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Subcommittee on Health

"An Examination of How Reining in PBMs Will Drive
Competition and Lower Costs for Patients"

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Chairman Carter, Ranking Member DeGette, and members of the subcommittee, thank you for inviting me here today. My name is Matthew Fiedler, and I am a health economist and the Joseph A. Pechman Senior Fellow in Economic Studies at the Brookings Institution.[1]

My testimony makes four main points about how the market for pharmacy benefit manager (PBM) services is working and the potential—and limits—of recent reform proposals:

- **The market for PBM services features limited competition, which likely allows PBMs to charge prices that exceed their cost of delivering services.** The three largest PBMs are estimated to control almost four-fifths of the market for PBM services. The dominance of a few large PBMs—along with various market frictions, including difficulties that payers face in comparison shopping and in switching PBMs—likely allow PBMs to charge their clients more than it costs to deliver PBM services and, thus, earn excessive profits.

- **Greater transparency could reduce the price of PBM services, albeit likely modestly.** Proposals like those considered in the last Congress that would require PBMs to disclose additional information to their clients would likely reduce prices by making it easier for payers to comparison shop or press their PBMs for better terms. However, these effects would likely be modest, as the complexity of PBM-payer contracts would continue to limit comparison shopping and difficulties in switching PBMs would remain.

- **Proposed restrictions on how payers compensate PBMs would have more complex effects on payers, both positive and negative.** Importantly, such restrictions are unlikely to directly reduce the price of PBM services. Barring PBMs from collecting certain forms of compensation (e.g., retained manufacturer rebates) would likely simply lead PBMs to collect more compensation in other forms (e.g., administrative fees).

[1] The views expressed in this testimony are my own and should not be attributed to the staff, officers, or trustees of the Brookings Institution. I gratefully acknowledge helpful conversations with Loren Adler and Richard Frank. Portions of this testimony are adapted from our prior joint work: Matthew Fiedler, Loren Adler, and Richard G. Frank, "A Brief Look at Current Debates about Pharmacy Benefit Managers," September 7, 2023, https://www.brookings.edu/articles/a-brief-look-at-current-debates-about-pharmacy-benefit-managers/.

Changing the structure of PBM-payer contracts could affect payers in other ways, both positive and negative. Consider, for example, proposals to bar PBMs from retaining a portion of the rebates they negotiate with drug manufacturers. This would reduce PBMs' incentives to prefer drugs with large rebates over drugs with low net prices when constructing formularies, which could reduce drug spending, but it would also reduce their incentives to negotiate larger rebates, which could increase spending. Restricting spread pricing or "delinking" PBM compensation from prices could similarly present tradeoffs.

Even when reforming how PBMs are compensated fails to benefit payers, it might sometimes benefit whoever ultimately pays a plan's premiums in settings where medical loss ratio (MLR) requirements apply. Barring PBMs from retaining rebates or using spread pricing would cause more of the compensation that payers provide to PBMs to take forms that are categorized as administrative costs rather than claims spending. This would tend to reduce payers' measured MLRs, potentially leading payers to reduce premiums.

- **If the goal is to make prescription drug coverage work better, PBM reform is one piece of the puzzle, but perhaps not the most important one.** Notably, PBM profits are equivalent to only several percent of overall drug spending, so even eliminating those profits entirely would only moderately reduce the overall cost of drug coverage. Achieving larger cost reductions would require reducing the prices that are received by other actors in the prescription drug supply chain, especially drug manufacturers.

  Additionally, a central concern in policy debates around PBMs is that high cost-sharing and onerous utilization management protocols can make it hard for patients to get the drugs they need. Where this occurs, it is typically not because the PBM is failing the payer, but instead because *payers'* incentives are poorly aligned with patients' interests (e.g., because payers have incentives to avoid high-cost enrollees or because problematic plan features are not salient to consumers when they choose a plan). Addressing these problems requires reforms to how insurance markets operate, such as improvements to risk adjustment systems or direct regulation of plan benefits, not reforms to PBM-payer relationships.

The remainder of my testimony examines these points in greater detail.

