Pharmacy Benefit Managers: Market Power and Lack of Transparency

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Pharmacy Benefit Managers (PBMs) administer prescription drug plans for sponsors (e.g., employers and insurers), negotiate drug prices with manufacturers, and negotiate reimbursement terms with pharmacies. This ConsumerGram analyzes the structure, conduct and performance of the industry and finds the lack of transparency in costs and prices leads to anticompetitive risks. The result can mean higher prescription prices for consumers.

A Market Failure

When a company hires a PBM to manage its employee prescription plan, who does the PBM represent? Typically, when a firm engages with a company to work on its behalf, it expects the hired company to act as a fiduciary, i.e., with the firm's best interest in mind. However, in some cases conflicts of interest create a *principal-agent problem*.[2] These problems can arise from a lack of transparency between the principal (the firm) and agent (the contractor). For sponsors that hire PBMs, this is indeed a problem.

While a plan sponsor faces the direct financial costs of the particular prescription plan being offered to its members or employees, only a PBM has a complete understanding of the prices and costs flowing between the various players involved in prescription plans.[3] This unique insight comes from a PBM's involvement in administering prescription plans for sponsors (and their employees and beneficiaries), and from the PBM acting as middleman in a series of opaque transactions involving sponsors, beneficiaries, pharmacies and manufacturers. These

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[2] Joseph E. Stiglitz, *The New Palgrave: A Dictionary of Economics*, v. 3, pp. 966–71, 1987.

[3] Allison Dabbs Garrett and Robert Garis, "Leveling the Playing Field in the Pharmacy Benefit Management Industry," *Valparaiso University Law Review*, Vol. 42, Rev. 33, 2007, pp. 33-80.

interactions among various parties create an environment for conflicts that drive PBMs to work for their self-interests, unbeknownst to the sponsor or beneficiary.

The lack of transparency leads to asymmetric market information, a *market failure*. PBMs access to better information about costs and prices gives it leverage in dealings with these other parties.[4] When there are substantial costs at stake, market failures can require regulatory and legal remedies to protect consumers.[5] The next sections will evaluate the industry structure, conduct and performance, in order to determine whether there is a presence of sustained market power that poses serious anticompetitive risks for consumers and that requires a public policy remedy.

Market Conduct and Performance

Plan sponsors hire and pay PBMs to run their prescription insurance plans and manage its costs. However, PBMs cut deals with pharmacies, promising them access to the plan's subscribers in return for cutting fees or reimbursement for what the pharmacies would normally earn for filing a prescription. This tactic, called *spread pricing*, adds additional profits for the PBMs over and above what plan sponsors pay PBMs for managing their plans. In other words, as the middleman, PBMs receive additional profit from the spread between plan sponsors payments and pharmacies' normal prices. This profiting occurs without the sponsors knowing what the various wholesale and retail prices are and without knowing the recovery of pharmacy fees.[6]

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[4] Asymmetric information always favors the party with better information. For example, say that a consumer negotiates to buy a used car. If the used car dealer has better information on the vehicle than the consumer has, then the consumer is more likely to overpay than the dealer is to undercharge.

[5] Some of the policy options are laid out and discussed by Ruth G. Thomas, "Consumer Protection, Education and Information: A Consumer Incentives Perspective," *Review of Policy Research,* Volume 2, Issue 3, p. 445-454, February 1983. Thomas analyzes policy alternatives as they impact consumer incentives in the context of different characteristics among consumers, products and market contexts. Also, see Aidan R. Vining and David L. Weimer, "Information Asymmetry Favoring Sellers: A Policy Framework," *Policy Sciences,* 21:4, 1988, p. 281. Vining and Weimer give the following guidance: "Three questions are important: first, under what conditions does the potential for significant inefficiency due to information asymmetry exist? Second, under what conditions are private responses likely to prevent the inefficiency from being realized? And third, what are the different potential, public interventions for reducing any inefficiency that does occur?"

[6] This was extensively investigated by Henry C. Eickelberg, "The Prescription Drug Supply Chain *Block Box* – How it Works and Why You Should Care," American Health Policy Institute, 2015.

In addition, PBMs establish menus and tiers of drugs available on the plan – called a *formulary*. In establishing the formulary, PBMs negotiate prices with manufacturers, sometimes promising manufacturers higher volumes of drug sales in return for lower prices or in return for promising formulary restrictions on competitive drugs through administrative steps. Essentially, PBMs limit price competition in return for deeper manufacturer discounts and rebates. However, the rebates are not necessarily known to or shared with the sponsor. The Pharmacy Benefit Manager Institute provides guidance on this practice for its members:

> *Rebates and/or negotiated price concessions from manufacturers are typically based on the predicted volume of drugs from covered lives. Additionally, price reductions (discounts) may be negotiated for including a single manufacturer's drug on the PBM's formulary and excluding competing drugs or by putting the drug on lower cost-sharing tiers.*[7]

As before, the specific terms and conditions agreed between PBMs and manufacturers are unknown to outside parties, including the pharmacies that fill the prescriptions and the plan sponsors. In other words, in addition to having plan sponsors pay PBMs for managing the plan, they profit from their dealings with drug manufacturers, as well as from squeezing pharmacies.

