VIEWPOINT

HEALTH POLICY

Pharmacy Benefit Manager Reform
Lessons From Ohio

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Supplemental content

Addressing soaring prescription drug prices is a health care reform priority in the United States.[1] While the pricing practices of pharmaceutical companies have been a subject of intense scrutiny and reform proposals, so have the practices of pharmacy benefit managers (PBMs), who are intermediaries in the drug supply chain.[2]

PBMs—third-party administrators of pharmacy benefits—arose in the 1980s to manage patient access to drugs through coverage and formulary designs on behalf of payers. The influence of PBMs on patients' access to drugs and the affordability of medications has increased substantially since then. The industry has also consolidated, with the 3 largest PBMs—Express Scripts, OptumRX, and CVS Caremark—accounting for more than 85% of the market.[3] In 2017, Express Scripts reported an annual revenue of $100 billion.[4] These revenues far exceed those of some of the highest capitalized pharmaceutical companies, such as Pfizer, with a reported annual revenue of $52 billion in 2017.[5]

PBMs are the focus of current proposed reforms from the White House and US Senate. They are also the subject of numerous new state statutory and legislative reforms of drug pricing. Recent reforms have taken place in Ohio. The state's approach to assessing whether and how current relationships between PBMs and Ohio Medicaid serve public interests provides an important window into PBM practices nationwide and also may have implications for other state and federal reform efforts.

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The Changing Ohio State Medicaid and PBM Relationship

In 2011, Ohio Medicaid, which spends an estimated $4 billion annually on prescriptions covering 3 million beneficiaries,[6] switched from a fee-for-service arrangement for its outpatient prescription drug benefit in favor of managed care. Ohio contracted with managed care plans that in turn contracted with the PBMs OptumRx and CVS Caremark to manage the state Medicaid beneficiaries' drug benefits. The PBMs managed the benefit using formulary design, pharmacy network access, and discounts and rebates off of the list price of drugs. The move to managed care appeared beneficial for the state, with an independent third-party analysis conducted in 2018 estimating $145 million in annual savings over the previous fee-for-service arrangement.[7] These savings were largely driven by the lower prescription claim prices billed to plans by PBMs relative to the Medicaid fee-for-service claims.[7]

However, Ohio pharmacists increasingly expressed concerns that PBMs were engaging in anticompetitive behaviors and taking advantage of opaque proprietary pricing practices. For example, PBMs were providing preferential pricing to affiliated pharmacies over independent pharmacies. Some PBMs also used a controversial technique, "spread pricing," charging Ohio Medicaid high prices while paying pharmacies lower prices for the same drugs and pocketing the difference.[7] Contracts between the PBM and the state specify how much Medicaid will pay when an insured beneficiary fills a prescription at a pharmacy.[8] The reimbursement the PBM pays to a pharmacy for a dispensed prescription and the payment the PBM receives from the state for the same prescription may differ, and when they do, PBMs profit from the transaction. For example, one Ohio Medicaid analysis found that the 2017 fourth-quarter cost to a pharmacy for a 30-day supply of the generic leukemia medication imatinib mesylate was $3859, with a cost to Ohio Medicaid of $7201, a difference of $3342.[9]

Moreover, some PBMs use "gag clauses," which prevent pharmacies from sharing with patients the most cost-effective option when purchasing medications. Gag clauses are contractual requirements, often used by PBMs, that would prevent a pharmacist from informing the patient if the out-of-pocket payment for a prescription would be less expensive than obtaining access to the drug through the patient's health insurance drug benefit coverage. Mounting public pressure and local media coverage led to Ohio Medicaid commissioning a third-party audit of PBM performance in the state.

The Ohio audit, released in June 2018, is to our knowledge the first comprehensive review of PBM practices by a government agency in any state. The audit incorporated 39 million drug transactions between March 1, 2017, and March 30, 2018. It reported that PBMs reimbursed independent pharmacies at a higher rate than their own proprietary pharmacies (eg, CVS Caremark PBM to CVS pharmacies). The audit also reported an 8.8% spread between the amount PBMs billed to Medicaid managed care plans and the amount paid to pharmacies; this spread amounted to $223.7 million in the

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audit year.[10] A subsequent report from the office of the Ohio Auditor of State found substantially higher spread pricing (31%) and associated revenue (93%) among generic drugs, which accounted for the highest volume dispensed (86% of claims), compared with branded drugs (13% of claims; spread pricing at 0.8%) and specialty drugs (0.5% of claims and spread pricing at 1%).[6]

The Intervention of State Regulators

In late summer 2018, Ohio Medicaid directed Ohio managed care plans to end their contracts with PBMs, effective January 2019. Plans were instead asked to adopt a transparent "pass-through" pricing model whereby the managed care plan would pay the PBM the exact amount paid to the pharmacy for the prescription drug, a dispensing fee, and, in lieu of spread-based revenue, an administrative fee. The dispensing fee payments are based on Ohio Medicaid's required survey of pharmacy dispensing costs. Further, Ohio Medicaid's largest managed care company, CareSource, is now contracting with PBMs to allow state officials and third-party auditors to see and monitor drug pricing.

Ohio policy makers also pursued the prohibition of gag clause use by PBMs via a bulletin issued by the Ohio Department of Insurance in April 2018. House Bill 479, prohibiting the same, was passed in June 2018 and introduced in the Ohio Senate on July 5, 2018, but failed by not coming to a vote by the end of the 2018 legislative session. However, in October 2018, the bipartisan federal Patient Right to Know Drug Prices Act and Know the Lowest Price Act were signed into law, banning gag clauses.

Lessons From Ohio

States have often been fertile testing grounds for health policy innovation and, as has been seen with states' efforts toward expanding insurance coverage, may act as leaders in improving patient access to, and affordability of, prescription drugs. Ohio has pioneered regulatory efforts to increase PBM accountability, eliminate spread pricing in favor of more transparent pass-through pricing, and reduce the use of pharmacy gag clauses.

Other states are increasingly active in considering and adopting some of these changes for their own state populations (eTable in the Supplement). As of March 5, 2019, state legislatures have filed approximately 233 bills referencing PBMs. With the passing of bipartisan federal anti-gag clause bills in October 2018, states have shifted the focus to other issues such as controlling pharmacy reimbursement rates (eg, via regulation of spread pricing [6 states], ensuring that patients' out-of-pocket costs better reflect actual acquisition costs by prohibiting PBMs from charging higher co-pays than the cost of the drug [2 states], or requiring rebates received by PBMs to be passed on to the enrollee [3 states]); increasing rebate transparency (eg, by mandating the reporting of rebate amounts [21 states]); instituting PBM licensure and registration processes (17 states); and regulating pharmacy networks and contracts (21 states).

What may be lacking from many of these efforts is Ohio's empirical approach to assessing the potential effect of these reforms on meaningful outcomes and the promise to evaluate gains, audit, and monitor after reform implementation. This is critical for establishing the direct benefits and costs of pursuing these reforms and understanding potential unintended consequences.

Ensuring patient access to affordable drugs is a national, bipartisan imperative. The empirical approach in Ohio to anticipating the effects of spread pricing reform is an encouraging sign of state leadership in this area. The effects of other state efforts on spending, patient out-of-pocket costs, and ultimately on patient outcomes, including regimen adherence and clinical response, deserve close observation and continued study.

ARTICLE INFORMATION

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