for drugs, which pharmacies they use, and even which drugs they take. By negotiating discounts with pharmacies and manufacturers and by managing drug benefits to ensure that members take the appropriate medication at the lowest price, PBMs save consumers and third-parties that pay for prescription drugs billions of dollars each year.³

However, recent mandatory disclosure regulations enacted in several states and at the federal level under the Affordable Care Act threaten to disrupt the cost savings that PBMs currently produce for consumers of prescription drugs. Mandatory disclosure regulations require PBMs to disclose competitively sensitive financial information to various participants in the prescription drug market. The additional disclosure increases both the direct costs and the litigation costs for PBMs. More importantly, the regulations foster tacit collusion and reduce PBMs' ability to negotiate discounts with pharmacies and rebates with drug manufacturers. As a result, drug prices will rise and total prescription drug spending will increase.⁴

PBMs manage the prescription drug benefits for health plan sponsors such as employers, labor unions, and health maintenance organizations (HMOs). The PBM business model incorporates several cost-saving practices that reduce prescription drug spending. For example, PBMs establish networks of local pharmacies where members can obtain medication at discounted prices, negotiate discounts and rebates from drug manufacturers in exchange for making their drugs a “preferred” medication, provide access to mail-order pharmacies that can dispense drugs at lower costs, evaluate prescribing patterns to ensure that consumers obtain appropriate

¹ See Letter from Federal Trade Commission to Senator Richard L. Brown, Senator, N.D. Senate 4 (Mar. 8, 2005), available at <http://www.ftc.gov/os/2005/03/050311northdakotacomnts.pdf> [hereinafter Letter to Senator Brown].

² See CONG. BUDGET OFFICE, ISSUES IN DESIGNING A PRESCRIPTION DRUG BENEFIT FOR MEDICARE 15 fig.4 (2002), available at <http://www.cbo.gov/ftpdocs/39xx/doc3960/10-30-PrescriptionDrug.pdf>.

³ See *id.* at 40 tbl.6; VISANTE, PHARMACY BENEFIT MANAGERS (PBMS): GENERATING SAVINGS FOR PLAN SPONSORS AND CONSUMERS 3 (2011).

⁴ See discussion *infra* Part IV.

drugs for the lowest price, and efficiently process claims for their health plan sponsor clients.⁵ As a result of these cost-saving practices, PBMs have been able to significantly reduce both the price of prescription drugs for covered individuals and the overall plan costs of prescription drug coverage. Indeed, research shows that consumers with PBM-administered prescription drug coverage pay between 15 and 50 percent less for drugs than noninsured consumers buying the exact same drugs.⁶

Yet, despite evidence of the significant cost savings that PBMs generate for consumers and health plan sponsors, competitors of the PBM industry have successfully lobbied state legislatures for more regulation of these companies in recent years. An increasingly popular PBM industry regulation mandates disclosure of PBMs' arrangements with pharmaceutical manufacturers and pharmacies. These regulations are premised on the belief that to ensure that health plan sponsors are paying a competitive price for PBM services, the sponsors must know the details of the rebates and discounts their PBM partners are able to negotiate with manufacturers and pharmacies. Mandatory disclosure regulations enacted recently in the District of Columbia, Maryland, Mississippi, North Dakota, South Dakota, and Vermont require PBMs to turn over this competitively sensitive information. Similar regulations are currently under legislative consideration in several other states. Moreover, regulations enacted under the Affordable Care Act will require PBMs to disclose competitively sensitive financial information to both health plan sponsors and the federal government.⁷

Despite the growing number of mandatory disclosure regulations, there is no theoretical or empirical reason to believe they are essential to ensuring that health plan sponsors are paying a competitive price for PBM services. Health plan sponsors are sophisticated, repeat purchasers of PBM services that can simply compare the services offered with the price of services among different PBMs. Moreover, existing contracts require PBMs to pass through to plan sponsors a significant portion of the rebates and discounts they negotiate, and empirical evidence indicates that PBMs do pass on the majority of their negotiated savings.⁸ Finally, health plans are already able to negotiate contract terms that include

⁵ U.S. GEN. ACCOUNTING OFFICE, FEDERAL EMPLOYEE'S HEALTH BENEFITS: EFFECTS OF USING PHARMACY BENEFIT MANAGERS ON HEALTH PLANS, ENROLLEES, AND PHARMACIES 9–19 (2003), *available at* <http://www.gao.gov/assets/240/236828.pdf>.

⁶ *See* FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES 36 (2005), *available at* <http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf>.

⁷ *See* discussion *infra* Part II.

⁸ *See* U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 9–19.

disclosure and audit rights when they want them and are willing to bear the additional resulting administrative costs. The ability of plan sponsors to negotiate tailored disclosure and audit rights renders mandatory disclosure regulations superfluous.

Mandatory disclosure regulations also impose significant costs on PBMs. The additional disclosure directly increases costs for PBMs as they collect, prepare, and present the new information. Moreover, regulations requiring additional disclosure increase litigation costs following allegations of insufficient or misleading information disclosure. In contrast to situations where the parties negotiate the extent of contractually agreed upon disclosures, there is likely to be uncertainty and potential disagreement over the scope and content of regulation-mandated disclosures. Furthermore, these regulations enable pharmacies and pharmaceutical manufacturers to obtain PBMs' competitively sensitive cost information, reducing PBMs' ability to negotiate discounts with pharmacies and rebates with drug manufacturers.⁹ These costs will weaken competition in the PBM industry and, in turn, increase the cost of prescription drugs and drug coverage for consumers and health plan sponsors.

This Article proceeds as follows. In Section I, I describe the structure of the PBM industry. I also describe the business model PBMs employ to administer prescription drug coverage and the methods they use to reduce prescription drug spending. In Section II, I discuss mandatory disclosure regulations enacted in several states and at the federal level under the Affordable Care Act. In Section III, I explain why mandatory disclosure regulations are not needed to ensure that health plan sponsors pay a competitive price for PBM services. In Section IV, I discuss the various costs that mandatory disclosure regulations will impose on PBMs. I also explain how these costs will weaken competition in the PBM industry, compelling both consumers and health plan sponsors to pay more for prescription drugs and prescription drug coverage.

