

Comparing Pharmacy Benefit Managers: Moving Well Beyond the Simple Spreadsheet Analysis

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Unabated increases in prescription drug demands, advancing technology, and rising drug inflation rates combined with a sagging economy, continue to intensify budget pressures for payors responsible for delivering pharmacy benefits to plan members. At the same time, high levels of complexity and resource requirements in drug benefit administration have led to a state in which plan sponsors remain heavily dependent on pharmacy benefit managers to assist in these efforts. With pharmacy representing such a critical component of healthcare delivery from clinical and economic perspectives, it is essential that sponsors exercise high levels of due diligence in pharmacy benefit manager review and

appraisal to ensure proper balance of quality clinical care, sufficient access, and optimal cost-efficiency in the delivery of such benefits. This review is designed to provide a comprehensive understanding of current pharmacy benefit management business practices and help equip plan sponsors with the knowledge, strategies, and safeguards to drive a well-informed pharmacy benefit selection process and, inevitably, a better-aligned pharmacy benefit management–payer relationship. [AHDB.2008;1(5):9-19.]

The annual rate of increase in prescription drug spending has clearly tapered in recent years, and yet the share of prescription drug expenditures paid by public and private health insurers continues to grow.¹ Pressures to effectively manage prescription drug costs remain as high as ever, given the many factors (eg, increasing demand, drug inflation rates, specialty drug development, and aggressive drug marketing) working collaboratively to drive even higher drug spending. It is essential that plan sponsors wishing to partner with a pharmacy benefit management (PBM) organization to gain more adequate control of drug benefit programs exercise extreme vigilance in the selection of such a service provider.

Plan sponsors must strive to gain a thorough understanding of current PBM business practices and how

such practices may directly influence the sponsor's ability to optimize clinical outcomes and cost control in drug benefit programming. Sponsors also need to develop sound processes to compare and contrast PBM options, leading to the selection of a vendor whose interests are most clearly well-aligned with their own, and whose business practices substantiate such levels of alignment. It is therefore essential that any comparative assessment of potential PBM partners goes beyond rudimentary spreadsheet comparisons of one PBM's proposed pharmacy discount rates, administrative fees, and/or drug rebate projections versus another's.

This article outlines comparative considerations in PBM assessment and insights into traditional PBM business tactics and their potential impact on a plan's ability to effectively manage quality of patient care and overall drug expenditures. It further describes strategies for plan sponsors to perform a well-informed PBM evaluation process. Careful attention to these issues and implementing these strategies can help in the selection of a well-aligned PBM business partner, better protect

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KEY POINTS

- ▲ Despite a clear tapering in drug expenditures over the past few years, prescription drugs remain a significant component of the total healthcare dollars.
- ▲ A common shortcoming of PBM vendor evaluation processes at the plan sponsor level is an undue level of focus on reimbursement rates for brand-name medications and manufacturer rebate earnings.
- ▲ Many PBMs have been generating substantial revenue for years through business practices that are not appropriately aligned with the best interests of their clients, resulting in unnecessarily higher prescription drug spending at the plan sponsor level.
- ▲ Over the past decade, several plan sponsors have filed high-profile lawsuits against major for-profit PBMs, alleging a variety of inappropriate business tactics that have led to hundreds of millions of dollars in fines and settlements.
- ▲ PBMs are in a unique position to assist plans in driving higher levels of quality and value in the delivery of health-care to plan members. It is therefore essential that PBMs are held to the most rigorous of standards.

the organization in its PBM contracting, and secure a trusting, satisfactory, and long-term payor–PBM working relationship.

Spreading the Wealth

Anyone who has ever purchased a theater ticket through a ticket broker has experienced first-hand the effects of “spread” pricing. Ticket brokers will typically purchase tickets at one price and then resell them at an inflated level, keeping the differential for themselves as their service fee. Similarly, many PBMs have been generating substantial revenue for years by paying their contracted network pharmacies at one rate and then charging their clients a higher rate, pocketing the difference. But unlike ticket brokers, the net differential kept by PBMs has not always been as apparent to its clients, nor have these PBMs been forthcoming in sharing this information.

Charging plan sponsors a higher rate for prescription drugs than the PBM had actually paid for the drugs, and retaining the difference, is referred to as “differential pricing” or “spread pricing.”² As an example, let’s assume a PBM contracts with a plan sponsor at a pharmacy reimbursement level for brand-name drugs based on the average wholesale price (AWP) of the medication minus a 14% discount. This may seem a reasonable and acceptable discount, but unbeknown to the

client, often the PBM’s actual contracted rate of discount with its network pharmacies is significantly more aggressive (eg, AWP minus 17%), thus allowing the PBM to keep a significant differential on every branded claim as undisclosed revenue. This remains a common PBM practice and applies to brand-name and generic drugs. With generic drugs, revenues generated through retained pharmacy spread can be even more substantial and more worthy of close examination. Strategies for plan sponsors on how to avoid potential conflicts with PBMs are listed in **Table 1**.

