



**The Anticompetitive Business Practices of Pharmacy Benefit  
Managers (PBM)  
and  
Their Impact on the Outpatient Prescription Drug Supply Chain**

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*About AMAC Action*

*AMAC Action, a 501(c)(4) nonprofit conservative advocacy organization, was created to support AMAC – Association of Mature American Citizens and its over 2.3 million members by advancing initiatives on Capitol Hill, in state legislatures, and at the local level through grassroots advocacy.*

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## Executive Summary

Pharmacy Benefit Managers (PBMs) have been present for over 50 years in the drug supply chain, however, the impact their business practices have on the cost of prescription drugs has gone under the radar. AMAC Action has a keen interest in prescription drug pricing and its impact on seniors. When polled, an overwhelming majority of seniors report that they are currently taking a prescription medication, 75 percent of Americans aged 50-64 and nearly 90 percent of respondents over age 65 report they are currently taking prescription medications.<sup>1</sup> This white paper is meant to inform policymakers and regulators on the impact of anti-competitive business practices used by PBMs to reduce market competition for drugs, overburden consumers with excess payments, and shift patients to costlier drugs for profit motive instead of the best interest of the patient.

The business practices used by PBMs create an unnecessary burden on patients, physicians, employers, independent and chain pharmacies, and other businesses across the pharmaceutical distribution system. While PBM's initial purpose was to lower prescription drug prices, the anti-competitive business practices that have resulted from policies like the safe harbor protection for rebates have made it impossible for Americans to reap the full intended benefits of lower prescription drug prices. AMAC Action strongly believes more can be done to help seniors save on prescription drugs and understanding the anti-competitive business practices of PBMs is an excellent first step.

The anti-competitive business practices used by PBMs include:

- The use of rebates which change the decision-making process by PBMs away from patient care to revenue. PBMs disrupt the middle of the distribution chain for prescription drugs by

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<sup>1</sup> Kaiser Family Foundation, Data Note: Prescription Drugs and Older Adults, August 9, 2019, <https://www.kff.org/health-reform/issue-brief/data-note-prescription-drugs-and-older-adults/>.

negotiating rebates as kickbacks for the use of specific drugs instead of other prescription options and use their purchasing power to reduce competition from other treatments.

- PBMs utilize administrative fees to maximize revenue by charging manufacturers, insurance providers, and pharmacies to distribute prescription drugs.
- Spread pricing allows a PBM to keep a portion of the reimbursement charged to an insurance provider, either public or private, on top of the fee paid to the fulfilling pharmacy. Often insurers are unaware that the negotiated reimbursement price to the pharmacy is lower than the price paid to the PBM leading to excess payments by the insurer, which are passed on to premium payers, or taxpayers in the case of public health plans like Medicare and Medicaid.
- The general nature of PBMs provides a lack of transparency, which leads consumers to overpay for drugs without knowing there are cheaper options available.
- PBMs create a conflict of interest by owning mail-order and specialty pharmacies. By operating substitutes to the traditional supply chain, PBMs are incentivized to shift the beneficiaries of insurance plans under their control to their pharmacies regardless of the beneficiary's circumstances. This, combined with allowing PBMs to decide which medicines insurance covers, how much consumers pay the pharmacy, and how much the pharmacy will be reimbursed, create a conflict of interest as PBMs are direct competitors to smaller pharmacies.

These business practices have been allowed to develop as PBMs operate behind the scenes and maintain as much secrecy as possible. AMAC Action hopes the information in this white paper can help policymakers reign in these organizations.

## Background

Insurers began using PBMs in 1968 to help restrain the growing prices of prescription drugs.<sup>2</sup> These organizations were independent of drug manufacturers and pharmacies. It was to the benefit of the insurance industry to have an organization that could manage the benefits offered by various plans to reduce the cost of drugs for the patient population these insurers covered. PBMs' original purpose when contracted with health plans, both public and private, were to process pharmacy claims, maintain the insurer's list of covered generic and name-brand drugs (known as a drug formulary within the industry), and keep drug costs at a minimum by negotiating lower reimbursement rates with pharmacies.<sup>3</sup>

Pharmacy Benefit Managers are the administrative middlemen of the pharmaceutical industry, meaning they do not physically distribute or sell prescription drugs but provide administrative support for drug manufacturers, pharmacies, and insurers (see Figure 1). In the 1980s, PBMs managed prescription benefits for 60 million people. However, it was not until the 2000s that the PBM industry began its roaring decade. Starting in the 2000s, large chain pharmacies began purchasing PBMs, which allowed these conglomerated pharmacies/PBMs to both develop the list of allowed drugs for the insurers and fulfill those prescriptions, a prima facie conflict of interest. By 2010, PBMs managed insurance benefits for prescription drugs for more than 200 million Americans, effectively giving monopoly power for prescription drug choices to a small handful of companies

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<sup>2</sup> The Stone Institute, *PBMs*, June 20, 2017, <http://www.thestoneinstitute.com/blog/posts/pbms>.

