

Prescription Drug Resource Center

Pharmacy Benefit Managers and How they Relate to States

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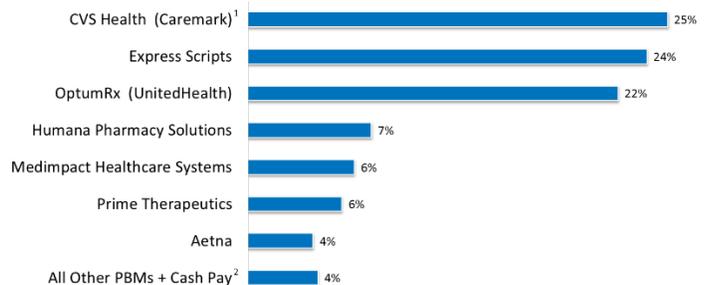
As state lawmakers continue to grapple with rising prescription drug spending within the parameters of their state’s budget, transparency in the pharmacy supply chain is increasingly seen as an approach to mitigate the cost. Until recently, drug manufacturers often found themselves in the political crosshairs but now more attention is being drawn to the role of pharmacy benefit managers (PBMs).

[According](#) to the Centers for Medicare & Medicaid Services (CMS), pharmacy-based and mail-order consumer purchases of prescription drugs were a \$333 billion market annually in the United States in 2017. Furthermore, the Pharmaceutical Research and Manufacturers of America (PhRMA) [estimates](#) that physicians and other prescribers write approximately 6 billion prescriptions in the U.S. every year with approximately two-thirds of them being processed by a PBM. This has led to many lawmakers asking, “What are PBMs and what is their role?” This brief is intended to help answer those questions.

What are PBMs and What is Their Role?

Pharmacy benefit managers are third-party administrators of prescription drug coverage for insurers and employers who pay a fee to the PBM for their services. These services include developing and maintaining formularies, processing claims and negotiating discounts and rebates. PBMs manage plans for millions of Americans who have health insurance from a variety of sponsors including commercial health plans, self-insured employer plans, Medicare Part D plans, state government employee plans, and Medicaid managed care organization (MCO) plans. According to the Drug Channel Institute, as of 2018, the three largest PBMs, ExpressScripts, CVS Caremark and OptumRx, controlled over [70%](#) of the market.

BPM Market Share, by Total Equivalent Prescription Claims Managed, 2017



1. Excludes claims processed by Aetna. For 2017, CVS Health changed its publicly reported computation of equivalent prescription claims filled in network pharmacies.
2. Figure excludes cash pay prescriptions that use a discount card processed by one of the 7 PBMs shown on the chart.
Source: Drug Channels Institute research and estimates. Total equivalent prescription claims includes claims at a PBM’s network pharmacies plus prescriptions filled by a PBM’s mail and specialty pharmacies. Includes discount card claims. Note that figures may not be comparable with those of previous reports due to changes in publicly reported figures of equivalent prescription claims. Total may not sum due to rounding.



PBMs use formularies, which are lists of preferred drugs, to negotiate price discounts and rebates with manufacturers. In this way, manufacturers compete to be placed more favorably on the PBMs formulary by offering discounts off the list price. Competition among drug products depends on the number of alternative therapies available within each therapeutic class, or tier. In classes where several products may be considered therapeutically equivalent, PBMs can negotiate with drug manufacturers for higher rebates.

Another PBM utilization management tool is the establishment and upkeep of pharmacy networks. PBMs develop pharmacy networks by entering into contractual agreements with retail and mail-order pharmacies to dispense drugs to enrollees of prescription drug coverage offered by insurers. By creating [networks](#) of multiple pharmacies, PBMs leverage



their size to negotiate contracts between drug manufacturers and retail outlets. To control costs, some PBMs have moved to preferred, or narrow, networks, which requires enrollees to get their prescriptions from certain pharmacies specified in the drug plan.

To receive compensation for the prescriptions they dispense, pharmacies submit claims to PBMs and are reimbursed based on a negotiated rate. These negotiated rates are typically proprietary. However, the pharmacy reimbursement rate is usually a discount from average wholesale price (the average price that wholesalers purchase a drug from a manufacturer) plus a dispensing fee, and minus any patient cost-sharing collected by the pharmacy.

PBMs [attest](#) that they lower overall drug spending by negotiating discounts from manufacturers on behalf of insurers, pharmacies and wholesalers. In exchange for their services, PBMs usually retain a percentage of those discounts and rebates paid by manufacturers, which are meant to be shared with health plans. Plan sponsors often use the rebates and discounts they receive to help reduce plan costs or premiums. Rebate amounts are based on the contracts negotiated between the PBM and plan sponsors, and the PBM and manufacturers. These contracts are typically considered proprietary and not available to the public.