Although no one would argue that PBMs are entitled to a fair profit for their efforts on a plan’s behalf in building and maintaining an effective pharmacy distribution network, manipulation of actual pharmacy reimbursement rates raises the following concerns. A spread-pricing model:

- Can prevent plan sponsors from achieving the maximal discount possible on their drug spending. Dollar values of such spread among traditional PBMs have been reported to routinely amount to as much as \$2 to \$4 for a prescription claim.³ Depending on the size and demographic makeup of a plan, such spread-pricing models can result in lost cost savings to the plan of hundreds of thousands of dollars.
- Creates an incentive for PBMs to promote higher-cost branded agents: the higher the AWP of a given agent, the greater the spread (or profitability) on that claim to the PBM.
- Offers an incentive for PBMs to unnecessarily drive a greater volume of prescriptions, and/or a disincentive to curb inappropriate drug overutilization, because the more prescriptions are filled, the greater the number of spreads retained by the PBM.
- Provides an opportunity for PBMs to deliberately manipulate AWP prices. Plan sponsors need to be aware that PBMs can use various price reference databases to obtain AWP prices, which can vary significantly on any given product from one database to another. A spread-pricing model also allows PBMs to pay network pharmacies off of one reference database (the one with the lowest referenced AWP) and then charge its plan sponsors off of another (the one with the highest AWP listing), thus further enhancing its retained spread on every claim.

Generic Drug Pricing: No Longer an Afterthought

In evaluating PBM vendors, a common mistake plan sponsors make is their undue focus and attention on brand-name medications and branded drug pharmacy discount levels. With generic utilization rates exceed-

ing 60% within many plans today,⁴ and with vast differentials in ingredient cost for prescriptions between a brand and a generic drug, generic products represent an enormous opportunity for cost savings to payors.⁴ However, sponsors must also recognize that reimbursement rates for generics are subject to a much greater variability than branded drugs among different PBMs, and this can have a much more significant impact on a plan sponsor's bottom-line drug spending than may be expected.⁵ Therefore, sponsors should pay close attention to the comparative performance of generic drug pricing programs among competing PBMs and the speculative impact of such pricing variation on that plan's specific drug expenditures.

In processing payment to contracted pharmacies for the dispensing of generic drug products, almost all PBMs today will use a maximum allowable cost (MAC) reimbursement program. MAC was originally established by the Health Care Finance Administration to prevent pharmacies from purchasing a lower-priced product from one generic manufacturer and then billing the government for a higher-priced product from another manufacturer.⁶ MAC represents the highest price a health plan or other intermediary will pay retail pharmacies for the dispensing of a specific medication when that medication is available from different generic manufacturers. With MAC pricing, wholesale acquisition costs for a given generic product available from various manufacturers are routinely compared, and a standard markup is applied to establish a MAC reimbursement rate. The goal of MAC pricing is to establish a fair and equitable level of reimbursement for all pharmacies, while ensuring that plan sponsors are not paying overly inflated rates for drug products.

In marketing their services, many PBMs will use MAC pricing programs to attract new clients, claiming extensive savings relative to such programs. Purchasers of PBM services, however, should be aware of the ways in which a PBM can manipulate MAC pricing programs (Table 2) to make them attractive to clients, while inevitably serving as yet another tool to drive greater revenues for the PBM and potentially depriving clients of maximal dollar savings with generic drugs. The key tactics PBMs use to maximize profitability by MAC pricing are:

- Many PBMs will reimburse their national network of pharmacies off a very broad and aggressive MAC pricing list, but then turn around and charge plan sponsors for the same drugs off of a much less broad and much less aggressively priced list, once again netting the difference for themselves.

Table 1 Plan Sponsor Strategies: Contracting a PBM

1. Demand full transparency in your contract negotiations with a PBM about network pharmacy discounts. PBMs should divulge to you their contracted rate and their blended effective rate for branded and for generic agents within your geographic region. If there is one large chain in your area, demand to know the specific contracted rate for that pharmacy; a PBM's contracted rate may vary from one pharmacy chain to another, and among independent pharmacies
 - *Contracted rate* is the reimbursement rate that a specific pharmacy or pharmacy chain contractually agrees to accept for processing prescription drug claims on behalf of a specific PBM
 - *Effective rate* is the actual blended performance rate of discount for the AWP, accounting for differences in reimbursement rate among individual pharmacies and the net effect of drugs that process at a customary level (the pharmacy's retail price of a drug), which may be lower than the negotiated AWP discount
2. Consider a requirement of full pass-through in contracting, ensuring that you will be charged no more than the actual amount paid by the PBM to their network pharmacies, including all net pharmacy discounts and dispensing fees. Ensure that the pass-through pricing applies to both in-state as well as out-of-state pharmacies
3. Consider using contractual commitments from the PBM of pricing guarantees that hold the PBM financially accountable for projected effective rates put forth during request for proposal response processes
4. Contractually secure full auditing rights to PBM actual acquisition cost data and network pharmacy contracts
5. Ask the PBM what reference it uses in determining AWP pricing for pharmacy reimbursement and contractually obligate the PBM to use a single, mutually agreed on reference for all claims processed, with full audit rights; such reference should be specifically defined in the final contract

AWP indicates average wholesale price; PBM, pharmacy benefit management.

