THE MIDDLEMEN

The Opaque Industry Secretly Inflating Prices for Prescription Drugs

Pharmacy benefit managers are driving up drug costs for millions of people, employers and the government.


By Rebecca Robbins and Reed Abelson

This is the first article in a series about how pharmacy benefit managers prioritize their interests, often at the expense of patients, employers and taxpayers.

- June 21, 2024

Americans are paying too much for prescription drugs.

It is a common, longstanding complaint. And the culprits seem obvious: Drug companies. Insurers. A dysfunctional federal government.

But there is another collection of powerful forces that often escape attention, because they operate in the bowels of the health care system and cloak themselves in such opacity and complexity that many people don't even realize they exist.

They are called pharmacy benefit managers. And they are driving up drug costs for millions of people, employers and the government.

The three largest pharmacy benefit managers, or P.B.M.s, act as middlemen overseeing prescriptions for more than 200 million Americans. They are owned by huge health care conglomerates — CVS Health, Cigna and UnitedHealth Group — and are hired by employers and governments.

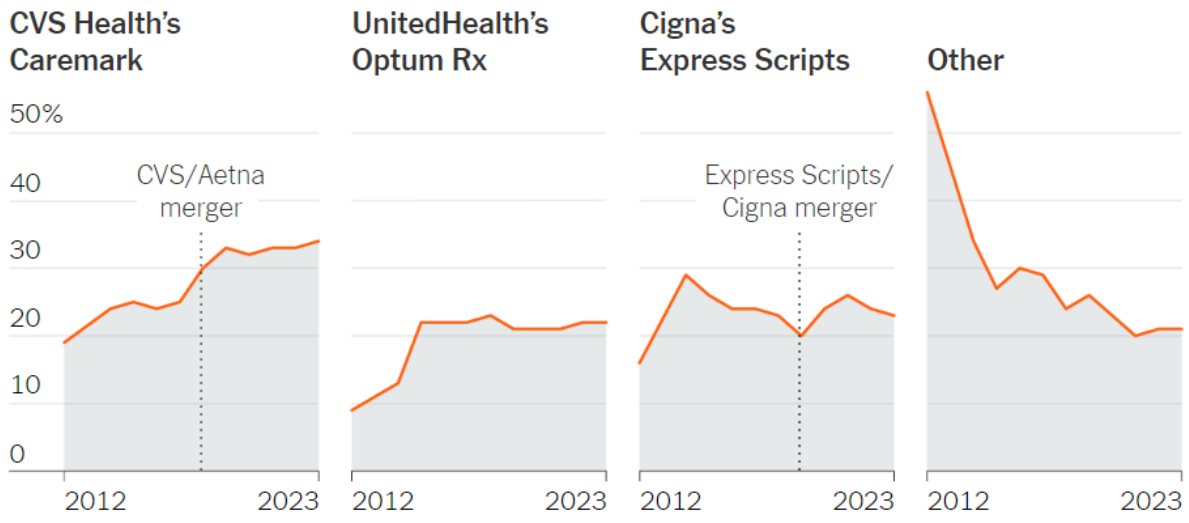
The job of the P.B.M.s is to reduce drug costs. Instead, they frequently do the opposite. They steer patients toward pricier drugs, charge steep markups on what would otherwise be inexpensive medicines and extract billions of dollars in hidden fees, a New York Times investigation found.

Most Americans get their health insurance through a government program like Medicare or through an employer, which pay for two different types of insurance for each person. One type covers visits to doctors and hospitals, and it is handled by an insurance company. The other pays for prescriptions. That is overseen by a P.B.M.

The P.B.M. negotiates with drug companies, pays pharmacies and helps decide which drugs patients can get at what price. In theory, everyone saves money.

Biggest P.B.M.s Dominate

Each P.B.M.'s estimated share of prescriptions filled in the United States.



Notes: Data missing for 2013. • Source: Drug Channels Institute • By Ella Koeze

"We're really, really good at what we do," Jon Mahrt, president of UnitedHealth's P.B.M., Optum Rx, said in an interview. The main lobbying group for the P.B.M.s says that in 2022 they saved their clients and patients $286 billion.

