SPECIAL REPORT

HEALTHCARE

THE PBM POWER PLAY:

How Pharmacy Benefit Managers are Driving Up Prescription Drug Costs, and What South Carolina Can Do About It

SPANDANA ANCHOORI
RESEARCH FELLOW - HEALTHCARE
PALMETTO PROMISE INSTITUTE

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PALMETTO PROMISE INSTITUTE

P.O. Box 12676 | Columbia, SC 29211 | 803-708-0673

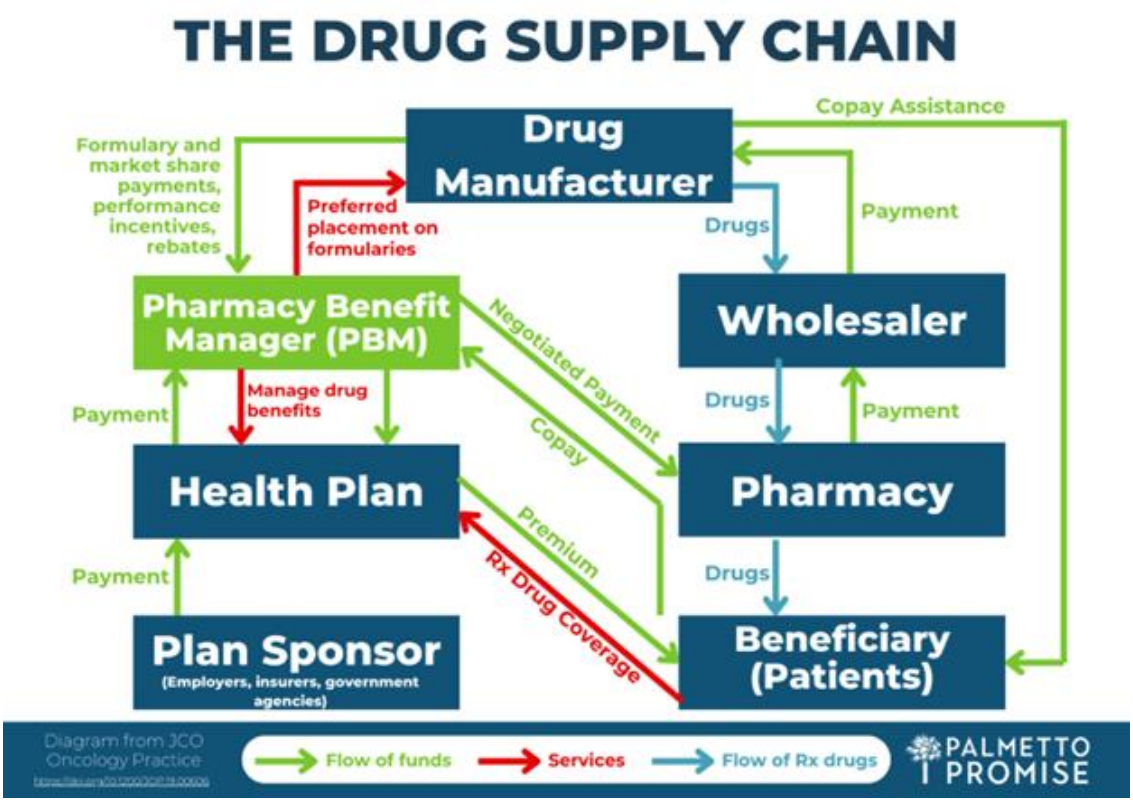
INTRODUCTION

The role of Pharmacy Benefit Managers, more commonly known as "PBMs," has been mentioned frequently in debates and discussions in the South Carolina State House in recent months, mirroring national attention on the topic by Republicans and Democrats alike. But the topic brings with it lots of confusion. Thus, the Palmetto Promise team has taken a deep dive into this complex topic. We break down what PBMs are, whether there is a need for PBM reform, and if so, what actions might be taken at the state level here in South Carolina and across the nation.

WHAT ARE PBMS?

Pharmacy Benefit Managers, PBMs, are companies that act as intermediaries between drug manufacturers and health insurers and pharmacies. The accompanying diagram, adapted from JCO Oncology Practice and a video explanation supported by AHealthcareZ, offers descriptions of the entire drug supply chain, including the role of the PBM.

