PBM PUGILISM

With the Big Three pharmacy benefit managers facing greater scrutiny, more independent players are jockeying for position

Written By Bruce Shutan

A David vs. Goliath battle continues to intensify across the pharmacy benefit management landscape as self-insured employers struggle with reining in their Rx spend.

In one corner lie the so-called Big Three PBMs, which are vertically integrated with the nation's largest health insurance companies and control about 80% of U.S. prescription drug claims. They include Express Scripts, which is owned by Cigna, CVS Caremark, which owns Aetna, and OptumRx, which is owned by the same parent company as UnitedHealthcare.

At the other end of the ring are nearly 100 independent PBMs scrambling for the remaining slice of market share. Many claim their model is "transparent," while a handful go out on a limb to describe their offering as "fiduciary." But industry experts say semantics can be misleading.

Self-insured group health plans appear to be giving the proverbial Davids of this industry a closer look. Consider, for example, that as many as 92% of 300 benefits decision-makers surveyed by the Penta Group for Evernorth believe a model that passes savings directly to members would improve transparency. Moreover, 90% said a PBM model without rebates would make it easier for employees to afford their medications and improve benefits satisfaction.

HIGHER EXPECTATIONS

Jeff Malone

Whereas transparency was a differentiator nearly a decade ago in the PBM space, it's now a minimum expectation, opines Jeff Malone, Co-Founder, President, and CEO of RxPreferred. He says the conversation has shifted to whether transparency is complete, auditable, and aligned, while the future will be backed by aligned incentives and real-time data.

"Independent PBMs are gaining traction, especially among employers and health systems seeking greater flexibility and alignment," Malone observes, noting how employers are now looking beyond size and perceived discounts. "They're asking tougher questions about pricing, rebates, data ownership and conflicts created by vertical integration."

A mass migration among small and midsize businesses from fully insured health plans to level-funding and self-funding has changed the rules of engagement with PBMs in recent years. "We're seeing a big shift of market share increasing into that transparent PBM tranche in the market simply because of affordability," says Jake Velie, Chairman and CEO of National Integrative Health.

Another huge driver is the federal government ramping up regulatory scrutiny of PBM practices, with Acting Labor Secretary Keith Sonderling making the drafting of new PBM transparency regulations a top priority.

Several states have also tried to block PBM ownership of pharmacies, concerned about conflicts of interest that may arise with such enormous scale. Arkansas is the only state that has enacted a law to do just that (in 2025), while proposals are pending in Tennessee and Arizona and under consideration in Indiana and Connecticut. Iowa also is considering aggressive PBM reforms.

Renzo Luzzatti

A CURTAIN OF COMPLEXITY

It's easy to see why this is happening. The fact is that PBMs have operated behind a curtain of complexity for far too long, earning billions each year from spread pricing, rebate retention and opaque formulary steering in contracts with health plan sponsors, Velie argues.

US-Rx Care President Renzo Luzzatti doesn't see much clinical diligence or rigor across the transparent PBM industry in part because many of those owners haven't ever done a prior authorization. "You got folks that were tired of pharmacy margins, and so they started a PBM," he opines.

In light of these headwinds, his firm fields peer-to-peer calls with doctors on a regular basis, noting that the quickest way to resolve a disagreement is to simply pick up the phone and have a conversation with a clinician. In one case, he recalls how a doctor eventually admitted to prescribing a 40% higher growth hormone dosage for a patient that needed to be corrected. It saved the plan $33,000. "This stuff happens every day," he reports.

A pioneer in the independent PBM space, Luzzatti is aware of only a handful of organizations in the marketplace that – like his firm and Velie's – actually describe themselves as a "fiduciary" PBM or pharmacy program. To do that, it means pledging that there will be no conflict of interest, such as accepting rebate money; they will look out solely for the best interest of the plan and its participants; and all utilization and financial information is in full view.

"We cite the ERISA regs, and it means that we're held to the same legal standard as our self-insured employer clients are as fiduciaries of their own plan," he says.

That contrasts with common language in PBM contracts that explicitly state that they're not a fiduciary and not obligated to act in a fiduciary manner, he adds. Some will even allow for contracts to be canceled if a state requires PBMs to be a fiduciary.

In addition, he says there are PBMs that call themselves transparent while also claiming they're not obligated to act in a fiduciary manner. Most times, the inference is that they charge an admin fee and don't do spread pricing. In that regard, Luzzatti explains that the word transparency is nebulous. "It's not a legal term. You can't take them to court over that. It's whatever they say it is," he says.

A PBM may position certain formulary drugs in tier one and tier two to access greater rebates from the manufacturer, and hence usually pocket them, Velie observes. "You're keeping certain brand drugs in a preferred tier when you should be putting a biologic there," he says.

