Pharmacy benefit management: Pros and cons of various approaches

One size does not fit all

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Pharmacy benefit managers (PBMs) historically operated using industry-tested practices such as broad pharmacy networks and pricing models that may rely on several revenue sources, including the spread between what the PBM pays the pharmacy and what it charges its clients (sometimes referred to as *lock-in* or *spread* pricing). Recently, new PBM models have emerged that challenge the traditional approaches and suggest there may be a better way.

New and alternative approaches place substantial emphasis on transparency and suggest that cost savings are available under such concepts as limited networks (with *preferred* pharmacies or some pharmacies excluded altogether) and pass-through pricing (where the PBM charges the client exactly what it pays the pharmacy, along with an explicit administrative fee). Such approaches have built-in appeal, with the common thinking that greater transparency is essential to minimizing costs to plans and members alike, as well as to maintaining quality of service. But is transparency really the silver bullet for those seeking optimal pharmacy benefit management?

The short answer: It depends. One can construct scenarios in which, for a given plan sponsor, a limited pharmacy network might be more desirable—or less desirable. Similarly, some PBM contract offers generate savings based on pass-through pricing, but some do not. There are also mixed approaches blending various elements and factors beyond the pricing and distribution that determine the value a PBM brings to a client (such as clinical programs designed to improve a beneficiary's overall health). There is no one size that fits all!

This paper examines pricing models, distribution models, and other factors that determine the cost and value of PBM services.

PASS-THROUGH VERSUS LOCK-IN PRICING– AND THE RELATED (BUT DIFFERENT) TRANSPARENCY QUESTION

In pass-through pricing, the PBM charges a client exactly what it pays the pharmacy on every prescription, passes back all rebates to the client, and makes money from explicit client administrative fees. In contrast, traditional lock-in pricing charges the client an agreed-upon price for each prescription that may differ from the price the PBM pays the pharmacy (generally higher but in some cases lower, depending on the particular prescription). The difference, or spread, is a source of revenue for the PBM. In the lock-in model, the PBM may also charge a fee (typically lower than the pass-through fee) and it might also retain some portion of the rebates from pharmacies or pharmaceutical manufacturers.

Transparency is a related, but different, issue, speaking to the degree of disclosure of contract terms and to awareness of the PBM's revenue sources. Lock-in contracts can (theoretically) be as transparent as pass-through arrangements if the revenue sources are understood and a high degree of communication exists between the PBM and its client. In practice, however, they rarely are.

On the surface, pass-through pricing offers a high degree of transparency—it is a simple pricing mechanism that, when well-defined, removes the potential of gamesmanship and hidden markups, and it promotes competition by focusing on fees that can be easily compared among competitors. This is one reason why the Centers for Medicare and Medicaid Services (CMS), in a 2009 decision, insisted on pass-through pricing for reporting and pricing of Medicare Part D contracts. The CMS decision is considered controversial by some parties, but the idea is now being slowly explored in the commercial group market, although the dynamics of those plans are quite different from Medicare.

Viewed from another angle, however, transparency may be the answer to the wrong question. The ultimate question that a plan sponsor needs to answer is: How much does the pharmacy benefit cost? This answer is more complicated than simply PBM fees, prescription prices, spreads, and rebates; it also has to do with the long-term benefits and costs associated with improving patient health, increasing medication adherence, and other factors. (More on this later.)

A second key point is that, generally, lock-in pricing better aligns PBM incentives with its clients. Spreads on generic prescriptions tend to be substantially higher than narrow (or even sometimes negative) brand-name spreads, which thus creates a substantial financial motivation for PBMs to push generic substitution heavily under lock-in arrangements. Generic prescriptions, even with the higher spreads, are almost always the better option for the plan from an overall cost perspective, and member out-of-pocket costs are almost always lower as well. Conversely, this economic incentive to strongly encourage generic substitution is often weaker under pass-through pricing, where the PBM is financially indifferent to generic dispensing rates. Similar arguments can be made for aligned incentives to use mail-order pharmacies over retail pharmacies.

