As pharmacy benefits management continues to evolve, plan sponsors may be able to negotiate more favorable contracts and benefit their members by taking advantage of trends such as market consolidation and transparency fostered by health care reform.

Finding More Value
In an increasingly cost-conscious and results-driven health care system, pharmacy benefits management (PBM) is evolving. While PBM firms still seek greater efficiencies in pricing and distribution, they also are concerned with health management. That involves improved monitoring of plan members’ product use and guidance and incentives for making choices that will improve health outcomes and lower the cost to the health care system.

PBM is also being reshaped by factors such as an aging population, increased prevalence of diabetes and obesity, and technological advancements, including better access to online drug information and social networks. However, while these overarching trends impact plan sponsors’ choices in managing their prescription benefit, plan sponsors also should be aware of additional drivers of change. Among these are five trends that could have immediate impact on pharmacy benefit programs:

1. Market consolidation
2. Specialty drug management
3. Retail network participation
4. New generics entering the market
5. The 2010 Patient Protection and Affordable Care Act (PPACA) and its impact on transparency.

Whether these trends have positive or negative impacts depends on the level of knowledge and effort plan sponsors put into learning their implications. Plan sponsors that successfully manage these trends will be able to negotiate more favorable contracts, implement features that benefit their members and improve their pharmacy benefit programs’ bottom lines.
Market Consolidation

The “big three” PBMs became the “big two” when Express Scripts acquired Medco Health Solutions last year. CVS Caremark, also a product of consolidation, and Express Scripts together administer about half of the coverage among U.S. outpatient prescription benefit programs. Another six mid-tier PBMs administer approximately 30% of the U.S. market, while more than 30 companies with an average share of less than 1% serve the remaining 20%.1

PBM consolidations are expected to continue as the mid-tier companies strive to join the top-tier group. Health plans own about half of midtier PBMs, and the rest of the midtiers are independent. That limits the pool of potential acquisition targets for the midtier companies to the smaller PBMs or those midtiers not owned by competing health care organizations.

This dynamic mergers-and-acquisitions market creates opportunities for plan sponsors to negotiate deeper discounts and lower fees. Why?

- The “big two” have greater negotiation leverage with their supply chains and may be in a position to offer plan sponsors a better financial deal.
- As the midtier PBMs aggressively position themselves to join the top tier, they may offer more competitive deals to grow market share.
- The smaller tier PBMs may offer alternative pricing models to differentiate themselves in the market.

For these reasons, plan sponsors can use their market share of covered lives as leverage to negotiate better deals with PBMs jockeying for position in a consolidating industry.

Specialty Drug Management

The specialty drug market is growing faster than any other segment. Plan sponsors are keenly aware of the high price of specialty drugs and their impact on program costs. Specialty drugs, large-molecule drugs or biologics typically targeted at small patient populations, are often self-injectable or bioengineered for use by patients with diseases such as rheumatoid arthritis, multiple sclerosis, cancer and other conditions with lower prevalence but intricate treatment protocols (e.g., hemophilia, Crohn’s disease and Gaucher’s disease). Representing more than 20% of pharmaceutical costs today,2 specialty drugs could possibly consume 40% of drug expenditures by 2020.3

Plan sponsors must manage this class of drugs effectively because they:

- Trend at double-digit cost inflation of more than 15% annually4
- Probably will represent seven of the top ten drug costs for plan sponsors by 20145
- Cost an average of more than $2,000 per month, with some topping $100,000 per year6,7
- Have robust pipelines in the pharmaceutical industry.

But plan sponsors can expect some relief in specialty drug pricing within the next decade as it relates to specialty drugs currently on the market. By 2020, branded specialty drugs with sales of $45 billion will go off patent,8 with market availability of less expensive alternatives for nearly 25% of this amount, including a new class of products referred to as biosimilars.

In addition, an increasing number of injectable specialty drugs are becoming available as oral products—particularly for the treatment of cancer—providing less expensive alternatives, not only in terms of ingredient costs but also in drug administration.