Background on PBMs' Role

A PBM is an entity that administers prescription drug benefits under a health plan.

PBMs perform three main functions, which closely parallel the functions that health insurers (or third-party administrators) perform for non-drug benefits under a health plan:

- *Establishing formularies and negotiating prices with drug manufacturers:* PBMs' most important functions may be establishing plan formularies, which specify which drugs a plan covers as well as what cost-sharing and coverage restrictions apply, and negotiating prices with drug manufacturers. These two PBM activities are closely linked; a PBM will typically offer to give a manufacturer's drug a more favorable place on a plan's formulary (which increases sales of the drug) in exchange for a discount from the manufacturer. This

discount can take many forms but is often provided as a "rebate" that the manufacturer pays to the PBM after the drug is dispensed.

- *Establishing pharmacy networks and negotiating prices with pharmacies:* Other consequential PBM functions are establishing pharmacy networks, the list of pharmacies that a plan's enrollees can access (or access at reduced cost-sharing), and negotiating prices with pharmacies. PBMs typically offer a pharmacy a place in a plan's network in exchange for the pharmacy's agreement to dispense drugs at a contractually specified price.
- *Claims processing:* PBMs are typically responsible for processing pharmacy claims.

In practice, many PBMs also operate pharmacies. The largest PBMs all operate their own mail-order pharmacies and specialty pharmacies (pharmacies that dispense drugs that are high-cost or require special handling). PBMs generally do not operate retail pharmacies; CVS Health, which owns a PBM and a large chain of retail pharmacies, is a notable exception.

A PBM's client is generally the payer responsible for the health plan in question, but who that is depends on the nature of the health plan. For a self-insured employer plan (an employer plan where the employer pays enrollees' claims costs), the PBM's client is typically the employer. For other types of plans, the PBM's client is the insurer offering the plan. Importantly, many large insurers (including Aetna, Cigna, Elevance, Humana, Kaiser Permanente, UnitedHealthcare, and many non-profit Blue Cross Blue Shield plans) now either own PBMs or are part of companies that own PBMs, so there is not always a meaningful distinction between the PBM and its client. Many recent PBM reform proposals, including the ones I focus on in this testimony, aim to reform PBMs' relationships with their clients and, thus, would likely have limited effects in these instances.

The PBM Market Features Limited Competition, Resulting in High Prices for PBM Services

A small number of firms control a large share of the PBM market. Estimates from the Drug Channels Institute indicate that the three largest PBMs processed 79% of U.S. prescription drug claims in 2023.[2] While some other sources estimate somewhat lower levels of PBM market concentration, possibly because they exclude much or all activity under self-insured plans, there is little doubt that the largest PBMs control a large fraction of the overall market.[3]

Economic theory shows that when there are few firms competing in a market, they can often demand prices that exceed their cost of delivering services and earn excessive profits. That may be particularly likely in the PBM market for a couple of reasons. First, different PBMs' services are not perfect substitutes for one another. Particularly important, *switching* from one PBM to

[2] Adam J. Fein, "The Top Pharmacy Benefit Managers of 2023: Market Share and Trends for the Biggest Companies—And What's Ahead" (Drug Channels Institute, April 9, 2024), https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of html.

[3] Dennis W Carlton et al., "PBMs and Prescription Drug Distribution: An Economic Consideration of Criticisms Levied Against Pharmacy Benefit Managers" (Compass Lexecon, October 2024), https://compass-lexecon.files.svdcdn.com/production/files/documents/PBMs-and-Prescription-Drug-Distribution-An-Economic-Consideration-of-Criticisms-Levied-Against-Pharmacy-Benefit-Managers.pdf?dm=172850386; José R Guardado, "Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2024 Update" (American Medical Association, September 9, 2024), https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf.

another may be quite costly to a health plan's enrollees since different PBMs may offer different formularies or pharmacy networks; this may force enrollees to change which drugs they are taking, navigate new prior authorization processes to continue taking the same drugs, or change which pharmacies they use to obtain their prescriptions. Second, it may be costly for PBMs' clients to solicit and compare bids given the complexity of typical PBM-payer contracts, making it hard to "shop around." In short, there is good reason for policymakers to worry that PBMs wield market power and to consider steps to ensure that PBM markets operate as efficiently as possible.