But those savings appear to be largely a mirage, a product of a system where prices have been artificially inflated so that major P.B.M.s and drug companies can boost their profits while taking credit for reducing prices.

The Times interviewed more than 300 current and former P.B.M. employees, patients, physicians, pharmacists and other industry experts, and reviewed court documents and patient records. The investigation found that the largest P.B.M.s often act in their own financial interests, at the expense of their clients and patients. Among the findings:

- P.B.M.s sometimes push patients toward drugs with higher out-of-pocket costs, shunning cheaper alternatives.

- They often charge employers and government programs like Medicare multiple times the wholesale price of a drug, keeping most of the difference for themselves. That overcharging goes far beyond the markups that pharmacies, like other retailers, typically tack on when they sell products.
- The largest P.B.M.s recently established subsidiaries that harvest billions of dollars in fees from drug companies, money that flows straight to their bottom line and does nothing to reduce health care costs.
- The P.B.M.s, which are responsible for paying pharmacies on behalf of employers, are driving independent drugstores out of business by not paying them enough to cover their costs. Small pharmacies have little choice but to accept these lowball rates because the largest P.B.M.s control an overwhelming majority of prescriptions. The disappearance of local pharmacies limits health care access for poorer communities but ultimately enriches the P.B.M.s' parent companies, which own drugstores or mail-order pharmacies.
- P.B.M.s sometimes delay or even prevent patients from getting their prescriptions. In the worst cases, patients suffer serious health consequences.

Many patients learn about the existence of P.B.M.s only when they have a problem getting medications and spend hours navigating a byzantine system of approvals and restrictions.

But the P.B.M.s' business practices touch virtually every American family. Even people who don't take prescription drugs end up paying higher insurance premiums and taxes as a result of inflated drug costs.

In Oklahoma, for example, CVS's P.B.M., Caremark, overcharged the health plan for state employees by more than $120,000 a year for one patient's cancer drug, according to his insurance documents.

In Illinois, a woman with cancer paid hundreds of dollars more than she should have for her pain medication because Caremark required her to use a more expensive version.

In New Jersey, Cigna's P.B.M., Express Scripts, wanted Joseph Kaplan, a 77-year-old retiree, to pay $211 for a three-month supply of his allergy drug when he could have paid $22 at Costco. "It's just nuts," he said.

Smallish sums quickly add up when applied across the health care system. It is a big reason the P.B.M.s have become a fast-growing and profitable industry.

If they were stand-alone companies, the three biggest P.B.M.s would each rank among the top 40 U.S. companies by revenue. The largest, Caremark, generates more revenue than Ford or Home Depot.

Because of recent mergers, they are becoming more dominant, collectively processing roughly 80 percent of prescriptions in the United States. In 2012, the figure was less than 50 percent.

Executives at the P.B.M.s say their size is essential to counteract the companies that make brand-name drugs.

“The biggest driver of cost in this country is the brand manufacturers,” David Joyner, president of CVS Caremark, said in an interview. “Size and scale really matters in order to be able to influence and be able to lower the overall cost of branded pharmaceuticals.”

Officials at Caremark, Express Scripts and Optum Rx defended their business models. Some executives acknowledged that there were times when they overcharged for specific drugs, but the companies said they offered the lowest overall prices to their clients. (The system’s opacity makes that claim impossible to verify.)

The P.B.M.s also say that tightfisted employers are to blame when patients are charged high out-of-pocket costs or can’t get their medications. Indeed, many employers skimp on the health benefits they offer workers.

Yet employers don’t always grasp the impact of their choices. They have outsourced so much of the responsibility for handling their workers’ drugs that employers often can’t understand — much less control — how the system works.

Few issues are as politically explosive as drug prices. For years, drug companies bore the brunt of the public ire. Increasingly, that anger is also being directed at P.B.M.s.

In Washington and state capitals, lawmakers, regulators and attorneys general have suggested that the benefit managers may be inflating drug prices and engaging in anticompetitive behavior.

“They’re seeking to extract from the system, without creating any corresponding value for the system,” said Dave Yost, the Republican attorney general in Ohio, who has sued Express Scripts and Optum Rx over their business practices. “The patients are the ones that are suffering.”