Such spread pricing on generic drugs is extremely important for plan sponsors, as it can average as much as 10% to 15% per generic prescription processed and can amount to lost cost savings to a plan sponsor of as much as \$2 million annually per 100,000 lives covered.⁷

- It is not uncommon for PBMs to maintain multiple MAC lists and charge individual clients off of the list that will actuarially prove most profitable to the PBM.
- Many PBMs will quote a highly aggressive MAC effective rate (eg, AWP minus 60%+), but fail to

Table 2 Plan Sponsor Strategies: MAC Pricing

1. Demand full pass-through of MAC pricing from your PBM and full audit rights to network reimbursement rates and data
2. Request the PBM to divulge the total number of different MAC lists it uses nationally and the rationale for having more than 1 list. Ask yourself, "If the PBM were truly acting in the best interests of its clients, why would it need to maintain multiple MAC lists?"
3. Demand full, regular access to the MAC list applied to your specific plan. Many PBMs will be reluctant to share their list, considering it proprietary in nature. In such a case, question the PBM's commitment to transparency and partnership with your organization
4. Ensure mutual understanding of how your PBM defines a generic drug
5. Ensure full disclosure of the discount level for generic drugs not included on the MAC list applied to your plan
6. Be sure you understand the methodology and frequency with which the MAC list is updated
7. Ask for the PBM's most recent performance figures for generic reimbursement in your geographic region, including:
 - Current MAC effective rate—the average percent discount off the AWP for drugs processed by the MAC list to be applied to your organization
 - Percent of total frequently dispensed generic drugs represented on that MAC list (ideally, at least 95%)
 - Number of individual line items on that MAC list
 - Overall generic effective rate (the average percent discount off the AWP for all generic drugs) whether reimbursed at MAC, usual and customary pricing, or AWP discount. This performance metric is probably the most important, because it is the most equitable means of comparing generic reimbursement rates of PBMs
 - Overall PBM generic utilization rate—percent of total prescriptions filled for generics by plan sponsors. Ask for clear description of what drug benefit products and/or classes (eg, insulin, diabetic test strips, medical devices, over-the-counter medications, compounds) may be excluded
8. Establish clear terms about the PBM's policy for establishing MAC pricing on new generics from multiple manufacturers. Consider establishing performance guarantees for the timing of MAC price establishment on new generics
9. Strongly consider using performance guarantees for the overall generic effective rate. Avoid guarantees around MAC effective rate, which can easily be manipulated by the PBM to meet performance standards while retaining significant spread

AWP indicates average wholesale price; MAC, maximum allowable cost; PBM, pharmacy benefit management.

reveal that the rate quoted was based on a MAC list that only covers a limited percentage of the total generic drugs most commonly used by a plan's members. Those drugs that are excluded from the MAC list will be charged to the plan sponsor at a much less attractive level (eg, AWP minus 15%-20%), resulting in even greater spread revenue for the PBM.

- If the PBM is failing to provide all plan sponsors with access to its most broad and aggressive MAC pricing list, then there is also a disincentive for the PBM to act quickly in passing along aggressive MAC pricing discounts to clients when new generic agents become available. The longer the PBM delays the pass-through of its MAC pricing on these drugs, the greater the revenues it retains for itself.

As an example, in April 2007, the popular sedative/hypnotic agent Ambien (zolpidem) became available generically via several generic manufacturers. While the price of the branded version of this medication was as much as \$4.90 per tablet, the acquisition cost of this product to most pharmacies plummeted almost overnight to as low as \$0.30 per tablet.⁸ In situations like this, most major PBMs will move quickly to establish aggressive MAC pricing with their national network of pharmacies. However, this does not mean that the PBM will move quickly to pass along the newly established aggressive MAC rate to its contracted clients. The longer the PBM delays doing so, the greater the spread on this new generic product the PBM retains, and the more substantial the lost cost savings opportunity for the plan sponsor.

- If the PBM is owned by or directly affiliated with a retail pharmacy chain, there may be further disincentive to quickly and aggressively establish MAC pricing, as doing so runs the risk of negatively affecting the profitability of its parent retail chain affiliate, who dispenses such drugs.

Manufacturer Rebates: Reservations Required

Another major revenue source for traditional PBMs is drug rebates from pharmaceutical manufacturers. Traditionally, rebates are dollars paid back to PBMs by the drug manufacturer in exchange for favorable positioning of its products on the PBM's drug formulary or within a specific plan design. Rebates can also be paid to the PBM for less restricted access to drugs (eg, no prior authorization) within a drug benefit program or for market share performance of a manufacturer's products versus current competitors.

