COMPETITIVE ENTERPRISE INSTITUTE

A Free Market Solution for Drug Distribution

How PBMs Enhance Competition, Lower Costs, and Improve Drug Utilization and Health

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Executive summary

This paper describes and explains the function of Pharmacy Benefit Managers (PBMs) in the American health care economy. PBMs are private businesses that developed in the free market to manage prescription drug benefits for health insurance plan sponsors. Nearly all Americans have private or government prescription drug insurance coverage that is managed by PBMs. PBMs enhance competition through group purchasing and negotiated discounts that provide substantial economic and health benefits for consumers and taxpayers.

Multiple legislative proposals are pending that would restrict PBM functioning by limiting or eliminating rebates and discounts that pass through PBMs and by requiring PBMs to disclose pricing and other confidential terms of their contracting. But the legislation is likely to be counterproductive, resulting in reduced competition, higher costs, and an end to the natural evolution in the market of terms and arrangements which benefit the actors in the drug distribution system.

Introduction

The United States is unique in the extent to which it relies on private markets to deliver and fund health care. Despite significant government involvement in health care funding and regulation, many government payers utilize private market mechanisms in their programs and most Americans still obtain their health care through private markets. The reason is simple: in market economies, free choice among competing suppliers generally leads to an efficient allocation of resources that maximizes consumer welfare. This is also true in health care where market forces enhance patients' welfare by allowing all parties in the system to act in accord with their own, self-determined interests.

For a free market to be efficient, free choice and competition must exist to allow consumer demand to be met by suppliers. Prices reveal economically important information about costs and consumer preferences and send signals to both sides of the market to ensure an efficient allocation of resources.

Many markets, though, do not meet all the conditions under which markets are perfectly competitive and efficient. These types of market failures occur to a greater or lesser extent throughout the economy and health care is no exception.

Health care is characterized by uncertainty in the incidence of disease and in the effectiveness of treatment, and therefore the likelihood of recovery. In response to this uncertainty, health insurance and third-party payment have arisen to mitigate the financial risk of illness and allow individuals to pool the risk.

Over time, more and more insurers, including the federal government through its Medicare Part D program, have offered prescription drug insurance coverage. About two-thirds of adults use prescription drugs. Almost 300 million people – about 90 percent of the population – participate in prescription drug insurance plans.

Most drug insurance plan sponsors, seeking to lower their costs and the premiums their subscribers pay, have found value in pharmacy benefit management services (PBM services) that include designing benefit plans, negotiating lower prices, and processing prescription drug claims. Pharmacy Benefit Managers (PBMs) are private companies that provide PBM services.

PBMs manage prescription drug benefits for some 275 million Americans who have health insurance from a variety of sponsors: commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program, state government employee plans, Medicaid plans, and others.

Many are highly critical of PBMs, deriding them as "middlemen." U.S. Representative and former pharmacist Earl "Buddy" Carter (R-Ga) "identifies PBMs as a root cause of high prescription drug costs. … everyone from pharmacy owners to patients to taxpayers are victimized by the predatory practices of PBMs."[1]

The reality is far different and quite complex. This paper will discuss how PBMs arose in the market to fill a need. PBMs are a free market solution that enhances competition through group purchasing and negotiated discounts that provide substantial economic and health benefits for consumers and taxpayers.

[1] Rep. Earl L. "Buddy" Carter, "Pulling Back the Curtain on PBMs: A Path Towards Affordable Prescription Drugs," *Harvard Journal on Legislation*, Vol. 59 (2022), p. 258, https://journals.law.harvard.edu/jol/wp-content/uploads/sites/86/2022/06/201_Carter.pdf.

The first section describes the prescription drug market and distribution system and PBM's role in it. PBMs, acting on behalf of drug insurance plans, negotiate with drug manufacturers on the one hand and with pharmacies on the other. They design drug benefit plans, selecting drugs to include on the plan's formulary (a list of available drugs covered by the plan) and allocating those drugs to different copay tiers. They also select which pharmacies to include in their plan networks and on what terms to do so. This selective contracting allows PBMs to obtain rebates and discounts that result in lower drug costs. It also allows PBMs to design their plans so that subscribers are more likely to use more effective medicines and cheaper drugs such as generics.

The next section describes how PBMs obtain value for prescription drug plan sponsors and, through lower premiums and improved drug utilization, their patient-subscribers. PBMs function much like buyers' clubs do, obtaining lower prices for their members and facilitating increased use of beneficial drugs. PBMs generate billions of dollars in benefits over their costs in consumer savings resulting from manufacturer and pharmacy rebates and discounts, the value of better drug utilization in preventing more serious illness and expensive healthcare use, an increased pace of drug development, and government savings from decreased premium subsidies and premium tax expenditures.

Finally, the paper examines legislative proposals to restrict PBM functioning. These focus on two areas: limiting or eliminating rebates and discounts that pass through PBMs and requiring PBMs to disclose their pricing and other currently confidential contract terms. The discussion demonstrates that these proposals could decrease competition and result in higher, not lower, costs. They will sacrifice much of the value that PBMs provide and limit the ability of smaller PBMs to evolve and compete in the market.

PBMs in the prescription drugs market

Most Americans are enrolled with a third-party plan (government and/or private insurance company) for prescription drugs.[2] Eighty-four percent of all Americans, including 97 percent of those with public insurance such as Medicare and Medicaid and 92 percent of those with private insurance, have prescription drug insurance coverage.[3]

Most of these third-party insurance plans have found value in pharmacy benefit management services to lower their costs and improve drug utilization. Most plans use PBMs to manage the process. PBMs negotiate prescription drug prices with drug manufacturers and pharmacies, create networks of pharmacies to fill prescriptions for insured individuals, and process insurance claims when prescriptions are filled.

The Government Accountability Office (GAO) found that in 2016 Medicare Part D plan sponsors used PBMs to provide 74 percent of drug benefit management services and performed the remaining 26 percent of services themselves.[4] PBM use has continued to rise in government plans and is higher in private plans.