Third, spreads and rebate margins fund many value-added PBM services (such as pharmacy utilization review and medication adherence management) and keep administrative fees lower.

Eliminating spreads and rebate margins in some cases can lead a PBM to cut back on its value-added services (in order to keep explicit fees lower and more competitive), to the long-term detriment of a health plan and its members. To maintain its services (and relatively thin profit margins), a PBM has to get its revenue from somewhere—and that means increased fees if fees are the only source of income (as under a pass-through arrangement).

Finally, some PBM lock-in contracts contain features that can mitigate client concerns about spreads. Guarantees are one such feature—for example, guaranteeing a minimum discount level. Another feature that many clients demand is a market check at specified intervals during a typical three-year contract—say, every year or at the 18-month mark—such that there is an opportunity to review and renegotiate some of the terms if market conditions change.

LIMITED PHARMACY NETWORKS: HOW MUCH POTENTIAL?

The concept of limited pharmacy networks is somewhat analogous to a preferred provider organization (PPO) under medical plans; the PBM negotiates terms with a set of preferred pharmacies that agree to discounted pricing in exchange for the promise of more customer volume. In some arrangements, insured members only have coverage if their prescriptions are filled at in-network pharmacies, and in other structures, copay differentials apply between pharmacies that are in- versus out-of-network. These arrangements have gained publicity recently in light of the Medicare Part D collaboration between Humana and Wal-Mart, as well as the UnitedHealthcare deal with Safeway and Kroger.

By working with a small number of preferred retailers, a PBM may be able to get greater discounts than through an unrestricted pharmacy network. The incentive for pharmacies is that the plan drives foot traffic to network stores, thereby selling more prescriptions, and also creates increased ancillary retail sales (cosmetics, etc.), which can contribute significantly to a retail pharmacy's bottom line.

The prospect of greater discounts is an attractive feature for PBMs and their clients, but there are several issues standing between the concept of the limited networks and their actually working in practice.

- **Meaningful cost-sharing differentials are needed to move volume.** For the limited pharmacy network to succeed, plan members must find it in their interest to use the preferred outlets for their prescription drug needs. In cases where a preferred pharmacy is geographically convenient for a member, it may be easy. In other cases, however, a member might object to shopping at a given pharmacy if there are others outside the network that are more easily accessible, or for some other reason. In the latter case, a plan will need to include a meaningful copay differential to change members' behavior and the resulting copay differential may offset any enhanced discounts and actually increase plan costs.
- **Network feasibility.** The U.S. retail pharmacy landscape has seen a lot of consolidation in recent years. In 2010, the top two retail chains, CVS and Walgreens, accounted for 30.3% of all pharmacy revenues. Adding the figures for Rite Aid and Wal-Mart (6.2% each) brings the total to 42.7% of the market for these four retailers.[1] On a regional basis, consolidation can be even more pronounced.

  Given these facts, developing a limited network of preferred pharmacies may be difficult in many parts of the country. On one hand, the preferred network could include two or more retailers whose combined market share is very high, in which case the potential for greatly enhanced discounts is minimal. On the other hand, the network could exclude one or more players that occupy a major position in the retail configuration, in which case a substantial portion of members may object to the arrangement because it either forces them to travel relatively long distances to get to a preferred pharmacy or excludes their preferred option.

  Further, a national plan sponsor undoubtedly requires a national network to service its employees around the country. Major pharmacies are dispersed unevenly across the United States, making it complicated to choose appropriate options nationwide. Even with the significant market consolidation, acquisition, and expansion of the past several years, each of the major national retail changes has geographic limitations in its retail distribution. Each chain still has *holes* (low market presence) in certain regions of the country:

  — CVS has a limited presence in the Pacific Northwest, for example.

  — Walgreens is limited in the upper Great Plains states.

  — Rite Aid is very limited in a number of states, for example Minnesota and Arizona.

  — Even Wal-Mart, the world's largest retailer, has had limited presence in certain urban areas, especially in New England.

  As a result, the large national chains may be poorly suited for a national limited-pharmacy network unless members have another choice.