The only industry players that actually meet the definition of a fiduciary PBM are those that are willing to do the reporting necessary for the fiduciary filing for the plan sponsor and hand them over to comply with their duties under the Affordable Care Act and Consolidated Appropriations Act of 2021, Velie notes.

AN ABILITY TO ACCESS DATA

True price transparency lies in how PBMs get paid. "If we look at the PBMs that we like to work with, there's no funny business in the contracts," he explains. "They're not trying to hide behind intellectual property contingencies in the contract. They're showing you what the pricing is. Their fees are flat."

His company works with some PBMs that charge a per-script fee, while others charge an admin fee. Neither of those natural-flow models is easy to manipulate. He says there's very little that a PBM can hide if the data is available. National Integrative Health deploys a multi-lever approach to achieve the lowest net cost on every claim for every member. It includes 340B pricing, biosimilars, 503B manufacturer direct contracting, variable copay programs, clinical interventions and clinical trial program access.

Jake Velie

Many of the transparent and fiduciary PBMs are operating on Big Three chassis that they're white labeling, Velie says. What's different is their business and contract practice, as well as a commitment to data transparency for the end client. Their relatively slow adoption can be traced to the snail's pace of imposing regulatory changes on the healthcare industry when lobbyists still hold considerable sway over lawmakers, he adds.

While jumbo employers can afford to stay with the Big Three, he notes that they've already been forcing them to improve practices because they have the leverage to do just that. Significant change is already afoot. For example, CVS Caremark recently agreed to allow clients to opt out of standard rebate-based payment designs and pass discounts directly through to consumers as part of a settlement with the Federal Trade Commission. Despite that move and any others that might follow, Velie believes the Big Three will still give careful thought to how they're going to recover that lost revenue in other areas.

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UNDERWRITING DECREMENTS

Scott Byrne

From a high-level strategic standpoint, the PBM serves as a linchpin to get underwriting consideration for plan design and execution on high-cost drugs, according to Velie.

"We are constantly working with stop-loss carriers in underwriting and actuarial practices because we can predict our outcomes when we have the right plan design," he reports. "So, when we give them our analysis during the underwriting process, it is guaranteed to work, and we are seeing normally up to 10% reductions in stop-loss renewals because we have the right formula and we cannot execute on the right formula without the right PBM partner."

Blackwell Captive Solutions President Scott Byrne notes that as recently as three to five years ago, "most stop-loss carriers were not offering decrements for PBMs. It just wasn't being factored into their manual rate whatsoever. They would factor in network and TPA, but PBMs surprisingly were left out of the mix."

Since that time, he says prescription drug costs swelled from roughly 20% to 25% of an employer's annual health plan spend to more than 50%. Therefore, he believes this bigger piece of the pie deserves to be addressed and accounted for in a health plan's pricing.

Given all that's at stake, pharmacy benefits are becoming a year-round risk management function instead of an annual renewal discussion, according to Malone. He says claim-level visibility allows employers to identify high-cost trends early, manage specialty drugs and GLP-1s proactively and coordinate pharmacy strategy with the broader health plan.

