The Pharmacist Activist

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Editorial

Reducing Drug Costs – PBMs are Not Needed and Should Not be Used!

Some may believe that pharmacy benefit managers (PBMs) initially had a useful role in increasing the utilization of generic medications and other less expensive therapeutic alternatives on their formularies for the purpose of reducing drug costs. However, the PBMs now must be viewed as a self-serving, highly-profitable industry that is partly responsible for the continuing increases in drug costs and, most importantly, creates barriers for patients and health professionals in attaining optimal and safe use of medications. Generic utilization rates now approach 90% in many programs/areas, and other competitive pressures also contribute to some containment of drug costs. Nevertheless, drug costs continue to rapidly increase as the PBMs, pharmaceutical companies, and health insurance companies accuse each other as being primarily responsible for the increased costs, while at the same time these industries generate greater profits for their companies.

All three of these industries are complicit in the situation that presently exists that is characterized by costs that are not sustainable. However, the PBMs warrant thorough investigation because they contribute nothing to the access, quality, or scope of health care for patients. Indeed, they impose restrictions and barriers on patients, pharmacists, and prescribers that compromise the attainment of treatment goals with prescription medications.

The Auditor General of Pennsylvania has been holding hearings across the state because of concerns brought to his attention regarding questionable/abusive practices of PBMs, the closing of a number of independent pharmacies, and the challenges faced by some patients in obtaining their medications. I was among the pharmacists who presented testimony at one of these hearings and much of the following information was considered at this hearing.

Patient experiences

The following patient experiences were identified:

- A man taking 5 medications for chronic conditions was notified that his prescription benefit plan was being changed. The revised plan would only permit two 30-day supplies of chronic medications to be obtained at a local pharmacy. Following that, 90-day supplies could be obtained from a CVS Caremark mail-order pharmacy or a CVS local pharmacy, and there would no longer be coverage for prescriptions for these medications at any local pharmacy other than CVS. In discussing this situation with his local independent pharmacist, the patient learned that he could obtain 90-day supplies of all 5 medications from this pharmacy at a cost that was lower than the co-pays he would have had to pay if the CVS mail-order or CVS local pharmacy was used.

- A 4-year old girl experienced a painful swimmer's ear infection for which antibiotic ear drops were prescribed. When the mother presented the prescription to her local

pharmacy, she was informed that the prescribed product was not on the formulary of her prescription plan and that the cost would be $300. The pharmacist indicated that a generic formulation was available at a cost of $150, but further identified another alternative in which the same antibiotic was dispensed as drops and for which the usual co-pay of $15 would be applicable.

- A woman with diabetes was being treated with metformin. As a consequence of a mistake and/or a change in her prescription plan she started receiving 90-day supplies of metformin that she had not requested and resulted in her receiving quantities far in excess of what she needed.

- A woman with asthma was away on vacation and realized she had not brought enough of her Flovent inhaler. She knew that additional refills were authorized and went to a pharmacy at her vacation destination to arrange for a transfer from her home pharmacy for a prescription refill. She was informed that there was no problem with the prescription transfer but that the PBM would not authorize/pay for the refill because it was requested too soon. An override of the policy was requested but the PBM representative responded, "Your plan has no provisions for granting a refill when we calculate it's too soon." Subsequent discussions with a PBM supervisor and a representative of the health insurance company that contracted with the PBM brought the same response.

PBM practices/abuses

The practices/abuses inherent in many PBM prescription plans include, but are not limited to, the following:

- Some PBMs own their own pharmacies that patients are required to use or are provided financial incentives to do so.

- Denial of freedom of choice for patients to choose their pharmacy – Many pharmacies are excluded from participation in certain PBM programs. Even in situations in which they are included, financial incentives are often provided to patients to use the PBM's pharmacy or another pharmacy. This eliminates or reduces freedom of choice for patients in selecting the pharmacy they choose to use.

