'Incestuous exploitation?' PBMs and corporate healthcare consolidation

“This inbreeding, this consolidation, this vertical and horizontal integration, this mess of corporate takeover drives up the cost for all of us, hides their costs, makes it so convoluted that you can't even figure out what's going on.” - *Dr. Ed Weisbart*

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!** We’re taking another look at **Pharmacy Benefit Managers** or PBMs, which are increasingly in the news these days. Why were PBMs started and how did they morph to become one of the most powerful entities in health care? Why have they caught a government watchdog’s attention and how are they a threat to consumers? To find out, we spoke to **Dr. Ed Weisbart,** the national board secretary of **Physicians for a National Health Program** and former chief medical officer of one of the biggest PBMs in the country. This is the first episode in a two-part series.

Hi, welcome to Code WACK! Dr. Weisbart

Weisbart: Oh, hi Brenda. So nice of you to have me back.

Q: Thanks so much for joining us again for a deep dive on pharmacy benefit managers or PBMs. We've been hearing the term a lot, but lots of people are asking, what the heck are they? And why should we care? Since you're a retired chief medical officer for a PBM, we thought you'd be the perfect person to break it down for us. Tell us briefly about your professional experience with one of the largest PBMs in the country.

Weisbart: When I first started working within the PBM industry or was offered a job there, I actually couldn't spell PBM. I had no idea what that was, but one of the large PBMs called me and asked me if I'd want to come work there, and I had to literally go talk to a pharmacist. I had no idea and so then I spent seven and a half years as the chief Medical officer at a large pharmacy benefit manager. I think I do understand it a bit, but why I'm so glad to talk to you about this right now is 'cause that industry that I was in from 2003 to 2010 and then I left has changed a lot since I left in 2010, and in my mind, foreshadows what is happening within the Medicare Advantage community.

Q: So what is a PBM?

Weisbart: So what is a PBM? A PBM is a pharmacy benefit manager. So they literally manage the pharmacy benefit for insurance companies or union groups or whoever else might be providing a pharmacy benefit for people. So PBM manages the pharmacy part of the health insurance benefit. In my mind, it actually started as a really good thing. It began for good reasons. Pharmacists were faxing their bills to insurance companies or mailing them. So there were big delays. Things would get lost. There was no data. It was a mess. So PBMs first began actually automating that and getting pharmacies to be able to be connected, having data around. And when I joined the industry, so to speak, our entire mission was centered around getting the country to be comfortable using the less expensive drugs that were not being used. So generic drugs, specifically. When I joined there, generic drugs were hardly ever used.

It was something like 30% of drugs that were dispensed were generics and 70% were brands at a much, much higher price. And so for the time that I was there, we worked on that, getting people to realize that generic drugs are pretty much the same drug – only much, much less expensive. So we put in tools. We used the data that the PBM was collecting from pharmacies, and I think we did a lot of good and lowered the cost of that, made some things maybe even safer. But right around shortly after I left, generic drug utilization had increased from 30% or so to nearly 90%. And so there was no longer really a niche for a business case for keeping to push that. So frankly, the PBM industry gradually shifted towards other things that they could do that I am nowhere near as happy about.

The FTC released a new report about the pharmacy benefit management industry, and I could barely recognize the industry from where it is today to where it was when I left it. Some of the things that they do are, well, they're outrageous, and it made me long for the days of Teddy Roosevelt who used to be the trust buster. And I don't know if people know trust busting was actually corporate busting. Oh my gosh, uh, that's what's going on in the PBM industry. It's gotten so profit centric and self-interested and so much less concerned about good health outcomes.

Q: Yeah, That's really interesting. So when you joined this major PBM, how long had this industry been around?

Weisbart: Well, it actually started sometime in the late seventies, maybe the early six, maybe the late sixties, um, is a sort of a small, not really well established industry. And probably about four or five years before I joined, maybe in the early to mid nineties, it really kind of became dominant. But what's interesting is our view of what was dominant then what's dominant today is pretty different. So one of the things that the FTC report revealed was that the top three PBMs now control 80% of the prescription drugs in this country. The top three biggest PBMs now control 80% of the prescriptions, the top six control more than 90%. So this interesting set of organizations now controls frankly, which drugs we're allowed to take, what prices we pay and which pharmacies we can use. And they so

enmeshed themselves, so embedded themselves in the system that they often are owned by the same outfits that own insurance companies.

