Myths vs. Fact
Pharmacy Benefit Management

Pharmacy Benefit Managers (PBMs) are working every day to help over 260 million Americans get their prescription drugs safely, efficiently, and affordably. By leveraging proven tools, PBMs will save health plans and consumers more than $1 trillion — over 30% — on prescriptions over the next decade[1] and will help prevent 1 billion medication errors.[2]

Working in partnership with more than 3.2 million U.S. businesses, PBMs provide prescription drug benefits to 156 million employees and their families. PBMs also support government healthcare programs, such as Medicare Part D, Medicaid, and the Veterans Administration (VA), that provide prescription benefits to more than 112 million beneficiaries across the country, as well as the Federal Employees Health Benefit Program (FEHBP).[3]

MYTH: PBMs are "middle-men" in the pharmacy supply chain, contributing nothing and taking outsized profits at the expense of plan sponsors and their beneficiaries.

FACT: PBMs perform a wide variety of valuable services that not only lower drug costs, but also improve health outcomes, benefitting their sponsors, members, and the health care system as a whole. PBMs reduce drug costs by encouraging the use of more cost-effective drugs, such as generics. They also improve health outcomes by implementing clinical programs to help drive medication adherence, which saves the health care system up to $300 billion in health care costs annually.[4] PBMs leverage the combined membership of the plan sponsors they serve to negotiate rebates from drug manufacturers, which helps drive lower net costs.

A new study focused on the Medicare Part D program estimates Part D costs would be **58% higher** absent PBMs' evidence-based clinical programs and price negotiations with pharmacies and manufacturers. The study estimates that as a result of PBM-negotiated discounts and price concessions, shifting utilization towards generics, and the use of evidence-based clinical programs that improve patient adherence, PBMs saved the Part D program **$47 billion** in 2014, with projected savings of **$896 billion** over ten years, from 2016 to 2025. The study also estimates that without PBMs, beneficiary premiums would be 66% higher. PBM tools are projected to save the Centers for Medicare & Medicaid Services (CMS) and beneficiaries on average $153.81 per enrollee per month over the 2016-2025 period, which translates to more than $1,800 per enrollee, per year.[5]

MYTH: Drug prices are high because of PBM business tactics.

FACT: Pharmaceutical manufacturers set drug prices, not PBMs. Drug companies continue to raise their prices, year after year, sometimes multiple times a year, often for the exact same product. Over the last 10 years, drug companies' price hikes **increased the price of drugs by 159%**.[6] Only 10% of U.S. prescriptions are brand drugs, but they make up 80% of U.S. drug spending.[7] CMS projects that over the next five years, national spending on prescription drugs will increase by more than $100 billion.[8] Drug companies use tactics like product hopping, patent thickets, and abusing the Food and Drug Administration's (FDA) citizen petition process to manipulate the patent and regulatory process to block competition and keep prices high. The U.S. health system would stand to gain $31.7

[1] PCMA, Vistante, *Pharmacy Benefit Managers (PBMS): Generating Savings for Plan Sponsors and Consumers*, February 2020. Available at: https://www.pcmanet.org/wp-content/uploads/2020/02/Pharmacy-Benefit-Managers-Generating-Savings-for-Plan-Sponsors-and-Consumers-2020-1.pdf
[2] PCMA, Visante, *The Return on Investment (ROI) on PBM Services*, February 2020. Available at: https://www.pcmanet.org/wp-content/uploads/2020/02/ROI-on-PBM-Services-FINAL_.pdf
[3] PCMA, *The Value of PBMs, PBMs are Trusted Business Partners for Healthcare Payers*, Available at: https://www.pcmanet.org/wp-content/uploads/2017/04/PBM-Payer-Relationships_inforgraphic_FINAL-1.pdf
[4] New England Healthcare Institute, *Thinking Outside the Pillbox*, August 2009. Available at: https://www.nehi.net/writable/publication_files/file/pa_issue_brief_final.pdf
[5] Coalition for Affordable Prescription Drugs, Oliver Wyman, *Savings Generated by Pharmacy Benefit Managers in the Medicare Part D Program,* June 2017. Available at: https://www.affordableprescriptiondrugs.org/resources/savings-generated-by-pharmacy-benefit-managers-in-the-medicare-part-d-program/
[6] Hernandez, Inmaculada et al., *Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018*, JAMA, March 3, 2020; 23(9):854-862. Available at: https://jamanetwork.com/journals/jama/fullarticle/2762310
[7] Association for Accessible Medicines, *2020 Generic Drug and Biosimilar Access and Savings in the US*, September 2020. Available at: https://accessiblemeds.org/sites/default/files/2020-09/AAM-2020-Generics-Biosimilars-Access-Savings-Report-US-Web.pdf
[8] CMS, *NHE Fact Sheet*. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet

