

Pharmacy Benefit Managers' Impact on Patient Access



Madelaine A. Feldman, MD, FACR

With the cost of health care increasing in recent decades, pharmacy benefit managers, or PBMs, have become an increasingly prominent player in the lives of Americans and their clinicians.

They are a classic “middleman,” hired by insurance plans to negotiate drug prices with manufacturers and to manage prescription drug claims with pharmacies.

Today just three PBMs – CVS Caremark, Cigna and OptumRx – control approximately 79% of the market.¹

These three pharmacy benefit managers play an outsized role in determining which medications patients may take to treat their conditions. This is primarily because pharmacy benefit managers determine the standard formulary, a list of medications that have been pre-approved for coverage by insurers.

How Formularies are Constructed

Each health plan maintains a list of covered medications, often organized into tiers based upon level of coverage.

Some medications are more fully covered by the health plan and require a minimal out-of-pocket payment by the patient. Health plans may itemize these in what's known as a preferred drug list.

Other medications are covered only partially and may require substantial cost sharing by the patient. These are often more expensive medications known as specialty drugs, and they may come with procedural burdens on patients and their health care providers. But what determines which drugs are included, or where in the formulary they are placed? It is not always just safety, efficacy and cost.

A number of factors influence formularies, including research, expert opinion, and third-party costs and rebate agreements, and these factors may change frequently.



Rebates & Formulary Design

Rebates negotiated by pharmacy benefit managers can heavily influence which drugs are selected for a formulary.

Patients might think that rebates are a positive contribution of the pharmacy benefit managers. Most consumers have had the experience of buying a retail product and mailing their receipt in for a rebate check they can later cash.

But PBM rebates are leveraged to get certain drugs placed on formularies. They aren't directly for pharmacy consumers. The savings created by the rebate, which is paid by the manufacturer to the PBM, are split between the health insurance provider and the PBM.

Savings are not directly passed to the patient.

Patients see these rebate agreements reflected in which medications are included in the formulary and in which tier. PBMs may "prefer" highly rebated medications to the exclusion of other medications that might work better for individual patients. Higher list prices also yield higher fees for PBMs.

In fact, many formulary rebates have been reclassified over the years as fees because, unlike rebates, PBMs keep the entirety of fees paid to them. Even if the other drugs appear on the formulary, patients may face more hurdles and higher out-of-pocket costs to access them.



Using Coverage Rules to Enforce the Formulary

With formularies in place, pharmacy benefit managers work to steer patients toward the medications that are preferred by the formulary and away from drugs that are not preferred — without regard to what’s best for each individual patient. This practice, known as utilization management, can be wasteful, counterproductive and even harmful to patients.

The three most common utilization management tactics are prior authorization, step therapy and non-medical switching.

Prior Authorization

Insurance companies use prior authorization to limit access to certain treatments. Rather than relying on a physician’s clinical experience and judgment, health plans use prior authorization to force physicians to spend significant time filling out insurance paperwork. The red tape needlessly complicates a patient’s course of treatment and can delay or obstruct a patient’s access to prescription medication. Prior authorization can negatively affect patient care while

adding costs and increasing administrative burdens.²

One study examined 626 prior authorizations and found that clinic staff spent 170 hours for a median cost of \$6.72 per prior authorization. The costliest prior authorization cost more than the clinic visit itself. Ironically, prior authorizations are often approved after the health plan initially denies them, making the practice an expensive nuisance that delays access to treatment that’s often ultimately deemed appropriate.³

Step Therapy

This practice requires patients to “fail first” on medications that are preferred by formularies before insurance will cover the medication prescribed by a patient’s clinician.

While patients wait for access to the medication they were originally prescribed, they may experience disease progression, recurrent symptoms or new side effects. Some patients may grow frustrated at being required to take ineffective treatments and simply abandon their medication regimen altogether.⁴

Non-Medical Switching

This is a practice whereby a health plan or pharmacy benefit manager changes a stable patient's treatment for reasons other than efficacy, side effects or adherence.⁵ Such a switch prioritizes insurers' profit over patients' health and, like step therapy, can have consequences: new side effects, re-emerging symptoms or interactions with medication the patient takes for other conditions.

This can occur through various formulary changes such as exclusion of a medication or placing it on a higher tier, both of which can put the medication out of a patient's reach.

In a national poll of patients who experienced non-medical switching, two-thirds of respondents said it affected their productivity at work, and over 40% said they couldn't care for their children, spouses or other family members after their non-medical switch. Almost 40% of patients said their new medicine was not as effective as their original, while nearly 60% had complications.⁶

Utilization management tools are too often used to the exclusive benefit of the insurers — at the expense of patients. They can hinder patient care unless patients and providers have clear and timely approval or denial decisions and an easy appeals process that reflects clinical guidelines.

Costs, Copays & Coinsurance

A closer look at costs and payments reveals a central reason that pharmacy benefit managers' negotiating often works against patients' best interests.

Understanding Copays & Coinsurance

Patients typically pay at least something out of pocket for any prescription medication, but the exact amount can vary widely. Many medications require a patient copay, generally a fixed dollar amount. Copays often apply to generic and lower-cost medications.

But plans are increasingly requiring coinsurance, where the patient must pay a percentage of the drug's list price. This is especially true with higher-cost drugs such as those placed on formularies' upper specialty tiers. The out-of-pocket amount for coinsurance is usually much higher than a copay — prohibitively high for many patients.

