The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access

WHO REALLY CONTROLS DRUG PRICING?

Pharmacy benefit managers (PBMs) claim to work for insurers to get lower-cost drugs from manufacturers, but in the same breath PBMs claim that drug manufacturers alone set drug prices.

Those deals with manufacturers? PBMs raise drug costs by almost 30% due to the rebates they charge manufacturers to be on their formularies. **PBM rebates, at $143 billion in 2019, add nearly 30 cents per dollar to the price consumers pay for prescriptions.**[1]

To make matters worse, the largest 3 PBMs control 76% of all the prescription drug business in the US. Thus, the vast majority of Americans are overpaying on their prescriptions due to PBMs. At the same time pharmacy reimbursements from PBMs are steadily declining because of the take it or leave it contracts offered to pharmacies by the largest PBMs who control an inordinate percentage of the business.

Who benefits from the rebates? Not patients or pharmacies! The PBMs' bottom line and their executives' benefit. The CEO of CVS Health, which owns one of the largest PBM's, pocketed $36.5 MILLION in 2019. [2] That's about 700 times higher than median annual wage in the United States.

WHO IS REALLY IN CHARGE OF PRESCRIPTION DECISIONS?

If you think its solely physicians and pharmacists, you would be WRONG! When a physician prescribes a drug for you, that decision is based on what's best for your health and your needs. Similarly, when a pharmacist dispenses the drug, the pharmacist provides advice and services based on what's best for your individual circumstances.

While most patients think their physician makes the final decision about which drug is best for them, they would be wrong. The prescription drugs PBMs decide they will cover are based largely on the drugs for which they get the highest rebate from manufacturers, rather than on what might be best for a patient's health care needs.

Why do PBMs prohibit patients from visiting their pharmacy of choice? The answer is simple. Some PBMs are owned by or own the pharmacies they mandate or steer patients to use. It's an anti-competitive weapon. PBMs determine which pharmacies are in their network and the amount that the pharmacies will be reimbursed for a prescription.

PBMs own retail, mail order and specialty pharmacy facilities. PBMs not only set reimbursements for their competitors (i.e. local independent pharmacies) they also decide which pharmacy the patient can use.

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[1] *Medicine Spending and Affordability in the United States: Understanding Patients' Costs For Medicine.* IQVIA Institute for Human Data Science

[2] https://www.fiercehealthcare.com/payer/here-s-what-top-health-plan-ceos-earned-2019

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That's right, PBMs are deciding where patients get prescription medications. If you receive your prescriptions in the mail, there's a good chance that mail-order pharmacy is owned by your PBM.

And considering the amount of money PBMs can make by steering patients to their own pharmacies, it is not surprising that PBMs want to force patients to use those pharmacies, especially for costly "specialty" drugs. In 2017, the top four specialty pharmacies were all owned or co-owned by a PBM.[3] Specialty drugs accounted for one-third of total prescription dispensing revenues, and that number will increase to 47% by 2022.[4]

WHAT IS THE IMPACT OF PBM PRACTICES ON TAXPAYER-FUNDED PROGRAMS?

PBMs claim they save money for state-funded health plans like Medicaid managed care yet report after report shows something very different- **excessive amounts of taxpayer dollars remain with pharmacy benefit managers (PBMs).**

- ✓ **Kentucky:** A state report that found state PBMs keep $123.5 million in spread annually, in addition to the other fees they were paid.
- ✓ **Michigan:** Drug price manipulation allowed PBMs to overcharge Michigan Medicaid by at least $64 million.
- ✓ **Virginia:** A state-commissioned report on Medicaid found PBMs pocket $29 million in spread pricing alone.
- ✓ **Maryland:** A state Medicaid report found PBMs pocket $72 million annually in spread pricing alone.
- ✓ **Louisiana:** PBMs retained $42 million that was incorrectly listed as "medical costs."
- ✓ **Pennsylvania**: State auditor found that between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion.
- ✓ **Ohio:** State Auditor found that, of the $2.5 billion that's spent annually through PBMs on Medicaid prescription drugs, PBMs pocketed $224.8 million through the spread alone during a one-year period.
- ✓ **New York:** A legislative committee investigated PBM practices and found "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies.
- ✓ **Florida:** A report on Florida's Medicaid managed care program found PBMs steered patients with high-cost, high-profit prescriptions to their own pharmacies and charged higher prices, revealing that "when it comes to dispensing brand name drugs, [managed care organization]/PBM--affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."[5]

What's the solution? States should FIRE PBMs or at the very least limit PBMs involvement to a purely administrative roll in state-funded programs like Medicaid and the state employees' health benefit plan.

West Virginia recently did just this and saved $54 million in the first year. **Based on a report released by West Virginia Medicaid, the state saved a little over $6 PER INDIVIDUAL PRESCRIPTION.** [6]

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[3] Adam J. Fein, *The Top 15 Specialty Pharmacies of 2017: PBMs and Payers Still Dominate,* DRUG CHANNELS (Mar. 13, 2018) https://www.drugchannels.net/2018/03/the-top-15-specialty-pharmacies-of-2017.html.

[4] *Id.*

[5] 3 Axis Advisors, *Sunshine in the Black Box of Pharmacy Benefits Management: Florida Medicaid Pharmacy Claims Analysis* 126 (Jan. 27, 2020).

[6] https://dhhr.wv.gov/bms/News/Documents/WV%20BMS%20Rx%20Savings%20Report%202019-04-02%20-%20FINAL.pdf

WHAT ABOUT THE SUPPOSED "MASSIVE BARGAINING POWER" OF INDEPENDENT COMMUNITY PHARMACIES THAT PBMS SUGGEST?

PBMs like to point to the fictitious massive bargaining power of the small independent pharmacy. The truth is that the three largest PBMs are Fortune 50 companies and control 76% of the market.

When it comes to "negotiating" fair reimbursements, PBMs give independent community pharmacies take it or leave it contracts. It is difficult for pharmacies to refuse a contract when up to one third of their patients or more may be covered by one PBM.

The Government Accountability Office conducted a study on the role of pharmacy services administrative organizations (PSAOs) and stated that "over half of the PSAOs we spoke with reported having little success in modifying certain contract terms as a result of negotiations. This may be due to PBMs' use of standard contract terms and the dominant market share of the largest PBMs. Many PBM contracts contain standard terms and conditions that are largely non-negotiable."[7]

Most importantly, independent pharmacies face antitrust risks that prevent the pharmacies from joining together to blanketly refuse to take a contract-even under a PSAO.

THE VALUE OF NEIGHBORHOOD PHARMACY TO PATIENTS AND COMMUNITY

Community pharmacies do much more than just dispense medications.

- ✓ 76% of independent community pharmacies provide immunizations
- ✓ 76% offer delivery to the home or workplace
- ✓ 65% of community pharmacy owners financially contribute to 5 or more community organizations, such as the little league[8].

Additionally, community pharmacies play a critical health care role in underserved communities**. 20.5% of United States ZIPS that currently have a retail pharmacy, only have an independent pharmacy to serve the community.**[9] These are communities where PBM owned pharmacies and large chains ARE NOT located. Patients will be the ones to suffer if PBMs continue to be allowed to engage in unfair business practices.

[7] GAO-13-176.
[8] 2019 NCPA Digest
[9] National Community Pharmacists Association analysis of NCPDP data