billion in savings if brand drug gamesmanship was prohibited and generic drugs came to market 2.2 years faster.[9]

Drug companies also continue to enjoy some of the highest profit margins in the health care industry. In 2017, 14 pharmaceutical manufacturers made nearly $70 billion in profits. The 61 other companies in the health care sector made just under $49 billion in profits. These 14 pharmaceutical companies made $21 billion more in profits than the rest of the health care sector resulting in a profit margin of 21.8% — seven times larger than the 3.1% margin of the broader health care section.[10]

MYTH: PBMs make more money because they earn higher rebates when drug manufacturers' list prices are high.

FACT: According to a recent study, there is no correlation between the prices drug manufacturers set and the rebates they negotiate with PBMs.[11] The findings contradict claims asserted by manufacturers that they have to raise drug prices in order to make up for the rebates they pay PBMs. The study analyzed data on gross and net sales for the top 200 self-administered, patent-protected, brand-name drugs and found no correlation between the prices drug manufacturers set for those drugs and negotiated rebates. A follow-up analysis also noted that "[t]op brand drugs that offered little to no commercial-sector rebates during the 2011-2016 time period still increased their prices."[12]

MYTH: Rebates negotiated by PBMs are driving up the prices of prescription drugs for consumers and plan sponsors.

FACT: Pharmaceutical manufacturers set the list price for a given drug. PBMs then negotiate with manufacturers to secure the drug at a lower cost for their plan sponsors and their members. With more than 60 different PBMs, the industry is highly competitive; employer, union and government plans have a variety of choices when considering how best to manage their pharmacy benefit. In order to win business, PBMs have every incentive to reduce drug costs for their plan sponsors by eliminating excessive fees and passing rebate savings along to their plan sponsors, who typically use rebate dollars generated by PBMs to maintain lower premiums for their members.

In Medicare Part D, health plans rely on competitive bidding to determine the appropriate level of government subsidies and beneficiary premiums. PBMs competing for Part D business have a strong incentive to keep costs low in order to avoid their Part D clients from losing market share from beneficiaries seeking lower cost plans. A 2019 report by the Government Accountability Office (GAO) found that PBMs passed 99.6% of all Medicare Part D rebates on to plan sponsors, helping plans keep premiums and costs low for seniors. This report shows how PBMs work to lower the cost of health care for the millions of American seniors who depend on Medicare Part D for their medications.[13]

MYTH: PBMs don't share the rebates they obtain from manufacturers with their plan sponsor clients.

FACT: PBM clients use rebates to lower the costs of providing prescription drug benefits for their employees and members. In the case of CVS Caremark, we pass along approximately 98% of rebates to our clients to help lower out-of-pocket costs and premiums for their members. PBMs aggregate claims volume from the millions of health plan clients they serve to more effectively negotiate with manufacturers in exchange for favorable formulary placement. This process generates rebates, which are discounts on drugs.

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[9] Coalition for Affordable Prescription Drugs, *Gamesmanship and Other Barriers to Drug Competition*, July 2019. Available at: https://www.affordableprescriptiondrugs.org/resources/gamesmanship-and-other-barriers-to-drug-competition/

[10] Coalition for Affordable Prescription Drugs, *Most of the Profit in Health Care Goes to 14 Pharmaceutical Companies.* Available at: https://heatinformatics.com/sites/default/files/images-videosFileContent/1-resources_fortune500_factsheet_0.pdf

[11] PCMA, Visante, *No Correlation Between Increasing Drug Prices and Manufacturer Rebates in Major Drug Categories*, April 2017. Available at: https://www.pcmanet.org/wp-content/uploads/2017/04/Visante-Study-on-Prices-vs.-Rebates-By-Category-FINAL-3.pdf

