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Prescription Drug Benefit Plans: A Buyer's Guide

January 2003

Prescription Drug Benefit Plans: A Buyer's Guide

Prepared for
CALIFORNIA HEALTHCARE FOUNDATION

by
Mercer Human Resource Consulting

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Acknowledgments

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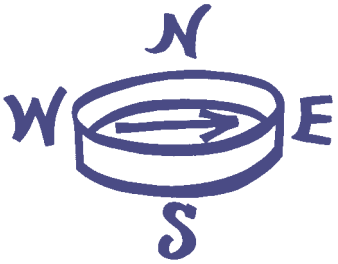
I. A Strategic Guide for Plan Sponsors



PRESCRIPTION DRUG BENEFIT PLAN SPONSORS face a daunting array of complex purchasing options. Management services are often priced in such a way that overall costs are obscured. Comparison-shopping can be next to impossible because elements of pricing are not consistent from one pharmacy benefit provider to the next and can depend on factors that are not easily assessed. To navigate this confusing landscape of pharmacy benefit providers and products, and to make appropriate choices, it is essential to understand the lay of the land.

This guide will help plan sponsors negotiate contracts with prescription drug benefit service administrators — whether they be stand-alone pharmacy benefit managers (PBMs), such as Medco Health, AdvancePCS, or Express Scripts, or those housed within a health plan, such as Aetna, CIGNA, or a BCBS organization. This guide can be used as a tool to review pricing options, evaluate the cost of prescription drug plans, and know which questions to ask and how to interpret the responses.

Starting with the basic decisions — to insure or self-insure, to carve-in or carve-out — this guide will alert buyers to the nuances and complexities of retail and mail-order pricing, manufacturer rebates, administrative costs, and clinical services, and provide a list of key questions to ask providers about each of these areas. In addition, it will consider the pros and cons of collective purchasing, as well as some less tangible items that contribute to a pharmacy benefit plan's long-term success. The intent is to provide sufficient information to help plan sponsors negotiate the most favorable financial arrangements, resulting in lower costs for the plan sponsor and greater affordability for plan members — the consumers.

II. To Insure or Self-Insure?

A PLAN SPONSOR'S DECISION WHETHER TO PURCHASE an insured pharmacy benefit or to self-insure depends upon the sponsor's willingness and/or ability to accept financial risk. In a self-insured arrangement, the plan sponsor assumes risk for the impact of fluctuations in prescription drug costs from month to month. In an insured arrangement, the risk is transferred to an external pharmacy benefits administrator, and the plan sponsor is responsible solely for the payment of monthly premiums.

Arrangements with health plans can be either self-insured or fully insured. Arrangements with stand-alone PBMs tend to be self-insured, though there are exceptions. (If a PBM offers a fully insured arrangement to a plan sponsor, the PBM generally needs to partner with a reinsurer, because PBMs are generally not licensed insurance carriers.)

While purchasing an insured benefit absolves the employer from assuming greater risk and potentially higher costs, self-insurance provides more opportunity to exercise input on how the benefit is structured and allows for more direct negotiation of discount levels. The main advantages and potential drawbacks of each of these arrangements are summarized in Table 1.

Table 1. Advantages and Drawbacks of Self-Insured vs. Insured Pharmacy Benefit Services

Main Advantages	Potential Drawbacks
Self-Insured	
• Allows flexibility in plan design, formulary, and pharmacy management. • Avoids legislated coverage mandates and risk premiums (appeals to national employers because it avoids mandates that differ by state).	• Increases sensitivity to annual volatility of prescription drug costs and rising drug benefit expenses. • Imposes a greater burden on implementing programs to control costs. • May pose too great a financial risk for small plan sponsors.
Insured	
• Avoids risk and potentially higher costs by transferring claims risk to health plan or PBM.	• Limits or prohibits control of mandated benefits, premium increases, and plan design, which are determined by the health plan's cost-control measures. • May impose stricter access and utilization controls on members. (These controls can also exist under a self-insured arrangement.)

How PBMs Absorb Financial Risk

While it is rare for stand-alone PBMs to fully insure pharmacy coverage, they usually absorb some portion of financial risk by offering guarantees for the following:

Brand-name drug discounts. Discounts on brand-name drugs filled in a retail setting are based on the PBM's contracts with retail pharmacies. Generally, if the discount percentage guaranteed is not achieved, the PBM is obligated to provide some compensation to the plan sponsor, either making up the difference dollar for dollar or paying a predetermined penalty. Conversely, brand-name discounts for prescriptions filled at mail-order pharmacies are negotiated directly with the PBM, so there is little risk for the PBM that the negotiated discount will not be reached.

Generic drug discounts. PBMs are willing to guarantee the discount achieved on generic medications through maximum allowable cost (MAC) pricing (see sidebar on page 8). It is important for a plan sponsor to understand how the effective discount will be measured. Guarantees are only meaningful if they can be successfully measured, reported, and enforced.

The generic dispensing rate. PBMs are willing to guarantee the generic dispensing rate because they can influence the degree of generic substitution (substituting a generic for a brand-name drug), although to a lesser extent at retail than via mail order.

Average annual per member prescription costs. It is not common for PBMs to price drug benefit management services on a per member, per year (PMPY) basis, as the PBM usually has limited control over the number and type of prescriptions written and the associated average cost per prescription. In a situation such as this, where a PBM is essentially being asked to share in the financial risk for an aspect of the plan over which it has little or no control, plan pricing will likely be less aggressive.

Health Plans and Financial Risk

Since health plans or insurers do not exclusively focus on pharmacy benefits as PBMs do, the level of attention devoted to pharmacy varies from one plan to another. Some of the largest national health insurers operate their own PBMs; other national insurers subcontract all or some portion of pharmacy benefit management to an outside PBM. Nationally, different Blue Cross Blue Shield plans have adopted variations on both strategies.

Under an insured arrangement with a health plan, pharmacy costs are sometimes blended with medical costs in the premium. In other cases, there is a separate prescription drug-rider rate. When plan sponsors purchase the coverage on a fully insured basis, they limit their risk for the prescription drug benefit, but they may also limit their input on how the prescription drug benefit is constructed. To maximize the possibility of a financially viable pharmacy benefits program, a plan sponsor should ask its health plan to do the following:

- ***Separate prescription drug cost, utilization, and trend data from the medical data.*** This will make it easier to compare PMPY drug benefit costs and annual trends with national benchmarks.
- ***Clarify whether rebates are built into the benefit premium.*** While plan sponsors may believe that they are not receiving rebates from a health plan because rebate checks are rarely, if ever, issued, rebate savings may be provided indirectly as part of the premium.

- ***Provide documentation of the utilization management programs included in the premium cost.*** These programs are critical to successful cost containment and may ultimately help to lower medical benefit plan increases through more competitive experience-based premium adjustments. Plan sponsors can compare the health plan's utilization programs to similar programs offered by PBMs.
- ***Provide a clear statement of health care management strategies and review these to identify cost containment opportunities.*** The more effectively the health plan is able to influence the prescribing physician's behavior, the greater the cost savings potential.

Under self-insured arrangements with health plans, plan sponsors can directly negotiate financial terms such as discounted prices, dispensing fees, and rebates with the health plan, just as they can in a stand-alone PBM arrangement. The health plan's flexibility in altering these financial terms, however, is usually limited. This is particularly true when the health plan outsources these services to another provider. In addition, financial terms offered by a health plan are rarely guaranteed.

