PBM QUAGMIRES TROUBLE EMPLOYERS

Editor's Note: For more information about this topic, please plan to attend SIIA's High-Cost Drug Stakeholder Forum, scheduled for May 28-29 in Minneapolis. Event details can be accessed at www.siia.org

Written By Laura Carabello

Amid a barrage of high-profile lawsuits, legislative challenges and widespread employer/payer dissatisfaction with escalating drug prices, the Pharmacy Benefit Management (PBM) industry is awash in negative publicity and uncertainty. In the wake of these complaints, the Pharmaceutical Care Management Association, a trade group representing the six-largest PBMs and others, said in a statement that the industry welcomes competition from newer entrants.

Now in the crosshairs of Congress, as well as State legislators such as Illinois, PBMs face a host of pending regulations to address criticisms such as steering patients toward their own pharmacies, requiring patients to use an in-network pharmacy or paying a pharmacy an amount less than the national average drug acquisition cost for the drug dispensed. Congress is tackling these issues, with proposals under consideration that include:

- Requiring PBMs to charge flat fees that are not linked to drug prices
- Creating standard pharmacy performance metrics on which fees are based
- Requiring PBMs to disclose negotiated drug rebates and discounts -- and requiring those rebates and fees to be passed through to employers
- Prohibiting spread-pricing

Employers lay blame on PBMs, generally described as "behind-the-scenes middlemen" that negotiate discounts with drug manufacturers and reimbursement rates with insurers to determine which medications qualify for coverage. Accusations include demanding discounts and rebates from drugmakers, which leads the manufacturers to charge higher list prices, which can drive up the price patients pay at the pharmacy. Concurrently, retail pharmacies say PBMs are literally driving them out of business by paying them less than what the PBMs charge health plans — a practice known as spread-pricing, where PBMs charge more to health plans than they pay pharmacies for prescription drugs.

Julie A. Wohlstein, M.A.S., CSFS ®, President and CEO, Centrix Benefit Administrators, Inc., specifies the challenge, "PBMs often present self-funded employers with a double-edged sword. While they play a critical role in managing prescription drug plans and negotiating discounts, their opaque practices often lead to hidden costs and misaligned incentives."

She says PBMs typically steer members toward higher-cost drugs as way to maximize rebates, a practice which inflates the overall costs.

"Employers are burdened by complex contractual terms that obscure true drug prices and make it difficult to identify cost-saving opportunities," she continues. "Furthermore, the adoption of narrow pharmacy networks may limit employee access, which creates dissatisfaction among the workforces."

Across the board, plan sponsors say they have no idea what a drug will cost because many PBM contracts contain nondisclosure clauses. There are varying reports regarding the stranglehold on the industry. According to the American Medical Association, together, the big three -- CVS Caremark, Cigna's Express Scripts and United Health's OptumRx -- hold nearly 60% of the pharmacy benefits market based on their control over rebate negotiations, retail network management, and claims adjudication.