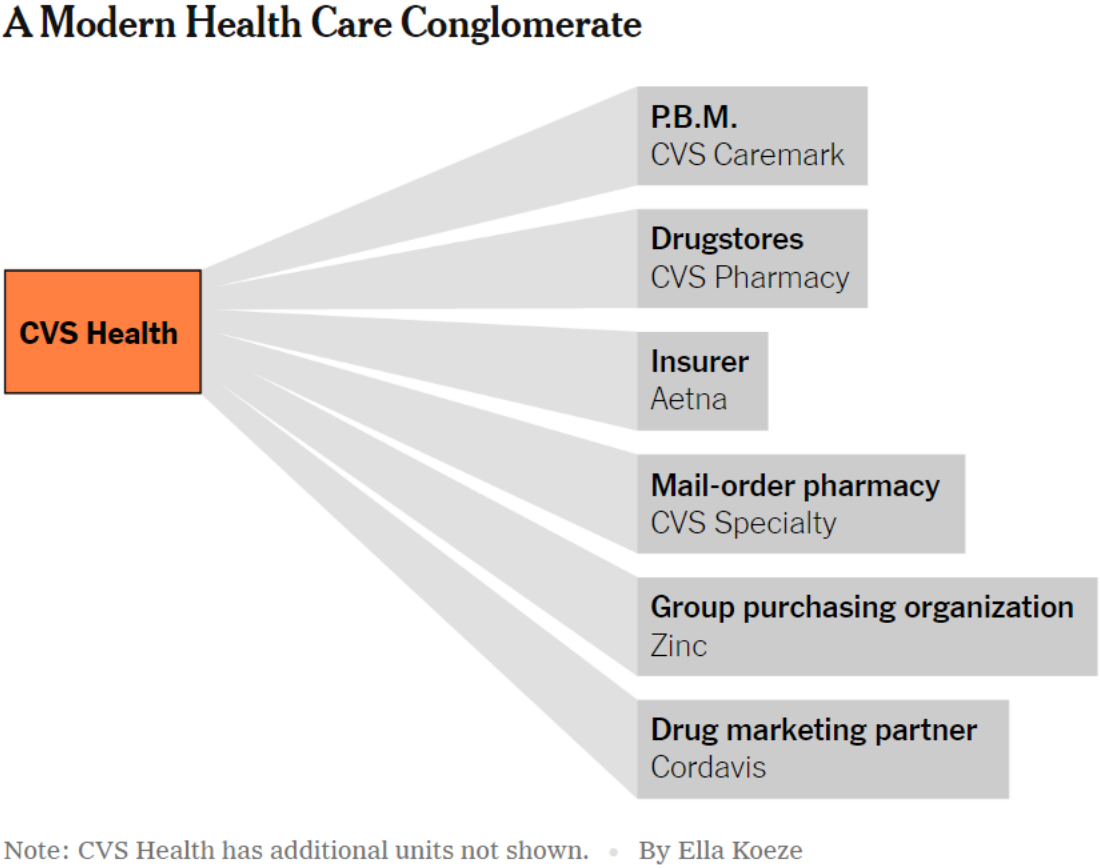
‘The Arsonist and Firefighter’

P.B.M.s have been around since the late 1950s. They initially handled requests mailed in by pharmacies and patients seeking reimbursement for the costs of prescription drugs.

Over the decades, P.B.M.s have had different owners, including drug makers and large chains of pharmacies. They were often credited with saving money for patients and employers, including in the early 2010s when they embraced a new wave of generic drugs. They kept a slice of the savings for themselves.

The modern P.B.M. emerged in 2018. The giant health insurers Aetna and Cigna were trying to achieve the growth demanded by Wall Street. They sought to merge with the P.B.M.s, whose profits were soaring. Aetna and CVS combined. Cigna bought Express Scripts. (UnitedHealth had built its own P.B.M.)

It would turn out to be a seminal moment, one that would rapidly and radically change the American health care system by further shifting power into the hands of giant conglomerates and away from employers and patients.



Today, P.B.M.s feed off a system where everything is extraordinarily complicated — including how much a drug actually costs.

Here's how it works.

When you hear about a $16,000-a-year obesity drug or a $275 vial of insulin, that's not the final price of the medication. This sticker price is just the starting point for negotiations between P.B.M.s and drug companies.