Prices & Payments



LIST PRICE:

Original "sticker price" of the medication, set by the manufacturer



REBATE:

Discount paid to pharmacy benefit managers by drug manufacturers



NET PRICE:

The list price minus the rebate negotiated and received by the pharmacy benefit manager



COINSURANCE:

A percentage of a medication's list price, which the patient pays out of pocket

The Real Costs

Pharmacy benefit managers often celebrate their success by pointing to the net price of a medication – the original list price of the drug minus the rebate that the pharmacy benefit negotiated with the drug’s manufacturer. The bigger the price drop, the PBM suggests, the greater the savings.

The problem is that patients don’t pay the net price. Instead, they often pay coinsurance, which is a percentage of their medication’s higher, original list price. And PBMs’ demands for rebates drive up that list price.



PBMs’ approach requires manufacturers to compete with one another for preferred placement on a health plan formulary by offering higher and higher rebates. The dynamic creates a perverse incentive, compelling manufacturers to increase medication list prices to allow for ever-higher rebates.

As a result, the rebate system actually pits PBMs’ financial interests against patients’ financial security and medication access. PBMs benefit from a higher list price, because it results in a higher rebate payment for them. But patients benefit from a lower list price, because they then pay less out of pocket and have a better chance of being able to afford their medication.

When it comes to developing formularies, then, pharmacy benefit managers may be apt to select and prefer the very medications that will require unmanageable out-of-pocket costs for patients.

As the chart nearby demonstrates, the rebate system can paradoxically create an incentive for the health plan formulary to prefer a medication that burdens patients with higher out-of-pocket costs.

Higher Rebates Can Mean Higher Costs for Patients

	Medication A		Medication B	
 Patient Would Prefer	\$2,000/mo	List Price	\$5,000/mo	 Pharmacy Benefit Manager Prefers
	40%	Rebate Discount	60%	
	\$800	Rebate Amount	\$3,000	
	\$400	Patient’s 20% Coinsurance	\$1,000	

The Scope of Pharmacy Benefit Managers' Control

Once a medication is approved by the Food and Drug Administration, pharmacy benefit managers control many of the levers that determine which medications patients can access.

Pharmacy benefit managers control:



The formulary, which they design by excluding certain medications and giving preferential placement to others.



Patient access, which PBMs influence through utilization management tools that may require patients to waste valuable treatment time on medications they don't need or switch them off of medications that work.



Patients' out-of-pocket payments, which PBMs influence by driving up list prices and dictating copay and coinsurance amounts.

Pharmacy benefit managers control which drugs patients can take, when they can take them and how much they will pay for them. Despite their tremendous influence, many pharmacy benefit managers lack accountability, harbor conflicts of interest or fall short of their fiduciary responsibility – all at the expense of patients and patient health.

Policy Solutions

Transparency is key to meaningful reform of the pharmacy benefit manager industry. But efforts by certain states to reform pharmacy benefit managers have fallen short. And pharmacy benefit managers continue to thwart well-intended policymakers by reclassifying rebates as fees or hiding rebates with “rebate aggregators.” These aggregator arms can shift rebates and discounts into a less transparent structure if policymakers target them with regulations requiring rebates to be passed through to patients.

Formularies should be based not on high prices that bring high rebates but rather on efficacy, safety and low list prices to incentivize affordability for patients. Certain policies could help. Pharmacy benefit managers could be paid a fixed fee based on the market value of their services, and patients could pay coinsurance on the net cost of the drug. Policies could protect stable patients' medications by guaranteeing coverage regardless of formulary changes.

Policymakers will have to dive deep into this issue to stop the tactics pharmacy benefit managers have used – or simply eliminate the middleman altogether.



References

1. Market share of the top pharmacy benefit managers in the U.S. prescription market in 2022. Statista. 2023 May 23. <https://www.statista.com/statistics/239976/us-prescription-market-share-of-top-pharmacy-benefit-managers>
2. Wallace, Z. S., Harkness, T., Fu, X., Stone, J. H., Choi, H. K., & Walensky, R. P. (2020). Treatment Delays Associated With Prior Authorization for Infusible Medications: A Cohort Study. *Arthritis care & research*, 72(11), 1543–1549. <https://doi.org/10.1002/acr.24062>
3. Carlisle RP, Flint ND, Hopkins ZH, Eliason MJ, Duffin KC, Secrest AM. Administrative Burden and Costs of Prior Authorizations in a Dermatology Department. *JAMA Dermatol*. 2020 Oct 1;156(10):1074-1078. DOI: 10.1001/jamadermatol.2020.1852. PMID: 32845288; PMCID: PMC7450401. <https://pubmed.ncbi.nlm.nih.gov/32845288/>
4. Tharp L, Rothblatt Z. Do patients benefit from legislation regulating step therapy? *Health Econ Policy Law*. 2022 Jul;17(3):282-297. DOI: 10.1017/S1744133121000153. PMID: 33843568. <https://pubmed.ncbi.nlm.nih.gov/33843568/>
5. Dolinar R, Kohn CG, Lavernia F, Nguyen E. The non-medical switching of prescription medications. *Postgraduate Medicine*. 2019 Jun; 131(5): 335-341. DOI: 10.1080/00325481.2019.1618195. PMID: 31081414. <https://pubmed.ncbi.nlm.nih.gov/31081414/>
6. Alliance for Patient Access. A Study of the Qualitative Impact of Non-Medical Switching. 2019 February. https://admin.allianceforpatientaccess.org/wp-content/uploads/2020/02/AfPA_Qualitative-Impact-of-Non-Medical-Switching_Report_Feb-2019.pdf

ABOUT THE AUTHOR

MADELAINE A. FELDMAN, MD, FACR

Madeline Feldman, MD, FACR, is a rheumatology specialist with more than 30 years of experience. She is a member of the Alliance for Patient Access.



Alliance for
Patient Access

www.allianceforpatientaccess.org

The Alliance for Patient Access is a national network of policy-minded health care providers advocating for patient-centered care.