



POLICY & ACTION FROM
CONSUMER REPORTS

Written Testimony of

Lynn Quincy

Associate Director for Health Reform Policy

Pharmacy Benefit Managers:
Strategies To Increase Their Value For Consumers

Submitted to

the U.S. Department of Labor,
Advisory Council on Employee Welfare and Pension Benefit Plans
June 12, 2014

Introduction

Consumers Union, the policy and advocacy arm of *Consumer Reports*,¹ appreciates this opportunity to provide testimony on the topic of Pharmacy Benefit Managers – also known as “PBMs.”

Consumer Reports is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. A core service we provide is to guide consumers to the best value when purchasing a wide range of products and services, including a program dedicated to identifying value in prescription drugs. In 2004, we launched *Consumer Reports Best Buy Drugs*. This program uses evidence-based systematic reviews of prescription drugs to clearly demonstrate the efficacy and safety in over 30 categories of commonly used medicines.²

As we discuss below, PBMs could better protect consumers’ and employers’ interests by improving the transparency of their business practices, thus allowing plan sponsors to ensure that prescription drugs are fairly priced and formulary designs reflect appropriate safety, efficacy and value considerations.

Approximately 10 percent of our nation’s health spending is for outpatient prescription drugs³ and clear, transparent information about clinical effectiveness and pricing are paramount in ensuring that we spend this money wisely. But, as detailed below, the opaque business practices that are commonplace in the PBM industry can result in unfair arrangements between employers and PBMs. Lacking a ready ability to audit these business practices, the arrangements can drive up costs for both employers and consumers, and has the potential to put the wrong prescription drugs into consumers’ hands.

¹ Founded in 1936, *Consumer Reports* is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. *Consumer Reports* has over 8 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace. This division employs a dedicated staff of policy analysts, lobbyists, grassroots organizers, and outreach specialists who work with the organization’s more than 1million online activists to change legislation and the marketplace in favor of the consumer interest.

² <http://www.consumerreports.org/health/best-buy-drugs/index.htm>

³ [http://www.cdc.gov/nchs/data/13.pdf#112](http://www.cdc.gov/nchs/data/hus/13.pdf#112)

Lack of Transparency in PBMs

Pharmacy Benefit Managers administer prescription drug benefits for more than 215 million Americans.⁴

The PBM industry has done several things to streamline and modernized pharmacy management. They've helped propel the shift to generic drugs, encouraged the use of "step therapy," introduced techniques to improving medication adherence, and brought focus to safer use of drugs through monitoring of drug interactions and dosage reviews.

On the other hand, the PBM industry has come under fire for certain practices, including:

- (1) using opaque rebates schemes to generate revenues;
- (2) using opaque pricing spreads to generate revenues;
- (3) formulary designs and drug switching driven by PBM profits; and
- (4) mail order prescriptions that utilize these practices.

Concern about these practices has resulted in litigation, anti-trust complaints, and calls for reform.⁵ In response, more than 20 states have either passed or have laws pending that attempt to regulate aspects of the industry, though these laws generally are limited in scope.⁶ However, many of the PBM contracts are not subject to state law because most health benefits plans offered by self-funded employers are exempted from state regulation under ERISA.⁷

Speaking to this issue, the ERISA Advisory Council is examining the need for and potential scope of compensation and fee disclosures by PBMs under ERISA section 408(b)(2). This provision requires administrators to ensure that arrangements with their service providers are "reasonable" and that only "reasonable" compensation is paid for services.

As consumer advocates, we consider this the correct and proper role for a plan administrator, even if it were not enshrined in law.

⁴ Pharmacy Benefit Manager (PBMs): *Generating Savings for Plan Sponsors and Consumers*, Visante, September 2011, 3. Available at:

<http://pcmanet.org/images/stories/uploads/2011/Sept2011/pbms%20savings%20study%202011%20final.pdf>

⁵ Mark Meador. "Squeezing the Middleman: Ending Underhanded Dealing in the Pharmacy Benefit Management Industry through Regulation," *20 Annals of Health Law*, 77 (2011)

⁶ State Regulation of Pharmacy Benefit Management, www.truthrx.org.

http://www.approx.com/media/documents/PUTT_State%20Regulations_061713a.pdf

⁷ The Employee Retirement Income Security Act of 1974, or ERISA, establishes employee protections that apply to private employers that offer employer-sponsored health insurance coverage and other benefit plans to employees. ERISA does not require employers to offer plans; it only sets rules for benefits that an employer chooses to offer.

As detailed below, today's complex and opaque contract arrangements and pricing spreads increase costs to employers and health plan enrollees, and can lead to formulary designs that inappropriately incentivize consumers toward or away from certain medication choices.