For a variety of very good reasons, rebates today represent one of the most controversial areas of PBM busi-

ness practice, which is also highly scrutinized. The challenges and controversy stemming from branded drug rebates include:

- Similar to the different forms of spread revenue retained by PBMs with network pharmacy discounts, many traditional PBMs will also retain a significant proportion of any rebate dollars generated by a plan's utilization and collected from pharmaceutical manufacturers on a plan's behalf.⁹
- Many PBMs are reluctant to divulge actual rebate agreements between themselves and the pharmaceutical manufacturer and the portion of rebates it retains, deeming such agreements as proprietary in nature. This creates a major dilemma for plan sponsors, because the sponsor then remains largely in the dark in knowing how one drug product in a class compares with another from a net pricing perspective.

As will be discussed later, a variety of prominent lawsuits have been waged against the major for-profit PBMs over the past decade by plan sponsors alleging the promotion of more expensive drug products as a way of enhancing the PBM's own rebate revenues at the plan sponsor's expense.

- As a means of further retaining rebate earnings from its clients, many PBMs may forego the negotiation of aggressive rebates and alternatively negotiate additional administrative fees into their contracts with drug manufacturers. Such fees can take many shapes and forms and are routinely disguised as incentive fees, data management fees, data-sharing fees, performance fees, rebate management/administration fees, access fees, formulary management fees, professional services fees, health management fees, educational grants/fees, and drug promotional/advertising fees.

By reclassifying rebates and collecting greater administrative fees from manufacturers, a PBM can then tout the fact that they are passing through a large portion (up to 100%) of the rebate dollars to its clients, but in reality is still retaining major revenues for itself by shifting such dollars out of the rebate bucket and into the administrative fee bucket, of which it retains 100%.

Administrative fees also create an incentive for PBMs to be less aggressive in negotiating actual rebate discounts off of the price of a drug, so that more of those discount dollars can be shifted into the PBM's fully-retained administrative fees.

- Academic research has reported that major PBMs can retain, on average, 38% to 40% of rebate dollars collected from drug manufacturers, and such rev-

Table 3 Plan Sponsor Strategies: Manufacturer Rebates

- Require that the PBM disclose all contracts with drug manufacturers yielding any payment to the PBM
- Consider a requirement of full pass-through for all rebate earnings (including administrative fees) driven by plan's specific utilization, with full audit rights to manufacturer contracts, rebate payments, and administrative fees
- Establish performance guarantees related to the invoice timing and as collection of and dispersing of rebate dollars back to the plan
- Demand access to plan-specific net drug cost information (after rebate and network pharmacy discounts) down to the individual national drug code level within all major drug classes
- For specific utilization management and educational programs the PBM may wish to implement in your plan (eg, provider/member education, medication adherence, therapeutic interchange), consider requiring full disclosure of any manufacturer revenue generated by such programs; use policies that require plan-specific sign-off before implementation

PBM indicates pharmacy benefit management.

enues can represent a significant, however decreasing, proportion of a PBM's gross annual profits.¹⁰

- When rebate income and administrative fees tied to branded drugs outweigh revenue from plan sponsors, one must question whose best interests the PBM is truly representing.

Such undisclosed earnings raise a number of important questions:

1. Do such branded revenue streams create a disincentive to fully optimize the formulary positioning and maximize utilization of high-value generic drugs in several key drug classes?
2. Do such earnings create further disincentives for the PBM to streamline the number of products within key formulary classes or to employ more rigorous utilization management techniques (eg, step therapy, prior authorization, over-the-counter coverage) proven to yield substantial savings to plan sponsors?
3. Do such earnings compromise the true evidence-based nature of formulary decision-making at the PBM level?
4. Are educational efforts conducted by PBMs truly educational in nature, or simply the end result of a behind-the-scenes, revenue-generating commitment by the PBM to help promote a pharmaceutical company's newest brand-name drug product?
5. An additional revenue source for PBMs is the float on rebate dollars. For every day the PBM delays cred-

Table 4 Plan Sponsor Strategies: Mail-Order Pharmacy

- Ask your PBM for detailed information on all their mail-order pricing components and demand full audit rights
- Push for MAC pricing on generic drugs dispensed by mail; ensure the safeguards described earlier for a MAC list
- Before implementing a mail service program, particularly a mandatory mail-order benefit design, carefully model the actuarial impact of such a program. Such modeling should incorporate differences in comparative reimbursement rates between mail and retail, dispensing fees, lost copay revenue, disenrollment rates, and potential waste
- Request that the PBM provide an acquisition cost-based pricing model for its mail service, with direct 100% pass-through of its actual acquisition cost for drug products acquired via mail facilities, but at a higher dispensing fee; note that many PBMs will likely be reluctant to provide such a model, which can significantly limit their profitability potential
- Consider shopping mail-order service from many vendors as a separate carve-out benefit
- Recognize that to retain prescription volume and foot traffic, many retail pharmacies are willing to accept lower discounts and dispensing fees from PBMs on 90-day supplies of long-term medications dispensed via their retail outlets. Ask your PBM if it provides a 90-day retail network and compare discounts with mail; this may allow the plan sponsor to capitalize on greater discounts, while providing similar conveniences of mail, but with a more personalized option for its members
- If implementing a mail benefit, consider requiring that the first fill of a newly prescribed long-term drug be limited to a 30-day supply at retail; this may help mitigate issues of waste from intolerance or dosing changes
- Contractually prohibit mail services from engaging in:
 - Unauthorized therapeutic interchange programs
 - Unauthorized promotion of brand drugs to plan members
 - Repackaging of products
 - NDC up-charging
- Require full disclosure of all administrative fees and other incentives offered to the PBM by drug manufacturers for product acquisition and mail distribution activities
- Ensure that the PBM's rebate guarantees include prescriptions dispensed by mail