  Finally, it is important to note that the upside available under limited pharmacy networks will vary depending on the strength of existing pharmacy contracts. Larger PBMs have been more successful in negotiating strong contracts with national pharmacies without having to go the limited-network route, reducing their potential upside relative to smaller PBMs.

1 According to Adam J. Fein of Pembroke Consulting, from his 2010-11 Economic Report on Retail and Specialty Pharmacies; statistics above cited in Fein, 2010 market share of top retail and specialty pharmacies. *DrugChannels,* December 1, 2010. Retrieved March 24, 2011, from http://www.drugchannels.net/2010/12/2010-market-share-of-top-retail-and.html.

- **The adherence issue.** Many studies have emphasized the value of medication adherence in lowering overall medical costs. Limiting pharmacy choice by requiring plan members to fill prescriptions only at certain stores may make it more difficult for some members to get their prescriptions filled. Importantly, difficulty in accessing pharmacies is believed to be a factor in reducing medication adherence rates.[2]

  And this is where short-term savings meets the issue of longer-term member health and costs. Low medication adherence rates have been shown to lead to higher medical costs down the road.[3] Failure to take hypertension or cholesterol medications on schedule, for example, may not show adverse results in the short term but can, over time, lead to drastically more serious conditions (e.g., a heart attack), poorer member health, and resulting higher medical costs.

- **The bigger picture.** Beyond the question of prescription drug distribution, there are other considerations related to limiting the pharmacies in a plan sponsor's network. Some plan sponsors may find the reality of a limited network uncomfortable because of which retailers are excluded. In particular, businesses that have material commercial relationships with the non-network pharmacies may find it difficult to exclude them from their employee health benefit network.

THE VALUE OF PBM SERVICES

Lastly, as we consider both pricing structures and distribution networks, it is important that we not simplify PBM issues down to a purely financial equation. A PBM is more than a claims administrator, more than just an instrument to pay for prescription drugs. A strong PBM works to partner with the plan sponsor to improve member health and lower costs by building a strong, thoughtful formulary and using tactics like step therapy to enforce it and move people to the right drug at the right time. This in turn leads to:

- Increasing the use of generics (as discussed earlier)
- Increasing the use of mail-order and retail 90-day supplies when financial incentives exist to do so
- Improving medication adherence, which may lower medical costs
- Monitoring prescription drug interaction and review dosages (e.g., patient safety quality management; fraud, waste, and abuse; medical therapy management, etc.)

If plan sponsors focus solely on lowering the immediate costs of PBM services, they may be cheating themselves out of important services that can reduce overall healthcare costs in the long term. Increasingly, today's leading PBMs are seeking answers to the ultimate question: How can we improve the health of members while slowing the growth of total healthcare costs (medical plus pharmacy) at the same time?

CONCLUSIONS

When it comes to PBMs, one size definitely does not fit all. Specific circumstances will determine what contractual options, pricing structures, distribution channels, and other value-added services work best for a given plan sponsor. It is important to take a macro view of PBM pricing and services. Pass-through pricing and limited networks are interesting concepts that may lower costs, but they do not inherently provide financial advantages, particularly in the long term.

In the end, the fact that competing models exist suggests that plan sponsors and PBMs alike derive benefits from multiple options. Pass-through contracts and limited pharmacy networks would have been around for a much longer period of time and would have all but eliminated lock-in contracts and broad pharmacy networks if they were universally the better approaches; instead, it required a mandate from the federal government to get pass-through contracts accepted in the marketplace and limited networks are still fairly uncommon.

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2 Adult Meducation (2006). Overview, Medication Adherence–Where Are We Today? American Society on Aging, American Society of Consultant Pharmacists Foundation. Retrieved March 24, 2011, from http://www.adultmeducation.com/OverviewofMedicationAdherence_4.html.

3 Roebuck, M. Christopher et al. (January 2011). Medication adherence leads to lower health care use and costs despite increased drug spending, *Health Affairs*, 30: 1. Retrieved April 7, 2011, from http://content.healthaffairs.org/content/30/1/91.