The Secret Drug Pricing System Middlemen Use to Rake in Millions

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Not everybody reads the legal notices inside the Ottumwa Courier. But in January, Iowa pharmacist Mark Frahm noticed something unusual in the paper.

For years, Frahm's South Side Drug bought pills from distributors, and dispensed prescriptions to the Wapello County jail. In turn, the pharmacy got reimbursed for the drugs by CVS Health Corp., which managed the county's drug benefits plan.

As he compared the newspaper notice with his own records, and then with the county's, Frahm saw that for a bottle of generic antipsychotic pills, CVS had billed Wapello County $198.22. But South Side Drug was reimbursed just $5.73.

So why was CVS charging almost $200 for a bottle of pills that it told the pharmacy was worth less than $6? And what was the company doing with the other $192.49?

Frahm had stumbled across what's known as spread pricing, where companies like CVS mark up—sometimes dramatically—the difference between the amount they reimburse pharmacies for a drug and the amount they charge their clients.

It's where pharmacy benefit managers (PBMs) like CVS make a part of their profit. But Frahm says he didn't think the spread could be thousands of percent.

"Middlemen have to make some money, but we didn't expect it to be this extreme," said Frahm, who said his pharmacy lost money in the jail account last year because CVS paid so little. "We figured everyone was playing fair."

How Spread Pricing Works

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- Cost to pharmacy

- Payment to pharmacy
- Charge to employer or health plan
- Spread

The prices change frequently and can vary widely.
$6$8$16$12.4$3$8$9.4Q1 2014Q4 2017$0$5$10$15

In an analysis of pharmacy and middleman markups in Medicaid plans around the country, Bloomberg found big spreads on dozens of drugs, and evidence that the spreads are growing. For many widely used generic drugs, state insurance plans are collectively paying millions of dollars in fees to private companies.

CVS is run from Woonsocket, Rhode Island, and is best known for its thousands of drugstores across the U.S. But more than 40 percent of the company's operating income comes from the other side of its business—administering prescription drug benefits for companies, governments and until recently, in Wapello County, the local jail.

Spread pricing is a practice that's most common with generic drugs, which make up almost 90 percent of all prescriptions dispensed in the U.S. Generic pills often cost pennies on the dollar compared with brand-name versions, and promoting them has been the focus of U.S. efforts to keep drug costs under control—especially in insurance programs like Medicaid that provide care to millions of lower-income people.

Yet critics argue the practice of spread pricing may actually be propping up costs as middlemen divert fees and markups to themselves, undercutting the savings generics are supposed to offer.

CVS and other PBMs say that pharmacists cherry-pick examples like Frahm's bottle of antipsychotics because they want to agitate for more money.

Spread pricing "is not a secret to our clients," Richard Ponesse, a senior director at CVS, told Iowa state lawmakers at a hearing in April. Many choose it because it's "more predictable" than being exposed to pharmacy rates for drugs.

"Ultimately, under this model, we make money on some drugs and lose money on others," CVS spokeswoman Christine Cramer said in response to questions about the practice.

To probe what middlemen make, Bloomberg examined the prices of 90 of the best-selling generic drugs used by Medicaid managed-care plans. In 2016, the drugs made up a large portion of Medicaid's spending on generics.

Markups on these commonly prescribed generic drugs are growing, with huge markups on some well-known medicines, Bloomberg found. For the 90 drugs analyzed, which includes more

than 500 dosages and formulations, PBMs and pharmacies siphoned off $1.3 billion of the $4.2 billion Medicaid insurers spent on the drugs in 2017.

While pricing data for benefit managers and their corporate clients, as well as some governments, is hidden, state Medicaid programs regularly publish comprehensive spending and price data that provide a window into how much middlemen and pharmacies make on markups.

The biggest markups tended to come on newer generic drugs. In 2017, markups in some states increased the price paid by state Medicaid plans for generic versions of the Novartis AG's leukemia pill Gleevec by as much as $3,000 per prescription.

Imatinib 400 mg (generic Gleevec) in Ohio

Disease: Leukemia

- Cost to pharmacy
- Cost to state Medicaid program
- Combined pharmacy and PBM spread and fees

Q2 2016Q4 2017$9,499$9,017$7,201$3,859$482$3,342Q2 2016Q4 2017
Note: Drug prices reflect a 30-day supply; numbers may not add precisely due to rounding

Aripiprazole, a generic antipsychotic drug that was one of the most costly drugs to Medicaid programs in 2016, was also heavily marked up in many states. While the market price for aripiprazole dropped rapidly during 2017 to about $20 a month, many state Medicaid plans, including in Ohio, New York, Arizona and Texas, were still paying more than $140 a month for the drug, according to the data.