<sup>3</sup> Connection Coalition, *Fact Sheet Pharmacy Benefit Managers*, <http://www.mhac.org/wp-content/uploads/2018/03/Fact-Sheet-PBMs-Final.pdf>.

with little to no oversight from industry or government. Today the three largest PBMs manage prescription benefits for 77 percent of insured Americans.<sup>4</sup>

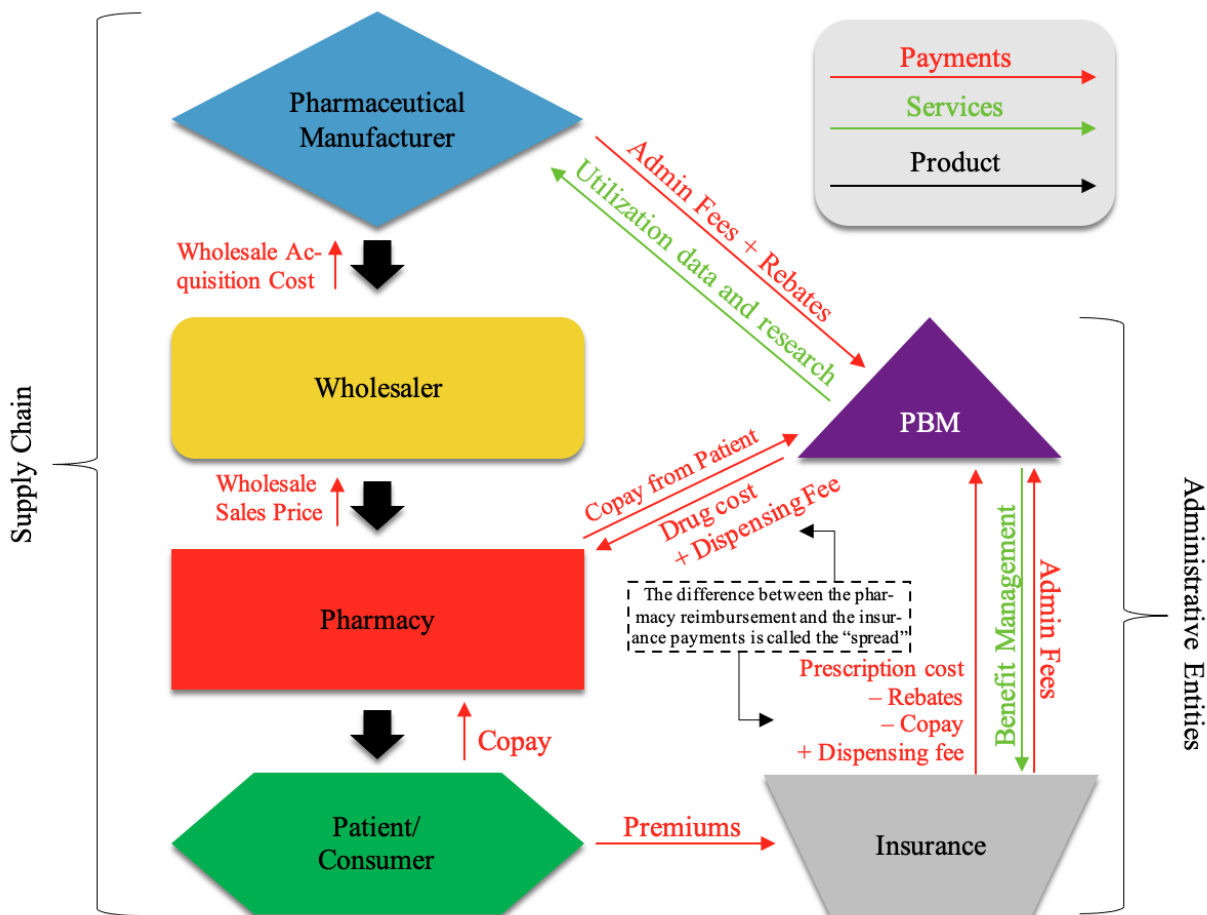


Figure 1 Prescription Drug Supply Chain with Administrative Entities

Over the last decade, the prescription drug market has changed; the pharmaceutical industry has gone through a renaissance in specialty drug development. Specialty drugs are differentiated from the rest of prescription drugs because they are high cost and often used to treat either rare and complex diseases or require complicated administration to the patient. Examples include biologics,

<sup>4</sup> Gaby Galvin, *Pharmacy Benefit Managers Are Feeling a Push From States to 'Turn the Lights on' to Their Business Practices*, Commissioner of Securities and Insurance Office of the Montana State Auditor, August 26, 2021, <https://csimt.gov/news/pharmacy-benefit-managers-are-feeling-a-push-from-states-to-turn-the-lights-on-to-their-business-practices>.

radiopharmaceuticals, cellular therapy, and gene therapy.<sup>5</sup> If we examine the types of pharmaceutical drugs even further, we can classify the products into three categories: brand-name, generic, and specialty. We can also classify each category as either for treatment, where the illness or injury is temporary, or chronic-care, where the infection or disease will require treatment through the rest of the patient's life.<sup>6</sup>

The rise of specialty drugs and increasing treatment of chronic illnesses has been profitable for PBMs. Over the last decade, prescription drug spending rose with the increase in the use of specialty drugs. By the end of the decade, specialty drugs accounted for half of all pharmacy dollars spent, and when combined with chronic medications, the cost rises to \$0.65 for every pharmacy dollar.<sup>7</sup> PBMs have an inherent profit motive in keeping patients on long-term prescription over short-term treatment medications. In addition, the combination of PBMs and large pharmacies has consolidated control of the market to just a few companies in control of which drugs are available in each insurance plan, further preventing competition necessary to drive down prices.<sup>8</sup>

Consolidation within the PBM industry to include the pharmacies fulfilling the prescription benefits administered by PBMs is just the base layer of anti-competitive practices. This paper will outline several additional areas of anti-competitive behavior by the industry.