Greater Transparency Could Reduce the Price of PBM Services, Albeit Likely Modestly

One strategy policymakers could use to combat PBMs' market power is to require PBMs to disclose more information—including information on utilization, gross and net spending, cost-sharing, and formulary construction—to their clients. There is little relevant empirical evidence on how greater transparency would affect negotiations between PBMs and their clients, but economic theory suggests that this step could help payers negotiate somewhat better terms.

Notably, giving a payer more complete information about how its current PBM contract is operating could make it easier for the payer to estimate the costs it would incur under contracts offered by another PBM, making it easier for the payer to "shop" across PBMs. This, in turn, could put pressure on PBMs to lower prices or even encourage new PBMs to enter the market by making it easier for new entrants to lure clients away from incumbent PBMs. More information could also help payers enforce existing contracts or assess how their current PBM contracts compare to "typical" PBM-payer contracts and, thus, how much room there may be to press for better terms.

The Congressional Budget Office has estimated that transparency proposals targeting the employer market that were considered by this committee in the last Congress would reduce PBM revenues by around $900 million per year during the five years following implementation and generate federal savings averaging around $300 million per year during that period by reducing the cost of the tax exclusion for employer provided coverage, although these effects would fade in later years.[4]

While not trivial, this reduction in PBM revenues is modest relative to PBMs' profits. Indeed, the combined operating income of the three largest PBMs totaled around $18 billion in 2022.[5] This reduction would look even more modest if compared to the total cost of PBM services, which includes both PBMs' profits and the costs that PBMs incur to deliver those services. The modest size of this reduction is consistent with the fact that transparency would only very partially mitigate the frictions that make it hard for payers to shop around and substitute one PBM for another.

In practice, generating much larger reductions in PBM profits would likely require reducing PBM market concentration. This may be challenging in practice; PBM markets are already highly concentrated, and breaking up existing PBMs may not be feasible, although antitrust regulators may be able to make some progress by preventing incumbent PBMs from acquiring smaller,

[4] Congressional Budget Office, "Estimated Direct Spending and Revenue Effects of H.R. 3561, the PATIENT Act of 2023," July 11, 2023, https://www.cbo.gov/publication/59361.

[5] Fiedler, Adler, and Frank, "A Brief Look at Current Debates about Pharmacy Benefit Managers."

disruptive entrants.[6] Reducing the market share held by the largest PBMs could also pose tradeoffs. While reducing the market share held by the largest PBMs could reduce PBM profits (or encourage PBMs to operate more efficiently), it could also reduce PBMs' leverage in negotiations with manufacturers and pharmacies, thereby increasing negotiated prices. In principle, those higher prices could offset the benefits to payers from lower PBM profits. Evidence from health insurance markets, which are similar to PBM markets in some respects, suggests that lower concentration would reduce payers' costs on net, but this evidence is only an imperfect guide.[7]

Restricting How Payers Compensate PBMs Could Have Both Positive and Negative Effects

Another reform strategy that policymakers have considered is restricting how payers compensate PBMs. For example, proposals that Congress considered at the end of 2024 would have required PBMs to pass all rebates along to payers, barred PBM-payer contracts in Medicare Part D from linking PBM compensation to drug prices, and limited use of "spread pricing" (charging the payer more for a prescription than the PBM pays the pharmacy) in Medicaid.

Importantly, restricting the form of PBM-payer contracts is unlikely to directly reduce the price of PBM services. PBMs are compensated by payers in many different ways, and barring PBMs from collecting one form of compensation (e.g., retained manufacturer rebates) is likely to lead them to demand more compensation in other forms (e.g., administrative fees). In practice, payers are likely to accede to these demands since barring a particular contract structure does nothing to change the quantity or quality of a payer's alternatives to contracting with a particular PBM, which is what ultimately determines a payer's ability to push back on a high price.

