NATIONAL CENTER FOR POLICY ANALYSIS

A Bogus Solution for High Drug Costs

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Most of the drugs Americans take are lower cost generics — accounting for about 88 percent of prescriptions. Generics are cheap because they are no longer protected by patents and different manufacturers compete on price. Yet, drugs whose patents have not yet expired can sometimes be very expensive; especially those recently approved and those derived from living substances. As a result, national spending on drug therapies increased by nearly one-quarter (23 percent) in the past two years.[1] Much of that increase is on expensive brand-name drugs and high-tech, specialty drugs — such as those used to treat cancer, hepatitis, rheumatoid arthritis and multiple sclerosis.

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Lately, a few politicians (and lobbyists for pharmacies and drug makers) have been attempting to divert some of the blame for high drug prices to the administrators of employee drug plans. They worry that pharmacy benefit managers (PBMs) mark up drug prices well above the PBMs' costs or fail to pass along manufacturers' drug rebates and other discounts to their clients (employers and insurers) and consumers with drug plans. The blame-shifters have suggested that employers and their workers could potentially benefit if PBMs were forced to disclose the (net) wholesale prices they paid for drugs.

Economists, the U.S. Federal Trade Commission (FTC) and even the actuarial consulting firm Milliman, Inc. are rather skeptical of this argument.[2] The FTC is responsible for preventing unfair or deceptive trade practices and unfair methods of competition. The agency has conducted numerous studies of the business practices of PBMs — including the effect of mandatory price transparency on competition. The FTC is concerned that mandating price disclosure will remove a bargaining tool used by some firms to compete with others. The FTC also worries the loss of proprietary pricing information could reduce aggressive bargaining or potentially encourage price collusion among manufacturers.

According to the FTC, "…harm may result if plan sponsors are denied the ability to choose the level of transparency that best suits them, within the context of their overall plan design."[3] This is because the market for drug plan managers (that is, PBMs) contains both large and small firms. Small firms often attempt to differentiate themselves by offering different pricing models.

Placing wholesale drug prices in the public domain would also violate the standard operating procedures that virtually all other competitive industries follow. [See the sidebar, "The Role of Price Transparency in Retail Competition."] Regardless of the industry, wholesale prices are often negotiated among private parties and are generally considered proprietary. For example, big box retailers pay lower wholesale prices than small, independent stores. If competing hardware stores knew the exact wholesale

prices Home Depot negotiated with suppliers, all competing stores would bargain aggressively for the same price. Over time, the likely result is that manufacturers would ultimately set one uniform wholesale price higher than the price volume purchasers would otherwise obtain. Highly competitive firms would no longer be able to leverage buying power and pass on discounted prices to consumers.

Moreover, just because Home Depot doesn't reveal what it paid for a piece of lumber does not mean consumers don't benefit from the lower wholesale prices it negotiates with suppliers. The reality is that mandatory wholesale price disclosures is unlikely to lower drug prices according to an opinion piece in the *New England Journal of Medicine*.[4] Indeed, many pharmacy owners seem to believe drugstores could charge higher prices if drug plans were required to reveal their wholesale prices.[5]

How Wholesale Drugs Are Sold. Drug makers have taken a lot of heat lately for the high prices of some of their newer drugs. They often counter that prices for many drugs are merely "list prices," sort of like the sticker price on new cars. The makers of brand-name drugs provide discounts off list price in the form of rebates that lower the final cost from 20 percent to 30 percent, on average. But the actual rebate varies from one drug to the next.[6] As is common in most markets, the wholesale price of a drug varies slightly from one purchaser to the next. For instance, General Motors benefits more from lower drug prices for its employee health plan than small employers with only 100 workers. This is true for brand drugs and, to a lesser extent, generic drugs.

How Drug Plans Help Make Drugs Affordable. Drug plans managed by PBMs use a variety of techniques to control costs for their clients and consumers.[7] With multiple clients, large national PBMs can negotiate lower prices from manufacturers, and therefore possess far more bargaining power than individual employers. They also negotiate with pharmacies and build preferred pharmacy networks. PBMs assist health plans to manage chronic diseases, to analyze the effectiveness of drugs and to track patient compliance.[8] PBMs also consult with health plan sponsors to determine which drug therapies to include in their formularies, and to encourage enrollees to use cost-effective alternatives.

PBMs must compete for the business of health plan sponsors (insurers and employers), who are their clients. When negotiating a mutually beneficial arrangement, it is up to plan sponsors to decide whether they want to capture rebates or allow their plan administrators to profit from each claim adjudicated. It is a competitive market; if one PBM is not willing to accommodate a potential client's needs, another will.[9] PBMs adapt their business model to the preferences of the client. Plan sponsors are free to negotiate whichever method suits them and meets their enrollees' needs. The following are some of the pricing strategies negotiated between PBMs and their clients.