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<sup>5</sup> United Healthcare, *Understanding the Differences Between 7 Medication Types*, <https://newsroom.uhc.com/open-enrollment/prescription-drug-types.html>.

<sup>6</sup> Ibid.

<sup>7</sup> RxBenefits, *Top 25 Moments in the History of Pharmacy Benefits Management*, November 16, 2021, <https://www.rxbenefits.com/blogs/25-moments-of-pharmacy-benefits-management-history/>.

<sup>8</sup> Ibid.

## Rent-seeking Behavior by PBMs

With the monopoly PBMs have over Americans' access to prescription drugs, oversight is essential to carefully examine how PBMs are using unfair business practices to maximize their three sources of revenue: rebates, administrative fees, and spread pricing at the pharmacy counter. These revenue sources move profits to PBMs while contributing no productivity to the supply chain or meaningfully reducing the cost of prescription drugs on the whole. The actions of PBMs are a textbook definition of rent-seeking behavior: "[A]n economic concept that occurs when an entity seeks to gain added wealth without any reciprocal contribution of productivity."<sup>9</sup>

PBM revenues have been steadily increasing over the last two decades.<sup>10</sup> This growth in revenue for an industry meant to lower drug prices while playing no part in the physical distribution or delivery of prescription drugs is a prime example of why regulators should investigate the anti-competitive business practices of PBMs.

### Rebates

The use of rebates by PBMs has a significant impact on the prescription drug market. Rebates are not only used to promote name-brand drugs over the generic competition but also used to keep patients on specific drugs when other options would provide better treatment.<sup>11</sup> The use of rebates changes the decision-making process by PBMs away from patient care to revenue. This inevitably plays a huge role in Americans spending on prescription drugs. PBMs pursuit of profit provide an

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<sup>9</sup> Investopedia, *Rent Seeking*, December 3, 2021, <https://www.investopedia.com/terms/r/rentseeking.asp>.

<sup>10</sup> Modern Healthcare, *PBMs' profit swells as sector consolidates, report shows*, <https://www.modern-healthcare.com/supply-chain/pbms-profit-swells-sector-consolidates-report-shows>.

<sup>11</sup> National Community Pharmacists Association, *The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access*, <https://ncpa.org/sites/default/files/2020-09/ncpa-response-to-pcma-ads.pdf>.



incentive to push higher priced drugs over similar medications that are more cost-effective because of the revenue impact of selling larger quantities of higher-priced pharmaceuticals. For this reason, PBMs disrupt the middle of the distribution chain for prescription drugs by negotiating rebates as kickbacks for the use of specific drugs instead of other prescription options and use their purchasing power to reduce competition from other treatments.<sup>12</sup> An example of this is in the generic vs. name brand space, a PBM can negotiate a rebate for the name brand to reduce the price to be less than the generic competition, however, the price charged to insurance is the same after part of the rebate is retained by the PBM for negotiating the rebate (see Figure 2). This system helps PBMs while doing nothing to actually reduce drug prices.

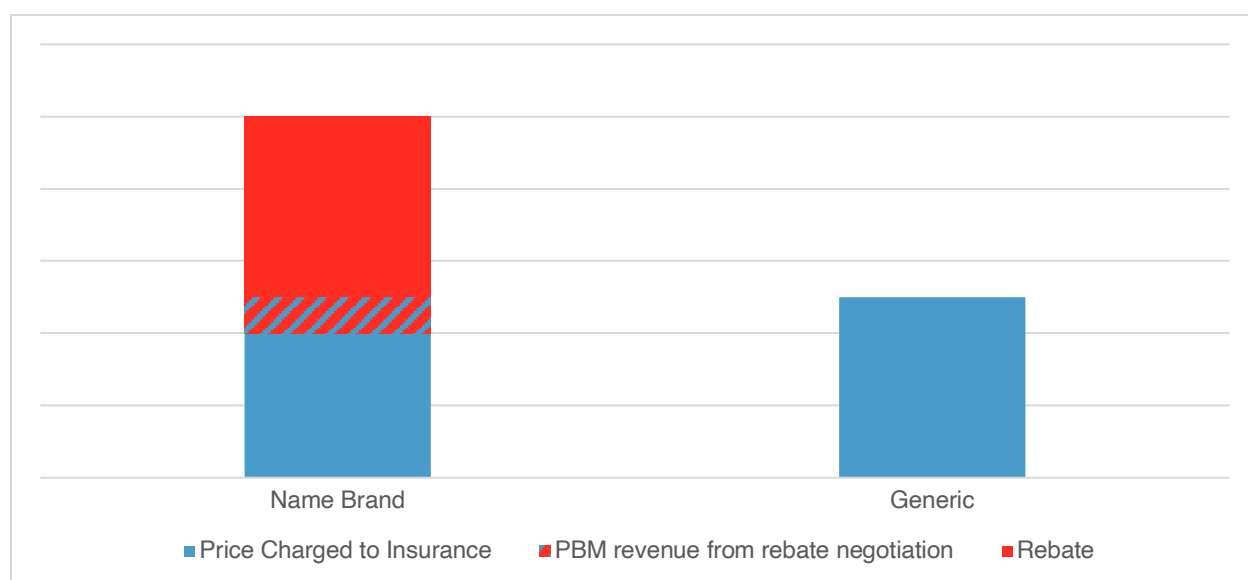


Figure 2 Rebates reduce drug prices, add to PBM revenue

Rebates not only impact the prices of prescription choices paid by insurance, they also provide no benefit to out-of-pocket payers. In examining the correlation between rebates and list prices over the last decade there is clear evidence that as list prices increase so too does the size of the rebates