I

BACKGROUND OF PHARMACY BENEFIT MANAGEMENT

Many health plan sponsors—such as employers, labor unions, and HMOs—offer their members both medical insurance and prescription drug benefits. Plan sponsors hire PBMs to manage the cost and quality of the prescription drug benefit programs. More than 215 million Americans have prescription drug coverage that is managed by a PBM.¹⁰ As part of their prescription benefit management responsibilities, PBMs negotiate on behalf of their

⁹ See discussion *infra* Part IV.

¹⁰ See VISANTE, *supra* note 3, at 3.

client plans for discounts with pharmacies and pharmaceutical manufacturers, ensuring that covered individuals are getting the appropriate medication at the lowest price.

In this section, I briefly discuss the PBM industry structure. Then I describe the business model PBMs employ to administer prescription drug coverage and the methods they use to reduce prescription drug spending. Finally, I explain that by making prescription drugs more affordable, PBMs enable more Americans to take their medication as prescribed.

A. PBM Industry Structure

There are approximately sixty PBMs that operate in the United States today.¹¹ In 2011, the PBM market included three large, independent, full-service PBMs with national scope—Medco, Express Scripts, and CVS Caremark—that were the major players in many markets.¹² In that year, these three PBMs processed approximately 1.9 billion prescriptions: about 45 percent of all prescriptions nationally.¹³ In 2012, Express Scripts and Medco merged.

The Federal Trade Commission considers the PBM market to have at least ten significant competitors.¹⁴ Several large retail supermarket or pharmacy chains, such as Costco, also own PBMs.¹⁵ In addition, there are many smaller, privately held PBMs, such as Prime Therapeutics.¹⁶ The relative size and ranking of these companies varies according to the measurement used, but smaller PBMs make up almost one half of the PBM market.¹⁷ As a result, the FTC has concluded that competition in the PBM industry is

¹¹ See Letter to Senator Brown, *supra* note 1, at 4. The Pharmacy Benefit Management Institute (PBMI) lists fifty PBMs in its online directory. However, the directory may be under inclusive because the PBMI charges a fee for inclusion in their directory. See *PBM Directory*, PHARMACY BENEFIT MGMT. INST., LP, <http://www.pbmi.com/pbmdir.asp> (last visited Mar. 20, 2013); see also FED. TRADE COMM'N, *supra* note 6, at v (discussing the size and rankings of PBMs).

¹² See Thomas Gryta, *What is a 'Pharmacy Benefit Manager?'*, WALL ST. J. (July 21, 2011), <http://online.wsj.com/article/SB10001424053111903554904576460322664055328.html>.

¹³ See *PBM Market Share*, PHARMACY BENEFIT MGMT. INST., LP, <http://www.pbmi.com/PBMmarketshare2.asp> (last visited Mar. 14, 2013).

¹⁴ See FED. TRADE COMM'N, STATEMENT OF THE FEDERAL TRADE COMMISSION CONCERNING THE PROPOSED ACQUISITION OF MEDCO HEALTH SOLUTIONS BY EXPRESS SCRIPTS, INC. 2 (2012), available at <http://www.ftc.gov/speeches/rosch/120402expressmedcostatement.pdf>. The FTC defines this market as the market for full-service PBM services to health plan sponsors; it does not include any PBM services provided to health plans, as they do not typically involve the same capabilities and services as the PBM services to health plan sponsors. See *id.*

¹⁵ See Adam J. Fein, *Costco Unveils Its Own PBM*, DRUG CHANNELS (Jan. 17, 2013), <http://www.drugchannels.net/2013/01/costco-unveils-its-own-pbm.html>.

¹⁶ See FED. TRADE COMM'N, *supra* note 6, at iii.

¹⁷ See Gryta, *supra* note 12.

“vigorous.”¹⁸

B. PBM Business Model and Prescription Drug Spending

PBMs act as intermediaries among health plans, covered individuals, pharmaceutical manufacturers, and retail pharmacies. The PBM business model incorporates several cost-saving practices that reduce prescription drug spending: establishing networks of local pharmacies where members can obtain medication at discounted prices; developing drug formularies and negotiating discounts and rebates from drug manufacturers in exchange for preferential placement in the formulary; providing access to mail-order pharmacies; evaluating prescribing patterns to ensure that consumers obtain appropriate drugs for the lowest price; and processing claims for their health plan sponsor clients. As a result of these cost-saving practices, PBMs have been able to significantly reduce both the price of prescription drugs to covered individuals and the overall plan costs of prescription drug coverage.

PBMs contract with health plan sponsors to manage the prescription drug benefits of their members. When a sponsor, such as a large employer or union, wants to offer prescription drug coverage to its members, it issues requests for proposals to several PBMs that are interested in administering the sponsor’s drug benefits. In evaluating the proposals, the sponsor considers a variety of price and non-price factors to ensure that the PBM can offer the services the sponsor wants to include in its prescription drug coverage at the most competitive price.¹⁹ For example, some sponsors may prioritize offering a broad range of drug choices while others value minimizing the co-payments that members pay for drugs. Ultimately, the contract between the PBM and health plan sponsor will specify both the services the PBM will offer in the prescription drug coverage and the amount that the plan sponsor will pay to the PBM when a pharmacy dispenses a prescription to a member.²⁰

After securing a health plan sponsor account, a PBM establishes a network of local retail pharmacies that will fill prescriptions for the plan members. When a network pharmacy fills a covered member’s prescription, the pharmacy receives payments both from the member (in the form of a co-payment) and from the PBM (in the form of a payment for the discounted drug price).²¹ Plan members are given significant financial incentives to fill prescriptions at the network

¹⁸ FED. TRADE COMM’N, STATEMENT OF THE FEDERAL TRADE COMMISSION: IN THE MATTER OF CAREMARK RX, INC./ADVANCEPCS 3 n.6 (2004), *available at* <http://www.ftc.gov/os/caselist/0310239/040211ftcstatement0310239.pdf>.

¹⁹ *See* FED. TRADE COMM’N, *supra* note 6, at 9.

²⁰ *See id.*

²¹ *See id.* at 4.

pharmacies.²² Thus, pharmacies often compete to be included in a PBM's network by offering discounts to the PBM; inclusion in a network generally leads to significant revenues for the pharmacies. In general, pharmacies are willing to offer steeper discounts when the PBM represents more members and when the pharmacy network is more exclusive; both of these variables give the pharmacy the potential to fill more prescriptions and increase their revenue.²³ The PBM generally uses the discounts offered by the pharmacy both to lower the cost that consumers pay directly for the drug and to lower the amount the health plan sponsor pays to the PBM for a prescription.

