Pharmacy Benefit Managers Make Billions Off the Backs of Patients, Pharmacies & Health Plans

Patient Steering

PBMs present preferred pharmacy status contracts with at-cost or below-cost reimbursement under the guise that status as a preferred pharmacy will offset the lesser reimbursement. PBMs are fully aware pharmacies will opt-out and immediately bombard the customer with calls, texts and correspondence boasting copay reductions, blatantly steering patients to pharmacies of the PBM's choice.

Example of a Medicare plan sending notice to one of our patients about their requirement for that patient to use a PBM-owned pharmacy or be forced to pay out of pocket.

INTERNET RESPONSE TEAM

8/3/2023 • 12:40 PM

Dear [redacted]

Thank you for contacting Aetna. We strive to provide quality service to every one of our members.

Your plan allows you to fill a specialty prescription one time at a network retail pharmacy. After that, you must get your refills through CVS Specialty Pharmacy for the drug to be covered under your prescription drug plan. If you try to fill at a retail pharmacy, you won't be covered. If the retail pharmacy can fill your drug, your cost will be 100 percent of the full drug price.

For further information, you can call us directly at 1-866-782-ASRX (1-866-782-2779). You can reach us Monday through Friday from 8:00 a.m. until 7:00 p.m. ET.

Spread Pricing

What is it? When the PBM charges the payer more than the pharmacy is paid for a medication and keeps the difference as profit.

Typically spread pricing is not disclosed to the payer, so they pay more than they realize due to these markups.[1]

Banning spread pricing in state Medicaid managed care programs would save federal taxpayers $1 billion over 10 years[2].

Example:

PBM pays Table Rock Pharmacy $10 for metformin

PBM charges NC $40

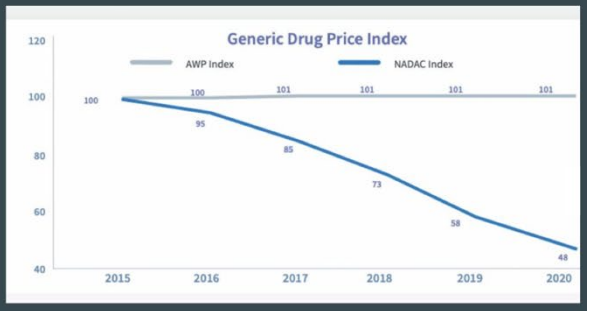
PBM pockets the difference ($30)

PBM makes **$360** off this one medication for one patient over the course of the year.

Reimbursement Models - AWP vs NADAC

Average Wholesale Price (AWP):

- A benchmark commonly used by PBMs to set reimbursement rates for pharmacies[1]
- Fails to accurately represent retail generic drug prices[1]
- Over a 5 year period, rose by 1% while NADAC decreased by 44%[1]



National Average Drug Acquisition Cost (NADAC):

- Jointly developed by the Centers for Medicare and Medicaid Services (CMS)[2]
- Calculates the average price that pharmacies pay for prescription drugs.[2]
- Publicly available data
- Preferred over AWP by the majority of state Medicaid plans[3]
- When the real cost of a drug goes down, NADAC follows suit and deflates. This eliminates the PBM's ability to "mine the pricing gap" for profit, as they do with AWP[3]

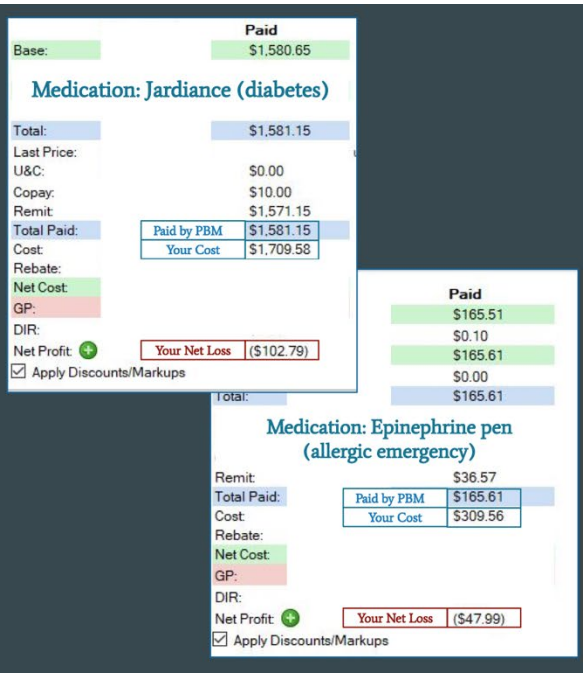
1. https://www.pharmacytimes.com/view/benchmark-does-not-represent-retail-prices-research-finds
2. https://www.cap-rx.com/insights/what-is-nadac-how-does-it-differ-from-awp
3. https://www.cap-rx.com/insights/why-use-nadac-based-pricing-over-awp

The previous slide refers to the importance of NADAC in fair reimbursement. H246 calls for a NADAC reimbursement model for North Carolina's pharmacies.

