Understanding the Pharmacy Landscape:
Insights from 20 Years in Pharmacy Benefits

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The health care industry has garnered a lot of attention lately, especially regarding pharmacy benefit managers (PBMs). Due to the complex pharmacy landscape, clients often look to the Employers Health team to provide context on issues or opine on current events. After recently celebrating twenty years at Employers Health, we asked Chief Sales Officer Mike Stull to weigh in on some of the most common questions asked about the current state of pharmacy benefits.

Where are most of the state legislative efforts coming from?

Most of the legislation introduced at the state level is being promoted by independent retail pharmacies. They are small businesses within their states, so their voices resonate with lawmakers. These state laws are mainly about how independent pharmacies can get higher reimbursements from PBMs and, ultimately, purchasers and their plan participants. In my opinion, the idea that these state laws will save individuals money is a stretch. Some laws mandating minimum reimbursement and dispensing fees will absolutely increase prices.

How did PBMs get to be so large?

I would argue that PBMs must be large entities to effectively negotiate with other players in the supply chain. Pharmaceutical manufacturers are large entities given competitive protections through U.S. patent law, so to have any chance negotiating lower prices or better rebates, you need scale. Large pharmacy chains make up a majority of the retail network, with a handful of specialty pharmacies, owned mostly by the big PBMs, dominating the specialty dispensing channel. The three largest wholesale distributors control 90% or more of their respective pieces of the supply chain. So, without a single-payer system, entities negotiating for lower prices on behalf of patients and health care purchasers need leverage.

Why did the PBMs and the insurance carriers come together to form these vertically integrated organizations?

It seems each deal is a little unique in terms of how it came together, but at the end of the day what I see is an opportunity for the insurers to keep more of their premium dollars under their corporate umbrellas. The Affordable Care Act requires insurers to spend a specific percentage of premium dollars on health care services (medical loss ratio). So, if you acquire physician practices, hospitals, specialty pharmacies, etc., you can pay those entities for services AND still meet your statutory requirement. Whether we agree with it or not, the market provided the opportunity for this type of consolidation.

Will rebates ever go away?

In a perfect world, manufacturers would offer medications at a truly low price. Until that becomes a reality, purchasers need a way to negotiate additional discounts off the list price of brand drugs without running afoul of anti-competitive pricing settlements agreed to in the late 1990s between manufacturers and retail pharmacies. The answer lies in retrospective rebates.

Yes, rebates are distorted and serve as impediments to the inclusion of lower-priced, lower-rebated products in PBM contracts. These conflicts arise from purchasers demanding multiple years' worth of rebate guarantees and PBMs profiting from their own group purchasing organizations. If purchasers are going to give up rebates as their tool for negotiation, they need a good replacement. Plan sponsors continue to rely on rebate dollars to offset increased premium costs and so far, have been reluctant to explore point of sale rebates. Organizations promoting elimination of rebates the loudest are mostly competitors of or those negotiating against the big three PBMs.

How is the PBM industry different today than it was twenty years ago?

In the early 2000s, the costs for pharmacy were much less and even getting a rebate was the mark of an exceptional contract. We still had three dominant PBMs, although Optum Rx has taken the place of Medco after Medco was bought by Express Scripts. I remember when we started talking about specialty drugs and how eventually they would make up half of drug costs. Back then, we were debating which branded statin should be on formulary. The evolving market, including legislative and regulatory changes, and increased utilization has led purchasers to be more active in managing their pharmacy benefit than ever before. In turn, consultant practices geared specifically to pharmacy have grown substantially.

Regardless of these changes, the fundamental pharmacy strategies have stayed almost the same: have a solid contract, use plan design to promote desirable behavior and set appropriate clinical management strategies that balance your appetite for cost savings versus participant disruption. Today, having an independent and unbiased consultant is a must as purchasers' fiduciary duties are under scrutiny. A prudent process is key and using advisors who steer clients into their own collectives or products will be challenging to defend.

What are the biggest challenges for 2025?

For our clients, it's keeping up with the legislative and regulatory changes. There are plenty of state laws we believe are preempted by the Employee Retirement Income Security Act (ERISA,) but those challenges will need to work their way through the court system. Having a contract that can adjust and implementing adaptive plan designs is important.

Managing glucagon-like peptide 1 (GLP-1) spend for diabetes will continue to be a challenge given its newer position as a first-line therapy for Type 2 diabetes. I'd like to see health plans report more data on hemoglobin (A1c) levels and spend on diabetes conditions under the medical plan to see if these medications are having the desired impact.
On the weight loss side, I'd hope to see prices come down now that both major products are off the shortage list. The direct-to-consumer strategies by the manufacturers will complicate the PBM rebate model for these drugs, meaning you shouldn't have a drug that cost $499 by going direct and $1,200 under the high-deductible plan (price before rebate).

Lastly, navigating the biosimilar landscape will be challenging, yet rewarding. There's an opportunity for plan savings with the launch of biosimilars for Stelara. Employers Health clients with CVS had great success moving utilization from Humira to its biosimilar products and we expect to see the same results with Stelara. Excluding these originator products from the formulary is the only way to get significant movement to the biosimilar, and I was happy to see CVS and some of the smaller PBMs make that move. The challenge with biosimilars is for consultants to be able to appropriately model the lower list prices, the expected utilization shift and the impact on rebate guarantees. We've already seen one of the major PBMs play pricing games in order to inflate its own value.

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