So they're integrated fully with the large... The largest PBMs have the same owners as the largest insurance companies, and in some cases have the same owners as the largest pharmacy chains. So it's all one big but not so happy family. And that creates new opportunities for them to be self-referring and to be frankly, changing the prices on things in ways that serve their interests, but don't really serve our interests.

So we know that they're doing that actually. We know that they can direct people towards their pharmacies.

Q: Wow, can you share an example?

Weisbart: So CVS, you know, one of the – actually the largest pharmacy benefit management company – they have their own insurance system. They have their own healthcare providers, Minute Clinic, Signify Health. They have their own pharmacies. Obviously they have their own specialty pharmacies. They are owned as I was saying by Aetna. Express Scripts is the second largest one and they're owned by Cigna.

And they have their own pharmacies, not retail that I know of, but they have their own specialty pharmacies. And then Optum is the third largest, and they're owned by United. Humana has their own – you know Humana. So they're all interwoven and they take advantage of this inbreeding. So,one example that's in the report shows that the PBM pays the pharmacy sometimes as much as 20 times more for the same drug as what that drug actually costs the pharmacy to get.

Unbelievable.

Weisbart: So the one drug that they said in particular, they were talking about Gleevec just as one example that they spell out. And Gleevec actually costs pharmacies around the country a total of $48 million to purchase. Pharmacies spend a total of $48 million purchasing that so that they can dispense it – $48 million.

But the FTC report shows that the pharmacies are paid $950 million for the drug. So they spend $48 million and they are paid $950 million because their owners are the insurance companies. So the insurance companies can't look like they're making too much profit. So they're able to hide that profit as an expense so to the insurance company, they treat that extra payment to the pharmacy as an expense, but they own that pharmacy. So that other, what $900 million of overpayment that PBM can treat as an expense, but the pharmacy that doesn't have those constraints on profit can rake in as a profit. And it all goes back to the same owner. So the reason I'm going into that detail is that this inbreeding, this consolidation, this vertical and horizontal integration, this mess of corporate takeover drives up the cost for all of us, hides their costs, makes it so convoluted that you can't even figure out what's going on. It took this long FTC report for this stuff.

Q: Yeah. Wow. So it sounds like they're exploiting consumers by inflating drug prices by multiple means, including by all this consolidation that's so incestuous …. So CVS is a pharmacy and a pharmacy benefit manager and a provider and it's also an insurer? Did I get that right?

Weisbart: Well, they're Aetna, right? So Yeah. And an insurer, they're all, they're the whole thing. They're the whole package – one stop shopping. Unlike an integrated single-payer national health insurance program that's actually doing this to improve the nation's health. Unlike that, this complex integrated program is for profit, and they don't care that something like 30% of Americans can't afford to even take their meds. Something like 30% of Americans either ration or skip doses due to the high cost of medications. They don't care about that. I mean, they would rather you didn't because then you're not filling a prescription and that's how they make their money. But, you know, I'm sure they maximize their profit on this. Yeah, you're right. I like the way you said that to put your two words together, you said it's an incestuous exploitation.

Right.

Weisbart: And the group that's really hurting from this really are the retail pharmacies. So the contracting between a pharmacy and the PBM, unless they're owned, you know, like the CVS owns CVS is really lopsided. And as a result, we're

seeing rural independent pharmacies closing – something like 10% of rural independent pharmacies closed from 2013 to 2022, according to the FTC report.

They have these contracts that the pharmacy is precluded from negotiating. They're non-negotiable. They don't know what they're being reimbursed for dispensing. They hide this through this really opaque set of algorithms. It's way worse. Have you ever tried to look at your cable bill or look at the detail on your airplane ticket or look at your phone bill and see all these, 'I don't know what that is.' You know, 'I don't know what that is.' 'I don't know what that is.' And that's nothing compared to the contracts that these poor retail pharmacies have to deal with.

Q: Oh yeah? How so?