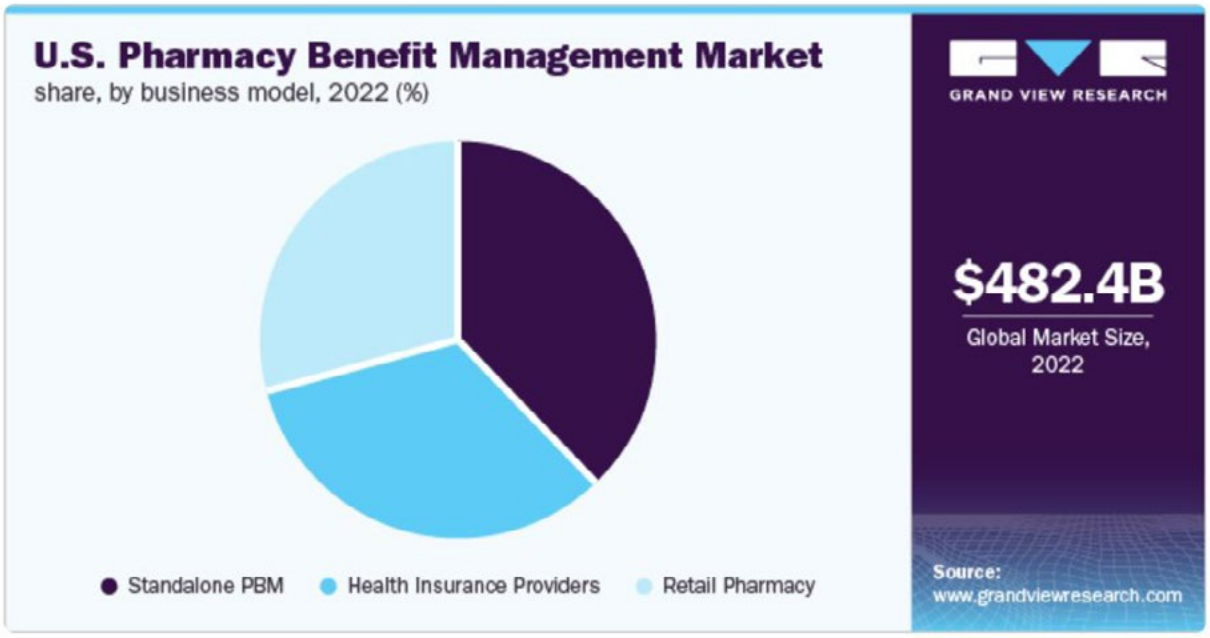
Furthermore, a recently released report from the Federal Trade Commission (FTC) shows that these three PBMs processed almost 80% of the 6.6 billion prescriptions filled nationwide last year, and the top six players control more than 90% of the market. The FTC found that those companies use tactics to point patients toward drugs that are more costly.

Wohlstein maintains that a major challenge lies in the lack of transparency in rebate structures, adding, "PBMs frequently retain a significant portion of manufacturer rebates rather than passing on the savings to the employer or employees, creating an environment where profitability outweighs patient outcomes. To navigate these challenges, self-funded employers must prioritize transparency and explore innovative solutions such as pass-through PBMs or carving out pharmacy benefits for direct negotiation. By adopting proactive measures, employers can better align PBM practices with their financial goals and the health needs of their workforce."

In this current environment, employers are certainly scrutinizing PBM policies and capabilities more closely.

Lori Daugherty, CEO, RxLogic observes, "Employers select PBMs based upon transparency, cost savings, service quality, and alternative solutions. A transparent PBM ensures clear pricing, eliminates hidden fees, and passes through negotiated savings. While rebates may seem attractive, employers should assess total cost impact rather than just rebate amounts."

She says that superior service and clinical support help optimize medication access while controlling expenses, noting, "Additionally, PBMs offering alternative pricing models, such as direct manufacturer savings and pass-through pricing, providing additional cost-cutting opportunities. Our model powers PBMs with the technology and services needed to meet these employer demands, enabling PBMs to deliver transparency, cost-efficiency, and advanced analytics, ensuring a superior service model for their clients."



Re-cap of Some Issues to Date:

- Last year, the FTC sued the three jumbo PBMS for anti-competitive practices, alleging that their practices artificially raised the price of insulin drugs. While the PBMs asked a Missouri district court to block the agency's suit, as of mid-February, the lawsuit was slated to move forward after a federal judge declined to halt the case. Later in the month, the Big Three elevated their suit and asked the Missouri district judge to halt the FTC's administrative case against them. Stay tuned to the see-saw battle.
- In 2024, The House Oversight Committee kept pressure on PBMs during hearings that criticized industry practices to steer patients to PBM-owned pharmacies while underpaying competing pharmacies. There is increased scrutiny on the way PBMs treat independent pharmacists, who say

they're being drummed out of business by PBMs.

- PBM executives were also summoned before Congress and reproved for creating corporate entities in Switzerland and Ireland to centralize the negotiation of rebates and fees. They were grilled with accusations of creating entities in Ireland and the Cayman Islands to manufacture and market certain highly profitable generics and biosimilars -- locations purportedly lacking in financial transparency and movement of operations that would be subject to impending regulations.

