PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

ISSUE BRIEF

REINING-IN PBMS PROMOTES PATIENT-CENTERED HEALTHCARE

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Introduction

When the market is functioning properly, pharmacy benefit managers (PBMs) provide valuable services that include ensuring patients have access to their medicines at reasonable prices, facilitating payments on behalf of insurers and other payers, and managing payers' drug formularies or the list of drugs approved for patients. Unfortunately, PBMs have leveraged government-created inefficiencies to facilitate an opaque pricing environment and impose questionable fee structures. These practices undermine the ability of PBMs to play their value-added roles.

Take their price negotiation role as an example. PBMs are supposed to represent the interests of patients – the ultimate consumer – when negotiating the prices of drugs with manufacturers. However, patients lose under the current opaque pricing environment that PBMs foster. Market efficiency is also compromised because consumers (i.e., patients) have limited ability to seek out competitors who can meet their needs more effectively because three PBMs control 80% of the pharmacy benefit market and are all subsidiaries of major health insurers – CVS Health/Caremark, Express Scripts (part of Cigna), and OptumRX (part of UnitedHealth).[1]

The current broken system incentivizes PBMs to follow policies that benefit insurers and themselves, while making drugs less affordable for patients.

These PBM-created affordability problems argue for changes that reduce the consequences from the misaligned incentives. Toward this end, the 118th Congress is currently considering several beneficial reforms including the *Delinking Revenue from Unfair Gouging Act and the Modernizing and Ensuring PBM Accountability Act*.[2] If passed, these proposals would help alleviate several of the current anti-market outcomes that are harming patients.

Some critics of these proposals mistakenly claim that reforming PBM practices would push the healthcare system "one step closer" to a complete socialized system.[3] Nothing could be further from the truth. In fact, PBMs and their misguided policies have led to higher out-of-pocket costs for consumers, while often limiting patients' access to life saving medications. Restricted access to innovative drugs is what patients experience in the socialized health care systems of Canada and Europe.

The purpose of this *Issue Brief* is to demonstrate that the current PBM system is rife with anti-market and anti-patient incentives that need to be eliminated. Ideally, comprehensive reforms would replace the current third-party payer system with a patient-centered healthcare system. As such changes are politically infeasible currently, it is essential to implement reforms that eliminate the current anti-market practices. The Acts currently under consideration in the 118th Congress would implement several of these pro-market reforms and are, consequently, an important step toward establishing a more efficient pharmaceutical market.

PBM Practices Are Harming Patients

To understand the pro-market benefits from reforms, it is important to first document the problems plaguing the PBM market. The root of these problems is the current PBM revenue structure. PBMs earn revenues from:

- Charging fees to pharmacies and plan sponsors
- Capturing a percentage of the discounts off the list price of drugs that they negotiate with manufacturers
- Charging additional fees to pharmacies, employers, and manufacturers that are linked to drugs' list prices, an even larger revenue source of late.

Due to these links between prices and PBM revenues, PBMs earn more money when drug list prices are high which enables PBMs to negotiate large discounts. This incentive grossly misaligns the interests of PBMs relative to patients, however.

Compensating PBMs based on the size of the discounts they negotiate with manufacturers is consistent with current market theories. And this compensation system would make sense if PBMs' incentives were aligned with patients' interests, but this is not the case. PBMs are hired by the payers – whether they are insurers, employer sponsored plans, or the government. As such, PBMs are responsible for minimizing the costs for insurance companies when patients are prescribed medicines, particularly expensive medicines. PBMs are not directly responsible for controlling costs for patients.

> “PBMs and their misguided policies have led to higher out-of-pocket costs for consumers, while often limiting patients' access to life saving medications.

Worsening the problem, drug manufacturers do not generally sell their medicines directly to patients. Instead, manufacturers must bypass the PBM gatekeepers to get the insurer to allow the manufacturer to sell their drug to the patient. PBMs are the gatekeepers because they determine the list of approved medicines (i.e., the drug formularies) that patients can access.

