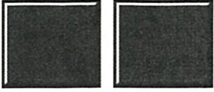

MEDCITY INFLUENCERS, PHARMACY

PBMs Are in Regulators' Crosshairs But Are Regulators Missing the Point?

Proposals targeting misaligned financial incentives, price transparency, and pharmacy access are important and necessary reforms. But the consequences of failing to address pharmacy benefit managers' use of market power to block competition and extract monopoly profits from payers and consumers will not be limited to drug costs – it will change all of healthcare for generations.

By CHRIS BLACKLEY

Post a comment / Nov 23, 2023 at 2:00 PM

There's finally a spotlight on pharmacy benefit managers, or PBMs – the drug industry intermediaries who control the price of and access to prescription drugs in the U.S. The Senate Finance Committee's plan for PBM reform cites four key challenges that need policy solutions, including "behind-the-scenes practices that impede competition and increase costs."

But the Big 3 PBMs – CVS Health's Caremark, UnitedHealth's OptumRx and Cigna's Express Scripts – already control nearly 80% of the U.S. market. I applaud all efforts to increase transparency and competition to make drugs more affordable for average healthcare consumers. But I still question: Will legislation be enough?

The cost of consolidation and monopoly market power

Initially, PBMs provided administrative services to help payers efficiently manage pharmacy benefits, creating value by negotiating lower drug costs on payers' behalf, serving as a counterweight to the pricing power of pharma and pharmacy chains. At some point, this objective changed: PBMs leveraged their scale and control over benefit design to establish themselves as the primary path to market for pharma and the only customer of consequence for pharmacies. PBMs use their new power over market access and price to extract hundreds of billions of dollars from the market through tactics under investigation by regulators and which, according to my research and others', drive up drug costs for Americans by at least 30% – over $150 billion – per year. And now, the Big 3 PBMs are vertically integrated with three big medical insurance carriers: Aetna (CVS Health), Cigna (Express Scripts) and UnitedHealth Group (Optum Rx). A quick skim of the Fortune 50 is all it takes to find these conglomerates near the top of the list.

The power of vertical integration

Now that these three companies collectively control price and market access for nearly 80% of over 300 million patients and half a trillion dollars in annual drug spend, their purpose has changed once again. The PBM's role as a vertically integrated partner is to leverage their significant profits to fund cross-subsidies on the medical insurance side of the combined entity. By funding a competitive price advantage and taking share in the medical insurance market, they'll aggregate more patients who need pharmacy benefits and services. This is a classic case of tying a profitable, non-competitive product – PBM and pharmacy services – to create leverage for a competitive (and less profitable) product – medical insurance.

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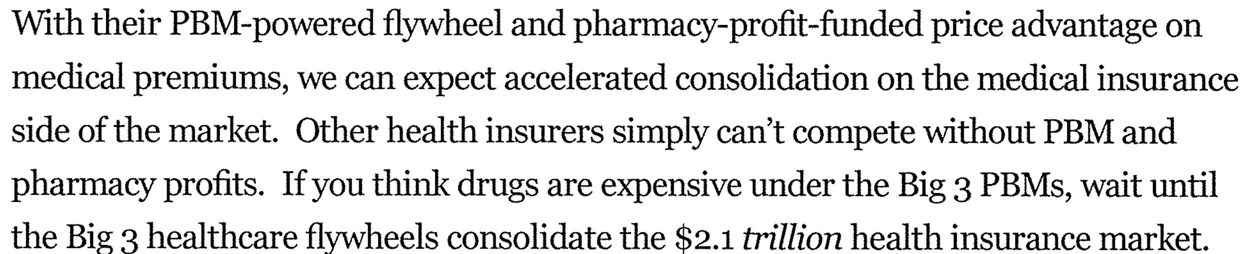
Bundled pharmacy and medical benefits mean patients are steered in one direction

You may ask, "why would sophisticated organizations want to create a competitive advantage to take share in a *less profitable* business?" Because the health plan's role has also changed in this vertically integrated paradigm. Its role is to require and steer medical plan members to use their profitable PBM and pharmacies – specialty, mail order and, in the case of CVS/Caremark, retail. By tying medical coverage to pharmacy coverage and services, more health plan members equal more (profitable) PBM members and pharmacy customers. Together, the bundled pharmacy + medical benefit plan is possibly the most powerful and profitable business flywheel ever invented. UnitedHealth Group, CVS Health and Cigna are now numbers 5, 6 and 15 in the *Fortune* 50 with combined revenues of over $800 billion reported for fiscal year 2022.

The coming consolidation in health insurance has irreversible consequences

If you, like others, are more worried about the power of Big Pharma, consider the first pharma company doesn't show up until number 38 on the *Fortune* list, and the power of their monopoly from patents, albeit subject to controversy, does at least *eventually* end. In contrast, the "invisible hand" of these three vertically integrated businesses, acting in their own self-interests and steering patients to their PBM and pharmacy profit factories, presents a perpetual threat to the broader U.S. healthcare market. According to *Forbes*, CVS Health, UnitedHealth Group, and Cigna collectively represent just over 11.5% of the total health insurance market based on number of individuals covered as of 2022. But the average annual growth rate for all three companies nearly doubled immediately after acquisition and integration with their PBM, while competitors grew at half this rate.



With their PBM-powered flywheel and pharmacy-profit-funded price advantage on medical premiums, we can expect accelerated consolidation on the medical insurance side of the market. Other health insurers simply can't compete without PBM and pharmacy profits. If you think drugs are expensive under the Big 3 PBMs, wait until the Big 3 healthcare flywheels consolidate the $2.1 *trillion* health insurance market.

This consolidated power will also transform what it means to be a healthcare provider. Doctors, to see your future, just ask today's pharmacists how hard it is to negotiate fair reimbursement for delivering quality healthcare services. Constant downward reimbursement pressure will drive providers to close their doors or join the Big 3. This already happened to my primary care provider – and no, my healthcare costs haven't gone down since. American healthcare consumers will lose, particularly communities in existing or soon-to-be care deserts.

I already hear economists arguing for lower costs through efficiency and scale. And sure – if you regulate PBMs, it *could* drive up the total cost of healthcare. But it's important to understand *why* healthcare costs go up when you regulate PBMs – because they *will* raise their prices on medical insurance. It has absolutely nothing to do with market or operational efficiencies, and everything to do with raising medical premiums on customers trying to shop for lower drug costs – to block competition from disrupting their new flywheel. So, yes, healthcare costs may go up if pharmacy and medical benefits get unbundled or PBMs are regulated. But only because PBMs are unwilling to share the savings with those who actually pay for and deliver care – employers, patients, and providers (including pharmacists).

Photo: gerenme, Getty Images

Chris Blackley

Chris Blackley is the CEO and Co-Founder of Prescryptive Health. Chris brings more than 20 years of startup and leadership experience to Prescryptive Health. His prior startup in this industry delivered to market the first multi-tenant hosted platform for retail and mail order pharmacies and was recognized as a Visionary in Gartner Group's Magic Quadrant.

Prior to launching Prescryptive, Chris spent 14 years at Microsoft leading commercial enterprise and public sector licensing in their Worldwide Licensing and Pricing business. Previously Chris led teams in software engineering and cyber security consulting at IBM and Ernst & Young LLP. He is a graduate of Texas A&M University (B.B.A) and Seattle University School of Law (J.D. cum laude).

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