- A group of legislators called upon the Department of Justice to investigate whether PBMs played a role in the opioid epidemic, pointing to reports that suggest the three largest PBMs worked together to steer patients to OxyContin prescriptions in exchange for $400 million in rebates and fees from Purdue Pharma across a yearlong period ending in late 2017.

Tangentially, in welcome news for the employer community, the Groom Law Group reported that the US District Court for the District of New Jersey dismissed in January 2025 a putative ERISA class action lawsuit in a much-followed case involving Johnson & Johnson (J&J). The plaintiff alleged that the plan fiduciaries for J&J's group health plan violated ERISA by mismanaging its self-funded health plan's prescription drug benefit. The Court found that the plaintiff's allegations that she paid too much in premiums, copays, and coinsurance and that her wages were adversely impacted by prescription drug costs were speculative "at best," and that her allegations regarding higher out-of-pocket costs for prescription drugs were not redressable.

At year-end 2024, while Congressional lawmakers reached a deal to put guardrails around these so-called "middlemen," the agreement fell apart because it was tacked onto a larger spending package that

crumbled during a final vote. The employer PBM provision would have created new reporting requirements for employers' PBMs and required employers' PBMs to pass all rebates on to the employers' plans rather than keeping a percentage of the discounts they negotiated. When the spending package stripped out this provision, PBMs got a temporary reprieve -- but it's likely to be a short honeymoon for them in Washington.

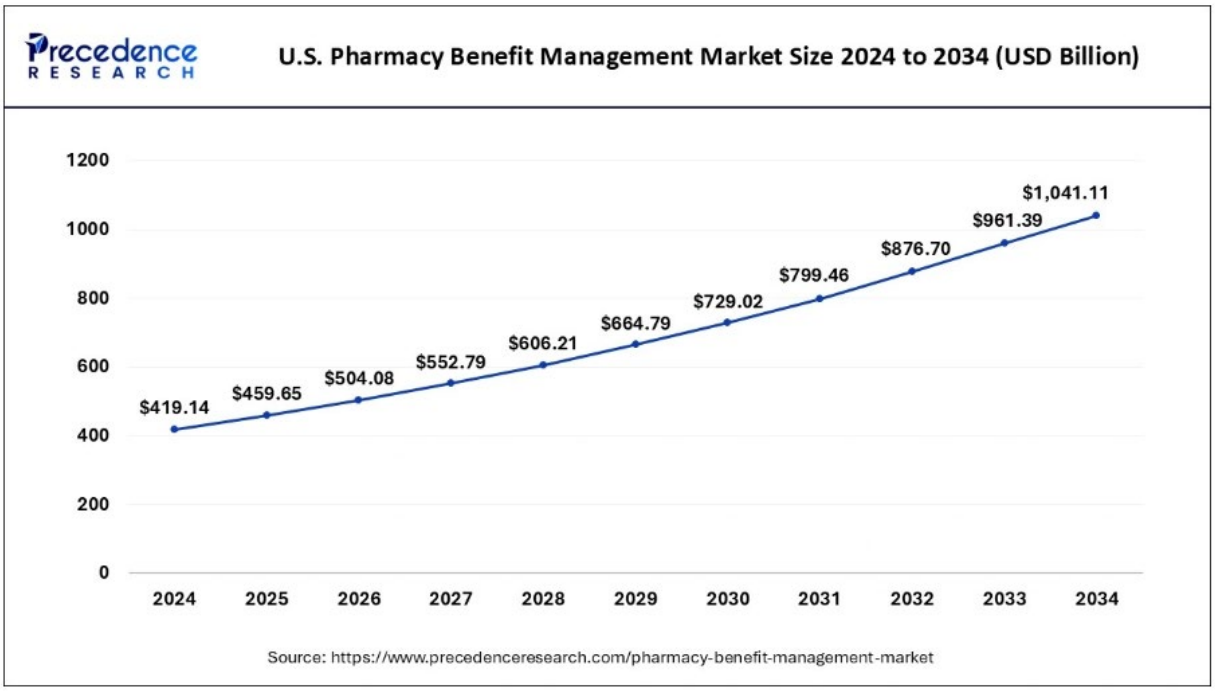
The issues are bubbling up in 2025 with bipartisan efforts that press the FTC to be tough on PBMs. The FTC's ongoing campaign, which most recently focused on charges for high-cost specialty drugs, accused the three biggest PBM pharmacies of collecting $5.9 Billion in specialty drug mark-ups.

