Time To Lift the Curtain On PBM Wheeling and Dealing

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Robert Calandra

For all the money he spent on his MBA, Ted Okon says the best life lesson he ever received cost him $80. It came from a guy dealing Three Card Monte on a New York City street corner. He was up $40 but in no time lost that $40 plus $40 more. So what lesson did he learn?

“It showed me that you can’t win a rigged game,” says Okon, executive director of the not-for-profit Community Oncology Alliance. “And right now PBMs have a rigged game akin to that Three Card Monte where they basically control all the terms.”

The Community Oncology Alliance is among several groups fed up with the PBM industry’s infamously convoluted pricing schedules and contracts. It’s time, they say, for the industry to make its murky business practices Windex clear.

When it comes to drug costs, it’s a rigged game, says Ted Okon of the Community Oncology Alliance. “Right now PBMs have a rigged game ... [and] basically control all the terms.”

“We’d like to see a tone of more candidness and straightforward communication about what money is being spent for what and what value is being returned to patients and people who pay the bill so we can move past the sloganeering and finger pointing that we are seeing so much of now,” says David Lansky, president and CEO of the Pacific Business Group on Health, a 75-member, not-for-profit organization of medium and large private employers and public agencies.

But indignant calls for more PBM transparency are on a loop, according to Brian Henry, vice president of corporate communications for Express Scripts. They first happened decades ago and cycle around every so often. More telling than the message is its provenance, argues Henry.

“It is predominately pharma companies and pharmacies,” he says. “If we were transparent with them it has been shown many times over that they would use that information to actually raise prices, not lower them.”

Everyone needs to move past sloganeering and finger pointing in order to concentrate on cost transparency, says David Lansky, CEO of the Pacific Business Group on Health.

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True, pharmaceutical companies and pharmacists have pushed for transparency, and they are among the noisiest in the current hue and cry. But this time, they have plenty of company. Every sector of the health care economy that deals with prescription drugs—insurance plans, employers, doctors, state legislatures—want PBM pricing decoded.

The widespread agitation is fueling some bipartisan support for legislation that would force more openness about PBM discounts and pricing. In early March, Georgia Republican Rep. Doug Collins introduced HR 1316, the Prescription Drug Price Transparency Act, with Democrat Dave Loebsack of Iowa as a cosponsor.

A few weeks later, Oregon Sen. Ron Wyden, a Democrat, submitted C-Thru, the Creating Transparency to Have Drug Rebates Unlocked Bill. Co-sponsored by his fellow Democrats, Sens. Sherrod Brown of Ohio and Heidi Heitkamp of North Dakota, it hasn't garnered any Republican support so far.

"As dysfunctional as Washington is, as tough as it is to get anything moving, I think this is an issue that is bipartisan," says Okon, whose organization advocates for community oncology practices across the country. "There is a growing concern and awareness that this is out of hand."

Meanwhile, lawsuits against PBMs are also piling up. The website PBM Watch, a not-for-profit organization with the goal of educating consumers about issues surrounding PBMs, notes that in the past few years "numerous federal or multidistrict cases" have been filed against CVS Caremark, Express Scripts, Optum Rx, and Prime Therapeutics. According to the website, the lawsuits stem from a variety of issues including clawbacks of consumer copays; fraud; misrepresentation to plans, patients, and providers; unjust enrichment through secret kickback schemes, and failure to meet ethical and safety standards.

But it just isn't true that PBMs aren't transparent enough or are deliberately obfuscating so they can greedily stuff their pockets, pushes back Henry. Express Scripts' clients, he says, receive about 90% of rebate money. They can also demand an audit at any time of any aspect of their contract to ensure that Express Scripts is adhering to it chapter and verse.

What is true, he says, is that drug prices have increased significantly in recent years, so PBMs, as the prime negotiators with the manufacturers about price, have a larger role than they did five or 10 years ago. Nailing down exactly how much of the prescription and specialty drug market the big three PBMs control can be a bit slippery. But Okon estimates that CVS Caremark, Optum Rx, and Express Scripts control between 80% and 85% of the market.

"We are in a different position, and maybe a more important position, than we have ever been before," Henry says. "But that's because pharmacy costs have gone up and drug costs have gone up and you need us to drive it down."