Currently, there are at least 66 PBM companies[5] administering prescription drug plans for more than 275 million Americans who have health insurance from a variety of private and government sponsors.[6] Three companies comprise much of the PBM market with CVS Caremark having a 33 percent market share, Express Scripts having 24 percent market share, and OptumRx having 22 percent market share.[7] Together they account for nearly 80 percent of the PBM market. The next three largest PBMs together account for 17 percent of the market.[8]

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[2] Retail drugs represent 86 percent of medicine use in the U.S. Medicine use in non-retail settings has been declining since 2017 and accounts for only 14 percent of total use. IQVIA Institute for Human Data Science, *The Use of Medicines in the U.S. 2022*, April 2022, https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2022.

[3] Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, "Increase the proportion of people with prescription drug insurance — AHS-03, Data," Healthy People 2030, accessed August 7, 2023, https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-prescription-drug-insurance-ahs-03/data?group=All%20groups&state=United%20States&from=2019&to=2021&populations=#edit-submit.

[4] Data was for 2016. U.S. Government Accountability Office, *Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization* (GOA-19-498, July 2019), https://www.gao.gov/assets/gao-19-498.pdf.

[5] "Pharmacy Benefit Managers," Center for Insurance Policy and Research, National Association of Insurance Commissioners, last updated June 1, 2023, https://content.naic.org/cipr-topics/pharmacy-benefit-managers; a recent estimate from the trade association the Pharmaceutical Care Management Association puts the number of PBMs at 73. https://www.pcmanet.org/wp-content/uploads/2023/04/PBM-Marketplace-Continues-to-Evolve_r4.pdf.

[6] "The Value of PBMs," Pharmaceutical Care Management Association, accessed August 7, 2023, https://www.pcmanet.org/value-of-pbms/.

[7] Matej Mikulic, "Market Share of the Top Pharmacy Benefit Managers in the U.S. Prescription Market in 2022," Statista, May 23, 2023, https://www.statista.com/statistics/239976/us-prescription-market-share-of-top-pharmacy-benefit-managers/.

[8] Adam J. Fein, "The Top Pharmacy Benefit Managers of 2022: Market Share and Trends for the Biggest Companies," Drug Channels, May 23, 2023, https://www.drugchannels.net/2023/05/the-top-pharmacy-benefit-managers-of.html.

PBMs act within a complex supply chain. They manage the flow of dollars by providing reimbursements and payments to all entities in the drug supply chain. PBMs play no direct role in the physical distribution of prescription drugs. They only handle negotiations and payments within the supply chain.

Consumer-beneficiaries (either directly and/or through employer or government provided insurance) pay premiums to a health plan, in exchange for drug coverage benefits. Health plans or self-insured employers (collectively sponsors) contract with a PBM to manage drug benefits in exchange for fees and payments. The PBM negotiates with drug manufacturers to provide preferred formulary placement for the manufacturer's products in exchange for discounts, rebates and other types of payments.

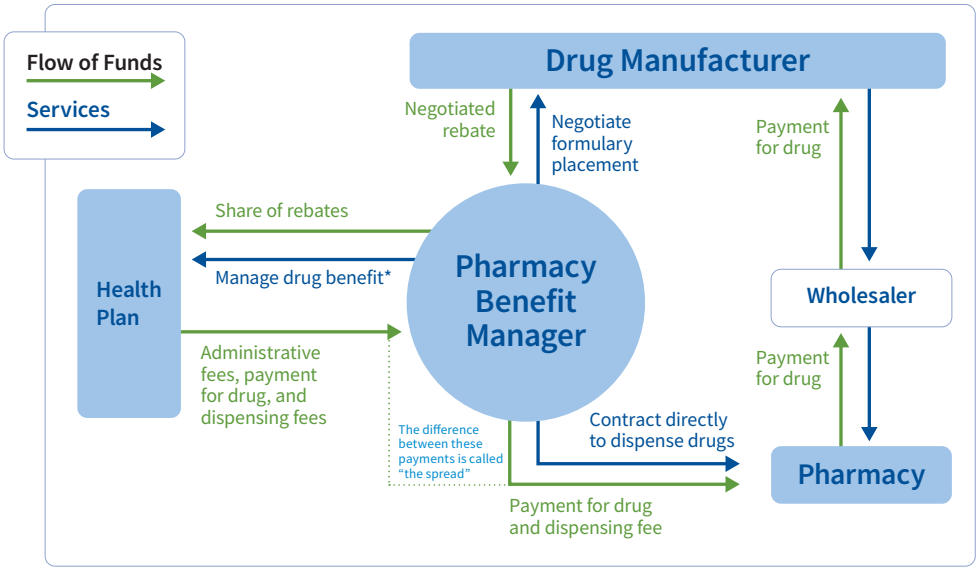
The PBM also negotiate with pharmacies, setting terms for them to participate within their network of pharmacy providers and setting reimbursements for dispensing the drugs. PBMs obtain discounts and superior retailing in exchange for favorable placement in drug plan pharmacy networks that drives patients to participating pharmacies. Contracts specify performance goals and negotiated discounts, and incentivize dispensing less expensive generics.

In recent years there has been increasing vertical integration in the industry. PBMs are merging with health insurance companies on one side and specialty and retail pharmacies on the other side. This is especially the case for the largest PBMs: CVS Caremark is integrated with Aetna's insurance plan and CVS Pharmacy, the nation's largest drugstore chain; Express Scripts merged with Cigna's insurance plan and Express Scripts' mail-order pharmacy; and OptumRx merged with United Healthcare's insurance plan and runs its own mail-order pharmacy.[9] Two of the three largest pharmacies by total prescription revenues— Caremark (CVS Health), Express Scripts (Cigna)— were central-fill mail and specialty pharmacies owned by the PBMs.[10]

This creates complex competitive dynamics where PBMs are both suppliers to health plans and sometimes competitors with their in-house PBMs. And since all major PBMs operate their own mail order pharmacies, they are both purchasers from retail pharmacies and competitors.

