AV POLICY FOCUS: PHARMACY BENEFIT MANAGER

Arnold Ventures

Pharmacy Benefit Manager (PBM) Policy Brief

THE ISSUE

While the high prices that manufacturers set for brand-name drugs is the primary reason drug costs are rising so quickly there also exists a complex web of economic incentives reverberating throughout the pharmaceutical supply chain that may increase drug costs. Centered in the middle is the highly concentrated Pharmacy Benefit Manager (PBM) industry.[1]

PBMs evolved over the decades from basic claims administrators to more complex organizations offering a wide range of prescription drug management tools to payers, such as drug utilization review, disease management, and consultative services. To manage the cost of their prescription drug benefit, most payers contract with a PBM. PBMs negotiate rebates with brand drug manufacturers and negotiate with pharmacies for lower prices. Terms of these arrangements are usually held confidential to clients of PBMs.

Mergers in the PBM industry (between PBMs as well as between PBMs, insurers, and pharmacies) created a highly concentrated industry, which can exacerbate issues of transparency and create conflicts of interest. In addition to being integrated with insurers, the three largest PBMs – CVS Caremark (Aetna), Express Scripts (Cigna), and OptumRx (UnitedHealth Group) – also own their own specialty pharmacies. Merged entities profit as both volume and price of prescriptions dispensed at their own pharmacies increases. That does not always align with its primary responsibility to lower drug costs for payers.

THE EVIDENCE

Three PBMs (Express Scripts, OptumRx, and CVS Caremark) control nearly 80% of the market and fall within the top 15 Fortune 500 companies.[2,3] Moreover, each of the three aforementioned PBMs merged with a large health insurer. The merged entity serves insurers as clients of its PBM but also competes with those same insurers in the marketplace. This creates an incentive for the merged entity to charge competing health insurers more for its standalone PBM services.[4]

The little we know about PBM business practices is gathered from a variety of sources including government records state audits and case documents.[5,6,7] Supply chain profits generated from generic drugs can be particularly problematic to payers. When Ohio's state Medicaid program was audited, PBMs were found to retain a spread (i.e., received more than paid out) equal to about 30 percent of the cost of generic drugs in a single quarter (Medicaid was charged $663 million for generic drugs but pharmacies were paid $208 million less than that amount – which was retained by PBMs).[8] One study found that Medicare Part D paid $2.6 billion more for generic drugs relative to prices charged by Costco in 2018 – suggesting that PBMs and other participants in the supply chain are overcharging Medicare for these drugs.[9]

Some – but not all – plan sponsors prefer a PBM benefit design (known as "traditional pricing") that allows PBMs to retain a share of the rebates instead of charging higher administrative fees under a pass-through pricing model. Traditional pricing, at times, leads PBMs to prefer that manufacturers of brand-name drugs give price concessions in the form of rebates, rather than in the form of lower list prices.[10] Manufacturers have responded by increasing both list prices and rebates as they compete for preferred placement on the PBM's formulary. As a result, the gap between list and net prices has grown substantially over time – especially in competitive therapeutic classes where PBMs have more leverage to negotiate for price concessions.[11]

It's incumbent upon employers, states, and the federal government to pursue evidence-based strategies to protect consumers and foster meaningful competition by preventing PBM anticompetitive business practices. At the same time, rigorous and independent research is necessary to target these efforts and inform ongoing policy discussions. Importantly, policies should be carefully designed to avoid unduly constraining PBMs' ability to negotiate rebates. If PBMs lose leverage to negotiate rebates with manufacturers, that would lead to higher prices paid by patients, taxpayers, and employers.