Industry critics counter Henry, saying that as the PBM industry has grown, the major companies have constructed a complicated, secretive pricing system and cooked up contractual language so confusing that it would tie a linguist in knots. Transparency advocates want contracts simplified so they know exactly how much PBMs are receiving from administrative fees, discounts, rebates, and side deals, and how much of that money is passed on to their customers, insurers, and employers. It is the only way, they say, to assure that the interests of patients and employers are being protected.

"We don't have confidence that the system right now is treating patients and employers fairly," says Lansky. "We need our suppliers to give us that confidence with more transparency and clearer information flow among all the components."

One way to regain that confidence in PBMs, says Linda Cahn, founder of Pharmacy Benefit Consultants in Morristown, N.J., is for PBMs to become more transparent. Until that happens, clients will need consultants like Cahn to comb their existing PBM agreements to clean up their contracts. A long-term solution will require large insurers and employers to flex their market power muscle and demand changes. Or just maybe a new type of player will emerge, one that does things differently.

Swallowing bitter pills

There was a time when Okon believed that PBMs served a "valid purpose." Not anymore.

"PBMs now, in my book, are destructive and adversely impacting patient care and they are fueling specialty drug prices," he says.

The discernible edge in Okon's voice when he talks about the PBM industry was honed by reading documented cases from community oncology practices with a retail pharmacy or a dispensing facility where PBMs have switched dosages and swapped out drugs without consulting the patient's physician. In fact, COA has published two volumes of "horror stories" of PBMs getting in the way of patient care.

"These are real-life stories, they are verifiable, and the stories keep flowing in," he says. "You have an entity that gets in the way of a patient getting his medication, not facilitating it. That is absolutely, positively wrong."

In the past few years, Okon says, the number of specialty oral cancer drugs has risen dramatically. In turn, PBMs switched from charging a $3 to $5 fee per prescription at retail, to tacking on a percentage of up to 11% per prescription "Why can they do this?" asks Okon. "The answer is, because they can."

PBMs make money in several ways, starting with reimbursing a pharmacy slightly less than what it is paid by the insurer or employer that hired them to manage the group's pharmacy benefits. For example, an insurer or employer may pay $87 for a medication. The PBM may reimburse the pharmacy $85 and keep the $2 difference, which is called the spread.

But the PBM may have also negotiated a $15 rebate on that medication. Depending on the contract language, all or most of that rebate is supposed to be passed straight through to the insurer or employer. According to Henry, each Express Scripts client decides how much, if any rebate money, the PBM may keep. Most clients, he says, allow Express Scripts to take 10% or 11%.

Administrative fees are another way PBMs make money. Administrative fees can cover things like processing claims for clients, offering solutions to control specialty drug costs, managing adherence programs, and developing narrow networks.

But critics say that over time, all the terms and conditions governing the average wholesale price of a drug; how much of rebates, discounts, and coupons are passed through to the client; what constitutes an administrative fee,

and how side deals with manufacturers are reported have been relabeled or otherwise morphed to take on a different meaning. There seems to be no standard, agreed-upon language or definitions.

“One contract equals one contract,” Henry says. “It is not off the shelf. It is tailored to the needs of that client. We work with them to get the value that they realize and we are rewarded for bringing down those costs and realizing better outcomes.”

That’s not the way John Norton sees it. The public relations director for the National Community Pharmacist Association says his members are offered take-it-or-leave-it contracts where PBMs set the terms and conditions, including reimbursement levels, anytime audits, and monetary clawbacks. And if a small pharmacist doesn’t take it?

“We’ll go out of business because insured patients will pay more if they still use our pharmacies,” says Norton, whose members operate one and two stores located in population centers of 50,000 or less. “They can steer our own patients with chronic conditions or who use specialty drugs to their mail order pharmacies and we can’t do anything about it.”

Direct and indirect remuneration

Norton says his members would just like PBMs to address direct and indirect remuneration. It works like this: Say a pharmacist dispenses a prescription on September 1 and is reimbursed by the PBM later that week. Close the books, right? Not quite. During its quarterly reconciliation, the PBM can claw back more money from the pharmacist.

