PCMA

April 6, 2023

The Honorable Donna Bailey
The Honorable Anne Perry
Members, Committee on Health Coverage, Insurance and Financial Services
Cross Building, Room 220
100 State House Station
Augusta, ME 04333

RE: LD 1165 An Act to Enhance Cost Savings to Consumers of Prescription Drugs; Opposed

Chair Bailey, Chair Perry and Members of the Committee,

My name is Sam Hallemeier, Director of State Affairs, and I am writing on behalf of the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans and operate mail-order and specialty pharmacies for more than 275 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA opposes LD 1165, which requires that rebates negotiated by PBMs on behalf of health plan sponsors be applied to a patient's cost-sharing at the point of sale. While we appreciate the legislature's concern with the rising cost of prescription drugs, **LD 1165 is a one-size-fits-all mandate that will do little to address the increasing price of drugs and will only serve as a windfall to drug manufacturers.**

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. One fundamental way PBMs help consumers obtain lower prices for prescription drugs is by negotiating rebates (discounts) with drug manufacturers. Negotiations between PBMs and manufacturers are the only tool to leverage competition and drive lower drug costs. Rebates are typically used to keep costs down across the board as employers and other plan sponsors use the savings from rebates to lower premiums for everyone. While point-of-sale rebates are possible under specific plan designs, the decision to apply rebates at the point-of-sale or as a hedge against rising premiums is and should be determined by the plan sponsor.

When considering mandatory POS rebates, it is crucial to keep in mind that:

1. **Rebates have consistently been shown to save consumers money**: Recently, the Centers for Medicare & Medicaid Services (CMS) found that a federal proposal for POS rebates in Medicare Part D would **increase** premiums by up to **25%** and **increase** drug spending by **$196 billion**.[1]

[1] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

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2. Under the federal proposal, CMS actuaries predicted **manufacturers would keep at least 15%** of what they would have offered in rebates and also found that **drug spending would increase by $137 billion as they would have little incentive to lower their list prices**.[2]
3. **Mandatory POS rebates under the federal proposal would provide drug manufacturers a $40-$100 billion windfall.** [3] The fact that drug manufacturers applauded a federal proposal to restructure rebates should reinforce that manufacturers, not consumers, taxpayers, and employers, would be the real winners.

Additionally, mandatory POS rebates would require releasing confidential information that inadvertently discloses actual rebate amounts. Eliminating this type of confidentiality of rebate levels and undermining the negotiating power held by payers, including employers, would inhibit a PBMs' ability to negotiate a better price for consumers. **As CMS noted in their assessment of a federal proposal, rebates would be reduced by 15%[4], meaning consumers pay more.** Finally, the FTC has long stated that "if manufacturers learn the exact amount of the rebates offered by their competitors...the required disclosures may lead to higher prices for PBM services and pharmaceuticals."[5]

By disrupting competition in the prescription drug market, mandatory rebates, whether at 100% of rebates or less, ultimately will increase the prices that all pay for health care and prescription drugs.

Please let me know if you have any questions or would like more information.

Sincerely,

Sam Hallemeier
Pharmaceutical Care Management Association
(202) 579-7647
shallemeier@pcmanet.org

[2] A recent study, *Reconsidering Drug Prices, Rebates, and PBMs*, shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases

[3] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).

[4] A recent study, *Reconsidering Drug Prices, Rebates, and PBMs*, shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases.

[5] FTC, "Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts

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With Point-of-Sale Rebates, Everyone Pays Except Manufacturers

Rebates Lower Health Care Costs for Everyone

- **Rebates have consistently been shown to save consumers money.** Most recently, Centers for Medicare & Medicaid Services (CMS) actuaries found a federal proposal for point-of-sale (POS) rebates in Medicare Part D would increase premiums by up to 25% and increase drug spending by $196 billion.[1]
- **Negotiations between PBMs and manufacturers leverage competition and drive lower drug costs overall.** Rebates also help keep health care costs down across the board, as employers and other plan sponsors use the savings from rebates to lower premiums for everyone.
- **Mandatory POS rebates would reveal rebate amounts, thereby fostering tacit collusion, reducing plan sponsors' ability to negotiate lower drug prices, and raising health care costs for *everyone*.** The U.S. Federal Trade Commission (FTC) found that "if manufacturers learn the exact amount of the rebates offered by competitors... the required disclosures may lead to higher prices for PBM services and pharmaceuticals."[2]