The drug companies generally agree to reduce prices on brand-name medications by giving rebates and other payments to the P.B.M.s. The P.B.M.s then share most of that with employers. But they also pocket a portion — sometimes about 10 percent — for themselves. Because of the huge national volume of drug spending, that adds up to billions of dollars.

Greater discounts do not necessarily benefit patients. While lower costs for employers can translate into lower insurance premiums for workers, some out-of-pocket costs are

set as a percentage of the original sticker price. So when sticker prices are higher, patients pay more.

The P.B.M.s' demands for greater discounts often lead drug companies to increase sticker prices so that they can maintain their profit margins.

As a result, it is common for a drug's final price after discounts to plateau even as patients' out-of-pocket costs for that drug go up.

Consider Eliquis, a brand-name blood thinner that is widely used to prevent blood clots and strokes. The manufacturer, Bristol Myers Squibb, has more than doubled the sticker price in the past decade. But Bristol is also now paying much more in discounts, according to the data provider SSR Health.

That means P.B.M.s are delivering big rebates on Eliquis to employers. But because some out-of-pocket costs are a percentage of the sticker price, many patients are now paying hundreds of dollars more per year.

"P.B.M.s save money off bogus inflated prices that should not exist in the first place," said Antonio Ciaccia, a consultant hired by Ohio and other states that are investigating the benefit managers. "They are the arsonist and firefighter of high drug prices."

A Bizarre Incentive

The Federal Trade Commission is concerned that the rebate payments from drug companies to P.B.M.s may be illegally distorting the market.

"We've heard a lot of complaints about the rebate system and whether the rebates may effectively be functioning as kickbacks that are diverting people to more expensive medicines at the expense of lower-cost generics," Lina Khan, the F.T.C. chair, recently told reporters.

Image

She was alluding to a bizarre incentive that will sound familiar to many people who routinely take prescription drugs: Even when an inexpensive generic version of a drug is available, P.B.M.s sometimes have a financial reason to push patients to take a brand-name product that will cost them much more.

For example, Express Scripts typically urges employers to cover brand-name versions of several hepatitis C drugs and not the cheaper generic versions.

The higher the original sticker price, the larger the discounts the P.B.M.s can finagle, the fatter their profits — even if the ultimate discounted price of the brand-name drug remains higher than the cost of the generic.

P.B.M. executives say they are not to blame when patients are saddled with higher out-of-pocket costs on brand-name drugs. They say they're just doing what their clients, the employers, want. The P.B.M.s recommend different options, but the employers have the final say.

In some cases, employers actually prefer the use of brand-name drugs, even when a generic is available, because their final costs can be lower once discounts are taken into account — even if the costs go up for their employees.

On a snowy February afternoon in rural Middleport, N.Y., a customer came to the local pharmacy to pick up an inhaler. He normally got the generic version of Symbicort, which is used to treat conditions like asthma.

This time, though, the patient's P.B.M., Caremark, would pay only for the more expensive brand-name version. The pharmacist on duty, Mark Stahl, said it would cost the patient more than $300 out of pocket — about $60 more than he would have had to pay for the generic version that was no longer covered. The frustrated customer left without the inhaler he came for.

A Times reporter witnessed the interaction. Mr. Stahl said that P.B.M. tactics like this were common. "It's a constant struggle all day long," he said.

An Irish Workaround

A short walk from the bustling pubs and shops in central Dublin, a glass-paneled office building houses the latest secret to the P.B.M.s' success. Inside is a subsidiary that Optum Rx — itself a subsidiary of UnitedHealth — set up to negotiate discounts with drug manufacturers.

The creation of the subsidiary, Emisar, has allowed UnitedHealth to retain billions of dollars of those savings, without having to share them with employers.

Emisar and similar subsidiaries established by Express Scripts and Caremark are known as group purchasing organizations, or G.P.O.s. They were created, starting in 2018, amid growing pressure from employers to share with them more of the manufacturers' discounts.

