How pharmaceutical profiteers are screwing us over

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911. What's your emergency?

America's healthcare system is broken and people are dying.

Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on **Code WACK!** So you may have heard the term **Pharmacy Benefit Managers** – **or PBMs** – in the news. But what are they? And what role are they playing in customers being able to get the drugs they need and skyrocketing drug prices? How did these middlemen get to be so powerful and what’s the **Federal Trade Commission**, the independent government agency that works to prevent fraudulent, deceptive and unfair business practices, doing about it? To find out, we recently interviewed **Hannah Garden-Monheit**, **FTC’s** director of the Office of Policy Planning. This is the first episode in a two-part series with Hannah.

Welcome to Code WACK! Hannah!

Garden-Monheit: Thanks for having me. Brenda.

Q: Thanks for being here. In July, the FTC issued a report entitled 'Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies.' First, can you tell us what are pharmacy benefit managers or PBMs and why has the Federal Trade Commission launched a general inquiry into them?

Garden-Monheit: So, pharmacy benefit managers are these extremely powerful middlemen in our prescription drug supply chain. They started out, originally they processed pharmacy reimbursement claims between pharmacies and insurers. But today they've expanded to control or influence almost every aspect of our prescription drug supply chain. For example, they design insurers' pharmacy networks, which means they design what pharmacies your insurance will work with and how much those pharmacies will get reimbursed for filling your prescription. They design what your insurance coverage will be, establishing the formularies that say what drugs are covered and at what cost to the patient. And then they negotiate contracts with pharmaceutical manufacturers – the drug companies for rebates, which are these payments that the prescription drug manufacturers make to the PBMs and the insurers to influence what that insurance coverage on the formularies would be.

And because there has been a huge amount of vertical and horizontal consolidation over the last couple of decades, we now have essentially three giant conglomerates that overwhelmingly control these functions in our healthcare system and our report is focused on some of the different ways these industry dynamics – this concentration, vertical integration – can create opportunities for gamesmanship, self preferencing, disfavoring lower cost generic drugs, and the ways in which these practices can [hurt] patients.

Q: Sorry, what was the word that you used, 'disfevering?'

Garden-Monheit: Oh, disfavoring, disfavoring, dis-advantaging. Right, so we worry a lot when we have vertical integration that companies will self-preference. They'll

give an advantage to their own affiliated companies over independent businesses with whom they compete. So for example, when you, a giant healthcare conglomerate owns the insurance company and you also own a pharmacy, you're not a disinterested player in terms of the rate at which a pharmacy will be reimbursed and which pharmacies patients are sent to, right? As a company, you have your own financial stake in that. And so that's the sort of practice that we worry about and that our report puts a spotlight on.

Q: Right, right. Okay. Wow. They are very powerful entities. So you mentioned some already, but were there any other big takeaways from this recent report that you think are important to mention?

Garden-Monheit: Yeah, so I think there's two sort of clusters of practices that we really focus on in this report. One of them is our concern that this conflict of interest is enabling these big companies to inflate the prices that they're paying to their affiliated pharmacies and self-preferencing themselves in ways that jack up their revenues while increasing costs for patients. And in particular, our report looks at two cancer drugs as a case study and on those we find that they are paying their own pharmacies 25 [or] 40 times the average cost of acquiring those drugs while paying significantly less to independent pharmacies. And that in turn raises costs for patients both at the pharmacy counter and then also, you know, via their insurance premiums 'cause It's inflating the cost of prescription drugs. And then ... the other sort of cluster of practices that the report looks at is on rebate practices, where we're very concerned about exclusionary rebating practices.

Again, rebates are these payments between the pharmaceutical manufacturers and the PBMs to influence how things are covered on your insurance plan and we're concerned about contract terms that may disfavor coverage for drugs that have a cheaper list price. So for example, we saw in our review of their documents contract terms that say, 'your insurance coverage will not reimburse a pharmacy if they fill a prescription with a generic drug.' That can frustrate things like state substitution laws, which are intended to enable your pharmacist to give you the cheaper generic drug regardless of how your prescription is written. That is wonky

but these are, you know, very concerning practices with respect to competition and effects on people's out-of-pocket costs for prescription drugs in this country.

Q: So are you noticing already an impact on patients not being able to get generic drugs or what are you noticing at the patient level?

