



Weekly Checkout

Whose Benefit?

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Pharmacy benefit managers (PBMs) are a hot topic right now, with several hearings and even a few legislative markups in the past few weeks in the House and Senate taking aim at their business practices. To explain what's going on, my colleague Laura Hobbs has written [a handy insight](#) on what PBMs are, their role in the U.S. health care system, and why they're so controversial. Let's take a look at the highlights of her insight and what it tells us about these reform efforts.

To start, what's a PBM? As the name implies, a PBM manages the pharmacy benefit for a health insurance plan on behalf of the plan sponsor. It is critical to note, however, that the PBM has no financial or contractual relationship to the beneficiary. As Hobbs explains, PBMs are tasked with “designing a prescription drug formulary, creating a network of pharmacies for beneficiaries to visit, and reimbursing pharmacies for dispensing and purchasing a drug.” How do PBMs make money for the services they perform? Generally, through two models: spread pricing and pass-through pricing. Spread pricing can be done one of two ways: The PBM negotiates a rebate on the list price of a drug and keeps a percentage of it, and/or the PBM secures a set payment from the plan for a prescription but negotiates a lower reimbursement for the pharmacy and keeps the difference. (Though PBMs assume financial risk with this latter arrangement and can face a negative spread.) Pass-through pricing means the PBM passes along the rebate to the plan sponsor (and in some cases directly to the plan sponsor's enrollees), but in return charges higher administration fees.

It's the spread pricing that has made PBMs so controversial. Independent pharmacies feel it's unfair for PBMs to use their market leverage to lower the dispensing and acquisition fees they pay to pharmacies and keep the difference from what the plan paid them for those fees. And when the PBM is compensated through a percentage of the rebate from a drug's list price, it has an incentive to choose a drug with a higher list price to secure a larger rebate (and thus a larger percentage for itself). What's more, Hobbs notes that “[some studies](#) have shown that their negotiations may artificially increase drug list prices” because pharmaceutical manufacturers will raise list prices and offer larger rebates to entice PBMs to give their drug preferential treatment on a plan's formulary. While PBMs pass back around [90 percent of total rebate dollars](#) for brand-name drugs to plans (generic drugs generally do not have rebates), the beneficiary's copayment for the drug is usually charged as a percentage of the list price, so higher list prices have a direct effect on increasing the beneficiary's out-of-pocket spending. It's very difficult to base the beneficiary's copay off the rebated price at the pharmacy counter: The actual rebate amount isn't determined until the end of the quarter or year and can vary based on volume of sales, patient utilization, and other measurements the PBM hashes out in its contract with the manufacturer.

Despite the logistical challenges, Congress has introduced [multiple bills](#) that seek to create a more transparent PBM industry, with the hope that a better understanding of how rebates are negotiated and fees are determined will create incentives for plan sponsors to shop around and, through competition, lower prices. But, warns Hobbs, “in mandating that PBMs comply with costly and time-consuming reporting requirements as outlined in [\[various Senate proposals\]](#), lawmakers risk increasing costs for plan sponsors – and likely their beneficiaries – as PBMs will likely charge health plans for the costs of such disclosures.”

The last few months of debate over PBM practices have included voices from across the health care industry, from PBMs to pharmaceutical manufacturers to pharmacies, but insurers have so far been less prominent.

Notably, insurance companies have not been featured at recent hearings, despite the fact that, ultimately, PBMs work for them and respond to the incentives in the plan contract. Insurers argue that rebates are used to keep premiums lower, and that may be, but the magnitude of those premium savings is somewhat unclear. In any case, the debate over how to manage and regulate a major piece of our pharmaceutical system is missing some key context and necessary answers that only insurers can provide. Future legislative hearings would do well to include the full spectrum of perspectives across the pharmaceutical supply chain.