<sup>12</sup> The Commonwealth Fund, *Pharmacy Benefit Managers and Their Role in Drug Spending*, April 22, 2019, <https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending>.

paid to health insurers. Additionally, uninsured patients are ineligible for PBM negotiated rebates and see out-of-pocket costs increase with list price increases.<sup>13</sup>

Rebates also trick insurance providers into believing they are offering a better deal to enrollees than if the list prices were lowered across the board. Government healthcare plans were the largest collectors: Medicaid (\$32 billion) and Medicare Part D (\$31 billion).<sup>14</sup> Additionally, private insurers are estimated to have collected \$23 billion, and manufacturers provide \$10 billion in copay coupons.<sup>15</sup> As both the regulator and receiver of drug price rebates it is difficult for the federal government to view rebate policy changes through an impartial lens due to the change in costs when scored statically. AMAC believes the reduction in rebates would change list prices and have a much smaller impact on drug outlays by the federal government and private insurers.

The PBM industry would like to make it look like rebates flow through to consumers, however customers rarely see the rebates and in fact see increases in premiums due to changing list prices. When a patient visits a pharmacy, any copay owed as part of their prescription drug benefit terms is often based on a percentage of the list price rather than the rebated amount paid by the insurance company.<sup>16</sup> Because an insured individual's out-of-pocket costs are frequently based on a percentage of the Wholesale Acquisition Cost/list price and the reimbursement is based on the rebated

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<sup>13</sup> Jama Network, *Association of Branded Prescription Drug Rebate Size and Patient Out of Pocket Costs in a Nationally Representative Sample, 2007-2018*, June 14, 2021, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780950>.

<sup>14</sup> Health Affairs, *Rebates, Coupons, PBMs, and The Cost of The Prescription Drugs Benefit*, April 26, 2018, <https://www.healthaffairs.org/doi/10.1377/forefront.20180424.17957/full/>.

<sup>15</sup> Ibid.

<sup>16</sup> Federal Register, *Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point of Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees*, <https://www.federalregister.gov/documents/2019/02/06/2019-01026/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals>.

price, as the list price increases, so does the revenue to these PBMs.<sup>17</sup> This means the net revenue to the PBM and manufacturer generally increase as the WAC increases regardless of rebate status. Additionally, the net revenue the pharmacy receives may increase as well but would be subject to the pharmacy's contract with the PBM.<sup>18</sup>

It becomes obvious from the effect increased WAC has on PBM revenues that the rebate system is ineffective at not only reducing drug costs but also fuels part of the anti-competitive business practices used by PBMs. The rebate system also has a profound impact on taxpayers. The interdependent nature of WAC/list price and rebate increases also increases Medicare and Medicaid payments on prescription drugs. It can only be concluded that the safe harbor protecting PBMs negotiation of rebates has become adversarial to the regulatory goal of reducing costs for consumers and government health programs.<sup>19</sup>

In the best interest of patients, some rebate critics have proposed doing away with rebates altogether. Federal law prohibits kickbacks paid to encourage business, including within Medicare and Medicaid programs, however, PBMs are granted a "safe harbor" against these anti-kickback laws.<sup>20</sup> In January 2019, the Department of Health and Human Services Office of Inspector General released a Notice of Proposed Rulemaking that would eliminate the "safe harbor" exemption used by PBMs.<sup>21</sup> The proposed rule would eliminate the safe harbor for rebates paid by manufacturers to plan sponsors under Medicare Part D and Medicaid Managed Care Organization (MCO)

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<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> 42 U.S.C. § 1320a-7b, (2000).

<sup>21</sup> Shepherd, Joanna, Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs (January 1, 2019). Yale Law & Policy Review, Vol. 38, 2019, Available at SSRN: <https://ssrn.com/abstract=3313828>.

and create cost savings for the final customers through a new safe harbor at the point of sale price. In proposing the rule, the Department of Health and Human Services believed that shifting the safe harbor would create multiple positive outcomes: slow the increase of prescription drug list prices, reduce financial burdens on consumers, lower federal expenditures, improve price transparency, and reduce the likelihood that rebates would serve to encourage anti-competitive business practices inappropriately.<sup>22</sup>

Even pharmaceutical manufacturers claim that the growing rebates cause increasing list prices. Between 2012 and 2016, rebates paid to PBMs increased from \$39.7 billion to \$89.5 billion.<sup>23</sup> While a certain amount of list price increases can be attributed to inflation, a large portion of the cost increases can be tied directly to the rebate system. Eliminating the rebate safe harbor and investigating the double-dipping of administrative fees are two recommendations for reducing the cost of prescription drug prices.

