Lowering Drug Prices in Maryland: Bringing Transparency to Pharmacy Benefit Managers

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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 that the lack of transparency in costs and prices leads to anticompetitive risks. The result can mean higher prescription prices for consumers. Legislation under consideration in the Maryland General Assembly would help mitigate these risks and introduce much-needed transparency into this opaque industry.

A Market Failure

When a Maryland 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*.[1] 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

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

prices and costs flowing between the various players involved in prescription plans.[2] 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 interactions among various parties create a conflict environment that drive PBMs to work for their self-interests, unbeknownst to the sponsor or beneficiary. As a result, Maryland consumers are paying more for their prescriptions at the pharmacy counter.

A recent study by IQVIA Institute reports that drug makers charged on average 13 percent more for their products in 2018 than they did in 2014, after deducting all the rebates they provided to PBMs.[3] Over the same four-year period, overall inflation increased 9 percent. But the shocking news was that since 2014, the "invoice price" for these drugs rose 47%. If drug makers aren't benefiting from higher prices, where did all that money go? PBMs.

The lack of transparency leads to asymmetric market information, a *market failure*. PBM's access to better information about costs and prices gives it leverage in dealing 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

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[2] 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.

[3]Steve Pociask, "Consumers Deserve More Transparency from High Drug Prices," Real Clear Health, Feb. 14, 2019, https://www.realclearhealth.com/articles/2019/02/14/consumers_deserve_more_transparency_from_high_drug_prices_110867.html.

[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?"

market power that poses serious anti-competitive risks for consumers and which 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]

In addition, each PBM establishes a menu with 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 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

[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.
[7] Pharmacy Benefit Manager Institute, 2016, "Trends in Drug Benefit Design," p. 40.

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. In short, 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 the Robert Goldberg of the Center for Medicine in the Public Interest writes, "most of the increase in drug spending were rebates pocketed by PBMs."[9] This flow-thru problem was also recently highlighted in a report published by 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 as 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 the 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.

Maryland has already made important progress in curbing PBMs' anticompetitive practices. In 2018, Governor Hogan signed into law a prohibition on "gag clauses" which PBMs used to contractually prevent pharmacists from disclosing to patients when their copayment

[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.
[9] Ibid., p. 2.
[10] "Medicare Part D – Direct and Indirect Remuneration," Centers for Medicare & Medicaid Services, Jan. 19, 2017, https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-direct-and-indirect-remuneration-dir.

exceeds the retail cost of the drug.[11] The practice is called *clawbacks*, and it has been widely used by PBMs to increase drug costs for consumers.[12] Clawbacks illustrate that PBMs have incentives to keep prescription costs high, instead of working on behalf of the sponsors by lowering costs without sacrificing quality. By simply allowing pharmacists to inform consumers save money by paying cash and not by using their PBM plan, Maryland is providing much-needed transparency and helping consumers make more informed decisions at the pharmacy counter.

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

It should be clear who PBMs represent. According to estimates, PBMs failed to pass $120 billion back to consumers, and retained another $30 billion in additional out-of-pocket costs.[13] 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 recent years.[14] This comes in stark contrast with data from the Bureau of Economic Analysis showing that, across all industries, after-tax corporate profits did not increased in those same years.[15] As middlemen, PBMs are making money on all sides.

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[11] Richard Cauchi, "Prohibiting PBM 'Gag Clauses' that Restrict Pharmacists from Disclosing Price Options: Recent State Legislation 2016-2018," National Conference of State Legislatures, Dec. 1, 2018, http://www.ncsl.org/Portals/1/Documents/Health/Pharmacist_Gag_clauses-2018-14523.pdf.

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

[13] Jonathan Wilcox, "PBMs Must Put Patients First," *Huffington Post*, Feb. 28, 2017, http://www.huffingtonpost.com/entry/pbms-must-put-patients-first_us_58b60bd8e4b02f3f81e44dcc.

[14] Based on data from Yahoo Finance on Mar. 1, 2017.

[15] See www.bea.gov for after tax profits.