The following figure outlines the flow of products, services and funds in our drug distribution system.

Figure: Role of Pharmacy Benefit Manager in providing services and flow of funds for prescription drugs



* Includes establishing formulary and patient adherence programs and implementing utilization management tools – such as prior authorization, step therapy, and tiering – to steer patients toward certain drugs on formulary.

Source: Commonwealth Fund[11]

[9] Adam J. Fein, "Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?," Drug Channels, December 12, 2019, https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

[10] Adam J. Fein, "The Top 15 U.S. Pharmacies of 2021: Market Shares and Revenues at the Biggest Companies," Drug Channels, March 8, 2022, https://www.drugchannels.net/2022/03/the-top-15-us-pharmacies-of-2021-market.html.

[11] Commonwealth Fund, "Pharmacy Benefit Managers and Their Role in Drug Spending," April 2019, https://www.commonwealthfund.org/sites/default/files/2019-04/Explainer_PBMs_1.pdf.

Manufacturers sell their drugs to wholesalers who distribute the drugs to pharmacies, including PBMs' mail order pharmacies. Pharmacies dispense the drugs and obtain reimbursement from PBMs.

Manufacturers of on-patent branded drugs typically sell their drugs to wholesalers at the manufacturer's list price or Wholesale Acquisition Cost (WAC), net of any discounts such as for prompt payment.[12] The average wholesale price (AWP) of prescription drugs represents the average price at which wholesalers sell drugs with a markup over the WAC to physicians, pharmacies, and other customers. Third-party database companies typically calculate and publish an AWP list which is generally based on the standard formula (WAC+20%).[13]

Pharmacies then add a mark-up to the price at which they purchased the drug plus a dispensing fee. Hence, the price charged by the retail pharmacy at the point of sale is essentially the price paid to the manufacturer, marked up twice: first by the wholesaler and then by the pharmacy retailer.

When pharmacies dispense a drug, they receive a payment from the PBM on behalf of the sponsor plan, at a contractually determined amount negotiated by the pharmacy and the PBM. The patient also pays the pharmacy any cost-sharing that might be due—copayment, coinsurance, or deductible[14] based on the PBM-pharmacy contractually determined rate at the point of sale, excluding any post-sale adjustments.

PBMs provide savings for sponsor/payers by negotiating discounts on pharmacy mark-ups and dispensing fees and on manufacturers' prices.[15] Many of these fee and payment adjustments occur after the point of sale and are collectively referred to as direct and indirect remuneration (DIR). These include rebates, discounts, or other price concessions that manufacturers on one side and pharmacies on the other, pay to PBMs and plans.[16]

DIR has been steadily growing. In the Medicare Part D drug program DIR grew from 11.7 percent of total Part D drug costs in 2012 to 27 percent in 2020 and is credited by the Medicare Trustees with holding down overall Part D spending.[17]

PBMs collect rebates and other discounts from manufacturers that are largely passed back to sponsors. These are the largest category of DIR.

For pharmacies, DIR payment adjustments are often made months after the point of sale. Pharmacies return some of the funds to the PBM based on contractually specified performance metrics such as medication adherence, generic drug dispensing rates, high-risk medications in the elderly, formulary compliance rate, or other plan-specific quality metrics.[18]

Plan sponsors are not required to contract with PBMs. Yet, remarkably, most choose to do so. Over 90 percent of Americans with prescription drug insurance coverage receive benefits though a PBM.[19] The advent, survival, and proliferation of PBMs in the free market suggests they provide value to plan sponsors offering net savings on claims processing, management of drug utilization and prices, and management of pharmacy dispensing costs.

Similarly, manufacturers and pharmacies could refuse to negotiate and offer discounts to PBMs, but they continue to deal with PBMs. This suggests that all the actors in the market feel they gain something from dealing with PBMs.

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[12] Medicare defines the WAC as "the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price." 42 U.S.C. § 1395w-3a(c)(6)(B).

[13] Patricia M. Danzon, "Pharmacy Benefit Management: Are Reporting Requirements Pro- or AntiCompetitive?," *International Journal of the Economics of Business*, Vol. 22, No. 2 (2015), https://doi.org/10.1080/13571516.2015.1045741.

[14] Copayment is a set dollar amount paid at the time a drug is purchased. Coinsurance is cost sharing paid at the point of purchase based on a set percentage of the drug's cost.

[15] Danzon, "Pharmacy Benefit Management."

[16] T. Joseph Mattingly II and Ge Bai, "Reforming Pharmacy Direct and Indirect Remuneration in The Medicare Part D Program," Forefront (blog), *Health Affairs*, July 19, 2021, https://www.healthaffairs.org/content/forefront/reforming-pharmacy-direct-and-indirect-remuneration-medicare-part-d-program.

[17] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2022 Annual Report*, June 2022, pp. 149-150, https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

[18] Mattingly and Bai, "Reforming Pharmacy Direct and Indirect Remuneration in the Medicare Part D Program."

[19] Joanna Shepherd, "Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs," *Yale Law & Policy Review*, Vol. 38 (2020), p. 364, https://openyls.law.yale.edu/bitstream/handle/20.500.13051/17295/auto_convert.pdf?sequence=3&isAllowed=y.

How PBMs create value

PBMs are a free market solution that enhances competition through group purchasing and negotiated discounts. They function in a matter similar to buyers' clubs that obtain manufacturer discounts on behalf of their members. These clubs pool purchasing power to counteract the exercise of market power by manufacturers. This is particularly important in the world of prescription drugs where manufacturers can be sole source providers of new, patent protected, brand name drugs or sometimes older generic drugs that have only one maker and where the top three wholesalers make up more than 80 percent of the market and the top three pharmacies more than 50 percent.[20]

Buyers' clubs have more market power than individual purchasers because they negotiate on behalf of many clients. In economic terms, they convert the relatively price-inelastic demand curve that individuals have for the very price-elastic demand that buyers' clubs have.[21]

PBMs obtain discounts on drug prices and pharmacy fees by restricting the number and choice of drugs or pharmacies in the plan, thus increasing volume for preferred suppliers that accept discounted prices.[22] A drug manufacturer knows it must discount because a small price increase could lead a PBM to select a competing drug for its formulary (the drugs available to plan participants), costing the manufacturer all its sales to the PBM (high price elasticity).