MAC indicates maximum allowable cost; NDC, national drug code; PBM, pharmacy benefit management.

it of rebate dollars back to its plan sponsors, the PBM collects additional revenue in the form of interest (or float) on those dollars. In evaluating PBM vendors, comparative rebate projections should serve, at best,

as a tertiary determinant in the selection process (Table 3). Plan sponsors should recognize that projections of higher rebate earnings from its PBM will often equate to a broader access, promotion, and use of branded drug entities (many of which may offer little to no clinical value over less costly alternatives), and inevitably higher net plan costs.

Mail-Order Pharmacy: Friend or Foe?

As the PBM industry has grown and evolved, many larger PBMs have expanded their business model and profitability through the development and/or acquisition of in-house mail-order prescription drug delivery services. PBMs have worked hard to popularize such mail-order programs as a key strategy that plan sponsors should use to enhance control over rising prescription drug expenditures. Mail-order pharmacy has become a core component of the business model for most major PBMs and is currently reported to represent a significant portion of their overall profitability.¹¹

Plan sponsors and their patients can clearly benefit from certain advantages of mail-order prescription service, such as enhanced convenience, dispensing accuracy and efficiency, formulary adherence monitoring, and patient compliance programming. More controversial, however, is the validity of claims by PBMs that mail-order programs offer significant cost savings to plan sponsors.

Very limited research has been conducted to definitively establish a significant economic value of mail-order pharmacy service. The limited study data published show mixed results, raising questions about the cost impact to the plan sponsor.¹²⁻¹⁶ Adding to these questions are more recent trends toward greater rates of discount in the retail setting, higher generic utilization rates, and increased levels of patient cost sharing. With these trends, plan sponsors can run a significant risk of greater cost exposure through mail-order, particularly if the plan elects to waive copayments as an incentive for its members to use mail service.

When evaluating the utility of mail-order programs (Table 4), plan sponsors need to keep in mind the following important facts:

- Dispensing of generic drugs via mail represents one of the largest opportunities for profitability for PBMs who own such facilities.¹⁷ As such, PBMs will often refuse to accept MAC reimbursement for generic drugs dispensed via mail, and will typically push for a fixed discount off of AWP (eg, AWP minus 50%-55%) instead.¹⁸ Although such discounts may seem significant, those familiar with the nuances of gener-

ic drug pricing understand that use of an aggressive MAC pricing program can yield substantially better discounts (eg, AWP minus 65%-70%).

- Allowing PBMs to use an AWP-based discount on generics by mail opens the door for the PBM to use up-charges to plan sponsors. Up-charging involves the selective purchasing of products at lower acquisition costs and charging plan sponsors for an alternative national drug code (NDC) number of the same product that carries a higher AWP.
- Another form of up-charging used by many mail facilities is repackaging. Given the volume of prescription drugs being dispensed through most mail facilities, such facilities will typically purchase drug products from manufacturers in larger bulk quantities at a substantially lower acquisition cost per unit. Many of these facilities will also carry repackager licenses, which permit the mail facility to repackage drugs purchased in bulk into much smaller containers for distribution. Many PBMs will then bill the plan sponsor, using the smaller-sized repackaged NDC number that will almost universally carry a significantly inflated AWP unit price.
- PBM-owned mail facilities can directly influence prescribers to switch prescription drug products to alternative agents representing higher profitability to the PBM (via rebate retention or purchasing margins), but not necessarily representing lower net costs to plan sponsors.
- Many PBMs may offer to waive dispensing fees and/or administrative fees on mail prescriptions as an enticement to plan sponsors to promote mail programs. However, if the net costs of claims filled through mail distribution are higher than retail, the bottom line may simply be higher costs to plan sponsors and greater revenue to the PBM.
- Many of the administrative fees described earlier that are paid to PBMs by drug manufacturers can also be tied directly to promotional programs employed in conjunction with mail distribution. Once again, the plan sponsor may not be aware of any of these programs, which are not entitled to any of the revenues they generate for the PBM.
- Some PBMs may exclude the sharing of rebate earnings via mail-order prescriptions as a means to offset their service charges for the provision of mail distribution.
- Intuitively, mail dispensing also poses a greater risk of waste to plan sponsors. If a patient receives a 90-day supply of medication by mail and then develops an adverse effect, requires a different dose strength

