

THE “TROUBLES” WITH PHARMACY BENEFIT MANAGERS

If markets are competitive, there is little need to regulate PBM practices.

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Whenever U.S. policymakers and business executives discuss health care, the issue of ever increasing costs quickly arises. And for good reason. According to a recent analysis by the Kaiser Family Foundation, U.S. per capita expenditures on health care are expected to increase from \$9,695 in 2014 to \$15,618 in 2024, an average annual growth rate of 5%.

Drug therapy, compared to hospital treatment and surgical procedures, is often the most efficient form of medical treatment. But it is costly nonetheless. For 2014, prescription drug costs made up 9.8% of total annual health care expenditures, with total retail prescription drug spending accounting for \$297.7 billion. That is a 12.2% increase over 2013.

To hold drug costs down, many private employers, insurers, and even states and the federal government use pharmacy benefit managers (PBMs). PBMs are third-party administrators of prescription drug programs. Some 266 million Americans—approximately 82% of the total U.S. population—are covered by these programs as part of their commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefit Program, state government employee plans, and Managed Medicaid plans.

Cost-saving PBM services have evolved since they first became popular in the early 1970s. Where they once simply facilitated prescription billing, today they use complex business models to manage prescription drug program services for employers and health care insurance companies. They also negotiate rebates from

drug manufacturers and discounts from retail pharmacies, offer patients more affordable pharmacy channels and more effective delivery channels, encourage the use of cost-saving generics and affordable brands, reduce waste by efficient processing of claims and improving patient compliance with medication, and manage high-cost specialty medications.

How have PBMs performed? A February 2016 report for the Pharmaceutical Care Management Association estimated cost savings as a result of PBM services over the decade 2016–2025 will be approximately \$654 billion. A June 2016 report by the National Center for Policy Analysis identified PBM services as one of the top five factors expected to affect medical costs through 2017.

But all are not platitudes for the PBM industry. A November 2015 report for the National Community Pharmacists Association identified three legislative and regulatory concerns raised by legislators, policymakers, customers, and pharmacies about business practices in the PBM industry:

- a lack of accuracy and transparency in PBM revenue streams
- potential conflicts of interest by retail pharmacy networks with PBM-owned mail-order and specialty pharmacies
- unclear generic drug pricing and Maximum Allowable Cost payment calculations.

Specifically, criticisms of PBMs center around a business practice called “lock-in” or “spread pricing.” This refers to the difference between what a PBM pays the pharmacy for a drug and what the PBM charges its client organizations for the drug. Why is this practice controversial? In some cases, spread pricing is alleged to be costing clients, government agencies, pharmacies, and patients more money for the delivery of pharmaceuticals.

THE INTRICACIES OF SPREAD PRICING

How do PBMs make additional profit beyond their client-negotiated prescription drug program management fees? For example, there are instances where PBMs negotiate generic drug prices that are lower than the copay deductible paid by the patient (an industry practice referred to as a “clawback”). The PBM is discounted a portion of that payment from the pharmacy after determining what it will actually pay the retail pharmacy for the drug. Why would the retail pharmacy agree to such a business arrangement? The PBM offers the pharmacy access to the PBM’s subscribers, a financial incentive that retailers are loathe to refuse. Contrarily, PBMs (depending on their level of buying power) can threaten to drop otherwise qualified retail pharmacies to leverage further price concessions from those vendors.

Another PBM “profit center” involves negotiating with pharmaceutical manufacturers for rebates in exchange for a prescription program plan promise of an increased volume of pharmaceutical sales. As a result, neither the patient nor the retail pharmacy financially benefits from these incentives, only the PBM. This business practice may translate into higher pharmaceutical benefit plan costs to the client and patient, as the PBM could add the manufacturer’s higher-cost generic drug to the benefit plan’s drug formulary.

Yet, according to some analysts, spread pricing better aligns PBM incentives with its clients. For example, pricing “spreads” on generic pharmaceuticals tend to be higher than brand-name pricing spreads, creating a strong financial incentive for PBMs to choose generics for their drug plan formulary. Generic prescriptions, even with higher spreads, are usually the better benefit plan option from an overall cost perspective, and the subscriber copay deduction is almost always lower. Also, spread pricing may cross-subsidize other value-added PBM services, such as pharmacy utilization review and medication adherence management, as well as reduce administrative fees. Moreover, as is often the case under spread pricing arrangements, the third-party administrator guarantees drugs delivered at negotiated prices and is contractually required to supply the agreed upon drug formulary to subscribers at either a profit or loss to the PBM.