Below Cost Reimbursement

Reimbursement below cost becoming more prevalent across payers.

Contracts forbid us from telling the patient we are unable to fill their medication because of the loss we would incur. Pharmacies that have not taken heed to this have had customers complain to the PBM and have had their contract revoked.



Forced Brand Dispensing

Follow the Money

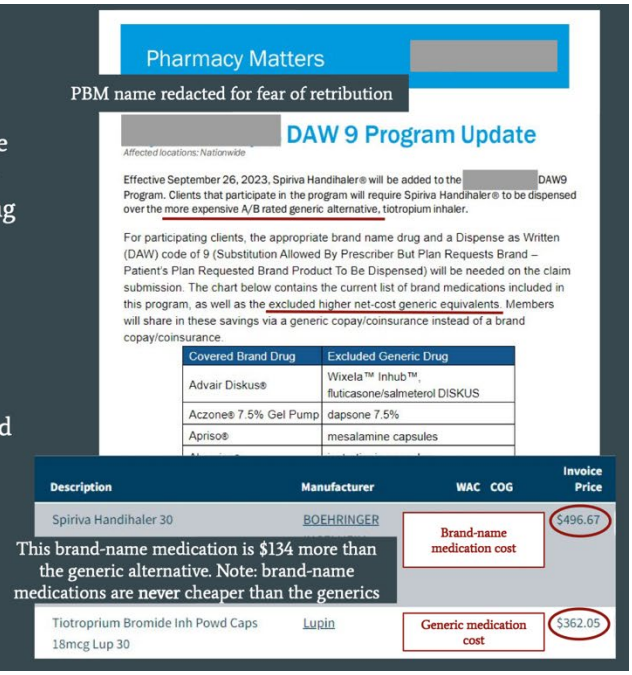
PBMs often require pharmacies to dispense brand-name medications. This is more expensive for the patient, the taxpayer and the pharmacy. This is particularly troubling for Medicare patients as they're pushed into the donut hole MUCH quicker.

PBMs are even bold enough to send communication to pharmacies stating generics are MORE expensive than brands. Because they get millions in rebates from manufacturers, they are the ONLY ones for whom brand medications are cheaper. Who do they think they're fooling with this memo?


PBM rebate schemes to suppress biosimilar Humira cost patients $6B, IQVIA analysis finds

The Biosimilars Council released a new analysis by IQVIA that reveals a PBM strategy to protect $2 billion in profits by "strangling" the biosimilar market and preventing savings for patients.

Sandra Levy

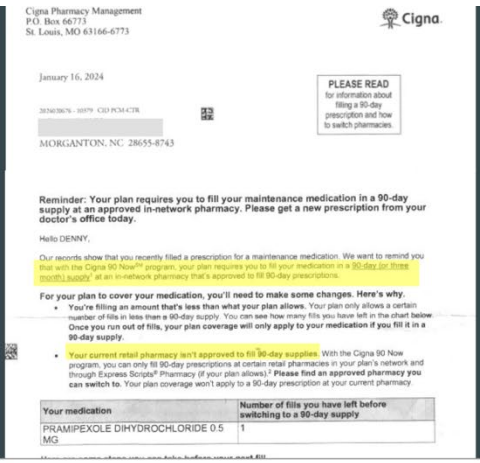


Some believe that pharmacies should just negotiate better contracts. Pharmacies are not permitted to negotiate PBM contracts.

Unfair Contracting

PBMs present contracts that allow no negotiation. If a pharmacy can't survive on the terms, the only choice they have is to not accept those patients.

Express Scripts (one of the big 3) is notorious for reimbursing pharmacies far below cost but their contract introduced in 2024 is unsustainable.