Restricting the form of PBM-payer contracts could also change how PBMs manage drug benefits, but these effects could be both positive and negative for payers. For example, barring PBMs from retaining a share of rebates eliminates their incentive to favor drugs with large rebates over drugs with low net prices when constructing formularies, which would tend to reduce payers' costs. But it also reduces PBMs' incentive to negotiate aggressively for larger rebates, which would tend to increase payers' costs. I am not aware of any empirical evidence that speaks to which of these effects is larger. Economic theory suggests that PBMs and payers will tend to select the contract terms that strike the best balance between these competing considerations (since otherwise they could adopt a better approach and split the savings). This logic suggests that restricting how rebates are shared could leave payers worse off, although it assumes that both parties are well-informed about the implications of different contract structures, which may not be the case.

Other restrictions on PBM-payer contracts could have similarly ambiguous effects. Delinking PBM compensation from prices would bar contracts where PBMs are compensated based on total spending under a plan, which can create perverse incentives to favor high-priced drugs or increase utilization. But it would also bar "shared savings" contract structures in which PBMs are paid more

[6] Colleen Cunningham, Florian Ederer, and Song Ma, "Killer Acquisitions," *Journal of Political Economy* 129, no. 3 (March 2021): 649–702, https://doi.org/10.1086/712506.

[7] Leemore S. Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry," *American Economic Review* 102, no. 2 (April 2012): 1161–85, https://doi.org/10.1257/aer.102.2.1161.

if they hold drug spending below a target level. (In any case, delinking proposals limited to Medicare Part D would likely have relatively little effect since the Part D market is dominated by insurers that are integrated with PBMs;[8] the formal terms of the PBM-insurer contract is unlikely to have much effect on a PBM's decisions in these cases, if such a contract even exists.) Some forms of spread pricing can also strengthen PBMs' incentives to negotiate low prices with pharmacies if they allow a PBM to retain all or part of the savings when it negotiates a lower price.

One caveat is that even where restricting the form of PBM-payer contracts does not reduce *payers'* costs, it could reduce costs for whoever is ultimately responsible for paying a plan's premium in settings where the payer is subject to an MLR requirement.[9] (These rules require a payer to keep its MLR, the ratio of claims spending to premium revenue, above some level. They apply to insured plans in the commercial market, to Medicare Part D plans, and to Medicaid managed care plans.)

For example, if PBMs were required to pass all rebates along to payers, this would reduce payers' net claims spending as reported for MLR purposes. If PBMs then offset the lost rebate revenue by increasing their administrative fees, that would increase payers' *administrative* spending, not their claims spending. Thus, these shifts in how PBMs are compensated could reduce payers' MLRs and force them to reduce their premiums to remain in compliance with the MLR standard. Something similar could happen if PBMs responded to a ban on spread pricing by reducing how much they charge payers for pharmacy claims. Importantly, however, premiums are not guaranteed to fall even where MLR requirements apply. Premiums would not fall if a payer started out far above the MLR standard. Nor would premiums fall if payers increased their MLRs in other ways, either through accounting changes or by managing claims spending less effectively.[10]

PBM Reform is Only One Piece of the Puzzle, and Perhaps Not the Most Important One

In closing, I note that addressing many concerns that are commonly expressed about the cost and quality of prescription drug coverage would require looking beyond the PBM market.

One such concern is that drug coverage is too costly to consumers, employers, and governments. As discussed above, PBM reform can help reduce these costs by squeezing PBM profits and, in turn, reducing premiums. However, PBM profits constitute only several percent of overall drug spending,[11] so even eliminating these profits would only modestly reduce overall costs. Achieving larger savings would require reducing the revenue captured by other entities in the prescription drug supply chain, particularly manufacturers. To be sure, policies that reduce manufacturer revenues raise thorny questions about how to balance lowering prices for consumers against

[8] Juliette Cubanski and Anthony Damico, "Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2024" (KFF, July 2, 2024), https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2024/.

[9] These interactions with MLR requirements may be one instance where reforming PBM-payer relationships could matter even when the PBM and payer are part of the same entity, as it could change how the combined entity must account for the relevant costs for MLR purposes.

