FAQ Pharmacy Benefit Managers

The skyrocketing cost of pharmaceutical drugs is creating health care headaches for millions of Americans, rising by an estimated 26.8 percent from 2012 to 2016 according to the Pew Charitable Trusts. These increases outpace all other categories of health care expenditures.

Due to the untenable cost of prescription drugs, state and federal policymakers are taking a closer look at why these costs are rising so fast. One component of the drug system that has come under increased scrutiny are pharmacy benefit managers (PBMs), who act as middlemen between drug manufacturers and pharmacies.

What are pharmacy benefit managers?

Pharmacy benefit managers are employed by health insurers, Medicare Part D drug plans, large employers, and other health care payers to help manage prescription drug benefits. PBMs consolidate drug needs from multiple employers and insurers to negotiate lower costs.

Nearly all major payers work with PBMs instead of managing drug procurement internally. This includes government payers. According to the Pharmaceutical Care Management Association, PBMs strike deals that impact more than 266 million Americans and will help consumers save $654 billion from 2016 to 2025.

How do PBMs impact the drug market?

PBMs effect the cost and availability of drugs in three major ways. First, PBMs build and maintain drug databases, commonly known as formularies. These databases determine which drugs consumers can access, as well as the cost of the drug. Second, PBMs use their large-scale purchasing power to negotiate rebates and discounts. Third, PBMs work directly with pharmacies to reimburse for drugs that were sold and dispensed to consumers.

Although PBMs can help drive drug prices down, their operations are not transparent. Consumers and regulators are unaware of how these drug prices are determined and if PBMs are passing savings from rebates to consumers. In fact, the U.S. Government Accountability Office found PBMs passed nearly all Medicare Part D rebates on to plan sponsors in 2016. Some critics have questioned whether this is occurring across the entire health care market. One recent study by the Pew Charitable Trusts found "PBMs passed through 78 percent of manufacturer rebates to health plans in 2012 and 91 percent in 2016."

What role do rebates play in the debate over the need for PBMs?

The number of rebates received by PBMs from drug manufacturers has grown immensely over the past decade. According to the 2019 Pew study, manufacturer rebates to PBMs increased from $39.7 billion in 2012 to $89.5 billion in 2016. According to the U.S. Department of Health and Human Services, the average difference between the list price of a drug and the net price after a rebate is 26 to 30 percent. Some drug manufacturers have argued the increasing rebates have forced them to raise list prices for their products.

Under the current system, PBMs have an incentive to favor certain higher priced drugs due to the nature of the rebate process. Because PBMs generally determine the value of a rebate based on the manufacturer's list price, PBMs receive a larger rebate for more costly drugs. This encourages PBMs to favor higher cost drugs and could lead to higher costs for consumers in a connected insurance plan.

What is spread pricing?

Another PBM practice drawing criticism is spread pricing. Under the spread pricing system, PBMs charge payers more than it reimburses the pharmacy for a certain drug and keep the difference. Like the rebates, the funds received and the effects on prices are kept confidential from health plans and regulators.

What reforms should states consider to better regulate PBMs?

Three simple reforms could add transparency to the PBM system while ensuring consumers benefit. First, states and federal lawmakers should propose new laws and rules that would require PBMs to submit more data on how they negotiate prices and determine rebates. It is important to not eliminate rebates. However, a large portion of these savings should be passed on to consumers.

Second, states should introduce legislation that would end the practice of spread pricing. This would ensure payers are not overpaying PBMs for prescription drugs. States should consider moving to a "pass-through model," where PBMs charge payers the same amount they reimburse pharmacies, along with a set administrative fee.

Third, the U.S. Department of Health and Human Services should consider new rules that would require PBMs to pass along rebates to payers or to patients. To main the incentive to negotiate price reductions with drug makers, PBMs would be allowed to keep part of these rebates. One approach recommended by the Commonwealth Fund would necessitate PBMs to pass through 90 percent of their rebate savings to payers. This would likely allow insurers to reduce premiums and cost-sharing payments. The federal government already requires Medicaid fee-for-service programs to use the pass-through model.