Maximum Allowable Cost (MAC) Pricing for Generic Drugs

When a drug is no longer protected by a commercial patent, other manufacturers have the right to produce it as cheaply as possible and sell it. After a drug's patent has expired, generic versions of the same compound will often be introduced to the market to compete with the original branded version. There can be many generic equivalents of a brand medication. For widely used products, generic manufacturers may introduce a number of generic medications into the market, and their prices will likely vary by manufacturer.

Reimbursement for generic drugs is based on either of two pricing methods:

1) **Discounted average wholesale prices** (the "average average wholesale price" or AAWP). These benchmark prices, set by averaging across the spectrum of chemically equivalent compounds available in generic form, are published for many generic medications. This average includes both brand-name and generic drugs.

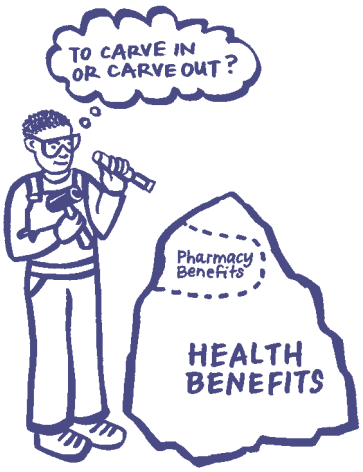
2) **Maximum allowable cost (MAC) pricing.** MAC prices are a schedule of pricing for generically equivalent drugs.

The federal government originally introduced the concept of MAC pricing for generic medications in the Medicaid program as a mechanism to lower costs. The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) still maintain the CMS MAC list and continue to use it to set Medicaid generic reimbursement levels. Several PBMs have developed their proprietary MAC based on the CMS MAC. In comparison to current PBM MAC lists, the CMS MAC sets a ceiling price for relatively few generic products, is not updated frequently, and sets relatively high prices.

Because the generic marketplace is dynamic, MAC pricing can be somewhat difficult to compare. Although the methodology used to determine the MAC price varies from PBM to PBM, the effect is to set a reasonable price limit on the unit cost of a particular generic drug. The PBM reimburses the retail pharmacy no more than the MAC price, regardless of which manufacturer's product or package size the pharmacy dispensed. This encourages the pharmacy to exercise prudence in their choice of generic products. If they dispense a generic product that is more expensive relative to competing products, they may not make a profit on that sale.

Each PBM maintains its own proprietary MAC list, and their MAC price lists vary in the number of generic products included on the list and the *maximum price for generic products in relation to the average wholesale price (AWP).* The composition of the MAC list changes over time as more generic products are introduced. The financial impact of these variations over time and between PBMs can be significant. Furthermore, several PBMs have more than one MAC list, which can result in more or less savings to the plan sponsor. To further complicate matters, the financial impact of a particular MAC list will vary from plan sponsor to plan sponsor because of the impact of such factors as demographics and plan design.

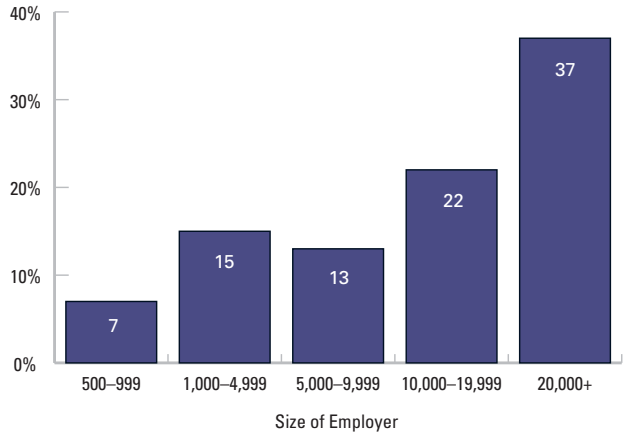
III. To Carve-in or Carve-out?



IN ADDITION TO DECIDING WHETHER TO INSURE or self-insure, employers must decide whether the pharmacy benefit will be administered by a health plan or by a PBM. Some plan sponsors choose to separate, or "carve-out," pharmacy benefits from medical benefits provided by a health plan. These plan sponsors contract separately, typically with an outside PBM, to administer or manage the pharmacy benefit. Other plan sponsors choose to leave pharmacy benefits with the health plan, or "carve-in."

Larger plan sponsors are more likely to carve-out the pharmacy benefit. According to a national survey, 37 percent of employers with more than 20,000 employees carved-out the pharmacy benefit in 2000, compared to 15 percent or less for those with less than 5,000 employees (see Figure 1). Carved-out contracts are predominantly self-insured by the plan sponsor.

Figure 1. Percent of Employers Who Carved-Out Pharmacy Benefits: 2001



Source: Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2001.

Plan sponsors that carve-out pharmacy benefits usually select a single PBM to manage the prescription drug program and negotiate with that PBM for discounted prices, dispensing fees, administration and management costs, and minimum formulary rebate earnings. These plan sponsors usually have a better opportunity than those that carve-in to monitor prescription drug expenditures.

In a carved-in arrangement, the health plan manages and administers the pharmacy benefit. While most carved-in arrangements tend to be insured by the health plan, there are some plan sponsors (usually the large ones) that have self-insured arrangements with their health plans. In fully insured carved-in arrangements, the employer can sometimes negotiate an overall medical and prescription drug premium with the plan. Many health plans use PBM services selectively to manage certain portions of the pharmacy benefit, such as mail-order services. These financial provisions are usually not disclosed, so a plan sponsor that is interested in knowing about such provisions should ask its health plan about the use of outside entities.

PBMs vs. Health Plans

Both PBMs and health plans leverage the size of their respective business to negotiate rates with retail pharmacies. PBMs tend to leverage their national scope, and sometimes their regional presence, to secure competitive discount and dispensing fee arrangements. Health plans tend to leverage geographic concentrations of plan participants to secure aggressive discounts and dispensing fee agreements with retail pharmacies.

A potentially significant advantage of purchasing pharmacy benefit coverage through a health plan is that medical and pharmacy claims can be integrated, facilitating health care management. By combining information derived from both sources, plans can identify at-risk patients and set up potentially cost-saving disease and health management programs. In practice, however, the level of integrated care taking place in health plans varies significantly. And in some instances, pharmacy costs can be difficult to isolate and control when medical and pharmacy coverage are integrated.

One of the primary disadvantages of using a health plan for pharmacy benefit management services occurs when pharmacy and medical premium rates are combined, thus leaving the plan sponsor with no ability to negotiate prescription drug premium rates. However, if the prescription benefit arrangement is self-insured, a plan sponsor can directly negotiate financial terms such as discounted prices, dispensing fees, and rebates with the health plan. On the other hand, the health plan's flexibility in altering these financial terms is usually limited.

PBMs typically provide greater flexibility in terms of size and composition of the pharmacy network than do health plans. The competitiveness of a PBM's discounts can depend on the pharmacy network access arrangement that the plan sponsor selects. Most PBMs offer more than one pharmacy network to plan sponsors, usually including a restricted network option with more aggressive discounts and lower dispensing fees.

