The Problem with PBMs

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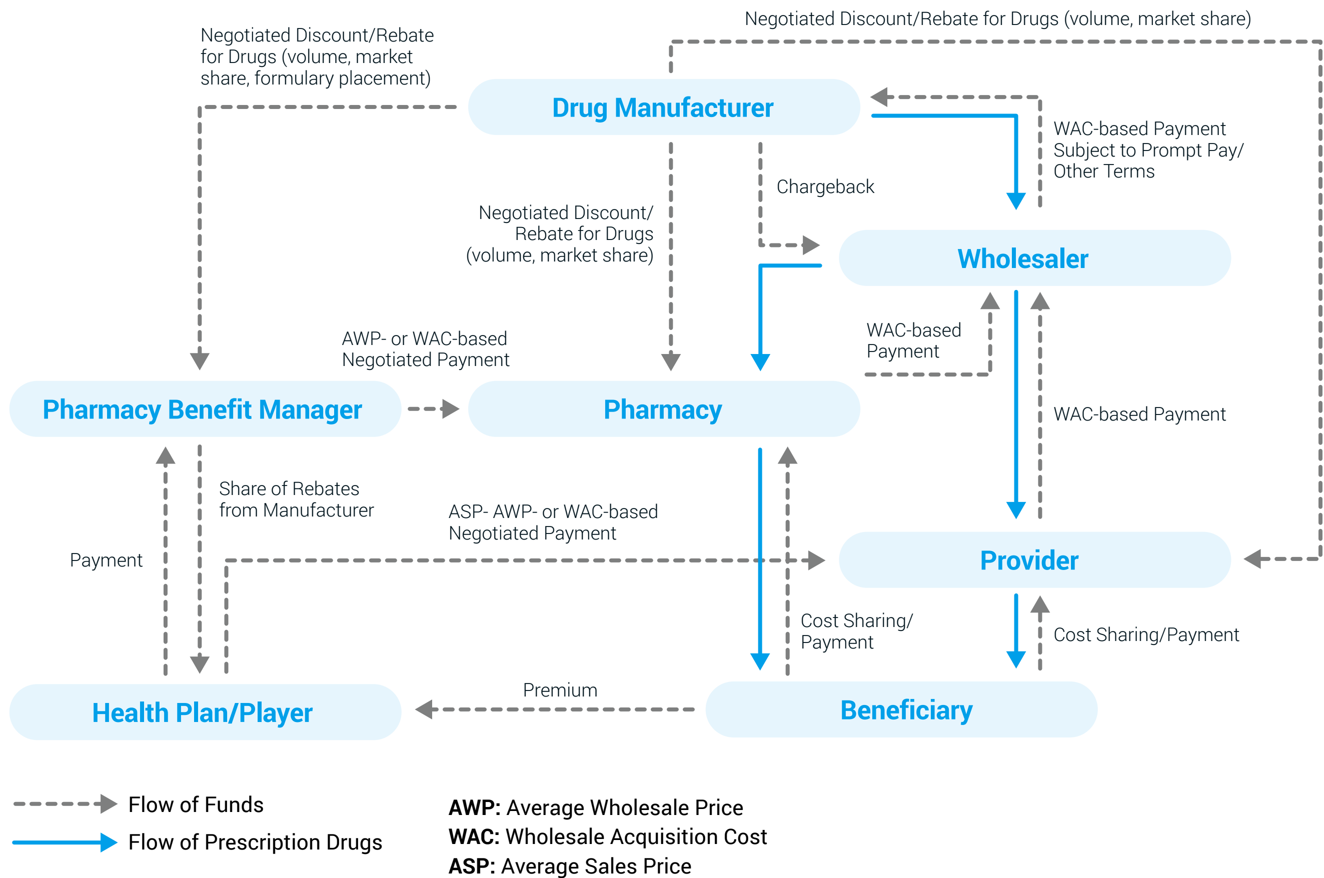
Arielle Kane

Carl Icahn, the billionaire businessman and investor, recently advised shareholders to reject Cigna's proposed $67 billion acquisition of the pharmacy benefit manager (PBM) Express Scripts. He says that a reckoning is coming for PBMs and that the price grossly exaggerated their value as "over-earning middle men."