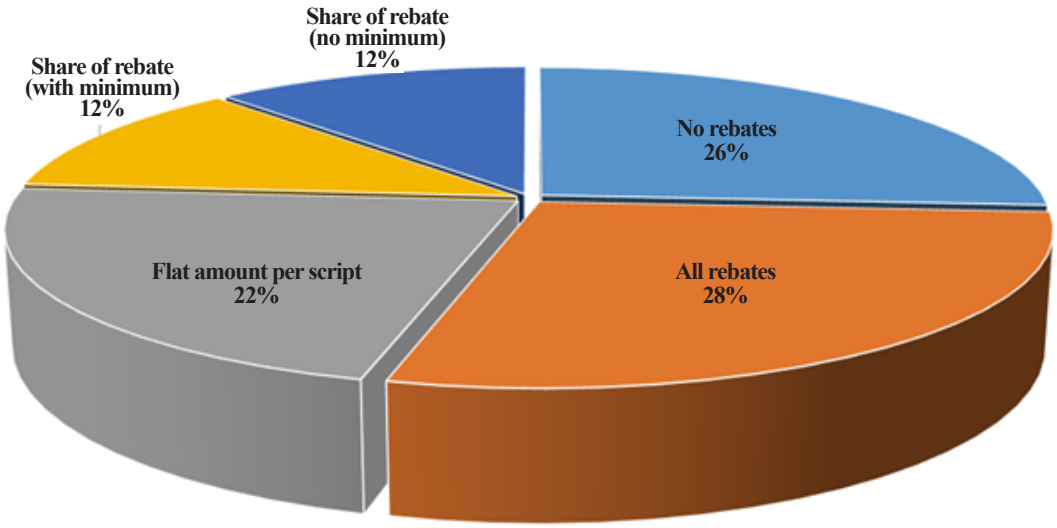
Pass-through Pricing. Some PBMs agree to surrender all manufacturers' drug rebates to their plan sponsor in return for a higher negotiated management fee. With *pass-through pricing* the PBM might agree to pass through all rebates, or an agreed upon portion thereof, to the plan sponsor. The amount of the fees are determined by the variety of services the PBM provides to the plan. According to a 2015 report, about one-fourth (26 percent) of employer plans received no share of the rebates;

The Role of Price Transparency in Retail Competition

In competitive wholesale markets, prices are often negotiated among parties and considered proprietary. The ability to secure lower wholesale prices is often considered a competitive advantage of a volume purchaser like a big box store.

By contrast, price transparency is a benefit to consumers in *retail markets*. Indeed, consumers engaging in comparison shopping often discover prices at retail pharmacies can vary from one drugstore to another. Consumers generally encounter few problems when calling a pharmacy to ask what a given drug will cost on their drug plan. It also pays to confirm the price in advance to prevent being charged more than your drug plan's contractual discount — which sometimes occurs.[10]

Figure I
Rebate Pass-Through Agreements
(Employer Plans 2015)



Note: Estimate is for (non-specialty) brand medications.

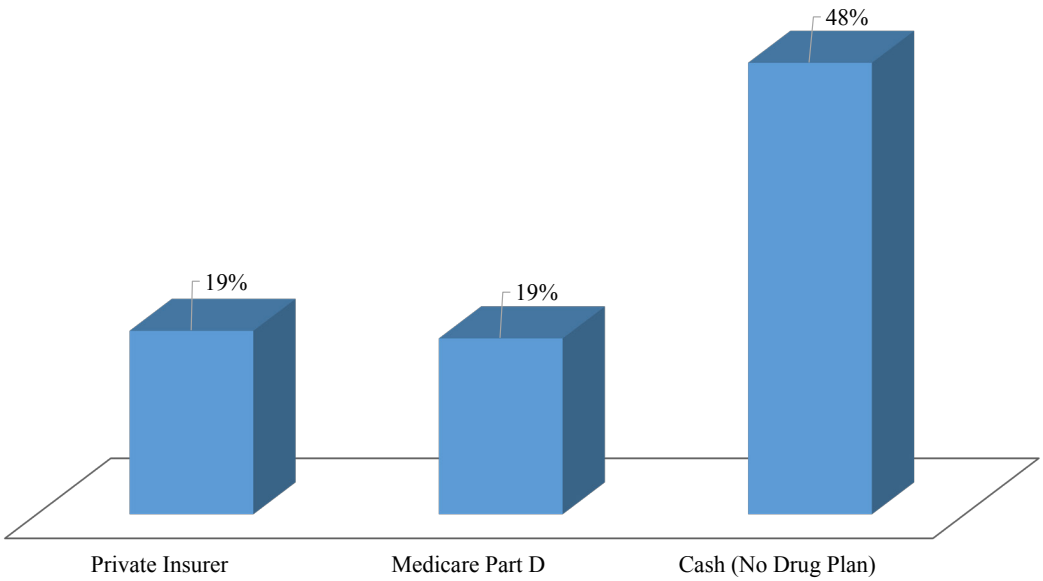
Source: Pembroke estimate based on "2015-2016 Prescription Drug Benefits Cost and Plan Design Report, "Pharmacy Benefit Management Institute, 2015.

presumably forgoing rebates to offset management fees. [See Figure I.] However, about three-fourths of employer plans share in the rebates negotiated by PBMs:[11]

- More than one-fourth (28 percent) received the entire rebate.
- More than one-in-five (22 percent) received a flat fee per script (worth about $24).
- About 12 percent received a share of the rebate with a guaranteed minimum.
- About 12 percent received a share of the rebate with no guaranteed minimum.