[10] Steve Cicala, Ethan M. J. Lieber, and Victoria Marone, "Regulating Markups in US Health Insurance," *American Economic Journal: Applied Economics* 11, no. 4 (October 2019): 71–104, https://doi.org/10.1257/app.20180011.

[11] Fiedler, Adler, and Frank, "A Brief Look at Current Debates about Pharmacy Benefit Managers."

providing appropriate incentives for the development of new drugs.[12] But if policymakers want to achieve large reductions in overall drug costs, then this is where they need to look.

Another common concern is that drug coverage places inappropriate burdens on patients by subjecting them to too much cost-sharing, narrow formularies, and onerous utilization management processes. While cost-sharing and coverage restrictions can help discourage inappropriate utilization,[13] they can also prevent patients from receiving needed care or unravel the financial protection that health insurance is supposed to provide.[14] Plan designs clearly do not always balance these competing considerations appropriately.

Where such problems arise, it is typically not because PBMs are failing payers, but instead because *payers'* incentives are poorly aligned with patients' interests. This may be the case for many reasons. Payers often have incentives to avoid high-cost enrollees, and imposing high cost-sharing or stringent utilization management on drugs that these enrollees need can be an effective way of doing so.[15] Additionally, high cost-sharing or stringent utilization management requirements may not always be salient to enrollees at the point that they select plans, leading insurers to offer plans with these features in hopes of attracting consumers via lower premiums.[16]

Addressing these problems requires reforms to how insurance markets operate. This could include improving risk adjustment systems to remove the incentive to avoid high-cost enrollees and, in turn, to distort plan designs. It could also include directly regulating plan designs to require plans to offer adequate coverage or changing how plans are subsidized to drive enrollment toward higher-quality plans. But reforms to PBM-payer contracts are unlikely to be an effective tool.

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[12] For a discussion of policy options and the associated tradeoffs, see Congressional Budget Office, "Alternative Approaches to Reducing Prescription Drug Prices," October 4, 2024, https://www.cbo.gov/publication/58793.

[13] See, for example, Zarek C. Brot-Goldberg et al., "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," Working Paper, Working Paper Series (National Bureau of Economic Research, January 2023), https://doi.org/10.3386/w30878; Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*," *The Quarterly Journal of Economics* 132, no. 3 (August 1, 2017): 1261–1318, https://doi.org/10.1093/qje/qjx013.

[14] See, for example, Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review* 100, no. 1 (March 2010): 193–213, https://doi.org/10.1257/aer.100.1.193; Katherine Baicker, Sendhil Mullainathan, and Joshua Schwartzstein, "Behavioral Hazard in Health Insurance," *The Quarterly Journal of Economics* 130, no. 4 (November 1, 2015): 1623–67, https://doi.org/10.1093/qje/qjv029; Brot-Goldberg et al., "What Does a Deductible Do?"

[15] See, for example, Liran Einav, Amy Finkelstein, and Mark R. Cullen, "Estimating Welfare in Insurance Markets Using Variation in Prices," *The Quarterly Journal of Economics* 125, no. 3 (August 1, 2010): 877–921, https://doi.org/10.1162/qjec.2010.125.3.877; Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107, https://doi.org/10.1257/pol.20170014; Mark Shepard, "Hospital Network Competition and Adverse Selection: Evidence from the Massachusetts Health Insurance Exchange," *American Economic Review* 112, no. 2 (February 1, 2022): 578–615, https://doi.org/10.1257/aer.20201453.

[16] Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," *American Economic Review* 101, no. 4 (June 2011): 1180–1210, https://doi.org/10.1257/aer.101.4.1180; Saurabh Bhargava, George Loewenstein, and Justin Sydnor, "Choose to Lose: Health Plan Choices from a Menu with Dominated Option*," *The Quarterly Journal of Economics* 132, no. 3 (August 1, 2017): 1319–72, https://doi.org/10.1093/qje/qjx011.

In short, while policymakers have good reasons to believe that drug coverage could work better that it does, PBM reform is only one piece of the puzzle, and perhaps not the most important one.