Aripiprazole 5 mg (generic Abilify) in New York

Disease: Schizophrenia and depression

- Cost to pharmacy
- Cost to state Medicaid program
- Combined pharmacy and PBM spread and fees

Q4 2015Q4 2017$431$382$163$21$49$142Q4 2015Q4 2017
Note: Drug prices reflect a 30-day supply; numbers may not add precisely due to rounding

The broad-brush analysis doesn't distinguish between how much of the markup is going to the pharmacies and how much is retained by PBMs. But independent pharmacists interviewed by Bloomberg say the money largely isn't going to them.

State Medicaid programs have increasingly turned to managed-care plans to keep costs under control. Bloomberg's analysis included 31 states and the District of Columbia where reliable drug data was available from 2015 to 2017.

Among the generic drugs examined, pharmacies and supply chain middlemen on average added to the bill almost 32 percent in 2017, up from 24 percent in 2015. That was still lower than markups in the traditional fee-for-service Medicaid programs, although the gap has been narrowing, Bloomberg found.

Drug plans have fought to keep the spreads secret.

In Ohio, CVS manages drug benefits for four out of five Medicaid managed-care plans, which are run by private insurers and cover roughly 90 percent of the state's 2.8 million full Medicaid beneficiaries.

In July, CVS sued the state to prevent the release of a report on how much spread it received from Medicaid programs there. A summary released in June found that CVS and other PBMs' 8.8 percent spread came to $5.70 per prescription across all brand-name and generic drugs.

Ohio could have gotten the same services for $1.90 per prescription or less by switching to a fee-based model, according to the state-sponsored analysis. The hidden fees Ohio paid amounted to $223.7 million in a 12-month period through March, according to the consultant.

CVS said that revealing pricing details would keep it from getting the best rates, and that money it makes on spreads pays for other services the company provides. CVS said that last year its margins in the PBM business were 3.5 percent, and that overall privatized Medicaid has saved Ohio money.

Following the report, Ohio ordered managed-care plans in the state to terminate their spread pricing contracts for 2019.

"We intend to open up the black box once and for all," said Tom Betti, a spokesman for the Ohio Department of Medicaid. He said Ohio's report appeared to be the first time a state had looked at spread pricing in detail. "Manufacturers go to great lengths to keep the prices secret," he said.

Drug Markups in Ohio

Generic drugs in Ohio Medicaid managed-care plans and their markups in Q4 2017
-$40 or less-$20+$2+$10+$500 or more100k prescriptions30k prescriptions3k prescriptions

In August, a separate study conducted by the Ohio auditor found that PBMs were receiving $6.14 per generic drug prescription in Ohio's managed Medicaid programs in the 12-month period through March.

That’s consistent with Bloomberg’s findings, which indicate that combined pharmacy and PBM markups in the Ohio program were just under $8 per prescription in 2017 and early 2018. Taken together, it suggests that PBMs, not pharmacies, have been getting most of the markups on generic drugs in Ohio.

While Ohio’s markups on generic drugs are above average, according to Bloomberg's findings, they’re nothing compared with those in neighboring Indiana. Generic drug markups in that state's four privately run Medicaid plans averaged well over $13 per prescription in 2017—more than any other managed-care state Bloomberg reviewed.

In late 2017, private Medicaid plans in Indiana spent more than $800 for a 30-day supply of entecavir, a hepatitis B pill that cost pharmacies less than $140 to buy. State plans paid more than $100 per prescription for generic versions of the heartburn drug Nexium, which cost pharmacies less than $25 at the time.

Entecavir 0.5 mg (generic Baraclude) in Indiana

Disease: Hepatitis B

- Cost to pharmacy
- Cost to state Medicaid program
- Combined pharmacy and PBM spread and fees

Q2 2015Q4 2017$1,011$889$846$138$122$709Q2 2015Q4 2017
Note: Drug prices reflect a 30-day supply; numbers may not add precisely due to rounding

Esomeprazole 40 mg (generic Nexium) in Indiana

Disease: Heartburn

- Cost to pharmacy
- Cost to state Medicaid program
- Combined pharmacy and PBM spread and fees

Q2 2015Q4 2017$204$197$147$17$7$129Q2 2015Q4 2017
Note: Drug prices reflect a 30-day supply; numbers may not add precisely due to rounding

Pharmacists in Indiana say they are getting a tiny slice of those markups.

“We’ve seen nothing but declining margins,” says Josh Anderson, co-owner of Crowder’s Pharmacy, an independent drugstore in Bedford, Indiana.