Chairman of the House Energy and Commerce Committee recently declared that he and his colleagues hope to pass new versions of the bipartisan health bills, many that have lingered for more than a year without final action. One measure that could be included is a bill that would regulate how PBMs serve employer-sponsored health plans.

The latest salvo came in February when A broad coalition of healthcare companies, employers, labor unions and trade associations called upon the White House and Congress to enact legislation to curb PNMs: Blue Shield of California, employers represented by the ERISA Industry Committee, pharmacies represented by the National Association of Chain Drug Stores and the National Community Pharmacists Association, and an umbrella group called America's Agenda that includes the insurers Elevance Health, Centene and Kaiser Permanente along with unions and drugmakers, made their plea.

There's even proposed legislation in Texas that could stop health insurers or other coverage issuers in the Lone Star State from requiring patients to use the carriers' own pharmacy benefit managers.

Amid all this market uncertainty, pharmacy spend is expected to rise 3.8%, with specialty pharmaceutical costs as the main driver and price increases to classic specialty drugs that treat oncology conditions and autoimmune disorders. A Vizient study showed that Humira, Stelara and Skyrizi, which all can treat Crohn's disease, are projected to have the largest price increases.



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GAUGING EMPLOYER DISSATISFACTION

Faced with projected healthcare cost pressures, employers are trying to hold their PBMs accountable – especially for pharmacy costs. According to the Business Group on Health, pharmacy costs accounted for more than a quarter of healthcare costs in 2023, with rising drug costs largely driven by expensive specialty medications, cell and gene therapies (CGTs) and GLP-1s.

A survey by the National Alliance of Healthcare Purchaser Coalitions, an advocacy organization for employers and purchasers, substantiates these perceptions: about 99% of respondents listed drug prices as a significant threat to affordability. Purchasers cite PBM vertical integration and opaque practices as the culprits.

Every size employer-sponsored health plan is facing increasing healthcare costs, but the impact on small employers and their employees is more acute and likely to continue. Many believe their PBM isn't always looking out for their needs.

The National Alliance of Healthcare Purchaser Coalitions survey also documented employer dissatisfaction with their PBMs: 52% are considering changing their PBM in the next one to three years. According to their leadership, PBMs use "opaque business practices" that allow them to change the status of a drug from generic to specialty to name brand without the employer's consent. They also point the finger at the big three PBMs that all own their own specialty, retail, and mail-order pharmacies and "strategically price drugs to maximize revenue to their internal pharmacy chains."

EMPLOYERS MAKING A SWITCH

A growing number of employers would rather 'switch than fight' with their PBM partners, opting for a vendor that is more agile and offers alternative network models with greater price and quality transparency. Status quo PBM contracts may go by the wayside in favor of dropping the "Big Three" PBMs to "transparent PBMs," which don't camouflage their pricing and drug choice decisions.

In the Business Group on Health's annual survey published in late January, respondents indicated concerns about a lack of transparency in contracts with PBMs. While 6% of employers plan to change PBMs next year, nearly one-third said they will reassess their partnerships next year. Switching drug benefit policies at larger companies takes time since PBM contracts with the big three typically last three to five years. PBMs pay benefit plan consultants and brokers handsomely to steer business their way.

A few big employers are already changing their drug plans. Back in 2019, the State of Connecticut became CVS' first PBM customer to negotiate a transparent fee structure. Its contract required 100% of drug rebates to be passed along to the state and eliminated spread pricing.