These developments should create increased competition and prescriber choice among specialty drugs. Plan sponsors should respond as follows:

- Implement more aggressive clinical benefit administration programs, such as prior authorization and step therapy, and member cost-sharing configurations to promote the use of the most cost-effective products.
- Negotiate deeper discounts through existing specialty channels.
- Consider more deeply discounted specialty distribution channels, such as retail-based specialty networks.
- Access more prevalent pharmaceutical company rebates available through PBMs.
- Explore migration from medical channels (doctors’ offices and clinics) to less expensive pharmacy channels.

While plan sponsors need a multidimensional strategy for stabilizing specialty drug costs, any long-term solution requires channel management. Although challenging, channel management could become one of the more important areas in the management of specialty drugs. Channel management strategies that plan sponsors should consider include:

- Establish parity between the medical and pharmacy channels as it relates to member cost sharing.
• Establish clinical protocol parity between the medical and pharmacy channels.
• Assess the value of alternative distribution models, such as “white bag” drop shipments between pharmacy and medical channels.
• Evaluate exclusive distribution channels for select specialty drugs.

Plan sponsors will want to find PBM partners capable of providing and delivering the most comprehensive specialty management programs and services available. Sponsors should require PBMs to identify and quantify the most effective channels for specialty drug distribution and clinical programs to push market share to less expensive—yet equally effective—alternatives, including biosimilars when they become available. PBMs also should enhance their rebate negotiations for specialty drugs with pharmaceutical companies, return greater percentages of those rebates to plan sponsors, and implement cost-sharing options that could lead members to the most cost-effective products.

Retail Network Participation

Plan sponsors should consider the use of limited preferred provider organization (PPO) retail pharmacy networks, either in conjunction with their PBMs or independently. While the PPO concept is not new, interest by plan sponsors has picked up recently, most likely because a major PBM successfully eliminated—albeit temporarily—one of the largest retail pharmacy chains from its network when neither party could agree to contract terms. Yet this tactic is also not new. Plan sponsors with a high geographical density of members historically have been able to execute limited PPO strategies while maintaining acceptable member access and lowering plan costs through deeper discounts.

Plan sponsors might find the ease and lower overhead associated with using a PBM to administer a PPO network appealing, but those with adequate geographical density may prefer to eliminate the middleman—the PBM—which often retains a portion of the negotiated discount. This direct network contracting model can provide plan sponsors with additional control over the retail network service quality, financial reimbursement model and depth of potential savings.

By implementing a PPO network, plan sponsors likely can preserve acceptable access for members while lowering drug costs by up to 1-2%. Savings are greater when the sponsor contracts directly with network pharmacies. Some points to consider are:

• Retail pharmacies are expanding into organized specialty drug distribution channels. These emerging retail specialty networks represent one of the fastest growing industries in the United States. They are positioning themselves to provide private and public payers with alternatives to mail-based PBM specialty operations, and they often offer better access and lower cost.
• These retail networks also can provide members with a local, “high-touch” experience that may be lacking from a central-fill specialty drug facility. This personal service can be extremely important, given the nature of the diseases the specialty drugs often treat.

Although PBMs require plans to use their own exclusive specialty drug distribution centers, plan sponsors should ask them to consider including alternative retail-based specialty networks when negotiating PBM agreements.

New Generics Entering the Market

Loss of brand exclusivity and resulting generic competition in the market provide an opportunity for significant savings for any prescription benefit program. A generic alternative generally is 30% less expensive than the competing branded drug during the first six months, and often 80-85% less by the end of one year.9, 10, 11

While the number-one branded drug in the United States, Lipitor, lost exclusivity to generic competition in 2011, loss of brand exclusivity reached its pinnacle in 2012, when nearly $36 billion in branded drug spend became vulnerable to generic competition.12

We expect to see this record-breaking figure drop by 75%...
this year before rebounding to about $15 billion per year from 2014 to 2016. Starting in 2017, the market will reach a “generic cliff” when the branded drugs reaching expiration of their market exclusively with no available generic competition will drop to only $2 billion to $4 billion per year, staying in that range through 2021.13