Thus, PBMs' negotiated arrangements with retail pharmacies lower both the cost of prescription drugs and the cost of prescription drug coverage. Indeed, empirical studies have found that because of the discounts PBMs negotiate with retail pharmacies, consumers with prescription drug coverage pay significantly less for prescription medication.²⁴ Consumers with PBM-administered drug coverage pay an average of 18 percent less for brand name drugs and 47 percent less for generic drugs compared to consumers without drug coverage.²⁵

PBMs also establish relationships with pharmaceutical manufacturers. The manufacturers pay rebates or give price discounts to the PBMs in exchange for having their drugs listed on a health plan's formulary. The formulary is the list of approved or preferred drugs for the plan. Members are given incentives, such as lower co-payments, to use the formulary drugs. Thus, formulary status can greatly increase a manufacturer's sales of a drug.²⁶ As a result, pharmaceutical manufacturers compete intensely for formulary status and often give considerable rebates or discounts in exchange for this status.²⁷ To the extent specified in its contract with the health plan sponsor, the PBM will pass on the discounts and rebates to consumers and health plans, lowering the cost of prescription drugs and drug coverage.

A recent study measured the rebates that PBMs were able to negotiate with drug manufacturers in 2012. PBMs were able to negotiate rebates of \$16.70 per prescription for each brand name

²² See *id.* at 37.

²³ See Gryta, *supra* note 12.

²⁴ See U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 9.

²⁵ See *id.*

²⁶ See FED. TRADE COMM'N, *supra* note 6, at 1.

²⁷ See Letter from the Federal Trade Commission to Greg Aghazarian, Assembly Member, Cal. Gen. Assembly 6-7 (Sept. 7, 2004), available at <http://www.ftc.gov/be/V040027.pdf> [hereinafter Letter to Assembly Member Aghazarian].

drug dispensed at a retail pharmacy and \$6.13 for each generic drug dispensed at a retail pharmacy.²⁸ That is, manufacturers paid PBMs a rebate of \$16.70 or \$6.13 *each* time a pharmacy dispensed a prescription for a brand name or generic drug to one of their covered consumers.²⁹ Moreover, empirical research shows that large PBMs pass on significant portions of the rebates so that both consumers and health plans pay lower prices for prescription drugs.³⁰

When PBMs process drug claims for their health plan sponsor clients, they ensure that every time a consumer fills a prescription at a network pharmacy, the consumer pays the correct co-payment, the PBM pays the pharmacy the correct discounted drug price, and the health plan sponsor pays the PBM the contractually agreed upon price per prescription dispensed.³¹ Because of the discounts that PBMs negotiate with pharmacies and the rebates they negotiate with manufacturers, consumers are able to pay lower prices to the pharmacy³² and health plan sponsors are able to pay lower prices to the PBM. To illustrate these complex arrangements, Figure 1 shows the basic flow of money and prescription drugs in the market between PBMs, health plan sponsors, retail pharmacies, manufacturers, and plan members.³³ Solid arrows represent the flow of money and dashed arrows represent the flow of prescription drugs. When a retail pharmacy is involved, the prescription drugs flow only from manufacturer to pharmacy to member—PBMs never take possession.

²⁸ See PHARMACY BENEFIT MGMT. INST., LP, 2012–2013 PRESCRIPTION DRUG BENEFIT COST AND PLAN DESIGN REPORT 29 (2012), *available at* <http://benefitdesignreport.com/>.

²⁹ *See id.* at 28.

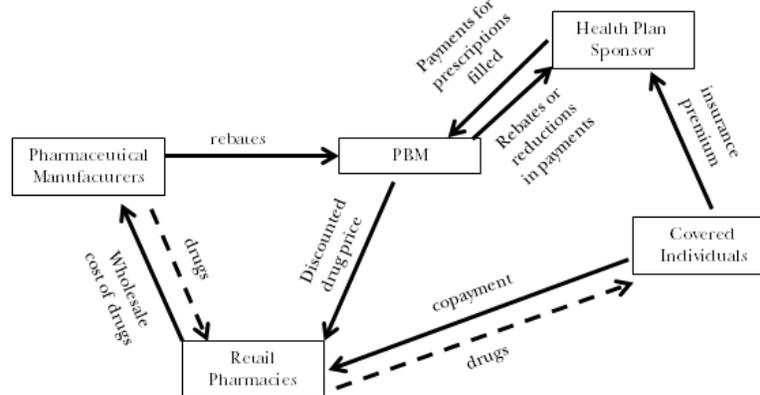
³⁰ *See* FED. TRADE COMM'N, *supra* note 6, at 59.

³¹ *See id.* at 3–10.

³² Also due to the discounts and rebates negotiated by the PBMs, consumers pay lower premiums to the health plan sponsors.

³³ Figure 1 presents the basic set of arrangements. Often, drug wholesalers are also involved.

FIGURE 1
Flow of Payments and Prescription Medications



In addition to retail pharmacy services, many PBMs also offer mail-order pharmacy services. Although many PBMs own their own mail-order pharmacies, some of the smaller PBMs contract with other mail-order pharmacies owned by another PBM or a retail pharmacy. Mail-order pharmacies can offer significant discounts for many prescription drugs by dispensing larger quantities of the drug and ensuring that consumers receive the cheapest drug within a therapeutic class.³⁴ To encourage these savings, PBMs offer incentives for members to fill prescriptions through mail-order pharmacies when appropriate.³⁵ Empirical research shows that PBMs' utilization of mail-order pharmacies has reduced prescription drug spending. Consumers and health plans pay, on average, 27 percent less for brand name drugs dispensed from mail-order pharmacies than noncovered consumers pay at retail pharmacies for the exact same drugs. Prices for covered consumers of generic drugs dispensed from mail-order pharmacies are 53 percent lower than the prices noncovered consumers pay at retail pharmacies.³⁶ Thus, PBMs' use of mail-order pharmacies has produced significant savings for consumers.

PBMs utilize various additional techniques to ensure that consumers obtain appropriate drugs while saving money for consumers and health plan sponsors. For example, many PBMs have successfully reduced drug spending by substituting generic drugs for

³⁴ See FED. TRADE COMM'N, *supra* note 6, at 23–40.