From a theoretical perspective, PBMs' control over the formularies is supposed to be fine because insurers want patients to use drugs with a low net price and this pricing system incentivizes manufacturers to offer PBMs the lowest net price on their drugs. But it is the term "net price" that complicates the issue in practice.

There are two ways to get to a low net price. Manufacturers can list the drug at the lowest price they are willing to offer, or they can list the drug for a higher price and then offer a discount that, once deducted from the higher price, equals the lowest price they are willing to offer. Since a PBM's reimbursement is based on the size of the discount, PBMs earn more money from the latter arrangement – when manufacturers set high list prices that enable the payment of large discounts.

The incentive of drug manufacturers is to ensure that their medicines receive the best possible placement on the PBM formularies. This means that manufacturers must satisfy the needs of PBMs to meet the needs of patients. All else equal, manufacturers are agnostic between the two pricing systems since their net revenues are the same. Consequently, it is in the interest of manufacturers to accommodate the preferences of PBMs – otherwise, patients won't be able to access the manufacturers' drugs.

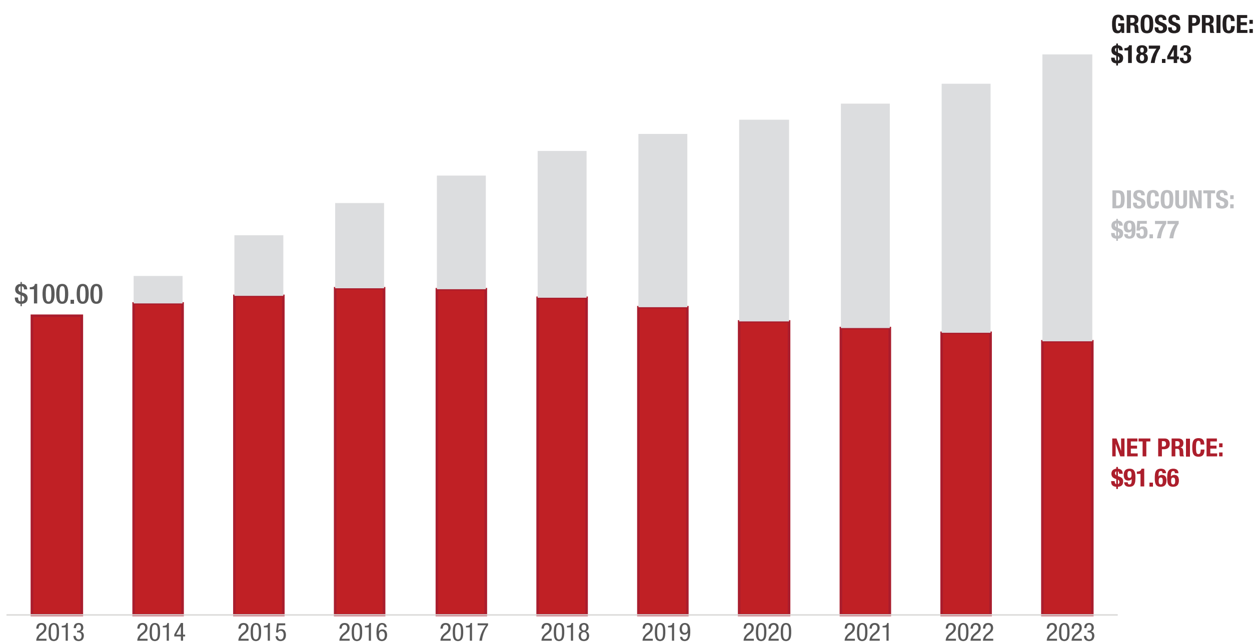
PBMs prefer the latter compensation structure because larger discounts enable PBMs to earn higher revenues. Consequently, PBMs' incentives are to use the formularies as a tool to maximize the size of the concessions gained from the biopharmaceutical industry rather than as a tool to ensure patients have access to medicines that are safe, effective, and as affordable as possible.