Table 5 Plan Sponsor Strategies: Claims Data Access

- Demand access to routine sharing of electronic claims data detailing all the plan’s prescription transactions; try to provide this with every billing cycle for auditing and reconciling billing information from the PBM
- Compare and contrast reporting packages from various PBMs to assess level of detail and practicality of the information for assisting the plan in monitoring utilization patterns
 - Understand the number of standard reports to be delivered, at what frequency, and any associated charges
 - Assess potential charges for changes to the standard reporting package or for any ad hoc reporting and typical turnaround time
- Determine if the PBM provides a tool that permits plan sponsors to directly access its utilization data by a web-based dashboard or query platform
- Ask the PBM to share its policies about data sales and require full disclosure of sales revenues
- Assess the relative value of your plan’s claims data and consider contractual language to limit the aggregation and sale of the data or to add provisions requiring some revenue sharing in exchange for permitting the PBM to aggregate and sell such data

PBM indicates pharmacy benefit management.

or formulation, or terminates membership early in that 90-day course of therapy, a good portion of the medication is wasted at the plan’s expense.

- Wall Street analysts have estimated that the average profitability to a PBM of a prescription dispensed through their own mail facility is approximately 4 times that of a retail prescription, with generic drugs being the most profitable of all transactions.¹⁹

Data Access, Data Protection

Historically, plan sponsors have required very limited depth of data from their PBMs for plan-specific utilization, reporting, and trending. Savvy plan sponsors, however, are now demanding much greater access to such information to reconcile PBM billing information, validate PBM commitments to transparency, and monitor pricing and trending, particularly if performance guarantees have been established contractually with their PBM (Table 5).

Plan sponsors should also be cognizant of their members’ prescription utilization data being very valuable for market research firms and drug manufacturers who stand to gain significant benefit from a plan’s specific utilization patterns, member demographics, and prescribing habits of its network physicians. Consequently,

Table 6 Plan Sponsor Strategies: Audit Rights, Obstacles

- Build contract language allowing full audit rights to all PBM network pharmacy contracts, claims data, manufacturer rebate and administrative fee contracts, mail service purchasing invoices, clinical coverage criteria, and formulary decision-making records
- Include contract clauses that identify all documents and data to be made available to your auditors
- Include contract terms that prohibit the PBM from limiting who may perform such audits, at what times, and under what circumstances. This is key, because PBMs can create significant road blocks to limit a plan sponsor's auditing capability
- PBMs that outsource relevant functions should commit to full transparency and audit rights to its subcontracted vendor relationships and services

PBM indicates pharmacy benefit management.

many PBMs have for years capitalized on this opportunity by routinely aggregating and selling patient de-identified claims data to third parties, including drug manufacturers. Such data sales have translated into yet another lucrative revenue stream for the PBM.

For PBMs that engage in this type of data sales activity, plan sponsors must carefully call into question that PBM's level of integrity and commitment to their clients. Often today, heavily promoted brand-name drugs offer little to no added clinical value, but significantly higher costs, compared with traditional, often generically available, alternatives. Hence, sales of prescription drug data can clearly provide drug manufacturers enhanced leverage in the promotion and sales of their branded drug products in a given region, potentially conflicting with appropriate prescribing and utilization messages a plan wishes to deliver to its providers and members.

Audit Rights, Obstacles

In light of the various methods by which PBMs can generate significant profit and the potential for conflicts of interest in doing so, it is of vital importance that plan sponsors protect themselves by taking appropriate measures to ensure full access to all required PBM data and information validating the PBM's contractual commitments and fiduciary duty on the plan's behalf (Table 6).

Evidence, Innovation in Clinical Support

Evidence-based medicine (EBM) is defined as "the conscientious, explicit, and judicious use of current best evidence to make decisions about individual

patient care."²⁰ The practice of EBM involves combining clinical expertise with the best available clinical research, patient values, and best practice standards. Following EBM is considered central today across all components of our healthcare system as a means to improve quality of care at a more manageable cost.

PBMs are in a unique position to assist plans in driving higher levels of quality and value in the delivery of healthcare to plan members. It is therefore essential that PBMs are held to the most rigorous of standards to ensure that the clinical programming they use on behalf of their clients (eg, formulary development, provider and patient education, and all aspects of clinical drug utilization management) is anchored in the most sound, evidence-based clinical processes possible.

Hence, plan sponsors must carefully compare and contrast the true depth and evidence-based value of clinical programs offered by one PBM versus another. Sponsors should seek to gain an understanding of the clinical, academic, and practice-based resources embedded within a PBM's clinical program development and implementation processes.