Thus, eliminating spread pricing (and its attendant revenue sources exclusive of administrative fees) will financially prevent traditional PBMs from continuing to offer most or all of their value-added management services. This would result in “transparent, pass-through” pricing where a PBM typically receives a flat administrative fee per member, employee, or claim per month plus agreed-upon incentive awards for positive results the PBM obtains through clinical programs. It would also result in disclosure-based approaches to pharmaceutical benefit plan pricing, leading to increased (and explicit) fees to clients if similar levels of value-added management services are to be maintained. A transparent business model, if effectively designed and implemented, should guarantee that all revenue streams will be passed through to the benefit plan’s sponsor.

THE LEGISLATIVE AND REGULATORY RESPONSE

Iowa, Kentucky, Maine, South Dakota, and the District of Columbia have passed financial disclosure laws requiring PBM

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transparency in their drug pricing to plan sponsors. Under these laws, PBMs are required to disclose all rebates, discounts, and other revenue-generating arrangements made with drug manufacturers and pharmacy networks, all of which are generally considered proprietary information. As of June 2016, legislative proposals requiring drug pricing transparency requirements by PBMs have been filed in eight other state legislatures and Puerto Rico.

Considering this flurry of legislative activity, one should wonder if employers are either unaware of their prescription benefit pricing options with PBMs or taking advantage of the range of pricing options. It appears the latter. In an April 2015 survey conducted by the Pharmacy Benefit Management Institute of 302 large (> 5,000 employees) and small (< 5,000 employees) employers (representing 16.3 million subscribers), a diverse range of rebate pass-through agreements was reported:

- 26% of employer drug plans received no rebates
- 28% received the entire rebate
- 22% received a flat fee-per-script
- 12% received a share of the rebate with a guaranteed minimum
- 12% received a share of the rebate with no guaranteed minimum

The survey results show that nearly as many employers receive no rebates from PBMs and receive value-added services as those receiving the entire rebate and receiving no value-added services.

If nearly three-quarters of employee prescription benefit plans already require “pass through” of all or a share of rebates (and presumably discounts or payments), why is there a need for state legislation to require what is already available through marketplace negotiations (and embedded in contracts) between employers and PBMs? Competition among PBMs is apparently intense enough to allow each employer to negotiate for the level of transparency in prescription drug pricing (and subsequent level of value-added service) that it prefers. Moreover, as a codicil in such contracts, confidential annual independent audits of prescription payment processes can be required.

ARE PBMS THE “BAD GUYS”?

When it comes to the issue of spread pricing, PBMs are considered the prime candidate as designated “bad guys.” As Kathleen Eban wrote in a November 23, 2013 *Fortune* article:

Even as the PBM industry has grown over the past two decades, it has been dogged by state investigations, class-action suits, and allegations that the industry uses opaque contracts to maximize profits. PBMs have been accused of everything from shorting pills in mail-order prescriptions to selling patient data they didn’t own to covertly shifting patients to higher-cost drugs. As a federal judge in Maine put it in 2005, PBMs

“introduce a layer of fog to the market that prevents providers from fully understanding how to best minimize their net prescription-drug costs.”

There is plenty of finger-pointing to go around when searching in the pharmaceutical supply chain for who is attempting to “maximize profit” through less than noble business practices. For example, the vigorous support of increased regulatory oversight of PBM pricing transparency by the National Community Pharmacists Association may indeed be motivated by legitimate concern for the financial welfare of its customers, but there might also be a pecuniary motive behind its intensive lobbying efforts. According to a February 25, 2010 *Drug Channels* article, independent drug stores have an average gross margin on cash prescriptions (“no drug plan”) of 48%, as compared to a 19% gross margin on prescriptions of private insurers or Medicare Part D. Unsurprisingly, the independent pharmacies are looking to acquire a larger share of the PBM’s “spread” to enhance their profit margins. Already, two of the five top PBMs—CVS/Caremark and Envision—are owned by two of the country’s largest drug store chains, CVS and Walgreens, two classic examples of backward vertical integration in the supply distribution chain. As for pharmaceutical manufacturers, suffice it to say that they have been under relentless public scrutiny in recent years as to numerous examples of exorbitant—and often poorly explained—consumer drug pricing increases.

PRIVATE SOLUTIONS

Today, the pharmaceutical/biologic industry is at a critical inflection point where the regulatory state will further restrict its business practices (and negatively affect its customers’ choices) if there is not a groundswell of support for further transparency throughout the pharmaceutical supply chain. As it is, Steve Pociask, president of the American Consumer Institute, succinctly described the end-game in a recent column on *RealClearPolicy.com*, “If public policies were in place to add more transparency to wholesale and retail pricing, PBMs would have the right incentives to work on behalf of sponsors and consumers.”