And, lo and behold, the pricing structure that prevails is consistent with the PBMs' incentives.

To accommodate the need for large discounts, the list prices of drugs have been rising quickly. Although down from their double-digit growth rates in the early 2010s, list prices still grew 5.4 percent in 2023 according to the industry research source Drug Channels.[4] Unlike list prices, net prices, the systemically relevant price that includes the large discounts PBMs negotiate, have been declining for the last 6 years. Therefore, the spread between the gross and net prices (what Drug Channels has designated the gross-to-net bubble) has grown tremendously.

Tracing these impacts over time reveals how distorted the current drug market has become, see Figure 1. Figure 1 traces out how the implications from the trend of growing list prices but declining net prices between 2013 and 2023.

Figure 1
The Growth in List Prices, Net Prices, and Discounts and Concessions Applied to a Hypothetical Branded Drug 2013 - 2023



Source: Author calculations based on data from Drug Channels

Figure 1 sets the 2013 list and net price of a hypothetical drug at $100 (i.e., there are no discounts offered initially) and then applies the average annual percentage change to the gross and net prices that occurred between 2014 and 2023. The average growth in drugs' list prices indicates that a drug with a list price of $100 in 2013 would cost $187.43 in 2023, or 87.4 percent more expensive. On the other hand, the net price of the drug – the amount of revenue that the manufacturers earn – would have declined to $91.66 over this same period, an 8.3 percent decline. The difference between these two prices reflects all the discounts and concessions that manufacturers give, which include the discounts negotiated by PBMs.[5]

The PBMs benefit from this policy because they keep an unknown percentage of the concessions, indicating that the revenues of PBMs have been steadily growing during this period. This is why PBMs prefer higher-priced/ higher rebated medicines instead of lower-priced/lower discounted alternatives. For example, in their 2023 national preferred formulary, Express Scripts prefers coverage of Epclusa and Harvoni brand name medicines rather than the authorized generic options offered by the same manufacturers,[6] which are 67% and 62% cheaper than their respective brand medicines.[7] The preference for the medicines with a higher list price has created the opportunity for the PBM to negotiate larger discounts and thus earn higher revenues than is possible had the authorized generics been the preferred medications for patients living with hepatitis C.

Insurers also benefit from this pricing system because PBMs pass along a substantial share of the discounts to their customers, offsetting insurers costs.[8] Since insurers often use these revenues to offset other costs and keep overall premiums lower, PBMs and insurers claim that these negotiated discounts are benefiting patients. Undoubtedly, lower premiums are a benefit, but the pertinent question is: A benefit to whom?

The lower premiums enabled by the negotiated discount indirectly benefit all patients and since that benefit is spread out over tens of millions of policies, the dollar benefits are relatively small. The patients who required the expensive medicines do not directly benefit from these discounts, however. In fact, the current discount system raises costs for most patients who require expensive drugs.

Patients without insurance typically must pay the inflated list prices when purchasing drugs and bear the highest costs of all. Patients with insurance are harmed because their cost sharing expenditures are not based on the significantly lower net prices. Instead, their out-of-pocket costs are set as a percentage of the inflated list prices. Therefore, the more than 87 percent increase in drugs' list prices between 2013 and 2023 has led to a comparable increase in patients' out-of-pocket costs.

In the illustrative example in Figure 1, a patient with a 20 percent co-insurance would have paid $20 per prescription back in 2013, but $37.49 per prescription in 2023. This growth becomes particularly problematic for high value innovative drugs where the current discount system has unnecessarily driven up patients' out-of-pocket costs by hundreds or even thousands of dollars.

