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Preferred Provider Networks in Employer-Sponsored Drug Insurance Sector

Some necessary considerations

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Marc-Andre Gagnon and Quinn Grundy collaborate on a research project titled: ***Branded care: Understanding the policy impact of industry support programs for high cost specialty medicines,*** funded by the Social Sciences and Humanities Research Council. They write this paper not only as independent academic experts on pharmaceutical policy issues, but also as patients, consumers and insurees under private drug plans provided by Ontarian employers.

The format of this consultation does not really allow detailed exploration of the different aspects of Preferred Provider Networks (PPNs) in employer-sponsored drug insurance sector that may create challenges for consumers as well as for publicly-funded drug insurance and health services. Some preliminary remarks are thus necessary before answering the questions of the consultation.

The pharmaceutical markets and distribution networks have greatly evolved in Canada in the last fifteen years. The main elements to take into consideration are: 1) the proliferation of confidential rebates and, 2) the rising importance of manufacturer-sponsored patient support programs.

1) A world of confidential rebates

The official prices of patented drugs are normally not the prices paid by drug plans, because most payers negotiate confidential rebates, which are not publicly disclosed. It is estimated that the confidential rebates obtained by public drug plans is normally between 20% and 29% of the official price (Morgan, Vogler, and Wagner 2017). In Canada, public drug plans collectively negotiate these rebates through the Pan-Canadian Pharmaceutical Alliance (pCPA), which includes all provincial, territorial, and federal public drug plans. The pCPA successfully secures approximately $3.9 billion in confidential rebates annually. This level of rebate is comparable to that achieved in other OECD countries. However, almost all OECD countries have a universal pharmacare system and negotiate confidential rebates for their whole population. In Canada, pCPA negotiates confidential rebates only for public drugs plans, which represents only 42% of expenditures. Note that people insured through public drug plans still pay their co-insurance rates and deductibles based on the official – not the rebated – price of drugs.

Private drug plans, on the other hand, have a more fragmented approach to negotiating confidential rebates. The prevailing culture within private insurance tends to prioritize broad coverage of approved drugs without substantial negotiation for rebates (O'Brady, Gagnon, and Cassels 2015). Some private insurers, like Sun Life (considered to be the most active insurer in negotiating rebates (20Sense 2022)), reported securing $500 million in rebates from 2014 to 2023, which represents an average of $56 M annually (SunLife 2023). However, this is not uniformly practiced across the industry (Barkova and Malanik-Busby 2023). Even if the rebate levels achieved by Sun Life were extended to the entire private sector, they would still represent a fraction of the rebates obtained by public drug plans.

Thus, **PPNs offer the possibility for private insurance companies to become more active in negotiating confidential rebates**. Nevertheless, because insurees pay their co-pays and deductibles on the official price, there is no assurance that these rebates benefit the insured individuals rather than the insurers' shareholders. Because the rebates are confidential, there are also perverse incentives for private insurers to prioritize more expensive drugs with higher rebates rather than cost-effective drugs that offer the best therapeutic value, as is observed in the United States (Robbins and Abelson 2024; Federal Trade Commission 2024). Already in 2017, these practices were already considered common in the United States if we consider this excerpt in *American Prospect* (Dayen 2017):

> "Let's say there are two drugs in the same therapeutic category—one for $500 and one for $350," says Linda Cahn, an attorney and founder of Pharmacy Benefit Consultants, which helps health plans negotiate contracts with [Pharmacy Benefits Managers] PBMs. "Which manufacturer can promise more rebates? Obviously the one with the $500 drug." And because drug companies establish their own prices, they can use a higher ceiling to give more in rebates to get on PBM formularies. This practice creates incentives for drug manufacturers to raise prices, and if the PBMs keep the rebates, the health plan pays more. Even if the rebates offset the list price, they are used to determine patient co-pays, so the consumer feels the burden from an increase in price that might otherwise never have taken place.

Here is an example: Imagine two similar drugs (A and B) offering the exact same level of therapeutic benefit. Let's suppose drug A is sold at $100 with no confidential rebates, while drug B is sold at $300 with a 60% confidential rebate. Let's suppose private drug plans require a 20% co-pay from insurees (the co-pay is paid out of the pre-rebate listed price). Let's now compare what happens if one drug plan establishes a preference network for drug A, while the other establishes a preference network for drug B.