### *Administrative fees*

As previously mentioned, PBMs use the rebate system, in which their contracts allow them to keep a portion of the rebate, to increase revenue rather than passing the savings on to the final customer. Additionally, PBMs also collect fees from other parts of the supply chain, allowing them to spread their revenue sources.<sup>24</sup> At the top of the supply chain, manufacturers pay for PBMs' role in providing utilization data, administering rebates, and other activities such as evaluating economic

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<sup>22</sup> Federal Register (n 14).

<sup>23</sup> The Commonwealth Fund, *Pharmacy Benefit Managers and Their Role in Drug Spending*, April 22, 2019, <https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending>.

<sup>24</sup> Pharmacists Society of the State of New York, Inc., *PBM Basics*, <https://www.pssny.org/page/PBMBasics>.

outcomes, research, or key account planning.<sup>25</sup> The PBM also negotiates rebates from the manufacturer, which then pays these rebates to the PBM for preferred placement on a plan's formulary. At the bottom of the supply chain, the PBM negotiates with the pharmacy over reimbursement for drugs and dispensing fees.<sup>26</sup> Additionally, the insurance company also gets hit with service fees to manage its drug costs and is paid rebates from manufacturers after the PBM takes a portion of the rebate.<sup>27</sup> While these fees on their own seem legitimate, when combined with PBMs' use of rebates and spread pricing, it becomes clear they put their rent-seeking behavior above the best interests of the industry and consumer.

### *Spread pricing*

When a PBM charges an insurance provider, either public or private, more than they pay the fulfilling pharmacy, the PBMs can keep the difference as profit; this is known as spread pricing.<sup>28</sup> Often insurers are unaware that the negotiation reimbursement price to the pharmacy is lower than the price paid to the PBM leading to excess payments by the insurer, which are passed on to premium payers, or taxpayers in the case of public health plans like Medicare and Medicaid. This has been a reported problem for generic prescriptions by states administering Medicaid programs. State Medicaid programs have discovered that PBMs are using lower pricing schedules to reimburse pharmacies for generic medications than the rates used for charging the state for the same prescriptions. This spread pricing is on top of administrative fees paid to the PBM for

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<sup>25</sup> John Moose, Samantha Sutherland, *Do PBM Administrative Fees Have an Impact on Drug Prices?*, IQVIA, May 11, 2019, <https://www.iqvia.com/blogs/2019/03/do-pbm-administrative-fees-have-an-impact-on-drug-prices>.

<sup>26</sup> Investopedia, *Pharmacy Benefit Management (PBM) Industry*, January 27, 2022, <https://www.investopedia.com/articles/markets/070215/what-pharmacy-benefit-management-industry.asp>.

<sup>27</sup> Ibid.

<sup>28</sup> National Community Pharmacists Association, *Spread Pricing 101*, <https://ncpa.org/spread-pricing-101>.

administering the programs' prescription benefits.<sup>29</sup> The use of spread pricing is so rampant by PBMs that the Congressional Budget Office found that banning spread pricing could save state Medicaid programs over \$1 billion over a 10-year budget window, savings that would be passed on to federal taxpayers.<sup>30</sup>

## Lack of Transparency Reduces Competition in the Industry

The general nature of PBMs provides a lack of transparency, which leads consumers to overpay for drug costs without knowing. This lack of transparency includes federal programs such as Medicare Part D and Medicaid MCOs. PBMs pass along a limited amount of information about the percentage of rebates kept by PBMs and how much is given back to the programs.<sup>31</sup> For federal programs, this makes it impossible for them to track, report adequately, and account for how the rebates are used and to whom the rebates end up benefiting, even though program rules require transparency.<sup>32</sup> The pricing of medications for insured patients (in both private and government insurance programs) is determined by individual contracts with each provider. There is no way of knowing what beneficial pricing is given to one party over another. Recognizing that this lack of transparency impacts the Medicaid program, the federal government implemented the “federal upper limit” (FUL) price for prescription drugs with at least three generic competitors to ensure the program does not waste dollars on over-priced medication. Third parties, including states and insurance companies, have adopted a similar approach to reimbursement costs for generic

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<sup>29</sup> CMS, *CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers*, May 15, 2019, <https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not>.

<sup>30</sup> National Community Pharmacists Association (n 26).

<sup>31</sup> Federal Register (n 14).

<sup>32</sup> Ibid.

medicines called the maximum allowable cost (MAC). By complying with a MAC, the PBM must limit its reimbursement to the pharmacy filling the prescription even if the cost to the pharmacy exceeds the MAC. This will force the pharmacy to either offset the loss elsewhere in the business or withdraw from the network using the MAC. For those pharmacies operating at a loss, they must find additional revenue either through increases in prices paid by uninsured customers or through other non-prescription products and services.<sup>33</sup> This overall lack of transparency ends up costing consumers more at the pharmacy than if the contracts were negotiated more openly.