At the most basic level, completely accessible and transparent disclosures about PBM pricing practices are needed so employers can ensure that drugs are priced fairly and that the financial incentives facing consumers correctly reflect the clinical safety and effectiveness of the drug.

Rebates

A rebate in the context of PBM practices is an “incentive” payment made by a drug manufacturer to the PBM based on how much the PBM increases the market share or sales of a drug. Rebate arrangements vary widely and PBMs may not be obligated to share with clients the details of its rebate arrangements.

For example, one industry analyst estimates that more than 80% of rebates are passed on to employers.⁸ From that, we conclude that the remaining 20% of rebates may never be passed on. Even if rebates are partly or wholly passed on, PBMs may also be paid rebate administrative fees by a drug manufacturer. These rebate administrative fees are typically not disclosed, or passed on.

Rebates based on volume metrics effectively can undermine PBM's role as an intermediary working on behalf of employers and other health plan sponsors to negotiate lower costs, especially when PBMs obscure the actual net costs of the drugs to an employer. Lucrative rebate deals may encourage the placement of more expensive drugs onto a formulary. In some cases, it is possible that, unbeknownst to the employer, a PBM pockets the rebate, while sticking the full cost for the more expensive choice to the employer. As discussed further below, if these considerations affect formulary design, they undermine a consumer and their physician's choice of drug based on the best evidence available, and the clinical needs of each individual patient.

For example, formularies that place the popular, brand-name heartburn drug, Nexium on its preferred-brand list may incentivize consumers toward using that drug because the PBM has negotiated a rebate deal with a manufacturer. We estimate a month's supply of 20-mg of Nexium might have a total cost (health plan plus consumer's cost-share) of about \$240. But another drug, equally safe and effective and in the same class as Nexium, is an over-the-counter generic called omeprazole. A similar quantity of this drug could be bought for just \$17 or less, no prescription needed.⁹

In a perfect world, rebates based on prescription volume metrics should be eliminated.

⁸ Adam J. Fein, Pembroke Consulting. January 2014. 2013-14 *Economic Report on Retail, Mail and Specialty Pharmacies*

⁹ See “Got heartburn? The best treatment for you” Consumer Reports Online, March 2014 available at: <http://www.consumerreports.org/cro/2014/03/find-the-best-heartburn-treatments/index.htm>

We believe there's no way to structure rebates that does not essentially constitute a form of kickback. In the intermediate term, we recommend strengthening transparency requirements so that the net cost that the PBM pays, after all rebates are factored in, is made available to employers.

Pricing Spreads

Audits and industry analysts have found some PBMs pocketing 50 percent or more of the price difference between what the PBM actually pays a pharmacy for prescriptions and what they charge their clients – the employer/consumer.¹⁰ This pricing difference is known as the “spread.” And to do this, the PBMs often anchor what the employer is charged use a pricing reference list such as the Manufacturers’ Average Cost list, or “MAC.”

Unlike volume-discounts or rebates, which may be shared with employers/consumers, employers and consumers do not typically share in any part of the price spread or “hidden mark-up” revenue mechanism. Moreover, this pricing scheme adds another layer of complexity in an already complex chain of supply, distribution, and pricing. Thus, even in rare cases where full transparency around spread pricing is written into a PBM-employer contract, it can be difficult, if not impossible, for the employer to police.

Some savvy employers have begun to prohibit hidden pricing spreads in their contracts with PBMs. Following the lead of the Medicare program in 2009, many have adopted straightforward “pass-through” pricing wherein the PBM fully discloses the actual price it pays the pharmacy. It then either passes the discount on to the employer, charging a transaction fee instead, or shares an agreed upon proportion of the transparent price spread. All things considered, we find this fee-based mechanism to be preferable. It is simpler, easier to administer, and less vulnerable to manipulation and gamesmanship. It also promotes competition among PBMs by allowing employers to more easily compare drug prices against those from other plans.

The profits connected to spread pricing may give PBMs a financial motivation to favor and push the consumption of generics, but this is not a compelling reason to support this mechanism. Spread pricing is too open to PBM manipulation and too difficult for employers and others to monitor. We could find no credible evidence that the size or amount of hidden PBM pricing spreads increases the rate of generic prescription use. Further, the underlying cost of generics are already a fraction (often 10% or less) of the cost of brand name drugs, creating a strong incentive for their use. Generic pricing should adhere as closely as possible to this underlying cost to manufacture and those savings should be passed directly to consumers.

¹⁰ Meador, *op. cit.*

Formulary Design And Drug Switching

Formulary design is an essential component of pharmacy management. Formularies can be successful at compelling doctors and consumers to choose effective, less expensive medicines. However, when formulary design is used to amplify the benefits to the PBM of rebate concealment and spread pricing profits, it ill serves plan sponsors and consumers.