PBMs obtain lower prices through their ability to exclude manufacturers' products or place them less favorably in the plan as compared to alternative drugs that treat the same condition. Manufacturers trade lower prices for formulary access and increased sales volume. This involves a PBM's decision whether or not to include a drug on a formulary and, once on the formulary, a decision about customers' costs of accessing it via formulary placement. Most health plan sponsors negotiate a tiered co-pay arrangement (three or more tiers), with the PBM, with the lowest co-pay for generic drugs, the middle tier for brand-name drugs with no generic equivalent, and the highest co-pay for brand-name drugs with a generic equivalent. The general principle is that PBMs incentivize patients to use the least costly drug appropriate for their condition.

PBMs also obtain pharmacy discounts and higher-quality retailing in exchange for favorable pharmacy placement in drug plan pharmacy networks, which drives traffic to cooperating pharmacies. The end result is that patients can utilize more of beneficial drugs at lower costs which translates into lower insurance premiums.

This selective contracting is procompetitive and allows PBMs to negotiate lower drug prices with both pharmacies and drug manufacturers and gives covered individuals a financial incentive to obtain health care from a limited panel of providers. It has been common in health care services since the 1980s.[23] As the Federal Trade Commission wrote,

> "The ability of health plans to construct networks that include some, but not all, providers (so called 'selective contracting') has long been seen as an important tool to enhance competition and lower costs in markets for health care goods and services. Both economic principles and empirical evidence support that view."[24]

Economist Casey Mulligan has estimated that PBM services produce at least $145 billion in annual value to society beyond the PBM resource costs—including consumer savings net of manufacturer losses resulting from manufacturer and pharmacy rebates and discounts, the value of better drug utilization in preventing more serious illness and expensive healthcare use, an increased pace of drug development, and government savings from decreased premium subsidies and premium tax expenditures—as compared to a baseline of no PBM services to manage utilization. Having plan sponsors self-provide PBM

[20] Fein, "The Top Pharmacy Benefit Managers of 2022"; Fein, "The Top 15 U.S. Pharmacies of 2021."

[21] Casey B. Mulligan, "Restrict the Middleman? Quantitative Models of PBM Regulations and their Consequences," NBER Working Paper 30998, March 2023, pp. 28-29, https://www.nber.org/papers/w30998.

[22] "The basic principle is that PBMs can drive discounts on drug prices and pharmacy fees by restricting patients' choice of drugs or pharmacies, thereby increasing volume for preferred suppliers that accept discounted prices. Thus, more restrictive drug formularies or pharmacy networks generally obtain larger discounts." Danzon, "Pharmacy Benefit Management," p. 246.

[23] Shepard, "Pharmacy Benefit Managers, Rebates, and Drug Prices," p. 365.

[24] Andrew I. Gavil, Martin S. Gaynor, and Deborah Feinstein, Comment Letter to Centers for Medicare and Medicaid Services on "Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," Docket No. CMS-4159-P, Federal Trade Commission, Mar 7, 2014, https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf.

services "would preserve about 60 percent of the net value of PBM services but forgo the other 40 percent largely by increasing the cost of providing PBM services," Mulligan figures.[25]

In other words, every prescription drug plan sponsor either hires a PBM or brings one in-house (either acquiring one or creating its own) because of the value of these services. Sponsors retain PBMs because pharmacy management provides significant economic value and PBMs do a better job at it than the sponsors could do themselves. PBM negotiations with manufacturers and pharmacies drive competition that lowers retail and manufacturing prices and redistributes from manufacturers and pharmacies to consumers.[26]

The value of PBM services was substantiated by a study of a U.S. government agency that failed to use them. The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP) manages the Federal Employees' Compensation Program (FECA) program which administers workers compensation benefits, including prescription drugs, for 2.6 million federal workers if they get hurt on the job. An audit by DOL's Office of the Inspector General (OIG) found that "OWCP had not done enough to ensure it paid the best price for prescription drugs in the FECA program. Specifically, the audits noted OWCP lacked a pharmacy benefit manager to help contain costs and had not determined if alternative prescription drug pricing methodologies would be more competitive."[27]

OIG commissioned an outside study to review six years of OWCP drug spending in the FECA program "comparing the FECA program to industry best practices and other workers' compensation programs." The study found that OWCP's failure to use a PBM to manage pharmaceutical spending and contain costs, led to $321.3 million in excess spending on drugs.[28]

PBMs have contributed to lower costs and improved health in several ways: First they have encouraged a shift to cheaper generic drugs. Generics are cheaper in the U.S. and account for 90 percent of all U.S. prescriptions, a much higher generic utilization rate than in Europe,[29] where PBMs are much less common. PBMs also provide clinical and disease management programs to encourage correct drug usage and patient compliance. Many PBMs have in-house pharmacists who call physicians to switch patients to preferred drugs and contact patients with reminders for prescription renewals. Finally, by obtaining substantial discounts, usually in the form of rebates, PBMs have facilitated access to and utilization of newer, branded, single-source drugs. Many of these new drugs add substantial health benefits improving and extending the lives of patients and, in many cases, reducing spending on other health services provided by hospitals and physicians.[30]

While manufacturers reduce consumers' costs via coupons, and health plans' costs via rebates for brand name drugs, they generally do not offer these price-reducing measures for generics. PBM management of generics utilizes a different pricing approach to decrease costs and encourage generic use.

