PBM 101

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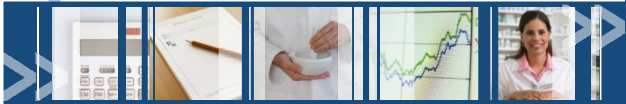

90% of all Americans get their pharmacy benefit through a PBM.

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- PBMs started in the 1970's.
  - Increase efficiency in claims management.
  - Increase efficiency in pharmacy reimbursement.
  - Help insurers manage their pharmacy costs.
    - Rx generally accounts for 20% of total health care dollars and rising.

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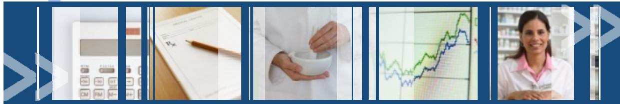

- Mail service origin.
  - Medco containment services.
- Pharmacy network.
  - Prescription Card Service (PCS).
- Clinical services.
  - Diversified Pharmaceutical Services (DPS).
- Despite their origin, PBMs essentially do the same thing.

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Common PBMs

- Aetna Pharmacy Management
- Argus Health Systems
- Caremark
- Catalyst Rx
- Cigna
- Envision
- Express Scripts
- HealthTrans
- Humana
- Innoviant
- Medco Health Solutions
- MedImpact
- MIM
- Prime Therapeutics
- PTI
- RxAmerica
- Regence RX
- RX West/Welldyne
- Systems Excellence (SxC)
- UHC
- Walgreen Health Initiatives
- Wellpoint

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PBMs Provide

- Claims processing.
- Access to networks.
  - Retail and Mail Order (MOD).
- Manufacturer relations.
  - Rebates.
- Various value-added services.
  - UM programs.
  - Rx Management.
  - Specialty injectable drug distribution.
  - Counter detailing.
  - Etc.

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- Generally PBMs do not take risk for prescription drugs.
  - This means that they are paid a negotiated fee per claim and are indifferent to the number of claims or the cost of those claims.
  - Conflict of interest.
- PBMs do not make clinical (or many other) decisions about care for members.
  - Although they would like you to think they do, their contracts expressly state that they are merely the middleman between the pharmacies and the client.

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- Enrollment/eligibility.
  - Group and carrier set up.
  - ID cards.
- Benefit design set up.
  - Copays.
  - Excluded drugs.
  - Formularies.
  - Prior authorization (PA), step therapy (SE), quantity limits, refill edits.

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- Claims adjudication.
  - Point of service processing.
  - Runs each claim through eligibility and benefit design checks.
  - Provides clinical input to the pharmacist.
  - Applies network discount and dispensing fee.
  - Pays pharmacist.
  - Sends data to PBM data warehouse.

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- Not a major source of revenue.
- Administrative fee (small).
- Switching fee or Access fee (from the retail outlet).
- Caremark processed around 125,000,000 employer claims in 2006.
- **A Switch/Access fee of $0.10 is about $12.4 million.**

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- PBMs contract with pharmacies to provide drug distribution services.
- Over 55,000 pharmacies available in United States and its territories.
- Generally, the larger the network required by the client (broad access) the smaller the discount.

- Pharmacy discounts.
  - Average wholesale price (AWP) minus a discount (generally 13-16% for retail claims) for single source brand name drugs, multi-source drugs, and non-MAC generic drugs.
  - Maximum allowable cost (MAC).
    - Pays a fixed fee per unit for generic regardless of the manufacturer or package size purchased by the pharmacist.
    - MAC discounts range from AWP minus 20% to over 95%.
  - Generic effective rate.
    - Is a generic drug really a generic drug?

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- Dispensing fee.
  - Fee paid to pharmacist each time a drug is dispensed.
  - Fees range from $0 to $10 (average $1.90).
- Other payments driven by processing a prescription.
  - Copay, tax, switch fee.
- Calculation of amount paid:
  - AWP-discount+dispensing fee-copay+tax.