Indiana is “very aware of the national dialogue and concerns regarding managed-care PBM transparency,” said Jim Gavin, a spokesman for the Indiana Family and Social Services Administration. “We are monitoring this issue very closely.”

PBMs say customers—governments and employers—have a choice about whether to use spread pricing, or fee-based arrangements where drug prices are passed along directly.

Spread pricing “continues to be the preferred way” by clients to pay for pharmacy benefits, said Brian Henry, a spokesman for Express Scripts Holding Co., which along with CVS is one of the U.S.’s largest PBMs. “It adds predictability for the plan sponsors” who don’t have to worry about costs that vary from pharmacy to pharmacy.

In Iowa, Wapello County is now buying the jail’s drugs directly from Frahm’s pharmacy after discovering that in some months it was paying CVS over $4,500 a month, while the company was reimbursing the pharmacy about $1,500, said county supervisor Jerry Parker.

It’s also investigating whether it could save more by cutting CVS out of its far-larger county employee drug plan.

“We didn’t have any idea,” said Parker, comparing dealing with the labyrinthine drug-benefits system with the county’s more workaday duties. “It is more complicated than fixing a road.”

The PBM industry’s lobbying group says criticism of the practice is driven by pharmacists greedy for more money.

“Our job isn’t to enrich drugstores, it is to save money for health plans,” said Mark Merritt, president of the Pharmaceutical Care Management Association. Some clients prefer spread pricing because it encourages PBMs to promote generics by allowing them to make money on the lowest-cost drugs, he said. They’ve also reduced the high markups some pharmacies have gotten in traditional Medicaid arrangements, Merritt said.

PBMs pricing practices have also generated lawsuits.

Four hundred independent pharmacies have accused UnitedHealth Group’s PBM, OptumRx, of manipulating its generic drug price lists “to line its pockets at the expense of independent pharmacies,” according to a lawsuit filed in 2017 in federal court in Pennsylvania.

The company maintained separate price lists for pharmacies and for its clients, and sometimes paid pharmacies a steeply discounted price for a drug, but then billed its clients a much higher amount, according to the lawsuit.

UnitedHealth Group said it offers a variety of arrangements to help keep costs down. The company called the lawsuit “meritless” and said it and other claims are “designed only to increase pharmacists’ income at consumers’ expense.”

In July of last year, West Virginia cut out PBMs, including Express Scripts and CVS, from its Medicaid managed-care program. By running the program itself and eliminating spreads and reducing administrative fees, it expects to save $30 million a year—about 4 percent of the state Medicaid drug spending, a state spokeswoman said.

And this June, Pennsylvania's auditor general started reviewing PBM practices in that state's Medicaid program, citing a lack of oversight into how they determine prices.

Despite the pushback, critics of the industry don't think that spread pricing will stop.

"The PBMs have found they can do it and get away with it," says Stephen Schondelmeyer, a professor of pharmaceutical economics at the University of Minnesota. "The way that spread pricing is being done these days, generics don't always save you money."

Methodology: Bloomberg News compared government spending on more than 90 top-selling generic drugs in Medicaid managed-care programs to a government survey of pharmacy purchase prices, the National Average Drug Acquisition Cost (NADAC). The analysis encompasses over 500 dosages and formulations. Medicaid reports state drug utilization data on a quarterly basis.

Bloomberg chose the drugs based on 2016 spending data tabulated by the Centers for Medicare and Medicaid Services; additional major recent generic introductions identified by GoodRx were also included. Drugs whose units couldn't be reliably matched between databases, or whose per-unit prices varied by package size, were excluded. Excluded drugs were primarily topical or injected medicines; almost all big-selling generic pills were included.

For each drug, weekly NADAC prices were averaged for a calendar quarter to generate an average price for the quarter. These prices were compared to quarterly Medicaid spending for the drug in each state's managed-care plan to determine the average quarterly markup over pharmacy purchase price. The analysis doesn't distinguish between how much money was retained by pharmacies and how much went to drug benefit managers. Patient copayments, usually minimal for generic drugs in Medicaid, were not included.

To generate national averages, Bloomberg analyzed data from 31 states and the District of Columbia with over $10,000 in generic drug Medicaid managed-care spending in each of 2015, 2016, and 2017. Hawaii was excluded due to data anomalies that resulted in implausibly large markups in some years.

The analysis does not include rebates that state Medicaid programs receive from drug companies based on prescription volume. The main rebates are based on manufacturer selling prices to wholesalers, and are not affected by what Medicaid plans are charged.