The largest PBMs own more than one mail-order facility. By handling a high volume of claims through these facilities, PBMs can secure more aggressive discounts from wholesalers and manufacturers than most retail pharmacy chains can. Plan sponsors with a high level of mail-order utilization can usually negotiate more competitive mail-order discounts with PBMs. Some health plans own mail-order facilities and can also leverage claims volume to secure competitive discounts on certain drugs, but many health plans outsource mail-order pharmacy to selected PBMs. The advantages and drawbacks of PBMs and health plans are summarized in Table 2.

Table 2. PBMs vs. Health Plans: The Pros and Cons

PBMs	Health Plans
Main Advantages	
• Regularly provide a full range of formulary options. • More likely to offer guarantees on discounts and financial and service performance. • Offer a greater degree of choice in size and make-up of pharmacy network. • Allow for plan design and utilization management customization. • Tend to provide more detailed, flexible reporting.	• Typically accept risk. • Offer the potential for integration of health care through clinical tie-in to medical data. • May provide for more aggressive financial terms leveraged by health plan's business, particularly for smaller plan sponsors.
Potential Drawbacks	
• Accept limited risk. • May offer complex and difficult to understand financial arrangements. • May seem unwilling to disclose key information about pharmaceutical agreements. • May have conflicting motivations caused by manufacturer agreements.	• Do not always separate pharmacy and medical cost data, making it difficult to isolate and control pharmacy costs. • Tend to provide less detailed reporting, leading to uncertainty about financial terms supporting premium rates. • Have limited flexibility to negotiate premium rates and modify pharmacy benefit. • Don't usually offer guarantees on financial terms and service or performance. • Provide a limited range of formulary options; usually have an established formulary that may be restricted or closed.

IV. Retail Pharmacy Network Pricing

THE PRICE THAT PLAN MEMBERS PAY FOR prescription drugs at a retail pharmacy is a primary function of the contractual relationships between (1) the PBM/health plan and the retail pharmacy, and (2) the PBM/health plan and the plan sponsor.

Contracts between the PBM/Health Plan and the Retail Pharmacy

PBMs and health plans negotiate with retail pharmacy chain stores as well as independent retail pharmacies to agree upon pricing for retail prescriptions. The resulting contract specifies the following:

1. ***A formula for the cost of the drug charge to the PBM.*** This is done by means of:
   - Discounts on brand-name medications set as a percentage of the average wholesale price (AWP) for each drug, published in FirstData Bank and its supplements or other nationally recognized pricing sources.
   - Discounts on generic medications, based on a MAC pricing schedule.
2. ***The dispensing fee*** (paid to the pharmacist for each prescription). Since generic medications are typically much less costly than brand medications, the PBM may attempt to negotiate terms to encourage the pharmacist to dispense generic drugs, such as setting a higher fee for generic prescriptions than for brand prescriptions, or offering a modest base dispensing fee in conjunction with a periodic bonus for pharmacies that achieve a certain level of generic dispensing. These strategies can lead to cost savings for the plan sponsor.

PBMs often develop more than one pharmacy network. The difference between networks is usually the number of pharmacies in the network and the discounts they offer. Some retail pharmacies are willing to offer deeper discounts on brand and generic medications and lower dispensing fees in exchange for the promise of greater volume of customers resulting from a smaller, more exclusive network.

Contracts between the PBM/Health Plan and the Plan Sponsor

The contractual relationships between the PBM/health plan and retail pharmacies form the foundation for the retail pricing offered to plan sponsors. The pricing arrangement negotiated between the plan sponsor and the PBM/health plan specifies a reimbursement formula that is used as the basis for each retail prescription drug purchase. A typical reimbursement formula looks like this:

PLAN SPONSOR PRICE = DISCOUNTED AWP (OR MAC PRICE) + DISPENSING FEE + TAX (IF APPLICABLE) − MEMBER COPAYMENT

The pricing elements that most significantly influence this formula are (1) brand-name drug reimbursement, (2) generic drug reimbursement, and (3) usual and customary retail pricing.

Brand-name drug reimbursement. AWP prices — the most commonly referenced pricing method for brand medications in the pharmaceutical community — change on a periodic basis. PBMs reimburse plan sponsors for brand-name drugs using either of the following methods:

- **A discount off the AWP.** The PBM guarantees a certain percentage discount, although for some prescriptions and pharmacies the discount may be greater.
- **An AWP discount range.** The PBM charges the plan sponsor at the rate it has contracted with each individual or chain pharmacy, which can vary. In some cases, even though the reimbursement rate varies by pharmacy, the PBM will guarantee the plan sponsor a minimum discount rate computed on an annual basis across all pharmacies.

Generic drug reimbursement. Reimbursement for generic medications is based on either of two pricing methods for any given drug: (1) a discounted AWP (as with brand products) or (2) MAC pricing. Accurately comparing the value of one MAC list against another is a complex process. However, most commercial MAC pricing lists usually result in more advantageous pricing to the plan sponsor than the MAC list maintained by the Centers for Medicare and Medicaid Services.

Usual and customary retail (UCR) pricing. This is generally the "everyday counter price" paid by cash-paying customers. When the UCR price is higher than the contracted price, the PBM pays only the contracted price. When the UCR price is lower than the contracted price, the PBM pays the UCR price. The UCR price is lower than the contracted rate when retail pharmacies offer special pricing on certain brand and generic medications, perhaps as a means of attracting business to the pharmacy.

In cases where the lowest price at the retail pharmacy is the UCR price, PBMs may pass the savings along to the plan sponsor, depending on the contractual arrangement. Two financial arrangements are possible:

1. The PBM may not include UCR pricing as part of the formula used to determine the price charged to the plan member and plan sponsor.
2. The PBM charges the plan sponsor whichever is lower, the UCR price or the discounted AWP (or MAC if it is a generic medication).

Note that the financial impact of UCR pricing on overall drug expenditures decreases as the contracted AWP discount increases and the dispensing fee decreases. This is illustrated in Table 3.

Table 3. The Financial Impact of UCR Pricing on Overall Drug Expenditures

AWP	Contracted AWP Discount %	Contracted Dispensing Fee	Contracted Price	UCR Price	UCR Savings over Contracted Rate
$100	13%	$2.50	$89.50	$88.00	$1.50 (1.7%)
$100	15%	$2.00	$87.00	$88.00	No savings

At the Pharmacy Counter

The PBM discount price arrangements take effect at the pharmacy counter when the members present their ID card along with the prescription they wish to fill. The pharmacist is able to contact the PBM online and determine how the claim is to be adjudicated. This enables the pharmacist to determine whether the prescription is covered by the plan, whether there are any requirements that must be satisfied before dispensing, and, most importantly, what portion of the cost the member should pay. On those occasions when a member does not present an ID card or is not already in the pharmacy system, he or she will not receive the negotiated discounted price, and may have to pay the AWP plus an additional markup. The member must then submit a claim form to the PBM to obtain reimbursement. PBMs often charge an additional premium to process paper claim forms, so plan sponsors should educate members on the importance of presenting the ID card at a network pharmacy.

Zero Balance Billing

PBMs vary in how they determine member copayment amounts. For inexpensive products, sometimes the entire cost of the prescription can be less than the required member copayment. Under some PBM arrangements, plan sponsors incorrectly assume the pharmacy will not charge the member a full copayment when it is more than the cost of the prescription. However, some PBMs' network pharmacy contracts allow the pharmacy to collect member co-pays that are in excess of the contracted price. The pharmacy keeps the excess payment. PBMs may use this practice to negotiate better discount rates with network pharmacies.