$2.6 BILLION

AMOUNT PBMS OVERCHARGED MEDICARE PART D FOR GENERIC DRUGS IN 2018

THE SOLUTIONS

A number of solutions are on the table to tackle misaligned incentives in the PBM market:

Increase transparency in PBM contracting. PBMs should provide plan sponsors visibility into (1) all monetary transfers between brand manufacturers and PBMs, (2) the final amount paid to the pharmacy on a claim by claim basis, including any other forms of discounts or price concessions given by the pharmacy to the PBM on an aggregate basis, and (3) the amount of fees and rebates received from brand manufacturers that are retained by the PBM's group purchasing organization or rebate aggregator. PBMs should not be required to report net prices at the national drug code (NDC) level, which the Congressional Budget Office (CBO) estimates would increase federal spending and Part D plan premiums.[12]

Transparency into all rebate collections. PBMs should either:

1. Pass-through 100 percent of rebates, fees, alternative discounts, reductions, or other clawbacks of any reimbursement made that are related to utilization of drugs under a plan sponsor's health plan or health insurance coverage, to the plan sponsor; or

2. The clients of PBMs should be able to choose to pay the PBM for its services by allowing the PBM to retain a share of the rebates as long as the PBM clients have complete visibility into total rebate payments and any other monetary flows between the manufacturer and the PBM.

Require reporting for intra-company prescription drug transfers. PBMs should provide plan sponsors with an explanation for policies that require beneficiaries to obtain their prescription(s) from any retail, mail order, or specialty pharmacy that is either affiliated with or under common ownership of the PBM. Additionally, PBMs should provide plan sponsors with a list of all drugs, including the price paid by the plan sponsor, dispensed by retail, mail order, or specialty pharmacies that are affiliated with or under common ownership of the PBM compared to rates of non-affiliated pharmacies within the plan network and within the same geography. This allows plan sponsors to know whether the PBM is breaching a conflict of interest by favoring its own pharmacies rather than allowing patients to access their prescription drugs at lower cost sites of service.

PBMS THAT HAVE MERGED WITH PHARMACIES PROFIT AS BOTH VOLUME AND PRICE OF PRESCRIPTIONS DISPENSED AT THEIR OWN PHARMACIES INCREASES. THAT DOES NOT ALWAYS ALIGN WITH ITS PRIMARY RESPONSIBILITY TO LOWER DRUG COSTS FOR PAYERS

80%: **THREE PBMS—EXPRESS SCRIPTS, OPTUMRX, AND CVS CAREMARK—CONTROL NEARLY 80% OF THE MARKET**

Increase the Federal Trade Commission's (FTC) regulatory authority over PBM vertical and horizontal integration. Direct the FTC to examine the effects of PBM vertical and horizontal integration on pricing and other potentially abusive behavior. Specifically, the FTC should highlight legal or regulatory obstacles that prevent it from enforcing antitrust and consumer protection laws in the pharmaceutical supply chain, and provide policy recommendations to Congress on improving transparency, preventing anticompetitive behavior, and ensuring consumers benefit from any cost savings generated by the PBM on drug purchases.

Require transparency on amounts earned through spread pricing. Require that under any PBM contract that utilizes a spread pricing model (that is, charging plan sponsors more than what's paid to pharmacies for a prescription drug), the PBM must report the amount it pays the pharmacy for the drug as well as the amount it charges the client, and all forms of price concessions received from pharmacies and retained by the PBM. Plan sponsors should have full visibility into the profits the PBM is making under any spread pricing arrangement.

Extend the Medicare and Medicaid inflation penalty to the commercial market. When the average price that manufacturers charge providers for a brand-name drug increases faster than inflation, an inflation penalty is paid on purchases of the drug by Medicare and Medicaid. This inflation penalty should be extended to drugs purchased by private health plans. Extending the inflation penalty to the commercial market will help close the growing list to net bubble by stabilizing price growth over time and decrease the reliance on rebates to lower net spending.

Establish fiduciary responsibility. PBMs should be required to have a fiduciary duty to its clients. This would result in contract terms between the PBM and the payer that works in the payer's best financial interest, particularly as PBMs negotiate with drug manufacturers and pharmacies for price concessions.

Endnotes

1 https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html

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