The Hidden Monopolies That Raise Drug Prices

How pharmacy benefit managers morphed from processors to predators

By David Dayen

March 28, 2017

This article appears in the Spring 2017 issue of The American Prospect *magazine.* ***Subscribe here.***

Rob Frankil of Sellersville, Pennsylvania, followed his father into the family business after college. "My entire life," he said, "I've been involved with managing and owning independent pharmacies." He now owns two stores, a traditional community pharmacy and another that caters to long-term care facilities.

Like any retail outlet, Frankil purchases inventory from a wholesale distributor and sells it to customers at a small markup. But unlike butchers or hardware store owners, pharmacists have no idea how much money they'll make on a sale until the moment they sell it. That's because the customer's co-pay doesn't cover the cost of the drug. Instead, a byzantine reimbursement process determines Frankil's fee.

"I get a prescription, type in the data, click send, and I'm told I'm getting a dollar or two," Frankil says. The system resembles the pull of a slot machine: Sometimes you win and sometimes you lose. "Pharmacies sell prescriptions at significant losses," he adds. "So what do I do? Fill the prescription and lose

money, or don't fill it and lose customers? These decisions happen every single day."

Frankil's troubles cannot be traced back to insurers or drug companies, the usual suspects that most people deem responsible for raising costs in the health-care system. He blames a collection of powerful corporations known as pharmacy benefit managers, or PBMs. If you have drug coverage as part of your health plan, you are likely to carry a card with the name of a PBM on it. These middlemen manage prescription drug benefits for health plans, contracting with drug manufacturers and pharmacies in a multi-sided market. Over the past 30 years, PBMs have evolved from paper-pushers to significant controllers of the drug pricing system, a black box understood by almost no one. Lack of transparency, unjustifiable fees, and massive market consolidations have made PBMs among the most profitable corporations you've never heard about.

Americans pay the highest health-care prices in the world, including the highest for drugs, medical devices, and other health-care services and products. Our fragmented system produces many opportunities for excessive charges. But one lesser-known reason for those high prices is the stranglehold that a few giant intermediaries have secured over distribution. The antitrust laws are supposed to provide protection against just this kind of concentrated economic power. But in one area after another in today's economy, federal antitrust authorities and the courts have failed to intervene. In this case, PBMs are sucking money out of the health-care system—and our wallets—with hardly any public awareness of what they are doing.

Even some Republicans criticize PBMs for pursuing profit at the public's expense. "They show no interest in playing fair, no interest in the end user," says Representative Doug Collins of Georgia, one of the industry's loudest critics. "They act as monopolistic terrorists on this market." Collins and a bipartisan group in Congress want to rein in the PBM industry, setting up a titanic battle between competing corporate interests. The question is whether President Donald Trump will join that effort to fulfill his frequent promises to bring down drug prices.

How the PBMs Take Your Money

PBMs were formed in the late 1960s, initially to help with claims processing. As insurance plans started to offer prescription drug benefits, PBMs filled out paperwork, making sure reimbursements were passed along to pharmacies. And for a while, they really did provide a service, as one of the first health-care players to fully computerize claims-processing. This made the system more efficient and enhanced the fledgling industry's credibility.

Over time, PBMs presented themselves as a cost-reducer. By aggregating customers of health-plan sponsors—insurance companies, big employers that self-insure, unions, state and federal employee plans, even Medicare and Medicaid—PBMs could form large patient networks, and negotiate discounts from both drug companies and pharmacies, which would have no choice but to contract with them to access the network. The savings would consequently pass through to plans and their patients. It sounded great.

This approach can work, when it truly represents what John Kenneth Galbraith termed countervailing power—when one large economic force counteracts another and prevents excessive advantage. But when one source of private power becomes the new monopolist, the idea backfires. A monopolist armed with state power and committed to serving the public interest—such as the VA's power to negotiate drug prices—is a very different story.

In the case of PBMs, their desire for larger patient networks created incentives for their own consolidation, promoting their market dominance as a means to attract customers. Today's "big three" PBMs—Express Scripts, CVS Caremark, and OptumRx, a division of large insurer UnitedHealth Group—control between 75 percent and 80 percent of the market, which translates into 180 million prescription drug customers. All three companies are listed in the top 22 of the Fortune 500, and as of 2013, a JPMorgan analyst estimated total PBM revenues at more than $250 billion.

The Pharmaceutical Care Management Association, the industry's lobbying group, claims that PBMs will save health plans $654 billion over the next decade. But we do know that PBMs haven't exactly arrested skyrocketing drug prices. According to data from the Centers for Medicare and Medicaid Services, between 1987 and 2014, expenditures on prescription drugs have jumped 1,100 percent. Numerous factors can explain that—increased volume of medications, more usage of brand-name drugs, price-gouging by drug companies. But PBM profit margins have been growing as well. For example, according to one report, Express Scripts' adjusted profit per prescription has increased 500 percent since 2003, and earnings per adjusted claim for the nation's largest PBM went from $3.87 in 2012 to $5.16 in 2016. That translates into billions of dollars skimmed into Express Scripts' coffers, coming not out of the pockets of big drug companies or insurers, but of the remaining independent retail druggists—and consumers.