POS Rebates Won't Help the Majority of Patients Who Take Generics or Lower-cost Brands. Most brand drugs do not have rebates; only those that have one or more competitors within the drug's class typically do.[3] While POS discounts would lower out-of-pocket costs for some – patients paying for the 2.4% of brand drugs through coinsurance[4] – evidence[5] shows these POS discounts would be lower than the current rebates they would replace. Moreover, two-thirds of patients with employer-sponsored insurance do not face any type of coinsurance for their prescription drugs.[6]

Current Rebate Model	Point-of-Sale Rebate Model
Rebates are used by employers and other plan sponsors to lower overall premiums—**leading to lower drug and health care costs for everyone.**	• Rebates for a particular drug are estimated and factored into patient coinsurance at the pharmacy. • No rebates are factored into the premium, leading to higher overall drug spending and premiums for all plan enrollees. • Estimates suggest 10% of patients would save more on cost sharing than they would spend on higher premiums—**and the other 90% would pay more overall.**[7]

[1] CMS Office of the Actuary, "Proposed Safe Harbor Regulation." (August 30, 2018).
[2] FTC, "Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts."
[3] Milliman, "Prescription Drug Rebates and Part D Drug Costs." (July 16, 2018). https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf.
[4] According to an analysis by America's Health Insurance Plans of REDBOOK™ drug pricing data.
[5] See, e.g., Ibid., CMS (August 30, 2018) and Congressional Budget Office, "Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections." (May 2019).
[6] Kaiser Family Foundation, "Employer Health Benefits: 2020 Annual Survey" (2020). Page 153, http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf.
[7] Pink Sheet, "Point-of-Sale Rebates in Part D: Study Highlights Trade-Offs for Medicare." (June 29, 2017).

February 2021

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POS Rebates Would Do Nothing to Address High Drug Prices... Under a federal proposal for POS rebates, CMS actuaries predicted manufacturers would keep at least 15% of what they would have offered in rebates. They also found drug spending would increase by $137 billion as manufacturers would not lower list prices as a result of the policy change.[8] The fact is manufacturers—and only manufacturers—set drug prices.[9]

... And Could Impair Transition to Value-based Health Care. Restrictions or requirements on use of rebates could limit the ability of plan sponsors and PBMs to develop and implement innovative benefit designs, like value- and outcomes-based payment models for prescription drugs. This is because the primary mechanism for reconciling payment based on past performance for value *is a rebate*. These models inherently rely on evaluating a drug's performance *after the fact* and adjusting payment according to whether measures on quality, safety, and adherence have been met.

Antitrust Case Law May Still Deter Manufacturers from Offering Up-front Discounts. POS requirements fail to address the fact that manufacturers could cite antitrust law (Robinson-Patman Act of 1936) and a related class action lawsuit as the reason not to give volume-based, up-front discounts. In that case, there would be **no viable alternatives to the current rebate system** that manufacturers themselves created.

Manufacturers Would Receive A Bailout. The fact that both PhRMA "applaud[ed]"[10] and BIO "strongly support[ed]"[11] a federal proposal to restructure rebates should reinforce that manufacturers—not consumers, taxpayers, or employers—would be the big winners under mandatory POS rebates. Under the federal proposal, with manufacturers *keeping* 15% of the discounts they currently pay in the form of rebates, manufacturers stood to receive a **bailout of between $40 and $100 billion over 10 years.**[12]

By disrupting competition in the prescription drug market, mandatory POS rebates, whether at 100% of rebates or a lesser percentage, ultimately will increase the prices that all pay for health care and prescription drugs.