Prescription plans often require beneficiaries (consumers) to cost-share through copays and deductibles. These sharing provisions are typically applied to the invoice or retail price for prescriptions. In recent years, there has been an increase in invoice prices for beneficiaries, accompanied with a much faster increase in manufacturer rebates for PBMs – all unbeknownst to plan beneficiaries.[8] This means that consumers are paying more because of higher invoice prices, while PBMs are profiting more because of a surging increase in manufacturer rebates. The rebates are not flowing through to consumers in the form of lower prescription prices.

PBMs appear to be a major driver in the prescription price increases that distress consumers. As one expert writes, "most of the increase in drug spending were rebates pocketed

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[7] "Trends in Drug Benefit Design," PBMI, 2016, p. 40.

[8] Robert Goldberg, "Drug Costs Driven by Rebates," Center for Medicine in the Public Interest, http://bionj.org/wp-content/uploads/2015/11/drug-costs-driven-by-rebates.pdf.

by PBMs."[9] This flow-thru problem was also recently highlighted in a report from the Centers for Medicare and Medicaid Services.[10] Effectively, these tactics represent a tacit form of price gouging.

For example, if a manufacturer pays a PBM an incentive to offer a higher cost generic drug, by adding the drug to the plan's formulary, the sponsor's costs increase, as will the PBMs profits. This clear conflict of interest illustrates how PBMs do not necessarily represent the interest of the plan's sponsors or their subscribers. Thus, the incentive for PBMs to do what is best for the plan and consumers is in direct conflict with the PBM's incentive to profit.

There are many cases where generic drug prices are lower than plan deductibles (for example, Walmart's list of $4 generics for 30-day prescriptions). Because some plan beneficiaries do not know this and pharmacists are not permitted to disclose this information under their agreements with PBMs, consumers are paying more than they should under their plans. The practice is called *clawbacks*, and it's just one of several ways that some PBMs are increasing drug costs and lining their pockets.[11] A simple solution would be to allow pharmacists to inform consumers that they could save money by paying cash and not using their PBM plan. Once again, this illustrates that PBMs have incentives to keep prescription costs high, instead of working on behalf of the sponsors by lowering costs without sacrificing quality.

PBMs have steady sources of profit when they manage sponsors' plans: 1) beneficiaries and plan sponsors pay for the PBM for its service; 2) PBMs funnel sales to favored manufacturers in return for rebates and discounts; and 3) PBMs threaten to drop qualified pharmacies in order to squeeze concessions for prescriptions filled at pharmacies. Nowhere are the wholesale and average selling prices between the various parties published or transparent – not to drug

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[9] Goldberg, p. 2.

[10] "Medicare Part D – Direct and Indirect Remuneration," Centers for Medicare & Medicaid Services, January 19, 2017, at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19-2.html.

[11] Julie Appleby, "Filling a Prescription? You Might Be Better Off Paying Cash," CNN, June 23, 2016, at http://www.cnn.com/2016/06/23/health/prescription-drug-prices-pbm/.

manufacturers, not to consumers, not to pharmacies, and not to sponsors who offer their employees prescription plans.

It should be clear who PBMs represent. By one estimate, PBMs fail to pass $120 billion back to consumers, and retain another $30 billion in additional out-of-pocket costs.[12] Meanwhile, the market leader, Express Scripts experienced an increase in net income from $2.0 billion in 2014 to 3.4 billion in 2016 – a 70% increase in profits in just two years.[13] This comes in stark contrast with data from the Bureau of Economic Analysis showing that, across all industries, after-tax corporate profits have not increased in the last two reported years.[14] As middlemen, PBMs are making money on all sides.

Market Structure

According to the Pharmaceutical Care Management Association (PCMA), the trade group that represents the PBM industry, PBMs manage pharmacy benefits for over 253 million Americans.[15] Express Scripts (now merged with Medco), CVS Caremark and OptumRX (now merged with Catamaran) account for 78% of PBM market share.[16] Among large businesses, the top two PBMs (Express Scripts and CVS Caremark) are reported to have 80% of the PBM market share.[17] Because of recent mergers, the PBM market has increased in concentration, and that provides negotiating leverage which enables them to extract additional revenues and earnings.

Increased market concentration has allowed PBMs to become *price-makers*, and pharmacies as *price-takers.* Imagine a pharmacy working with only two PBMs in a community.