In 2016, PBMs made $23 billion in gross profits – with most having never touched a drug.[1] They don't make them, they don't distribute them and they don't sell them. So what do PBMs do, and why is there so much misunderstanding about their value?

Because of the structure of PBMs, they create perverse incentives for drug makers to price drugs high. A flat fee structure, greater clarity of drug costs, and increased competition would help increase transparency, align incentives, and reduce costs for the pharmaceutical sector.

PBMs are a clear case of the law of unforeseen consequences. They evolved in the late 1960s and early 1970s when the number of drugs reaching the market was hard for health plans to manage. PBMs act as intermediaries between purchasers (typically health plans, Medicaid plans, or large employers) and drug companies. They negotiate with drug makers to determine benefits and drug formularies for health plans and process claims. A drug formulary is supposed to aggregate drugs into tiers based on value to determine which drugs are covered by the plan. In exchange for a preferred tier on a health plan's formulary, they negotiate discounts off of the list price. These discounts are known as "rebates" and are passed along to the client, after PBMs take a cut for themselves.



Source: Avalere Health

This means that the larger the gap between the list price and discount, the more the PBM makes. Additionally, PBMs can have fees that look similar to rebates but that technically aren't and therefore do not have to be passed along to employers or health plans.

Under this model, drug companies have an incentive to price their drug high, and offer a steep discount, rather than offer the lowest possible list price. Today's "big three" PBMs – Express Scripts, CVS Caremark, and OptumRx, owned by UnitedHealth Group – control over 70 percent of the market, covering roughly 180 million prescription drug customers. This gives the PBMs a great deal of negotiating power against both drug manufacturers and pharmacies. If drug manufacturers don't want to provide a discount, the PBM could simply list their drugs as "off formulary" and not cover the medication under a patient's plan. Because a portion of their profit is based on the rebate, PBMs rank drugs on their formularies based on the rebate amount rather than the lowest cost overall or drug efficacy. This encourages drug manufacturers to set artificially high list prices and offer steeper rebates rather than offer the lowest possible price. In this model, the health plan and consumer pay more as the PBM makes more money.

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With pressure to keep drug costs down, health insurance companies, employers and states are wondering if this payment structure creates perverse incentives. But the Trump administration can't seem to decide on the right path forward.

Although President Trump has continually railed against the high-powered, "rich" middlemen, his administration doesn't seem to know its own mind when it comes to PBMs.[2] Just last month, the administration announced it will allow "step therapy" in Medicare Advantage, which is administered by PBMs. Health plans will be able to require beneficiaries to try less expensive therapies before they "step" up to the expensive treatments.[3] U.S. Centers for Medicare and Medicaid Services (CMS) administrator Seema Verma said it would "strengthen the role of PBMs" to negotiate on behalf of CMS.[4] Conversely, however, the Department of Health and Human Services has proposed scaling back rebates to PBMs as a way to contain costs.[5] The changes to the anti-kick protections for PBMs are currently at the Office of Management and Budget for review. The PBM industry has challenged that proposal, saying Congress would need to change the federal statute. At this point, it is unclear how the administration will resolve the contradictions in its view of PBMs.

A problem Congress should tackle now is lack of transparency. On most of these formularies, list prices, discounts and profits are hidden from public view and scrutiny under "proprietary" information clauses. But the opaque nature of these arrangements greatly benefits PBMs. For example, one contract conferred on a PBM "full authority to determine whether a drug is brand or generic without being transparent" and that the PBM could "pocket the difference between a brand-drug discount and a generic-drug discount."[6]

Additionally, if pharmacies protest the model and try to demand a greater share of the sales price from the PBM, the PBM can just use another pharmacy – maybe even one they own. This leverage has allowed PBMs to continue generating larger profit margins. For example, Express Scripts earnings per adjusted claim jumped from $3.87 in 2012 to $5.16 in 2016.[7]