[8] Ibid. CMS (August 30, 2018).
[9] A recent study, "*Reconsidering Drug Prices, Rebates, and PBMs*," shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases.
[10] Pharmaceutical Research Manufacturers of America (PhRMA). "PhRMA Statement on the Administration's Proposed Rule to Reform the Rebate System." (January 31, 2019). https://www.phrma.org/press-release/phrma-statement-on-the-administration-s-proposed-rule-to-reform-the-rebate-system
[11] Biotechnology Innovation Organization (BIO). "BIO Statement on New Proposal for Lowering Out-of-Pocket Costs for Medicines." (January 31, 2019). https://www.bio.org/press-release/bio-statement-new-proposal-lowering-out-pocket-costs-medicines
[12] Ibid., Op. cit. CMS (August 30, 2018).

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Pitfalls of Requiring Point-of-Sale Drug Rebates and Pharmacy Price Concessions

Mandates to pass through rebates and price concessions at the point of sale (POS) would increase premiums for families and costs for taxpayers, while providing a windfall for drug manufacturers. Requiring employers, labor unions, retirement systems, Medicare Prescription Drug Plans (PDPs), and other drug coverage sponsors to pass through negotiated rebates and pharmacy price concessions at the POS would be enormously costly and have serious unintended consequences.

- **Requiring POS rebates in Medicare Part D would increase costs for most beneficiaries and taxpayers.** CMS estimated that requiring 100% of rebates to be passed through at POS would, over 10 years, increase government costs by $82.1 billion and beneficiary premiums by $28.3 billion (or 11%)—and save drug manufacturers $29.4 billion.[1]
- **Medicare Part D already requires rebates and price concessions be used on behalf of beneficiaries to improve benefits or to lower premiums.**
- **Employers and other drug coverage sponsors do the same,** using "rebates in numerous ways – such as through reduced premiums and reduced coinsurance" and also "to provide reduced cost sharing for participants and beneficiaries."[2]
- **Medicare Part D is voluntary for beneficiaries, just as employers and other drug coverage sponsors are not required to offer such benefits.** Lower premiums encourage younger, healthier beneficiaries to enroll, just as more affordable drug coverage encourages the availability of these important benefits.

Disclosure of negotiated pricing, through POS rebates, raises drug costs.

- **Public disclosure of confidentially negotiated pricing reduces negotiation leverage and undermines competition.** Analysts have predicted disclosure would have a "dampening effect on the magnitude of rebates," potentially increasing brand drug costs more than 2 percent and Federal spending by $20 billion over 10 years.[3]
- For example, the Federal Trade Commission (FTC) has warned of this for decades:
  - **In 2017:** "May harm competition by hindering the ability of plans to negotiate... resulting in less aggressive pricing by, or even collusion among, manufacturers."[4]
  - **In 2004:** Whenever competitors know the actual prices charged by other firms, tacit collusion—and thus higher prices—may be more likely."[5]
- **Giving competitors knowledge of price concessions of others – whether rebates by manufacturers or concessions by pharmacies – will actually raise drug costs.** Requiring certain percentage-based rebates at point of sale could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals...they need at a price they can afford."[6]

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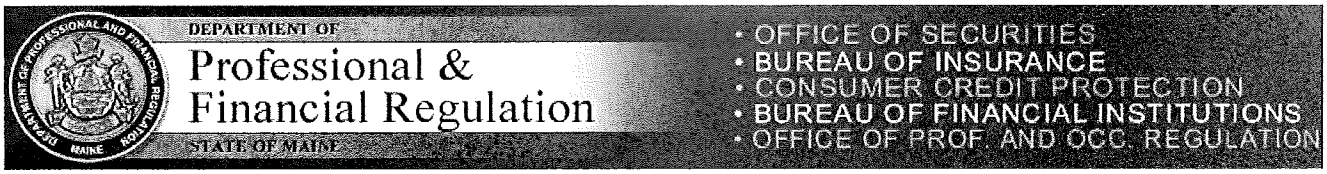
[1] CMS. "Proposed Rule: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan..." 82 Fed. Reg. 56336 (Nov. 28, 2017).
[2] American Benefits Council, "Letter to Aaron Zajic, Re: Fraud and Abuse; Removal of Safe Harbor Protection for Rebates..." (April 8, 2019).
[3] Moran Company. "Assessing the Budgetary Implications of Transparency of Prices in the Pharmaceutical Sector." April 2017.
[4] FTC. "Letter to Larry Good, Executive Secretary, ERISA Advisory Council." August 19, 2014.
[5] FTC and the U.S. Department of Justice. "Improving Health Care: A Dose of Competition." July 2004.
[6] See Letter from FTC to Representative Patrick T. McHenry, U.S. Congress (July 15, 2005) and Assemblyman Greg Aghazarian, California State Assembly (September 3, 2004).