Other payers may be following this lead and learning from the Connecticut experience. The CT State Comptroller's office reported a further step in the new contract for its 214,000 employees. Instead of discounts and rebates, it demanded the lowest net cost per employee, with projected savings of up to $70 million a year. Of the three big PBMs, only CVS bid on the contract, edging out a few "transparent PBMs" and signaling that CVS wants to stay in the game.

Other examples include:

- Highlighting the growing demand for change, Blue Shield of California made headlines by dropping CVS Caremark as its PBM in favor of a more transparent and innovative strategy. Partnering with companies like Amazon Pharmacy and Mark Cuban's Cost Plus Drugs, Blue Shield aims to bypass traditional PBM structures, focusing on value-based pricing and direct relationships with pharmaceutical partners.

- Purdue University, which sought control over the drug formulary to provide more lower-cost options for its 25,000 employees and dependents. They recently switched from CVS Caremark to AffirmedRx.

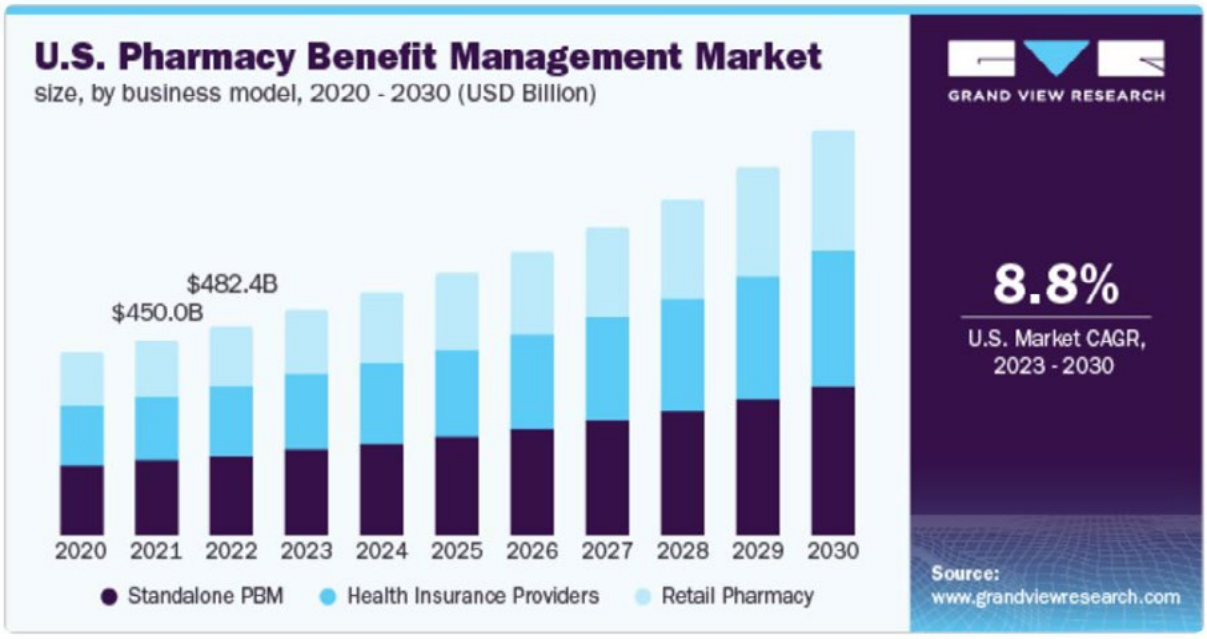
- Capital District Physicians' Health Plan dropped CVS Caremark two years ago to partner with CapitalRx to administer pharmacy benefits for its 400,000 members. The non-profit health experienced a 9% drop in costs for commercial members under the contract, noting that at times, CVS Caremark would recommend excluding a generic medication over a brand drug in favor of a higher rebate.

- The non-profit, 600,000-member health plan UCare ended its 13-year relationship with Express Scripts and in January began a multi-year contract with Navitus Health Solutions, a pass-through PBM owned by St. Louis-based SSM Health and Costco Wholesale Corporation. Citing another motivation for the switch, UCare sought to support local pharmacies, which have called out the major PBMs for forcing unfair contract terms that deliver lower reimbursements than those delivered to PBM-affiliated pharmacies.

