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Bringing Transparency and Accountability to Pharmacy Benefit Managers

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Key Points:

1) Structural reforms are needed to address the complex and influential role that intermediaries—especially pharmacy benefit managers (PBMs)—play in the pharmaceutical distribution system.

2) PBMs historically served a useful role to lower costs through price negotiation, greater use of generics, and expansion of mail-order services. But consumers have been left behind by recent trends in the PBM marketplace.

3) Rebates, spread pricing, clawbacks, vertical integration, and other practices allow PBMs to hide cost savings from patients and payers.

4) PBMs and other intermediaries capture an increasing share of drug expenditures—for example, more than half of spending on insulin—distorting drug pricing and reducing manufacturer incentives to innovate.

5) Greater transparency is needed in this marketplace, and PBMs should be required to share savings with consumers and plans.

Chairwoman Cantwell, Ranking Member Cruz, and other distinguished members of the Committee, thank you for the opportunity to testify before you today about the need for transparency and accountability in the pharmacy benefit manager market. The opinions I offer today are my own, and build on previous statements.

My name is Erin Trish and I co-direct the Leonard D. Schaeffer Center for Health Policy & Economics at the University of Southern California. The Schaeffer Center strives to measurably improve value in health through evidence-based policy solutions, research excellence, and public- and private-sector engagement. As part of this mission, my colleagues and I have been studying prescription drug markets for over a decade.

Prescription drug markets are complicated, and it takes a lot of boxes and arrows to show you even a simplified version of how the dollars and goods flow. While this complexity keeps health economists like me in business, it still remains a mystery to most Americans. And where there is mystery, there is margin.

Pharmacy Benefit Mangers ("PBMs")—which operate in the middle of the US pharmaceutical supply chain—play an important role in drug pricing. PBMs manage drug benefits on behalf of health insurers (including Medicare Part D plans) and employers, creating formularies and leveraging their bargaining power to negotiate rebates from manufacturers.

Historically, PBMs were independent from health plans and added value by reducing prices, encouraging uptake of generics, and expanding mail-order services. However, a wave of consolidation in the last few years—including health insurers buying up PBMs and PBMs expanding their footprint in pharmacy markets—and other activities have distorted behavior. Unfortunately, evidence indicates that PBMs are now leveraging their position to extract profits in ways that are detrimental to patients, payers, and the drug innovation system more broadly.

Perhaps one of the most well-studied issues has been the use of rebates. Rebates drive a wedge between a drug's list price and its net price, or the amount the manufacturer actually receives. In fact, increasing rebates are one of the key drivers of increasing list prices over time; Schaeffer Center research has shown that for every $1 increase in estimated rebates, list prices increased $1.17 between 2015 and 2018.

Our research sheds light on how patients have been harmed by rebates in the Medicare Part D program. Rebates—as a share of total drug costs in Medicare Part D—have more than doubled over the last decade. We estimate that about half of Part D beneficiaries who do not receive low-income subsidies would pay less out-of-pocket if rebates were applied at the point of sale. The incentives are particularly perverse—beneficiaries pay the most (as a share of the net cost of the drug) for drugs that face the most competition, where rebates tend to be largest.

PBMs have deflected blame for these rebate practices by pointing out that they pass through most of the rebates they collect to health plans, who may then use them to keep premiums low for beneficiaries. But the ultimate result of such practices is to decrease the effective

generosity of insurance by reducing premiums but increasing out-of-pocket costs. Put another way, this system transfers financial resources from sick patients to healthy premium-paying beneficiaries—the opposite of what insurance is supposed to do. Instead, with the current system, patients who do not respond to cheaper therapies are subject to "double jeopardy"— not only is their condition recalcitrant, but now they have to pay more out-of-pocket.

Beyond these distributional issues, rebates distort market incentives. There is indirect evidence to suggest that PBMs favor high list price, high rebate drugs over drugs with a lower net cost, although it is hard to prove definitively without access to actual rebate data. But, as an example, one analysis of Medicare Part D formularies demonstrated that 72% placed at least one branded drug in a lower cost-sharing tier than its generic product.