Weisbart: The algorithms are opaque, they're not shared. They don't know how they're making up the rules. The PBM decides how much it should cost the pharmacy to get the drug, and they make their own. The PBM makes its own rules about that. They have their list about that. PBM has a list of how much it should cost the retail pharmacy to get the drug and they don't tell the retail pharmacy what that amount is. They don't share that. They keep that member private. They constantly update it. They don't tell the retail pharmacy what it is. They have no way of looking at it. They decide on a dispensing fee. They decide on some tax system. They have other incentives. The patient pays out of pocket. They apply a transaction administrative fee. At the end of the day, I have a friend that owns a retail pharmacy, and over the last 10 years, I've watched him gain quite a bit of weight. Now I understand why. I'm joking about him, but that's why we're seeing retail pharmacies go out of business. There's no transparency to this model. I don't know how they stay in business, honestly.

Q: When you say retail pharmacy, how does that differ from a mom and pop pharmacy? Or is that the same thing?

Weisbart: Basically. Retail pharmacies would be all of the pharmacies that have storefronts, right? So CVS, Walgreens, but then a mom and pop would be one of the independent groups that has a storefront, you know, a brick and mortar sort of building. If you're in Chicago, there's retail pharmacies [on] every corner, every

street corner that you go into. And the Walgreens and CVS are set up, you know, like grocery stores in a lot of places. But if you're in a rural community, that retail pharmacy, which is probably mom and pop's retail pharmacy, they're central to the community. They employ people. They're where you go for your flu shot. They're where you go for your blood pressure check. They have good stability often amongst the pharmacists. So that's your trusted healthcare professional.

And there may not be a physician in the community. So having a retail pharmacy, especially in a rural area, having that close is a disaster. It's a quiet healthcare crisis that's going on. And like I said, the FTC documented it from 2013 to 2022, 10% of them went out of business. 10% of the retail and rural independent pharmacies closed during that period. We were starting to do this kind of stuff when I was working at the PBM that I was at. But we kept close track on whether pharmacies were closing and if we hit a point of cutting back rates to the point that we started to see any pharmacies closing, [we would say] that's too far. You know, it's, 'cause you know, it's always a negotiation. Everybody says, 'you're not paying me enough.' Everybody says, 'I want to pay you less.' That's every part of business in the way our country is set up. So, you know, having somebody say that's not enough money is kind of, you know, but when we started seeing that, actually no. It really wasn't, then we would back off. And they don't seem to be concerned about that today.

Q: ***Interesting. Well, the FTC is definitely concerned, because they put out the report earlier this summer saying that these prescription drug middlemen profit at the expense of patients by inflating drug costs. What do you think is the significance of this FTC report?***

Weisbart: It's a spectacular start. Being the start, it doesn't go so far as to recommend very much in the way of statutory change, but critics have been saying lots of things about PBMs for the last many years. But having the FTC validate those considerations in the way that only the FTC can do, I think that's really more powerful. So I think when the advocacy community tries to talk to Congress about this is just, you know, not acceptable, we now have a much, much more powerful tool to bring. Hopefully, the leadership of the FTC will stay in place and we'll be able to 'cause Lina Khan. Wow, what a jewel, the head of the FTC is

like. It's incredible that we have somebody that's spectacular as head of the FTC. So, hopefully she'll be able to stay there for several more years and kind of keep going to the next step.

Thank you Dr. Ed Weisbart of Physicians for a National Health Program. Since this interview, Cigna's Group Express Scripts sued the FTC over its interim report that the company said unfairly blames PBMs for rising drug prices and is seeking a court-ordered retraction. Meanwhile, the FTC has now also sued CVS Health Corp, Cigna Group and UnitedHealth Group alleging their PBMs have illegal rebate programs that are causing a spike in the price of insulin.

Stay tuned for next time when we hear more about the role PBMs are playing in squeezing consumers and pharmacies.

Do you have a personal story you'd like to share about our wack healthcare system? Contact us through our website at heal-ca.org.

And don't forget to subscribe to Code WACK! wherever you find your podcasts. You can also find us on ProgressiveVoices.com and on Nurse Talk Media.

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