Most states authorize pharmacies to substitute any bio-equivalent generic for the brand. Hence, PBMs treat all generic versions of a drug the same, reimbursing pharmacies using a maximum allowable cost (MAC) based on the PBM's estimate of pharmacies' generic acquisition costs. This incentivizes pharmacies to use the lowest cost generic available so they can capture the spread between the MAC and its acquisition cost. MAC prices are updated frequently, generally downward, to reflect market changes in pharmacies' purchase prices of generic drugs, thereby capturing some of the savings from competitive discounting.[31]

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[25] Casey B. Mulligan, "The Value of Pharmacy Benefit Management," NBER Working Paper 30231, July 2022, https://www.nber.org/papers/w30231.

[26] *Ibid.*

[27] U.S. Department of Labor, Office of the Inspector General, *Report to the Office of Workers' Compensation Programs: OWCP Did Not Ensure Best Prices and Allowed Inappropriate, Potentially Lethal Prescriptions in the FECA Program*, Report No. 03-23-001-04-431, March 31, 2023, https://www.oig.dol.gov/public/reports/oa/2023/03-23-001-04-431.pdf.

[28] *Ibid.*

[29] Olivier J. Wouters, Panos G. Kanavos, and Martin McKee, "Comparing Generic Drug Markets in Europe and the United States: Prices, Volumes, and Spending," *The Milbank Quarterly*, Vol. 95, No. 3 (September 2017), https://pubmed.ncbi.nlm.nih.gov/28895227/.

[30] Congressional Budget Office, *Prescription Drugs: Spending, Use, and Prices*, January 2022, https://www.cbo.gov/publication/57772.

[31] Danzon, "Pharmacy Benefit Management," p. 249. Most PBM contracts with plan sponsors (75 percent) bill for generics using MAC pricing. The remainder bill for generics using discounted AWP. Each PBM sets its own MAC reimbursement prices for pharmacies. In contrast, AWP is a list price schedule set by third party database companies.

PBMs also incentivize patients to use generics by preferentially placing generic versions in formularies when both generic and brand name versions of the same drug are available and by offering patients lower cost sharing on generics than on brand names. A study of drugs with both brand-name and generic versions found that most Medicare Part D plans (84 percent) covered the generic only. And in the 15 percent of plans that covered both brand name and generic versions of the same drug, 40 percent placed the generic in a lower cost-sharing tier than brand-name drugs. Less than 1 percent of brand names were in lower cost sharing tiers than their generic equivalents.[32]

PBMs are sometimes vilified as predatory middlemen who victimize all actors in the drug distribution universe "from pharmacy owners to patients to taxpayers."[33] Yet middlemen—intermediaries such as dealers, brokers or specialists who facilitate transactions between buyers and sellers—are ubiquitous in our economy because they provide value to buyers, sellers, and the public generally. Few goods are purchased by consumers directly from the manufacturers who produced them. Unless restricted by the government, middlemen are free to compete against other middlemen thereby ensuring that middlemen's earnings—typically in the form of commissions or selling the product for more than its purchase price—are subject to the rigors of the market.

PBMs' ability as middlemen to negotiate larger rebates and discounts from manufacturers and pharmacies has been credited with helping to lower drug prices and slow the growth of drug spending.[34] Lower drug prices and spending benefits private plan subscribers and taxpayers in the form of lower drug insurance premiums as well as the economy in general.

In fact, PBMs do not earn outsize profits. A study of profits across the flow of funds in the drug distribution system found that PBMs' net margins—revenues received less payments made and other expenses— were 2 percent, less than other participants in the system such as manufacturers (26 percent), pharmacies (4 percent), and insurers (3 percent), and only exceeding the net margins of wholesalers (0.5 percent). Moreover, PBM's net margins were lower than margins in similar industries.[35]

Counterproductive proposals to restrict PBMs

There are a slew of legislative proposals pending that would fundamentally change the way PBMs function in the market.[36] The Senate Finance Committee, for example, approved, 26-1, the Modernizing and Ensuring PBM Accountability (MEPA) Act on July 26, 2023. MEPA limits PBM income in the Medicare Part D prescription drug program (Medicare Advantage-PD and PDP) to "bona fide service fees," defined as "a flat dollar amount," rather than compensation based on drug prices or other benchmarks (rebates to plan sponsors that lower net costs for covered part D drugs would continue to be allowed); requires PBMs "to define and apply drug and drug pricing terms in contracts with Part D plan sponsors in a transparent and consistent manner" and give sponsors the right to audit PBMs for compliance; requires "PBMs to annually report drug price and other information to Part D plan sponsors and to the Secretary of Health and Human Services (HHS)."; directs HHS' Office of Inspector General to review the state of PBM compensation, study Part D drug mark-ups and to investigate the impact of vertical integration between Part D plans, PBMs, and pharmacies; bans the use of spread pricing in Medicaid; and require that Medicare Advantage and Part D plans use standardized pharmacy performance measures for incentive pay, price concessions, or fees charged to a pharmacy based on those measures.[37]

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[32] Stacie B. Dusetzina et al., "Medicare Part D Plans Rarely Cover Brand-Name Drugs When Generics Are Available," *Health Affairs*, Vol. 39, No. 8 (August 2020), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01694.

[33] Carter, "Pulling back the Curtain on PBMs."

[34] Commonwealth Fund, *Pharmacy Benefit Managers*.

[35] Neeraj Sood et al., "The Flow of Money Through the Pharmaceutical Distribution System" USC Schaeffer Center White Paper Series, June 2017, https://healthpolicy.usc.edu/research/flow-of-money-through-the-pharmaceutical-distribution-system/.

