Managing Pharmacy Trend Rates

Although determining the driving forces behind double-digit price inflation trends for pharmaceutical costs has proven increasingly difficult, one thing is clear: Drug trend rates are unsustainable for plan sponsors and will continue to be a top challenge in the coming years. This article discusses emerging strategies for dealing with prescription drug cost trends, best-in-class contracting, changing and affecting drug mix, the changing reimbursement model and what’s next in mitigating evolving pharmaceutical costs.

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Recently, several pharmaceutical manufacturers have been at the center of a national debate on prescription drug prices. Some of these companies have pointed the finger at pharmacy benefit managers (PBMs) as the reason for recent price inflation. Given the complexities around contracts and reimbursements, it has become increasingly difficult to determine the driving forces behind double-digit price inflation trends. However, one thing is clear: Drug trend rates are unsustainable for plan sponsors and will continue to be a top challenge in the coming years.

It’s no secret that the current pharmacy benefit landscape is opaque. To understand “the why,” it is important to reduce the problem to its fundamentals and understand “the how.” In the simplest of terms, imagine an activity as normal to daily life as grocery shopping. The consumer enters the supermarket with a grocery list, compares each individual product for price and quality and, ultimately, picks the one best suited to his or her needs. In the health care insurance industry, imagine the same task, only as the consumer enters the market, a salesman at the door provides a grocery list that specifies each item to be purchased. Upon checkout, the cashier rings everything up, makes a few switches from branded products to private label or sale items and requires payment of a fraction of the actual cost. Surprisingly, the relationship between PBMs and plan sponsors in today’s health care insurance industry often is similar to this scenario, spurring issues around transparency regarding costs.

The reality is that, in today’s health care market, the point-of-sale transaction frequently represents a fraction of the total cost of the drug. Members are able to pay less out of pocket in exchange for premiums paid throughout the year because plan sponsors pick up the remainder of the bill at rates negotiated with PBMs. PBMs leverage scale to negotiate drug prices with pharmacies, wholesalers and drug manufacturers in the form of discounts and rebates. Rebates are paid by pharmaceutical manufacturers to PBMs retroactively for reasons such as preferred placement on the formulary and may include, but are not limited to, volume purchasing, formulary access, market share incentives and exclusivity. In many cases, 80-100% of all rebates are passed back to the plan sponsor, with the PBM keeping 0-20%, while members typically get the benefit of rebates in the form of lower premiums.
Rebates typically are paid out on brand-name products. However, with generic dispensing rates (GDRs) in the high 80% range and sufficient competition to keep the cost of most generics to less than $30 per fill, most plan sponsors’ pain is caused by approximately 10-15% of prescriptions. One percent to 2% of prescription drugs are high-cost specialty products that treat chronic and complex disease states such as hepatitis C, rheumatoid arthritis and multiple sclerosis, while the rest are traditional brand-name medications. The focus of PBM cost-control efforts has shifted to the 10-15% of prescriptions driving costs through market share movement and rebates, but there are other strategies plan sponsors can use to mitigate trend.

Emerging Strategies for Controlling Prescription Drug Cost Trend

Plan sponsors should continue to encourage generics and use prior authorization, quantity limits, dose optimization and step therapies to promote clinical appropriateness at the lowest net cost. However, in the future, these traditional strategies will offer little additional value to curb trend. Instead, strategies have evolved to include new approaches to contracting, maintaining economic incentives, and increasing transparency and payment terms in rebate agreements.

Best-in-Class Contracting

The most important method of managing prescription drug costs is to ensure PBM agreements have best-in-class contract language. Competitive pricing starts with strong definitions and financial obligations. A small word change in a definition or the methodology for how financial performance is measured and reconciled can have material financial impact.

The type of financial arrangement is just as important. So-called transparent models, when investigated further, are not transparent. The transparency is limited to network contracts at retail, which mostly affects branded products. The adoption of mail-at-retail networks or mandatory mail programs pushes many maintenance medications out of the retail 30 network, which in turn erodes transparency (though pricing tends to be better). Traditional or spread pricing options tend to have deeper discounts and provide lower net cost than transparent deals, but the PBM still keeps spread at retail, as network improvements are not necessarily passed through to the plan sponsor.

To ensure that prescription drug costs are aligned with PBM cost-reduction initiatives, plan sponsors may want to consider an acquisition-cost-based pricing model. The model passes through the PBM’s acquisition cost for a drug regardless of where the drug is filled. PBMs will charge higher dispensing fees and administration fees than typical pricing arrangements, since this becomes their only source of profit. While on the surface this model may not appear to maximize plan savings, it does protect plan sponsors against spreads obtained through network price improvements or marketplace price inflation. Due diligence through market checks and benchmarking is key to maintaining a competitive deal.