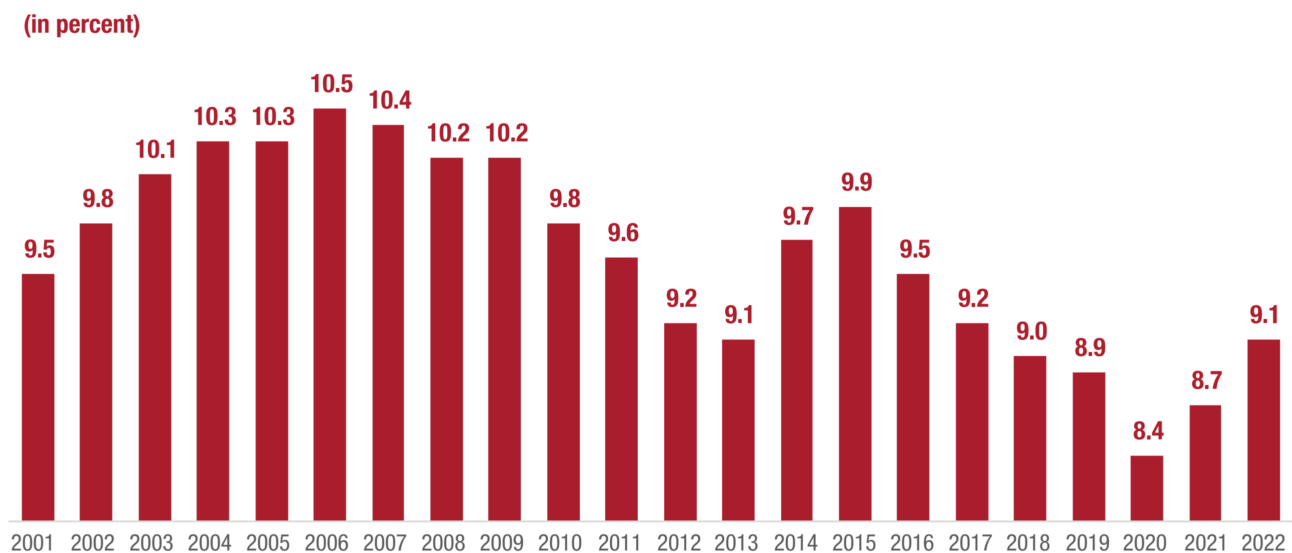
This reality demonstrates that the relevant patients – those who require expensive medicines – are being harmed despite the existence of large discounts. The retort of supporters of the current system that these costs are ok because the discounts are used to lower premiums for everyone rings hollow. Charging patients who require expensive medicines more money to lower premiums for healthy patients is both inequitable and antithetical to the principles of insurance. It is the equivalent of a discount bait and switch that would never arise in a free and competitive market.

As for drug manufacturers, the trend in overall expenditures on prescription drugs confirms that, while the current pricing system inflates costs for patients, it is not manufacturers who benefit from these inflated prices, see Figure 2. Figure 2 presents the share of healthcare expenditures devoted toward prescription drugs over the

last two decades. Prescription drugs' share of total expenditures in 2022 was 9.1 percent, which is below the two-decade average of 9.6 percent.[9]

These data provide important perspective on the drivers of the drug affordability problem. They confirm that patients' drug affordability problem is not caused by excessive manufacturer costs – otherwise pharmaceutical expenditures share of total healthcare expenditures would be rising. Instead, the affordability problem is better understood as a problem of rising out-of-pocket expenditures that is currently driven by the harmful pricing system.

Figure 2
Prescription Drug Expenditures as a Share of Total Healthcare Expenditures 2001 - 2022



Source: CMS

Summarizing the impacts from the current drug pricing system,

- PBM profits are high because they can extract expensive fees and earn a percentage of the spread between gross and net prices
- Insurers' costs are controlled because their costs are based on the less expensive net prices
- Manufacturer profits are based on net prices indicating they have been consistently receiving less money for drugs over the past 6 years, and
- Patients' costs are going up because their out-of-pocket expenditures are based on the inflated list prices.

The conclusion from these trends is that the current PBM controlled pricing system is extracting excessive revenues from the patients who require expensive medicines, which are then used to either subsidize other patients through lower premiums or used to inflate the profits of PBMs and/or insurers. Either outcome is the exact opposite of how an efficient pharmaceutical market should work. And it is why PBM reforms are necessary.