The recent FDA approval of the first interchangeable insulin biosimilar provides another instructive example. Viatris simultaneously launched two versions of the drug—a branded product (Semglee) with a relatively high list price and presumably large rebates, and an authorized but unbranded version (Insulin Glargine) with a list price 65% lower than Lantus (the reference drug). Despite that significant discount, Glargine has not gained traction on PBM formularies.

Insulin is a highly competitive drug class, with rebates typically greater than 50% of the list price. Nonetheless, many patients face high out-of-pocket costs for insulin—precisely because list prices are inflated so PBMs can extract large rebates. Efforts to cap patients' out-of-pocket spending on insulin help, but they are a Band-aid for a much more systemic disease.

Schaeffer Center research also demonstrates the importance of following the money. My colleagues found that, while total expenditures per unit of insulin remained relatively stable from 2014 to 2018, manufacturers are actually getting paid less year-over-year. You might ask who is making more. It turns out the share of spending captured by PBMs increased 155% over the five-year period. When we are spending roughly $400 billion per year on drugs, that increasing margin adds up.

At this point, less than half of each $1 spent on insulin goes to manufacturers. Instead, the majority gets siphoned away by distribution system intermediaries—a parasitic loss, if you will. This trend is true across other drugs too. This reduces incentives for innovation and redirects spending away from the companies developing new therapies to improve health and save lives.

PBM issues expand beyond rebates—take generic drugs, which typically do not provide rebates to PBMs. Nonetheless, there is evidence that PBMs often overcharge for generic drugs. My colleagues and I compared the prices that Medicare Part D plans pay for common generic drugs to the prices at Costco pharmacies. We found that—relative to Costco's member prices—Medicare Part D plans overspent on generics by $2.6 billion in 2018. While there is robust competition among these common generic drugs, the marketplace leaves

room for PBMs and other intermediaries to capture the value rather than share it with beneficiaries and taxpayers.

Other examples abound. A 2018 Schaeffer Center study found that 23% of prescriptions involved a patient copayment that exceeded the cost of the prescription to the PBM—or a so-called copay "clawback." This finding stands in stark contrast to testimony offered a year prior by a PBM lobbyist to the Senate HELP Committee that PBMs did not support the practice of collecting patients' copay in excess of the cash price and that, if such practices happened, they were "outliers."[i]

It is not only patients who bear the cost of these market distortions, but increasingly pharmacies too. In 2020, PBMs extracted $9.5 billion in price concessions—categorized as direct and indirect remuneration ("DIR")—from pharmacies on Medicare Part D transactions alone, up over 1,000% from a decade prior. Moreover, investigations and lawsuits in recent years have illuminated the pervasive practice of "spread pricing," where PBMs charge health plans and payers more for a given transaction than what they reimburse to the pharmacy, keeping the "spread" or difference. A 2018 Ohio Auditor report—one of the earliest such investigations—found that PBMs charged the state a spread of more than 31% for generic drugs for its Medicaid plans, with taxpayers ultimately footing the bill.

It is clear that reforms are needed to improve the functioning of the pharmaceutical distribution system and ensure that the system works to benefit patients and drive value. In today's market, PBMs are exploiting its complexity and opacity to increase profits while avoiding scrutiny.

More transparency is sorely needed, and policy solutions that work toward that goal should be pursued. Existing PBM tactics that feed off market opacity—like spread pricing and clawbacks—should be prohibited. More transparency is needed on the structure and magnitude of rebates and other fees, particularly as contracts and fee structures of PBMs and their affiliates evolve. Likewise, additional insight is needed into PBM-pharmacy reimbursement, particularly as PBMs play an increasing role in pharmacy and specialty pharmacy markets, with increasing vertical integration interjecting additional layers of complexity and scope for arbitrage.

While policy to provide such transparency is needed now, there is also more to learn. Further investigation is warranted to better understand the myriad ways the current system harms consumers and reduces innovation—especially innovation that will lower costs for everyone. In such a complex and opaque market, research using publicly-available data can only get us so far; more detail is needed to better follow the money. Regardless, more competition between PBMs would help, and increased transparency is an important first step toward achieving that goal.

I look forward to your questions.

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[i] Testimony of Mark Merritt, CEO of PCMA, to Senate HELP Committee, October 17, 2017. See exchange with Senator Susan Collins beginning at 1:15:55.