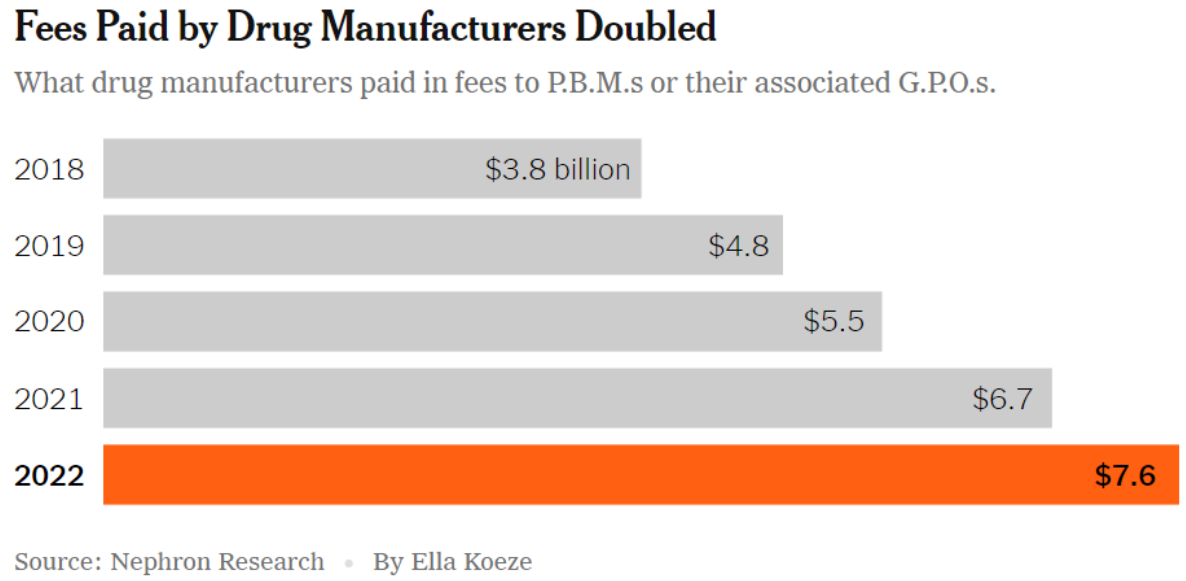
In response, the P.B.M.s altered their business model. The new subsidiaries still received rebates from drug companies, and they passed on those rebates to the P.B.M.s, which in turn sent the savings to employers. But the G.P.O.s also began imposing new fees on drug manufacturers.

Because those were fees, not rebates, and because the fees were technically collected by a different company, the P.B.M.s weren't contractually obligated to share them with

their clients. And the P.B.M.s could truthfully say that they were returning to employers almost all of the drug companies' rebates. They didn't have to mention the fees.

"The intention of the G.P.O. is to create a fee structure that can be retained and not passed on to a client," said Kent Rogers, a former Optum Rx executive who helped set up Emisar. "A P.B.M. has to keep some level of income for them to grow and satisfy stockholders."

In 2022, P.B.M.s and their G.P.O.s pocketed $7.6 billion in fees, double what they were bringing in four years earlier, according to Nephron, a consulting firm.



"We're excited about what Emisar is doing for us and, more importantly, for our clients in terms of creating affordability," Optum Rx's Mr. Mahrt said.

Emisar operates mainly in Ireland, and Express Scripts' Ascent is in Switzerland, which means their profits are taxed at much lower rates than if they were generated in the United States. (CVS's Zinc is in Minnesota.)

The P.B.M.s had an additional reason to create the G.P.O.s. The Trump administration was pushing for a rule that would classify rebates as kickbacks. Many in the industry feared that the rule would make the rebate system illegal, Mr. Rogers and others said.

Enter the G.P.O.s. They negotiate on behalf of not only the big P.B.M.s but also independent smaller ones. That structure was designed at least in part to allow them to escape the proposed rule, which has not been finalized.

A former executive of a major drug company, whose responsibilities included negotiating with G.P.O.s., said that he had a set pool of money to cover fees to G.P.O.s and rebates to employers. When he paid more in fees, he offered less in rebates.

Employers are none the wiser. They receive rebates. But they can't see the billions of dollars in fees that the G.P.O.s take for themselves.