Why haven't PBMs fulfilled their promise as a cost inhibitor? The biggest reason experts cite is an information advantage in the complex pharmaceutical supply chain. At a hearing last year about the EpiPen, a simple shot to relieve symptoms of food allergies, Heather Bresch, CEO of EpiPen manufacturer Mylan, released a chart claiming that more than half of the list price for the product ($334 out of the $608 for a two-pack) goes to other participants—insurers, wholesalers, retailers, or the PBM. But when asked by Republican Representative Buddy Carter of Georgia, the only pharmacist in Congress, how much the PBM receives, Bresch replied, "I don't specifically know the breakdown." Carter nodded his head and said, "Nor do I and I'm the pharmacist. ... That's the problem, nobody knows."

This lack of transparency enables PBMs to enjoy multiple hidden revenue streams from every other player. "It's OK to have intermediaries, we have Visa," says David Balto, an antitrust litigator and former top official with the Federal Trade Commission. "But these companies make a fabulous amount of money, even though they're not buying the drug, not producing the drug, not putting themselves at risk."

The PBM industry is rife with conflicts of interest and kickbacks. For example, PBMs secure rebates from drug companies as a condition of putting their

products on the formulary, the list of reimbursable drugs for their network. However, they are under no obligation to disclose those rebates to health plans, or pass them along. Sometimes PBMs call them something other than rebates, using semantics to hold onto the cash. Health plans have no way to obtain drug-by-drug cost information to know if they're getting the full discount.

Controlling the formulary gives PBMs a crucial point of leverage over the system. Express Scripts and CVS Caremark have used it to exclude hundreds of drugs, while preferring other therapeutic treatments. (This can result in patients getting locked out of their medications without an emergency exemption.) And there are indications that PBMs place drugs on their formularies based on how high a rebate they obtain, rather than the lowest cost or what is most effective for the patient.

"Let's say there are two drugs in the same therapeutic category—one for $500 and one for $350," says Linda Cahn, an attorney and founder of Pharmacy Benefit Consultants, which helps health plans negotiate contracts with PBMs. "Which manufacturer can promise more rebates? Obviously the one with the $500 drug." And because drug companies establish their own prices, they can use a higher ceiling to give more in rebates to get on PBM formularies. This practice creates incentives for drug manufacturers to raise prices, and if the PBMs keep the rebates, the health plan pays more. Even if the rebates offset the list price, they are used to determine patient co-pays, so the consumer feels the burden from an increase in price that might otherwise never have taken place.

Indeed, the very existence of consultants such as Cahn suggests another cost driver. PBMs themselves are intended to save costs. But now, PBM abuses require additional layers of consultants to limit mischief.

The Justice Department has fined
Medco and Express Scripts for receiving kickbacks from manufacturers to steer patients to higher-cost products, a process known as drug switching. "Look at a drug like [acid reflux medication] Nexium," says Susan Hayes, an industry consultant with Pharmacy Outcomes Specialists, a firm that audits PBMs and negotiates for health plans. "[PBMs] allowed it to stay as a covered drug, even though there was an over-the-counter pill available. They preferred a brand name over an OTC that was 1/100th the cost." AstraZeneca admitted in 2015 to giving kickbacks to PBMs to keep Nexium in their formularies, paying the government $7.9 million.

Additionally, *The Columbus Dispatch* explained last October how, in some cases, a consumer's co-pay costs more than the price of the drug outside the health plan. But the pharmacy is barred from informing the patients because of clauses in their PBM contracts; they can only provide the information when asked. The excess co-pay goes back to the PBM.

Game-playing with brand-name drugs pales in comparison to more profitable schemes for generics, which represent the vast majority of filled prescriptions (though they account for only about half of the revenues, since brand-name drugs are so much more expensive). PBMs reimburse pharmacies for generics based on a schedule called the maximum allowable cost (MAC). But the actual number is hidden until the point of sale. "The contracts are written in the form of algorithms," says Lynn Quincy, director of the Healthcare Value Hub for Consumers Union. "It's not a list of drugs with a price next to it. Nobody knows what they're up to."

The MAC list that goes to the pharmacy does not necessarily match the one for the health plan. By charging the plan sponsor more than they pay the pharmacy in a reimbursement, PBMs can make anywhere from $5 to $200 per prescription, without either player in the chain knowing. While some spread pricing can be expected, the opacity of the profit stream masks the allegedly low costs PBMs tout to health plans to get them to sign up.