This practice, known as "zero balance billing" (ZBB) or "zero balance pricing" (ZBP), results in additional revenue to the pharmacy because the members pay more than the cost of some prescriptions. Table 4 illustrates the impact of this pricing practice.

Table 4. The Impact of Zero Balance Billing on Member, Pharmacist, and Sponsor

	Retail Price Less Than Plan Co-pay
Contracted Price	$9.00
UCR Price	$12.00
Member Co-pay	$10.00
Amount Member Pays	
No Zero Balance Billing	$9.00
Zero Balance Billing	$10.00
Additional Member Co-pay to Pharmacist under Zero Balance Billing	$1.00
Plan Sponsor Pays	$0.00

As member co-pays increase, the amount of the "additional co-pay collected" will grow, and a greater percentage of drugs will be affected by zero balance pricing, thereby increasing the competitive advantage of those pharmacies using this practice.

The ZBB practice is not always clearly disclosed. However, the PBM providers for some large pharmacy chains appear to insist that ZBB be included in their network contracts.

Reporting

To verify that all aspects of plan pricing are administered according to the contract, plan sponsors should require their PBMs to provide regular periodic reports with sufficient detail to confirm that discounts and fees consistently meet expectations and negotiated arrangements. To date, the information provided by health plans has not been as detailed as that provided by PBMs. One of the reasons for this difference is that health plans often combine information on prescription drug spending and savings into a single report of overall medical costs and savings, making it almost impossible for a plan sponsor to identify items particular to the pharmacy benefit plan.

Key Questions to Ask About Retail Network Pricing

1. Is the reimbursement arrangement guaranteed for the length of the contract? What is the amount at risk if this guarantee is not met?
2. Will every prescription be adjudicated at this rate? If not, how is the reconciliation done?
3. Is there more than one MAC pricing option available? If yes, what pricing is associated with each option?
4. What is the effective discount associated with MAC pricing? Is this guaranteed?
5. If the member's copayment is greater than the actual cost of the prescription drug as determined by the reimbursement formula, what will the plan member be charged?
6. Can the financial terms of the reimbursement agreement be verified from the cost and utilization data provided on standard reports?
7. Are any drugs subject to different pricing (e.g., specialty or biotech drugs such as Betaseron, Avonex)?

V. Mail-Order Pricing

MOST MAJOR PBMS AND SOME HEALTH PLANS own and operate one or more mail-order facilities. Smaller PBMs and many health plans subcontract with a mail-order provider. Mail-order purchasing can be financially advantageous to the plan sponsor for several reasons:

- Mail-order facilities can purchase large volumes directly from manufacturers or wholesalers, thus reducing per-unit costs.
- Mail-order facilities can manage more effectively what members purchase to generate additional price breaks from manufacturers in the form of rebates.
- Automation and higher volume make the cost of filling prescriptions lower at the mail-order pharmacy.
- The administrative and dispensing fees are often lower at mail-order pharmacies.
- Greater days' supply limit (e.g., 90 days at mail-order vs. 30 days at retail) allows lower overhead cost per unit dispensed.

Pricing is typically expressed as AWP less a discounted percent for both brand and generic medications. Occasionally, PBMs offer MAC pricing on mail-order generic purchases, but MAC pricing at mail order does not generally convey a significant financial advantage over non-MAC generic pricing. The plan sponsor's reimbursement formula for a mail-order transaction is:

PLAN SPONSOR PRICE = DISCOUNTED AWP (OR MAC PRICE) + DISPENSING FEE + TAX (IF APPLICABLE) − MEMBER COPAYMENT

While this formula is identical to the retail pharmacy formula, the ultimate mail order price will also reflect elements unique to mail order:

Postal expenses. Mail order has the added expense of shipping costs, which are included in the dispensing fee or treated as an additional charge. When the shipping cost is included in the dispensing fees, there may be some contingency for increasing the cost when postal rates increase. Some PBMs provide postage-paid return envelopes to plan members.

Package size. PBMs typically save more money through mail order purchasing, and will often pass along some if not all of the entire benefit to the plan sponsor and members. The advantageous pricing is the result of buying large quantities of certain medications. The PBM often buys medications at a lower price per unit, but may charge the plan sponsor the higher unit cost. Similarly, for large volume liquid medications, the PBM may charge the plan sponsor on the basis of pint-sized packages, keeping the differential in price as profit.

In evaluating mail-order reimbursement formulas, an assessment of pricing proposals should include whether the PBM bases charges on costs for smaller package sizes or whether they pass on the savings from bulk purchases to the plan sponsor. As Table 5 illustrates, the price difference can be substantial.

Table 5. Price Differential between Sample Medications Supplied in Larger Quantities vs. Smaller Quantities

	100 TABLETS	
	Prinivil, 20 mg	Vasotec, 10 mg
Prescription Cost Using		
100-Tablet Package	$112.80	$123.85
10,000-Tablet Package	$110.57	$119.12
Price Differential for 100 Tablets	$2.23	$4.73
% Price Differential	2%	4%

Specialty drugs. Certain pharmaceuticals, such as injectable biotechnology medications (e.g., interferons), require special handling or may be too costly for retail pharmacies to keep on hand. These types of drugs are frequently available only from a mail order facility or a specialty drug distributor. Such medications may be sold at different discount levels than discount levels from those of other medications and may incur associated handling fees. Additionally, AWP pricing for these types of medications can vary from one PBM or health plan to another.

Even though these pharmaceuticals are small in number, they include relatively expensive pharmaceutical therapies, some of which cost upwards of $1,000 per dose. Plan sponsors need to explicitly inquire about the pricing of specialty drugs.

Zero balance billing. Some PBMs/health plans practice ZBB at mail order, collecting the full co-pay even when it is more than the cost of the prescription. Presumably, they then build these extra co-pays into their pricing model to offer sponsors a better financial arrangement. This practice is often justified to plan sponsors as a way to simplify the co-pay collection process.

Reporting

Periodic financial reports should show sufficient detail to confirm that discounts and fees consistently meet expectations. Plan sponsors should verify the contractual terms of plan pricing, and, as an added measure, consider performing an audit to determine whether contractual agreements are being upheld.

Key Questions to Ask About Mail Order Pricing

1. Is the reimbursement arrangement guaranteed for the length of the contract? What is the amount at risk if this guarantee is not met?
2. Is mail-order pricing based on the actual dispensed size or a fixed package size, such as 100s or pints?
3. Is MAC pricing used at mail order? What is the effective discount associated with this MAC pricing and is it guaranteed?
4. Are any drugs subject to different pricing (e.g., specialty or biotech drugs such as Betaseron, Avonex)?
5. Are dispensing fees subject to any increases (e.g., for postage increases)?

VI. The Ins and Outs of Rebates

THE MAJORITY OF PBMS AND HEALTH PLANS THAT provide pharmacy benefit services have contractual relationships with pharmaceutical manufacturers. Under these contracts, the PBM or health plan receives rebates — payments from manufacturers based on sales or market share targets for the manufacturers' drugs. Rebates provide a financial incentive for pharmacy benefit providers to include certain products in their formulary lists and to educate physicians and patients about these products.

