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Pharmacy Benefit Managers Are Not The Cause Of High Prescription Drug Prices

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The press has found no shortage of villains for the high cost of prescription drugs today. While the pharmaceutical companies typically receive the lion's share of the blame, of late the Pharmacy Benefit Managers have come under fire for their supposed role in high drug prices.

Pharmacy Benefit Managers work on behalf of health insurance companies to help them negotiate prices with the pharmaceutical companies, and the price breaks they obtain typically come in the form of rebates paid to the companies.

Some aver that the rebates solely benefit the health insurance companies, that they do nothing to reduce drug prices, and that they should be abolished. Even Scott Gottlieb, the FDA commissioner, has suggested that Congress consider legislation that would limit rebates in some way.

However, blaming the system of rebates for high drug prices completely misdiagnoses the prescription drug market, and eliminating them would accomplish nothing. In a recent study I wrote with Tony Lo Sasso of the University of Illinois at Chicago, we argue that tying the hands of PBMs could very well raise drug prices.

Pharmacy Benefit Managers arose simply because there was a lacuna in the healthcare market: put simply, nothing constrained the price of prescription drugs; Doctors would prescribe the drugs they thought necessary, pharmaceutical companies would charge whatever they wishes for drugs still on patent, and the insurance companies would foot the bill without any real recourse other than to raise their prices the following year.

Pharmacy Benefit Managers do two principal things: First, they negotiate prices for on-patent drugs. The high prices reported for new drugs are appropriately shocking, but those are not what insurance companies pay: they frequently negotiate a steep discount, which in turn allows insurance companies to keep premiums lower.

The second thing PBMs do is encourage competition in the drug market. They steer doctors to prescribe generic equivalents or other substitutes when available. For instance, while many activists decry the production of “me too” drugs that merely seek to duplicate existing drugs, rather than spending resources developing new drugs for other illnesses, such drugs allow PBMs to put pressure on the pharmaceutical company that makes the original drug to lower its prices.

The recent plethora of drugs that cure Hepatitis C bear this out: When Gilead put out Sovaldi at a list price of $84,000, the brunt of the media attention was not on the amazing accomplishment of curing an illness that had heretofore been incurable absent a liver transplant, but on the enormous cost. However, that list price was not anywhere near what insurance companies paid, precisely because of PBMs, and as other companies introduced their own Hepatitis C drugs--anxious to cut into Gilead’s market--prices fell even further.

Constraining health care costs is extremely difficult, especially in a marketplace like ours where the recipient of the treatment is largely insulated from its direct cost. Constraining Pharmacy Benefit Managers by eliminating their ability to procure rebates for insurance companies will make it more difficult for them to negotiate discounts. Letting pharmaceutical companies earn more money is not the route to constraining health care costs.

Healthcare costs are indeed going up, and if we could constrain them in a way so as to not reduce access or deter innovations then we would all benefit. However, it is worth keeping in mind that pharmaceuticals have been a highly cost-effective driver of mortality gains for a long period of time, not to mention a source of improved quality of life for millions of Americans. Limiting the ability of PBMs to negotiate discounts in drug costs is not the way to create a more value-oriented healthcare system.

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