You may have heard of some of the larger PBMs. According to the American Medical Association, CVS Health is the largest PBM (21.3% market share), followed by OptumRx (20.8%), Express Scripts (17.1%), and Prime Therapeutics (10.3%).



HOW DO PBMS AFFECT YOUR LIFE?

Most Americans have at some point in their lives been prescribed a medication and have been to a virtual or brick and mortar pharmacy to purchase it. If this applies to you, you may have been affected by a PBM without realizing it. That's because **at their core, PBMs help choose which medications your doctor is allowed to prescribe and how much you will pay for them.** The PBM works as **a liaison between your doctor, the pharmacy, your health insurance, and the companies that manufacture and market the medication**. In theory, they are supposed to make these medicines more affordable and more accessible.

But critics allege, sometimes PBMs work in their own interests and select more expensive medications simply to drive profits. How exactly does this happen?

1. A PBM may have a relationship with a drug manufacturer to get paid (through **rebates**) in exchange for prioritizing their drug on a list of medications covered by a health insurance plan (a list known as a **"formulary"**) and agreeing to push that medication to the exclusion of others.

   So instead of picking the best or most affordable option, a PBM may sometimes pick the drug with the highest rebate for them. In the worst cases, the PBM will not pass any savings on to the others in the chain who are primarily impacted, which in this case would be the insurer and the pharmacy. The individual is harmed secondarily when premiums and prices go up due to these market arrangements. Such behavior flies in the face of the purpose of a PBM to begin with: lower prices for the consumer of health services.

2. PBMs can engage in something known as **"spread pricing."** An example of this would be if a PBM agrees to pay a pharmacy $50 for a medication but the PBM charges $60 to a client (health insurer, large employer, Medicare Part D drug plans, etc.) and then pockets the $10 difference.

3. Beyond rebates and spread pricing, **some PBMs also own their own pharmacies**. How can this be harmful? Because PBMs then have the ability to steer patients with prescriptions towards their own pharmacies, even if it is not in the person's best interest. Most of the time, customers are unaware that there is a cheaper option for the

same medication. Small community pharmacies can lose customers to this system, risking their viability, and denying patients the care options they deserve.

4. And finally**, PBMs, with lack of transparency, can determine what is a *specialty* drug and which pharmacies can sell them**. These are often the costliest drugs and have the most significant revenue spread compared to generic and even preferred listing on formularies. With their ownership stake in pharmacies, some can write into their network contracts that their pharmacies are the only ones that may dispense specialty drugs, while independent pharmacies have no option to qualify or dispense.

WHAT'S THE CONTROVERSY?

The PBM system has come under fire in recent years due to its role in increasing drug costs and practices that prioritize profits. Just this January (2025), the Federal Trade Commission (FTC) found that PBMs have been found to markup specialty generic drugs by hundreds or even thousands of a percent, generating billions in revenue at the expense of patients and health care plan sponsors. These practices have led to steadily increasing drug costs for patients and employers. The FTC has reported that the three largest PBMs— CVS Caremark, Express Scripts, and OptumRx—are also steering highly profitable prescriptions to their own affiliated pharmacies, potentially limiting patient choice and access.

PBMs have also been criticized by the FTC for implementing unfair terms on independent pharmacies, jeopardizing the ability of these local drugstores to serve their communities. According to the FTC, the PBM industry's lack of transparency, including the use of gag clauses, that prevent pharmacists from disclosing cheaper drug options to patients, has further fueled public discontent.

PBMs are also heavily involved in designing **formularies**, which are the official lists of prescription drugs that are covered by a health plan. These listings are categorized into tiers that determine the level of patient cost-sharing. PBMs being involved in this formulary process presents a potential conflict of interest because they have the unfair opportunity to prioritize their priority medications, which maximizes their profits. Because PBMs receive rebates from drug manufacturers for including specific drugs on the formularies, they may favor high-rebate, high-cost medications over more affordable or effective options (such as generic drugs). This dual role of managing the

pricing and selection of drugs creates misaligned and often perverse incentives, driving up costs and limiting access to necessary medications.