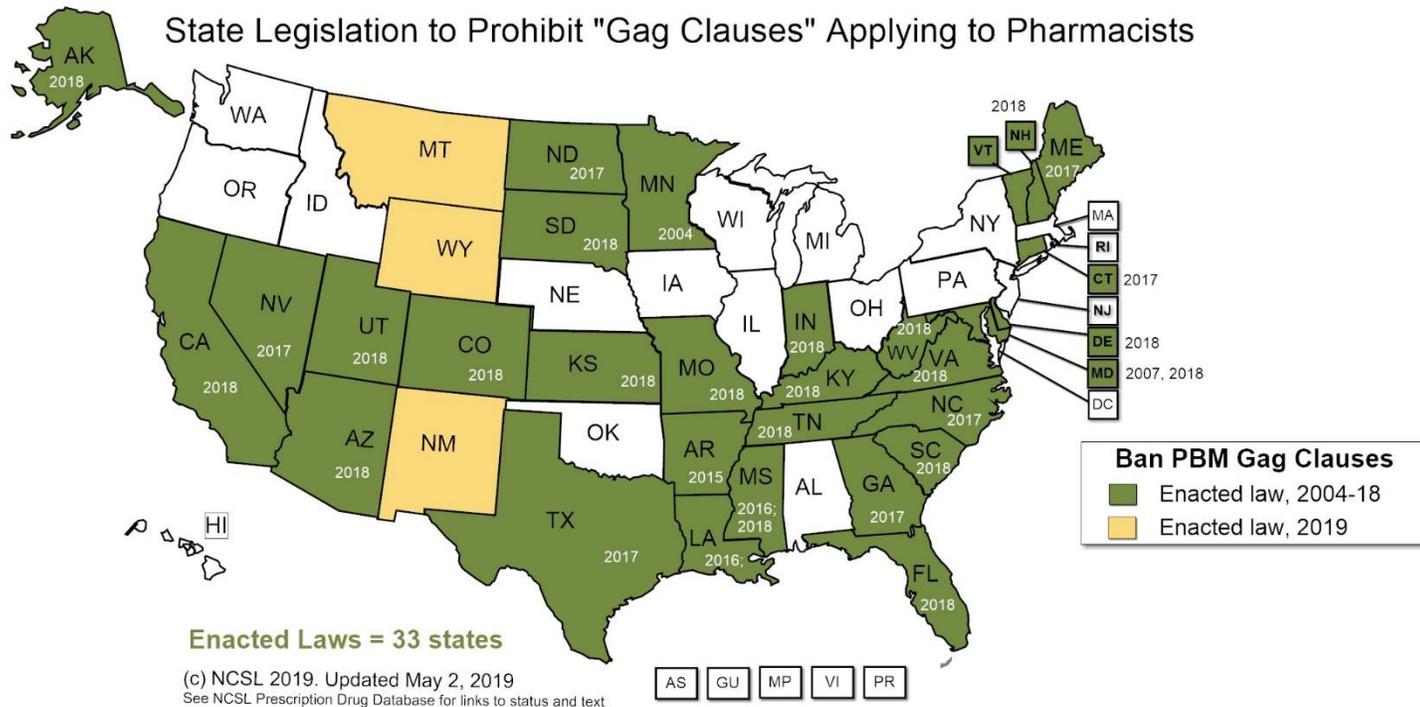
What are states doing?

Historically, the PBM industry has largely been left unregulated which some state lawmakers believe adds to the increased cost of pharmaceuticals. This has led some policymakers to explore policy levers related to PBMs. Over 175 bills in 44 states were introduced during the 2019 session alone. This brief captures some of the themes that emerged. Visit NCSL's [Prescription Drug Resource Center](#) where you can access NCSL's [Prescription Drug Law Database](#) to search among more than 4,600 pieces of legislation by state, year, topic, keyword, current status or primary legislative sponsor.

Gag clauses

Terms of the contracts between PBMs and other entities in the supply chain are usually proprietary to purchasers, including individual consumers. In some cases, these arrangements include restrictions that mean a pharmacist is contractually prohibited from informing consumers that the drug they want to buy could possibly be bought at a lower cost. In some cases, the consumer can receive a better deal if they pay out of pocket rather than purchasing through their insurance plan.

These gag clauses, as they have come to be known, have come to the attention of state policymakers seeking to lower drug costs by requiring extensive transparency at the retail pharmacy level. Seeking to block such provisions in commercial PBM or health insurer contracts, a wave of [state legislation in 2018](#) was enacted with at least 30 states adopting measures to counteract these gag clauses. For 2019, Montana, New Mexico and Wyoming also passed legislation. Many of these bills also addressed the issue of "copay clawbacks."



Copay Clawbacks

A copay clawback happens when a patient’s copay is more than the total cost of the drug to the PBM or insurer and those entities essentially “claw back” the overpayment from the pharmacy. For example, in a [study](#) performed by researchers at the University of California Schaeffer Center, out of over 9.5 million claims, almost 23% had an overpayment at an average of \$7.69 per claim. At least nine [states](#)—Connecticut, Georgia, Maine, North Dakota, North Carolina, Texas, Louisiana, Maryland and Virginia—have enacted legislation prohibiting copay clawbacks.