Yet effective voluntary, cooperative, and innovative private governance responses can do much to mute the call for blunt public regulatory restrictions on PBM business practices. To that end, the following private governance policy options are offered for consideration by PBMs and the general pharmaceutical/biologic industry:

- **Disclosure of least-cost option.** Pharmaceutical plan subscribers need to be notified by their pharmacy if their prescription benefit plan’s prescription copay exceeds the non-benefit plan pharmacy price. This revised business practice is of utmost importance for senior citizens and others living on fixed incomes. Both the Pharmaceutical Care Management Association and the National Community Pharmacists

Association should encourage members to engage in this type of consumer disclosure activity. A joint association endorsement of this policy will publicly signal that both of these key members of the pharmacy distribution supply chain place their customers' interests first, and will assuage retail pharmacy concerns that there will not be retaliation (e.g., removal from a PBM's pharmacy network) against pharmacies engaging in this disclosure activity. According to Mark Merritt, CEO of the PCMA, "Not everything has to go through the [sponsor's] plan. The only reason [for pharmacies] to process the claim is to keep the copay for themselves."

- **Update price lists in real time.** PBMs should be updating drug price lists and changes in medication tier assignments in their respective formularies in real time through use of low-cost digital means. Often, PBMs lower their "maximum allowable costs" (MACs) for pharmaceuticals quickly when drug costs decline, but raise MACs slowly when drug costs increase. With the latter situation, this not only places pharmacies in a precarious financial situation as to sustaining losses per prescription filled, but may also be placing patients in a position where they may not be able to get access to their medications if the pharmacies are not able to stock them at the price point determined by the PBM. Again, a sustainable pharmacy network is in the sponsors' and subscribers' best interests, and in the long-term business interests of the PBM itself as to subscriber satisfaction.
- **Maintain sponsor choice through pricing model transparency.** Ambiguity in product and service pricing creates greater financial risks for the sponsor and reduces the sponsoring organizations' ability to accurately evaluate its return on investment. Carefully designing contracts to reflect precisely what type of pricing model (and level of services) benefits the sponsor and subscribers will significantly reduce the inherent knowledge deficiencies of state-of-the-art business practices in contractual relationships. This results in the highest level of control by the sponsor, short of internalizing all pharmacy benefit management transactions. For client organizations, reducing the term of the PBM contract could ensure greater flexibility in adapting to emerging opportunities, but also increase contract costs. Some employers with sufficient market share could consider internalizing ("going in-house") certain PBM functions and rely on a PBM to administer the mundane functions of plan enrollment, claims processing, and billing. In summary, competition provides the platform for product and service adaptation and the level of disclosure (and risk) that customers desire.
- **Limit the public disclosure of proprietary information.** As transparency in pharmaceutical pricing contracting increases, the demand for public disclosure should decline. The concept of

disclosure is contextually relevant to the PBM and its client. Thus, the use, terms, and confidentiality of client-initiated audits of payment transactions should be negotiated between employers and the PBM. Restrictions on disclosure of such proprietary information are necessary to maintain a competitive environment in this industry.

- **Improve the knowledge base of pharmaceutical plan subscribers.** Employers need to do a better job of explaining the managerial rationale behind why they have chosen a specific pharmacy prescription pricing model to their employees, who will be financially contributing to the cost of the chosen plan over the ensuing years. Mitigating the knowledge deficiency can go a long way in reducing the need for employees to exercise their rights as citizens to support costly and often inefficient public regulation to "solve" perceived market failures.

CONCLUSION

Over the last quarter-century, the PBM has shown itself to be a generally effective participant in the U.S. pharmacy supply chain. However, the regulatory stakes are now in a state of flux, with momentum gathering to legislatively "fix" alleged PBM transparency problems. The movement toward increased transparency is not subsiding, but is moving from negotiated private markets to the public legislative, judicial, and regulatory arenas.

It is time for private governance to reassert itself and move constructively in the direction of having the key participants in the pharmaceutical value chain—the pharmaceutical manufacturers, PBMs, and retail pharmacies—cooperate where it is to their mutual advantage, and vigorously compete where sustainable competition drives cost reductions. Most importantly, the industry focus should be on where market innovations provide the most health benefit to the sponsors and subscribers, the latter being the patients who need the products and services, and who provide the focus of their respective company's values, vision, and mission statements. R

READINGS

- "A Bogus Solution for High Drug Costs," by Devon Herrick. National Center for Policy Analysis *Issue Brief* 194, June 2016.
- "Concerns Regarding the Pharmacy Benefit Management Industry," produced by Applied Policy for the National Community Pharmacists Association, November 2015.
- *Medical Cost Trends: Behind the Numbers – 2017*, by the Health Research Institute (PwC), June 21, 2016.
- "Painful Prescription: Pharmacy Benefit Managers Make Out Better than their Customers," by Katherine Eban. *Fortune*, Nov. 23, 2013.
- *Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers*, produced by Visante for the Pharmaceutical Care Management Association, February 2016.
- "The Middlemen in Higher Drug Prices," by Steve Pociask. *RealClearPolicy.com*, July 21, 2016.
- "Why Do Pharmacy Owners Care about PBM Transparency?" by Adam J. Fein. *Drug Channels*, Feb. 25, 2010.