PBMs and health plans may share some portion of rebate earnings with plan sponsors, but actual earnings are not always clearly disclosed. Usually, the rebate amounts of dollars that a plan sponsor receives from its PBM depends on factors such as drug utilization, formulary composition and management, plan design elements, and negotiated guarantees. Health plans generally do not share rebates directly with fully insured plan sponsors, but they may do so indirectly through reduced premium costs.

Formulary Composition and Management

A formulary is a list of preferred prescription drugs, selected on the basis of quality and cost by a PBM or health plan to encourage use of appropriate, cost-effective medications. Physicians may use the formulary when making decisions about what medication to prescribe to a plan member. Rebates vary depending on the type of formulary in place and the formulary management techniques utilized.

Most PBMs and some health plans offer more than one formulary for plan sponsors to choose from, with some formularies being more restrictive than others. A restrictive formulary is believed to result in greater cost savings. It may, however, have drawbacks such as member dissatisfaction due to coverage limitations or higher co-pays for a larger number of drugs.

In some cases, plan sponsors can customize their formularies to a certain extent. While a plan sponsor might then be able to benefit from designating an expensive new drug as non-formulary, or from encouraging members to move to a less expensive generic drug when a brand-name drug comes off patent, changes to the formulary might have a negative impact on rebates and other financial elements.

Formulary Intervention Programs

To encourage formulary compliance, PBMs and health plans may initiate various formulary management interventions, such as pharmacy point-of-sale messages, education targeted to patients and physicians, and therapeutic interchange programs that encourage physicians to substitute a formulary drug for a non-formulary drug. A plan sponsor's participation in these programs may increase rebate payments and lead to additional cost savings when a less expensive medication is selected.

When deciding whether to participate in a therapeutic interchange program, the plan sponsor should:

- Understand how guarantees work. Some PBMs are willing to guarantee that therapeutic interchanges will result in overall cost savings; others guarantee that each individual product interchange will result in cost savings.
- Probe if a PBM or health plan is unwilling to disclose the rationale behind specific formulary interchanges and how savings are achieved, or if the PBM or health plan is unwilling to provide a savings guarantee.
- Inquire about what is done when a drug interchange results in a higher-priced drug and how this charge may affect your rebates and overall costs. (The impact is not always negative. Even when the interchange substitutes a more expensive drug, the substituted drug may be more cost-effective after rebate.)
- Assess the implications if you decide not to implement the formulary interchange programs. The decision not to participate in these programs can affect rebate guarantees. By and large, plan sponsors receive a greater share of formulary rebate earnings if they allow more intensive intervention efforts, including targeted communications to patients and physicians.

Negotiating Rebate Guarantees

Since PBMs vary the amounts of the rebate payments they are willing to share with plan sponsors, a plan sponsor can benefit from negotiating financial guarantees for a minimum dollar amount or percent of rebates.

Comparing minimum rebate guarantees proposed by different PBMs can be confusing. Some PBMs guarantee a certain dollar amount for all processed claims, including both brand and generic drugs. Others guarantee a specific dollar amount only for each formulary brand claim processed or for each "rebatable" claim (drugs for which the manufacturer actually pays a rebate). When negotiating rebate guarantees expressed in an amount per "claim," determine whether the rebate is paid per:

- claim (all drugs),
- brand claim (all brand drugs),
- formulary brand claim (all brand drugs listed on the formulary), or
- rebatable claim (all drugs for which a rebate is earned).

The rebate payment basis affects the calculation of the total rebate earnings, as shown in Table 6 on the following page.

Instead of, or in addition to, guaranteed minimum amounts, some PBMs will guarantee a percent share of rebate payments. In this case, a formulary management fee is often embedded in the percentage of rebates retained by the PBM. Even when comparing percent formulary brand guarantees, it is necessary to evaluate the percent of brand drugs that are on the formulary to get a meaningful comparison. When a PBM quotes both a guaranteed rebate dollar amount and a percent of the actual rebates earned, the plan sponsor should receive the greater of the two.

Table 6. Comparison of Proposed Minimum Rebate Guarantees*

REBATE BASIS	ANNUAL REBATE EARNINGS Retail	Mail Order	Total
Per All Rx (generic & brand)	$1	$3	
	× 8,000	× 2,000	
	$8,000	$6,000	$14,000
Per Brand Rx	$1	$3	
	× 8,000	× 2,000	
	× .60	× .60	
	$4,800	$3,600	$8,400
Per Formulary Brand Rx	× .85	× .85	
	$4,080	$3,060	$7,140
Per Rebatable Rx	$1	$3	
	× 8,000	× 2,000	
	× .40	× .40	
	$3,200	$2,400	$5,600

*Assumptions: 1) Number of Annual Prescriptions: 10,000 (8,000 retail and 2,000 mail order); 2) 60% of all drugs are brand (of which 85% are on formulary); 3) 40% of all drugs are rebatable.

Plan sponsors can use these two strategies to increase the guaranteed rebate amount:

- ***Leverage tier plans.*** Manufacturers typically provide PBMs and health plans with increased payments for formulary designs that include incentives for members to utilize drugs on preferred lists. Plan sponsors can leverage their tier plans and potentially increase the amount of rebate they receive by moving to a three-tier plan. Most PBMs and health plans will recommend a certain copayment differential between the formulary brand drug and nonformulary brand drug to guarantee higher rebate amounts. In general, the recommended differential between the preferred brand and nonpreferred brand tiers is $15.
- ***Take advantage of mail order.*** Plan sponsors may also be able to increase rebate earnings through increased use of mail order. Because of a combination of larger fills at mail order and a greater ability to influence physician prescribing and formulary compliance, PBMs can usually command greater rebate dollars from the manufacturers. Plan sponsors who are able to increase mail-order utilization among their members may be able to take advantage of these higher rebates, as a greater number of prescriptions are filled with medications on formulary.

Reporting

Plan sponsors should require their PBMs to provide regular reports on rebate earnings. While PBMs do not typically disclose to plan sponsors the total value of their rebate earnings from particular pharmaceutical manufacturers, some are willing to provide fairly detailed information. Plan sponsors should request information regarding specific rebate payments by manufacturer and, if the PBM is willing, by drug. The more detailed the information, the easier it will be for a plan sponsor to calculate the actual impact of the rebate on the pharmacy benefit.

Plan sponsors can also require periodic reports on a number of other measurements of services provided from their PBMs or health plans. The PBM or health plan should be able to demonstrate the formulary's cost-effectiveness and clinical appropriateness. A pharmacy benefit provider should be willing to disclose both the clinical and cost rationale behind the drugs selected to be on the formulary.

If participating in a therapeutic interchange program, a plan sponsor can request periodic reports that effectively demonstrate program savings. Some PBMs guarantee "rebate" savings that are actually a combination of formulary rebates and ingredient cost savings achieved from the drug interchanges. In these cases, a plan sponsor should request detailed reporting and disclosure of savings elements, and consider modifying the guarantee to more clearly define the separate sources of savings and measurements.

Finally, plan sponsors should clarify how often they will receive rebate payments. The timing of payments can vary greatly from one PBM to another: Some pay once per year, while others pay semiannually or quarterly. Usually, there is a lag time associated with rebate payments. Pharmaceutical manufacturers use this period to reconcile rebate payments with PBMs. This lag time can be as long as 180 days after the end of the respective rebate reporting period.