[12] PCMA, Visante, *Increasing Prices Set by Drugmakers Not Correlated With Rebates*, June 2017. Available at: https://www.pcmanet.org/wp-content/uploads/2017/06/Visante-Study-on-Prices-vs.-Rebates-FINAL.pdf

[13] GAO, *Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization*, July 2019. Available at: https://www.gao.gov/assets/710/700640.pdf

For example, CVS Health, as an employer, requires that rebates earned should be used to help our members with their out-of-pocket (OOP) costs. CVS Caremark offers this program — known as point-of-sale (POS) rebates — to any client. The program enables the plan to apply rebates at the point of sale (the pharmacy counter) to lower the cost of the drug when a member is paying OOP or has coinsurance. Of the total rebates returned to CVS Health, $6.3 million in rebates were put toward lowering OOP costs for our members, helping improve adherence by 4% to 6%. The remaining rebates are used to reduce employees' cost share, and to reduce costs overall to CVS Health as the employer.[14]

MYTH: PBMs are not transparent with their clients about the rebates they negotiate with drug manufacturers.

FACT: The PBM client contract specifies the percentage of rebates, if any, that the PBM may retain. Some clients choose to get 100% of the rebates PBMs negotiate with manufacturers; others choose to allow the PBM to retain a portion of the rebates as payment for the services the PBM provides, as agreed to in their contracts. In addition, PBM clients generally have the contractual right to audit the PBM, or to enlist third-party experts to audit the PBM, to verify that the contractually agree-upon percentage of rebates is passed through to the client. Finally, in the case of government programs, which includes Medicare Part D, the FEHBP, Medicaid, and will soon include qualified health plans on the Exchanges, PBMs through their contractual requirements with plan sponsors are required by law to report all price concessions, including rebates earned from drug manufacturers.

CVS Health believes that it is important for both consumers and our clients to have the type of transparency in their prescription drug benefit that encourages competition in the marketplace and lowers the cost of health care. For consumers, it's important they have the tools they need to make informed choices about the medications they are taking. For our clients, we believe they should have visibility into the contracts they sign, including understanding the true costs as well as the savings they will realize.

We do not support requiring PBMs to publicly reveal the rebates they negotiate with drug manufacturers. This would allow manufacturers to learn what type of price concessions other manufacturers are giving and disincentivizes them from offering deeper discounts, which benefit PBM clients and their members. This type of transparency is anti-competitive, does not benefit consumers, and will not lead to better health care or lower health care costs. According to the FTC, disclosure of this information would chill competition in the marketplace, circumvent the competitive process, and ultimately result in higher drug prices for health plans sponsors and their members.[15]

MYTH: PBMs increase cost sharing burdens for beneficiaries.

FACT: Plan designs are determined by clients — employers and health plans — who decide how they subsidize their members' coverage. PBMs are selected based on their ability to hold down the cost of drugs for plans and their members while ensuring access to clinically appropriate drugs for members. PBMs' effectiveness in lowering prescription drug costs allows plan sponsors to apply savings to keep the amount their beneficiaries have to spend to cover their share of health insurance costs affordable. For those in high deductible plans, keeping cost-sharing affordable means plan sponsors can take actions such as adding additional qualifying products to the preventive drug list, providing lower deductibles or smaller co-pays, or lowering the overall premiums that beneficiaries may have to pay.