> Drug A is sold at $100: $20 will be paid by the insuree while $80 will be paid by the employer. The premiums for the private drug plan will have to cover $80. The manufacturer, distributor, pharmacy chain, and pharmacy benefit manager will receive their fair income without additional confidential income.
>
> Drug B is sold at $300 but comes with a confidential rebate of $180 which will be reimbursed by the manufacturer to the insurance company managing the employer-sponsored drug plan. The real cost of the drug is thus $120, but since insurees have a co-pay of 20% of the official price, they will thus pay $60 out-of-pocket for their co-pay. If the insurance company fully transfers the rebate to the employer, then the employer would need to pay only the remaining $60, and the premiums for the private plan thus only have to cover $60. That being said, *there is no reason for the insurance company to fully transfer the rebate, which is confidential*. The insurance company could transfer only $170, so the employer needs to pay $70 while the insuree still pays $60.

In this basic example, drug A costs a total of $100 for employers and employees while drug B ends up costing a total of $130 for employers and employees. However, and this is where there is a real problem, an insurance company with a preference network for drug B can sell a drug plan that covers the cost of $70 for that drug (and pocket a bonus of $10 in confidential rebates that will be given back to shareholders) while an insurance company with a preference network for drug A does not pocket a bonus of $10 and needs to sell a drug plan that covers the cost of $80 for the same drug.

In a nutshell, **the drug plan that would be most cost-efficient ends up being less competitive on the marketplace** since employers (and insurers) will have a normal preference to cover drug B instead of drug A. The financial incentives become misaligned with what would normally be socially desirable. Ongoing investigations by the Federal Trade Commission in the United States shows that these dynamics are not marginal, they are becoming central to ongoing business models of the drug insurance sector (Robbins and Abelson 2024; Federal Trade Commission 2024). There is no reason why these practices would not be emerging in Canada.

A **more effective approach** to obtain the best confidential rebates in a way that benefits all Ontarians could involve organizing bulk purchasing and negotiating rebates for the entire Ontarians population through institutions that ensure that rebates are transferred to insurees. In particular, the Parliamentary Budget Officer has estimated that a universal pharmacare program with minimal co-pays could increase prescription drug utilization by 13.5% and reduce overall drug costs by $2.2 billion annually for Canadians (Barkova and Malanik-Busby 2023), which would ensure more cost-effective and equitable access to medications.

2) Patient support programs

Complicating the issue of PPNs is that the higher-cost drugs, prioritized within PPNs, are now almost always accompanied by a manufacturer-sponsored patient support program (Grundy, Quanbury, et al. 2023). Once prescribed the treatment, patients are referred to the program by their health care provider or they may self-enroll. They are then contacted by a program coordinator, typically a registered nurse who may help the patient navigate insurance coverage options, coordinate home drug delivery, teach self-injection techniques, answer questions on an on-call basis and conduct follow-up to support patient treatment adherence (Weintraub and Silverman 2018; Grant 2018). Neither patients nor insurers pay for these services; thus, the cost of the medicine likely includes these supports.

A small number of large, third-party companies (e.g., Innomar Strategies, Bioscript Solutions, McKesson Canada, Bayshore Healthcare) operate patient support programs nationally, on behalf of pharmaceutical company clients. These companies also own and operate specialty pharmacies, infusion clinic networks, drug distribution networks, among other pharmaceutical industry services. Thus, they have a commercial interest to also create **exclusive distribution networks** and **patient-steering** to their own distribution networks, specialty pharmacies, or clinic networks.

An interesting case in point is the situation in Quebec where Association Québécoise des Pharmaciens Propriétaires (AQPP) is calling for a class action lawsuit against specialty pharmacies over the distribution of specialty drugs through PSPs (Association Québécoise des Pharmaciens Propriétaires 2024a). In their call for a class action lawsuit, AQPP explains how 6 of the 1900 pharmacies in Quebec end up controlling 40% of the specialty drug market in Quebec, or around 12% of prescription drug sales (Association Québécoise des Pharmaciens Propriétaires 2024b). The call for the class action lawsuit details a series of strategies that are being used to impose

exclusive networks of distribution, even when these preferred provider networks are "open and voluntary" (because of its legislation, mandatory or closed provider preference networks are not allowed in Quebec).