Key Questions to Ask About Formularies and Drug Rebates

1. Will formulary rebates be paid to the plan sponsor? If yes, what percent is paid to the plan sponsor and what percent is retained by the PBM?
2. Are there any guarantees on the amount of formulary rebates to be paid? What will be the terms of the guarantee?
3. Are greater rebate levels available under certain plan designs such as a three-tier co-pay? If yes, how do the co-pays need to be structured in order to qualify for the higher rebates?
4. How frequently will rebates be paid?
5. What cost savings can be expected from therapeutic interchange programs? Are these cost savings guaranteed?

VII. Administrative Costs and Fees

"ADMINISTRATIVE FEES" — IMPOSED BY PBMS AND health plans for a wide range of services and ancillary activities — can become a catchall phrase for unidentified charges. This phrasing leaves plan sponsors uncertain about what the money is being used for, and is often a source of confusion for them.

In general, administrative fees cover the cost of processing claims (including electronic, paper, out-of-network, and mail-order claims) and managing the account. In addition, PBMs may charge for such services as drug utilization review (DUR) programs, physician and pharmacist profiling, data reporting (standard, customer/ad hoc, online access), customer service, participant communication materials, ID cards, and coordination of benefits (COB).

Claims Processing

Many plan sponsors assume that there is a single charge for all claims processed, regardless of how the claim comes in or how many claims are handled. In fact, PBMs often charge different fees depending on whether a claim is received electronically or on paper, or whether the claim is from a prescription filled at a retail or mail-order pharmacy. In addition, some PBMs charge fees for paid claims only, while others charge for both paid and denied claims.

Whether a plan sponsor is looking for a new PBM or reviewing the performance of a current one, it pays to understand how the PBM charges for claims in order to make a meaningful comparison. Suppose, for instance, that two PBMs both charge $0.75 per "claim." It might be assumed that their total claims processing fees would be equal. However, if the first PBM charges for both paid and denied claims, and the other for paid claims only, total claims fees would differ (see Table 7).

Table 7. Total Claims Processing Fees Differ Depending on How PBMs Charge for Claims

NUMBER OF		PROCESSING FEES: PBM 1 (all claims)	PROCESSING FEES: PBM 2 (paid claims only)
Total Claims	10,000 × $0.75 =	$7,500	
Denied Claims (assuming 7%)	− 700		
Paid Claims	9,300 × $0.75 =		$6,975

To complicate matters, some PBMs have recently begun to use new terminology to discuss claims processing fees. In addition to the more standard "paid" and "paid and denied," new terms such as "paid, denied, and reversed" have made their way into PBM offerings. While these may be similar or equivalent to denied claims, they certainly add to confusion and could result in additional fees.

ID Cards and Member Communications

When introducing a new or changed benefit, plan sponsors often desire to provide their members with customized information and updated benefit ID cards. Some PBMs and health plans may not be able to provide customized ID cards at all; others may charge additional fees for these services. Plan sponsors are encouraged to question potential PBMs and health plans to determine whether they can provide such services, and if so what the costs will be. Even if the services are provided at no charge, it is important to find out whether such services are ongoing or if, for example, there is a charge associated with replacement ID cards or reprints of member information packets.

What Is — and Isn't — Part of the Basic Package?

Depending on such factors as plan design, the size of the account, the inclusion of additional services, and competitive circumstances, base administrative costs can range from nothing to more than several dollars per member per month. A health plan's administrative charges may be included within the overall medical administrative services (ASO) fee.

However, base administrative fees may not cover everything. Items such as monthly reports and coordination of benefits (COB) are part of a basic administrative services package, but PBMs often treat them as additional services, and charge accordingly. Table 8 enumerates some services for which a PBM may charge an additional fee. Plan sponsors should request that prospective PBMs itemize which services are — and are not — included in their basic fee.

Table 8. Typical Services for Which a PBM May Charge Additional Fees

- Online claims analysis tool
- Setup and loading of historical claims
- Hard copy eligibility submission
- Optional explanation of benefits (EOB) — explanation of why a claim was denied and member options surrounding this claim
- COB
- Medicaid subrogation
- Medicare coordination
- Ad hoc programming and reports
- Printing of customized and/or additional formulary booklets
- Personalized client Internet site
- Health and demand management programs
- Administrative functions related to integration with medical plan
- Appeals process
- Physician profiling (interventions)
- Prior authorization options
- Retrospective and enhanced drug utilization review options
- Plan design changes
- Implementation start-up
- Special audits or data requests

Health plans often charge higher per-prescription fees for basic administrative services than do PBMs. At the same time, health plans may offer limited ancillary services focused on pharmacy, such as online claims analysis tools and customized member communications. It is not always easy to discern the costs associated with a health plan's administrative services because under insured arrangements they are usually bundled with medical fees. Finally, while most of the larger PBMs offer financial guarantees that they will meet set administrative performance measurements, it is rare for a health plan to agree to guaranteed fees beyond one year.

Key Questions to Ask About Administrative Costs and Fees

1. On what basis (e.g., per paid claim, per paid and denied claim) is the administrative fee applicable?
2. Are the administrative fees guaranteed for the duration of the contractual agreement?
3. Are administrative fees paid on retail claims? On mail order claims?
4. Do administrative fees differ depending on plan design (two-tier vs. three-tier)?
5. What services does the administrative fee cover? What services are not covered in the administrative fee and require an additional charge?
6. Are customized ID cards available? If so, what are the costs?

VIII. Clinical Services and Pricing

As pricing for new business has become more competitive, PBMs have looked for other ways to distinguish themselves and earn revenue. Clinical programs have been a means by which PBMs attempt to distinguish their value. Plan sponsors typically try to choose the most suitable programs for their specific populations, making sure that the price paid and any accompanying savings guarantees are in line with expectations, and insisting that the information supplied in program reports be useful in evaluating the program.

What's Basic, What's Enhanced?

While PBMs endeavor to promote a variety of clinical program offerings, not all programs come free of charge. Plan sponsors should always ask which clinical programs are included in the base administrative fee and which will incur an additional charge. The same program that one PBM refers to as standard may be provided by another PBM at an additional charge. To effectively compare all programs, it helps to review the specifics of the various PBMs' or health plans' clinical programs side-by-side.

Almost every PBM has more enhanced, or value-added, programs in addition to its basic offerings. Most PBMs, for example, provide, as part of their basic package, concurrent drug utilization review (DUR) (online programs that track prescription utilization and alert pharmacists to potentially harmful drug interactions at the point of sale) as well as retrospective DUR.

Some PBMs also offer enhanced DUR programs. Exactly what "enhanced" means varies among the PBMs, but basically involves further intervention on the part of the PBM beyond the electronic messaging that pharmacists receive at the point of sale. There may be follow-up phone calls or faxes by a clinical pharmacist or other trained clinician to the prescribing physician or the member. Some PBMs provide other types of enhanced programs that attempt to inform physicians about prescribing alternatives. These programs may use targeted face-to-face physician interventions, often called academic detailing, whereby qualified clinicians supply useful information to doctors on issues such as formulary adherence and generic drug utilization. These enhanced programs are typically offered at an additional cost to the plan sponsor.

Can Clinical Programs Be Customized?