## Conflict of Interest

Since the details of the pricing negotiations are typically kept secret, it is impossible to determine how often significant conflicts of interest by PBMs occur as they attempt to maximize profits in every negotiation; however, an examination of several business practices points to conflict existing.<sup>34</sup> One conflict is PBMs' ownership of mail order and specialty pharmacies. By operating substitutes to the traditional supply chain, PBMs are incentivized to shift the beneficiaries of insurance plans under their control to their pharmacies regardless of the beneficiary's circumstances.<sup>35</sup>

Another conflict arises from allowing PBMs to decide which medicines insurance covers, how much consumers pay the pharmacy, how much the pharmacy will be reimbursed, and what penalties are paid by pharmacies for not fulfilling the terms of one-sided negotiations that will be addressed later.<sup>36</sup> With the rise of integrated pharmacies/PBMs, the entities that control drug pricing,

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<sup>33</sup> The pharmacist's Resource for Clinical Excellence, *Understanding Drug Pricing*, June 20, 2012, <https://www.uspharmacist.com/article/understanding-drug-pricing>.

<sup>34</sup> Shepherd (n 19).

<sup>35</sup> Ibid.

<sup>36</sup> The Hill, *Why the FTC should reconsider its vote on probing pharmacy benefit managers*, March 15, 2022, <https://thehill.com/blogs/congress-blog/healthcare/598210-why-the-ftc-should-reconsider-its-vote-on-probing-pharmacy/>.

supply availability, and network participation of community pharmacies are also their most significant competition. PBMs also remove local control of the types of medications and the supply duration that community pharmacies can dispense.<sup>37</sup> The modern nature of PBM businesses raises many anti-competitive issues alone; the fact that a PBM is allowed to dictate terms to their smaller pharmacies while also being in the direct competition should be cause for concern about the business practices of the entire industry.<sup>38</sup>

Allowing PBMs to create drug formularies based on payments received by pharmaceutical manufacturers to favor one brand-name drug over another creates another conflict of interest.<sup>39</sup> Doctors use these formulary lists to determine which drugs are suitable for the patient and most accessible for the consumer to acquire with their insurance plan; favoring certain medications based on kick-backs received by the PBM reduces the options for doctors to prescribe the best treatment for their patients. PBMs further limit the options for doctors by using open and closed formularies. Open formularies allow doctors to prescribe non-listed drugs but receive no incentives for the prescription, potentially increasing the cost; however, in closed formularies, a doctor cannot prescribe a non-listed medicine unless the prescribed drug is medically necessary. Pushing drugs that favor the PBM at the expense of the patient is a massive conflict of interest. Some patients react differently to drugs, and this puts the patients' health at risk. Only picking medicines that will bring in revenue and limiting the use of drugs that could have better health outcomes for patients is the root problem with controlled formularies.

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<sup>37</sup> National Community Pharmacists Association, *PBM abuses*, <https://ncpa.org/sites/default/files/2020-12/pbm-business-practices-one-pagers.pdf>.

<sup>38</sup> *Ibid.*

<sup>39</sup> The Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit*, January 2000. <https://www.kff.org/wp-content/uploads/2013/01/the-role-of-pbms-in-managing-drug-costs-implications-for-a-medicare-drug-benefit.pdf>.



An example of patients being forced to substitute different prescription drugs to maximize PBM rebates and fees is avoidance of generic substitution. Generic substitution offers a low-cost alternative to patients compared with name-brand products. Generic substitution aims to provide a lower-cost option to patients and have generic drugs dispensed whenever possible. Generic substitution is popular with consumers because of the lower costs, and pharmacists can receive higher dispensing fees than name-brand products. In some cases, they are also offered performance incentives for dispensing generics.<sup>40</sup> The cost savings of generic substitution has a significant impact on consumers; in 1994, purchasers were able to save between \$8 and \$10 billion compared to retail pricing of name-brand competition.<sup>41</sup> PBMs may view these savings by consumers as a lost source of revenue and can use their control of rebates and formularies to limit the availability of generic substitution.

## Overpayments and Coercive Contracting

Overpayments occur when a consumer's copayment exceeds the cost of the prescription, and the entire copayment is passed on to the PBM, where any excess payment is kept as profit.<sup>42</sup> While the overpayment is often small, the cumulative revenue generated by overpayments totaled \$135 million in 2013, with an average overpayment of \$7.69.<sup>43</sup> It is estimated that nearly one-quarter of

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<sup>40</sup> David H. Kreling, *Cost Control for Prescription Drug Programs: Pharmacy Benefit Manager (PBM) Efforts, Effects, and Implications*. Office of the Assistant Secretary for Planning and Evaluation, August 8, 2000, <https://aspe.hhs.gov/cost-control-prescription-drug-programs-pharmacy-benefit-manager-pbm-efforts-effects-implications>.

<sup>41</sup> The Henry J. Kaiser Family Foundation (n 37).

<sup>42</sup> USC Schaeffer. *Overpaying for Prescription Drugs: The Copay Clawback Phenomenon*. March 12, 2018. <https://healthpolicy.usc.edu/research/overpaying-for-prescription-drugs/>.

