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House Committee on Oversight and Reform
Forum on the Role of Pharmacy Benefit Managers in Drug Pricing

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Key Points:

1) PBMs historically served a useful role to lower costs through price negotiation, greater use of generics, and expansion of mail-order services.

2) More recently, patients have been left behind by recent trends in the PBM marketplace.

3) Hidden rebates allow PBMs to hide cost savings from patients and, increasingly commonly, charge them more than their fair share.

4) PBMs and other intermediaries are capturing a larger share of drug expenditures—for example, more than half of spending on insulin—distorting the focus of the drug pricing debate and reducing manufacturer incentives to innovate.

5) Greater transparency is needed in the marketplace, and PBMs should be required to share savings with consumers and plans.

Comments:

Ranking Member Comer and other distinguished Members of the House of Representatives, thank you for the invitation to speak with you today about the role of pharmacy benefit managers (PBMs) in drug pricing.

My name is Erin Trish and I co-direct the Schaeffer Center for Health Policy & Economics at the University of Southern California. The Schaeffer Center strives to measurably improve value in health through evidence-based policy solutions, research excellence, and public- and private-sector engagement. As part of this mission, my colleagues and I have been studying prescription drug pricing and PBM activities for over a decade.

PBMs—which operate in the middle of the US pharmaceutical supply chain—play an important role in drug pricing. PBMs manage drug benefits on behalf of health insurers (including Medicare Part D plans) and employers, creating formularies and leveraging their bargaining power to negotiate rebates from manufacturers.

Historically, PBMs were independent from health plans and added value by negotiating prices, encouraging uptake of generics, and expanding mail-order services. However, a wave of consolidation in the last few years—including health insurers buying up PBMs—and other activities have distorted behavior. As a result, patients are being left behind.

Perhaps the most egregious issue is the increase in the use of hidden rebates. Rebates drive a wedge between a drug's list price and its net price, or the amount the manufacturer actually receives. In fact, increasing rebates are one of the key drivers of increasing list prices over time.

Our research on the Medicare Part D program exemplifies this issue. Rebates—as a share of total drug costs in Medicare Part D—have more than doubled over the last decade. While this has helped keep Part D premiums low, it means that beneficiaries pay more out-of-pocket at the pharmacy counter.

Our research has shown that about half of Part D beneficiaries who do not receive low-income subsidies would pay less out-of-pocket if rebates were applied at the point of sale. The incentives are particularly perverse—beneficiaries pay the most (as a share of the net cost of the drug) for drugs that face the most competition, where rebates tend to be largest. Moreover, because cost-sharing in Part D is tied to list price, the growth in rebates over time has diluted the value of the Part D benefit for all beneficiaries.

These distortions not only harm patients, but they also obfuscate the bigger issues in the drug pricing debate. Insulin is perhaps the most salient example. The current drug pricing proposal under debate would single out insulin and subject the class to price negotiation.

But this misses the point: insulin is already a highly competitive drug class, with rebates typically greater than 50% of the list price. Beneficiary cost-sharing for insulin is often high, because list prices are particularly inflated due to these large rebates. That is why recent policy interventions—like CMMI's Senior Savings Model—have targeted policy interventions requiring PBMs and health plans to cap patients' out-of-pocket spending on insulin.

Recent research by the Schaeffer Center, led by Professor Karen Van Nuys, demonstrates the importance of following the money. They found that, while total expenditures per unit of insulin remained relatively stable from 2014 to 2018, manufacturers are actually getting paid less year-over-year, while the share of that spending captured by PBMs increased 155% over the five-year period.

They also found that less than half of each $1 spent on insulin went to manufacturers. Instead, the majority gets siphoned away by distribution system intermediaries. This trend

is true across other drugs too. This reduces incentives for innovation and redirects spending away from the companies developing new therapies to improve health and save lives.

PBM issues expand beyond rebates—take generic drugs, which typically do not provide rebates to PBMs. Nonetheless, there is evidence that PBMs often overcharge for generic drugs. To illustrate this point, my colleagues and I recently compared the prices that Medicare Part D plans pay for common generic drugs to the prices that Costco pharmacies charge their members for the same drugs. We found that—relative to Costco's member prices—Medicare Part D plans overspent by $2.6 billion in 2018. While there is robust competition among manufacturers of these common generic drugs, the marketplace leaves room for PBMs and other intermediaries to capture this value rather than share it with beneficiaries and taxpayers.

It is clear that reforms are needed to improve the functioning of the pharmaceutical supply chain and ensure that the system works to benefit patients and drive value. While broader reforms to the Medicare Part D market could improve competition—which would in turn improve the incentives for PBMs—there are also more direct policy options that should be considered. For example:

Require greater rebate transparency. My colleagues and I have been studying this market for over a decade, and we still have trouble understanding what the price of services are. We can't expect markets to work if analysts, policymakers, and regulators don't know actual prices. Requiring transparent reporting would enable scrutiny of where our dollars are going.

Pass rebates through to patients. Patients—particularly those taking drugs in the most competitive classes—should not be paying more at the pharmacy counter to subsidize costs for everyone else. Requiring rebate pass-through would ameliorate these distortions.

Encourage more competition in the PBM market. The PBM market has become consolidated and vertically integrated, fueling concerns that these dominant intermediaries are exercising market power at a cost to patients. Greater antitrust scrutiny is needed to evaluate the market and offer remedies to improve competition.

Align incentives. Refocusing competition in the PBM market—for example to contracts based on fixed fees per transaction rather than fees calculated as a share of drug costs—could better align incentives. Policies that impose fiduciary requirements on PBMs, forcing them to act in the best interests of patients and clients, rather than solely in the interests of their own shareholders, could help encourage this market evolution.