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- PBMs negotiate price with all network pharmacies.
- Price may be different than what they charge employers.
  - Example :

	Pharmacy	Employer
Drug	$83	$85
Disp.	$1.50	$2.25
Total	$84.50	$87.25
PBM earns $2.75		

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- Mail order drugs (MOD).
  - Most independent PBM's own and operate their own MOD facility.
  - Some have strategic partners with a MOD facility.
  - Buy drugs directly from manufacturer.
  - Sell to client for deeper discount.
    - AWP – 20-25% for brands.
    - AWP – 50-60% (or MAC) for generics.
  - Supply >30-day supply (generally 90 day).
  - Collect zero to 3 times retail copay for 90-day supply.

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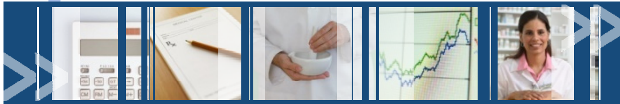

- This is MUCH more profitable for PBMs because in most cases the own the pharmacy.
- No middle man (pharmacy) negotiation.
- Example for a generic drug @ $100 AWP:

	Mail Order	Employer
Drug	$15	$45
Disp.	$0.00	$0.00
Total	$15	$45
PBM earns $30 for a 3-month supply		

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- Mail order.
  - Deeper brand name discounts.
  - Generic discounts may not be as deep overall.
  - No dispensing fee.
  - Copay relief.
    - Member pays less than three copays for a 90-day supply.
- Must determine if deeper discounts cover the cost of the lower member copayment amount.
- General rule is mail order copayment should be 2.5 times the retail copayment for a 90-day supply.

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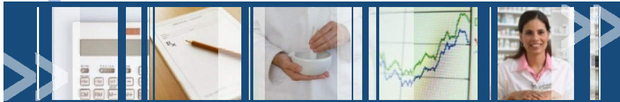

Overall Weighted Average Costs	Mail Order		Retail Eq Price		Variance	
Gross (Drug) Costs						
Total	$	211.75	$	226.31	**$**	**(14.56)**
Generic	$	69.13	$	63.82	**$**	**5.31**
Formulary	$	339.47	$	369.40	**$**	**(29.93)**
Non-Formulary	$	354.61	$	393.59	**$**	**(38.97)**
Plan Costs						
Total	$	167.24	$	158.78	**$**	**8.47**
Generic	$	49.49	$	34.14	**$**	**15.35**
Formulary	$	283.31	$	282.71	**$**	**0.60**
Non-Formulary	$	265.51	$	260.79	**$**	**4.73**

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Your Top 25 Comparative Drugs

	Drug	B/G	Plan Costs: Mail Order	Plan Costs: Retail Eq Price	Variance
1	SIMVASTATIN 20 MG TABLET	G	$7,210	$2,632	$4,578
2	NEXIUM 40 MG CAPSULE	B	$18,664	$19,581	$(917)
3	SIMVASTATIN 40 MG TABLET	G	$5,664	$1,803	$3,861
4	OMEPRAZOLE 20 MG CAPSULE DR	G	$8,011	$4,169	$3,842
5	AVONEX PREFILLED SYR 30 MCG	B	$20,473	$21,212	$(738)
6	SINGULAIR 10 MG TABLET	B	$14,292	$14,266	$26
7	PROGRAF 1 MG CAPSULE	B	$16,598	$17,724	$(1,126)
8	COMBIVIR TABLET	B	$15,706	$16,934	$(1,228)
9	LANTUS 100 UNITS/ML VIAL	B	$14,223	$12,797	$1,426
10	PREVACID 30 MG CAPSULE DR	B	$13,467	$14,078	$(612)
11	TABLET	B	$13,021	$13,453	$(432)
			$13,421	$13,464	$(44)
23	ACTOS 45 MG TABLET	B			
24	XELODA 500 MG TABLET	B	$9,019		
25	TRICOR 145 MG TABLET	B	$7,211	$7,178	$33
	Total Top 25		**$260,295**	**$248,883**	**$11,412**
	All Other Comparative Drugs		**$469,890**	**$444,343**	**$25,547**
	Total		**$730,184**	**$693,226**	**$36,959**

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- Summary:
  - Discount level for brand and generic drugs is not deep enough.
  - Client's copay for mail order is low.
    - Loss due to the mail discounts not deep enough to cover the current member copayment.
  - Adjust discounts and member share to assure mail order program is a savings.

