New business model, **optional**. Same profit-driven middlemen, **guaranteed**.

> After decades of profiting from a system built on opacity, the largest PBMs have been promising, "sweeping reforms." But those promises have only come after years of mounting bipartisan pressure for accountability by state and federal lawmakers and regulators. Policymakers should take notice of what's in these new models – and ask harder questions about what employers and patients need in these contracts.

Q: Will new offering models meaningfully change how PBMs operate?

A: PBMs are assuring investors that profits won't take a hit, suggesting these "new" voluntary models leave the core incentive structure untouched.

When the profit equation stays the same, so will the patient experience. OptumRx reported no changes to its financial forecasts, maintaining operating margins of 3% to 5%. Cigna predicted overall growth despite transition costs. While the proposed FTC settlements with major PBMs smartly maintain that they should no longer favor more expensive medicines, stricter enforcement is clearly required if PBMs are so confident about their bottom line. Time and again, PBMs have promoted transparency as an option rather than a standard, creating the appearance of reform while leaving traditional business practices largely intact.

Q: Will these new models will lower costs for patients?

A: PBMs openly admit their new business models don't guarantee savings for patients or employers.

CVS has explicitly stated its new "transparent" CostVantage and TrueCost models may not save clients or patients money. Cigna made the same acknowledgment about its ClearNetwork model. The pharmaceutical supply chain already delivers value: 90% of prescriptions dispensed in the United States are low-cost generics, and Americans pay less for generic medicines than patients in most other comparable countries. PBMs have designed their role in the health care system to obscure markups and the flow of money and ensure middlemen capture value that should be passed through to patients and plan sponsors.

Q: Are employers and patients satisfied with PBM business practices?

A: No. If they were, PBMs would not be introducing new models to address employer concerns.

PBMs have long argued that reforms are unnecessary because employer clients are satisfied with their services. Yet, those same PBMs are now introducing new models and claiming the changes are driven by employer demand. OptumRx now explicitly cites employer demand as the reason for its new "transparent" model.

A system built to **benefit middlemen**

A handful of PBM-insurer conglomerates control what patients pay, which drugs are covered and where they can get them. They negotiate massive discounts and collect savings instead of passing them to patients. Patients face the following as a result:

Care delayed or denied

Potential savings for patients diverted

Drug and pharmacy choices controlled

WHY THIS MOMENT MATTERS

We have seen Congressional action, crackdown in the states, proposed Department of Labor rulemaking, investigations from Attorneys General and the FTC, and continued bipartisan calls at both the federal and state level for additional reforms along with ongoing congressional scrutiny.

But this is just a start and the biggest problems remain:

- **Denial practices continue**
- **Savings don't reach patients**
- **Vertical integration drives conflicts of interest**

The same big three PBMs (United HealthGroup's OptumRx, Cigna's Express Scripts, CVS Health's CVS Caremark) are asking patients employers and policy makers to take them at their word. *They should not.*

WHAT NEEDS TO HAPPEN

1. Tackle growing consolidation in the PBM market that leads to higher costs for patients

2. Hold insurers accountable for increasing denials and delays

3. Ensure patients and employers get savings