³⁵ See *id.* at 37.

³⁶ See U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 9.

brand name drugs when clinically appropriate.³⁷ Generic drugs contain the same active ingredients as brand name drugs and are “chemically identical in strength, concentration, dosage form, and route of administration.”³⁸ However, the average total price for generic drugs was less than half that of brand-name prescriptions without generic alternatives.³⁹ Other PBMs employ approaches such as therapeutic interchange to substitute therapeutically similar but less costly drugs with physician approval,⁴⁰ step therapy that requires patients to try less expensive drugs that are often effective before the plan will pay for more expensive drugs,⁴¹ and utilization controls that prevent medication from being refilled too often.⁴² These and other cost-saving approaches have successfully reduced prescription drug spending for covered members.⁴³

Thus, PBMs negotiate rebates and discounts and manage dispensing to reduce the costs of prescription drugs. PBMs pass on these cost savings, reducing health plan costs and drug prices for consumers.⁴⁴ Confirming these lower prices, an extensive FTC study of the PBM industry found that PBM-administered drug plan members pay 15 to 25 percent less for brand name drugs than consumers without prescription drug insurance.⁴⁵ The difference in prices is even greater for generic drugs: plan members pay 50 percent less for generic drugs than noninsured customers.⁴⁶

By reducing the price of prescription drugs and the cost of drug coverage, PBMs save Americans billions of dollars each year. Indeed, aggregate estimates of the magnitude of PBMs’ cost savings range from 30⁴⁷ to 35 percent⁴⁸ of total prescription drug spending. Moreover, cheaper drugs allow more people to take their medication as prescribed.⁴⁹ Thus, PBMs’ cost savings lower drug prices and, in turn, result in improvements in consumer health.

³⁷ *See id.* at 4.

³⁸ *See* FED. TRADE COMM’N, *supra* note 6, at 61 (citation omitted).

³⁹ *See id.* at 28.

⁴⁰ *See id.* at 10–14.

⁴¹ *See id.*

⁴² *See id.*

⁴³ *See id.* at 12–14.

⁴⁴ *See id.* at 59.

⁴⁵ *See id.* at 36.

⁴⁶ *See id.*

⁴⁷ *See* CONG. BUDGET OFFICE, *supra* note 2, at 40 tbl.6.

⁴⁸ *See* VISANTE, *supra* note 3, at 5.

⁴⁹ *See* William M. Sage et al., *Why Competition Law Matters to Health Care Quality*, 22 HEALTH AFF. 31, 35 (2003) (“When costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions.”).

II

MANDATORY DISCLOSURE REGULATIONS

Despite the substantial cost savings outlined in the previous section, both state and federal governments have persistently pursued regulation of the PBM industry.⁵⁰ In this section, I discuss a recurrent regulation of the PBM industry in recent years: mandatory disclosure regulations. Lawmakers premise these regulations on the belief that to ensure that health plan sponsors are paying a competitive price for the PBM services they and their members require, the sponsors must know the details of the rebates and discounts that their PBM partners are able to negotiate with manufacturers and pharmacies.

A. State Regulations

Many states have implemented regulations requiring PBMs to disclose financial information. Typically, these regulations are relatively benign and only require PBMs to disclose publicly available financial statements from the preceding year. However, a growing number of states require PBMs to disclose more detailed financial information that could impair PBMs' bargaining position vis-à-vis pharmaceutical manufacturers, pharmacies, and health plan sponsors.

Several states have enacted regulations that require PBMs to disclose competitively sensitive financial information to health plan sponsors.⁵¹ The District of Columbia, Maryland, South Dakota, and Vermont all require PBMs to disclose information concerning agreements and rebate arrangements between PBMs and prescription drug manufacturers.⁵² Similarly, North Dakota allows health plan

⁵⁰ See discussion *infra* Parts II.A. and II.B.

⁵¹ See D.C. CODE § 48-832.01 (2012); MD. CODE ANN., INS. § 15-1624 (LexisNexis 2012); N.D. CENT. CODE § 26.1-27.1-05 (2013); S.D. CODIFIED LAWS § 58-29E-4 (2013); VT. STAT. ANN. tit. 18, § 9472 (2012).

⁵² The District of Columbia requires PBMs to disclose to health plan sponsors "all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefits manager and any prescription drug manufacturer or labeler, including, without limitation, formulary management and drug-substitution programs, educational support, claims processing, and data sales fees." D.C. CODE § 48-832.01(c)(1)(B) (2012).

In Maryland, PBMs must disclose "total manufacturer payments earned by the pharmacy benefits manager during the applicable reporting period; and . . . total rebates applicable to the purchaser during the applicable reporting period" to the health plan sponsors with rebate-sharing contracts. MD. CODE ANN., INS. § 15-1624(a) (LexisNexis 2012). Pending legislation would require PBMs in Maryland to disclose this information to all health plan sponsors. See H.D. 908, 2013 Gen. Assemb., Reg. Sess. (Md. 2013).

South Dakota requires PBMs to "disclose to the covered entity [health plan sponsor], the amount of all rebate revenues and the nature, type, and amounts of all other revenues that the pharmacy benefits manager receives from each pharmaceutical manufacturer or labeler with whom the pharmacy benefits manager has a contract." S.D. CODIFIED LAWS § 58-29E-4 (2013).

sponsors to directly audit PBMs' accounts and records to confirm that the PBMs are sharing the rebates they receive from manufacturers with the sponsors according to their contracts.⁵³ Most of the state regulations include provisions allowing PBMs to classify information disclosed to health plan sponsors as confidential.⁵⁴ However, these confidentiality provisions are often vague and inadequate.⁵⁵

In Vermont, "unless the contract provides otherwise," pharmacy benefit managers must:

[d]isclose to the health insurer [health plan sponsors] all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefit manager and any prescription drug manufacturer that relate to benefits provided to beneficiaries under or services to the health insurer's health plan, including formulary management and drug-switch programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees.

VT. STAT. ANN. tit. 18, § 9472(c) (2012).

⁵³ See N.D. CENT. CODE § 26.1-27.1-05(2) (2013).

⁵⁴ District of Columbia:

A pharmacy benefits manager providing information to a covered entity under this section may designate that information as confidential. Information designated as confidential may not be disclosed by the covered entity to any other person or entity without the consent of the pharmacy benefits manager, unless ordered by a court of the District for good cause shown.