Considering that a PBM's formulary often takes center stage in the development and deployment of its clinical programming strategies, formulary decision-making processes at the PBM level are important to evaluate. Plan sponsors should request a detailed description of the process flow involved in the development and management of a PBM's formulary. PBMs should be asked to provide credentials of all voting members serving on its formulary decision-making body—usually the Pharmacy & Therapeutics (P & T) Committee—as well as the policies used to screen for and manage potential conflicts of interest among its committee members. Sponsors should request sample copies of P&T agendas, minutes, and review materials to evaluate the degree to which that PBM is critically assessing the available clinical data, grading the level of integrity of published scientific evidence, and pinpointing for its P&T Committee members (or advising its clients' P&T Committees of) the potential strengths and weaknesses of a new drug product versus existing standards of care.

If all these things are not evident from a PBM's formulary review, sponsors must question the reason. For example, are there underlying manufacturer relationships that the PBM is unwilling to jeopardize by pointing out a new brand-name drug's potential clinical shortcomings versus existing brand-name or generic alternatives?

In addition, in recognition of the enormous opportunity that generic drugs represent for plan sponsors in driving higher levels of cost-efficiency without compromising

quality of care, plan sponsors are advised to assess the PBM's ability to assist in maximizing generic utilization. First, a PBM's formulary should be reviewed to determine the breadth of brand versus generic options within key therapeutic areas where well-tested, clinically sound generic products are available. For example, in high-profile categories, such as proton pump inhibitors, statins, antihypertensives, and antibiotics, a PBM formulary that consists of a high percentage of single-source branded entities, with limited utilization management controls around those entities, is more than likely the result of a PBM's intent to capture greater branded drug rebates. As discussed earlier, the end result of such a broad-based formulary is often higher revenues for the PBM and increased net bottom-line drug expenditures for the plan.

Second, PBMs should be asked to detail the various clinical and administrative programs available to influence physician prescribing of generic agents whenever clinically appropriate and to drive greater patient education and awareness of the value of generic drug options. Each PBM should also provide plan-specific speculative growth in generic utilization rates using benchmark results of such programming across its existing client base.

Finally, and probably most important, plan sponsors must assess the level of innovation that a PBM can deliver in its clinical programming. PBMs should be asked to illustrate the types of clinical programs and resources they believe can distinguish their organization in its ability to assist its clients in not only lowering drug costs but more important in enhancing the level of clinical outcomes for its members. As our industry evolves, plan sponsors should be holding PBMs to a higher clinical standard, thus driving a paradigm shift away from revenue-generating administrative activities and toward a more focused level of clinical innovation, improved quality of care, and patient-centered programming.

Administrative Fees: Seeking Stability

With every transaction processed on behalf of a client—a paid, rejected, or reversed claim—the PBM incurs a cost that is transferred to its clients in the form of a transaction fee. With most traditional PBM financial models, the PBM will apply a certain margin (often highly variable) onto each transaction fee as a means to cover its overall administrative costs. This practice is often referred to as “fee-per-transaction pricing model.” The challenge posed by this type of model is that it decreases incentive for the PBM to control excess utilization or inappropriate processing of prescription

Table 7 Plan Sponsor Strategies: Choosing Consultants

1. Conduct a thorough assessment of a consulting firm's previous experience
 - Require the consultant to provide details of the past several PBM consultation services provided: type of organization served, final recommendations, and rationale for these recommendations and vendors chosen
 - Be mindful if the consultant appears to be recommending one vendor on a more consistent basis than others
2. Ask potential consulting firms to conduct a complimentary assessment of your plan's PBM contract, benefit structure, and formulary to assess their level of expertise
3. Require consulting firms to provide full legal disclosure of potential conflicts of interest, with full audit rights
4. Request detailed information from consulting firms about the methodology for soliciting and evaluating PBM bids; carefully assess issues addressed in this article

PBM indicates pharmacy benefit management.

medications, because every added transaction translates into more fees paid to the PBM. Sponsors who elect to proceed with this type of pricing model should understand how such fees will be assessed, and whether they will be applied to all claims or just paid transactions. If applied to all claims, the sponsor must carefully examine its own historical claims activity to accurately project administrative fees that will be incurred from reversed and rejected claims.

As an alternative, plan sponsors can explore a per-member-per-month pricing model, which pays the PBM a flat monthly fee per enrolled member to cover all its administrative costs, regardless of the number of prescriptions dispensed. In this model, the plan sponsor will pay the PBM a per-transaction fee, but that fee is simply a pass-through of the PBM's entire actual incurred claim-processing costs, with no added margin per claim. This model provides plan sponsors with more stable upfront total administrative cost projections and less risk of significant cost fluctuation because of growth in per-capita volume of prescription drug claims processed.

Litigation Review

Within the past decade, plan sponsors have slowly become more privy to a number of the behind-the-scenes tactics described above that PBMs have used to exploit revenue for themselves, frequently at their clients' expense. In turn, several government agencies and other third-party payors have filed a number of high-profile

lawsuits against major PBMs alleging a variety of inappropriate business schemes, including fraud, kickbacks, overcharges, and breach of fiduciary duty to plan sponsors. Several of these lawsuits have since resulted in hundreds of millions of dollars in fines and settlements being paid by some of the largest for-profit PBMs.²¹

Despite the high-profile nature of these lawsuits and much greater demand from plan sponsors for a more transparent and well-aligned PBM business model, many of these PBM practices may still exist today. On evaluating potential PBM partners, sponsors are advised to carefully research lawsuits and government investigations against such PBMs. Sponsors should also require PBMs, by request for proposal processes, to fully disclose all past and present litigation or investigations involving their organization, including the nature of the allegations, their current status, and any resultant changes in policies and practices by the PBM.