- Restrictive formularies – Decisions to include medications on a formulary, or to designate medications as having a preferred "tier" or status on a formulary are based only on cost considerations rather than therapeutic, clinical, or convenience considerations for patients. Recent examples include decisions to offer/recommend prescription plans to clients that exclude coverage for expensive medications used for the treatment of rare diseases.

- Prior authorization – This practice is based on cost considerations and prevents or delays prescribers from exercising independent decision-making authority on behalf of their patients.

- "Take it or leave it" contracts – Contracts are developed unilaterally by PBMs without pharmacist input, discussion, or possibility of negotiation.

- "Gag clauses" – Many PBM contracts include restrictions that prevent pharmacists from identifying less expensive alternatives for obtaining medications.

- Inequitable reimbursement/compensation for pharmacists

- "Claw-back" fees and Generic Effective Rate deductions – Imposition of fees and reductions of compensation following dispensing/adjudicating of prescriptions/claims are inequitable for pharmacists.

- No transparency – PBMs refuse to provide information, explanation, or justification regarding their financial arrangements with clients and pharmaceutical and health insurance companies by claiming that it is proprietary information.

- Rebates/discounts – PBMs obtain substantial rebates and discounts from pharmaceutical companies for many drugs but clients and patients do not necessarily share in or benefit from these reduced prices of drugs to the PBM. Patients who participate in plans for which the cumulative costs of their prescription medications is a factor, are at a serious disadvantage if the list price, instead of the rebated/discounted actual cost, is used in calculating the cost of their medications.

- Patient communication – There is no opportunity for personal face-to-face communication between

pharmacists and patients who have been required or incentivized to obtain their prescriptions from a mail-order pharmacy. Although patients may contact a PBM call center, one of the criteria on which call center staff are evaluated by some companies is the number of phone discussions completed in a certain period of time. In other words, the briefer the conversation, the better the evaluation.

- Waste – "Drug take-back days" have been conducted during the last several years and vast quantities (tons!) of medications have been turned in. I recommend that the appropriate government agency evaluate a representative sampling of these medications (with patient confidentiality being protected). I anticipate that a large and disproportionate quantity of the returned medications will be prescriptions from mail-order pharmacies that were not needed and not requested by patients.

Consequences

The policies, restrictions, and financial incentives of many PBM prescription plans have serious consequences for patients. Many individuals have used their local pharmacy for many years/decades. Pharmacists have become trusted advisors for patients regarding their medications and health, and these relationships are often further enhanced through collaboration in community and civic programs and activities. When a PBM prescription program requires or provides a financial incentive for patients to use a mail-order pharmacy, the local relationships between patients and their pharmacists that are based on proximity, respect, and friendship are significantly compromised, if not broken.

Most individuals who use mail-order pharmacies to obtain their medications have no personal or direct communication with a pharmacist. This depersonalized experience has taken the "care" out of "health care" as it applies to the dispensing and counseling with respect to prescription medications. Unless needed interventions are implemented, the "health" in this designation will also disappear.

Dispensing errors, drug-related problems (e.g., adverse events, drug interactions, noncompliance), and patient safety continue to be extremely important challenges. Notwithstanding the increased recognition of these problems, the number of these events appears to be increasing rather than decreasing. It is more likely that such errors and problems can be identified and avoided when pharmacists and patients personally discuss the appropriate use of their medications. Such discussions do not occur when patients obtain their medications from a mail-order pharmacy. However, discussions are occurring less frequently than before in many local pharmacies (both chain and independent), and this situation is, in large part, due to the increased financial pressures on these pharmacies that result from inadequate compensation from PBM prescription plans.

Many independent pharmacies have closed, and many others are struggling to survive. The latter pharmacists must devote more time and effort to identify and implement financial strategies that will enable them to keep their doors open. However, these efforts are at the expense of time that previously would have been devoted to discussions with patients, with the result that these discussions do not occur or are much briefer. The challenge in many chain pharmacies is also great because management-imposed "more prescriptions faster" metrics in understaffed stores leaves no or little time for discussions with patients. The greater financial challenges for independent pharmacies can be even better understood in the context of the experience of Target stores, a large, successful national retailer for many years, not being able to profitably operate its prescription departments, with the result that it sold its pharmacies to CVS. Rite Aid had the third largest number of pharmacies in the country, but the best hope of its management was to sell the entire company which resulted in the sale of less than one-half of its pharmacies to Walgreens and subsequent failed efforts to combine with Albertsons.