“You make a certain amount of money on that script, but a portion of that money is probably going to be taken away from you at a time of the PBM’s choosing,” Norton says.

Even the Pacific Business Group on Health, whose membership includes some Fortune 500 companies, feels it has little choice but to play by the industry’s rules because the three major PBMs pretty much follow the same business playbook and with seemingly little incentive to change.

Rather than concentrate on a drug manufacturer’s initial pricing decision, Lansky and Pacific Business Group focus on trying to identify the loopholes that allow costs to be tacked on between factory and patient. The actual prices paid by the plan sponsor are generally impossible to decipher because of rebates, discounts, and administrative fees loaded into the supply chain, including PBMs. One example is the recent disclosure about PBMs covering high-cost brand drugs instead of generics to get the rebate.

“The supply chain is an incredibly complex, layered system constructed so that one can’t really tell who is being paid what for what,” Lansky says. “The entire pipeline is acting in the dark and ultimately it is the employer or government payer and their beneficiaries who pay a higher price for all of this lack of clarity.”

And there are 15,000 drugs with various dosages, packaging, and pricing. The Pacific Business Group companies that have hired pharmacy expert consultants to go over their PBM contracts with the finest of fine-tooth combs have found that dollars are divvied up in a way that isn’t always in their best interest.

One example, Lansky says, is the use of coupons and copay assistance discounts to motivate patients to use a certain drug. The out-of-pocket costs for the patient may be lower because of the PBM but the drug may cost the insurer or employer more. Another hidden cost is the price for various doses on a formulary, says Lansky. The PBM should choose the dosage that brings the highest value to the plan sponsor and the patient.

“Consultants have pulled out example after example where the PBM has turned the formulary to its advantage and not to the customer’s advantage,” he says. “That creates a lack of confidence that the PBM or health plan is acting fully in your best interest.”

The key to finding out if your PBM is working in your best interest, Cahn says, is to ferret out the drug-by-drug rebate and the drug-by-drug total money collected and passed through data.

"With those two sets of information you can figure out if the PBM is acting in your interest or, instead, favoring certain drugs because the PBM is getting scads of money it's retaining and not passing through."

In a recent National Rx Coverage Coalition blog post, Cahn dissected a publicly available draft of a contract between Express Scripts and Genesee County, Mich., which is about 75 miles northwest of Detroit and includes the city of Flint. In her critique, Cahn noted that the contract fails to spell out what share of its rebates Express Scripts will pass on to the county. Cahn also quoted from a financial disclosure that Express Scripts attached to the draft contract that says Express Scripts "often pays an amount equal to all or a portion of the formulary rebates it receives to a client based on the client's PBM agreement terms.

"As a plan administrator or fiduciary, you need to find out whether your plan is receiving 'all' or 'a portion of' the formulary rebates that your PBM obtains from manufacturers," she wrote. And if you are only receiving a portion, she continued, you should determine how much you might otherwise save if your PBM passed through 100% of all formulary rebates. "It's something plan administrators need to be aware of," Cahn said in separate discussion with Managed Care.

Express Scripts also outlined a number of administrative services for which it receives payments in the financial disclosure documents, according to Cahn. Express Scripts' administrative fees in Genesee County's draft contract are "calculated based on the price of the rebate drug or supplies along with the volume of utilization and do not exceed the greater of (i) 4.58% of the average wholesale price (AWP), or (ii) 5.5% of the wholesale acquisition cost (WAC) of the products." As a result of that provision, Cahn wrote, when there is an increase in either the volume of the drug sold or the drug's price, Express Scripts' administrative fees will also likely increase.

"That's a lot of money," Cahn said, "and potentially a conflict of interest."

The Genesee County draft contract, according to the blog post, also stipulates that the money from all of the administrative services "are not part of the formulary rebates or the other manufacturer fees that it collects." The financial disclosure also clearly states that any other financial benefits Express Scripts collects from manufacturers —discounts for its subsidiary pharmacies, payments for selling data, running therapy adherence programs, providing drugs for clinical trials—it retains for itself.

