American College of Rheumatology
Empowering Rheumatology Professionals

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Pharmacy Benefit Managers Drive Up Prescription Drug Costs

Pharmacy benefit managers (PBMs) are major contributors to ballooning prices and lack of transparency in prescription drug pricing–one of the most significant costs to patients and the American healthcare system. Transparency and accountability for PBMs would drive down drug costs.

ASK:

House: Support the Pharmacy Benefit Manager Accountability Study Act (S.298/H.R.1829)

Legislation requiring PBMs to publicly report their aggregate rebates, discounts, and other price concessions for prescription drugs would help patients, pharmacists, employees, and business owners understand and compare discounts that PBMs receive from drug manufacturers. Further, transparency allows Congress to take further action to lower drug costs.

S.298/HR.1829:

- **Requires the Government Accountability Office (GAO) to:**
  - **Report on the role of PBMs in the pharmaceutical supply chain**
  - **Recommend legislative actions to lower the cost of prescription drugs for patients**
- **Requires that the GAO report address the use of rebates and fees, the average prior authorization approval time, and the use of step therapy within the 10 largest PBMs.**

What are PBMs and how do they drive up drug costs?

- PBMs are companies hired by insurers, with no duty to patients, to manage prescription drug programs. Currently, three companies, two associated with insurers and one with CVS, have consolidated 77% of the market and make their billions by:
  - Acting as intermediaries between the insurers, drugmakers, and pharmacies.
  - Handling all logistics, including setting patient copayment amounts and determining which drugs are covered by which insurers.
  - PBMs use their position to negotiate discounts and rebates from drugmakers in exchange for preferred placement of drugs on insurers' formularies.
- While PBMs have become incredibly effective at negotiating discounts and rebates, they keep those profits for themselves rather than passing those savings onto patients, as they were originally designed to do.

Facts about rising drug costs:
Most drug pricing increases are for existing drugs rather than new drugs entering the market.

- Such brand name drugs cost 9% more each year, on average, exceeding inflation.
- In practice, the lack of transparency in the supply chain supports a market that does not allow informed-consumer choice to impact artificially rising costs.
- The AMA has included PBM transparency as a key part of its Truth in Rx campaign (truthinrx.org).

How do PBMs make profits at the cost of patients?

- **Rebates.** A rebate is money that a drugmaker agrees to pay a PBM each time a prescription for a specific drug is filled by a patient.
  - Whichever drugmaker is willing to pay the highest rebate is given preferential position on PBM formularies. **This means that the drug made by the drugmaker providing the largest rebate to the PBM becomes the preferred treatment of a patient's insurer.**
  - Out-of-pocket costs and co-pays are based off the original list price of a drug, not the negotiated amount after the rebate, so patients do not pay any less at the pharmacy and PBMs keep the rebates as profit.

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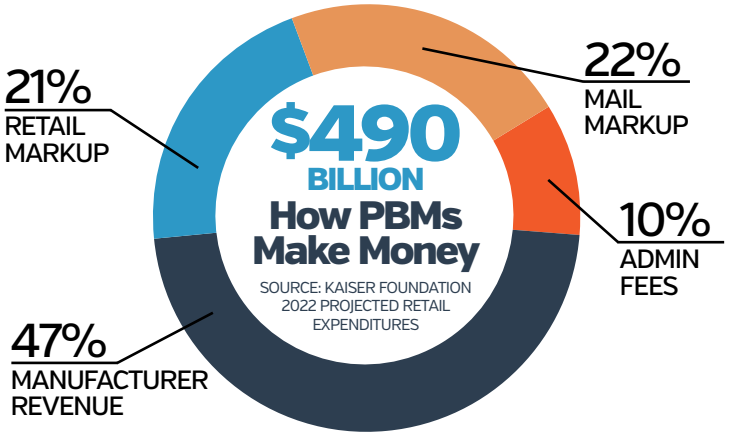
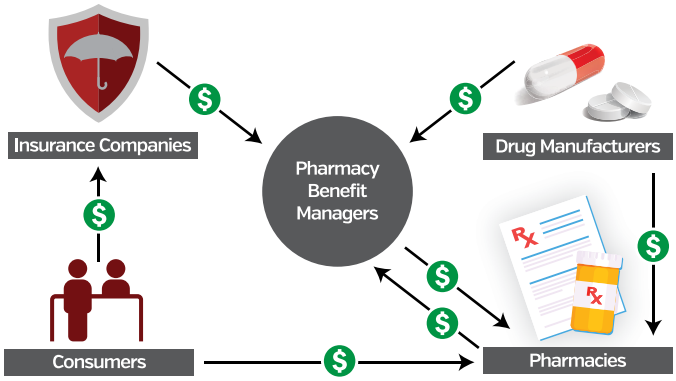
- **Spread Pricing.** The spread price of a drug is the difference between what the PBM charges the insurer for a treatment and the amount it reimburses the pharmacy for the same treatment when it is dispensed to a patient.
  - The pharmacy does not know what the insurer pays the PBM, nor does the insurer know how much the PBM reimburses the pharmacy.
  - PBMs use this lack of information to keep the spread as profit, which they publicly claim is used to reduce the cost of the drug to the patient (see example below).



Example of PBM Spread Pricing in Action



- **Example A (larger spread):**
- Manufacturer has a list price of $200.
- Insurer hires a PBM that negotiates a rebate of 20%, lowering the price down to $160.
- PBM charges the insurer at a higher price, 50% of the discount, than what it was able to negotiate of $180.
- PBM reimburses pharmacy at the negotiated price of $160.
- If 100,000 doses are sold, then total spread is $2 million ($20 x 100,000).
- Patient obtains drug and is charged a copay amount based off list price ($200).

- **Example B (smaller spread):**
- Manufacturer has a list price of $100.
- Insurer hires a PBM that negotiates a rebate of 20%, lowering the price down to $80.
- PBM charges the insurer at a higher price, 50% of the discount, than what it was able to negotiate of $90.
- PBM reimburses pharmacy at the negotiated price of $80.
- If 100,000 doses are sold, then total spread is $1 million ($10 x 100,000).
- Patient obtains drug and is charged a copay amount based off list price ($100).

In both examples, the PBM negotiates a 20% discount with the drugmaker and keeps 50% of the savings after its negotiation with the pharmacy. However, the spread price of Example A is double that of Example B. **Because a portion of the spread is retained as profit, PBMs are incentivized to add the drug with the largest rebate amount (Example A) to formularies versus the one with the lowest list price for the patient (Example B).**

This conflict of interest makes garnering a competitive rebate challenging for new drugs entering the marketplace that compete by lowering list prices and driving down costs for patients. Further, PBMs do not support the introduction of cheaper yet similarly effective medications and biosimilars of medications.

For more information about pharmacy benefit managers and their role in the rising cost of prescription drugs, visit atapadvocates.com/the-pbm-problem and stay up to date on what patients and providers are saying. You can also follow the conversation on Twitter @ATAPAdvocates.