Here are the main strategies identified in Quebec to impose exclusivity when mandatory and closed PPNs are not allowed:

> -Patients are enrolled in PSPs by their physicians and their prescription is sent directly to the PSP manager and its specialty pharmacy without giving any choice to the patient.
>
> -The patient's usual pharmacist is often never informed by the PSP manager that the patient is now taking the drug (creating important issues for the patients since they end up with two different pharmacists not interacting with each other and not knowing about potential issues of drug interactions).
>
> -When a patient expresses his willingness to obtain the specialty drug through its usual pharmacy, PSP managers often impose unnecessary barriers to access, for example by restraining the usual pharmacy in dispensing compassion doses to the patient (or by restraining the capacity to impose a dispensing fee for compassion doses), or by refusing for the usual pharmacy to deliver the drug to the PSP, or to have access to the fridges of the PSP, or by threatening the patient of having to pay for any waste of the doses if the cold chain is broken.
>
> -PSP managers impose stricter or more expensive conditions to usual pharmacies to obtain the specialty drug.
>
> -PSP managers often contact directly patients to dissuade them in using their usual pharmacy.

As an alternative, AQPP has developed its own PSP for specialty drugs, Accessa, which can be offered in any pharmacy in Quebec (Association Québécoise des Pharmaciens Propriétaires 2022). PSPs can be organized to serve the whole population without necessitating PPNs.

For manufacturers, PSPs are designed to both develop brand loyalty and lessen barriers for patients and prescribers to starting and sustaining treatment (Prémont and Gagnon 2014; Grundy, Huyer, et al. 2023). Thus, they typically wish to create wrap-around supports for physicians and patients to facilitate prescribing taking and staying on the drug. However, they also typically wish to have their drug *available* through as many pharmacies as possible.

However, in a system where confidential rebates have become standard, the middlemen never lack entrepreneurial imagination to capture some of the money available. It is not surprising that for the most expensive (and most profitable drugs), these dynamics have become the new normal. PSP managers, specialty pharmacies, pharmacy benefits managers and insurance companies can thus put in place profitable systems to the detriment of patients, employers, and smaller community pharmacies.

Creating further exclusivity and opacity – the rise of PPNs

In a world of high confidential rebates and of PSPs for high-cost (and very profitable) specialty drugs, PPNs are yet another mechanism that may be detrimental not only in terms of patient choice and accessibility, but also in terms of quality of care and in terms of costs. Collectively, these mechanisms work against transparency and informed consumer choice and do not lessen costs for consumers.

As employers and patients grapple with high and unaffordable drug prices, it is possible that a well-designed PPN can help reduce costs for patients and employers in the short run. However, allowing PPNs create dangerous dynamics as exemplified by ongoing trends in Canada and the United States. In particular, the current system sees the emergence of some corporate behemoths that can impose their conditions in terms of price and access to specific stakeholders. For example, in Canada, it is estimated that 80% of transactions for prescription drugs goes through Express Script Canada and Telus Health on behalf of companies such as Canada Life, Manulife and Sun Life (Phillips 2024). Express Script Canada is now using its market power to increase its fees to community pharmacies, which prompted a complaint at the Federal Competition Bureau (Krashinsky Robertson 2024), a strategy that pharmacy benefits managers, including Express Scripts, have been using in the United States, which led to driving many local drugstores out of business and even created some "pharmacy deserts" across the country (Abelson and Robbins 2024). Telus Health is compelling its Canadian employees to access drugs only through the specialty pharmacy owned by Telus Health, arguing that it allows them to reduce dispensing fees or negotiate rebates (Benchetrit and Patel 2024). However, a recent audit showed that US Federal postal workers, involved in a similar PPN, were overcharged US$45 Million by the pharmacy benefit manager Express Scripts, which skimmed confidential rebates even if their contract did not allow them to do so (Silverman and Herman 2024). Finally, as a warning about the shape of things to come, the same Express Scripts also handles drug transactions for West Virginia public employees and, in many cases, it paid itself more than 100 times as much for the most expensive class of drugs than it could have paid if it had gotten them elsewhere (Schladen 2024). Express scripts simply had the power to require employees to use its PPN through its own specialty pharmacy.

Under the current circumstances, the proliferation of PPNs creates exclusive business arrangements between private insurers and pharmacies, which are layered with further exclusivity between pharmacies, patient support program providers, and manufacturers. These practices are **anti-competitive**, particularly for generic, biosimilar, or other cost-effective alternatives, which in turn, may **reduce access** and **increase costs**, and ultimately, poor health and quality outcomes, even if PPN might allow some savings for some insurers or employers in the short run.

Before answering the questions found in the consultation document, we believe that the real questions are as follows:

> -Do we really want a system in which a patient might be forced to go to three different pharmacies and interact with three different pharmacists (not communicating with each other) to get three different drugs?