[36] These include, *inter alia*, the House Energy and Commerce Committee's bipartisan PATIENT act (H.R. 3561), unanimously passed May 24, which prohibits spread pricing and require PBMs to supply employers with detailed information on prescription drug spending; the Senate Finance Committee's Modernizing and Ensuring PBM Accountability Act which would limit PBMs' income to service fees, direct the HHS Office of Inspector General to evaluate the state of PBM compensation and study Part D drug mark ups, ban spread pricing in Medicaid, and require Medicare Advantage and Part D plans to use standardized pharmacy performance measures; the Finance committee's Patients Before Middleman (PBM) Act, which would delink PBM compensation from prescription drug list prices; an impending bill from the House Ways and Means committee; along with multiple other bills. See Gabrielle Wanneh, "More PBM Bills Emerge As Finance Markup Nears, W&M Drafts Its Own Bill," Inside Health Policy, July 21, 2023, https://insidehealthpolicy.com/daily-news/more-pbm-bills-emerge-finance-markup-nears-wm-drafts-its-own-bill?utm_medium=mh.

[37] Staff of the Senate Finance Committee, "Modernizing and Ensuring PBM Accountability Act Section-By-Section Summary," Senate Finance Committee, https://www.finance.senate.gov/imo/media/doc/Section-By-Section%20MEPA_Final.pdf.

The House Ways and Means Committee's Health Care Transparency Act requires PBMs and group health plans to report to plan sponsors prescription drug pricing and spending data, including the amounts of rebates or other discounts received from drug makers or any third party other than the plan sponsor.

Most of the legislative and "reform" proposals focus on two areas: 1) curbing or eliminating rebates from manufacturers and discounts from pharmacies, including those that result in spread pricing; and 2) improving transparency by imposing disclosure requirements. These proposals will likely do little to lower costs and could have deleterious side effects.

Targeting rebates and discounts

PBMs primarily earn revenue from plan sponsors through volume-based fees based on PBM processed claims; per-member per-month fees; or a combination of the two. PBMs also earn revenue from part of the rebates they negotiate with drug manufacturers and by keeping some of the discounts they obtain from pharmacies.

Rebates are price discounts based on sales volume. Rebates go up and prices come down when more of the drugs are sold. There is nothing particularly unique or nefarious in the use of rebates for drug sales. "Rebates are used by a wide array of manufacturers, such as automakers, electronics companies, and pharmaceutical manufacturers, to drive demand for their products."[38]

In fact, nearly all of the manufacturer rebates to PBMs are passed back to the plan sponsors. One study found that while manufacturer rebates increased from $39.7 billion in 2012 to $89.5 billion in 2016—thereby offsetting increases in drugs' list prices—the percentage of manufacturer rebates passed back to health plans rose from 78 percent in 2012 to 91 percent in 2016.[39] CVS and Express Scripts—two of the largest PBMs—reported that they return more than 90 percent of rebates to their commercial clients.[40] GAO found that PBMs retained less than 1 percent of rebates in the Medicare Part D program.[41]

Rebates have benefitted both payers and consumers in the form of lower premiums for plan enrollees. Plan sponsors have strong incentives to pass on rebates to their enrollees in the form of lower premiums and better benefits. Rebate payments have also lowered government costs and benefitted taxpayers. Government health plans achieved higher rebates (Medicaid 61 percent and Medicare 31 percent for branded drugs) than private plans (16 percent). It is estimated that in 2016 rebates to government plans such as Medicaid ($32 billion) and Medicare ($31 billion) were far greater than rebates to private health plans ($23 billion).[42]

Eliminating rebates altogether would likely raise costs. CBO analyzed a rule issued in the closing days of the Trump administration—but never implemented because of legal challenges and Biden administration resistance— that prohibited rebates from manufacturers to PBMs for Medicare Part D plans and managed care organizations (MCOs) in state Medicaid programs. Manufacturers would presumably continue to provide discounts by reducing list prices or by making a payment to the pharmacy of the full amount of the negotiated discount (referred to as a "chargeback") resulting in a lower post-chargeback price. Yet CBO estimated that manufacturers would decrease the discounts they were providing as rebates by 15 percent and that rather than lowering list prices, manufacturers would offer the remaining 85 percent discount in the form of chargebacks. CBO estimated this would result in $176 billion in extra federal spending over 10 years. The increase was primarily due to increased federal subsidies for Part D. Plan sponsors, deprived of rebates, would raise premiums. Since the federal government subsidizes 74.5 percent of the basic Part D beneficiary premium, federal premium spending would rise. CBO also estimated

[38] Gabriela Dieguez, Maggie Alston, and Samantha Tomicki, "A Primer on Prescription Drug Rebates: Insights Into Why Rebates Are a Target for Reducing Prices" (Milliman White Paper, May 2018), https://www.milliman.com/en/insight/a-primer-on-prescription-drug-rebates-insights-into-why-rebates-are-a-target-for-reducing.

[39] PEW Charitable Trusts, "The Prescription Drug Landscape, Explored: A Look at Retail Pharmaceutical Spending from 2012 to 2016," March 2019, https://www.pewtrusts.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored.

[40] See CVS Health, "CVS Health Responds to Request for Information on Trump Administration's Blueprint to Lower Drug Price," press release, July 16, 2018, https://cvshealth.com/news-and-insights/press-releases/cvs-health-responds-to-request-for-information-on-trump; "The Rebate Debate," Express Scripts, June 29, 2017, https://www.express-scripts.com/corporate/articles/rebate-debate.

[41] U.S. Government Accountability Office, *Medicare Part D: Use of Pharmacy Benefit Managers*.

[42] Charles Roehrig, "The Impact of Prescription Drug Rebates on Health Plans and Consumers" (Altarum, April 2018), p. 2, https://altarum.org/sites/default/files/uploaded-publication-files/Altarum-Prescription-Drug-Rebate-Report_April-2018.pdf.

that the cost of creating and operating chargeback systems would increase premiums by about 1 percent of the amount of the chargebacks.[43]

There is nothing keeping the market from transitioning to a different or no rebate system. Despite dramatic consolidation in the PBM market—Caremark (CVS Health), Express Scripts (Cigna), and OptumRx (UnitedHealth) are the three largest PBMs, and make up nearly 80 percent of the market—new market entrants are offering an alternative, fixed-fee business model that may disrupt this arrangement. Sponsors and employers pay these new PBMs a set fee for the administration of their pharmacy benefits, as opposed to a percentage of the discounts negotiated.