There is, consequently, a conflict between PBMs' fiscal interests (which is to prefer medicines with the biggest discounts and rebates) and patients' fiscal interests (which is for medicines' list prices to reflect the lowest potential net price). The untoward outcomes from this conflict go beyond the higher out-of-pocket costs for patients.

PBM Practices Are Distorting the Pharmacy Market

It is not just patients who are harmed by current PBM practices. Thanks to their government-enshrined market position, PBMs have been implementing fees and practices that harm smaller family-owned pharmacies often to the benefit of the PBM affiliated pharmacies and specialty pharmacies.

Competitive well-functioning markets empower customers to choose which supplier they want to patronize and encourage suppliers to offer a diverse range of products. Applied to pharmacies, patients can often choose between a large national pharmacy chain and a small local pharmacy. Both have their advantages.

Large chain pharmacies are often more convenient, provide online services, and may have the ability to provide more product options due to their scale. Large chains are better positioned to serve patients who require prescriptions when they are away from home by seamlessly transferring their prescription to the chain's local store. Patients can, consequently, often access their prescription when they need it.

Small locally owned pharmacies offer different services. Typically, a small pharmacy provides more personalized care that enables pharmacists to gain a better understanding of their patients. Pharmacists in these settings are often better positioned to tailor their counseling and advice to patients' individual needs. These personal connections can be highly valued by some people, particularly patients with complex health issues. Additionally, the more personalized setting may foster better communication between patients and their pharmacists, which can also lead to better health outcomes.

When the pharmaceutical market is functioning efficiently, patients express which suite of pharmaceutical services they value by choosing where they want to fill their prescriptions – at a large chain or a local store. Unfortunately, PBMs' actions are distorting this market. PBMs' position at the center of the drug market has enabled these middlemen to dictate unfavorable compensation terms to pharmacies. And these terms are making it increasingly difficult for small pharmacies to make ends meet.

> "Even when the prices for medicines should be low – such as when purchasing generic medicines – the PBM-owned specialty pharmacies charge exorbitantly high prices that far exceed the manufacturer price.

One pricing scheme long employed by PBMs charge pharmacies fees weeks or months after the drug has been dispensed – referred to as claw back fees. Thanks to claw backs, pharmacies don't know how much revenue they have earned when a prescription is filled. That answer will come weeks or months later when the pharmacy receives the final claw back bill.

In far too many cases, these bills will push the total revenues earned by the pharmacy below its costs, meaning the pharmacy has lost money from selling the medicine. Such losses are more problematic for smaller pharmacies as well as the large pharmacy chains not connected to a PBM.

Recognizing the inequities of claw backs, a new rule set to take effect in January 2024 will require PBMs to take most of their fees at the time prescriptions are filled for Medicare patients. Unfortunately, thanks in part to the still misaligned incentives, they have replaced their lost claw back revenues with demands for large cuts in PBMs' upfront payments to pharmacies.[10]

Worsening the market outcomes, PBMs leverage their privileged position to steer the more profitable specialty medicine prescriptions toward their own specialty pharmacies. Even when the prices for medicines should be low – such as when purchasing generic medicines – the PBM-owned specialty pharmacies charge exorbitantly high prices that far exceed the manufacturer price.[11] All these actions harm the broader pharmacy market and increase patients' out of pocket costs.

Another distortion to the pharmaceutical market occurs because PBM practices are influencing which medicines patients receive. Due to PBMs control over the drug formularies, doctors cannot base their prescriptions solely on the patients' medical needs. They must account for the drug formulary when making treatment decisions.