-Do we really want a system where distribution is organized to serve the commercial interests of corporate behemoths through an opaque structure of confidential rebates to the detriment of patients and employers?

Answers to Consultation Questions

1) Are there any qualitative differences between the service and care provided by pharmacy operators participating in PPNs (closed or open) and those that are not? Please explain.

PPNs are largely, a short-term solution to help employers and private insurers manage the high costs of specialty medicines. We found that 1 in 10 drugs, which are also largely high-cost, specialty medicines, have a manufacturer-sponsored patient support program. Complicating things, the company that operates the patient support program also often owns and operates the specialty pharmacy (e.g., insurer → PPN → Loblaw → Shoppers Health Network → PSP). High-cost drugs with patient support programs, paid for by the manufacturer, may offer case management to help navigate insurance coverage, schedule infusion clinic appointments, offer co-pay assistance, or provide medication-related education.

However, as the case of Quebec and Accessa shows, these services can also be operated through any/all community pharmacies, if manufacturers choose to pool these resources.

In our research with patients, participants report that they often take multiple medications (e.g., a specialty drug for their chronic disease plus other medications for acute or other chronic conditions such as high blood pressure). Quality differences arise when they are forced to go to multiple pharmacies to fill their prescriptions because some drugs have a PSP, or a PPN, and others do not. Patients report that this can lead to safety issues (e.g., the pharmacist is not aware of their multiple prescriptions and cannot identify dangerous drug interactions), that it is inconvenient, and they do not have a relationship with a knowledgeable and trusted pharmacist who understands their whole health picture, when they have questions or concerns.

2) Do closed and mandatory PPNs have an effect on consumer choice and accessibility for consumers of specialty medicine in Ontario?
    a) If so, does this effect differ from that of open PPNs? Please explain.
    b) How important a consideration is this for users of specialty medicine?

PPNs can have similarly harmful effects on consumer choice and accessibility regardless of whether they are closed and mandatory, or open and voluntary. For example, in Québec, because of its legislation, mandatory or closed provider preference networks are not allowed in Quebec. However, the recent class action lawsuit brought by the Association Québécoise

des Pharmaciens Propriétaires (AQPP) against specialty pharmacies over the distribution of specialty drugs through PSPs shows that similarly harmful effects on consumer choice and accessibility still can occur even when these "preferred provider networks" are supposedly open and voluntary. Thus, there is no real difference between the two since open and voluntary PPNs can often impose indirect pressure on patients and end up taking away patient choice in the same way that closed and mandatory PPNs do.

3) Would you prefer coverage with a higher co-pay and greater choice in pharmacy over coverage with a lower co-pay at a smaller network of preferred pharmacies?

The formulation of the question is wrong considering that, in practice, this choice does not continue to exist for consumers in the long term. First, consumers never benefit from the practice of confidential rebate negotiation – they continue to pay their co-pays on the official price. Without transparency, it is likely that PPNs will operate in the same way – there is no guarantee that PPNs will be accountable to consumers and pass on the savings. Second, mandatory PPNs often lead to higher dispensing fees in the long run, as shown by the case of Express Script in Ohio. Thus, the savings realized by consumers are not likely to persist.

24) *For All Stakeholders*: Is policy intervention regarding PPNs desirable? If the government were to intervene:
   a) What course of action would be best?
   b) Which category of stakeholder should be directly regulated, and which regulator should be responsible?

Policy intervention is highly desirable, aiming both insurers and pharmacies and the third-party companies that own and operate pharmacies, but also patient support programs and drug distribution services. Prescription drugs remain an essential health care service that should be de-commodified. Thus, we cannot understate how desirable it is for the Ontario Ministry of Health to regulate the distribution of prescription drugs. The best course of action would be to implement a universal pharmacare for all Ontarians, which would take away the possibility for predatory middlemen to benefit from the complex financial incentives at play in Canadian pharmaceutical distribution.

25) *For All Stakeholders:* How would AWP or OCP regulation impact cost, accessibility, quality of care?
   i. Cost of and access to specialty medicine?
   ii. Accessibility for consumers (including geographical access)?
   iii. Quality of care for consumers?

In a static comparison, both AWP and OCP regulations might increase costs while increasing accessibility and quality of care. However, in a dynamic comparison, in the long run these regulations would also reduce dispensing fees, reduce the incentives to artificially inflate drug costs (and provide higher confidential rebates), and allow better market entry for biosimilars. All these elements would reduce costs in the long run.

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