2021 Annual Report on Prescription Drug Compensation for the Benefit of Covered Persons

Prepared by the Maine Bureau of Insurance
March 2022

Janet T. Mills
Governor

Anne L. Head
Commissioner

Eric A. Cioppa
Superintendent

EXECUTIVE SUMMARY

Under 24-A M.R.S. § 4350-A, carriers must file an annual report with the Superintendent, demonstrating how they used compensation from a pharmaceutical manufacturer, developer or labeler to benefit their members during the previous calendar year. This report is for January 1, 2021 through December 31, 2021.

The Bureau received responses from Anthem, Aetna Life Insurance Company, Aetna Health, Inc., the State of Maine health plan, Cigna Health and Life Insurance Company, Community Health Options, Harvard Pilgrim Health Care and HPHC Insurance Company (combined), United Healthcare, and Wellfleet Insurance Company (provides student health plans in Maine). To protect the confidentiality of company information provided, we have assigned each carrier a random letter as indicated in the charts below.

STATUTORILY REQUIRED QUESTIONS AND CARRIER ANSWERS

1) The total amount the company, as a carrier[i], or a pharmacy benefits manager that the company as a carrier contracts with, received directly or indirectly from any pharmaceutical manufacturer, developer or labeler:

Carrier A	$44,796,843.00
Carrier B	$ 3,225,525.91
Carrier C	$ 321,452.41
Carrier D	$ 66,689.80
Carrier E	$ 7,176,240.44
Carrier F	$28,657,957.57
Carrier G	$ 4,316,812.00
Carrier H	$ 6,850,901.75
Carrier I	$ 1,968,956.96
TOTAL	**$97,381,379.84**

2) The percentage of the amount that was remitted directly to a covered person at the point of sale and an explanation of the methods by which the company is providing this amount directly to covered persons:

Carrier A	2.45%	For claims where a rebate is generated, the allowed cost is reduced by the rebate prior to cost share determination. The cost share is applied to the reduced amount, therefore deductible claims get the full rebate, coinsurance claims get a share of the rebate, and copay claims may experience savings if the reduced allowed is less than the copay

Carrier B	4.00%	At point of sale, rebates are applied to reduce the total cost of the drug before member cost share is calculated.
Carrier C	5.00%	At point of sale, rebates are applied to reduce the total cost of the drug before member cost share is calculated.
Carrier D	0.00%	Rebates are not applied at point of sale and provided directly to covered persons, but back to the plan to reduce claim costs.
Carrier E	0.00%	N/A
Carrier F	0.00%	N/A
Carrier G	0.00%	N/A
Carrier H	0.00%	N/A
Carrier I	5.00%	At the point of sale, a calculation is done to see if the member's liability per the members' benefit is greater than the cost of the drug less an estimated rebate amount. If it is, the member pays the cost of the drug less an estimated rebate in place of the normal member liability.

3) The percentage of the amount that was applied to its plan design to offset premium in future years and an explanation of how the company is applying these funds to offset premium in future years:

Carrier A	97.55%	Assumed prescription drug rebates are included in the rate development process for the Individual, Small Group and Large Group segments and factored in as a reduction to claims (for the individual and small group markets) or a reduction in administrative expense (in the large group market) in developing premium rates. Both approaches result in a reduction of premium.
Carrier B	96%	In calculation of premium, the value of rebates is considered in the administrative component of the calculation.
Carrier C	95%	In calculation of premium, the value of rebates is considered in the administrative component of the calculation.