As we have summarized here, **critics argue that PBMs' practices not only inflate prescription drug costs but also interfere with patient care and undermine local pharmacies.** The significant annual profits of $25 to $30 billion in the PBM industry have raised questions about whether their earnings are proportionate to the value they provide.

These concerns about PBMs have been raised by Republicans and Democrats alike, as both sides of the aisle sense how unfair the current system is for consumers.

WHY WOULDN'T EVERYBODY SUPPORT PBM REFORM?

The PBM issue is not cut and dried, however. PBM reform has been the subject of much debate on Capitol Hill and in Statehouses over the last few years.

PBMs, their allies, and their trade association, the Pharmaceutical Care Management Association (PCMA), oppose significant reform. They argue that these measures could undermine their ability to negotiate lower drug prices and may lead to higher insurance premiums for patients, especially seniors on Medicare Part D plans. The PBM lobby has fought legislative reform efforts, claiming that changes like banning spread pricing or delinking PBM compensation from drug prices would increase costs for health plan sponsors and patients. Additionally, some Republican lawmakers and other influential figures have resisted reform efforts due to concerns about increased government spending.

PBM advocates also argue that these middlemen help contain prescription drug costs and reduce overall healthcare expenses. They argue that they play a vital role in negotiating price discounts from retail pharmacies, securing rebates from pharmaceutical manufacturers, and providing mail-order pharmacy services, which can lead to lower drug prices and insurance premiums. PBMs consolidate the collective buying power of enrollees, enabling plan sponsors and individuals to obtain lower prices for their prescription drugs.

PBM advocates claim that PBMs incentivize and encourage the use of lower-cost generic and therapeutically equivalent branded drugs, leading to lower net costs in Medicaid programs, which is often true. But, Centene, a large PBM, has been ordered to repay South Carolina DHHS over $25 million because of overcharging. Ohio and Mississippi have found instances of PBMs

overcharging their Medicaid programs as well. Research from the PBM perspective suggests that forcing insurers to undertake PBM services in-house would increase management costs, potentially resulting in higher drug prices or premiums. PBMs are worth at least $145 billion annually.

THE COALITION SUPPORTING PBM REFORM

Though PBMs claim to achieve these beneficial goals, a wide range of stakeholders including Democrat and Republican lawmakers, advocacy groups, and organizations representing small pharmacies, have become increasingly outspoken on the issue of PBMs. The National Community Pharmacists Association (NCPA), which advocates for small pharmacies, and nearly 20 other advocacy groups, have been vocal in urging Congress to pass reforms aimed at increasing transparency, regulating PBM revenue practices like spread pricing, and ensuring fair competition in the pharmaceutical market. Bipartisan support exists at the federal level, with lawmakers seeking to address rising drug costs and the market dominance of the four largest PBMs. In a 2024 report published by the House Committee on Oversight and Governmental Reform, Chairman James Comer (R-KY) said:

> **Instead of prioritizing the health of Americans across the country, evidence obtained by the House Oversight Committee shows how the three largest pharmacy benefit managers colluded to line their own pockets. These self-benefitting pricing tactics pushed by PBMs have done nothing but jeopardize patient care, undermine local pharmacies, and raise prescription drug prices."**
>
> *- Rep. James Comer (R-KY)*

Additionally, some argue that PBMs' vertical integration with pharmacies creates significant conflicts of interest, potentially favoring their own affiliated pharmacies over independent ones. These concerns have led to increased scrutiny and calls for regulation of PBM business practices in several states.

While reform has garnered significant bipartisan attention and support, legislative progress on the national level has been hampered by advocacy by PBMs and legislative strategy disagreements. This has left many proposed measures stalled, despite widespread acknowledgment of the need for greater oversight in the PBM industry. Yet, this has opened the door to states having a chance to tackle PBM reform while awaiting Congressional action.

REAL LIFE PATIENT IMPACT IN SOUTH CAROLINA

Virginia Maxwell, a South Carolina resident, currently suffers from a rare autoinflammatory disorder that affects only 6,000 people globally. Though her condition can be managed with biologic medications, access to these drugs is frequently blocked by pre-authorization delays, step therapy requirements (requiring patients to try less expensive, preferred medications before being approved for the more expensive option for the same condition), and copay accumulator policies (where a health plan that does not allow assistance to count towards a patient's deductible or out-of-pocket maximum). These policies are being enforced by PBMs.