Cahn calls this the "rebate relabeling game." The bottom line is if a PBM calls a payment a rebate, it will pass through all or some of the money to the client. But, she says, a "manufacturer administrative fee" or anything by another label goes straight into the PBM's pocket. In Cahn's opinion, "every client should insist that its PBM pass through 100% of all manufacturer benefits—and 100% of all other payments—that manufacturers pay to its PBM."

Legislative movement

Given the current environment in Washington, it's hard to predict the fate of the two pieces of pending legislation. The bill introduced by Wyden would require PBMs to publicly post aggregated data about rebates and discounts from manufacturers for medications that are part of Medicare Part D and Medicare Advantage plans. The bill would also disclose "spread pricing," which is the difference between payments PBMs make to pharmacies compared to payments PBMs receive from health plans.

The Collins bill would require PBMs to update their WAC lists for Medicare Part D, Tricare, and FEHBP every seven days. It outlines the appeals process for pharmacies to dispute reimbursements. The bill would also prevent PBM-owned pharmacies from sharing patient information and mandating patients use those pharmacies.

Lansky and PBGH would like PBMs to provide transparency about net-of-rebate and all other fee prices.

But Lansky and PBGH don't think the political environment is right to push for regulatory or statutory changes concerning PBM transparency. Instead, the group will continue to work with its partners in the supply chain,

including manufacturers and the PBM industry.

“We see our members, as buyers in the market, having a powerful market influence,” he says. “If they want to exert pressure on their current supplier and PBM, they can do that through contract renewal negotiations, including bringing in the right consultants to more closely scrutinize the contract and collaborating with stakeholders and with each other to test new and innovative approaches.”

Lansky thinks large employers will start to bring their market power to bear. He believes that large insurers and employers will begin to show more interest in smaller PBMs.

“The large PBMs have the obvious advantage of volume purchasing and being able to achieve favorable rebates and discounts,” he says. “The smaller PBMs may not have the best discounts but their models might mean more transparency and allow for employers and patients to keep more of the savings. Additionally, they might be more willing to innovate with employers in terms of formulary or benefit design. Purchasers are increasingly recognizing the need to look beyond rebates and focus on total cost of care instead.”

The National Community Pharmacist Association’s Norton says his group will continue advocating for changes in PBM contracts through state governments where they have had some success. At least 22 states have crafted a total of 39 laws that try to reign in PBMs. Proposed legislation will compel the industry to adhere to fair and uniform pharmacy audits to anti-mandatory mail order requirements.

“We have been able to get a lot of states to create more transparency when it comes to generic reimbursement,” he says. “The states are not as difficult, although when a PBM gets particularly concerned about how a law might impact them they go the legal route.”

Norton’s association has filed an amicus brief with the U.S. Eighth Circuit Court of Appeals in support of an Arkansas law being challenged by the Pharmaceutical Care Management Association, the PBM national association. If upheld, the law would require PBMs to be more transparent in determining generic prescription drug reimbursement to pharmacies.

The Community Oncology Alliance’s Okon, once a proponent of PBMs, says the big three have become a virtual monopoly and should be broken up. Smaller, more competitive PBMs, he says, would be more responsive and not block cancer patients from getting the medications they need. And he would end all back-end rebates—those that are not passed on to patients—in Medicare Part D to put an end to “this arbitrage game of list and net that the PBMs are playing.”

He’s “not jumping up and down” that a bill will pass, but he does expect Washington to weigh in with legislation possibly this fall.

“It’s easy to imagine a new entity could come into the market and blow up the existing PBM business model,” says pharmacy benefit consultant Linda Cahn.

Not going to happen, is Cahn’s take on a legislative remedy. The state laws, she says, are a “hodgepodge” that are “barely scratching the surface of the problem” or “sufficiently comprehensive” enough to have an impact. And the

idea of federal legislation relief is “very farfetched.”

Cahn is advising plans and employers stuck with a bad contract to file what is known as an accounting procedure. The procedure would allow the client to determine exactly how much money the PBM is collecting and not passing through. And then she pondered another possibility. “It’s easy to imagine a new entity could come into the market and blow up the existing PBM business model,” she says. “They could do it differently. A Walmart or Costco or Amazon could create an entirely transparent PBM.”

Robert Calandra, a regular contributor to Managed Care, is an independent journalist in Philadelphia with more than 20 years experience writing about health care.

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