Response of Richard G. Frank to Question for the Record following the hearing entitled "The Role of Pharmacy Benefit Managers

Question for the Record from Representative Correa for Dr. Frank, Dr. LoSasso, Dr. Van Nuys, and Dr. Mattingly. "The Role of Pharmacy Benefit Managers" September 11, 2024.

During the hearing, witnesses suggested that clients may benefit if pharmacy benefit managers (PBMs) had fiduciary responsibilities to their clients. Do PBMs have a fiduciary responsibility to their clients at either the federal or state level? If not, should PBMs have a fiduciary duty to their clients? What specifically would this entail and what are the positive and negative costs, financial or otherwise, and *impacts of imposing a fiduciary duty to clients on PBMs on clients or any other entity or market?*

Thank you for the question.

In response to the first part of your question, it appears that one thing that the ERISA Industry Committee (ERIC) and the Pharmaceutical Care Management Association (PCMA) agree upon is that currently PBMs are largely viewed as Third Party Administrators (TPAs) and therefore are not fiduciaries of, say, an ERISA plan. This is in large part because TPAs are seen as agents of the plans and do not exercise discretion over key plan parameters and practices.

At the hearing a variety of concerns were aired about the conduct of Pharmacy Benefit Managers (PBMs). Those concerns included pursuit of rebates that can harm patients financially, use of spread pricing that results in overpayment by insurers, applications of post transaction price adjustments that harm retail pharmacies, forms of self-dealing with respect to PBM owned pharmacies, and participation in actions that game regulation of profits of health insurers among others. A central issue noted by several witnesses was the extent that some of the practices of concern relate to the inability to control undesirable conduct through contracts between employers and other payers, and PBMs or whether some of the practices are in fact sanctioned by payers through contracts. The answer to that contributes to deciding whether there should be a fiduciary obligation established for PBMs and the nature of that obligation.

Before turning to specific practices, the context within which PBMs function is important to acknowledge. First, the four largest PBMs are all vertically integrated with large health insurance organizations. Second, the concerns about PBM raised by sub-committee members and witnesses identified several key stakeholders affected by the conduct of PBMs. Those stakeholders include premium payers, employers, patients, health insurance parent companies (e.g., United, Cigna, CVS, Humana) and taxpayers. Finally, the impact of prescription drug formularies, benefit design and payment arrangements all have impacts on the use of medical care services, employer costs, premiums and ultimately employee earnings. Thus, determining the influence of various parties on the parameters of a prescription drug benefit is complicated and messy. In addition, deciding to whom the PBM must be loyal is also messy as is distinguishing trade-offs from conflicts of interest.

As I and others noted in testimony, PBMs are paid through combinations of administrative fees, retained rebates and spread prices. To the extent that these are explicit contract features arrived at through negotiation between employers and insurers/PBMs, it is not clear that fiduciary arrangements of the type that ERIC proposes will help. It is likely that the level of fees, retained rebates or spread prices may in many cases be the result of the exertion of market power by PBMs and their insurer parents. For

example, it is likely that the combination of asymmetric information between PBM/insurer and an employer can allow insurer/PBMs to exert market power, especially with smaller employers, that end in favorable contracts enabling insurer/PBMs to make excess profits in some cases. Yet while in some cases an incomplete ability to establish effective contracts can be remedied through fiduciary obligations, the details matter and it is not clear that would be the most effective approach to addressing the problematic insurer/PBM conduct. Furthermore, in examining the harms to patients from arrangements that promote list to net price differentials (a frequent complaint), it is important to note that it is the development of benefit designs that rely on deductibles and coinsurance (instead of copays) that contribute to the list-net price gap. Those benefit design features are clearly choices made or heavily affected by insurers and health plans.

The observations that PBMs may drive business to their own pharmacies, even when they are not the low-cost supplier reflects a conflict of interest and likely market power. The question this poses' is what the best mechanism for reining in such behavior is. A very narrowly drawn fiduciary arrangement might help but there are other mechanisms ranging from anti-trust action to payment policy in public programs that might be equally or more effective in improving efficiency.

The gaming of insurance regulations like the Medical Loss Ratio provision of the Affordable Care Act results from the vertical integration of health insurers and related businesses, as noted in my written testimony. In that care the incentives driving the conduct are those faced by the health insurer. The focus on the PBM *per se* is misplaced in that case. Instead, the rules governing insurance practices are the central issue. In that case I expect fiduciary requirement would have no clear effect.

Finally, as I noted in my testimony before the sub-committee, addressing these issues can improve the functioning of prescription drug market, however, the contribution to making prescription drugs more affordable will be modest.