Memo

TO: All Attorneys

FROM: John Marren

SUBJECT: Pharmacy Benefit Managers “PBM”

DATE: July 10, 2023

CC:

The CAA requires plan sponsors to be “active fiduciaries” which requires plan sponsors to evaluate all consultants, advisors, and contractors regarding pricing issues, this includes PBMs. As this memo describes, there are serious problems in the PBM industry.

PBM ISSUES

1. PBMs dramatically inflate drug prices by demanding huge rebates from manufacturers in return for placement on insurers’ lists of covered medications known as formularies. Since 2006, when PBMs took a more active role, drug prices have increased by 313%. Annual rebates now exceed $200 billion, approaching half of the country’s prescription drug market.

2. PBMs also drive-up costs through their aggressive pricing with independent pharmacies. For instance, PBMs routinely engage in spread pricing, paying pharmacies far less than what they charge payers and pocketing the difference. One PBM paid an independent pharmacy in Iowa only $5.73 for a bottle of antipsychotic pills it billed $198.22 to the payer.

   In 2020, total gross expenditures for branded medications reached $517 billion. Manufacturers earned only 31% of this spending, while middlemen made 69%. One analysis concludes that $339 out of the $425 cost of a box of insulin pens is rebate dollars. PBMs and their pay-to-play rebate scheme explain why this 100-year-old medication remains unaffordable for so many. By excluding low-rebate drugs from formularies, PBMs also routinely prevent patients from accessing their needed medications. The three largest PBMs block over 1,150 treatments from formularies, including a low-cost insulin alternative called insulin glargine. Patients prescribed these drugs often must endure long waits, so-called step therapy (where insurers force patients to fail on formulary drugs first), and far higher expenses.
   https://www.washingtontimes.com/news/2022/oct/18/prescription-drug-pricing-reform-must-rein-in-phar/

3. In three areas: consolidation, rebate revenue, and transparency.
   a. Consolidation: There are now three large PBMs — CVS, Express Scripts, and UnitedHealth’s Optum — that account for over 70 percent of claims volume. A concentrated market share should allow pharmacy benefit managers to extract deeper concessions from manufacturers and the rest of the supply chain. But

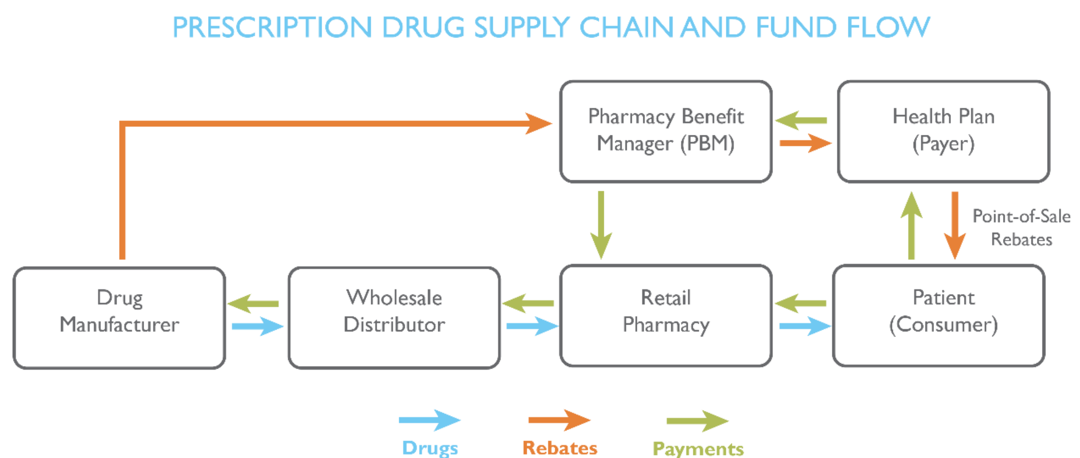
market power has made a flawed business model sticky, with payers finding few alternatives to the shared rebates.

b. Rebates: Many industries offer incentives for shared savings to align the interests of an intermediary and a buyer. And because payers do not know in advance which drugs and in what volumes they will need when signing a multiyear contract, a fixed-price contract is not realistic. However, rebates are now distorting incentives. Instead of placing the lowest-priced drug on the formulary and passing the savings to insurers, pharmacy benefit managers may simply supply the drug with the highest rebate. Pharma argues that rebates increase list prices. They also fail to lower premiums if they are not passed on to insurers. But rebates aren't the only cause of rising drug prices. For example, prices are high and increasing for drugs that don't offer rebates and in markets without rebates, such as Medicare Part B.

c. Transparency: The drug pricing world is shrouded in secrecy. Some economists argue that price discrimination — when no one knows what anyone else is paying — results in bigger discounts. This is similar to airline ticket pricing. Most travelers buy tickets without knowing what anyone else is paying for other seats on the same flight. Pharmacy benefit managers may get deeper discounts from drug manufacturers if the drug companies can keep the size of the discounts secret and not offer them to every other PBM. https://www.statnews.com/2018/08/27/pharmacy-benefit-managers-good-or-bad/

4. How do Rebates work: Drug manufacturers set prices and sell drugs to wholesalers, which then sell them to retail outlets, like a local pharmacy. Drug rebates refer to compensations provided by manufacturers to PBMs, typically negotiated between the buyer and payer (insurer or PBM). Rebates are typically provided by a manufacturer to a PBM, which in turn shares rebates with health insurance payers to help reduce the cost of specific drugs.