Second, pricing should be evaluated across the board (discounts, dispensing fees, administration fees, rebates, clinical program fees, etc.) and not focused on any individual factor, since financial performance can be measured differently across components and channels. For example, while an “all-in” traditional generic guarantee is best in class, a strong all-in specialty discount may look competitive at the headline rate, but contractual nuances may undermine the value. Maximum allowable cost (MAC) pricing for generic specialty drugs should be reviewed and factored into the evaluation of an overall effective specialty drug discount. Some drugs may be classified as specialty drugs but command discounts like traditional generics, which can artificially inflate the overall effective specialty drug discount. Accurately evaluating the treatment of these “generic” specialty medications for guarantees will help ensure competitive specialty pricing for the duration of the PBM contract.

As another example of how pricing can change across channels, when using a mail-at-retail network or an incentivized or mandatory mail-order program, it’s important to keep MAC lists stable across channels to ensure a consistent member experience. Mail-order pricing tends to be better than retail pricing because PBMs own the mail-order pharmacy, allowing them to purchase products at acquisition cost pricing. As a result, MAC pricing should be equal to or better than retail.

Regardless of the pricing model chosen, because the mar-
Pharmacy Challenges

Market is evolving year to year, plan sponsors should ensure their overall pricing and terms are competitive through a bidding process, renewal, market check or coalition purchasing.

**Changing and Affecting Drug Mix**

Plan sponsors can also manage costs by changing and affecting the drug mix of their populations through clinical programs. In some drug classes, there are many generic products, and there is value in promoting certain generics over others. There has been increased interest in bifurcating the generics into high-cost and low-cost generics with differential copays. In some cases, there is such a large difference in cost that plan sponsors could pay for the full cost of the low-cost generics and still see significant savings. Another example is dispense as written (DAW) programs. They positively impact drug mix by driving current brand utilization to the much cheaper generic. Though members can still get the brand product, they’ll have to pay the cost difference on top of their copay as a penalty for choosing the brand over the generic equivalent. Savings can vary depending on current multisource brand utilization.

On the flip side, drug mix can be negatively impacted by copay waiver cards currently being funded by pharmaceutical manufacturers, especially when a generic is available. For example, Pfizer currently covers up to $126 in copays for its brand Lipitor®, with the patient paying $4 for a 30-day supply. PBMs frequently exclude certain brands that have generics available where there is an aggressive copay waiver card. Plan sponsors can improve their rebate yield without eroding their generic utilization by (1) having an “all-in” rebate definition, (2) increasing the percentage pass-through of rebates from the PBM and (3) adopting the PBM’s formulary exclusions that target high-cost disease states or products that add cost with little to no clinical value.

**The Changing Reimbursement Model**

Over time, PBMs have increased rebate yields by creating competition among manufacturers by pitting therapeutically similar drugs against each other to drive the lowest net cost in exchange for formulary exclusivity. The result has been a large increase in the amount of available rebates from drug manufacturers and, due to the proprietary nature of these contracts, it has opened a new revenue source for PBMs.

For background, PBMs used to make most of their money at mail order, especially from generics. But now that most mail-at-retail networks have stagnated mail-order growth, the PBM revenue model has shifted toward specialty drugs and rebates. Generic continue to play a significant role, but the growth of specialty drugs in the pipeline and the success of exclusive specialty networks and exclusion-based formularies have created an incentive for PBMs to demand additional funds and other new revenue streams from pharmaceutical manufacturers. While the pay-to-play tactic is touted as being successful in bending drug trend, there is increasing interest in moving away from the current rebate-driven model to a net price model that captures all revenue received from pharmaceutical manufacturers. This shift has been driven by the lack of adequate transparency in certifying that all incentives are aligned among PBMs, manufacturers, payers and members/consumers. Plan sponsors should demand PBMs provide greater transparency around rebate agreements, other revenue streams from pharmaceutical manufacturers and acquisition costs to determine if narrowing access to pharmacies and products is curbing trend while maintaining clinically appropriate access to products for patients and physicians.

**What’s Next?**

The health care landscape is evolving rapidly, and the pharmaceutical industry is no different.

In the future, expect manufacturers to price their drugs based on individual outcomes. If a drug works for a patient for a particular condition within a certain time frame, the plan sponsor will pay for the drug. If the drug does not work, the cost will be significantly lower or free. This will require a significant change in data collection, negotiation strategy and payment structures.

In addition, expect plan sponsors to have preferred generics, where the cost is covered at 100%, because other products (including other generics) in the same class are much more expensive.

The need for measurable actual outcomes for high-cost
specialty claimants has sparked interest in separating specialty drugs from the PBM to ensure patients are getting the best service and clinical support while plan sponsors are getting the best price.

Mail-at-retail programs will continue to proliferate, and mail-order pharmacies will have to compete to maintain their share by improving the member experience and speed of delivery.

**Conclusion**

As reimbursement for traditional brands and specialty drugs shifts more to a rebate-driven model, the need for transparency in rebate contracts has never been greater to ensure that narrowing access to pharmacies and products is producing better clinical outcomes at the lowest net price. Plan sponsors should consider adopting acquisition cost pricing models that pass through the full purchase price PBMs pay for products to plan sponsors and consumers. In addition, plan sponsors should consider further adoption of consumer-driven health plans to promote consumerism, in order to increase price transparency to members. Consumers can and will make rational choices that best suit their health care needs, but only when they and their health care providers have adequate information on price and choice.

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