Consultants: Choosing the Right Dance Partner

In an effort to simplify the administrative complexity of a PBM assessment process and to ensure the best value in final PBM selection, many plan sponsors will use benefits consultants with specific expertise relative to the PBM industry and PBM contracting. Although such consultants can provide significant value to the plan sponsor, the selection should also be conducted with equal due diligence (Table 7).

Plan sponsors are advised to carefully assess a consulting firm's background and experience in this particular realm. Many consultant firms may also have their own conflicts of interest, including brokerage relationships with select PBMs generating sizable chunks of revenue for the consultant.

Conclusions

In light of unrelenting cost pressures and increasing complexity of pharmacy benefit programs, payors will undoubtedly continue to rely on the resources and expertise of PBMs. But with pharmacy benefits representing a significant component of overall healthcare delivery and healthcare spending, it becomes of paramount importance that plan sponsors exercise extreme due diligence in critically evaluating choices about PBM vendors. Keys to ensuring optimal selection of a PBM partner include a strong understanding of industry trends, keen awareness of PBM business practices, effective strategies to protect a plan's best interests, and a commitment to forego simple spreadsheet analyses in assessing PBM options. The end result is the promotion of a rewarding PBM-payor relationship and, ultimate-

ly, a better-quality, value-driven pharmacy benefit program for the plan and its members. Such concerted efforts among plan sponsors can help to drive further transformation within the industry, whereby PBMs that exemplify the key principles of alignment, transparency, business integrity, and clinical innovation can rise to lead this industry into the future. ■

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Stakeholder Perspectives

Maximizing Savings, Efficiency, and Quality when Contracting with a PBM

The management of a pharmacy program for a health plan or an insurance company is a complex task. To be effective, an active staff of skilled pharmacists is required to direct the clinical, qualitative, and financial components of the operation. Management of the pharmacy benefit, drug formulary, and contracts with a retail pharmacy, specialty pharmacy, or a pharmacy benefit management (PBM) company represent the core elements of such a task and require expertise, experience, and administrative acumen to successfully administer an effective program.

PHARMACY DIRECTORS: The pharmacy director or the vice president of pharmacy services must take the lead in all aspects of management of the pharmacy benefits of their organization. The decision whether to contract with a PBM or to perform the services in-house lies with the pharmacy and finance departments of the health plan or the health insurance company.

An effective method to evaluate potential PBMs involves the development of an extensive and de-

tailed request for proposal (also known as RFP) that addresses all the core business needs of the company, including a detailed list of all the services that will be covered by the terms of the contract.

The degree of control of the pharmacy benefits is established via the contract terms. A savvy pharmacy manager can effectively eliminate all gray areas from a contract by specifically defining all the financial terms and negotiating all necessary restrictions to protect the health plan or the insurance company, the patients, and any contracted pharmacies from inappropriate terms that diminish the quality of the program and increase the budgetary impact.

HEALTH PLANS: Relying on the PBM to direct the negotiations leaves the company open to significant lost opportunities for the best possible contract terms. Rather, the health plan/insurance company must determine its critical service needs, define the payment structure for each service, negotiate control over the fee structure for all participants, and maintain ownership of all claims data, with the goal of maximizing savings and efficiency without compromising quality or service.

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Aligning Incentives in Healthcare Transactions

MEDICAL DIRECTORS: Healthcare is a complex marketplace that requires integrated, cooperative interaction of many stakeholders with every transaction. Partners compete for position, and as in any competitive market that matures, competition may occur at different levels. The first level on which the subcontractor's performance is most often judged is price. If differentiating criteria are equal (or unidentified), the provider offering the lowest cost will be chosen. As prices stabilize and purchasers become more sophisticated, competition will occur at the levels of quality, or value-added service.

As payors and employers look to contract with pharmacy benefit management (PBM) companies, cost is often a primary driver. These companies have enough purchasing power to deliver lower acquisition costs, competitive retail pharmacy contracting

terms, and adequate networks, and infrastructure costs that may be diluted over a larger number of transactions. As costs become less of a differentiator in selecting a PBM partner, companies can now consider other qualities, such as those well illustrated in Mr Calabrese's article.

In the complex interaction that is healthcare, each link is trying to succeed on its own terms, and incentives are often not aligned across the continuum. By understanding how each party intends to succeed, and how the interaction can be mutually beneficial for all parties, and for the patients at the center of the transaction, the system as a whole can become more efficient. Mr Calabrese offers a wonderfully transparent view of one subset of these interactions that comprises a core of many healthcare transactions.

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