Drug switching is a practice where the doctor prescribes one drug for a patient, but the PBM uses “therapeutic substitution” and changes the prescription to a different drug it believes to be of similar therapeutic value. When structured appropriately, PBM intervention in this process can serve the dual purpose of saving money and ensuring that consumers get an effective and safe medication for their treatment.

However, drug switching can also be motivated by pure financial incentive on the PBMs’ part—either through manufacture rebates, spread pricing, or targeted discounts. In 2006, for example, Medco paid \$163 million to settle federal charges that it defrauded customers by shorting, changing and canceling their prescriptions. In a three-month period, Medco had persuaded doctors to switch more than 71,000 prescriptions from Lipitor, made by Pfizer, to Zocor, a more costly drug from Merck (then Medco’s owner).¹¹

Formulary design must be fully transparent to the health plan sponsor. Assignment to formulary tiers, as well as the rules for therapeutic substitution must reflect the best evidence regarding clinical effectiveness and safety, followed by the fully transparent bottom line cost reflecting all rebates, other fees, and the actual price pharmacies are paid for generics. Conversely, PBM revenue or profits on a drug should have no role in formulary design.

Mail Order Services

When properly designed and offered as a choice for consumers, not as a mandatory measure, a PBM’s mail order delivery option may provide consumers with cost savings, convenience, and potentially improved medication compliance.

However, it is critical to employers and consumers that PBMs not use mail order services as a vehicle for further opaque drug switching driven by rebates or generic spread pricing. Our main concern, as identified by industry analysts, is that PBMs that provide their own mail order services have the opportunity to both set the price of a drug using a different reference pricing or MAC list than they do with retail pharmacies, and also then determine how much they will charge the employer. Employers are likely to be unaware of this pricing mechanism, or that two reference price lists may be used to determine how much it will pay for an employee’s medications. For example, one recent

¹¹ “PBM Fiduciary Duty and Transparency,” Prescription Policy Choices, www.policychoices.org.

survey of employers found that a quarter of them said they did not know what pricing mechanism was in place for mail order services provided by their PBMs.¹²

These and other issues have already prompted several states to pass legislation to regulate aspects of pharmacy mail order.¹³ Transparency around mail order services is an important part of any effort to make PBM practices thoroughly known to employers, other plan sponsors, and consumers.

Conclusion

As currently structured, the highly convoluted drug supply and pricing chain offers too many opportunities for deception by PBMs and may be raising costs for consumers.

As an indication of how substantial price spreads and rebates can be, in 2009 the U.S. Military's health care provider, TRICARE, estimated it could save more than \$1.7 billion dollars by negotiating its own pharmacy benefits instead of using a PBM for its nine million covered lives.¹⁴

But it is often the case that buyers lack the tools to discipline PBM profiteering because they do not know the extent to which it is practiced. In most cases, plan sponsors do not have access to PBM rebate agreements and other contract terms.

Consumer Union supports reform of the system to allow purchasers, government, and consumer watchdog organizations to better monitor prevailing, average, and actual pricing so there is alternative access to pricing information by which to judge the effectiveness of PBMs in negotiating good net prices for prescriptions.

Hence, we support two action items for the Council:

ONE: Removal of the exemption for employee welfare benefit plans in 408(b)(2) ERISA Final Regulation; and,

TWO: inclusion of PBMs as a covered service provider (CSP) in the same.

¹² Pharmacy Benefit Manager (PBMs): *Generating Savings for Plan Sponsors and Consumers*, Visante, September 2011, 3. Available at:

<http://pcmanet.org/images/stories/uploads/2011/Sept2011/pbms%20savings%20study%202011%20final.pdf>

¹³ Adam J. Fein, Pembroke Consulting. *Economic Report on Retail, Mail and Specialty Pharmacies*, January 2014. 2013-14

Meador, op cit. And interview with Susan Hayes, Principal, Pharmacy Outcomes Specialist; June 12, 2014.

¹⁴ Kevin Schweers, *Community Pharmacists Hear Mail Order Complaints; Debunk PBM Myths*, NCPA Commentary (Sept. 23, 2009), <http://www.ncpanet.org/advocacy/pbm-resources>.

We believe these are important initial and overdue steps toward greater unified federal regulation and oversight of PBMs. These changes would provide employers and other plan sponsors with information they need to:

- Assess reasonableness of total compensation, both direct and indirect, received by the PBM service provider, its affiliates, and/or subcontractors; and
- Identify potential conflicts of interest inherent in certain PBM practices.

On behalf of consumers, I thank the committee again for this opportunity to speak on this important topic.