Virginia's story is particularly devastating because despite her physicians' consistently recommending specific biologics that she needs to function, she continues to face denials without explanation and must fight repeatedly to maintain access to lifesaving treatment. Her son has the same condition and has endured the same denials. She reports that there have been several occasions where she has been forced to share her medication with her son and endure the painful flares herself rather than see him suffer.

The barriers Virginia has faced have jeopardized her and her children's wellbeing. Despite physician support and documented treatment history, PBMs still force each child to repeat failed treatments before allowing them access to the known effective medication. **Virginia's story of her experiences and her family's experiences illustrates how PBM-imposed delays, denials, and cost-shifting tactics impose real harm**. Without reform, families like Virginia's will continue to face financial struggle, disability, or worse.

PBM REFORM = FREE MARKET

The power that the monopolistic PBM industry currently has is putting a strain on competition in the pharmaceutical industry. One proposed solution would help to remove these barriers and allow for smaller PBMs to enter the industry, renewing fair competition. At a March 18, 2025, meeting of the South Carolina House's Ad Hoc Committee on PBMs, legislators heard testimony from Charise Richard of the Pharmaceutical Research and Manufacturers Association (PhRMA). She emphasized that the large market share of the three major PBMs we have today create conflicts of interest that drive up prices by prioritizing high-rebate medications over low-cost alternatives.

The PBM reforms currently in play in South Carolina seek to eliminate practices such as spread pricing and require PBMs to pass on rebates, discounts, and fees which will aid in removing market distortions. At the same committee meeting, Addison Livingston from Independent Pharmacies of South Carolina pointed out that **small pharmacies are being squeezed out due to PBM practices.**

Reforms to eliminate anticompetitive practices such as a lack of transparency around rebates will promote fair competition and ensure that cost savings are passed to the consumer. Ad Hoc committee members Representatives Heath Sessions and Sylleste Davis questioned whether PBMs' rebate structures truly benefit patients or simply drive up drug prices. Based on the hearings of the ad hoc committee, it seems legislators are **considering requiring full rebate pass-through to consumers to increase transparency and benefits to the patient.** That will sell, but will need some adjustment to account for the fact that employers often cover 80% of employee healthcare expenses in one way or another. They should not be left out of the savings.

A benefit of these potential reforms is that both consumers and employers will be empowered to make more informed choices when given clear, transparent information.

Addison Livingston, who owns his own small independent pharmacy in South Carolina, advocated to legislators that PBM reform would mitigate the inflation of drug costs to improve accessibility for patients through market mechanisms instead of direct price controls.

WHAT CONGRESSIONAL ACTION IS BEING CONSIDERED?

The federal Continuing Resolution debated in December 2024 initially contained section 227, entitled "Modernizing and Ensuring PBM Accountability." Amid the debates on a potential federal government shutdown, lawmakers hoped to get PBM reform across the finish line. This section would have banned spread pricing, set reporting requirements for PBMs, and made sure PBMs act in the best interest of Medicare recipients, just to name a few. **Ultimately, PBMs were left out of the 2024 continuing resolution, but they remain a frequent topic of conversation in Congress.**

The fate of PBM reform has been the same in the One Big Beautiful Bill; the House's initial version contained provisions to ban spread pricing, require greater transparency, and "delink" PBMs' income from drug prices. However,

those pieces were cut by the Senate Parliamentarian and did not make it into the Senate's OBBB.

Federally, there are several pieces of standalone legislation that have been introduced or considered in Congress to reform and regulate PBMs.

1. The Pharmacy Benefit Manager Reform Act (S.1339) introduced in April 2023 aimed to address many of the issues with PBMs listed above. The bill would have required PBMs to report annually to plan sponsors about their services, including drug copayment assistance and total net spending on prescription drugs, prohibit spread pricing, where PBMs charge more for a drug than they pay to the pharmacy, and mandate PBMs to remit all rebates and fees received from drug manufacturers to plan sponsors.

2. The Patients Before Monopolies Act, a bipartisan bill introduced in December 2024, seeks to restrict PBMs' influence and control over pharmacy businesses, require insurers and parent companies of PBMs to divest all pharmacy assets, and prohibit common ownership of PBMs, insurance companies, and pharmacies.