- Geisinger Health Plan has 600,000 members, and while they never contracted with one of the major PBMs, it doesn't dismiss them when re-evaluating contracts. One of Geisinger's biggest challenges is persuading employers to adopt the transparent approach, saying it has lost employer

clients to health plans operated by the major players pitching large rebates.

- Investment company Voya Financial, with 7,200 U.S.-based employees, was rethinking its relationship with CVS Caremark and began a multi-year contract with retailer Costco Wholesale Corporation's PBM Costco Health Solutions. Voya anticipates 10% savings for both its employees and the company.



Throughout the industry, many groups are dealing with this issue. Wohlstein explains that as a TPA, her organization was faced with this conundrum and made the decision to look for another PBM.

Transparency was a top priority in their decision to make a change.

“Hidden fees, spread-pricing and unclear rebate structures were having a significant impact on our plan costs,” she continues. “Ensuring rebates are passed directly to the plan and eliminating unnecessary administrative charges are crucial in managing overall drug expenses and maintaining trust. Pharmacy spend was the highest claims increase trend for our Plans,” she continues.

While large PBMs bring scale, broad networks, and deeper manufacturer relationships, Wohlstein found this is often at the cost of transparency and member customization.

“Boutique PBMs, on the other hand, excel in personalized service, flexible solutions, and often better alignment with employers' goals,” she insists. “The trade-off depends on the employer's specific priorities, such as cost control or member satisfaction. As a TPA, we must align the PBM vendor with the employer’s benefit strategy to determine the best critical path forward for their plans.”

She further contends that because their current large national PBM was not meeting their clients’ needs, as stated above, “…we selected a boutique vendor who was more innovative, and their offerings could be more tailored to the needs of our clients. I think PBMs will face heightened scrutiny for their opaque practices, and therefore, government intervention seems increasingly likely.”

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As with any regulatory mandate, Wohlstein cautions that while such intervention might improve transparency and curb unethical practices, "This could also lead to unintended consequences, such as reduced flexibility or increased administrative burdens. The outcome will depend on how well regulations address the root causes of misaligned incentives without stifling innovation, and that is what is truly important to the self-funded community."

On a related front, Walgreens outlined its corporate turnaround strategy to include renegotiating contracts with PBMs and reports having renegotiated all contracts up for renewal in 2025, about a third of its total contracts. Walgreens says it is working with PBMs to balance brand-name drugs and generics, carve out new categories for high-cost drugs such as GLP-1s and implement alternative payment models.

INTEREST SPIKES IN SMALLER PBMS

Many smaller PBMs are seeing an uptick in interest, but the newer entrants will continue to face stiff competition and significant obstacles as they seek more business in the employer marketplace ---- from massive employers to small-to-midsize groups. These smaller PBMs usually offer more restricted drug formularies that can become a frustration point for members, while larger vendors typically feature attractive rebates and greater access to branded drugs resulting from their buying power to obtain medications at lower prices.

On the plus side, smaller PBMs are looking to attract customers by giving them more control over formularies and providing access to data. Many tout potential savings for employers between 30-50% on their pharmacy spend. These smaller companies are passing along drug rebates, disclosing cost negotiations with drugmakers, reimbursing pharmacies at higher rates and rejecting spread pricing.

Questioning the value of large PBMs, Rachel Strauss, VP of Strategic Development at Employee Health Insurance Management, Inc., says, "The big PBMs operate like monopolies, with complex systems that obscure true costs and limit choice for the employer. Their contracts often read like mortgages and have even harder-to-understand terms. However, when the correct contract is executed, they can offer the buying power the boutiques do. But this is often without guardrails. Would you rather get a bigger discount on a more expensive item, to begin with, or less of a percentage, but on a lower net cost product?"