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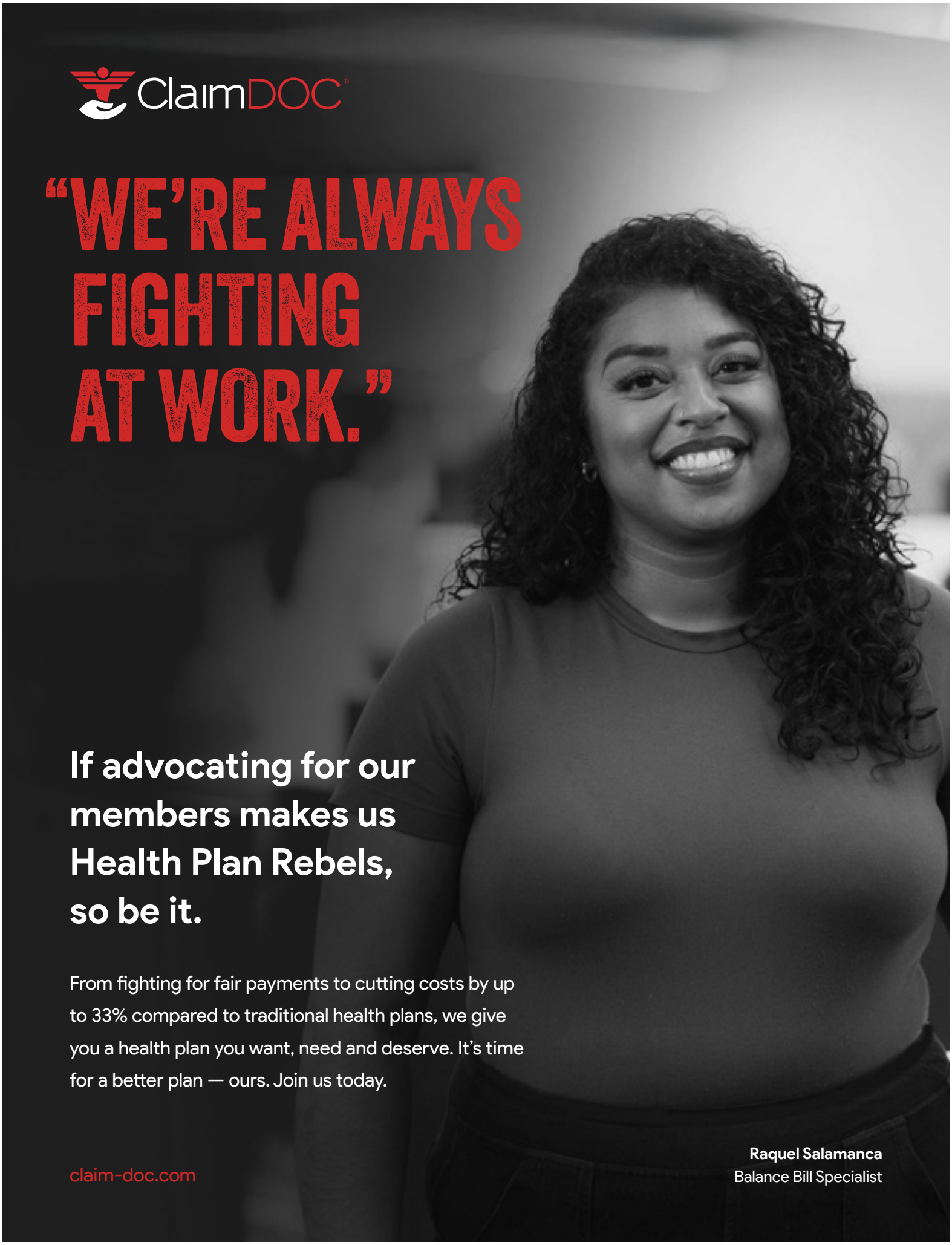

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EYEING EFFICACY

While the cost of prescription drugs is top of mind, so is the impact on clinical outcomes. Pressure is mounting on self-insured employers to determine whether drugs on their formulary are actually benefiting health plan members relative to other scripts in the face of rising medical and pharmacy costs, observes Katherine Shanahan, Director of Pharmacy Consulting for Merative. To put it another way, is there a meaningful enough return on investment?

The use of GLP-1s for weight loss has spotlighted this concern. She says there's such a high rebate percentage for these drugs that without price transparency, it's difficult to determine whether there are downstream health improvements and savings from patients no longer experiencing flare-ups.

While huge biometric improvements have been seen with GLP-1s, she notes that there's still a lot of exploration with regard to stepping down a patient over time and realizing that longevity requires a different cost model.

A RESTLESS MARKET

Katherine Shanahan

While some health plan participants are more comfortable having a household name on their ID card, Byrne believes smaller independent PBMs are achieving the most progress relative to the Big Three when it comes to transparency.

He uses a construction analogy to describe the captive-PBM relationship, noting that the captive serves as the general contractor that builds a meaningful risk-management strategy and hires a PBM as one of several subcontractors. Choosing the right PBM is critical. "We want to bring best-in-class point solutions to our members because ultimately we need to be good stewards of their money," he says.

As many as 30% of the employer population is out to bid now on a PBM in the course of a typical year, Luzzatti reports, noting that frustration is mounting upstream to jumbo employers and predicting that most self-insured clients will have made a change in three years.

"Their concern from a legal standpoint is that they might be the next target like Johnson & Johnson, Wells Fargo and JPMorgan Chase. Nobody wants that," he says.

Velie predicts that there will be a meaningful shift in the market away from the Big Three given these high-profile lawsuits alleging that employers are overcharging for prescription drugs, and as a result, breaching their fiduciary responsibility under ERISA to act in the best interest of plan participants.

"I think they can only survive so much bad publicity," he says of the Big Three, "and now that these fiduciary and transparent PBMs are getting up to the point where they're scalable, they can handle larger populations and serve their clients well. I think over the next five years, that segment of the PBM market will see more growth than they've seen in the last 15."

Historically, Shanahan points to constraints in the request-for-proposal process that have eliminated smaller or boutique PBMs from contention. However, she sees more midsize health plans having them at least fill out the remainder of the RFP and change some of the metrics they're looking at even though they didn't rank highest.

Adds Malone: "Transparency tells an employer what happened. Alignment determines why it happened and whether the PBM had an incentive to deliver the best result."

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for nearly 40 years.