Putting Prescriptions In Their Place

TRENDS IN PHARMACY BENEFIT MANAGEMENT

BY IAN TOCHER, SENIOR EDITOR

While coping with transparency requirements, changing Medicare Part D legislation and consumer-driven health care initiatives, pharmacy benefit managers (PBMs) are playing an ever-increasing role in helping large-scale employers control their prescription drug spend, as well as maximize employee/patient outcomes.

With health care costs typically rising annually at double-digit percentages, most large-scale employers turn to pharmacy benefit managers (PBMs) to help control their prescription drug spend, as well as maximize employee/patient outcomes.

"There aren't that many organizations that can afford to have a pharmacy or pharmacist on staff and provide good, solid outcomes information," said David Kwasny, vice president of sales and marketing for Restat, a full-service PBM based in West Bend, Wis. "As well, not all pharmacists are trained in benefit design. It's a special science."

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Kwasny

In the traditional PBM/employer relationship, the PBM negotiates discounts, fees and rebates with the retail community, drug manufacturer or wholesaler, then resells those products and services to an employer client at a different rate. Typically, the spread between the two, either positive or negative, is what the PBM realizes as income. Alternatively, in the transparent model, the PBM negotiates the best possible deals, then passes on to the employer all of the discounts and rebates in exchange for an administrative fee that will be his sole revenue source.

TRANSPARENCY

According to the Pharmacy Benefit Management Institute, transparency is "…the communication to the plan sponsor of all revenue the PBM receives from any external organization for performing a service on behalf of the plan sponsor, or on behalf of the external organization when that service involves the plan's beneficiaries, beneficiaries' utilization or beneficiaries' utilization history."

In its quarterly publication, *PBMnews* (Vol. 9, No. 3), PBMI also spells out an extensive list of business practices to which a transparent PBM should adhere, such as using original manufacturer National Drug Code (NDC) prices as opposed to repackaged NDCs, paying retail pharmacies the same amount the PBM bills the plan sponsor for each claim, and negotiating rebate contracts on individual drugs rather than on a bundled basis.

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"Where some clients get confused is when some PBMs use the terms 'transparency' and 'pass through' as being synonymous, but that's really not the case," said Cory Easton, senior vice president and senior consultant at Hunt Valley, Md.-based Kelly Benefit Strategies, brokers and consultants to the employer community.

"A transparent model says, 'You can come in and look at all my contracts, I'm going to be transparent in the way that I practice my trade. You can see what I've negotiated with CVS, or Rite-Aid, or Merck, or Pfizer, or whoever.' So it's completely transparent to see if you're getting a deal.

"Pass through is very different in that you're saying, 'I'm going to give you everything that I've got,' meaning I can be transparent, but I may not give you everything," Easton explained. "So if you hear somebody say they're a transparent PBM, on the surface you have to assume that they're going to open the books for you. If they're talking about pass through, that means they're going to give you 100 percent of everything that they're getting. The ideal situation is that you have both."

Still, while the number of transparent PBMs has increased over the last few years, Easton said that many employers are just now starting to understand PBMs in a traditional sense, so even if a PBM is transparent, quite often the employers are not sure of what they're seeing. "They don't know whether a 15 percent discount from someone like CVS is good, bad or indifferent."

Lanzet

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Employers may see one PBM offering 15 percent off a $90 drug and another at 13 percent off a $40 drug and right away think the first is the better deal, but Easton said it really depends on the actual cost to which the discount is being applied. "Obviously you'd rather have the lower discount off of the cheaper cost if you were the ultimate payer for the product. But there are still so many buyers out there that really don't understand the dynamics of PBM pricing," he said.

Easton

"I think the challenge is going to become even greater over time as pharmacy costs continue to escalate at 10 to 12 percent each year. I think more of the decision making, certainly more of the evaluation process, is going to reside with the CFO. I think benefits in general are starting to migrate to the CFO, not completely, but increasingly so as there's a greater emphasis on the bottom line when it comes to benefits."

PART D

No discussion of PBM issues can be complete without mention of Medicare Part D, the prescription drug coverage that went into effect Jan. 1, 2006, as part of the federal health insurance program for people age 65 and over, and certain disabled people.

To participate in Part D prescription drug coverage, current Medicare participants must pay an annual $250 deductible plus approximately $32 per month. Then they pay 25 percent and their drug plan pays 75 percent of annual drug costs up to $2,250. From $2,251 to $5,100 in drug costs the participant has to pay 100 percent, representing the "doughnut hole" gap in coverage. After drug costs exceed $5,100 ($3,600 out of pocket), the plan pays 95 percent and the participant pays the remainder (or a minimum co-payment of $5 for brand-name drugs or $2 for generics).

"Part D as a piece of legislation is very complex, and employers are left holding the bag regarding that complexity because their retirees are probably confused. Frankly, there are a lot of decisions and choices that employers need to make," said Jeffery Lanzet, senior vice president of product management at SHPS. "Right now we're seeing the vast majority of employers—I think the statistic is more than 90 percent—have retained retiree pharmaceutical coverage. There's a 28-percent subsidy if the employer's plan is at least as good as the Medicare Part D standard plan."

Jennifer Leone, a spokesperson for Medco, confirmed that most of its employer clients also retained their current prescription drug plans and are taking the subsidy. However, others are supplementing what Part D offers.

"Some employers have decided not to keep their pharmacy benefit for their Medicare-eligible retirees but offer an enhanced version of Medco's Medicare product," she said. "What this means is that these people will be enrolled in our plan, but their employer will provide some enhancement. They may pay the deductible for these people or fill in the 'doughnut hole,' the gap in coverage that's not part of our standard PDP. Basically, it's the employer subsidizing the Medicare plan a little bit."

