Ohio Medicaid officials pledged Wednesday to investigate claims that pharmacy benefit managers are paying pharmacists far less to fill prescriptions than they charge the state, allowing them to pocket the difference.

Critics say the practice, known as spread pricing, is increasing costs in the tax-funded Medicaid program and driving many pharmacies out of business because some drug reimbursements are less than the cost to pharmacies of acquiring the medication.

Medicaid Director Barbara Sears said, “We need more insight into ... how pharmacy benefit managers are working (and) a clearer picture of cost and reimbursement.”

State officials said they expect to find some instances of price spreading but are unsure how widespread the practice has become.

If the allegations are found to be true, Sears said, violators will face fiscal and administrative sanctions.

Sears said all five managed companies employed by Medicaid have agreed to provide data showing how much they paid their pharmacy benefit managers, known as PBMs, and how much the PBMs paid pharmacies to fill prescriptions during a 12-month period ending March 31. The state previously has not had access to the rates paid pharmacies.

CVS Caremark, PBM for four of the five managed-care plans, has repeatedly denied the allegations of spread pricing, insisting its overall profit margin is 3.5 percent and far lower than drug manufacturers’.
Sears’ announcement came mere hours after the Ohio Department of Insurance ordered health insurers and their pharmacy benefit managers to cease enforcement of gag orders preventing pharmacists from telling consumers of the lowest drug price available. Insurance regulators also prohibited them from charging consumers more for their prescription medication than it would cost without insurance, or out of pocket.

The crackdown comes after The Dispatch reported claims that CVS Caremark was overcharging taxpayers and driving out its retail competition by paying low reimbursement rates to pharmacists filling prescriptions for Medicaid managed-care patients. The Dispatch also showed how PBMs were in many cases charging the state multiple times what they paid pharmacies for certain medications.

In addition to reviewing pricing for the past year, Medicaid officials Wednesday announced that all five plans on April 1 signed amendments to their contracts with the state to provide additional pricing data starting July 1.

For instance, upon request the plans must disclose “all financial terms and agreements for payment of any kind” with subcontractors, including PBMs, and the rates paid pharmacists and other vendors.

In addition, PBMs will be required to disclose the different drug price lists they use. It’s not unusual for PBMs to use one list when billing the managed-care plan and another when reimbursing the pharmacist, casting more confusion about where tax dollars are going.

“Our goal in taking these actions is to ensure Ohio taxpayers continue to receive the best possible price for prescription drugs and Medicaid enrollees have access to pharmacy services, and to provide the information that is necessary to understand if any participant in the value chain is harmed by or engaged in anti-competitive behavior,” Sears wrote in a letter Wednesday to the five managed-care plans.

Still, Sears insisted that allowing managed-care companies to administer pharmacy benefits has saved Medicaid at least $130 million a year in administrative costs alone.

Medicaid, which covers more than 3 million poor and disabled Ohioans, spent $3.2 billion on prescription drugs last year.

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State probing whether pharmacy benefit managers are overcharging taxpayers