Marketplace conditions frequently change, which can result in large spikes in the prices of generic drugs. But in what can only be described as deliberate

laziness, the PBM often does not respond by altering the price on their MAC list, pocketing an even bigger spread. Pharmacies can lose hundreds of dollars on a generic prescription overnight. They can appeal to the PBM for paying a below-cost reimbursement, but pharmacists say those are routinely denied, and almost never retroactively reimbursed. "One of my colleagues said if you went on *Shark Tank* and proposed this idea they'd laugh at you," says pharmacist Frankil. "They underpay you and you can't do anything about it? It's insane."

PBMs can also charge pharmacies additional fees months after a sale. Direct and indirect remuneration (DIR) fees were originally conceived as a way for Medicare to discover the true net cost of the drugs Medicare beneficiaries purchased through Part D, by forcing disclosure of all rebates from drug manufacturers. But PBMs secured a key loophole keeping their disclosures to the federal government confidential, while arguing that DIRs also legally apply to pharmacies.

In theory, DIR fees deliver higher reimbursement rates to pharmacies that display better performance. But, as Frankil explains, druggists have little control over the outcomes that affect reimbursement. Pharmacies get rated partly on whether their customers stay on their medications. "I can't stop by your house and say take your pill every day," Frankil says. "We have strategies, but we're at the mercy of the customers." Another rating involves ensuring diabetics take medications to modulate their blood pressure, meaning Frankil has to call doctors to get them to prescribe the drugs. "Can you imagine how that call goes? The doctor says, 'Are you the doctor?'"

Lower performance ratings result in higher DIR fees, which the PBM takes out of pharmacies' reimbursement checks every quarter. A recent report from the Community Oncology Alliance estimates that DIR fees can amount to as high as a 9 percent tax on gross revenues, which cuts pharmacy profits by up to 50 percent on a single prescription. Uncertainty over the size of DIR fees means pharmacies cannot assess their profit margins. "It's impossible to operate a business when you don't know when the other shoe is going to drop," says John Norton of the National Community Pharmacists Association (NCPA), which represents 22,000 independent pharmacies.

The PBMs' use of these fees also harms patients and taxpayers. Consumers pay co-pays or deductibles for drugs based on the list price, without DIR fees or rebates that would lower them. And retroactive DIR fees are routinely not reported to Medicare, as PBMs call them "network variable rates" or "pharmacy performance payments" and keep them for themselves. Obscuring DIR fees makes the net costs of drugs look higher to Medicare than they actually are. As a result, patients hit the "donut hole" coverage gap in Medicare Part D faster, forcing them to pay the full cost of their drugs. And it accelerates high-usage patients into catastrophic coverage faster as well, where Medicare pays 80 percent of all costs. All of this leaves subscribers and Medicare, i.e. the taxpayers, to pay more out of pocket, as the Center for Medicare and Medicaid Services noted in a January report.

The question begging to be asked is why all the players in the market—plan sponsors, drug companies, and pharmacies—put up with a middleman that extracts profits from all of them? And the answer is the failure of federal antitrust policy.

The Abuses that Antitrust Missed

The first time PBMs tried to integrate with another part of the drug supply chain, the government took notice. A series of mergers in the 1990s put drug manufacturers Merck, Eli Lilly, and SmithKline Beecham in control of the most powerful PBMs. The drug companies could then view competitors' pricing information and place their own drugs over their rivals' on PBM formularies. "That raised eyebrows," says attorney Linda Cahn. "It's such a conflict of interest. Obviously, the PBMs were unlikely to negotiate aggressive terms with their manufacturer parent companies."

In 1997, Cahn filed class-action lawsuits against the two largest PBMs in America, Medco (then in the hands of Merck) and PCS Health Systems (part of Eli Lilly), for breaching their fiduciary duty to employee health plans and increasing drug costs. The high-profile cases motivated the Federal Trade Commission (FTC) to crack down on the PBM/drug company alliance. After a

series of settlements that removed the benefits of the vertical integration by requiring decisions on drug formularies to be delegated to an independent third party, Lilly, SmithKline, and Merck all sold their PBMs.

But although the antitrust laws initially worked, PBMs kept consolidating, insisting that gaining market share would produce benefits for consumers. And this time, the FTC kept their hands off. SmithKline sold their PBM, Diversified Pharmaceutical Services, to Express Scripts in 1999. PCS got bought by Advance Paradigm in 2000, and the new company became part of Caremark in 2003. And then, Caremark found a buyer in 2007—CVS, one of the nation's largest pharmacy chains. The Bush-era FTC barely blinked at this vertical combination of PBM and pharmacy.

