PATIENTS RISING NOW

COMMENT LETTER ON PBMs

Business practices by Pharmacy Benefit Managers (PBMs) have been pointed out as being anticompetitive for smaller independent pharmacies. While some of these tactics affect businesses, they also create access barriers for patients and impact their treatment plan, ultimately affecting patient health and disease outcomes. PBM business strategies also have cost implications for patients.

Cost of treatment

Who pockets the rebate dollars?

PBMs negotiate drug prices with pharmaceutical manufacturers on behalf of health plans, earning billions of dollars in annual rebates, none of which make it back into the patients' pockets. Rebates grant drug manufacturers a spot on the health plan's formulary, which is managed by PBMs. Ideally, if the rebate process worked as it was intended to, patients should see a lower cost for their drugs at the pharmacy counter. However, due to an absolute lack of transparency in the formulary decision-making process, PBMs and health plans may be incentivized to choose drugs that give them the highest rebate instead of choosing drugs that are priced lower and would cost the patient less.

In fact, while the PBMs profit from the negotiated rebates, patient cost is based on the original, significantly higher, list price. At the pharmacy counter, patients pay a co-insurance on the list price, which is the original price of the drug before the rebate. This is an unfair practice that creates additional layers within the healthcare system and adds unnecessary cost burdens on patients and their families.

Gag clause

This is a classic example of harm to patients because of the lack of price transparency in health care. Contracts between health insurers/PBMs and their network pharmacies (these are pharmacies that are a part of the health plan's network) often include a clause that prevents pharmacists from voluntarily sharing with the patient that they have additional purchase options and that their medication may cost less if they pay it directly out-of-pocket instead of through their insurance. Because of this gag clause, patients, especially those on commercial plans, may end up paying more in copayments than what the drug costs their health insurance plan/PBM.

Federal policies that can intentionally stop these unhealthy business practices are vital.

Access to treatment

Formulary restrictions

Patients face significant access issues due to restrictive formularies (drugs that are covered by a health plan), which are structured based on rebate negotiations. Formulary negotiations between PBMs and drug manufacturers can restrict patient access to treatments that may have been prescribed by their provider and that work well for the patient. Patients may be forced to take a different drug from another manufacturer simply because of PBM contracts, which could cause unnecessary disruptions in treatment

and might even harm the patient. Doctors should be the ones directing changes to a treatment plan, not the patient's health plan or PBM!

As our healthcare system transitions toward improving patient-centered care and infusing 'value' in every step of healthcare delivery, it is extremely difficult to abide the contradictory utilization management practices that PBMs implement.

Steering patients to PBM-owned pharmacies

Vertical integration has resulted in PBMs steering patients away from unaffiliated pharmacies and toward PBM-affiliated or owned specialty/mail-order/retail pharmacies, often without the patient's consent. Patients who choose a particular in-network pharmacy may be forced to pay higher out-of-pocket costs for their drug. Being forced to switch their pharmacy could be a barrier for patients, especially those who live in underserved neighborhoods and may have transportation issues with getting to the new pharmacy. These anticompetitive practices take business away from patients' community pharmacies.

Again, snatching the patient's right to control their healthcare decisions contradicts the essence of patient-centered care.