'Getting Ripped Off'

The rebate system is one big way that P.B.M.s can drive up costs. But there are others. And that is important, because generic drugs, which represent the overwhelming majority of American prescriptions, don't get rebates.

The conglomerates that own the big P.B.M.s also own pharmacies. CVS has thousands of drugstores. And all three operate warehouse-based pharmacies that send prescriptions to patients through the mail.

The three P.B.M.s push, and sometimes force, patients to use their pharmacies, whether mail-order or, in CVS's case, the physical drugstores. One common strategy is to not allow patients to receive 90-day supplies of drugs if they fill prescriptions at outside pharmacies.

These pressure tactics drive people crazy. If your mail-order medication from your P.B.M.'s pharmacy is delayed, for example, you may not be able to get it instead at your local drugstore.

But the tactics are profitable.

One of P.B.M.s' most important jobs is to handle payments for drugs. When an employee needs to fill a prescription, the P.B.M. charges the patient's employer and then pays the pharmacy to compensate it for buying and dispensing the medication.

One surefire way for the P.B.M. or its in-house pharmacy to profit is to charge thousands of dollars more than what a drug costs. The Times identified repeated instances of P.B.M.s doing just that.

The steepest markups often involve generic versions of expensive medications for conditions like cancer.

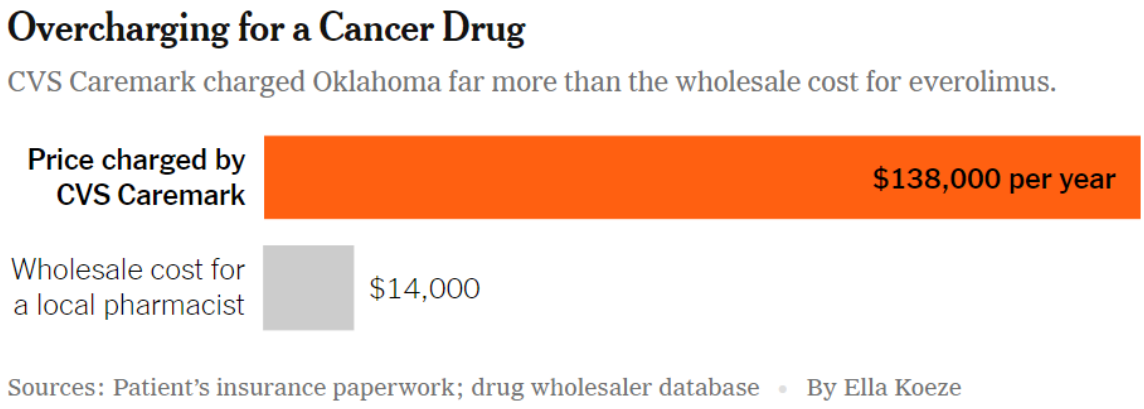
Kent McKinley is a county commissioner in Sulfur, Okla. He gets his insurance through the state's program for government employees, which uses CVS Caremark as its P.B.M.

Mr. McKinley has gastrointestinal cancer. For years, he had been getting his cancer medication, a generic version of everolimus, through the mail from a division of CVS devoted to expensive, or specialty, drugs. He hadn't realized he could go elsewhere to fill his prescription.

A few years ago, after Mr. McKinley's medication was delivered and left on his porch, his neighbor's dog chewed up the package. Mr. McKinley tried to get CVS to send a replacement, but he said a representative refused.

He went to the nearby Hobbs Pharmacy to see if he could get the prescription there.

The pharmacist, Russell Hobbs, made a startling discovery. Mr. McKinley's insurance paperwork showed that CVS was charging Oklahoma $138,000 a year for Mr. McKinley's everolimus. But the online portal that Mr. Hobbs used to buy drugs from wholesalers indicated that he could procure everolimus for about $14,000.



The $124,000 difference reflected the approximate yearly profit that CVS was collecting just on Mr. McKinley's prescription at the expense of Oklahoma taxpayers.

"We were getting ripped off," Mr. McKinley said.

The Times shared the details of Mr. McKinley's case with Oklahoma's attorney general, Gentner Drummond, who has been looking into the P.B.M.s. He called the case "alarming and concerning."

