Health Care for All Minnesota & Physicians for a National Health Program

Explanation of the State Prescription Drug Purchasing Bill - HF 1093 (Liebling)

Medical Assistance and MinnesotaCare cover prescription drugs, and like all other health insurers that cover prescription drugs (health insurance companies, self-insured corporations, and other public programs), Medical Assistance and MinnesotaCare are paying much more for drugs than is necessary because (1) the US doesn't set limits on drug prices; (2) rather than reimburse pharmacies directly, the Department of Human Services (DHS) that runs Medical Assistance and MinnesotaCare, pays health insurance companies to insure program enrollees, and; (3) health insurance companies in turn contract with "pharmacy benefit managers" (PBMs) to process prescription drug claims. These two middlemen between DHS and pharmacies – health insurance companies and PBMs – raise the cost of drugs that DHS and enrollees pay for. By authorizing DHS to purchase drugs for Medical Assistance and MinnesotaCare, HF 1093 removes the middlemen and the costs they add to the program.

PBMs first appeared in the 1960s to simply process prescription drug claims for health insurance companies. But as the number and cost of drugs grew, PBMs grew larger and took on price negotiating with drug manufacturers on behalf of health insurance companies and determining payments to pharmacies. The discounts the PBMs negotiated with manufacturers were sent to PBMs as rebates. The PBMs claim they pass all rebates on to the insurance companies, but that claim has been challenged by Congress and the Federal Trade Commission (FTC) and other parties. The PBMs have also been criticized for paying pharmacies, particularly independent pharmacies, too little to cover their cost of dispensing drugs.

In July 2024, the FTC issued a scathing press release stating: ". . . PBMs wield enormous power over patients' ability to access and afford their prescription drugs, allowing PBMs to significantly influence what drugs are available and at what price.… The interim report also finds that PBMs hold substantial influence over independent pharmacies by imposing unfair, arbitrary, and harmful contractual terms that can impact independent pharmacies' ability to stay in business and serve their communities." FTC Releases Interim Staff Report on Prescription Drug Middlemen | Federal Trade Commission

The "enormous power" the FTC described is due to the PBMs' large size and secrecy. The three largest PBMs, all owned by health insurance companies, control 80% of prescription drug sales; the top six control 90%. According to the PBM Accountability Project, "PBMs' general lack of transparency is critical . . . It allows them to buy a product or service from one stakeholder . . . and sell . . . to another stakeholder at a higher price without the payer understanding the true cost . . . of the services purchased." [b11210_264612f6b98e47b3a8502054f66bb2a1.pdf] A New York state Senate committee reported that in 2017, a 30-day supply of Aripiprazole cost $163 to New York Medicaid but only cost New York pharmacies $21 to dispense." final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf

Because PBMs are not lowering drug costs, eight states have instead authorized their Medicaid agencies to be the purchaser of prescription drugs known as "carving out" drugs from the state's contracts with the Medicaid insurance companies which has saved them money. Three other states require negotiating with a single PBM chosen by the states, and another 21 states decided to carve out "one or more drug classes" from their contracts with insurance companies.] [KFF]

It appears that the largest savings by "carve-outs" is reduced administrative costs generated by insurance companies and PBMs, as experienced by West Virginia which saved $54 million in 2018 (W VA Microsoft Word - WV BMS Rx Savings Report 2019-04-02 - FINAL.docx.