

Prescription for Drug Benefit Costs: A Transparent Partner

By Samuel H. Fleet

Prescription drug costs are the fastest rising component in health care spending today. That makes the pharmacy benefit in any health care plan a major target for employers who are trying to balance between keeping an attractive health care package that will help them retain the best employees and coping with a rising cost that can bleed profits out of the bottom line.

One solution that has been on the scene for years is contracting with a Pharmacy Benefit Management (PBM) company to negotiate the best pricing with pharmaceutical makers and distributors. But as sophisticated health care purchasers have become more aware of how PBMs generate revenue streams from their negotiations, they have begun to question what kind of deal they are getting. Is the PBM watching out for the employer, maximizing the anticipated cost savings? Or is the PBM more focused on encouraging drug buying patterns that will increase their own revenues?

As trust eroded, a new type of PBM emerged, offering transparency as the answer. But “transparency” is not always as clear as advertised – indeed, translucent might be a better word. What benefit plan directors are finding is that PBMs may talk about transparency but still keep them in the dark about what they are paying for, how the PBM is reaching decisions that impact costs and how much the annual bill is likely to be. Finding the right PBM partner, obtaining real transparency, gaining the benefits of smart purchasing power for the drug component of health care – these are all possible by sticking to some common-sense criteria.

Looking Back

Historically, PBMs promised deep drug price discounts and low administrative costs to employers through negotiating price rebates from drug companies, arranging bulk dispensing discounts from pharmacies and taking over the specialized pharmaceutical benefit administrative burden. PBMs are in business to make money, of course. Their profit margin came through taking a share of the rebates, discounts and other special fees they were able to arrange with the drug industry.

Eventually, plan administrators began to worry – not only about the fact that they were not receiving the full dollar value of rebates and discounts, but also about what might be driving decisions made by PBMs. The suspicion: PBMs had their own best interests at heart and were actually causing pharmaceutical costs to rise.

From the employers’ perspective, there were perverse incentives at play. If PBMs kept a share of rebates and dispensing-fee discounts, then the best way for them to increase their own revenue was to encourage drug use through a less-rigorous utilization review process. If one drug maker offered a better rebate or paid a higher access fee, then what was to stop the PBM from populating the formulary with that drug maker’s products? Since drug rebates are more frequently offered for the newest drugs and seldom are available for generics, then it only made sense that the PBM would be less enthusiastic about enforcing policies that would dictate use of generic or older drugs whenever clinical efficacy was the same. More frequent use of drugs, higher costs for the drugs dispensed – these increasingly common outcomes were the exact opposite of what plan administrators hoped to achieve when they contracted with a PBM.

In short, it seemed that PBMs had too many opportunities to generate revenue through actions and decisions that were not aligned with the cost-saving interests of the employers.

Enter “Transparency”

As dissatisfaction rose and rumblings of revolt grew, some PBMs began to differentiate themselves by offering a more transparent approach. Some provided a higher pass-through of rebates but raised administrative fees to counterbalance their own lost revenue. Others offered to forego a share of discounts but kept access fees off the table and out of sight.

Today, knowledgeable employers look not just for transparency but also for the key criteria that demonstrates a PBM is interested in being a full partner in the effort to contain drug purchasing costs while at the same time providing clinically appropriate care for employees. Those criteria include:

- **Per-member pricing vs. per-transaction costs.** The PBM that bases its charges on the number of members in the plan has no incentive to increase the number of transactions just to generate more revenue. In addition, per-member pricing provides the employer with a total annual cost for administration that will not fluctuate based on usage.
- **Rebate pass-through vs. retention of a portion.** Rebates and volume discounts should pass through to the employer rather than becoming a source of profit for the PBM. That way the profit motive is eliminated from decisions about why some drugs are on a formulary and others are not, and utilization review can focus on clinical effectiveness instead of letting new, higher-priced drugs slip through when an older, less-costly drug may be just as effective.
- **Independence vs. conglomerate subsidiary.** Huge drug companies may be inclined to offer the best pricing deals to their own subsidiaries, but the subsidiaries are less likely to make dispassionate decisions about what should be on a formulary and how much leverage to use in negotiating deals. A PBM that has no relationship to other industry companies but instead offers a solid track record of performance as an independent entity is in a better position to be an effective partner.
- **Rich formulary vs. few choices.** A formulary that is based on clinical proof of effectiveness and that offers the widest possible range of drug choices provides better service to employees and limits costly case-by-case reviews for necessary drugs. A PBM that provides multiple drugs per category can still perform cost-effective utilization review without disrupting care for members.
- **Consumer education vs. fiscal disincentives.** Where once the trend was to hike co-pays to convince consumers to be selective about their drug usage, studies are now finding that the non-compliance that results from high co-pays is more costly in the end. What is more effective is reaching out to members with education that will help them understand their options and how to make smart choices. PBMs that help with this educational effort add real value to their partnership with plan administrators.

Too many pressures already face the executives in charge of making health care benefit plan decisions. With the rising tide of older workers and their increasing use of pharmaceuticals, with new, expensive drugs continually entering the market, and with global competitors – many of whom have no health care costs at all – snapping at their heels, employers don't need health

benefit partners who are more interested in generating revenue than the cost savings they have promised. What they do need is a fully transparent partner who shares their goal of providing employees access to appropriate, effective drugs at the lowest possible cost. It's that clear.

Samuel H. Fleet is president of AmWINS Group Benefits Division. He can be reached at sfleet@nebenefit.com.