"That was the first unholy union," says consultant Susan Hayes. Caremark steered its giant patient network toward CVS stores, through lower co-pays or out-of-network bans. They also got to see all the information in CVS's other PBM deals, using the data to underprice rivals. CVS prescription revenue from Caremark plans nearly tripled in the seven years after the merger.

Other PBMs got the message. They started their own specialty and mail-order pharmacies, mirroring the CVS Caremark model. And they consolidated as well. In 2012, Express Scripts and Medco, two of the three largest PBMs, announced a $29 billion merger. Julie Brill was one of five FTC commissioners at the time. "I said, 'I need to understand the competitive justification,'" Brill says. "'My understanding from your papers is you don't need to get any bigger.' And they said, 'That's right. We're not making the argument that this merger is necessary to allow us to gain efficiencies of scale.'"

But despite the lack of justification for the consolidation, the danger of higher prices, and the unusually large congressional opposition, the FTC approved the merger. Brill was the only dissenting vote. "I thought it was wishful thinking and not smart economic analysis," she says.

Three years later, Optum gobbled up Catamaran, creating the current situation where three firms control 80 percent of the market. Brill adds that the Big Three carve up the market geographically, effectively not competing in certain regions of the country. Amid such concentration, plan sponsors have

little ability to select the best PBM on price or quality. "I just sat down with [one of the Big Three PBMs], I had half a billion dollars on the table," says Susan Hayes. "They said, 'Where are you going to compromise?' Really? Where else do I bring half a billion and they say where will you compromise?"

With such monopolized control, PBMs offer pharmacies take-it-or-leave-it contracts, with no opportunity to negotiate. These contracts employ punitive terms, including allowing the PBM to audit pharmacies, allegedly to ferret out waste, fraud, and abuse. "Minor technicalities are used to extract money," says Susan Pilch, vice president of policy and regulatory affairs for the NCPA. "There are examples where you were supposed to initial on the bottom right of prescription, not the bottom left. The PBM recouped all claims on that."

Besides being a business partner, the PBM is also a competitor that can use all the pharmacy's data against it. PBMs set up "preferred pharmacy networks" that give patients lower co-pays for using particular locations. Last year, 85 percent of all Medicare Part D plans used preferred networks, which often benefit large pharmacy chains that can afford to make deals for network access, like CVS Caremark. Specialty pharmacies report being frozen out by Express Scripts and other PBMs, with customers granted access only to its in-house specialty provider, Accredo. This practice has led to seven specialty pharmacy lawsuits against PBMs in the last year.

PBMs also aggressively steer patients to their mail-order pharmacies. Customers get constant solicitations by phone or mail, enticing them to use "Amazon-style home delivery," offering lower co-pays or larger supplies per order. "They take a customer list and solicit the customers while they're purchasing a prescription," says Representative Doug Collins. This persistent poaching has worked; a 2017 report from Drug Channels Institute found that PBM-owned pharmacies represented 46 percent of the industry's revenue growth last year.

Though PBMs challenge pharmacies to maintain customer compliance with prescription drugs, steering customers to mail-order pharmacies where they get no direction or personal contact can produce the opposite result. A 2013 study on patient adherence found that "personal connection with a pharmacy

or pharmacy staff" was one of the most important variables for taking medications.

In addition, mail-order pharmacies often auto-ship drug shipments before patients run out, and on a chronic prescription, the drugs pile up. The NCPA has documented dozens of examples of pill waste, disposed after a patients' death or when their doctor discontinues the treatment. People have brought in tens of thousands of dollars in unused meds, which often must be thrown away. That unnecessarily jacks up health-care costs, but the PBM profits on each pill shipped through its pharmacies.

Other pharmacies have little recourse to fight back. PBM contracts frequently contain gag orders, preventing them from talking to local elected officials or disclosing the terms of the contract. Pharmacists complain of being threatened for mailing or delivering drugs to local patients, which would compete with PBM mail-order operations. The combined toll makes it difficult for independent pharmacies to stay in business. "This takes away a medical provider patients have used for years," said Representative Buddy Carter. "I've had grandparents come to my store in tears and say 'I can't come here anymore.'"

Mergers Beget More Mergers

Chain stores have turned to defensive consolidation to stay in the game. In October 2015, Walgreens and Rite Aid, two of the three largest drugstore chains (CVS is the other), announced plans to merge. Walgreens has explicitly said that acquiring a handful of PBMs bundled inside Rite Aid will enable them to better compete with CVS Caremark. "It's the same story we've seen in so many industries, companies justifying their marriage on the basis of another company in the market with lots of power. It's an arms race," says Stacy Mitchell of the Institute for Local Self-Reliance. In the wake of the announcement, Walgreens inked lucrative new partnerships with Express Scripts and Optum, CVS Caremark's biggest rivals. The merger deal remains under review by the FTC.