price list, or "formulary," depending on deals the PBM has made with the pharmaceutical company or their distributor. In some cases, insurers and PBMs may refuse to cover certain drugs when a worthy, cheaper substitute is available (or as part of a strategy to convince a manufacturer to lower prices).[63] Yet even this standard pharmacy model is being challenged by so-called specialty pharmacies that stock a limited selection of drugs. We noted this practice earlier in the context of Daraprim, and will discuss it further in Chapter 4. By only allowing prescriptions for particular drugs to be filled at particular pharmacies, the potential for generic substitution, prescription changes, or insurer interference can be reduced dramatically for the brand-name company trying to hold on to its market position.

In general, PBM discounts and deals are so prevalent that few insurers actually pay the "list" price for a drug. Some commentators have compared the system to the maximum hotel room rate that hoteliers are required to post in a room – it is there and it represents some sort of theoretical maximum, but no one has actually ever paid that rate unless the Super Bowl or Beyoncé or both are in town.[64] Thus, no one really knows what a drug will cost for any given person – certainly not the doctor prescribing the drug or the patient paying for it!

Some pharmaceutical manufacturers have argued that these discounts from the "list price" should allay concerns about rising prices. If those high prices are never actually being passed on to insurers or consumers, perhaps the price is more of a negotiating tactic than an actual concern for the market. Recent *Bloomberg* data show, however, that postrebate price increases for many drugs still come in substantially above inflation.[65] Even after factoring in average discounts of 37 percent in 2015 for the drugs studied, list prices still increased anywhere from 22 percent to a whopping 442 percent from 2009 to 2015.[66]

At the end of the road, we finally meet our patient, who pays the pharmacist whatever the co-pay is for the prescription – which is the balance after insurance coverage is factored in. The uninsured often will face the list price of the drug, meaning they end up the worst of anyone in this complicated web. The insured, however, are not immune to sticker stock. Even with Medicare coverage, for example, yearly co-pay prices for expensive rheumatoid arthritis and cancer specialty medications can range from $4,000 to nearly $12,000 – staggering numbers that are prohibitive for many covered patients.[67]

[63] Carolyn Y. Johnson, *Secret Rebates, Coupons, and Exclusions: How the Battle over High Drug Prices Is Really Being Fought*, Wash. Post (May 12, 2016), www.washingtonpost.com/news/wonk/wp/2016/05/12/the-drug-price-arms-race-that-leaves-patients-caught-in-the-middle/.

[64] Thomas, *Drug Prices Keep Rising Despite Intense Criticism*, *supra* note 6.

[65] Robert Langreth, Michael Keller, & Christopher Cannon, *Decoding Big Pharma's Secret Drug Pricing Practices*, Bloomberg (Jun. 29, 2016), www.bloomberg.com/graphics/2016-drug-prices/.

[66] *Ibid*.

[67] Joseph Walker, *Patients Struggle with High Drug Prices*, Wall St. J. (Dec. 31, 2015), www.wsj.com/articles/patients-struggle-with-high-drug-prices-1451557981.