Other new entrants such as the Mark Cuban Cost Plus Drug Company are offering an entirely different model of selling generic medications directly to patients via mail order for a fixed markup over cost.[44] Insurer Blue Shield of California (4.8 million members) recently announced it is dropping its PBM, CVS Caremark, in favor of working with several companies such as Amazon, Mark Cuban Cost Plus, and Abarca to create its own drug negotiation and delivery system.[45]

Sponsors will be able to determine if these alternative payment models offer better value for them without government instruction. Indeed, the proposed legislation will foreclose sponsors making this determination and could mandate a less efficient, more costly arrangement.

PBMs also earn money from pharmacy fees and spread pricing where the payment the PBM receives from the sponsor may differ (usually higher) from the reimbursement amount it pays to the pharmacy. The difference between the sponsor's payment to the PBM and the PBM's payment to the pharmacy—the spread—is a significant source of PBMs' net revenue.[46]

Since most PBMs do not disclose the price they pay to pharmacies (or drug acquisition costs for their own mail order operations) sponsors do not know how large the spreads are. This presumably leads to excess PBM profits and higher costs for sponsors.

Some proposals to limit spread pricing[47] require "pass through pricing," where PBMs pass through actual pharmacy costs (net of rebates) to sponsors, charging only the actual cost of the drug plus a dispensing fee, and retain only a "reasonable" administrative fee.

However, sponsors are able to compare their costs—generally computed with AWP-x% pricing—for drugs across PBM proposals and presumably will negotiate for the best deals. Since PBMs compete on their ability to control drug spending and its growth for sponsors, sponsors are presumably seeking out the best deal already and should not be hurt by spread pricing. Moreover, the large amount of integration between PBMs and the insurer-sponsors they represent, should minimize any information deficiencies and spread pricing. But restricting spread pricing for small, independent PBMs could eliminate an important revenue source for them that enables them to compete against larger PBMs by offering lower rebates and fees. Finally, as outlined below, forcing disclosure of discounts and spreads could create problems of collusion.

Restrictions on DIR will reduce discounts by retail pharmacies making those pharmacies more profitable. But for every dollar of benefit to pharmacies, it is estimated that it costs plans and patients nearly $3.[48]

Nothing prohibits sponsors from contracting for the complete pass through of rebates and eliminating spread pricing if it is in their interest to do so. In evaluating a 2019 proposal[49] that contained many of the same provisions currently proposed, including requirements on PBMs operating in the commercial

[43] Congressional Budget Office, *Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections—Supplemental Material for Updated Budget Projections: 2019 to 2029* (May 2019), https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.

[44] Bobby Clark and Marlene Sneha Puthiyath, "Are Pharmacy Benefit Managers the Next Target for Prescription Drug Reform?," (blog) The Commonwealth Fund, April 20, 2022, https://www.commonwealthfund.org/blog/2022/are-pharmacy-benefit-managers-next-target-prescription-drug-reform.

[45] Anna Wilde Mathews, "A Big Health Insurer Is Ripping Up the Playbook on Drug Pricing," *Wall Street Journal*, last updated August 17, 2023, https://www.wsj.com/health/healthcare/a-big-health-insurer-is-ripping-up-the-playbook-on-drug-pricing-ec152227.

[46] Danzon, "Pharmacy Benefit Management," p. 248.

[47] See, e.g., H.R. 19 – Lower Costs, More Cures Act of 2021, 117th Congress, First Session, https://www.congress.gov/bill/117th-congress/house-bill/19.

[48] Mulligan, "Restrict the Middleman?"

[49] Congressional Budget Office, Cost Estimate for S. 1895, Lower Health Care Costs Act, July 16, 2019, Section 306, p. 13, https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

market to increase transparency, pass on 100 percent of rebates received to sponsors, and prohibit spread pricing, the Congressional Budget Office wrote,

> "CBO expects that under current law, a growing share of contracts between PBMs and plan sponsors in the private health insurance market will include terms that require full passthrough—from manufacturers to plan sponsors—of rebates received by PBMs and require payment approaches other than spread pricing for administering pharmacy benefits."

CBO concluded PBMs would recoup some of the income lost as a result of compliance with the proposal through higher fees charged to plan sponsors. On net CBO expected the entire package would reduce plan costs by roughly 1 percent for prescription drugs across all plans in the private health insurance market but that plan savings would erode quickly, resulting in negligible impact on premiums charged relative to those under current law.[50]

Transparency and reporting requirements

Reporting requirements may be counterproductive and reflect the interests of competitors rather than customers.[51] Moreover, "the precise problems and how reporting might improve performance are unclear."[52]

Reporting requirements, coupled with audits to ensure compliance, will generate administrative costs that will inevitably be passed on to sponsors.[53] More importantly, allowing some PBMs to learn what terms their competitors are offering could facilitate tacit collusion and reduce price competition in the concentrated PBM industry.[54]

Information about competitors' prices can enable sellers (PBMs are sellers of pharmacy management services) in concentrated industries to maintain an above market, oligopoly price.[55] This problem is exacerbated in the vertically integrated PBM industry where health insurers may also operate their own in-house PBMs and will thus be both customers and competitors of other PBMs.[56] Smaller, independent PBMs that are not integrated with insurance plans and pharmacies will be at a competitive disadvantage since they will have fewer ways to adjust their remuneration.[57]

As the CBO has noted, "under current law, smaller PBMs compete with larger PBMs by offering more transparent contracts. Removing that point of leverage may reduce the competitiveness of those smaller PBMs, which could reduce competition if larger PBMs garner greater market share as a result."[58]