To make certain that clinical programs being offered are actually relevant to a plan sponsor's population, the PBM should be requested to complete an analysis of the plan sponsor's claims. The PBM should be willing to identify the unique needs of a plan sponsor and present individualized clinical solutions. Some PBMs do not provide as much flexibility as others do in customizing their clinical savings programs.

How Savings Guarantees Work

Savings guarantees for clinical programs such as concurrent and retrospective DUR and disease management are an important aspect in negotiations. While many PBMs promise savings at some level, it is not always immediately clear how those savings are defined, how they will be measured, whether or not the savings will be shared with the plan sponsor, and if the savings can be effectively reported.

Plan sponsors will realize different savings depending on which of the following methods the PBM employs:

- Minimum percent savings.
- Minimum dollar savings.
- Defined cost-to-savings dollar ratios.
- Shared savings.
- Hybrids of minimum guaranteed savings and shared savings above the minimum guarantee.

Table 9 shows that for a plan sponsor with 500 employees, approximately 10,000 prescriptions per year, and drug costs of $500,000, the amount of savings will vary considerably depending on both the savings level achieved and the type of savings guarantee in place.

While PBMs rightfully try to recoup the costs they incur to provide clinical programs, plan sponsors should expect some type of savings guarantee for the cost of purchasing optional clinical programs. To determine whether the value of a clinical program is commensurate with the amount of savings retained by the PBM, a plan sponsor should clarify how savings are measured and insist that program measurement be well defined and the reporting clear. Savings can be measured as:

- A certain percentage of net plan cost,
- A specific percentage above the cost of the particular program, or
- An average savings per month, per quarter, or per year.

Table 9. Different Types of Guarantees Produce Different Savings

	ACTUAL SAVINGS LEVEL ACHIEVED ON $500,000 RX SPENDING					
	1.5% | $7,500		2.0% | $10,000		2.5% | $12,500	
SAVINGS GUARANTEE	Plan Sponsor	PBM	Plan Sponsor	PBM	Plan Sponsor	PBM
2% Savings	$10,000	$(2,500)	$10,000	$ —	$10,000	$2,500
Per Rx Cost $0.50/PMPM $1.00 Savings	4,500	3,000	5,000	5,000	5,000	7,500
50/50 Savings Split	3,750	3,750	5,000	5,000	6,250	6,250
2% Savings; 50/50 Split on Excess	10,000	(2,500)	10,000	—	11,250	1,250

Reporting

Program reports that provide data summarizing key measurements and are easy to understand can be of great value to a plan sponsor in evaluating a program's utilization and effectiveness. When evaluating potential PBMs, a plan sponsor should request sample copies of the reports each PBM will provide for each type of clinical program.

Many PBMs now provide plan sponsors with both written and electronic versions of reports. Some also make online reporting tools available and supply desktop access to various report formats. This service allows plan sponsors to make additional queries, run reports specific to their information needs, develop charts and tables, and, in some instances, "drill down" for more detailed information. Here are a few examples of reports that are typically available:

- Utilization detail by:
  - brand/generic
  - retail/mail order
  - formulary/nonformulary
- Top therapeutic classes/drugs by:
  - cost
  - volume
- Top drugs by:
  - cost
  - volume

Ask prospective PBMs for samples of all standard written and electronic reports available and a list of data elements available for ad hoc reports—and clarify the cost of these additional information tools. Request a demonstration of the PBM's online reporting capabilities to ascertain the level of flexibility and information availability.

Manufacturer and Pharmacist Involvement

Pharmaceutical manufacturers and/or retail pharmacists sometimes participate financially in clinical programs. It is worthwhile to find out the level of involvement of these groups in any clinical management programs.

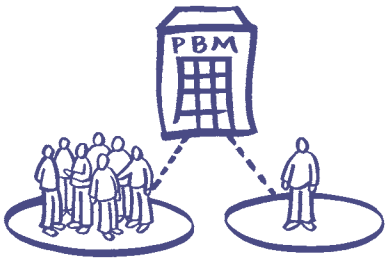
Manufacturers sometimes finance specific disease or health management programs offered by PBMs, particularly if they revolve around a class of drugs that includes products produced by the manufacturer. While this will often allow the PBM to offer the program at little or no cost to its customers, such involvement could, depending on a plan sponsor's view, call for additional discussion with the PBM.

Similarly, retail pharmacists are sometimes offered financial incentives for participation in clinical programs by both PBMs and manufacturers. While this may not change the overall goal of a particular program, such as increasing the number of cholesterol screenings, it could influence the number of people who become involved in a particular health management program and the level of patient intervention that takes place. Depending on the plan sponsor's point of view, programs that encourage pharmacists to be more influential may or may not be seen as valuable.

Key Questions to Ask About Clinical Services Pricing

1. What clinical services are being offered? Out of the list of services, what specific services are included in the base administrative service fee and what services require an additional fee?
2. What are the expected savings from each of the clinical programs being provided? What savings are guaranteed?
3. If savings guarantees are offered, describe the methodology for how savings will be measured. What amount at risk will be paid if the guarantee is not met?
4. For what disease/medical conditions does the PBM offer programs? What services are provided through these disease and health management programs? What cost impact, if any, is expected from these programs? Are any of these programs financed by pharmaceutical manufacturers?
5. Can the PBM customize pharmacy management? What is the charge, if any, for clinical program customization? How will these modifications impact the expected or guaranteed cost savings?

IX. Collective vs. Individual Purchasing



A GROUP OF PLAN SPONSORS MAY JOIN FORCES to leverage greater bargaining power and gain the benefits of economies of scale. PBMs often respond by offering aggressive financial terms such as deeper discounts, particularly at mail order, and more competitive administrative fees and rebates. PBMs may also be willing to place greater dollar amounts at risk for service performance guarantees. However, as coalitions become more prevalent and PBMs work to prevent erosion of existing business, it is likely that pricing will become more conservative.

A collective purchasing group's economies of scale may also enable it to obtain enhanced or dedicated customer service, greater account service resources, improved service standards, and expanded clinical management opportunities. An individual plan sponsor may also obtain such enhanced services, depending on its willingness or ability to pay for them.

Such pricing and service improvements are especially beneficial for smaller-sized plan sponsors that join a collective purchasing group. Plan sponsors who are interested in joining a coalition should review their current contracts, however, as some contracts may contain language regarding a plan sponsor's ability to break a contract earlier than the negotiated end date. Large employers may not gain as much through collective purchasing, since they are often able to negotiate fairly aggressive purchasing agreements on their own. However, the incremental gain is likely to be more than can be saved through individual negotiations.

Some coalitions are formed to let each plan sponsor decide on specific benefit alternatives; others offer only defined plan options. Depending on the group's terms, it may be possible for a plan sponsor to reduce prescription drug benefit costs simply by joining a coalition, without necessarily changing its plan design.

Depending on the purposes of the coalition, there could be a down side to collective purchasing. For example, if the coalition decides that all member organizations should use a single plan design, any plan sponsor involved is obviously limited in its ability to customize its own plan design. Although a single plan sponsor may be offered less aggressive financial terms than those it could receive through collective purchasing, it may also receive more individualized attention and more options to

customize various aspects of its program—including the financial aspects. A collective group may encounter more challenges, having to achieve consensus on various purchasing decisions.

