Reforming Pharmacy Benefit Managers — A Review of Bipartisan Legislation

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This year, U.S. congressional leaders have been prioritizing legislation to lower prescription drug prices by regulating pharmacy benefit managers (PBMs). PBMs act as pharmaceutical intermediaries, managing prescription drug claims and establishing formularies on behalf of insurers, contracting with networks of pharmacies, and negotiating rebates from drug manufacturers. Through these activities, PBMs directly affect patients' premiums and out-of-pocket costs for drugs. At least six congressional committees have introduced bipartisan PBM reform bills in 2023 (see table); many politicians expect that some of these reforms will receive floor votes by the end of the year. Although the bills address several well-known problems with the PBM industry, we believe they are unlikely to substantially reduce prescription drug spending in the United States.

One of the key roles of PBMs involves controlling prescription drug costs. PBMs help control costs by designing formularies that steer patients toward using lower-priced medications and by negotiating lower costs with drug manufacturers in exchange for offering preferred formulary positions for their products. Rather than negotiating prices directly, PBMs typically arrange confidential rebates that are provided by manufacturers after patients fill prescriptions. The size of these rebates has grown in recent years and varies substantially by drug class: in 2021, for example, average rebates negotiated on behalf of Medicare Part D plans were less than 10% for oncology drugs and more than 50% for diabetes drugs.[1]

Although rebates have tempered increases in prescription drug spending, PBMs sometimes arrange with insurers to either keep a portion of the rebates they negotiate or collect fees that are based on drugs' prices. These

Selected Bipartisan PBM Reform Bills Introduced in Congress in 2023.*	
Bill Name (Congressional Committee)	**Selected Policies Related to PBMs**
S. 1339: Pharmacy Benefit Manager Reform Act (Senate Committee on Health, Education, Labor, and Pensions)	Prohibits spread pricing Requires 100% pass-through of rebates and fees to the plan sponsor Mandates reports to plan sponsors
S. 127: Pharmacy Benefit Manager Transparency Act of 2023 (Senate Committee on Commerce, Science, and Transportation)	Prohibits spread pricing and retroactive pharmacy fees, unless PBMs pass 100% of rebates and fees to the plan sponsor and meet certain disclosure requirements Mandates reports to the Federal Trade Commission
S. 2973: Modernizing and Ensuring PBM Accountability Act (Senate Committee on Finance)	Prohibits compensation based on drug prices in Medicare Part D Prohibits spread pricing in Medicaid Mandates reports to Part D plan sponsors and the secretary of Health and Human Services
H. 5378: Lower Costs, More Transparency Act (House Committees on Energy and Commerce, Ways and Means, and Education and the Workforce)	Prohibits spread pricing and retroactive pharmacy fees in Medicaid Mandates reports to plan sponsors

* The table shows major policies related to pharmacy benefit managers (PBMs) that were included in the most recent drafts of bills considered by six congressional committees, as of October 12, 2023.

revenue streams result in perverse incentives for PBMs to favor brand-name drugs with high prices and large rebates offered by the drug's manufacturer over lower-priced options. Arrangements with PBMs therefore haven't stopped manufacturers from raising prices, even in cases in which there is competition among similar drugs. Such price increases are problematic for patients without insurance and for those with insurance who pay deductibles or coinsurance based on prerebate prices.

To address these perverse incentives, a bill considered by the Senate Committee on Health, Education, Labor, and Pensions (HELP) would mandate that PBMs pass along 100% of negotiated rebates and price-based fees to private health insurance plans, which could use the associated savings to reduce premiums or offer more generous prescription drug coverage. A related provision in a bill from the Senate Committee on Finance would prohibit PBMs working with Medicare Part D plans from collecting any compensation that is based on a drug's prerebate price. These bills aim to eliminate incentives for PBMs to favor drugs with higher prices, although it's unclear whether the changes would result in lower manufacturer prices. Medicare Part D plans already receive more than 99% of the rebates negotiated by PBMs,[2] although the same may not be true for private insurance plans. It's also likely that PBMs would charge additional fees to insurers to offset any losses associated with these policies.