<sup>43</sup> Ibid.

prescription payments involved an overpayment through the beneficiary's copayment in that same year.<sup>44</sup>

Coercive contracting is another harmful factor to consider. Because PBMs can set rebates, dispensing fees, and control access to patients served by various insurance plans, pharmacies are at a disadvantage when negotiating contracts with PBMs. As PBMs merge with pharmacies themselves, this further increases the bargaining power held by the PBM. Since PBMs monopolize the marketplace, pharmacies are forced to work within the boundaries set by PBMs even when the options put the businesses at a disadvantage because, without the PBMs, they would have no access to insured patients. If a pharmacy were to refuse a single contract with any one of the three largest PBMs, it could potentially lose 30-50 percent of an insured population that PBM represents.<sup>45</sup>

## Gag Clauses

The intended purpose of PBMs was to save consumers money on prescription drugs while managing the benefits offered by insurance through negotiations with drug manufacturers and pharmacies. Today's PBMs are facing scrutiny for their actions that seem contrary to the intended goals of the organizations.<sup>46</sup> One such source of scrutiny is the gag clauses used by PBMs to prevent pharmacies from disclosing ways to save on prescription drugs to consumers. Some states have started to prohibit gag clauses, and the concern over the negative impact of these gag clauses is spreading to other states. 33 states have instituted policies that would ban PBMs from using gag

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<sup>44</sup> Ibid.

<sup>45</sup> National Community Pharmacists Association (n 35).

<sup>46</sup> The New York Times. *Why Your Pharmacists Can't Tell You That \$20 Prescription Could Cost Only \$8*. February 24, 2018. <https://www.nytimes.com/2018/02/24/us/politics/pharmacy-benefit-managers-gag-clauses.html>.

clauses.<sup>47</sup> An excellent example of a gag clause is when a customer owes \$50 for a prescription covered by insurance but could have paid \$35 with cash. This difference goes to the PBM in the form of overpayment discussed earlier.<sup>48</sup>

## Mail Orders, Formulary Competition, and Vertical Integration

PBMs use many methods to steer patients away from unaffiliated pharmacies and ways of distribution toward PBM-affiliated specialty, mail-order, and retail pharmacies. In addition to the anti-competitive business practices covered earlier to move patients away from independent pharmacies, PBMs also utilize the growing trend of mail-order pharmacies that can potentially put patients at risk.<sup>49</sup> PBMs can encourage insurance providers to use mail-order pharmacies over traditional retail pharmacies to reduce costs. While the PBMs use their ownership of the mail-order pharmacies to maximize profits, these arrangements ignore the patient's health outcomes.<sup>50</sup>

Customers are unaware of these ownership structures and typically view this option as convenient because of a higher discount on medication prices. The mail service option targets those who struggle with chronic illnesses and cannot leave their homes. While there can be benefits to mail-order pharmacies, problems can also arise due to the lack of face-to-face communication and patient consultation, consumers being forced into receiving medication by mail, mail delays, and the

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<sup>47</sup> John McGuinness, *Non-Transparent PBM Cash Flows: Balancing Market Forces Under a Reluctant Legislative Regime*, 11 Wm. & Mary Bus. L. Rev. 289 (2019), <https://scholarship.law.wm.edu/wmblr/vol11/iss1/7>

<sup>48</sup> The New York Times (n 44)

<sup>49</sup> The Hill (n 34).

<sup>50</sup> Federal Trade Commission, *FTC Issues Report on PBM Ownership of Mail-Order Pharmacies*, September 6, 2005, <https://www.ftc.gov/news-events/news/press-releases/2005/09/ftc-issues-report-pbm-ownership-mail-order-pharmacies>.

stability and integrity of mailed drugs.<sup>51</sup> Some of these shortcomings can be overcome with planning; however, the risk of these failures should outweigh the profit motive of PBMs.

Change of medication is standard amongst individuals due to generic versus name-brand prices and different side-effects of other medicines used to treat the same disease or symptom. However, PBMs often push consumers to continue to use the same type of drug instead of changing medication due to their profit motive.<sup>52</sup> In 2005, the FTC found that PBMs could reduce plan sponsor costs through drug switching; however, they chose to keep patients on the same drug.<sup>53</sup> It is easy to understand why PBMs would keep patients on one drug instead of switching to another cheaper alternative when we remember how the rebate kickbacks discussed earlier help bring in revenue to the PBM regardless of the actual cost to the insurer. The rebate system must be replaced to ensure insurers and, by extension, premium payers are paying the least for prescription drugs.<sup>54</sup>

In recent years, insurers, PBMs, and pharmacies have merged into vertically integrated organizations.<sup>55</sup> Vertical integration is when a company owns multiple parts of a product's supply chain; in this case, an insurance company, PBM, and pharmacy are all combined into a single company able to negotiate rebates with manufacturers, select which drugs are dispensed, and limit patients' choices in where to fulfill their prescriptions. An example of how the PBM industry is becoming

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<sup>51</sup> Kreling (n 38)

<sup>52</sup> Federal Trade Commission (n 48).

<sup>53</sup> Ibid.

<sup>54</sup> The Commonwealth Fund, *Pharmacy Benefit Managers: Practices, Controversies, and What Lies Ahead*, March 26, 2019, <https://www.commonwealthfund.org/publications/issue-briefs/2019/mar/pharmacy-benefit-managers-practices-controversies-what-lies-ahead>.