Cigna Pharmacy Management
P.O. Box 66773
St. Louis, MO 63166-6773

Cigna

January 16, 2024

PLEASE READ
for information about filling a 90-day prescription and how to switch pharmacies

MORGANTON, NC 28655-8743

Reminder: Your plan requires you to fill your maintenance medication in a 90-day supply at an approved in-network pharmacy. Please get a new prescription from your doctor's office today.

Hello DENNY,

Our records show that you recently filled a prescription for a maintenance medication. We want to remind you that with the Cigna 90 Now℠ program, your plan requires you to fill your medication in a 90-day (or three month) supply[1] at an in-network pharmacy that's approved to fill 90-day prescriptions.

For your plan to cover your medication, you'll need to make some changes. Here's why.

- **You're filling an amount that's less than what your plan allows.** Your plan only allows a certain number of fills in less than a 90-day supply. You can see how many fills you have left in the chart below. **Once you run out of fills, your plan coverage will only apply to your medication if you fill it in a 90-day supply.**
- **Your current retail pharmacy isn't approved to fill 90-day supplies.** With the Cigna 90 Now program, you can only fill 90-day prescriptions at certain retail pharmacies in your plan's network and through Express Scripts® Pharmacy (if your plan allows).[2] **Please find an approved pharmacy you can switch to.** Your plan coverage won't apply to a 90-day prescription at your current pharmacy.

Your medication	Number of fills you have left before switching to a 90-day supply
PRAMIPEXOLE DIHYDROCHLORIDE 0.5 MG	1

Intentional Tactic?

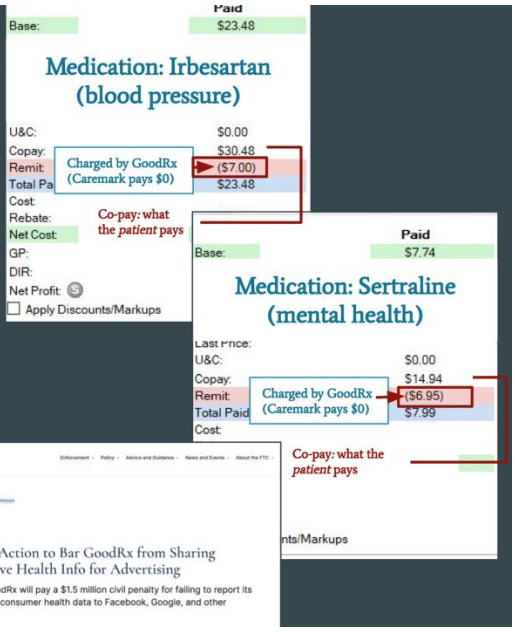
New patient transferred into our store for our service and free delivery
After filling one month's worth of medications, he receives a letter from his insurance company
He is required to fill his prescription for 3 months at a time (he only wants 1 in case of changes)
We are not contracted for 3-month fills (due to unsustainable reimbursement rates)
His insurance prohibits him from continuing to fill with us and suggests their own pharmacy

Caremark + GoodRx

New atrocity in 2024. CVS Caremark partnered with GoodRx. GoodRx is a discount card - the company makes their profit by paying nothing for medications but charging pharmacies to dispense them.

This practice is done without the patient's awareness or consent.

NCDOI can do nothing about it due to a loophole that prevents them from intervening on any state or federal healthcare insurance issue.



Paid
Base: $23.48

Medication: Irbesartan (blood pressure)

U&C: $0.00
Copay: $30.48
Remit: ($7.00)
Total Pa $23.48
Cost:
Rebate:
Net Cost:
GP:
DIR:
Net Profit:
Apply Discounts/Markups

Charged by GoodRx (Caremark pays $0)

Co-pay: what the *patient* pays

Paid
Base: $7.74

Medication: Sertraline (mental health)

Last Price:
U&C: $0.00
Copay: $14.94
Remit: ($6.95)
Total Paid $7.99
Cost:

Charged by GoodRx (Caremark pays $0)

Co-pay: what the *patient* pays

nts/Markups

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For Release

FTC Enforcement Action to Bar GoodRx from Sharing Consumers' Sensitive Health Info for Advertising

Under proposed order, GoodRx will pay a $1.5 million civil penalty for failing to report its unauthorized disclosure of consumer health data to Facebook, Google, and other companies

Many States have already taken action to rein in these actions by PBMs. North Carolina legislators can and should do the same by passing H246.