3. The Pharmacy Benefit Manager Transparency Act of 2023 (S.127), introduced in January 2023, aims to: prohibit PBMs from charging plans differently than they reimburse pharmacies and require PBMs to report annually to the FTC about payments received from health plans and fees charged to pharmacies.

4. The DRUG Act (H.R. 6283), introduced in November 2023 aims to enhance transparency in the industry by mandating clear reporting from drug manufacturers on pricing and distribution. It also includes provisions to prevent market manipulation and ensure that PBMs and other intermediaries do not engage in anti-competitive practices that could harm access to affordable medications.

President Donald Trump has voiced support for PBM reform, saying in a December 2024 press conference that "We're going to knock out the middleman" in the drug supply chain, saying the change would "get drug costs down at levels that nobody has ever seen before." With the Trump administration vowing to tackle drug pricing, it is likely that PBM reform will remain a frequent part of the conversation in the White House and in Congress.

HOW ARE OTHER STATES HANDLING PBMS?

As of early 2025, all 50 states have passed some form of PBM reform.

Currently, our neighboring state of Georgia is considering multiple PBM reform bills, including GA SB91 and GA SB60. These bills aim to regulate PBM practices, increase transparency, and ensure fair reimbursement to independent pharmacies. SB 60 specifically proposes the establishment of a duty of care for PBMs to insureds, health plans, and providers.

Tennessee has been actively pursuing PBM reform aimed at increasing transparency, preventing unfair practices, and ensuring fair reimbursement for pharmacies, similar to South Carolina and Georgia. Recent and ongoing efforts include TN SB0569, which proposes changes to pharmacy practices, including removing administrative fees for pharmacist-provided hormonal contraceptives when covered by insurance. While not directly targeting PBMs, it reflects broader efforts to streamline pharmacy operations and improve patient access to care.

We have already seen a successful slate of PBM bills adopted in Iowa. Senate File 383 passed both houses. It was loosely modeled off of West Virginia policies enacted over multiple years since 2021. Iowa also recently considered a PBM reverse auction bill (S.F. 315), but the Senate bill didn't advance in the House.

WHAT STEPS HAS SOUTH CAROLINA TAKEN?

South Carolina is actively pursuing PBM reform at the state level, with several recent developments and ongoing initiatives.

S.330 and H.3934 are companion bills regarding cost-sharing requirements within health plans to address PBMs. Both bills hope to define terms related to cost-sharing and clarify cost-sharing applications. The bills would prevent insurers and PBMs from setting health plan terms based on available financial assistance for a specific prescription drug. Additionally, they would ensure that federal annual cost-sharing limitations apply to all healthcare services covered by health plans, including the services of PBMs. This regulation of PBM practices aims to protect enrollees from unfair cost-sharing practices and ensure transparency in health plan coverage.

Another proposal is S.342, which proposes new reimbursement requirements for PBMs. This includes a minimum reimbursement rate of 104% of the

National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee.

Finally, legislators are considering an adjacent reform in S.378, which amends SC's Pharmacy Practice Act. This bill would allow pharmacists to prescribe certain drugs and devices in limited situations, including patient's emergencies and minor, self-limiting conditions, while simultaneously establishing guidelines for professional conduct and care standards. The bill helps the PBM issue by increasing accessibility to prescriptions and through a broadening of a pharmacist's scope of practice. Such a change could potentially reduce patients' reliance on PBMs for a minor or routine drug need, which can help to streamline the medication process and reduce administrative barriers and costs.

But many ideas are still in development, with members of the House and Senate both taking thoughtful approaches to studying the PBM issue thoroughly.

During an hours-long meeting of the South Carolina House's Ad Hoc committee on PBMs, representatives heard presentations from both sides of the PBM debate. The meeting revealed deep concerns about PBM's role in drug pricing, transparency, and market control. The ensuing discussion showed that lawmakers were hoping to continue to pursue pathways to increase accountability and increase cost savings that benefit consumers directly. A similar meeting in the South Carolina Senate's Banking and Insurance committee showed the same concerns in the upper chamber.