<sup>55</sup> Drug Channels. Insurers, PBMS, *Specialty Pharmacies, Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?*, December 12, 2019, <https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html>.

more vertically integrated is illustrated in Figure 3.<sup>56</sup> In 2019, UnitedHealth disclosed that 46,000 physicians operated under the umbrella of its Optum businesses. This means that doctors employed or contracted by the insurer can be mandated to send patients to the specialty pharmacies and providers owned by the vertically integrated organizations helping to ensure the PBM retains more profits. Physicians can also be rewarded for prescribing medicines from the PBMs' preferred formulary through the same rebate safe harbor that helps PBMs reduce competition in the marketplace.<sup>57</sup>

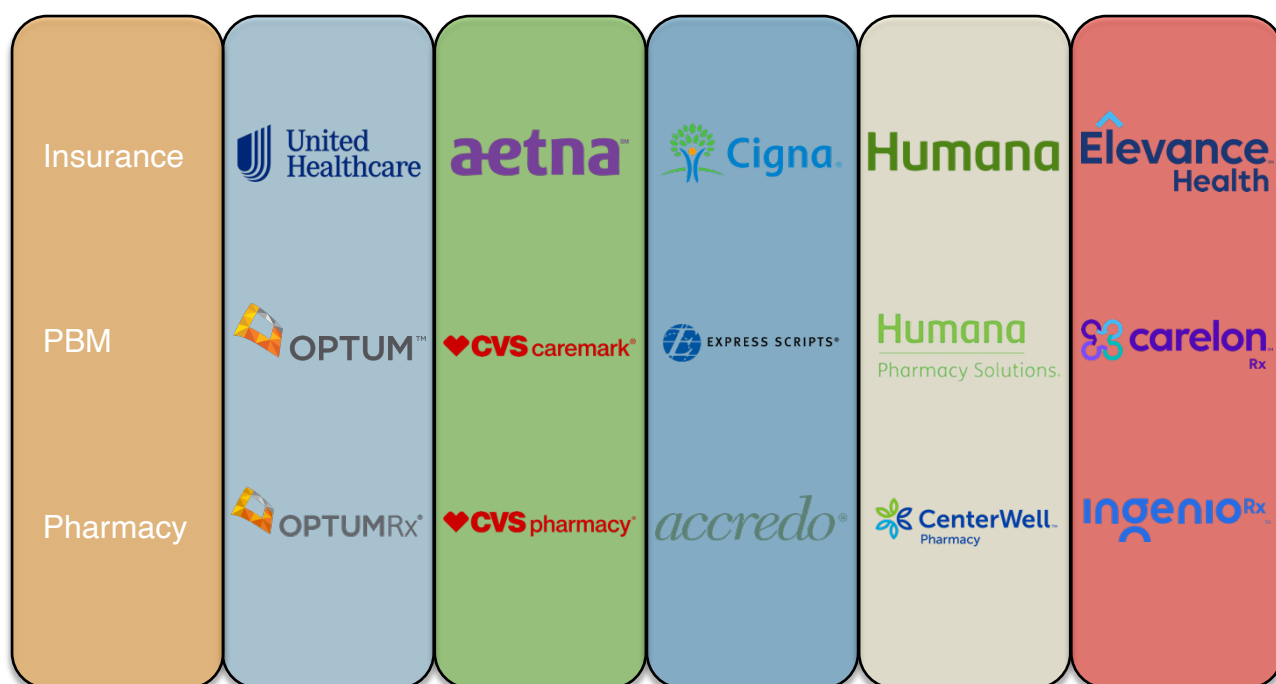


Figure 3 Vertical Integration within Insurance, PBM, and Pharmacy industries, Note: Anthem became Elevance in June 2022 and rebranded the PBM to Carelon RX

<sup>56</sup> Ibid.

<sup>57</sup> Ibid.

## Conclusion

In recent decades, the PBM industry has evolved from helping consumers save money on prescription drugs to increasing profits for PBMs, often to the detriment of the entire supply chain. PBMs exemplifies the worst of the dreaded middlemen stereotype and deserve federal oversight. As this paper has outlined, PBMs use anti-competitive business practices to increase revenues across the supply chains, abuse their status to create unfair negotiating positions for independent pharmacies, use vertical integration to create conflicts of interest that increase profits, and abuse the safe harbor that shelters the industry from anti-kickback scrutiny for the use of rebates.

The continued use of anti-competitive business practices has reached a saturation point in which action must take place. If PBMs were to return to their original business model, with restrictions like anti-kickback regulations, the industry would move back to keeping their interests aligned with patients instead of profit.<sup>58</sup> As time goes by, doctors, practices, and patients become increasingly powerless because of PBM consolidation and vertical integration with insurers. The result is a system designed for patients to receive inferior treatment while paying more for their medications. PBMs have abused the drug supply chain for their gain and used the murkiness of how their businesses operate to hide how these organizations affect the actual price of prescription drugs.<sup>59</sup>

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<sup>58</sup> John Arnold, *Are Pharmacy Benefit Managers the Good Guys or Bad Guys of Drug Pricing?*, STAT, August 27, 2018. <https://www.statnews.com/2018/08/27/pharmacy-benefit-managers-good-or-bad/>.

<sup>59</sup> Frier Levitt Attorneys at Law. *Pharmacy Benefit Manager Expose: How PBMs Adversely Impact Cancer Care While Profiting at the Expense of Patients, Providers, Employers, and Taxpayers*. February 2022. [https://communityoncology.org/wp-content/uploads/2022/02/COA\\_FL\\_PBM\\_Expose\\_2-2022.pdf](https://communityoncology.org/wp-content/uploads/2022/02/COA_FL_PBM_Expose_2-2022.pdf).