An important consideration is that these proposals would require PBMs to pass rebates along to health plans but not to patients, some of whom would continue to pay out-of-pocket costs that are based on prerebate list prices. Enacting more aggressive rebate reforms would be politically and economically challenging. Policies that lower out-of-pocket costs by tying them to postrebate prices could lead insurers to raise premiums in response. Eliminating rebates altogether might be costly if drug manufacturers didn't lower prices enough to fully offset rebate amounts. For example, former President Donald Trump proposed a rule that would have effectively eliminated Medicare Part D rebates, but this policy was abandoned after government economists estimated that over 10 years it would cost the federal government $196 billion, reduce out-of-pocket costs for patients by only $93 billion, and increase Part D premiums by $50 billion.[3]

Lawmakers are also attempting to regulate pharmacy reimbursements provided by PBMs and fees charged by PBMs that may increase costs, particularly for generic drugs. PBMs sometimes charge insurers more than the amount they pay to pharmacies, a strategy known as "spread pricing." This practice can lead to sizable overpayments. In Ohio's Medicaid program, for example, spread-pricing charges represented 31% of state spending on ge-

neric medications in 2017–2018, costing $208 million.[4] Bills considered by the Senate HELP Committee and the Senate Committee on Commerce, Science, and Transportation propose prohibiting PBMs from using spread pricing in arrangements with private insurers, with some exceptions; bills considered by the Senate Finance Committee and several House committees would prohibit this practice in the Medicaid program.

Another criticized PBM practice is the growing implementation of retroactive fees charged to pharmacies. A final rule released by the Centers for Medicare and Medicaid Services in April 2022 will prohibit PBMs from charging pharmacies retroactive fees in Medicare Part D, starting in 2024. The Senate Commerce Committee bill proposes extending this prohibition to PBMs working with private insurers.

The three largest PBMs — CVS Caremark, Optum Rx, and Express Scripts — process 80% of the prescriptions filled in the United States. Such consolidation empowers PBMs in their rebate negotiations with drug manufacturers, but it also limits competition for contracts with health plans. In addition, the major PBMs are now also affiliated or vertically integrated with health insurers and specialty, mail-order, and in some cases, retail pharmacies. Because health plans contract with PBMs to negotiate pharmacy reimbursement rates, mergers of PBMs and pharmacies are particularly problematic since they result in PBMs effectively negotiating with themselves. In addition, PBMs frequently steer patients toward filling prescriptions at their own pharmacies. The effects of integration between PBMs and pharmacies on prescription drug prices are unknown, although such arrangements are being investigated by the Federal Trade Commission (FTC). Consolidation between PBMs and insurers may lead to higher premiums for patients enrolled in rival plans that contract with the PBM.[5]

To address integration between PBMs and pharmacies, several bills under consideration would require PBMs to report differences in reimbursement rates for affiliated and nonaffiliated pharmacies to plan sponsors; in addition, the Senate Finance Committee bill would request a federal investigation into the effects of PBM–pharmacy integration in Medicare Part D. Congress could also require the FTC to automatically review PBM–pharmacy mergers. Increased transparency and further investigation to better characterize the effects of PBM consolidation on patient outcomes would help inform policy responses.

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Finally, the various bills include additional reporting requirements aimed at improving transparency of PBMs. Revenue sources for PBMs are varied and tend to be kept confidential. In some cases, even the health plans that hire PBMs struggle to obtain important information about the cost of medications. The current bills include provisions that would require PBMs to submit reports about fees, formulary changes, and net reimbursement to insurance plans, regulatory bodies, and pharmacies. These proposals wouldn't improve public price transparency, however. Postrebate drug costs would remain confidential for physicians and patients who might want to integrate cost information into clinical decisions. Enhancing public access to price information would allow policymakers to further hone regulatory reforms, although health care price-transparency policies haven't always reduced costs for patients.

The reforms described above would prevent PBMs from employing certain business practices that have contributed to higher prices for patients. We believe these policies have limitations, however, and their effects would depend on how PBMs respond to their implementation. Although it's encouraging to see bipartisan support for lowering prescription drug costs, we believe Americans shouldn't expect the proposed federal PBM regulations to substantially reduce spending by patients or the government.

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