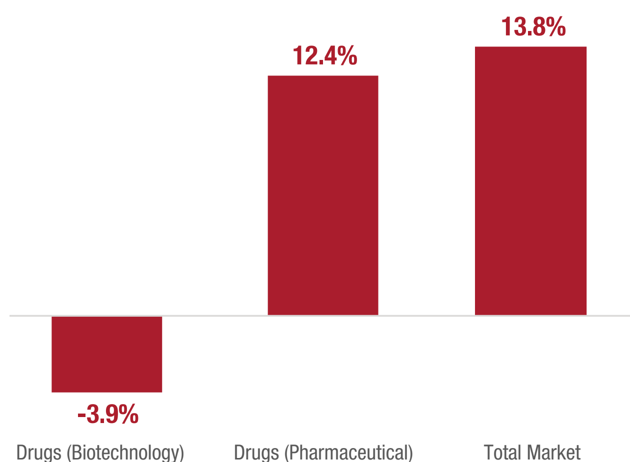
A November 2023 analysis found that 30 percent of U.S. localities had very little PBM competition and in these concentrated local markets "a dominant PBM's choice of preferred products" influenced "prescribing market-wide, even for patients not covered by the dominant PBM."[12]

In other words, PBMs not only have an undue influence over where patients can receive their medicines; they also have undue influence over which medicines patients are prescribed. The fact that PBMs interfere in the doctor-patient relationship is an unintended, and adverse, consequence of the current inefficient PBM market structure. Empowering middlemen rather than doctors is precisely the opposite of how a patient-centered healthcare system should work.

Reforms Are Needed

Many of the arguments against reforming PBMs are specious. For instance, the claim that reforming PBMs is unnecessary because "we have paid drug manufacturers too much" makes no sense.[13] As the gross and net pricing trends indicate, the prices received by manufacturers have been declining for years. Pharmaceutical companies' lower return on equity compared to the overall market confirm this result, see Figure 3.[14] Figure 3 presents the return on equity as of January 2024, a standard profitability metric, for the overall market (13.8 percent) compared to the pharmaceutical (12.4 percent) and biotechnology (-3.9 percent) sectors. Figure 3 illustrates that neither the pharmaceutical nor biotechnology sectors are earning over-sized profits. Importantly, this result is not unique to 2023. Over time the pharmaceutical and biotechnology sectors do not outperform the broader markets, indicating that the claims that drug manufacturers are gouging patients are without merit.

Figure 3
Return on Equity: Pharmaceutical and Biotechnology Sectors Compared to U.S. Total Market, 2024



Source: Damodaran

Another odd argument against PBM reform is the claim that reforms somehow stifle competition. This is the exact opposite of what will happen – the proposed PBM reforms will remove government created market distortions that obstruct the development of a patient-centered healthcare system. Toward this end, there are several key reforms that would alleviate the costs on patients and improve the market incentives.

Decoupling PBM Fees: Revenue streams tied to the costs of the medicines rather than the service provided by the PBM misaligns incentives when developing formularies. Specifically, the link between PBM compensation and the size of the negotiated discounts incentivizes PBMs to prefer drugs with higher list prices and higher discounts when developing their formularies. This preference inequitably shifts costs from insurers to patients, whose costs are based on the inflated list prices.

The system persists because PBMs are responsible to insurance companies, not patients. Put differently, coupling PBM compensation with the size of the negotiated discounts aligns the interests of PBMs and insurers (as economic theory suggests), but misaligns the interests of PBMs and patients. It is this misalignment that is driving up out-of-pocket costs for patients who require expensive medicines even though net drug prices are declining. This inequitable transfer drives the current drug unaffordability issues, which is better understood as a problem of excessive out-of-pocket costs for patients not excessive drug prices.

Prohibiting rebate contracting fixes the current misaligned incentives between PBMs and patients. Additionally, because PBMs will no longer prefer drugs with higher list prices and larger discounts, manufacturers will have an incentive to focus on offering their best net price to PBMs. Instead of complicated payment models tied to the cost of the medicine, PBM fees should be straightforward and reflect the value created by PBMs' formulary management services. The result will be lower out-of-pocket costs for patients directly addressing the out-of-pocket affordability problem.