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- Rebate contracting.
  - More than 70 manufacturers in the market.
  - Separate contracts for each manufacturer.
  - Spell out the discount the PBM will receive (either for itself or on behalf of its client) for each unit dispensed.
  - Can be market share or access based, tiered or flat.
  - Generally for brand name drugs only.

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- What the PBM does.
  - Negotiates the discount with each manufacturer.
  - Keeps track of utilization data for each of its clients.
  - Submits data and invoices (usually quarterly) to each manufacturer on clients behalf.
  - Collects payment from each manufacturer.
  - Resolves disputes around data and market share.
  - Sends appropriate rebate to client.
  - Collects fee for services (usually a % of rebate is shared between client and PBM).

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- Other services PBMs provide:
  - Build formularies based on rebates.
  - Build utilization programs based on rebates.
  - Perform counter-detailing activities to steer physicians away from non-formulary drugs.
  - Use mail order distribution to increase the use of formulary agents (drug switching programs).
  - Provide manufacturers with access to data on utilization for a fee.
  - Many of the above items are framed to clients as “Value-Added Benefits.”

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- PBMs employ a host of people, activities, and strategies that "help" clients manage their drug benefits.
  - Need to look for what is in it for the PBM (there is no such thing as a free lunch).

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- Utilization management programs.
  - Will inform doctors when a member is not receiving medications appropriately (E.g., members with asthma not on steroid inhaler).
    - Remember, PBMs are paid per claim.
  - Will inform providers when members seem to be doctor shopping for narcotics.
  - Provider data sharing.
    - Shows doctors when they are not prescribing according to the formulary or when their prescribing activities are not in the "norm."

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- Disease management.
  - PBM’s hire nurses and physicians to provide disease management services.
  - Usually these programs are for very specific disease states.
    - Ironically they tend to focus on diseases where there is a good chance a brand name formulary drug will be used.
  - Examples: asthma, diabetes, heart disease, hepatitis C, renal disease, etc.

- Counter detailing.
  - PBM employs pharmacists, nurses and/or physicians to visit high volume physician practices.
  - Intended to push formulary medications.
    - May use specific provider prescribing data if available.

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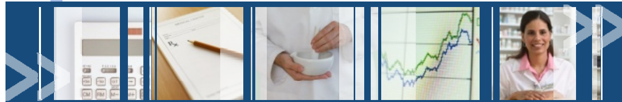

PBM Rebate – Revenue 80% Employer Share

$100,000	Starting rebate pool
3%	Administrative fee
5%	Data fee
5%	Clinical program fee
$87,000	**Available for sharing**
$17,400	PBM keeps 20% share
$69,600	Employer’s share of $100,000

Actual Employer Share of Manufacturer Dollars = 69.6%

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Transparency

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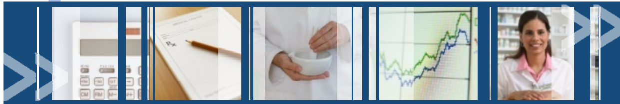

"There is nothing more complex than the negotiation to try to figure out what you're purchasing," says Keith Bruhnsen, assistant director of benefits at the University of Michigan and who manages the university's pharmacy plan. "It's the most ambiguous and convoluted part of my job."