D.C. CODE § 48-832.01(c)(2) (2012).

Maryland:

Notwithstanding the provisions of paragraph (1) of this subsection, if a pharmacy benefits manager requires a nondisclosure agreement under which a purchaser agrees that the information in subsections (a) and (b) of this section is proprietary information, the pharmacy benefits manager may not be required to provide the information until the purchaser has signed the nondisclosure agreement.

MD. CODE ANN., INS. § 15-1624(c)(2) (LexisNexis 2012).

North Dakota does not have a provision allowing PBMs to classify information disclosed to health plan sponsors as confidential; however, "[a]ny information disclosed to the commissioner under this section is considered a trade secret." N.D. CENT. CODE § 26.1-27.1-06 (2013).

South Dakota:

Except for utilization information, a covered entity shall maintain any information disclosed in response to a request pursuant to § 58-29E-4 as confidential and proprietary information, and may not use such information for any other purpose or disclose such information to any other person except as provided in this chapter or in the pharmacy benefits management services contract between the parties. Any covered entity who discloses information in violation of this section is subject to an action for injunctive relief and is liable for any damages which are the direct and proximate result of such disclosure. Nothing in this section prohibits a covered entity from disclosing confidential or proprietary information to the director, upon request. Any such information obtained by the director is confidential and privileged and is not open to public inspection or disclosure.

S.D. CODIFIED LAWS § 58-29E-6 (2013).

Vermont: "A pharmacy benefit manager providing information under this subsection may designate that material as confidential." VT. STAT. ANN. tit. 18, § 9472(c)(1) (2012).

⁵⁵ See Letter from the Federal Trade Commission to James L. Seward, Senator, N.Y.

Mississippi has recently gone beyond trying to assist health plan sponsors by requiring PBMs to disclose enormous amounts of competitively sensitive information directly to the Board of Pharmacy,⁵⁶ the entity that regulates PBMs in Mississippi.⁵⁷ Under Mississippi law, the Board can require PBMs to disclose any “information relating to the operations of the pharmacy benefit manager required by the board.”⁵⁸ Mississippi law further entitles the board to “provide a copy of the financial examination to the person or entity who provides or operates the health insurance plan or to a pharmacist or pharmacy.”⁵⁹ The statute includes a provision stating that “no pharmacy benefit manager shall be required to disclose proprietary information of any kind to the board,” but it is presently unclear what qualifies information as proprietary.⁶⁰ Also, the law puts PBMs in the impossible situation of having to justify to the board on a case-by-case basis why the board should consider particular information “proprietary,” which PBMs might only be able to do by first disclosing to the board the very information it believes it should withhold from the board as “proprietary.”

Moreover, legislatures in several additional states are currently considering similar mandatory disclosure regulations. During the 2013 legislative sessions, legislatures in Connecticut, Oregon, South Carolina, and Tennessee are considering regulations that would require PBMs to disclose competitively sensitive information to health plan sponsors.⁶¹

B. Regulations Under the Affordable Care Act

Federal regulators have generally concluded that “vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation.”⁶² Indeed, many commentators have asserted that state-level regulation of the PBM industry is unnecessary and that misguided administrative actions by regulators that do not fully understand the complexity of the PBM

Senate 5 (Mar. 31, 2009), *available at* <http://www.ftc.gov/os/2009/04/V090006newyorkpbm.pdf> [hereinafter Letter to Senator Seward].

⁵⁶ *See* MISS. CODE ANN. § 73-21-157 (2013).

⁵⁷ *See id.*

⁵⁸ MISS. CODE ANN. § 73-21-157(3)(b) (2013).

⁵⁹ MISS. CODE ANN. § 73-21-159(3) (2013).

⁶⁰ MISS. CODE ANN. § 73-21-157(3) (2013).

⁶¹ *See* S. 31, 2013 Gen. Assemb., Jan. Sess. (Conn. 2013); S. 371, 77th Legis. Assemb., Reg. Sess. (Or. 2013); H.R. 3151, 120th Gen. Assemb., Reg. Sess. (S.C. 2013); H.R. 228, 108th Gen. Assemb., Reg. Sess. (Tenn. 2013).

⁶² DEP’T OF JUSTICE & FED. TRADE COMM’N, IMPROVING HEALTHCARE: A DOSE OF COMPETITION 23 (2004), *available at* <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

business model could negatively affect the integrity of the healthcare system.⁶³

The federal government also recently enacted mandatory disclosure regulations. Statutes enacted as part of the Affordable Care Act require PBMs to disclose competitively sensitive information to certain health plan sponsor clients and to the federal government. Specifically, the Act requires PBMs that manage drug coverage under a contract with a Medicare Part D drug plan or qualified health benefits plans offered through a state exchange to disclose certain financial and prescription drug dispensing information relating to their client contracts.⁶⁴ The required information includes: (1) “the aggregate amount, and the type of rebates, discounts, or price concessions . . . that the PBM negotiates that are attributable to patient utilization under the plan,” (2) “the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor,” (3) “the total number of prescriptions that were dispensed,” and (4) “[t]he aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies”⁶⁵ From this information, PBM clients can calculate amounts relevant to the contractual arrangement between the PBM and sponsor clients.

The federal laws under the Affordable Care Act include provisions to protect the confidentiality of information disclosed by the PBMs.⁶⁶ However, like the state regulations, it is unclear whether these provisions will be sufficient to prevent the competitively sensitive information from leaking to other participants in the prescription drug market.

III

ARE MANDATORY DISCLOSURE REGULATIONS NECESSARY?

Despite the growing number of mandatory disclosure regulations, there is no theoretical or empirical reason to believe they are essential to ensure that health plan sponsors pay a competitive price for PBM services. In this section, I discuss the arguments and evidence suggesting that these regulations are unnecessary.

When health plan sponsors contract with PBMs, they know the

⁶³ See, e.g., Mark Meador, *Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry Through Regulation*, 20 ANNALS HEALTH L. 77, 109 (2011).

⁶⁴ See 42 U.S.C. § 1320b-23 (Supp. V 2011).

⁶⁵ 42 U.S.C. § 1320b-23(b)(2)–(3) (Supp. V 2011).