Garden-Monheit: Yeah, so as I said, we did case studies on some cancer drugs. So take for example, generic Zytiga. It's a drug for prostate cancer. It's not a particularly expensive drug. It costs about, give or take $200 for a pharmacy to buy the drug. But what we saw is that the big PBMs, however, are paying their affiliated pharmacies about $6,000 for this drug. [To an] Independent pharmacy by the way, they pay about half that. And that, you know, for a patient, when the price of your drug's inflated like that, that means that you know your insurance costs more because that's to cover it right in the premium. It means that you at the pharmacy counter when your copay or your deductible is based on that inflated price, you're paying more. And on that particular drug, we looked at the Medicare Part D data and we can see there that the average cost sharing for patients in Medicare in part D on that generic Zytiga in 2021 was higher than the acquisition costs. So you're paying more just out of pocket – setting aside the insurance reimbursement than the average cost of the drug.

Q: Okay, got it. So the report mentions vertical integration. Can you explain a little bit more about what that is and how it's enabling the six largest PBMs to manage nearly 95% of all prescriptions filled in the country?

Garden-Monheit: Vertical integration is when a company and its affiliated entities control multiple parts of the supply chain, whether that's up the supply chain and down the supply chain. And so I'll give you an example to get a little more precise – take, Optum. Optum is the pharmacy benefit manager. Optum is owned by UnitedHealth. UnitedHealth is the largest insurer in the country. Optum also operates specialty and mail order pharmacies. And then through its affiliated Optum Health arm, Optum employs one in 10 doctors in the country.

Another one of the big three is CVS/Caremark, right? Caremark is the PBM. It's owned by CVS. CVS also owns the fourth largest insurer. [Aetna] It owns the largest chain of retail pharmacies in the country. And now CVS is also getting into

the drug relabeling and repackaging business. It's selling drugs itself, operating as a manufacturer of sorts in selling CVS-label drugs.

So that creates all of these, these opportunities, right, when you are the health insurer who stands to benefit when patients go to your pharmacy, because that's money you make too, right, that gives you the ability and incentive to steer patients to your affiliated company irrespective of whether that is in fact the best deal for them and can create other opportunities for gamesmanship.

There are allegations around CVS, for example. There's a drug called HUMIRA where CVS in that repackaging and relabeling business made a biosimilar, which is like a generic for a biologic for this drug. And then coverage... that drug that was CVS's own drug got better placement on insurance coverage so then people don't have access to the cheaper competitor drugs. There are all sorts of opportunities like that that exist when you control all of these different points along the supply chain.

Q: Wow. So I guess one of my main questions is, and I'm not sure you can answer this, but how did we get to this point where all of this is allowed? Why aren't there more regulations on this industry?

Garden-Monheit: Part of the story here is past unchecked consolidation in these industries, meaning that there were mergers and acquisition activity that happened over the 2000s that ultimately went unchallenged by antitrust enforcement agents. And that is part of the story about how we got to such a consolidated and vertically integrated state. You know, in the 2000s, there were dozens of players and then by 2021 it had winnowed down to essentially three that manage 80% of prescription drug claims. That is part of the story here. This administration certainly is committed to a robust enforcement of the antitrust laws. In this highly concentrated and vertically integrated state, the absence of regulation also matters as well. And so we are encouraged to see that there's bipartisan interest in Congress in filling that gap.

Q: Uh-huh, great. So can you contrast the difference between vertical and horizontal integration for people?

Garden-Monheit: Yeah, so horizontal integration is when there's a merger or acquisition between companies that are competitors or potential competitors. So we say they are horizontal because they're on the sort of same geometry -- they are competitors across. And then vertical is when it's up and down the supply chain. So the insurance plan, the PBM, the pharmacy, the health service, the provider, those are in a vertical chain. That said, in the modern economy, these sorts of traditional characterizations of the geometry of our economy don't always map perfectly but that is sort of historically how those terms have been thought about and how antitrust historically thought about them.

Thank you, Hannah Garden-Monheit of the Federal Trade Commission. Stay tuned for next time when we dive deeper into what is and can be done to rein in these powerful entities known as PBMs.

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Code WACK!'s powered by HEAL California, uplifting the voices of those fighting for healthcare reform around the country. I'm Brenda Gazzar.