The Maryland Public Policy Institute

Maryland Policy Report

No 2016-05 October 5, 2016

NO NEED TO INTERFERE IN PRESCRIPTION DRUG MARKET

BY MARC KILMER

INTRODUCTION

With an increasing number of Americans relying on prescription drugs to maintain health and prolong life, there is more focus on the laws that regulate the prescription drug market. At the state level, Pharmacy Benefit Managers (PBMs) are receiving significant attention.

PBMs work with their clients to manage prescription drug benefits that millions of Americans use every day. Their work to increase efficiency in the marketplace has helped contain drug costs, but some pharmacists are unhappy with how PBMs operate. This has led to calls from legislators to regulate PBMs, especially the way that these organizations reimburse pharmacists for drugs.

However, legislators should be cautious before interfering in this marketplace. Imposing restrictions on reimbursement rates will have adverse consequences on overall health care spending. In addition, it could hurt the efficiency of the health care market. A better course is to resist calls for regulation and let pharmacists and PBMs develop solutions without government interference.

WHAT ARE PBMS?

Pharmacy Benefit Managers are third-party organizations that manage the prescription drug benefits offered by insurance companies. Insurance companies or businesses that self-fund their insurance benefits can contract with PBMs to handle the prescription drug portion of the insurance plan. PBMs offer a variety of options for management, and each client can choose among these options for their plans.

PBMs have a range of functions, from handling billing issues to deciding what drugs an insurer will cover. They can also set a maximum price for drug reimbursements. By aggregating enrollees from a variety of different sources, PBMs are more able to seek discounts or introduce efficiencies into the system than would individual plans that cover fewer people.

Published by the Maryland Public Policy Institute
One Research Court | Suite 450 | Rockville, Maryland 20850 | Telephone 240.686.3510 | mdpolicy.org

WHAT BENEFITS DO PBMS PROVIDE?

For their clients, PBMs provide the benefit of specialized knowledge and services in dealing with prescription drugs. Rather than hire a special workforce to handle its prescription drug services, an insurance company can instead simply contract with a PBM to do this work. By participating in a larger network, PBM enrollees also have access to services and products that may not be available if they were in a plan that was regional or had a smaller number of beneficiaries.

For enrollees, PBMs use a network of retail pharmacies, called a preferred pharmacy network, which provides their members with discounts and other benefits. They also provide the option to have drugs mailed if these pharmacies are not near where beneficiaries may live.

From a health policy standpoint, the main benefit of PBMs is that they can lower overall spending on prescription drugs. One study prepared for the PBM trade association concluded that PBMs will save $2 trillion between 2012 and 2021, compared to what would have been spent on prescription drugs without PBMs.[1]

WHY ARE PBMS CONTROVERSIAL?

PBMs can reduce costs from two sources: drug companies and pharmacies.

PBMs can use their size to negotiate lower costs than drug companies may want to charge for their products. When PBMs buy large volumes of drugs, they have leverage to use with drug companies to force prices down. Without PBMs, drug companies would not face as much pressure to offer lower prices to pharmacies or consumers. In general, however, drug companies are large enough that this type of cost containment is not an issue.

Pharmacists in a PBMs preferred network benefit from the growth of PBMs. Those that are not, such as independent pharmacists, are at a distinct disadvantage when competing with PBMs. There are many ways that PBMs work within the market to disadvantage these independent pharmacists.

PBMs reduce costs from pharmacists by doing things like refusing to reimburse more than a certain price for drugs. This either pressures pharmacies to shop around for the best price for drugs, or forces pharmacies to take a loss if they cannot find a price that is lower than what the PBM will pay for reimbursement.

PBMs have better access to rebates than pharmacies do, since PBMs have a higher volume. This, too, gives PBMs a wholesale price advantage that gives them a larger profit margin than an independent pharmacist may receive.

Independent pharmacists also dislike preferred pharmacy networks. If independent pharmacists are not part of this network, they are at a disadvantage in attracting customers. PBMs will naturally steer their enrollees to the pharmacies in their network. Enrollees that instead choose an independent pharmacist will suffer financial penalties for choosing to go outside of the network.

Not only will PBMs strive to have enrollees use pharmacists in their network, they will also offer the option of mail-order pharmacies. These pharmacies can ship drugs directly to the recipient's mailbox, which reduces the need for drug purchasers to shop at their local pharmacist—a pharmacist who may be independent of the PBM network.

Yet another cost-savings measure that PBMs may use is limiting coverage of certain drugs. PBMs may refuse to pay for some drugs unless these drugs are pre-approved. Or they may require that doctors try less-expensive drugs before paying for drugs that cost more. Most drug consumers dislike this practice, finding that the PBM interferes with the patient-doctor relationship.

In all these instances, PBMs are attempting to control spending on drugs. Those who benefit from higher drug spending, whether pharmacists or patients, tend to disapprove of these practices. The complaints about PBMs, in turn, lead to calls for federal and state legislators to regulate them.

PROBLEMS WITH REGULATING PBM PRICING

It is undeniable that PBMs work to disadvantage independent pharmacists. That, however, is the nature of competition. The PBM business model only works if drug purchasers buy drugs from affiliated pharmacists, whether online or brick-and-mortar. They cannot control costs and produce a profit for themselves in a system where independent pharmacists are treated equally as pharmacists within their network.

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Clearly, PBMs have found a way to make the drug market more efficient. As in other industries, this involves larger organizations that can cut costs while offering the same (or better) service to consumers. This naturally hurts pharmacists who lack access to the type of discounts or other perks available to PMBs because of the volume of drugs they order.