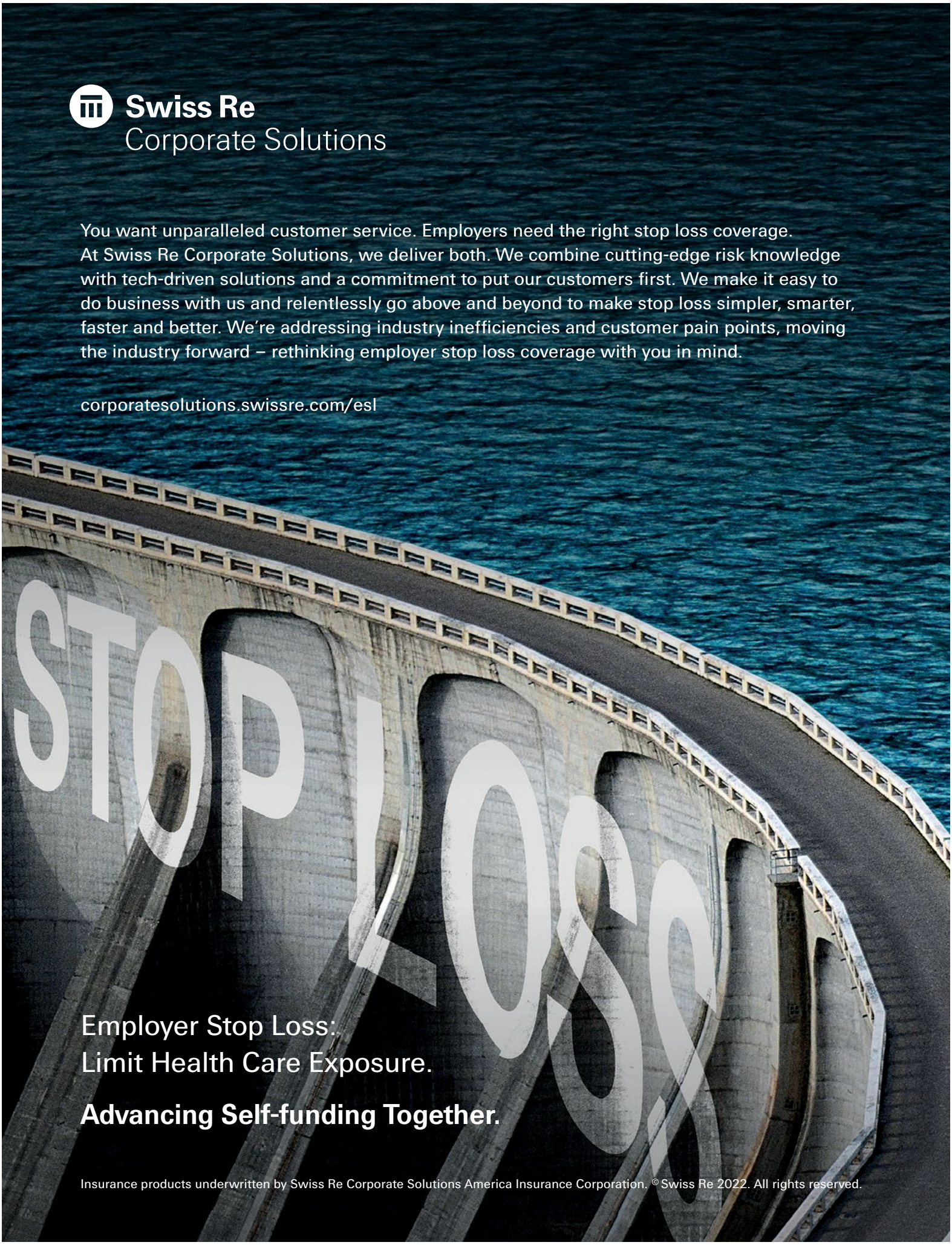
Conversely, she thinks boutique PBMs are "…refreshingly straightforward, prioritizing transparency and a tailored approach to optimize costs and care for their clients. Employers often find they get far more value from the smaller, hands-on players with the creativity and flexibility they offer."