⁶⁶ See U.S.C. § 1320b-23(c) (Supp V 2011) (“Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information . . .”).

price of the services they are obtaining and can compare prices among competing PBMs. Mandatory disclosure regulations are premised on the belief that health plan sponsors also need to know the PBM's costs, which are affected by the rebates they are able to negotiate with manufacturers, to ensure they are getting a good deal.⁶⁷ Thus, disclosure requirements are analogous to requirements that firms reveal aspects of their cost structures to consumers purchasing their finished products.⁶⁸ However, in most markets, consumers do not know anything about underlying costs, and there are no regulations premised on the idea that they should. Purchasers of consumer goods know nothing about underlying raw material costs and purchasers of services know nothing about the sellers' opportunity costs that inform their hourly rates. Similarly, consumers of PBM services do not need to know anything about PBMs' costs to ensure they are paying a competitive price. They can simply compare the services offered and the price of services among different PBMs. Health plan sponsors are sophisticated, repeat purchasers of PBM services that often use a bidding process to choose a PBM, and there is no reason to think they are unable to get a good deal on their own.⁶⁹ Indeed, the FTC has indicated that "[t]here is no theoretical or empirical reason to assume that consumers require sellers' underlying cost information for markets to achieve competitive outcomes."⁷⁰

Moreover, empirical evidence indicates that the potential problems that mandatory disclosure regulations attempt to address are not prevalent. Both the FTC and the GAO have conducted extensive analyses of the PBM industry and found that PBMs reduce health plan prescription benefit costs by agreeing to pass through to plans a significant portion of the payments they receive from drug manufacturers.⁷¹ The FTC has found that, although the pass-through of manufacturer rebates varies among PBMs, PBMs typically pass on more than 50 percent of manufacturer rebates to health plan sponsor clients.⁷² More recently, information indicates that PBMs pass through to plan sponsors almost 90 percent of manufacturer rebates.⁷³ Consequently, the GAO found that PBMs' sharing of

⁶⁷ Letter to Assembly Member Aghazarian, *supra* note 27, at 9.

⁶⁸ See Letter from the Federal Trade Commission to Nellie Pou, Assemblywoman, N.J. Gen. Assembly 12 (Apr. 17, 2007), available at <http://www.ftc.gov/be/V060019.pdf> [hereinafter Letter to Assemblywoman Pou].

⁶⁹ See Letter to Assembly Member Aghazarian, *supra* note 27, at 9.

⁷⁰ See Letter to Senator Seward, *supra* note 55, at 6.

⁷¹ See FED. TRADE COMM'N, *supra* note 6, at 57–60.

⁷² See *id.* at 59.

⁷³ See PHARMACY BENEFIT MGMT. INST., *supra* note 28, at 3; see also Adam J. Fein, *A Peek at Manufacturers' PBM Rebates*, DRUG CHANNELS (Jan. 24, 2013), <http://www.drugchannels.net/2013/01/a-peek-at-manufacturers-pbm-rebates.html#more>

manufacturer payments reduce total annual drug spending by as much as 9 percent.⁷⁴

Indeed, most contracts between PBMs and plan sponsors require that PBMs pass through to the plan sponsor a very large fraction of the rebates and discounts they negotiate with manufacturers.⁷⁵ Moreover, as competition for sponsor contracts has intensified, evidence suggests that PBMs have agreed to pass through more of the cost savings to remain competitive. For example, the 2010 financial statements from one major PBM indicate that the company passed on 87.5% of the drug manufacturer discounts to customers.⁷⁶ Similarly, Express Scripts stated in its 2010 Form 10-K that “[h]istorically in the PBM industry, competition in the marketplace has also caused many PBMs, including us, to reduce the prices charged to clients for core services and share a larger portion of the formulary fees and related revenues received from pharmaceutical manufacturers with clients.”⁷⁷ Indeed, the FTC has found that as existing contracts have been amended over time, the contractually agreed upon amount of manufacturer rebates that PBMs pass through to health plan sponsors has increased.⁷⁸ As a result, a recent survey of health plan sponsors indicates that the vast majority of sponsors are happy with the amount of rebate and discount sharing in their PBM contracts.⁷⁹

Finally, reviews of contracts between health plan sponsors and PBMs show that mandatory disclosure regulations are unnecessary. Health plans are already able to negotiate contract terms that include disclosure and audit rights when they want them and are willing to bear the resulting additional administrative costs.⁸⁰ Indeed, many contracts provide for full disclosure to client health plans, even without mandatory disclosure regulations.⁸¹ Vigorous competition for health plan contracts encourages the PBMs to disclose cost and rebate information when their clients want that information. Just as competitive forces induce PBMs to offer their best price and service combinations to prospective clients, competition also encourages PBMs to offer the desired disclosure terms in private contracts.

(reviewing the Pharmacy Benefit Management Institute’s report).

⁷⁴ See U.S. GEN. ACCOUNTING OFFICE, *supra* note 5, at 11–12.

⁷⁵ See FED. TRADE COMM’N, *supra* note 6, at 57–58.

⁷⁶ See Medco Health Solutions, Inc., Annual Report (Form 10-K), at 55 (Feb. 22, 2011).

⁷⁷ See Express Scripts, Inc., Annual Report (Form 10-K), at 16 (Feb. 16, 2011).

⁷⁸ See FED. TRADE COMM’N, *supra* note 6, at 58.

⁷⁹ See J.P. MORGAN, PHARMACY BENEFIT MANAGEMENT 7–8 (2012), available at http://executivecouncil.com/reports/12_May_JPMorgan_PBM.pdf.

⁸⁰ See FED. TRADE COMM’N, *supra* note 6, at 58.

⁸¹ See, e.g., Milt Freudenheim, *Big Employers Join Forces in Effort to Negotiate Lower Drug Prices*, N.Y. TIMES, June 12, 2004, at C1; Milt Freudenheim, *Employers Unite in Effort to Curb Prescription Costs*, N.Y. TIMES, Feb. 3, 2005, at C3.

Consequently, the FTC has concluded that “vigorous competition in the marketplace for PBMs is more likely to arrive at an economically efficient level of transparency than regulation of those terms.”⁸²

Thus, there is no theoretical or empirical reason to think that health plan sponsors require legislatively mandated access to PBMs’ cost information to achieve a competitive deal. Evidence suggests that PBMs pass through the vast bulk of the manufacturer rebates to sponsors, and sponsors are already able to negotiate pass-through rates and disclosure terms in existing contracts. Allowing competition among PBMs is more likely to yield efficient rebate pass-through and disclosure than are mandatory disclosure regulations.