The public policy result is what we see in other areas of the market—when conditions change to disadvantage a certain group, that group appeals to lawmakers to intervene in the market in its favor.

There are many proposals to regulate PBMs at the state level. One gaining support among state legislators mandates that PBMs reimburse pharmacists for whatever these

pharmacists pay for drugs. This law would stop PBMs from setting reimbursement rates. Instead, these reimbursement rates will fluctuate based on the invoice price.

Under current practice, PBMs set a maximum allowable cost (MAC) for drugs. If pharmacists want to prescribe the drugs, they have a large incentive to find the lowest cost possible for them. The proposal being pushed by some legislators, however, removes the incentive for pharmacists to shop around for the best price for drugs. If PBMs are required by law to pay the invoice price, then there is no point in trying to find a better price. In fact, this proposed law would mandate payment of whatever invoice price a pharmacist submits, even if he or she could have paid less from another supplier. That is a good deal for pharmacists, but it hurts PBMs and the companies they are serving.

One state—Arkansas—has actually enacted such a law. The law works, in part, by giving pharmacists the right of appeal if the MAC rate is below the acquisition cost of the drug. An early draft of the bill contained language allowing an appeal if the reimbursement rate was "below the cost at which the pharmacy may obtain the drug." That language would have avoided the problem described above, where pharmacists simply purchase a drug without shopping around for the lowest price. This language, however, was changed, and the final draft allowed an appeal if the reimbursement is "below the pharmacy acquisition cost." The bill was specifically changed to remove the incentive for pharmacists to seek lower prices.[2]

Furthermore, this legislation requires that PBMs pay reimbursements that may be above the actual acquisition cost, since it bases reimbursement on what appears on an invoice. However, an invoice price may not reflect rebates or other "off invoice" discounts. This situation could lead to guaranteed profits for pharmacists, with the cost borne by PBMs and their clients.

The push for this law came from independent pharmacists who did not like that PBMs may pay reimbursements that were below the cost of the drugs they purchased. While this situation may occur, it is difficult to see why this is a proper matter for government intervention. Whether a company uses cost-based pricing (that is, basing reimbursements on invoice costs) or maximum allowable cost pricing (companies setting a ceiling on reimbursement rates) is best determined by the market, not by legislators. Interfering in the market process serves to advantage one group, but as is the case with much special interest legislation, it could have significant negative side effects for others.

That is the case with the Arkansas legislation. It will also have a larger effect on overall effort to keep health care costs down, since it would remove a major incentive for pharmacists to shop around for lower drug prices. This has happened in other areas where cost-based reimbursements have been tried, according to David Hyman, professor of medicine at the University of Illinois:

> *"The inflationary consequences of cost-based reimbursement are well known, and help explain why such reimbursement schemes have fallen into disfavor. For example, prior to 1983, Medicare relied on cost-based reimbursement for inpatient hospitalization. Medicare payments were accordingly based on whatever costs the hospital incurred—and each hospital had virtually complete freedom to determine its own cost structure. The result was entirely predictable: Medicare costs for inpatient treatment skyrocketed, as hospitals determined that there were no effective constraints on the amounts they could bill, as long as they had legitimately incurred the associated costs."*[3]

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The fate of the Arkansas law is unclear, however. Soon after enactment, a national association representing PBMs sued the state to overturn the law. This suit is currently ongoing.

Devon Herrick, a senior fellow at the National Center for Policy Analysis, sums up why consumers should be concerned when legislators propose new rules on PBMs:

> *"Efficiently managed drug benefit plans have positive effects on consumers' cost-sharing and premiums, and help make most medications affordable to most patients. Though restrictive drug plan regulations are often touted as consumer protections, they are designed to benefit local pharmacy service providers at the expense of consumers."*[4]

CONCLUSION

Managing pharmacy benefits is a complex marketplace that is constantly evolving. Few legislators clearly understand the dynamics of that marketplace or what PBMs actually do. We discourage interference in this marketplace to privilege pharmacists over PBMs. Any efforts to do so should be done with much caution. Misguided attempts to 'fix' what pharmacists perceive as a problem can have significant unintended consequences. In fact, this interference will likely work against other efforts to contain overall health care costs.

Mandating reimbursement rates for drugs is an area where the government should remain neutral. If the market is allowed to work, then we can expect efficient operations

to emerge. That is what has happened with PBMs, which work to contain cost increases for drugs, with the benefit of making a profit. And, just as certainly, this work can squeeze pharmacists, especially independent pharmacists. However, the market's evolution in a way that may hurt some pharmacists is inadequate justification for the heavy-handed interference seen in Arkansas. Legislators should let PBMs and pharmacists work out their differences on pricing through the mechanisms of the market.

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1. Pharmaceutical Care Management Association, "PCMA: PBMs will save nearly $2 trillion in prescription drug costs over the next decade," http://www.pcmanet.org/2011-press-releases/pcma-pbms-will-save-nearly-2-trillion-in-prescription-drug-costs-over-the-next-decade
2. David Hyman, "The adverse consequences of mandating reimbursements of pharmacies based on their invoiced drug acquisition costs," January 2016, http://www.pcmanet.org/images/stories/uploads/2016/hyman%20paper%20on%20consequences%20of%20mandating%20pharmacy%20reimbursement%20based%20on%20invoiced%20costs%20-%20final.pdf
3. Ibid
4. Devon Herrick, "New drug plan regulations protect pharmacies, hurt consumers," The National Center for Policy Analysis, April 2015, p. 10. http://www.ncpa.org/pdfs/st365.pdf

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