Strauss believes the government and new administration will step in during 2025 to implement regulations aimed at reining in the PBM industry, adding, "This will be a positive shift for the self-insured community which can hopefully transfer to the patient itself. Increased oversight and transparency will help eliminate hidden fees and conflicts of interest that have long driven up costs without adding value."

She thinks these regulations could empower employers to make better-informed decisions, negotiate more effectively, and ultimately provide their members with more affordable, high-quality care.

"While change can be hard, these reforms are a necessary step to level the playing field and prioritize the needs of patients and employers over PBM profits – finally," concludes Strauss.

Staying the course, Nick Soman, CEO of Decent, reports that they proudly partner with DisclosedRx, a PBM committed to transparency through full rebate pass-through and no hidden fees.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"Their exceptional member services team and Prescription Navigators provide 24/7 support, expert advice, and consistent follow-through, ensuring a seamless experience for members," says Soman. "DisclosedRx aligns with our mission of delivering affordable, transparent healthcare by prioritizing the well-being of employers and their members."

With tailored solutions, flexibility, and an innovative approach, Soman says DisclosedRx stands out as a trusted partner.

"Their commitment to clear, predictable pricing drives cost savings and satisfaction across the community," he states.

For John Wiklund, FSA, MAAA, Vice President and Actuary, Small Business Benefits, a preferred PBM is offered to clients so they can access the financial benefits and programs.
"Important considerations are the pharmacy network, formulary disruption, administrative capabilities, customer service, adaptability to legislative actions, access to mobile apps and cost comparison tools," expands Wiklund. "Transparency is important for a great user experience, though its true impact on pharmacy spend is unknown. We currently utilize rebates to offset admin costs, keeping coverage affordable. Regulatory changes could potentially jeopardize the cost offset structure we implement today."

Wiklund and his colleagues continually evaluate their choice of PBM, emphasizing, "Prescription drugs are the largest category of health plan spend and represent a high volume of members' interactions with the plan. We need to be vigilant with our plans' funds, offer state-of-the-art coverage options, and feel confident in the value of our pharmacy services."

He observes that despite partisanship, "The government's strong focus on PBMs will likely lead to regulation. State and federal proposals could increase transparency but may also result in higher costs for plans and members."

Employers often require guidance when choosing a PBM and establishing benchmarks to support a decision.

Paige Zimmer. EVP of Business Development, RxLogic, explains, "We empower employers with data-driven solutions to optimize pharmacy benefits while reducing costs. Employers should prioritize transparency, flexibility, and analytics-driven decision-making when selecting a PBM."

The organization provides a PBM claim adjudication platform that is tailored for self-funded employers, allowing for customized, cost-effective pharmacy benefit management. Through rebate

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administration services, a copay program, eVoucher programs, discount card network and commercial network partners, employers can provide solutions that can be essential to lowering their costs, as well as their employees.

"Employers also seek advanced analytics and reporting tools that provide insights into medication usage, cost trends and opportunities to optimize their plans," says Zimmer. "Employers need ways that deliver transparency, efficiency, and innovative solutions. By equipping employers with these capabilities, we help employers access the best financial and healthcare outcomes."

JUMBO PBM RESPONSE

One large PBM is taking the rebate criticism off the table. Optum Rx announced that it will soon pass all rebates it gets from prescription drug manufacturers on to employer health plan sponsors and other clients. Leaders maintain that the PBM already passes 98% of the rebates it negotiates on to the customers, but customers that account for about 2% of the rebates have voluntarily chosen compensation arrangements that let UnitedHealth keep about 2% of the rebates.

UnitedHealth does not post details about the cash flow related to drug debates, but it reported in its annual financial statement for 2023 that it accumulated $11 billion in prescription rebate receivables on its consolidated balance sheets as of the end of 2023, up from $8.2 billion at the end of 2022.

Signaling change, CVS Health continues to undergo significant leadership shuffling as it navigates challenges in its insurance and PBM segments. Its Caremark PBM ushered in a new president as part of the executive shifts as the company grapples with increased medical costs and heightened regulatory scrutiny. ■

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