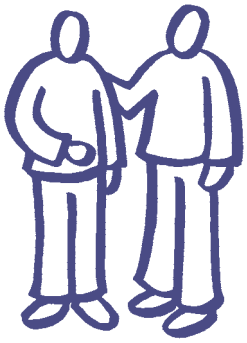
Also, financial, service performance, or clinical savings guarantees for coalitions may be measured and structured for the group as a whole, and the benefits may not filter down equally to each of the coalition members.

Table 10 summarizes the advantages and disadvantages of collective and individual purchasing.

Table 10. Advantages and Disadvantages of Collective Purchasing

Individual Plan Sponsor	Collective Purchasing Group
Potential Advantages	
• Negotiate directly with PBM to meet individual needs. • May receive more individualized attention. • Gain more flexible plan design. • Retain independent decision making.	• Receive more aggressive financial terms. • Gain more dedicated resources. • Receive improved service guarantees. • Receive expanded clinical management opportunities.
Potential Disadvantages	
• Receive less aggressive financial terms than in a coalition. • Receive fewer enhanced services.	• May need to compromise to gain group consensus. • May not have as much flexibility around all plan design issues.

X. Less Tangible Values



THE TOTAL VALUE OF A PHARMACY BENEFIT cannot be measured solely by looking at the financial offer. Being aware of this fact, PBMs have begun to bring other measures to the table to demonstrate the overall value of their program. Unfortunately, it is not so easy to evaluate overall value, as it is less tangible than a discount off a published price or a fee charged on some defined basis.

When reviewing a PBM's financial offer, consider the following issues, which will ultimately impact the success of a pharmacy benefit program:

Medical cost offsets. The idea that appropriate drug use can be an effective way of reducing overall medical costs is not entirely new; both manufacturers and PBMs have promoted this concept heavily in past years, particularly when negotiators raise concerns about the rising cost of prescription drugs. In fact, focused studies have demonstrated that use of certain medications, such as anti-asthmatics, can help decrease the number of visits to the emergency room, thus lowering total medical costs. Apart from such studies, it makes sense that if taking a medication will prevent an individual from entering the hospital, then, unless the cost of the drug is greater than a hospital stay, use of the medication does result in a medical cost offset.

Workplace productivity. While there are a growing number of studies being conducted about this subject — which is much talked-about among many plan sponsors — there is still a great deal to be learned about the connection between improved health and increased productivity. What has been looked at to date does appear to make a strong connection between being healthy and working more effectively. Prescription drug manufacturers have worked to show that proper use of prescription drugs leads to improved physical and mental health, which in turn increases workplace productivity.

Quality of care and member satisfaction. Access to pharmacies, availability of pharmacists to answer questions, and convenient and easy-to-access member support services are essential to a pharmacy benefit plan's success. PBMs and health plans work constantly to improve standards in these areas, gathering data and measuring results through customer and member satisfaction surveys. Manufacturers are also investing significant resources to fund studies, looking for ways to work more closely with plan sponsors.

Although the financial aspect of procuring pharmacy benefit management services is paramount in most plan sponsors' minds, these other, less easily measured aspects of the benefit are vital to any pharmacy benefit program's long-term success.

XI. What's Ahead?

THE PBM AND HEALTH PLAN MARKETPLACE IS constantly evolving. With changing marketplace needs and competition between providers, the structure and make up of pricing arrangements will continually change. An evolving regulatory environment can, of course, also impact plan sponsor purchasing decisions.

Advances in science and technology will continue to impact the cost of pharmacy benefits. Various new treatments including biotech drugs have emerged to replace older drugs or fill a void where no drug treatment previously existed. Scientific advances are also leading to more preventive drugs for various conditions, sometimes resulting in additional plan costs for previously untreatable conditions. Plan sponsors can expect to be faced with new decisions regarding the best management methods for their pharmacy benefit program.

New purchasing opportunities may emerge as plan sponsors seek alternative solutions. For instance, on-site company pharmacies, supplemental discount card programs, and defined contribution initiatives have surfaced as possibilities among some plan sponsors.

With all of these new challenges and opportunities ahead, plan sponsors whose negotiating skills rest on an informed grasp of the prescription drug marketplace will retain the buyer's edge.

Glossary

Average wholesale price (AWP) — A list of benchmark prices set by averaging across the spectrum of prices charged to pharmacies by wholesalers for both brand-name and generic drugs. The current list price is published in recognized sources, including Medi-Span, FirstData Bank and its supplements, and Medical Economics' Red Book.

Collective purchasing group — Also known as group purchasing organizations or GPOs, these are groups of retail entities that join together to leverage their combined purchasing power to negotiate discount pricing from wholesalers or manufacturers.

Formulary rebates — Remuneration received from certain drug manufacturers as a result of inclusion of those manufacturers' products in the formulary.

Formulary — A list of preferred prescription drugs chosen by a pharmacy benefit manager on the basis of quality and cost.

Generic dispensing rate — The percentage of generic drugs within the total of prescription drugs dispensed under a program in a contract year.

Generic drug — A medication that is the chemical equivalent of a brand-name drug with an expired patent. When a brand-name drug's patent expires, other pharmaceutical companies can produce the same active chemical compound and sell the drug under its generic name, typically at a lower price.

Generic substitution rate — The total number of prescriptions dispensed under a program in a contract year that consists of generic drugs, divided by the total number of prescriptions dispensed under the program in the same contract year for which a generic is available on the market.

Health and disease management programs — Some PBMs offer clinical programs that maintain wellness, provide case management services for particular conditions, such as asthma and diabetes, and disseminate educational information to patients and physicians. Manufacturers often subsidize development and management of these programs by the PBM, believing that they will help achieve greater product recognition and influence physicians and consumers toward a preferred therapy.

Maximum allowable cost (MAC) pricing — MAC prices are a schedule of pricing for generically equivalent drugs based upon the listed average wholesale prices (AWPs) of competing generic drug manufacturers. The federal government originally introduced the concept of MAC pricing for generic medications in the Medicaid program as a mechanism to lower costs. The CMS issues a MAC price list for generic products that have three or more manufacturers or distributors on the market. Because of this limitation, not all generics have a corresponding CMS MAC price. PBMs often utilize this government-issued MAC as the basis of their MAC list and supplement the list with other generic products.

Pharmacy benefit managers (PBMs) — Organizations that help manage the purchasing, reimbursement, and dispensing of prescription drugs for employer plan sponsors or health plans. PBMs create and maintain pharmacy networks. They also create formularies that influence physician prescribing patterns and dispensing. Through formulary guidelines and their large customer base, PBMs can secure substantial manufacturer rebates.

Retrospective Drug Utilization Review (DUR) — Retrospective DUR is a program designed to measure and assess utilization, quality, medical appropriateness, and appropriate selection and cost of prescribed drugs. It involves evaluating pharmaceutical therapies after the medications have been dispensed.

Therapeutic interchange programs — These programs are employed by PBMs to substitute generic or less expensive brand medications for higher-cost brand drugs when available and appropriate. The ability to make such changes is often dependent on the physician's willingness to modify prescriptions (has not indicated "dispense as written"), as well as the patient's willingness to change medications.

Third party administrators (TPAs) — Organizations that process pharmacy claims, but have no influence over what the retail pharmacy charges, nor what is dispensed. Plan sponsors rarely use TPAs to process pharmacy claims without PBM support as it greatly increases expense.

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