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[12] Jonathan Wilcox, "PBMs Must Put Patients First," Huffington Post, February 28, 2017, at http://www.huffingtonpost.com/entry/pbms-must-put-patients-first_us_58b60bd8e4b02f3f81e44dcc.
[13] Based on data from Yahoo Finance on March 1, 2017.
[14] See https://bea.gov/national/pdf/SNTables.pdf. Fourth quarter 2016 was not available at time of this release.
[15] Testimony of Mark Merritt, President and CEO of the Pharmaceutical Care Management Association before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, October 21, 2015.
[16] Health Strategies Group, "Research Agenda 2015: Pharmacy Benefit Managers," available online: http://www.healthstrategies.com/sites.default.files:PBM_Research_Agenda_PBM_RA101513.pdf. Similar figures come from "Prescription Medicines: Costs in Context," PhRMA presentation, August 2016, p. 16, available at http://phrma-docs.phrma.org/sites/default/files/pdf/prescription-medicines-costs-in-context-extended.pdf. This is similar to data published from the Drug Channels Institute, see http://www.drugchannels.net/ for more information.
[17] David A. Balto, Testimony Before the Vermont Legislative House, H. 97, February 26, 2015.

In this example, the pharmacy's access to the total market of consumers is highly restricted, since it must work through one or two PBMs to reach customers. Unless these pharmacies accept the terms of the PBMs, they are left serving a narrow cash market.

Even if pharmacies concede heavy discounts to PBMs, there is no market pressure for the PBMs to flow these savings through to sponsors or to consumers in the form of lower prices. Therefore, while PBMs benefit, consumers are not benefiting from industry concentration.

There is yet another conflict of interest. Large PBMs also provide mail-order prescriptions. If you are a customer that regularly gets drugs for a medical condition, PBMs can easily capture that customer for (typically for lower-cost) reoccurring business, thus entirely bypassing the pharmacy. In other words, PBMs can *cream-skim* customers to its own mail-order business. Because of conflicts of interest, self-dealing and the lack of transparency contributing to a market failure, PBMs have market power. For this reason, some have concluded that the PBM industry's conduct is "anticompetitive and, in some cases, plainly illegal conduct,"[18] and others are calling for industry regulation.[19]

In summary, high market concentration provides PBMs substantial negotiating power in the marketplace and raises anticompetitive risks for consumers. Based on structure, conduct and performance, there is market failure, and that failure calls for regulatory remedies to lessen PBM market power and increase market transparency.

Summary and Recommendations: Need for Transparency

After reviewing the principal-agent problem, market failures caused by asymmetric information, conflicts of interest, collusive pricing, spread pricing, price gouging, self-dealing, clawbacks, undisclosed rebates from manufacturers (including increases in manufacturer's rebates along with increases in invoice prices for beneficiaries), and establishing formularies that

[18] Mark Meador, "Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry Through Regulations," *Annals of Health Law*, Vol. 20, 2011, pp. 77-112.
[19] Meador, at p. 111. Also see, Regina Sharlow Johnson, "PBMs: Ripe for Regulation," *Food and Drug Law Journal*, Vol. 57, 2002, pp. 323-369.

maximize profits instead of minimizing beneficiary costs – it can be concluded that PBMs are major drivers affecting higher prescription drug prices for consumers.

To the address these market failures and anticompetitive risks, as well as heighten market competition, the following public policy remedies need serious consideration:

- PBMs should provide the formulary, information on deductions and other out-of-pocket costs, and any administrative burdens (including preauthorization requirements) to consumers and employers before they sign up for a plan;
- Patients paying coinsurance and/or deductibles should pay the negotiated price and not pay the full price for drugs;[20]
- Pharmacies should to be allowed and encouraged to disclose to patients when lower cost generics or over-the-counter medications are available outside of patients' drug plans;
- Pharmacists should be allowed and encourage to disclose to patients when out-of-pocket costs are lower – if prescriptions are paid in cash instead of using insurance benefits; and
- In dealing with the flow-thru of manufacturer discounts and rebates, the U.S. Department of Health and Human Services (HRSA) or another government agency should be given federal auditing oversight to collect the information necessary to measure the extent to which PBMs are flowing (or not flowing) additional revenues back to beneficiaries. This measure of pass-thru should be made available to the public for each PBM on a macro level.

To this last point, PBMs are virtually unregulated in what is an otherwise regulated healthcare sector. Having government-run audits of PBMs – including the collection of costs and prices – would help direct PBMs in providing a quality service to beneficiaries, while minimizing plan costs for sponsors. The HRSA (or another federal agency) would maintain confidentiality of the disaggregated data, and it would retain the data in case it is needed for any future trade or antitrust investigation. Most importantly, the federal agency would make the aggregated flow-thru estimate available to the public. While this auditing oversight would be for informational

[20] The post adjudication of manufacture rebates and fees could to be determined or reasonably approximated at point-of-sale to reflect negotiated price to keep beneficiaries from overpaying a share (though copay) of inflated invoice or list prices.

purposes only, it would provide an increased level of transparency without imposing overly intrusive regulations. Consumers and sponsors would now have this information available to them when making choices about their prescription plans.

The structure, conduct and performance of the industry confirms the presence of market failures and it provides evidence that total consumer welfare is being adversely affected – consumer prices are being intentionally inflated and PBMs have a fiduciary duty to sponsors that is not being honored. The "light touch" regulatory remedies recommended here seek to reduce market power, increase transparency, provide consumers with more options, and heighten competition within the PBM market. The goal is to provide consumers and sponsors the information they need to make better market decisions.