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.[16] Express Scripts (now merged with Medco), CVS Health (Caremark) and OptumRX (United Healthcare, now merged with Catamaran) account for 71% of 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. 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 consumer 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 (typically for lower-cost) for recurring business, thus entirely bypassing the pharmacy. In essence, 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, several studies have concluded

[16] 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, Oct. 21, 2015.
[17] "Market Share of the Top 5 Pharmacy Benefit Managers in the U.S. Prescription Market: 2017," Statistica, Downloaded Mar. 4, 2019, https://www.statista.com/statistics/239976/us-prescription-market-share-of-top-pharmacy-benefit-managers/.

that the PBM industry's conduct is "anti-competitive and, in some cases, plainly illegal conduct,"[18] and, for many years, calling for industry regulation.[19]

Summary and Recommendations: Need for Transparency

In summary, high market concentration provides PBMs substantial negotiating power in the marketplace and raises anti-competitive risks for Maryland consumers. Based on the industry's structure, conduct and performance, a market failure exists that calls for regulatory remedies to lessen PBMs' market power and increase market transparency.

After reviewing the principal-agent problem, market failures caused by asymmetric information, conflicts of interest, collusive pricing, spread pricing, price gouging, self-dealing, undisclosed rebates from manufacturers (including increases in manufacturer's rebates along with increases in invoice prices for beneficiaries), and establishing formularies that maximize PBM profits instead of minimizing beneficiary costs, the problem is clear. PBMs are major drivers of higher prescription drug prices for consumers in Maryland and around the country.

PBMs are virtually unregulated in what is an otherwise tightly regulated healthcare sector. To address market failures, limit anticompetitive risks and heighten market competition in the PBM market, 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] and
- In dealing with the flow-through of manufacturer discounts and rebates, a state

[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] Ibid., p. 111. Also see, Regina Sharlow Johnson, "PBMs: Ripe for Regulation," *Food and Drug Law Journal*, Vol. 57, 2002, pp. 323-369.
[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.

government agency should be given 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 flow-through should be made available to the public for each PBM, while safeguarding confidential information.

Several states have already implemented legislation that requires PBMs to report pricing and rebate information to promote transparency.[21] Maryland should do the same.

Bipartisan legislation pending before the Maryland General Assembly, S.B. 819, would enact several of these reforms and shine a light on Maryland's opaque PBM industry. The bill would significantly enhance transparency surrounding how PBMs operate, the profits they collect, and the extent to which their actions translate into lower costs for plan sponsors and beneficiaries.[22] Under the legislation, PBMs operating in Maryland would be required to:

- Publicly disclose their formulary, prior authorization, and cost-sharing information for every drug covered under the plan; and
- reveal what percentage of pharmacy payments are not passed on to plan sponsors or beneficiaries.

In addition, the Maryland Insurance Commissioner would annually publish a publicly-available report on manufacturers payments, administrative fees, and other financial information, while maintaining the confidentiality of disaggregated data. Instituting government-enforced audits would provide an increased level of transparency without imposing overly intrusive regulations, help hold PBMs accountable for anti-consumer tactics and incentivize quality service to beneficiaries and lower plan costs for sponsors. Sharing the aggregated flow-through estimate with the public would inform consumers and sponsors with the knowledge to make smart choices about their prescription plans.

[21] "Comparison of State Pharmacy Benefit Managers Laws," National Academy for State Health Policy, https://nashp.org/comparison-state-pharmacy-benefit-managers-laws/.
[22] "An Act Concerning Health Insurance – Pharmaceutical Manufacturers – Transparency and Reporting," General Assembly of Maryland, Feb. 4, 2019, http://mgaleg.maryland.gov/2019RS/bills/sb/sb0819f.pdf.

While this bill avoids onerous regulations, it provides the information necessary for the public, consumers, patients and plan sponsors to make better market decisions.[23] That, in term, should heighten market forces and put downward pressures on prices.

While greater transparency is essential, policymakers must resist the urge to impose government price controls on PBMs. A bill before the Maryland General Assembly, S.B. 759, would take the dangerous step of granting a bureaucratic board the authority to fix rates for certain pharmaceuticals, stifling market forces.[24] Economic theory, as well as historical experience, teach that price regulation is inefficient, causes shortages, and ultimately endangers patients' access to treatments.[25]

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.

[23] It is not unreasonable for the bill to include an amendment that would exempt smaller firms from these reporting requirements, as not to impose an unreasonable regulatory burden.
[24] "An Act Concerning Health – Prescription Drug Affordability Board," General Assembly of Maryland, Feb. 4, 2019, http://mgaleg.maryland.gov/2019RS/bills/sb/sb0759f.pdf.
[25] Edmund Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation, Mar. 8, 1993, https://www.heritage.org/health-care-reform/report/why-global-budgets-and-price-controls-will-not-curb-health-costs.