The most important consequences of the financial challenges for local pharmacies are the probability of increased dispensing errors and drug-related problems, with resultant increases in hospitalizations and deaths. Similar errors and problems occur in the high-volume, fast-paced operations of mail-order pharmacies.

Recommendations

The following recommendations are provided for the purpose of establishing a safer, more effective, more efficient, and more transparent local-pharmacy-based system for the provision of prescription medications and related services for patients and communities.

1. PBMs should not be permitted to own their own pharmacies. It is a blatant conflict of interest for PBMs to own pharmacies that they can require/incentivize clients and patients to use for the benefit and profit of the PBM.

2. Government agencies, employers, and unions should discontinue their use of costly PBM prescription benefit programs, and use companies and programs that will process/adjudicate prescription claims for low administrative fees that are a small fraction of what PBMs charge. For those who consider such an action to be impossible or difficult, it is already being done. Programs such as the Pharmaceutical Assistance Contract for the Elderly (PACE) in Pennsylvania have always, and efficiently, used a company to process/adjudicate prescription claims, rather than a PBM. In 2017, West Virginia cut out PBMs from its Medicaid prescription program and, by operating the program itself, eliminating spreads, and reducing administrative fees, it expects to save $30 million a year. A recent study in Ohio determined that PBMs were receiving $6.14 per generic drug prescription in its managed Medicaid programs, and its results suggest that PBMs, and not pharmacies, have been getting most of the markups on generic drugs. CVS manages four out of the five Medicaid managed-care plans in Ohio and it sued the state to prevent the release of a report on the amount of the spread it received from Medicaid programs there. As a consequence of its studies, Ohio has ordered managed-care plans to terminate their spread pricing contracts for 2019. A comprehensive study and commentary of these and other PBM programs is described in the article, "The Secret Drug Pricing System Middlemen Use to Rake in Millions," in the September 11, 2018 issue of *Bloomberg News* (by Robert Langreth, David Ingold, and Jackie Gu).

3. "Gag clauses" should be eliminated from PBM "agreements". The increased awareness of these egregious restrictions has resulted in outrage and legislative initiatives to ban such provisions in agreements. Even the Pharmaceutical Care Management Association (PCMA) that represents PBMs has now stated opposition to these restrictions, after conveniently ignoring them for many years until the public and legislators discovered how they increase the cost of medications.

4. Pharmacists should explore a class action lawsuit against the PBMs to reclaim losses from prescriptions for which they had to pay more for the drug than they received from the PBM for dispensing the prescriptions. If PBMs can protect and increase their profits by imposing claw-back fees and generic effective rates to reduce compensation to pharmacists, it is appropriate for pharmacists to be able to recoup their losses in programs in which they have been denied opportunity to discuss/negotiate terms.

5. Pharmacists and their professional organizations must persist in seeking exemptions for pharmacies from the provisions of antitrust laws. Most are not aware that these laws prevent even two pharmacists from agreeing on the amount of compensation they would determine to be fair and equitable for dispensing a prescription and providing related services. Most do not understand the distinction that permits a Walgreens to be in an excellent position to negotiate agreements because its 10,000-plus pharmacies are part of a single corporate entity.

The PBMs will strongly protest efforts of pharmacists to be exempted from antitrust laws, and will allege that this will result in increased fees for pharmacists and increased costs for prescription drugs. However, the secret deals, fees, and revenue streams of the PBMs expose their hypocrisy. Any increase in fees/compensation for pharmacists will be more than offset by the savings achieved by eliminating the use of PBMs who contribute nothing to the scope, quality, or safety of prescription programs for patients.

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