IV

COSTS OF MANDATORY DISCLOSURE REGULATIONS

Not only are mandatory disclosure regulations unnecessary to achieve competitive outcomes, the regulations also impose significant costs on PBMs. In this section, I discuss how recently enacted mandatory disclosure regulations increase both direct costs and litigation costs for PBMs. More importantly, the regulations will weaken competition in the PBM industry, and, in turn, increase the cost of prescription drugs and drug coverage for consumers and health plan sponsors.

A. Direct Costs of Disclosure

First, regulations requiring additional disclosure directly increase costs for PBMs as they collect, prepare, and present the additional information.⁸³ Typical disclosure costs include the costs of gathering, processing, auditing (if the information is audited), and disseminating the information.⁸⁴ Although the extent of additional disclosure will vary depending on the specific regulation, the out-of-pocket costs of additional disclosure can be substantial. PBMs will initially pay these additional costs out-of-pocket; however, the PBMs will likely pass these costs on to health plans and consumers in the form of higher prices. Indeed, the FTC has acknowledged that additional disclosure “will increase health care costs, and such costs may be reflected in the price of drug plans that health plans are able to offer . . . , the scope of coverage consumers receive under such plans, or the number of consumers who have access to such coverage.”⁸⁵

⁸² See Letter to Assembly Member Aghazarian, *supra* note 27, at 10.

⁸³ See Letter to Senator Seward, *supra* note 55, at 4.

⁸⁴ See Robert K. Elliot & Peter D. Jacobson, *Costs and Benefits of Business Information Disclosure*, 8 ACCT. HORIZONS 80, 81–84 (1994).

⁸⁵ See Letter to Senator Seward, *supra* note 55, at 4.

B. Litigation Costs

Second, regulations requiring additional disclosure will increase litigation costs following allegations of insufficient or misleading information disclosure. Unlike in situations where the parties negotiate the extent of contractually agreed upon disclosures, there is likely to be uncertainty and potential disagreement over the scope and content of regulation-mandated disclosures. The resulting lawsuits can impose significant costs on PBMs. Legal fees, court awards, and the costs of settlements made strictly as business decisions can be substantial.⁸⁶ Moreover, there can be additional reputational costs resulting from any negative publicity surrounding lawsuits.⁸⁷ Finally, distracting executives from productive activities as they deal with litigation creates efficiency costs for PBMs.⁸⁸ PBMs will finance the additional litigation costs by increasing the prices paid by health plans and consumers.

C. Competitive Harms

Although the direct costs and litigation costs of additional disclosure can be substantial, the most significant impact will result from the PBMs' weakened competitive positions. Regulations requiring financial disclosure will likely enable pharmacies and pharmaceutical manufacturers to obtain PBMs' competitively sensitive cost information. This will reduce PBMs' ability to negotiate discounts with pharmacies and rebates with drug manufacturers, thus increasing drug prices for consumers. As a result, prescription drug spending will increase.

Some mandatory disclosure regulations, such as those in Mississippi,⁸⁹ specifically allow pharmacies to obtain PBMs' financial information. However, even in states with regulations that only sanction the sharing of PBMs' financial information with health plan sponsors, there is a risk that the information may become public and available to pharmacies and manufacturers.⁹⁰ Although many regulations include confidentiality provisions, many of these provisions are unclear or inadequate.⁹¹ As a result, the regulations may permit the broader disclosure of competitively sensitive information which may, in turn, facilitate collusion, raise prices, and harm the patients the regulations aim to protect.⁹²

⁸⁶ See Elliot & Jacobson, *supra* note 84, at 83–84.

⁸⁷ See *id.*

⁸⁸ See *id.*

⁸⁹ See MISS. CODE ANN. § 73-21-157 (2013).

⁹⁰ See Letter to Assembly Member Aghazarian, *supra* note 27, at 9.

⁹¹ See Letter to Senator Seward, *supra* note 55, at 5.

⁹² See Letter to Assemblywoman Pou, *supra* note 68, at 11.

Pharmacies typically compete with one another by offering deeper discounts or lower dispensing fees in order to be included in a PBM's limited network or to become a preferred provider. However, pharmacies are less likely to offer the same price terms to PBMs when they know that rival pharmacies can learn the specifics of the arrangement.⁹³ When rivals can see the arrangement and offer the same or better terms, it blunts the incentive to offer PBMs favorable terms in the first place.⁹⁴ Hence, the disclosure of sensitive financial information will undercut the most efficient pharmacy network contracts, leading to higher prescription drug prices.

Indeed, federal antitrust agencies have explained how information sharing among rivals can increase prices: it "can blunt a firm's incentive to offer customers better deals by undercutting the extent to which such a move would win business away from rivals" and "also can enhance a firm's incentive to raise prices, by assuaging the fear that such a move would lose customers to rivals."⁹⁵ Similarly, regulations enabling pharmacies to know the pricing details of their competitors' arrangements with PBMs will likely increase the prices of prescription drugs.

If pharmaceutical manufacturers discover the precise details of rebate arrangements or price discounts offered by their competitors, then tacit collusion among them becomes possible.⁹⁶ Absent such knowledge, manufacturers have powerful incentives to bid aggressively in order to have their drugs listed on the health plan's list of preferred drugs; formulary status offers the prospect of significant sales.⁹⁷ When manufacturers do not know what rebates or price discounts their competitors are offering, they have the incentive to bid aggressively to try to outbid the "unknown" deals.⁹⁸ However, when the arrangements are no longer unknown, this incentive to outbid unknown price terms disappears. As a result, disclosure of sensitive business information will raise the price that consumers pay for pharmaceutical coverage by reducing competition among pharmaceutical companies for preferred formulary treatment.

A basic tenet in the economics and industrial organization literature is that sharing information about cost, transaction prices,

⁹³ See Letter from the Federal Trade Commission to Mark Formby, Representative, Miss. House of Representatives 7 (Mar. 22, 2011), available at <http://www.ftc.gov/os/2011/03/110322mississippiipbm.pdf>.

⁹⁴ See *id.*

⁹⁵ See U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 7, at 24 (2010), available at <http://ftc.gov/os/2010/08/100819hmg.pdf> (describing anticompetitive effects of coordination among rivals).