Comments in Managed Care Magazine, September 2002

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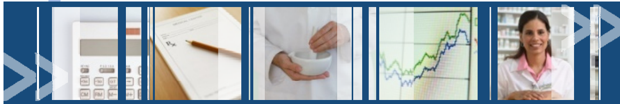
- Market definition.
  - PBM discloses and provides the full extent of pre-negotiated supplier discounts, in exchange for a flat billing mechanism (per claim, PEPM, PMPM, etc).
    - Retail network pricing.
    - Manufacturer discounts.
- Vendor definitions.
  - Disclosure only?
  - Disclosure + pass along some pricing?
  - Disclosure + pass along all pricing?



- Simplify the PBM procurement process.
- Leverage more value from the PBM supplier relationship.
- Reduce or eliminate the potential for perverse incentives to increase costs.
  - E.g., pushing higher cost brand drugs to obtain rebates.
- Obtain better information to facilitate better plan coverage and management decisions.
  - Net cost of drugs.
- Reduce overall cost of PBM relationship.

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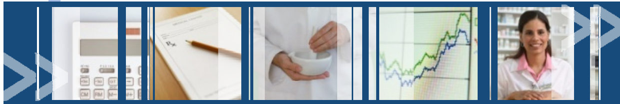

The Challenge of Transparency

- Could create a negative financial position for employers and other payers.
  - Upfront cash for admin fees that may not be offset by incremental supplier discounts.
  - Supplier contracting risk shifts to the employer or payer to manage.
    - Steerage management programs must be in place to obtain maximum value from the transparent contracting approach.
- Audits may be required to ensure transparency.
  - More comprehensive than past audits.
  - Different audit skill set/industry expertise required.
- Will PBMs lose their interest in negotiating aggressive supplier contracts?

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PBM Service Costs / Rx

Traditional Revenue Model

Admin Fees	$xx
Network Spread	$xx
Rebates	$xx
Pharma Admin Fees	$xx
Other Misc. Fees	$xx
Subtotal	**$3-$5/Rx**

Transparent Revenue Model

Flat fee / Rx. PEPM, or PMPM	$xx
Subtotal	**$3-$5/Rx**

Traditional PBMs that are willing to offer clients a transparent pricing model may seek to obtain the same level of revenue, all derived from the client in the form of higher administrative fees.

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- **The appeal…**
  - Know what you're paying.
  - Get appropriate value for those fees.
  - Chance to strip significant cost from the system.
- **The challenge…**
  - Difficult to know if you're really getting the full value of supplier discounts.
  - Fees paid by employers and payers could go UP, not down (if pricing discounts are not supplied).
  - Basic service levels could drop if firms choose inexperienced partners solely for their interest and ability to adopt this pricing mechanism.

Lowering your risk

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Diagnosis

- Review terms and definitions in contract.
- Review to assure financially adequate and measurable performance guarantees.
- Understand market-competitive pricing vs. current state.
- Mail order analysis.
- Plan design review.
- Do you have a host of clinical savings through implementation of various clinical programs.

- Need clear contract terms that govern the prescription drug program.
  - In order to protect Client's interests the following minimum terms should be included in any prescription drug addendum.
    - Definitions.
      - AWP.
      - Brand drug.
      - Generic drug.
      - Compound drug.
      - Covered drugs.
      - Rebates.
      - Specialty drugs.

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- Solid operational obligations.
  - Retail/mail order/specialty program.
    - Network requirements.
    - Claims processing.
    - Reporting.
    - Utilization programs.

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- Performance guarantees.
  - Client specific.
  - Operational requirements.
  - Member satisfaction.
  - Client satisfaction.
- All guarantees should include:
  - Measurement.
  - Penalties.
  - Process.
    - Action plans.

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- Pricing guarantees.
  - Brand name drug discounts.
  - Generic drug discounts.
  - Dispensing fee discounts.
  - Mail order discounts.
  - Administrative fees.
  - Rebates.
  - Clinical fees.
- Agree on measurement process and place terms in contract.

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- PBMs are a necessary entity in managed care pharmacy.
- They play a vital role in helping plan sponsors provide drug coverage to their members.
- They remove the administrative burden from the plan sponsors.
- Clients who are well educated on PBM processes will have the best opportunity to build a partnership with their PBM.