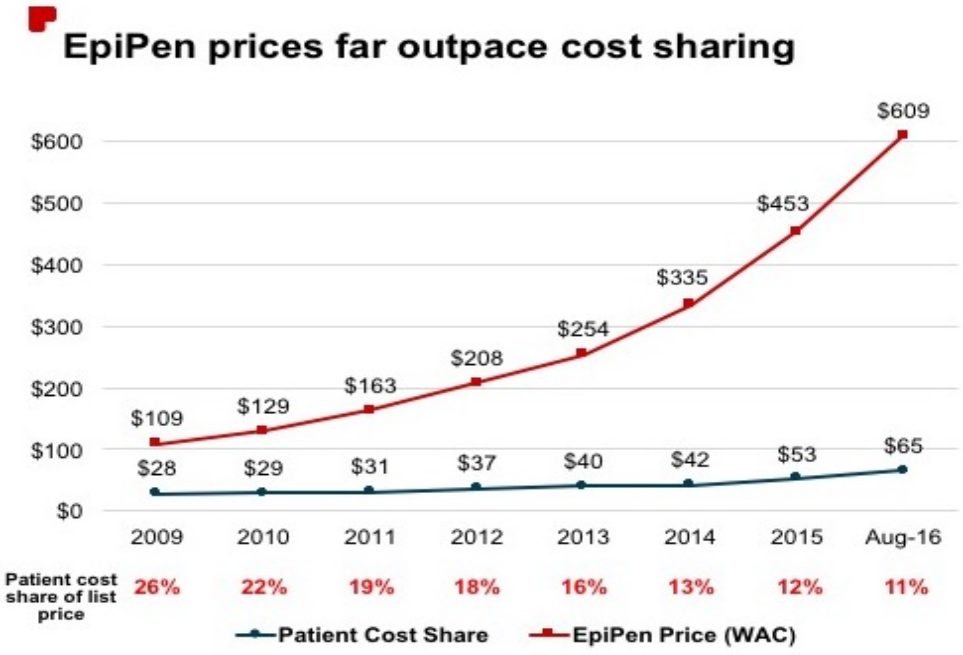
MYTH: PBMs helped cause the recent increase in prices on the lifesaving drug EpiPen.

FACT: Pharmaceutical manufacturers set the list price for a given drug. The controversy over unreasonable price increases on the lifesaving drug EpiPen, which increased more than 600% in recent years, is an example of how PBMs help keep out-of-pocket costs low for beneficiaries. As indicated in the table below, price reductions

[14] CVS Health, *Current and New Approaches to Making Dugs More Affordable*, August 2018. Available at: https://s2.q4cdn.com/447711729/files/doc_financials/quarterly/2018/q2/approaches-to-making-drugs-more-affordable.pdf

[15] Federal Trade Commission & US Department of Justice Antitrust Division, Improving Health Care: A Dose of Competition, July 2004. Available at: https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf

negotiated by PBMs have actually helped *decrease* overall average patient costs — including both copays and coinsurance — from 26% of the list price in 2009 to 11% in 2016.[16]



Note: Patient cost share is average for a preferred brand drug
Source: Pharmaceutical Care Management Association, *"The Facts on EpiPen Costs"*

MYTH: PBMs lower drug costs by restricting patient access to needed medications.

FACT: PBMs help ensure that beneficiaries have access to the prescriptions they need to stay healthy, at a price they can afford. For example, PCSK9's — a major advancement in cholesterol-lowing drugs — came to market with a price tag of $14,000 a year. As soon as there was more than one drug on the market, PBMs were able to negotiate significant rebates with the manufacturers, substantially lowering the cost of these medications. Similarly, Sovaldi — a highly-effective therapy to treat the Hepatitis C Virus — initially cost more than $85,000 for 12 weeks of treatment. With competition, PBMs successfully negotiated with manufacturers to reduce the cost while increasing patient access to Sovaldi.

PBMs also help plan sponsors' beneficiaries avoid unnecessarily expensive medications by encouraging the use of clinically-effective, but significantly less expensive, generic versions of brand name drugs, when available.

- According to a recent report, the use of generics over brand name drugs saved the U.S. health care system $313 billion in 2019 — nearly $2.2 trillion dollars over the last decade.[17]
- When the FDA approved generic versions of the best-selling Crestor cholesterol pill, PBMs were able to negotiate significantly more affordable options for consumers and lower their out-of-pocket payments.
- Lastly, recently published research from the CVS Health Research Institute showed that along with cost savings, more selective formulary designs, which encourage the use of generics, helps improve medication adherence and health outcomes.[18]

[16] PCMA, *Statement at Oversight Committee Hearing on EpiPen Price Hikes*, September 2016. Available at: https://www.pcmanet.org/pcma-statement-on-oversight-committee-hearing-on-epipen-price-hikes/
[17] Association for Accessible Medicines, *2020 Generic Drug and Biosimilar Access and Savings in the US*, September 2020.
[18] Shirneshan E, Kyrtchenko P. *Impact of a transition to more restrictive drug formulary on therapy discontinuation and medication adherence*. J Clin Pharm Ther. 2016 Feb;41(1):64-9.