Spread-pricing. Some employer plan sponsors prefer to allow drug plan administrators to earn a small profit on each drug reimbursed and retain some of the rebates or other fees in return for lower management fees. This is known in industry parlance as *spread-pricing*. Spread-pricing is one way employers compensate PBMs for their management services. Under spread pricing, the administrator generally guarantees prices at a predetermined level and is at-risk for obtaining those prices. Depending on market conditions and contract terms, an administrator can either earn a profit or suffer a loss.[12] For example, when an employee or health plan enrollee fills a prescription, assume the PBM pays the pharmacy a negotiated rate of 84 percent of average wholesale price (AWP). The enrollee and his or her employer may have to reimburse the PBM 85 percent of AWP. In this example

Figure II
Gross Margins on Prescriptions
(Independent Drug Stores)



Source: Pembroke Consulting analysis of 2009 NCPA Digest. See Adam J. Fein, "Why do pharmacy owners care about PBM transparency?" Drug Channels (Pembroke Consulting), February 25, 2010.

the PBM retains 1 percent of AWP as profit (the spread).[13] Regardless of how the arrangement is negotiated, it is estimated that most drug rebates — maybe 90 percent — ultimately flow back to employer plan sponsors.[14]

Nearly three-fourths of large employers with more than 5,000 workers (71 percent) sign agreements stipulating pass-through pricing, compared to only 51 percent of firms with less than 5,000 workers. Smaller firms apparently prefer to use spread pricing as a way to compensate the firms that administer their prescription drug benefits.

An estimated 70 percent of Americans have drug benefits through an insurer or employee health plan. Relatively few patients are unable to afford their medications. When consumers walk into their neighborhood pharmacy, most can rely discounted prices negotiated on their behalf. As Figure II illustrates, profits on drugs sold to patients with drug plans are considerably lower than for consumers who have no drug coverage and must pay cash. [See Figure II.] Arguably, much of the reason has to do with drug plans and competition among drug plans administrators.

According to industry data, nearly one-fourth (23 percent) of retail prescriptions are fully covered by insurance and require no copayment by the patient. An additional one-third (34 percent) cost the patient $5 or less. And three-fourths (78.6 percent) cost the patient $10 or less.

Conclusion. In most cases, drug therapy is a great value. However, some drugs are expensive because they are new; others because they are breakthrough therapies.

Currently much of the benefit from manufacturers' rebates are passed on to employers, workers and consumers in the form of lower retail prices or lower premiums. Passing poorly thought-out regulations on drug plans will not lower what Americans pay for drugs, but could increase them by reducing the ways drug plan managers are allowed to compete for the business of managing health plans' drug costs.

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Notes

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2. Thomas D. Snook and Troy M. Filipek, "Pharmacy Benefit Management: Pros and Cons of Various Approaches," White Paper, Milliman, Inc., May 2012
3. Andrew I. Gavil, Martin S. Gaynor and Deborah Feinstein, Letter to the ERISA Advisory Council from Office of Policy Planning, U.S. Federal Trade Commission, August 19, 2014.
4. Ameet Sarpatwari, Jerry Avorn and Aaron S. Kesselheim, "State Initiatives to Control Medication Costs — Can Transparency Legislation Help?" *New England Journal of Medicine* Vol. 374, No. 24, June 16, 2016, pages 2,301-2,304.
5. Adam J. Fein, "Solving the Mystery of Employer-PBM Rebate Pass-Through," Drug Channels (Pembroke Consulting), January 14, 2016.
6. Matthew Herper, "Inside the Secret World of Drug Company Rebates," *Forbes*, May 10, 2012.
7. Thomas D. Snook and Troy M. Filipek, "Pharmacy Benefit Management: Pros and Cons of Various Approaches."
8. Thomas Gryta, "What Is a 'Pharmacy Benefit Manager'?" *Wall Street Journal*, July 21, 2011.
9. "PBM Purchasers Guide A Quality Management Toolkit Evaluating and Managing PBM Services," URAC and the National Business Group on Health, December 2008, page 21.
10. Marlene Cimons, "Watch your co-pays. Your pharmacy may be overcharging you," *Washington Post*, April 18, 2016.
11. Pembroke estimate based on "2015-2016 Prescription Drug Benefits Cost and Plan Design Report," Pharmacy Benefit Management Institute, 2015.
12. "PBM Purchasers Guide a Quality Management Toolkit Evaluating and Managing PBM Services," URAC and the National Business Group on Health, Executive Summary, December 2008, page 10.
13. Ibid., page 22.
14. Adam J. Fein, "Solving the Mystery of Employer-PBM Rebate Pass-Through," Drug Channels (Pembroke Consulting), January 14, 2016.