

PBM Myths and Urban Legends: Top Ten Erroneous Statements Made by Express Scripts and Medco CEOs During December 6, 2011 Congressional Hearing

1. ***“PBMs simply do what plan sponsors tell us to do—it is solely the customer’s decision to use mail order.”***

This statement is disingenuous, at best. In most cases, plan sponsors make critical decisions based virtually exclusively on the PBMs sales teams’ recommendations. PBMs have no legal obligation to act in the best interest of the health plan and therefore are free to interpret and present the claims data in a fashion that aligns with their own profit motivations. PBMs have NO fiduciary responsibility to anyone but their shareholders. Since the “big three” PBMs own and operate proprietary mail order pharmacies that directly compete with retail pharmacies in the same network—PBMs have access to the competitively sensitive business information of the retail pharmacies and are able to “creatively” present a compelling case as to why the PBM mail order pharmacy should be used or encouraged. Plan sponsors are not empowered through information, expertise or resources to adequately drill down on the PBM data and conclusions. Thus, if a PBM says that mail order is cheaper, most customers will have no reason to doubt this.

2. ***“The PBM industry is a heavily regulated industry. We are regulated by every state board of pharmacy in the entire country, all fifty states. We are regulated by every single insurance department across the country.”***

The PBM industry has vigorously resisted any and all attempts at regulation at either the federal or state level. PBMs are not regulated at the federal level. There are eight states (not fifty) in which the PBM merely has to register with the State Insurance Department and pay a nominal fee. There are six states in which health plans have the right to request the disclosure of certain information from their PBM; however, none of these states actually require the PBM to affirmatively make these disclosures on a regular basis and most likely the health plans are not well versed in what information to request or how to decipher it in practical terms. There are a handful of states that have passed “fair audit” provisions to try to curb the frequently overreaching and abusive audits conducted by the PBMs of retail pharmacies, but these laws do not provide for a specific body to “regulate” the PBMs. Finally, while it is true that the PBM’s mail order pharmacies are regulated by the boards of pharmacies in the states in which they operate, there is only one state board of pharmacy that has any jurisdiction over the actual PBMs.

3. *“Independent community pharmacies are increasing in numbers and are still very profitable.”*

By NCPA’s most recent count, the number of independent community pharmacies has decreased slightly. We operate at net 2 to 3% profit margin before taxes. In addition, it has been estimated that 25% of all independent community pharmacies are currently “in jeopardy” or operating at a financial loss.

4. *“The PBM industry is very competitive and if the merger is allowed, other competitors in the market will help ensure price and service competition.”*

For a handful of small, regional pharmacy benefit management accounts, this may be true in some limited circumstances. However, the real area of concern is in the large plan market. Currently, for these large national players, there are three PBMs to choose from and the proposed merger would drastically reduce this to two. This drastic reduction in PBM options will negatively affect Medicare Part D, FEHBP and TRICARE. It has been argued that the PBM owned and operated by United Healthcare could rise to create a new configuration of the “big three”. However, any large health insurance plans that compete with United are very unlikely to contract with their health plan competitor, United, for PBM services. There’s no telling how many sponsors for whom that would be a non-starter or a serious detraction.

5. *“It’s not the PBMs that are hurting independent community pharmacies—it’s the large retail pharmacy chains.”*

NCPA member pharmacies will tell you that this statement is simply not true. Most individuals have prescription insurance coverage and pay the same copay whether they go to an independent or chain. Customers base their pharmacy choice on service rather than price, and independents are head and shoulders above the rest in that category. In reality, abusive PBM audit practices that recoup money from pharmacies based on typographical errors, below-cost reimbursement payments and requirements that patients use mail-order or pay extra to use their community pharmacy of choice are all far greater contributors to the closure of independent pharmacies than the actions of any national retail pharmacy chain.

6. “PBMs and mail order pharmacies are key to ensuring that patients remain adherent to their drug regimens.”

What PBMs and their mail order pharmacies conveniently fail to mention is how they measure adherence. If the medication is placed in the mail and is in fact delivered to the patient’s home, the PBM claims that adherence has been achieved. This is not adherence!! Adherence is best achieved through face to face behavioral interventions with patients, not through a faceless telephone call from a PBM mail order outlet. The 2011 CVS Caremark Trend report states that **face-to-face counseling by local pharmacists is two to three times more effective at ensuring that patients adhere to their medication regime than any other type of intervention.** Keep in mind that CVS Caremark is a “big three” PBM and as such owns its own proprietary mail order pharmacy.

7. “If there are concerns, health plans should conduct their own audits of their PBM.”

What the two CEOs conveniently left out was the fact that a standard contract term in most PBM contracts is a clause that requires the approval of both parties (the plan and the PBM) of any auditor chosen to audit the PBM. We have heard from at least one very large plan that they literally couldn’t find anyone to audit the PBM—the PBM refused to agree to any of the auditors they had chosen!! Moreover, ESI’s Mr. Paz said that they had 400 audits going on right now – what he didn’t say is if those were audits that health plans were conducting of ESI or whether they were audits ESI was conducting of community pharmacies – the latter being more likely.

8. “Manufacturer rebates are not a factor for PBMs when deciding whether to dispense brand name drugs or generics.”

As described by the Federal Trade Commission¹, pharmaceutical manufacturers recognize that having their drugs listed on the formulary or in a preferred spot on the formulary will increase the drug products’ sales..... “[P]harmaceutical manufacturers use formulary payments or rebates to encourage PBMs to dispense their drugs. PBMs profit from rebates by retaining some or all of them instead of passing the savings on to plans and consumers. In 2004, New York’s Attorney General filed suit against Express Scripts alleging that the PBM pocketed as much as \$100 million in drug rebates that should have gone to the state.”²

¹ Federal Trade Commission, Pharmacy Benefit Managers: Ownership of Mail Order Pharmacies (2005)

² Michael Gormley, CBS news (August 4, 2004). <http://www.cbsnews.com/stories/2004/08/04/health>

9. ***Express Scripts CEO George Paz at first seemed to have no knowledge about a recent Office of Inspector General (OIG) Report that found that PBMs were not always passing along rebate amounts to the Part D program. Only after prompted, he replied that “well, I believe that CMS disputed that report.”***

CMS did not refute any of the findings of this report. In March 2011, the HHS Office of the Inspector General issued a report that found that frequently Part D sponsors “had complex contractual relationships with PBMs that sometimes lacked transparency” and that “this lack of transparency raises concerns that sponsors may not always have enough information to oversee the services and information provided by PBMs. In addition, selected sponsors reported that their PBMs collected fees from drug manufacturers that were not always passed along to the Part D program.”

CMS did not fully agree with all of the suggested remedial measures recommended by OIG and in some cases, OIG and CMS came up with an alternate approach to address the issue, but CMS did not dispute the underlying contentions in the report.

10. ***“This is not the industry that people talked about being a black box ten years ago. There have been fundamental changes, and it is a transparent industry where clients know exactly what’s going on, they really do.”***

In the majority of cases, plan sponsors do not have full access to the terms of the rebate deals the PBMs have with drug manufacturers as well as other highly lucrative revenue streams and spread pricing games they play. PBMs are also deceptive masters at relabeling revenue streams and hiding them from plan sponsors. PBMs have a long history of claiming that the details of these arrangements are “trade secrets” and that transparency or disclosure of this information would jeopardize their ability to negotiate with different manufacturers. Even when it is suggested that they disclose this information to plans only when paired with a confidentiality agreement, the PBMs still vehemently oppose disclosure.