Ignoring these market realities, advocates claim that there are costs from decoupling PBM compensation to the size of the negotiated discounts. Specifically, they assert that decoupling eliminates PBMs incentive to negotiate discounts, which will drive up costs for Medicare and other payers. Ignoring that PBMs and insurers are often the same company, this response essentially argues that sophisticated insurance companies that are aware of the current net costs of drugs would sit idly by while PBMs allow insurers' drug costs to increase. This is clearly an unlikely outcome. Further, if PBMs can only reduce insurers costs if they are allowed to perpetuate the opaque pricing system that harms patients, then it is unclear whether PBMs add any value at all.

Full and Complete Price Transparency: Congress is also considering reforms that would ensure "full and complete disclosure" of prescription drugs' costs, prices, and discounts. Further, all fees, charges, and markups that PBMs charge health plans and pharmacies would need to be disclosed.

Markets can only work efficiently when the ultimate payer – whether that is the insurer, employer, government, or the patients themselves – has access to the actual price data. This reality does not change simply because it is the market for medicines. Creating price transparency empowers payers and patients to better understand the costs of medicines and better negotiate for lower prices.

Ensuring that prices, fees, costs, and discounts are disclosed addresses the price opacity problem that is a large enabler of the current misalignment of interests. When combined with the reforms that delink PBM fees from the list prices, the out-of-pocket costs would more accurately reflect the actual net prices of the medicines and create significant savings for patients.

> "Instead of complicated payment models tied to the cost of the medicine, PBM fees should be straightforward and reflect the value created by PBMs' formulary management services.

Eliminate Spread Pricing and Clawbacks: Another important reform addresses the PBM anticompetitive practices of spread pricing and clawbacks. Spread pricing occurs when PBMs receive repayment from health plans and insurers that exceed the medicine's actual costs – pocketing the difference as an unwarranted revenue boost. The difference – the spread – is currently pocketed by the PBM. Clawbacks charge fees to pharmacies long after the drug sale has been made and destabilize the revenues of pharmacies.

These practices are particularly harmful to smaller family-owned pharmacies who often lose money on the sale of a drug as a result. This is only possible because the current system has over-empowered the middlemen. Efficient reforms prohibit these types of exploitations that would not occur in a competitive market.

Prohibit Patient Steering: Steering patients toward PBM-owned pharmacies, especially specialty pharmacies, is another anti-competitive practice. Patients' ability to choose between pharmacies is essential for ensuring that pharmacies focus on serving their needs. Like any other market, patient choice sends important signals to both the pharmacies that provide value-added services and those pharmacies that are providing sub-optimal services or are charging excessively high costs.

Patient steering by PBMs interferes with this competitive process. PBMs are leveraging a privileged position created by government healthcare policies and the current third-party payer system when they are steering patients toward PBM preferred pharmacies. Patients are not voluntarily choosing to patronize the preferred pharmacy and often the preferred pharmacies do not serve patients' needs more efficiently. In other words, these choices do not reflect the workings of a competitive and free market and, once again, patients are receiving the short end of the stick. Prohibiting these practices, consequently, helps restore more competitive market practices.

Conclusion

The disincentives plaguing the PBM industry are distorting an important part of the drug supply chain. Instead of focusing on the important formulary management and payment services, too many PBMs use the current opacity to increase their revenues at the expense of patients' welfare and the retail pharmacies, particularly small family-owned businesses, who are competing with the PBM affiliated pharmacies.

Consequently, the current drug pricing system is rife with troubling conflicts of interests that inflate patients' out-of-pocket costs and often encourage the use of expensive drugs when more affordable alternatives exist. Due to these disincentives, policies that make sense under most market conditions create problems that harm patients.

> "The cure is simple: promoting a simple and transparent pricing system.

Since these adverse outcomes are enabled by the complicated and secrete pricing system, the cure is simple: promoting a simple and transparent pricing system. Reforms that include mandating greater transparency and delinking PBMs' revenues from the price of the drug can better align the incentives of PBMs with the interests of patients – the ultimate healthcare consumer. Implementing these reforms will meaningfully address the current drug affordability problem for patients while ensuring a higher quality of care.

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