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Eliminating pharma rebates will raise costs for physicians and payers

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The U.S. Department of Health and Human Services' (HHS) Office of Inspector General has proposed a rule to remove drug rebates and prompt direct discounts for federal beneficiaries. The proposed rule would eliminate Anti-Kickback Statute (AKS) safe harbor protection for rebates paid by drug companies to pharmacy benefit managers (PBMs), Medicare Part D plans, and Medicaid managed care plans. The rule would create a new safe harbor for drug discounts offered to patients at the point of sale and create a new safe harbor for PBM fees.

This change has the potential to significantly disrupt the drug supply chain. PBMs have an enormous influence on the prescription drug supply chain and marketplace. PBMs strive to help plans manage cost and drug utilization by negotiating with drug companies and pharmacies to improve access to appropriate medications for plan members and mitigate costs.

Critics of the proposed rule claim that rebates offered to PBMs, Part D plans and Medicaid managed care plans work to reduce drug prices. What's more, the change failes to offer a workable alternative for PBMs in terms of negotiating on behalf of beneficiaries. This could ultimately lead to increased drug costs, higher premiums, and higher out-of-pocket costs for federal beneficiaries. In the end, this would have a negative impact on access to cost-effective prescription drugs.

Impact on physicians

With the elimination of rebates as a revenue source for PBMs and insurers likely that they would begin to charge more for services currently offered for free, prompting insurers to compensate by raising co-pays and premiums to make up for the lost revenue, according to Todd Edgar, PharmD, senior vice president, payer access solutions for the consulting firm Precision for Value.

The change could also lead to a change in formularies and in what preferred medications physicians prescribe. If manufacturers fail to reduce prices, then formularies would become more restrictive, leading to a need for more intensive utilization management. This, in turn, would demand more time from physicians seeking to prescribe brand name drugs that may represent the most efficacious course for their patients

The value of PBMs

PBMs negotiate with drug companies who then give PBMs discounts known as rebates. They pass most of the rebates on to the insurer, which then benefits the patient by lowering premiums.

For instance, PBMs are highly effective at incentivizing the use of generic drugs over costly branded drugs. In the United States, nearly 90 percent of all prescriptions written today are for inexpensive generic drugs primarily because of the advanced formulary techniques introduced by PBMs.

It's important for policymakers to understand that PBMs play an important role in the pharmaceutical supply chain and are positioned to protect patients and save them out-of-pocket costs. PBMs have an established and successful track record of implementing patient-friendly, market-based tools, such as negotiating with drug manufacturers, to reduce costs for patients.

Given rising costs, the changing nature of prescription drugs and increased disease state complexity, if PBMs didn't exist in the healthcare system today, they'd have to be created.

How PBMs benefit patients and payers

PBMs serve patients and payers alike, delivering transparency, collaborating with clients, patients and payers to save money and reduce costs. PBMs help stakeholders navigate the complex world of drug pricing and high cost specialty drugs and create effective solutions that curb costs for Fortune 100 clients and health plans.

As a drug class that is higher in cost and generally for a much more focused value, specialty drugs are a critical area for patients. These drugs target, for example, orphan diseases (conditions that affect fewer than 200,000 people nationwide) or conditions such as Hepatitis C. Some estimate that specialty pharmacy costs may account for 40 percent of total drug spending by 2020.

The new proposed rule would essentially shift money away from PBM efforts to curb these costs and put it back into the coffers of Big Pharma.
PBMs have been pushing for greater pricing transparency, although this is not the fundamental issue in drug pricing. The larger issue is a fragmented market serving smaller patient populations, creating more individualized therapies that are, by definition, higher cost and that render patient compliance more difficult to ensure.

The role of PBMs is to protect patients—a function that is increasingly vital. In fact, each of the five largest health insurance companies in the country have an associated PBM, or are developing capabilities to launch one. PBMs provide bargaining power and strive to negotiate lower prices with drug makers to save seniors and other patients approximately 50 percent a year on their prescription drug and related medical costs.

A majority of rebates and discounts are passed back to patients, according to insurance executives. In fact, rebates reduce costs for patients and insurers. Without these cash flows, it is more likely that drug costs for patients and insurers will go up, rather than down.

In the end, the proposed rule could lead to higher premiums to make up for the roughly $29 billion paid in rebates to PBMs and insurers.

Disrupted Healthcare System

With the proposed rule, PBMs will be tasked to educate and explain to clients the effect of the rebate rule on their contracts and business model and help them understand the price/rebate dynamic: The way it works now, manufacturers are incentivized to raise drug list prices in the interest of offering ever-larger rebates to PBMs in exchange for preferred placement on formularies. These rebates, however, are rarely used to lower patients' out-of-pocket drug costs because they generally pay a sum based on a drug's list price.

If the proposed rule goes into effect, health insurers will likely have to raise Part D premiums because they currently use the rebates to push premiums down. That can be problematic for Part D plans because one of the main factors they compete on are low premiums.
Companies with integrated PBMs, such as CVS Health Corp., UnitedHealth Group and Cigna Corp., will no longer be able to subsidize premium bids with rebate dollars.

PBMs face even more impactful disruption because they would need to determine how to transition the revenue that they are receiving now from a percentage-of-a-rebate-type contract to a fixed-fee agreement.

As the entire healthcare marketplace brace for the impact of the proposed rule, the news should serve as a wake-up call for PBMs to play a greater role in guiding policy makers in Congress toward a clearer understanding of value drivers in drug pricing.

Final thoughts

The proposed rule is meant to lower drug prices but, by failing to require drug companies to lower drug prices, it could potentially lead to higher Medicare Part D premiums.

In anticipation of this, a number of healthcare leaders have voiced concern about the proposed rule: America's Health Insurance Plans (AHIP) has accused HHS of unfairly blaming insurance providers and their PBM partners for the health system's current high prices, while CVS blames drug makers for high drug costs. In fact, CVS credits PBMs for serving as the last line of defense for the patient.

If policy makers begin to recognize that price setting, and not rebates, are the source of high drug costs it's possible they can strike a legislative balance that strengthens the industry and allows a platform for constructive dialogue.

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