In March 2023, Governor Henry McMaster signed into law S.520, that required audits of PBMs to better define terms and make relevant changes based on those audits. The legislation, enacted on January 1, 2024, directed the South Carolina Department of Insurance to conduct an **audit on PBMs and Pharmacy Services Administrative Organizations (PSAOs**). This audit, recently finished, provides DHHS with a clear set of recommendations on how to proceed.

WHAT'S NEXT FOR PBMS IN THE PALMETTO STATE?

In a Senate Banking and Insurance Committee held March 26, 2025, Eunice Medina, the Department of Human and Health Services (DHHS) director, spoke on the agency's PBM reform plan that will be implemented in the next six months.

Her testimony provided background on South Carolina's current Medicaid and pharmacy landscape. South Carolina serves 1.1 million full-benefit members, 5 managed care organizations (MCOs) that cover 80% or more of this population. Each of those MCOs has a PBM. Beyond that, DHHS also has a fee-for-service delivery system, or as we better know it, a traditional Medicaid program. In the fee-for-service model, DHHS utilizes a PBM, giving them more control over rules and regulations on how pharmacies are reimbursed.

The aforementioned audit by the SC Department of Insurance provided DHHS clarity on how contracting and PBMs were handling prescriptions in the managed care space. The recommendations and transparency reforms for the upcoming years are based on this audit.

The following **five reforms are the result of this audit and will be adopted as DHHS policy in Fall 2025:**

1. **Prohibiting spread pricing across all of SC's managed care plan contracts:** The audit revealed one MCO that was conducting that type of activity but had already ceased that activity before the audit was complete.

2. **Increasing visibility into transaction fees:** This does not currently exist in SC. With the reform, reporting will be required on an annual basis.

3. **Increasing access by making sure independent pharmacies, particularly in rural areas, receive fair payment from PBMs:** Currently, the state only controls rules and regulations for PBMs on the fee-for-service side, while managed care sets their own rules.

4. **Implementing oversight by contracting with a third-party PBM monitoring entity:** This will monitor managed care plans and their PBMs to ensure they are adjudicating and paying in accordance with their contracts.

5. **Prohibiting Managed Care Organizations (MCOs) from requiring the use of mail order prescriptions and accommodating better member choice:** Many of SC's PBMs and MCOs require that members use the mail order. While in some cases that may be seen as a benefit, there is a push to have an opt-out option.

Director Medina provided this list of initiatives that they are launching. They have already begun working closely with providers, pharmacies, and managed care plans. She states that there are already tentative effective dates to implement these initiatives. However, the focus of this audit was contracting, payment, how DHHS receives the information from their managed care plans through their claims, and the dispensing fee. This effort is only a pilot program, as there has been no updating of the state plan, and that plan must be approved on the federal level to fully move forward.

CONCLUSION

Given the widespread acknowledgment of PBM issues, as evidenced by ongoing legislative efforts at both the federal and state levels, **there's a clear and bipartisan push for widespread reform of PBMs across the nation and in South Carolina**. With growing momentum for reform, the future likely holds significant changes. We will see increased state and federally-driven reforms, with key areas of focus including greater transparency in pricing practices, restrictions on spread pricing and rebate agreements, and measures to prevent conflicts of interest.

The success of these reforms will depend on navigating the complex political landscape and overcoming resistance from not only the powerful PBM lobby, but from some of our strong allies in the business community on other issues, who fear that if not crafted properly, legislated PBM changes can lead to higher health insurance coverage costs for businesses. These are valid concerns. We must tread carefully to ensure that the ultimate goal, more affordable and more accessible medications, is truly achieved.

Spandana Anchoori is a recent graduate of the South Carolina Honors College and Arnold School of Public Health at the University of South Carolina, where she completed a B.S. in Public Health with a minor in Neuroscience. Her senior thesis was a comprehensive report and podcast on the comparison of international health policy implementation and interventions in the United States, Italy, Japan, India, and Rwanda. In Fall 2025, she matriculates at the Johns Hopkins Bloomberg School of Public Health, where she is pursuing a Master of Science in Public Health (MSPH) for Health Policy and Management. Spandana served as a Research Fellow with Palmetto Promise Institute during the Spring 2025 semester.