In the future, Lanzet said he thinks there will be a strong shift to additional approaches.

"There are some really good reasons for it. Organizations did not have a lot of time to react

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and adopt new plan structures, and the expedient move was to take the 28 percent subsidy, which is, frankly, a very generous amount from the government."

However, he pointed out that Part D does nothing to affect the underlying trend of health care costs increasing at double-digit rates for years, especially in the pharmaceutical arena, which has been growing in cost at an even higher rate than the overall medical trend. Lanzet also said retiree care in particular imposes a significant expense burden for employers due to extensive accounting requirements for post-retirement benefits.

PDPs

Part D legislation also enabled many PBMs to apply to become Prescription Drug Providers (PDPs), either nationally or regionally. For instance, Medco is now one of 10 national PDPs available in the 34 Medicare regions that cover all 50 states, and Navitus Health Solutions, a privately held transparent PBM, became a PDP only in its home state of Wisconsin.

"In effect it allowed us to take a PDP solution to our current clients, like the state employee program," said Navitus CEO Allan Zimmerman. "We had several different ways that we interfaced with the state employee program. One was to offer them a PDP solution, number two we offered subsidy support capabilities, and we're offering a 'wrap' product, which is a means to fill in the gap between a PDP drug program and the coverage that a current state employee program has for benefits.

"So, if the desire of a particular drug benefits provider was to emulate their current drug benefit for their retirees, but they wanted to take advantage of a PDP, what they would do is encourage their members or enroll them in a PDP and then fill in the gap with additional coverage to essentially emulate the level of benefits they previously had."

Lanzet said he feels most PBMs eventually will have to file to become PDPs simply because it's such a "tremendous" market, and a large part of SHPS business will be helping them cope with compliance issues.

"One of the biggest issues facing PBMs right now, at least those who have decided to be a PDP, is a requirement to provide medication therapy management (MTM), and they need to do so by June 1, 2006," he said. "It's a requirement to being recognized as a PDP, so that is a fairly onerous requirement [because] it includes being able to give guidance to individuals."

CDHC

Perhaps of most interest to employers is how Part D and the role that PBMs play fits into an overall consumer-directed health care (CDHC) strategy.

Zimmerman

"You can only reach out to so many other areas of pharmaceutical distribution before you start having to look at whether that PBM is actually performing, whether or not that model actually is having a positive impact on drug cost and the quality of care."

"I think that the benefit design that's often offered and recommended for use by a PBM is fundamentally a consumer-directed model," Zimmerman stated, citing a three-tier benefit program, with the first tier being generics, the second being preferred brands on formulary, and a third tier being non-preferred, non-formulary brands.

"The very nature of that model, which is very common in the PBM industry and very well promoted, is in effect a consumer-directed model because it does direct consumers into certain products that are more cost effective, that provide better outcomes, that have lower co-pays and provide the greatest value for the member and the payer, as well," he said. "In addition, PBMs also provide data connectivity with medical carriers and other managed care organizations wherein the pharmacy data becomes integrated with medical for purposes of a total medical/pharmacy database which then can be used in a consumer-directed model."

Lanzet also suggested Part D legislation offers "tremendous opportunity" for extending consumerism to the retiree population through what SHPS refers to as Consumer-Directed Retiree Health Plans (CDRHPs). "Taking the subsidy allows employers to defer their cost, but it does nothing about the trend rate which is still escalating at 15 percent per year for pharmaceutical. What a CDRHP does is by fostering consumerism it places ownership of the pharmaceutical dollar into the retiree's hands and by doing so will materially affect the rate of consumption of care and lowering health care cost altogether."

He went on to call Part D "a very generous benefit" to employers and employees alike because for the first time it extends to Medicare a prescription drug benefit.

"It incents employers to continue providing retiree health care by subsidizing the cost; it provides another option for employers who opt to have the government step in and provide this coverage," Lanzet said. "What we see employers wanting to do is to retain the appearance of employer sponsorship of retiree health care. We're dealing in a world where we have an aging population, and there's a tremendous war for talent, war for labor coming. So employers, if at all economically feasible, would prefer to keep retiree health plans as a very popular and attractive retention tool."

According to Kwasny, there are a number of ways for a PBM to fit in to the CDHC model. For example, he said Restat has partnered with data aggregation firms and has established debit and credit "pipelines" to foster an information exchange between the data aggregators and those financial aspects.

"We also have the ability to simply plug-and-play as a PBM for those groups that have those services already worked out, whether they're a financial institution or managed care entity or third-part administrator, we can simply interface the infrastructure that those organizations have previously installed," he said. "It seems as though the space has been filled up pretty quickly with quite a number of interested parties, whether they're driving from the benefit side or the financial side.

PERFORMANCE

Zimmerman suggested the overall performance issue of PBMs would be the next major wave of interest.

"You can only discount so much," he said. "You can only reach out to so many other areas of pharmaceutical distribution before you start having to look at whether that PBM is actually performing, whether or not that model actually is having a positive impact on drug cost and the quality of care."

Lanzet agreed, saying that as PBMs gain influence over individuals' drug spend they will inevitably be charged with making sure they get it right the first time.

"If you look at PBMs, their model has been distribution to employer channels, but they're faced with the challenge now of going direct to the consumer. PBMs are now in the health care business more than ever before. I think that their clients, the employers, are going to be looking to them to help manage their health care costs more than ever."

PBMs are continuing to deal with transparency expectations, changing legislation, the move toward becoming PDPs and contributing to an overall CDHC approach, and they will become an ever-more-important factor in their clients' bottom lines. As PBMs continue to mature, they'll not just be about benefits management, but good business, too. B&CS