Mr. McKinley's situation wasn't a fluke. The Times also found several instances of CVS charging Oklahoma thousands of dollars more for generic multiple sclerosis drugs than what those same drugs would cost at online pharmacies like the one created by the billionaire Mark Cuban.

Employers often don't know they are being overcharged. Nor do they have much say over which pharmacies are available to their workers. "We do not have insight into the individual pricing of certain medications," said Christa Helfrey, a spokeswoman for the agency that oversees Oklahoma's insurance program for state employees.

The price that CVS Caremark is currently charging Oklahoma for generic everolimus recently declined sharply. Mr. Joyner, the Caremark president, said the P.B.M. has been cutting prices for some generic specialty drugs in response to pressure from clients.

When P.B.M.s overcharge, it can increase costs for patients, not just employers and government programs like Medicare.

The country's most popular Medicare drug plan, SilverScript Choice, covered nearly 3 million Medicare beneficiaries last year. Caremark is its P.B.M., and it overcharges.

Caremark uses Medicare's money to pay pharmacies, including its own, roughly $2,000 per month for a generic blood cancer drug, imatinib, according to a pricing tool on the SilverScript plan's website. Because that payment is so high, the out-of-pocket cost for Medicare patients is also high — $664 most months.

That is more than 10 times what imatinib sells for — often less than $50 — at online pharmacies when patients forgo insurance and pay using their own money.

For patients, the situation amounts to "highway robbery," said Stacie Dusetzina, a drug pricing expert at Vanderbilt University.

Fighting Self-Interest

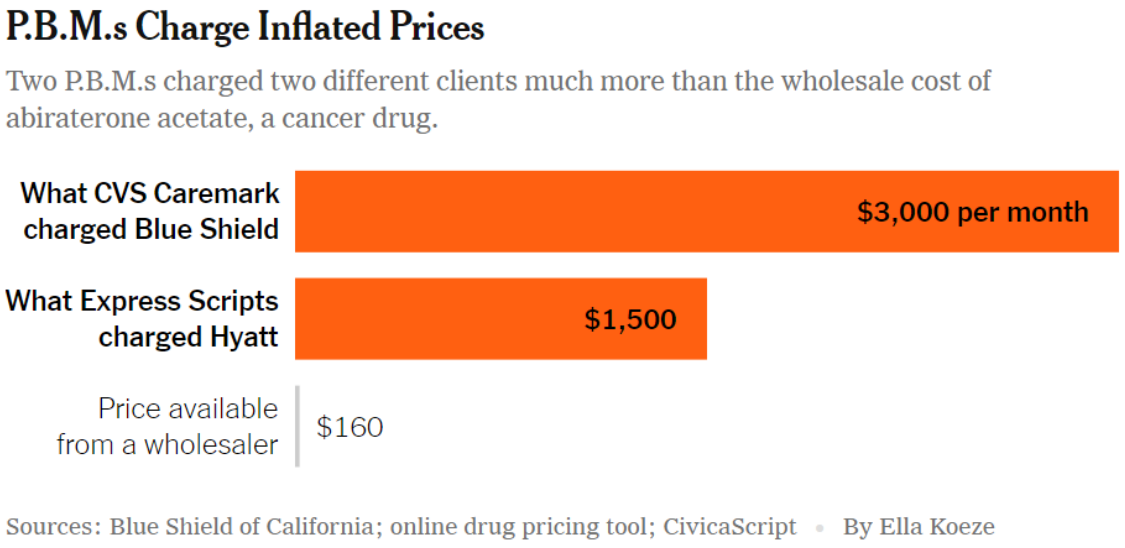
The big three P.B.M.s are winning business by promising huge savings. But when clients do the math, many are realizing that the expected savings don't exist.

Take abiraterone acetate, a generic prostate cancer drug that is available for well under $200 a month from sources like Mr. Cuban's pharmacy.

Express Scripts has been charging Hyatt nearly $1,500 a month to cover the drug for the hotel company's employees, according to the P.B.M.'s online pricing tool.

Express Scripts pockets most of the difference between what it charged Hyatt and the wholesale cost of the drug. An Express Scripts spokeswoman, Justine Sessions, said, "An isolated example of an individual medication — among the thousands we cover — does not accurately reflect how much a plan paid for its pharmacy benefits, the savings we help them achieve, and the prescription safety we ensure, or how much members pay for medications."