This ongoing annuity of expiring brand exclusivity over the next few years provides plan sponsors with substantial savings opportunities, assuming they deploy appropriate generic uptake and negotiated discount strategies, which might include:

- Negotiate new generic effective rate (GER) terms with existing PBM. The PBM should provide financial guarantees that result in an effective discount for generics of at least 75% to 80% off average wholesale price (AWP).
- Negotiate new terms related to generic dispensing rate (GDR). The PBM should provide generic dispensing guarantees that are at least 88% to 90%.
- Assess member cost sharing for generics. A robust differential between brands and generics can improve generic uptake. In general, consider a $25 differential between brand and generic co-payment tiers. Increasing the co-pay spread by $25 or more has shown a 25% increase in generic utilization.14
- Assess the potential of member cost-sharing incentives and therapeutic interchange programs to enhance the use of generics that are therapeutic equivalents, not just chemical equivalents, for additional generic penetration.

The increase of generics in the market provides plan sponsors not only with an opportunity to negotiate more aggressive rates with PBMs, but also to align incentives. Incentives should encourage physician generic dispensing, pharmacist generic dispensing, and member uptake and acceptance of equally effective generic products.

**ACA’s Impact on Transparency**

ACA and the 2003 Medicare Modernization Act (Medicare Part D) are having an impact on PBM pricing models. Health care reform has come at the same time that plan sponsors have been asking PBMs to provide greater transparency into their financial model and payment structure with pharmacy providers and pharmaceutical companies. Reform law mandates are improving transparency and could fundamentally change the basis by which the PBM industry conducts financial reimbursement and payment.

AWP has been the standard for payment of claim ingredient costs by plan sponsors to PBMs and subsequent payment by PBMs to pharmacy providers. The published AWP database historically has been the source of pricing ambiguity and, in some cases, manipulation by the PBMs and others in the pharmacy benefit supply chain.

But to comply with recent health care legislation, the Centers for Medicare and Medicaid Services (CMS) is compiling and publishing new drug price databases. These include the National Average Drug Acquisition Cost (NADAC) and the National Average Retail Price (NARP). Both CMS databases increase the level of transparency across the pharmacy supply chain and provide additional insights into PBM financial revenues and margins, which previously were difficult to quantify.

Many believe that the industry soon will follow an acquisition cost model that uses the drug’s true acquisition cost plus a fair pharmacy dispensing fee as the basis for pharmacy reimbursement. Plan sponsors should be able to assess how different models compare with their current financial arrangements.

Regardless of the alternative pricing model a PBM might propose, plan sponsors have the opportunity to negotiate financial arrangements that increase the level of transparency, will likely provide better financial results, and fundamentally reconfigure the historical methodologies that have been confusing for plan sponsors—and prof-
itable for PBMs. Such arrangements will benefit plan sponsors’ cost-control efforts.

A New Prescription for Value

These five trends in the pharmacy benefit landscape present opportunities to bring additional value to prescription drug benefit administration. Plan sponsors that are aware of these trends and understand their potential impact on their prescription program can develop a strategy to derive the most benefit from them. They will be able to increase the value of their health care spend.

Plan sponsors can seize upon these trends to:

- Renegotiate more aggressive financial arrangements with PBMs based on market consolidation and changing financial models
- Implement comprehensive and more aggressive administration of specialty drugs, the fastest growing areas of pharmacy drug spend, based on additional competition in the market
- Boost the uptake of generic drugs based on the record-breaking loss of brand exclusivity and availability of generic alternatives over the next few years
- Assess alternative pharmacy distribution channels and limited networks to lower costs while maintaining acceptable access.

Plan sponsors that recognize opportunities to harness change in the evolving pharmacy benefit landscape and develop their negotiating skills to match those opportunities will be able to deliver greater benefits to their members at lower cost.

Endnotes

12. L. E. Perry, “Record number of 2011 approvals leads to data-heavy, generic-focused year and continued shift to specialties.” Drug Topics, January 2012: 16-27.