   a. The graphic below illustrates the web of payments and services, including rebates:



b. Rebate payments typically function as a lever of negotiation by manufacturers with PBMs to earn favorable placement on the payer's preferred drug list, or formulary, to increase the drug's market share. Rebates reduce the cost of drugs to the PBM or health plan. Public payers like Medicare and Medicaid use drug rebates to reduce the overall cost of providing coverage. However, how commercial payers use rebates is unclear. Rebate savings can be shared to reduce premiums, providing an indirect benefit to consumers and employers. But because rebate contracts are kept as trade secrets, the flow of savings and payments is difficult to track, leaving it unclear how rebates are used and to whose benefit. https://civhc.org/2022/05/15/plaintalk-blog-what-is-a-drug-rebate/#:~:text=Drug%20rebates%20refer%20to%20compensations,the%20cost%20of%20specific%20drugs.

5. State case describing the issues: *State of Ohio v. Ascent Health Services LLC, Express Scripts,* the complaint is illustrated by the summary below.

a. Like the importation of kudzu to stop soil erosion, the creation of the pharmacy benefit manager ("PBM") was a solution that has become the problem. Through industry consolidation, the PBM landscape is dominated by three big players - including Defendant Express Scripts, Inc. ("Express Scripts" or "ESI"). With this dominance, they have created a black box that holds a complex administration system that allows the PBMs, including Express Scripts, to enrich themselves in multiple ways. This is all at the expense of consumers and other industry participants.

b. These ways include a complex "pay to play" rebate system that, perversely, pushes manufacturers to *increase* drug prices in order to be placed on or receive preferred placement on **PBM** formularies. The costs of Express Scripts' supercompetitive profits have been pushed onto those with the least power - including individuals whose prescription costs are calculated at, or as a percentage of, those same rising list prices. To paraphrase President Reagan, the scariest words in the pharmaceutical industry have become "I'm the **PBM,** and I'm here to help."

c. At one point, "Big Pharma" was justly criticized for overpricing medications.

d. PBMs were created as a market response to that criticism. PBMs were introduced to negotiate drug prices on behalf of payors, or "Plan Sponsors," such as employers, and the individuals receiving the medications, the "insureds." This intermediary negotiator system worked until PBMs grew powerful enough to extract exorbitant fees - and they did so. The solution became the problem.

e. Through industry consolidation, major PBMs affiliated with, and often became owned by, large health insurers and pharmacies. Now, the three largest PBMs - including Defendant Express Scripts - control over 75 percent of the prescription drug market. The next three largest PBMs control the bulk of the rest. Because of the nature of this market, both drug buyers and sellers have

little choice but to play the game by the PBMs' rules, allowing PBMs to extract both monopoly profits from individuals and monopsony profits from the market. The individual drug buyer faces Hobson's choice of either buying medications through the insurer/PBM selected by their employer or paying an inflated "list" price. From the drug manufacturer's perspective, the insurer/PBM controls access to millions of covered lives. Pharmacies are often left not knowing whether they will book a profit or a loss on a transaction until long after they fill a prescription. The insurer/PBM controls it all.

f. Also in 2019, Express Scripts invited its putative competitor, Prime Therapeutics LLC ("Prime Therapeutics"), into Ascent's ownership. Express Scripts remains the majority and controlling owner of Ascent. Ascent's owners use it as a vehicle to share pricing, to the detriment of the other market participants, including individual purchasers of medications like insulin. Through Ascent, it is believed that Express Scripts, Prime Therapeutics, and Ascent customer Humana Pharmacy Solutions can share drug pricing and rebate information with one another and fix rebate prices among them. It is further believed that - contrary to their stated business purpose - Ascent, Express Scripts, and Prime negotiate with manufacturers biologics, and cancer-fighting drugs.

g. PBMs also use their market power to hurt competing pharmacies, and particularly independent pharmacies. To stay in insurance networks - and remain able to service patients with private insurance - pharmacies are often forced to accept drug reimbursement rates significantly below what the pharmacies must pay for those drugs. Little, if any, of these cost savings are passed on to the Plan Sponsors or covered individuals. Instead, those customers pay contracted rates, which generally exceed what the pharmacy is paid for the drug. The PBM then pockets the "spread" between the prices or diverts these funds to PBM-owned or affiliated pharmacies through so-called performance payments. Pharmacies in under-served areas or rural communities in Ohio, which often operate as a patient's first line of treatment, are struggling to stay in business due to these punishing price demands by the PBMs. PBMs with affiliated pharmacies - either brick-and- mortar or mail-order - further benefit by pushing customers away from their local pharmacies into one that the **PBM,** or a company related to the **PBM,** controls.

h. Defendants know that Ohioans needing medication, particularly life-saving medication, will pay the asking price. The choice is binary - pay or suffer. Defendants also know that because of the predominance of prescription insurance, pharmacies and manufacturers will agree to the pricing demands of large PBMs and GPOs to gain access to the lives that the latter entities control. Defendants have morbidly manipulated both sides of the market, demanding higher drug prices while negotiating larger fees from the manufacturers. Patients pay more, manufacturers get less, and the PBMs profit.

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