Caremark was charging at least one client, Blue Shield of California, $3,000 a month for the same drug. "The fundamental issue was the incentive structure," said Paul Markovich, Blue Shield's chief executive. "You can't fight self-interest." Blue Shield dropped Caremark as its main P.B.M.



Mr. Joyner said Caremark offered low overall prices for the portfolio of drugs Blue Shield was paying for.

Other big companies are also growing suspicious of the P.B.M.s.

“Our interests were not aligned,” said Linda Gulbrandsen, who oversees benefits for the retailer Foot Locker. It replaced Optum Rx with a smaller competitor, Navitus.

In New Mexico, the agency that provides health insurance for public school workers commissioned an audit of its arrangement with Express Scripts. The audit found a nearly $5 million discrepancy between what Express Scripts promised and how much the P.B.M. actually paid in discounts. That represented about 13 percent of the New Mexico Public Schools Insurance Authority’s annual spending on prescription drugs.

“That could have helped offset premiums,” said Patrick Sandoval, the agency’s executive director. “Anything that we don’t get back affects our members at the end of the day.”

Ms. Sessions of Express Scripts disputed the auditor’s conclusion that the P.B.M. had underpaid the agency.

Few employers have the wherewithal to closely monitor their P.B.M.s, and those that do are often reluctant to go through the process of finding a new benefit manager, in part to avoid disruptions for their employees.

The P.B.M.s’ parent companies often have another powerful lever: health insurance.

In 2022, Milano Restaurants International picked UnitedHealth to handle insurance for 85 employees and their family members. To the frustration of executives at the restaurant company — which operates dozens of pizzerias and burger joints in California

and Arizona — UnitedHealth forced Milano to use Optum Rx as its P.B.M. Price shopping for a different P.B.M. was not permitted.

A UnitedHealth spokesman, Eric Hausman, said that having health insurance and prescription drugs under one roof allowed his company to manage costs and the experiences of clients and patients.

An Undisclosed Conflict

Perhaps the clearest example of how the P.B.M.s find creative ways to profit is Humira, the blockbuster medication for conditions like arthritis.

After two decades of the brand-name drug being the only version available, lower-cost alternatives came on the market in 2023. Collectively, employers, insurance programs and patients stood to save up to $6 billion a year by switching to copycat drugs, according to the data company IQVIA.

But P.B.M.s would lose money from switching. Humira had become a big moneymaker for P.B.M.s, in large part because its manufacturer, AbbVie, was shelling out hundreds of millions of dollars in fees to the benefit managers' G.P.O.s. Those fees would vanish if the P.B.M.s switched patients off Humira.

The P.B.M.s moved slowly. In March, 14 months after the first cheaper version became available, 96 percent of prescriptions for the drug in the United States were still for the brand-name version, according to IQVIA.

P.B.M. executives denied that this was motivated by greed. CVS Caremark officials, for example, said that they had struck all-or-nothing arrangements with AbbVie. If Caremark steered some of an employer's workers toward cheaper versions of the drug, that employer would not receive any rebates from AbbVie for patients who stayed on Humira. As a result, Caremark said, sticking with Humira was better for many employers until a critical mass of patients switched.

Caremark has recently stopped recommending Humira, instead primarily favoring a copycat version called Hyrimoz.

There was more to the switch than saving money for clients. CVS had struck a deal with Hyrimoz's manufacturer to promote the drug to employers in exchange for a cut of its sales. (This was not a rebate or fee, but a new way of making money, via a new CVS subsidiary called Cordavis.)

One of the clients to whom Caremark recommended Hyrimoz was the health insurance program for state employees in North Carolina. Caremark didn't tell state officials about the company's stake in Hyrimoz. They only learned of it when an official, Dr. Peter Robie, stumbled upon an online mention of the partnership.

“The appearance is that you are encouraging the prescription of a medicine that will financially benefit CVS,” Dr. Robie said during a meeting with CVS in February.

At the meeting, the company’s representatives played down the conflict of interest. But a few months later, CVS apologized.

Susan C. Beachy contributed research. Portraits by Desiree Rios and Andres Kudacki for The New York Times.