Carrier D	100%	Rebates are applied back to the plan to reduce claim costs.
Carrier E	100%	No explanation given.
Carrier F	100%	For the small group and individual markets, Rx rebates are credited as an offset to pharmacy claims directly in the rate development process thereby reducing premiums to all covered members. In our large group market, Rx rebates are reflected in the premium through the underwriting process. Note that when setting premiums, we project pharmacy rebates based on future expectations. This may not exactly match the pharmacy rebates received during the year. There is also uncertainty inherent in estimating pharmacy rebates in a given year.
Carrier G	100%	The rebate funds will continue to be used at 100% to reduce premiums through the pricing and underwriting premium development.
Carrier H	100%	We apply 100% of manufacturer compensation received by us and our PBM to individual and small group business to offset future premiums. Premiums in the pricing period are based on the claims experience in the experience period adjusted forward to the pricing period for trend, benefit and cost-sharing differences, changes in network contract terms, changes in membership demographics, retention, etc. For example, premiums in the pricing period 1/1/2022-12/31/2022 were based on claims experience from 1/1/2020-12/31/2020 with adjustments as previously mentioned. The claims experience in the experience period is net of pharmacy rebates received for the pharmacy claims incurred in that period.
Carrier I	95%	Rebates retained by the health plan are used as an input in determining what the premiums in the future years will be.

SUMMARY

Five carriers applied 100% of the amount received directly or indirectly from any pharmaceutical manufacturer, developer or labeler to its plan design to offset future premiums. Four carriers reported that less than 100% of the amount is applied to offset future premiums, but in each of those cases, the remaining amounts were applied to lower the cost of the drug prior to the sale to the consumer.

For this report, carrier* was defined by 24-A M.R.S. § 4347 as follows:

Carrier. "Carrier" has the same meaning as in section 4301-A, subsection 3, except that "carrier" does not include a multiple-employer welfare arrangement, as defined in section 6601, subsection 5, if the multiple-employer welfare arrangement contracts with a 3rd-party administrator to manage and administer health benefits, including benefits for prescription drugs. " Carrier" also includes the MaineCare program pursuant to Title 22, chapter 855 and the group health plan provided to state employees and other eligible persons pursuant to

PBM-Negotiated Rebates Reduce Costs for Plan Sponsors

Price concessions, in the form of rebates, negotiated by pharmacy benefit managers (PBMs) significantly lower the cost of drugs. According to researchers, PBMs, who are hired by plan sponsors to maximize the value of prescription drug benefits, help patients and payers save $941 per enrollee per year in prescription drug costs,[i] equaling $654 billion over the next 10 years.[ii] Plan sponsors use these savings to benefit patients by lowering premiums, deductibles, and cost sharing.

Drug Manufacturers Set Drug Prices; PBMs Work to Achieve the Lowest Net Cost for Drugs: It is always the drug manufacturer who decides what the price of a given drug will be. PBMs do not set drug prices—rather, PBMs evolved as a means to lower the cost of drug benefits by negotiating price concessions with manufacturers and pharmacies on behalf of plan sponsors, such as large employers, government programs, and insurers. In addition, PBMs lower costs by encouraging use of generics, offering specialty pharmacy services, and helping patients with drug adherence. PBMs would not serve 266 million[iii] enrollees through all kinds of health plans if they did not bring down costs.

Negotiated Drug Rebates Are the Only Practical Method to Apply Pricing Concessions: Drug manufacturers facing competition for their products are usually willing to negotiate on the price they initially set if a large purchaser can demonstrate that its enrollees account for a given market share. Because PBMs recommend and administer formularies that encourage enrollees to prefer some medications over others, PBMs, rather than insurers, negotiate with manufacturers. As benefit administrators, PBMs never take physical possession of a drug and thus a simple volume discount, which the manufacturer may give a wholesaler, say, is not possible. The only way a PBM can prove that its enrollees used a given drug -- its sales volume -- is through a tally of paid claims at the end of a period, which typically is quarterly. Based on the market share tally, the manufacturer pays the contractually agreed rebate.

