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How the secrecy of middlemen inflates drug prices

BY NEERAJ SOOD AND KAREN VAN NUYS, OPINION CONTRIBUTORS - 10/14/23 11:00 AM ET

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Most Americans believe drugs cost too much and big pharma is to blame. That powerful political sentiment undergirds Medicare's new authority to negotiate prices directly with manufacturers. The negotiations may result in lower revenues for pharma but will also imperil future drug development.

There is a better solution: Force transparency into the drug supply chain, unleashing market forces on middlemen whose hidden deals generate excessive profits. They contribute nothing to the development of new medicines yet soak billions of dollars from taxpayers, employers and patients.

As health policy researchers, we have seen how this plays out in secret. While drug spending based on manufacturers' list prices (which are public) more than doubled in the last decade, what manufacturers collected based on net prices (which are confidential) increased only 15 percent. In the insulin market, for example, the share of spending accruing to middlemen increased 155 percent over five years, while the share accruing to manufacturers decreased 33 percent.

Most people or organizations buying drugs, like self-insured employers, do not know how great the gap is between what they are paying and what drug makers receive. Research by our organization, USC's Schaeffer Center, shows that intermediaries in the system make higher profit margins than the average firm in the S&P 500 after accounting for the riskiness of investments in different industries.

Drug costs can be driven down if market forces are allowed to target those profits, but first everyone needs to know what is being charged, and by whom to whom. Policymakers also need that information to fully understand how the system is going astray.

The chief concealers are pharmacy benefit managers, large companies that sit astride the supply chain. They manage drug benefits for health insurers, employers, unions and government entities and contract with pharmacies to deliver the drugs to consumers.

Pharmacy benefit managers capture profits from each prescription by setting prices based on a fictitious benchmark rather than a fixed dollar amount. For example, the typical employer's contract with a pharmacy benefit manager does not say that a 30-day prescription of a drug will cost $5. Instead, it might guarantee a certain discount off a benchmark such as an average wholesale price (sometimes referred to as Ain't What's Paid) that can be manipulated.

As a result, employers do not know ahead of time what they will pay for the drugs they purchase on behalf of their workers and cannot judge whether the prices they are being offered are competitive. The pharmacy is also in the dark about precisely what compensation it will receive from the pharmacy

benefit manager. It is no surprise that given those conditions, consumers don't know what they will be charged to fill a new prescription.

Bipartisan bills from three committees in the House and two in the Senate aim to reform drug distribution in part by reining in the pharmacy benefit managers. To ensure market transparency, the final legislation should include a simple mandate for the government to collect actual transaction prices among insurance companies, pharmacy benefit managers and pharmacies, and then publish real benchmarks based on real prices.

For example, pharmacy benefit managers would have to report to the government the price they charge employers for each drug and the reimbursement they pay to pharmacies. Similarly, pharmacies would report the cost of acquiring the drugs from wholesalers and the reimbursement received from the pharmacy benefit manager. From these data, the government could calculate and publish averages based on true transaction prices for each drug across all sales at each transaction point.

Armed with that information, employers' contracts with pharmacy benefit managers could be based on real rather than fictitious price benchmarks. Employers could shop for a better deal by comparing prices in their pharmacy benefit manager contracts with published average prices received by other employers. Similarly, pharmacies could compare the reimbursements they are offered with the average across all pharmacies for filling the same script.

Real benchmarks could also be used to estimate gross profits for each segment of the supply chain; if margins are growing rapidly in one part, new competitors might be attracted to enter. If new entries did not materialize, the government could look for anticompetitive conduct by companies that dominate those segments.

Needless to say, pharmacy benefit managers oppose shining any light in their corner. They maintain that they need to protect their pricing from public disclosure to enable them to wrest discounts from manufacturers. Transparency, they contend, would undermine their negotiating leverage while opening the door to collusion among drug makers.

But that's not what has happened in Medicaid, the federal-state public health program for people with low incomes. In a useful precedent — and possible model for other pricing benchmarks — the government surveys pharmacies each week to determine National Average Drug Acquisition Costs, which are published and used to calculate Medicaid reimbursements to pharmacies. The result has helped ensure that fee-for-service Medicaid plans are getting fair prices for prescription drugs.

Congress can't count on price negotiations alone to get the job done for the American people on containing drug costs. Even if Medicare secures improved deals, middlemen will continue to siphon billions away unless their methods for doing so are addressed. Transparency is essential to allowing market forces to disinfect the supply chain and clean up the drug pricing mess.

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