The Federal Trade Commission has repeatedly stated that disclosure requirements could suppress competition among manufacturers, pharmacies and PBMs. FTC noted that the amount of transparency in plan design is a differentiating factor that PBMs use to compete for accounts.[59] Subsequently, FTC staff noted that plan sponsors negotiate over various plan characteristics including varying degrees of transparency and disclosure, rebate levels, and formulary restrictiveness. Plans with relatively restrictive formularies, for example, often receive higher rebates. Plan sponsors can choose varying levels of disclosure, trading more transparency for lower rebates or worse formulary placement. Mandatory disclosure requirements "may prevent plan sponsors from negotiating the level of disclosure that they deem useful and raise plan sponsors' costs of providing pharmacy benefits." Moreover, public disclosure of "previously proprietary and private information about discounts negotiated with PBMs, disclosure may result in less aggressive

[50] *Ibid.* CBO estimated that the resulting lower private health insurance premiums could reduce federal subsidies for insurance purchased through the ACA marketplaces and shift some employees' compensation from tax-favored health insurance to taxable wages resulting in increased federal tax revenues and a decrease in the deficit of $1.7 billion over the 2019-2029 period. But it acknowledged its estimates were highly uncertain. *Ibid,* pp. 14, 20.

[51] Danzon, "Pharmacy Benefit Management," pp. 245, 259.

[52] *Ibid,* p. 256.

[53] Congressional Budget Office, Cost Estimate for S. 1895, p. 20.

[54] *See* Danzon, "Pharmacy Benefit Management." The CBO agrees that reporting requirements for rebates and other information could lead to disclosure and "result in tacit collusion among competing manufacturers." Congressional Budget Office, Cost Estimate for S. 1895, p. 20.

[55] George J. Stigler, "A Theory of Oligopoly," *Journal of Political Economy*, Vol. 72, No. 1 (February 1964), https://www.jstor.org/stable/1828791.

[56] Danzon, "Pharmacy Benefit Management."

[57] For example, MedImpact, an independent PBM, competes by offering clients full disclosure on rebate administration. *Ibid,* p. 253.

[58] Congressional Budget Office, Cost Estimate for S. 1895, p. 20.

[59] Edith Ramirez, Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., Federal Trade Commission, FTC File No. 111-0210, April 2,2012, https://www.ftc.gov/sites/default/files/documents/public_statements/statement-federal-trade-commission-concerning-proposed-acquisition-medco-health-solutions-express./120402expressscripts.pdf.

pricing by, or even collusion among, pharmaceutical manufacturers."[60] More recently, FTC staff wrote that requiring plans "to publicly disclose competitively sensitive information, including information related to price and cost. …may chill competition by facilitating or increasing the likelihood of unlawful collusion, and may also undermine the effectiveness of selective contracting by health plans, which serve to reduce health care costs and improve overall value."[61]

Disclosure and transparency requirements will reduce discounts by manufacturers and pharmacies. Once pharmacies know what discounts competing pharmacies are offering for the same drugs, pharmacies that offer bigger discounts will lower their discounts toward the lowest level discount in the market. Pharmacies will do better if the average discount comes down, but this represents a transfer from plans and their subscribers, who will pay higher premiums.

For generic manufacturers where the products are interchangeable, the situation is analogous to what would likely happen with pharmacies, with average discounts/rebates declining toward the lowest current level. Lowering PBMs' margins on generics could undermine PBM's incentives to encourage generic utilization/substitution which has yielded dramatic savings to consumers and plans and helped control drug prices.

Things are more complicated for manufacturers of branded, patented drugs since they are the only providers of that particular drug, thereby already limiting PBMs' negotiating power. Nevertheless, many single-source, branded drugs compete with other medicines that treat the same condition and PBMs are therefore able to obtain larger rebates than with drugs without any competition.[62] Once rebates are disclosed, branded manufacturers that offer higher rebates will lower their discounts down toward the lowest level rebate of similarly effective drugs in that therapeutic market.

Ultimately, customers of PBM services—health plans and employers—are interested in comparing competing PBMs' performance in controlling total drug expenditures and the impact of drug spending on total health care quality and costs. They do this through negotiation and contracting on a variety of terms in the free market.

> **"There is no compelling evidence of contracting problems, if any, faced by health plans and employers in contracting with PBMs, or how proposed transparency reporting would address these problems. … By contrast, requirements to report competitively sensitive information to customers offer little benefit but could entail significant cost and anti-competitive risk."[63]**

Conclusion

PBMs are a pro-competitive creation of the market for prescription drugs that improve consumer welfare. They lower costs for drug insurance plan sponsors and their patient-customers through group purchasing and negotiations on a variety of contract terms leading to lower drug prices, better drug utilization, and improved health. The fact that PBMs have flourished in a free market confirms that they add value for participants in the prescription drug distribution system.

The prescription drug distribution market is not perfect. But the various legislative proposals to restrict PBMs are more likely to make it worse than better. Congress should not enact them. There are signs that new entrants could disrupt the current market, further improving consumer welfare. The market for prescription drugs should be allowed to continue to evolve and become more efficient through negotiations among the market actors.

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[60] Andrew I. Gavil, Martin S. Gaynor, and Deborah Feinstein, Letter to ERISA Advisory Council, Federal Trade Commission, April 19, 2014, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-erisa-advisory-council-u.s.department-labor-regarding-pharmacy-benefit-manager-compensation-fee-disclosure/140819erisaadvisory.pdf.

[61] Marina Lao, Deborah Feinstein, and Francine Lafontaine, Letter to Minnesota Representatives Joe Hoppe and Melissa Hortman on "Amendments to the Minnesota Government Data Practices Act Regarding Health Care Contract Data," Federal Trade Commission, June 29, 2015, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf.

[62] Darius Lakdawalla and Meng Li, "Association of Drug Rebates and Competition with Out-of-Pocket Coinsurance in Medicare Part D, 2014 to 2018," *JAMA Network Open*, Vol. 4, No. 5 (May 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2779453.

[63] Danzon, "Pharmacy Benefit Management," p. 259.

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