Finally, reports from the Schaeffer Center outlined how consumers' co-pays can cost more than the drug itself – and that PBMs pocket the difference. This practice, known as clawbacks, involved almost a quarter of all filled pharmacy prescriptions in 2013 amounting to millions in overpayments. For example, a drug's acquisition cost could be $5 but the health plan could chart a $10 copay for the prescription. Because the PBM processes these claims, they keep the difference. PBMs often have "gag" clauses that prohibit pharmacists from telling a patient when their prescription might be cheaper if paid out of pocket.[8]

Recent media disclosures about PBMs have caused some employers and state Medicaid programs to kick them to the curb. Just last week, Ohio announced it was ending its contracts with all PBMs after reporting showed that PBMs billed taxpayers 8.8 percent more than was paid to pharmacies for prescriptions covered by the Medicaid program.[9] This meant that the PBM's received about $225 million more per year from the state than they reimbursed pharmacies for drugs used by Ohio's poor and disabled.[10] Beginning in 2019, PBMs in the Ohio Medicaid program will only be able to charge Medicaid what it pays the pharmacy for the prescription drug plus a small fee – they won't get a portion of the rebates. Dispensing fees and administrative fees are projected to cost $0.95 to $1.90 per prescription.[11] Additionally, West

Virginia said it would no longer pay insurers to contract with CVS Caremark and Express Scripts for pharmacy benefits and that it expects to save $38 million this year by acting as its own pharmacy benefit manager.[12]

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PBMs do help plans manage contracts with hundreds of drug makers and process claims. But, under increased scrutiny, they may have to change their business model. For example, CVS Caremark said it is updating many contracts to a “pass-through” model where it is paid fixed fees and the savings from rebates are passed along to the customer. Lawmakers are looking to limit gag clauses, and states are considering more transparent contracts.

The reality is, PBM revenue accounts for only a small piece of the pharmaceutical sector – $23 billion is only 5 percent of net revenue of the pharma sector. Put another way, even if reforms eradicated CVS Caremark and Express Scripts profits entirely, the savings to the systems wouldn’t cover the cost of the top-selling drug, Humira.[13] However, the unintended consequences of PBMs are indicative of larger, systemic issues that need to be solved. If policymakers can grapple with the perverse incentives in PBMs, it will better align the whole health care system.

A model where all PBMs take a flat administrative fee on each prescription, with all rebates and discounts fully disclosed and with no hidden spreads, could help reduce costs. Currently, more transparent PBMs do exist but have little leverage because the market is dominated by the big three. However, a hospital nonprofit, Meridian Health Systems, said that a transparent PBM saved it $2 million in the first year, about one-sixth of its total drug costs.[14]

But more can be done, including requiring greater transparency. If health plans could see what it costs to make generic drugs it would correct the current information imbalance between plans and PBMs, giving them better negotiating leverage for generics. The need for greater transparency is also clear in the Medicaid market, where states can pay radically different amounts for the same pills. For example, imatinib mesylate, the generic version of Novartis' cancer drug Gleevec, costs Indiana's Medicaid program $300 per pill, Washington's Medicaid program $109 per pill and several other states more than $200 per pill.[15]

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Finally, increased competition could help on another front. In North Dakota only pharmacists can operate drugstores, thus prohibiting chain pharmacies from entering the state. North Dakota has among the lowest prescription drug prices in the country without the perverse incentives PBM-owned pharmacies create. Because independent pharmacies are the only option in North Dakota, PBMs have to negotiate with them, giving them leverage to negotiate prices.

Carl Icahn may or may not succeed in derailing Cigna’s proposed acquisition of Express Scripts. But the reckoning in the PBM marketplace already is underway.

Endnotes

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Progressive Policy Institute
1200 New Hampshire Ave NW,
Suite 575
Washington, DC 20036

Tel 202.525.3926
Fax 202.525.3941

info@ppionline.org
progressivepolicy.org