⁹⁶ See, e.g., Svend Albaek et al., *Government Assisted Oligopoly Coordination? A Concrete Case*, 45 J. INDUS. ECON. 429, 441 (1997).

⁹⁷ See Letter to Assembly Member Aghazarian, *supra* note 27, at 9.

⁹⁸ See *id.*

and other competitively sensitive information among rivals makes tacit collusion more likely.⁹⁹ Similarly, numerous empirical studies have also established that the disclosure of competitively sensitive information is associated with higher prices.¹⁰⁰ As firms learn of their rivals' cost structures, their willingness to bid aggressively disappears.

Federal antitrust agencies have also recognized that the disclosure of sensitive business information can lead to tacit collusion among pharmaceutical manufacturers and higher prices: "[T]he sharing of information related to a market in which the collaboration operates or in which the participants are actual or potential competitors may increase the likelihood of collusion on matters such as price"¹⁰¹ Similarly, they note that disclosure of price and cost information is particularly harmful to competition: "[T]he sharing of information relating to price, output, costs, or strategic planning is more likely to raise competitive concern than the sharing of information relating to less competitively sensitive variables."¹⁰²

Hence, regulations requiring PBMs' disclosure of sensitive business information will reduce competition in the market for prescription drugs. Pharmacies and manufacturers will no longer compete as intensely for PBMs' business when business arrangements are no longer private. Moreover, PBMs will no longer be able to effectively compete for contracts with health plan sponsors by offering exclusive prices they were able to negotiate with pharmacies and drug manufacturers. This will ultimately lead to higher prices for PBM services and pharmaceuticals. Discussing the specific risks of disclosure in the health care industry, the FTC and DOJ have explained that "information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices . . . , resulting in increased prices, or reduced quality and availability of health care services."¹⁰³

⁹⁹ See Alback et al., *supra* note 96, at 430 ("At least since Stigler's [1964] seminal article, this [industrial organization] literature has stressed the importance for (tacitly) colluding oligopolists of observing firm-specific transactions prices of their rivals and rapidly detecting changes in these. Otherwise, collusion is prone to break down."); Kai-Uwe Kuhn, *Fighting Collusion: Regulation of Communication Between Firms*, 16 *ECON. POL'Y.* 168, 170 (2001) ("The notion that communication is central to collusion is without doubt part of the general folklore of competition policy at least going back to Adam Smith.").

¹⁰⁰ See, e.g., Stephen W. Fuller et al., *Effect of Contract Disclosure on Price: Railroad Grain Contracting in the Plains*, 15 *W. J. AGRIC. ECON.* 265, 270-71 (1990); see also Maura P. Doyle & Christopher M. Snyder, *Information Sharing and Competition in the Motor Vehicle Industry*, 107 *J. POL. ECON.* 1326, 1329 (1999) (finding evidence that automakers respond strategically to production announcements by rivals).

¹⁰¹ See FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS* § 3.31(b), at 15 (2000), available at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>.

¹⁰² See *id.*

¹⁰³ See U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *STATEMENTS OF ANTITRUST*

Finally, the increase in drug prices and reductions in competition can extend beyond the states with disclosure regulations. PBMs' business practices are likely similar across states so that disclosing information about PBMs' practices in one state informs pharmacies and manufacturers about PBMs' practices in other states.¹⁰⁴ Pharmacies and manufacturers can use the information from states with disclosure regulations for their benefit in other states; for example, pharmacies and drug manufacturers negotiating with PBMs in a nonregulated state may demand the same pricing arrangements as PBMs negotiated in a state with disclosure regulations. Thus, state regulations requiring the disclosure of competitively sensitive information can reduce competition across the industry and cause prescription drug prices to increase nationwide.

CONCLUSION

PBMs save Americans billions of dollars each year by lowering the prices that consumers pay for prescription drugs and health plans pay for drug coverage. However, mandatory disclosure regulations recently enacted in several states and at the federal level, under the Affordable Care Act, threaten to undercut competition in the PBM industry and disrupt the cost savings PBMs currently generate. These regulations require PBMs to disclose competitively sensitive financial information to various participants in the prescription drug market. The additional disclosure increases both the direct costs and litigation costs for PBMs. More importantly, the regulations weaken PBMs' competitive position and reduce their ability to negotiate discounts with pharmacies and rebates with drug manufacturers, thus increasing the drug prices for consumers.

Lawmakers premise mandatory disclosure regulations on the belief that to ensure that health plan sponsors are paying a competitive price for PBM services, the sponsors must know the details of the rebates and discounts their PBM partners are able to negotiate with manufacturers and pharmacies. However, there is no theoretical or empirical reason to believe that mandated disclosure of this information is necessary to ensure that health plan sponsors are paying a competitive price for PBM services. Health plan sponsors are sophisticated, repeat purchasers of PBM services that can simply compare the services offered with the price of services among different PBMs. Moreover, existing contracts require PBMs to pass through to plan sponsors a significant portion of the rebates and

ENFORCEMENT POLICY IN HEALTH CARE 49 (1996), *available at* <http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf>.

¹⁰⁴ See Gryta, *supra* note 12 (describing top three PBMs with national scope).

discounts they negotiate, and empirical evidence indicates that PBMs do pass on the vast bulk of their negotiated savings. Finally, health plans are already able to negotiate contract terms that include disclosure and audit rights when they want them and are willing to bear the resulting increased administrative costs, rendering mandatory disclosure regulations superfluous.

Unfortunately, mandatory disclosure regulations do more than just undermine competition in the PBM industry: they will also increase the prices that consumers and third parties pay for prescription drugs. Industry estimates suggest that PBMs' cost-saving practices save as much as \$100 billion annually.¹⁰⁵ Mandatory disclosure regulations threaten to undo these cost savings and increase prescription drug prices, contributing to the nation's ever increasing healthcare costs.

¹⁰⁵ Total prescription drug spending is approximately \$325 billion. Katie Thomas, *U.S. Drug Costs Dropped in 2012, but Rises Loom*, N.Y. TIMES, Mar. 19, 2013, at A1. Estimates of PBMs' cost savings range from 30% to 35% of total prescription drug spending, suggesting that total drug spending would range from \$422 to \$438 billion without PBMs' cost-saving practices. See CONG. BUDGET OFFICE, *supra* note 2, at 40 tbl.6; VISANTE, *supra* note 3, at 5.