



Pharmacy Benefit Managers, or PBMs for short, are middlemen companies that administer prescription drug plans. They determine which medicines will be covered by health insurance plans and how much patients pay for their prescription drugs.

In short, they take the decision making out of the hands of doctors, putting patient health at risk and prioritizing profits above all else.

What They Do

PBMs create tiered lists of medicines covered by health plans – formularies – that enable them to **steer patients to medicines with higher profit margins for PBMs**, but may not be the best choice for the patient. They also play a central role in determining out-of-pocket cost charges for people covered, negotiate rebates and discounts from drug manufacturers, and contract with pharmacies to reimburse for drugs dispensed to patients.

Further, PBMs may require or incentivize consumers to use one of the PBMs' own pharmacies, making it possible for PBMs to **generate additional income** and **driving away business from independent pharmacies** – while doing nothing to make it easier for patients to access their medication.

Their tactics have a little known yet significant behind-the-scenes impact on the price patients pay at the pharmacy counter. Unfortunately, this can vastly limit patient access to medications prescribed by doctors.



How They Do It

The absence of accountability for PBMs enables them to reap excess profits at the expense and choice of patients.

Three PBMs control 77 percent of all prescription claims managed in 2020, according to the Drug Channels Institute, and are among Fortune's top 25 companies in the US.1

PBMs make among the highest rates of profit of any corporation in the prescription drug supply chain. PBMs' opacity and pricing complexity manipulates the price and undermines the possibility for competition that would drive value, savings and prescription access for patients.

PBM's financial incentives often conflict with what's best for patients:

- Establish barriers to access medication, including step therapy, prior authorization and other barriers, that go against what a doctor prescribes based on a doctor's clinical expertise and patient needs.
- Use patient cost-sharing and formulary tiering to favor medications based on PBM profitability instead of clinical benefit to the individual patient.
- Require or steer patients to use pharmacies they own or have affiliations instead of allowing patients to use a pharmacy of choice.
- Refuse to share rebates and cost reductions directly with patients at the pharmacy counter.
- Fight proposed laws that would allow states greater oversight over PBMs and public transparency over practices.

Patients shouldn't be denied access to life-saving medicines by PBMs or insurance companies – especially those prescribed by a doctor.



- Requiring or financially steering patients to use a PBM-owned pharmacy instead of a community pharmacy a patient may prefer.
 - » Half of PBM gross profits are estimated to come from mail and specialty pharmacy services.²
- Collecting large rebates from pharmaceutical companies often based on the list price of a medicine. This practice leads to higher prices and favoring medicines based on the rebate instead of clinical benefit.³
- Administrative fees charged to pharmacies, pharmaceutical companies, health plans, and employers.
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Top 3 PBMs control
77% of claims



^{2.} https://www.drugchannels.net/2021/03/the-top-15-us-pharmacies-of-2020-market.html

^{4.} https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html; https://fortune.com/fortune500/