Rebates Drive Competition among Brand Drug Manufacturers: PBMs and health plan sponsors create formularies to give patients an incentive to take the most clinically appropriate and cost-effective medication. The formulary drugs are recommended by independent scientific experts who consider the latest clinical evidence. Ultimately, the PBM client determines which drugs will be in its formulary and how they are covered. When therapies are judged equivalent, PBMs can negotiate rebates from manufacturers for favorable positions on formularies.

Plan Sponsors Decide the Portion of Rebates They Receive: PBMs are transparent to clients with respect to rebates, in accordance with contractual requirements. Nearly half of employer plan sponsors negotiating to receive manufacturer rebates elect to receive 100% of the rebate amounts[iv] and pay administrative fees to the PBM. Other payers negotiate for their PBMs to receive a portion of the rebates. Payers may also negotiate to put drug inflation risk on the PBM by locking in a specific rate for their drugs. Plan sponsors may negotiate any combination of these payment methods and other provisions, and always have the right to audit their PBMs' performance under their contracts. On average, PBMs pass back 90% of negotiated rebates from drug manufacturers, which payers use to lower enrollees' and their own health spending.[v]

PBM-Negotiated Rebates Are Like a Sealed-Bid Contracting Process: A number of policy makers and other observers have called for revealing drug prices negotiated between PBMs and manufacturers, in the mistaken belief that this so-called transparency would lower costs. In fact the opposite is true. If rebates were made public, the companies giving the biggest rebates would likely stop giving them and costs would rise. Drug price negotiations operate more like sealed-bid auctions where bidders offer the lowest price they can in hopes of winning business.

Revealing or Interfering in Confidential Negotiations Undermines Competition, Raising Costs for Consumers and Plan Sponsors: Respected government bodies and universities have established that confidential negotiations result in more competition and lower costs for patients and plan sponsors:

- The Federal Trade Commission has stated that, "[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors ... then tacit collusion among manufacturers is more feasible ... Whenever competitors know the actual prices charged by other firms, tacit collusion — and thus higher prices — may be more likely."[vi]
- The FTC has also warned several states that legislation requiring PBM disclosure of negotiated terms could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[vii]
- Additionally, the Department of Justice and the FTC issued a report noting that "states should consider the potential costs and benefits of regulating pharmacy benefit transparency" while pointing out that "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."[viii]
- Researchers at the University of Pennsylvania find that, "[t]ransparency requirements that attempt to set actual reimbursement for drugs at the pharmacy's or PBM's actual cost or acquisition price may have unintended consequences, leading to higher real costs and/or manipulated prices."[ix]

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[i] Visante, Inc. "The Return on Investment (ROI) on PBM Services," Prepared by Visante on behalf of PCMA, November 2016. https://www.pcmanet.org/wp-content/uploads/2016/11/ROI-on-PBM-Services-FINAL.pdf
[ii] Visante Inc., "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," Prepared for PCMA, February 2016. https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf
[iii] PR Newswire, "PBMs Provide Policy Solutions to Increase Competition, Reduce Rx Costs," Feb 04, 2016.
[iv] Pharmacy Benefit Management Institute, "PBMI Research Report: Trends in Drug Benefit Design," 2016.
[v] Written Testimony of Joanna Shepherd, Ph.D, Emory University for the ERISA Advisory Council Hearing on PBM Compensation and Fee Disclosure, June 19, 2014, Citing J. P. Morgan, "Pharmacy Benefit Management, Takeaways from Our Proprietary PBM Survey," May 21, 2014.
[vi] U.S. Federal Trade Commission and the U.S. Department of Justice, Improving Health Care: A Dose of Competition (July 2004)
[vii] Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004).
[viii] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004.
[ix] Danzon, P. "Pharmacy Benefit Management: Are Reporting Requirements Pro or AntiCompetitive?" https://bepp.wharton.upenn.edu/files/?whdmsaction=public:main.file&fileID=9696