Spread Pricing

Another practice garnering attention is spread pricing. With spread pricing, PBMs are compensated by retaining the difference, or spread, between the amount they charge a plan sponsor and the amount they reimburse a pharmacy.

For [instance](#), a pharmacy purchases a bottle of medicine for \$5. A patient uses their insurance benefit to fill a prescription and their PBM pays the pharmacy \$10 to cover the cost allowing the pharmacy to pocket \$5. The PBM also bills the insurer \$20 for the medication. The \$10 difference in what the PBM paid the pharmacy and what it billed the insurer is the spread, which the PBM keeps.



This data shows the spread as percentage of total paid to a PBM for each of the five Medicaid managed care plans.

Managed Care Plan	Total Spread (millions)	Total Paid (millions)	Percentage
Buckeye	\$32.8	\$298	11.0%
CareSource	\$113.5	\$1,386	8.2%
Molina	\$27.1	\$310.2	8.8%
Paramount	\$22.3	\$244.4	9.1%
United	\$28.9	\$287.8	10.1%
Total	\$224.8	\$2,526.5	8.9%

¹ Source: Data files submitted by CVS Caremark and OptumRx
² Based on the period of April 1, 2017 through March 31, 2018

In 2018, Ohio conducted an [audit](#) of its Medicaid MCOs who contract their prescription benefit plans to PBMs. The attorney general’s [report](#) found that while the overall spread in 2017 was \$224.8 million, or 8.9%, a significant portion of the spread occurred on generic drugs. The PBMs charged the state a spread of more than 31% for generic drugs which comprised more than 86% of all prescriptions.

Subsequently, Ohio Medicaid officials directed

the state’s five MCOs to terminate contracts with PBMs using the spread pricing model and to renegotiate them using a more transparent pass-through pricing process. A pass-through structure requires a PBM to charge an MCO the exact amount the PBM pays for prescriptions and dispensing fees to the pharmacy. The state first sought nonbinding mediation, but after 30 days of no response, the attorney general filed a lawsuit asking for recompense of \$16 million in overpayments from PBM OptumRx.

Kentucky’s five MCOs contract with two PBMs to administer pharmacy benefits, filling approximately 25 million prescriptions per year. After legislation was passed in 2018 to investigate MCO contracts with PBMs, the Kentucky Cabinet for Health and Family Services [reported](#) that PBMs were paid \$957.7 million, of which \$123.5 million, or 12.9%, was kept by PBMs as the spread.

West Virginia abolished all Medicaid MCO contracts with PBMs in 2017, carving out all pharmacy benefits from their MCOs and opting to process their own pharmacy claims. The state uses West Virginia University College of Pharmacy to help advise providers to make improved clinical decisions, and by having the state administer the program, it eliminated spreads and reduced administrative fees. Moving to this structure has saved the state an [estimated](#) \$38 million a year—about 4% of the state Medicaid budget spent on drug spending.

Texas was one of the first states to closely regulate PBMs. The state uses a [Uniform Managed Care Contract](#) (UMCC) which governs the role and operations of each of their 20 MCOs and six PBMs. All MCOs are accountable for the performance of their PBMs and the MCO is ultimately responsible for compliance with state regulations. Contractual requirements prohibit PBMs from engaging in certain business practices, including spread pricing as well as from receiving rebates from drug manufacturers.

Fiduciary Duty

Some states require PBMs to act as a fiduciary. A fiduciary is a person or entity who holds a legal or ethical responsibility to act in the best interests of their clients. At the time of this report, one state—Nevada—had implemented a law requiring that a PBM has a fiduciary duty and at least four states are considering it. [Nevada’s law](#) specifies that a PBM has a fiduciary duty to a third party with which it has entered into a contract to manage that party’s pharmacy benefits plan. This means the PBM must act in the best interest of the pharmacies or consumers it serves rather than a health plan.

Registration and Licensing



These laws require PBMs to either be licensed or registered with a state administrative agency before conducting business in the state. Often, the agency that oversees PBMs is the office of the insurance commissioner, who then can investigate claims of wrongdoing. Typically, these laws require a PBM to apply for and annually renew their registration, pay fees, and maintain a board as well as identify their members. At least [20 states](#) have enacted this type of legislation.

Conclusion

Although more attention has been drawn to the role of PBMs, opinions are divided on if and how to regulate them. As some states seek to rigorously oversee them, others have left them to do business as usual. The political landscape is constantly evolving and NCSL provides state legislators and their staff with reliable, accurate and unbiased resources to make informed policy decisions. NCSL will continue to monitor state actions regarding PBMs and will update as information becomes available.