Chapter37

Pharmacy Benefit Management: New Strategies

by Craig S. Stern

The pharmacy benefit expense is increasing 15-18% each year and is the fastest rising expense in health care. Further, it is expected to increase by 25% by 2007, or double every four years. In 2001 the Health Care Financing Administration of the U.S. government (formerly HCFA, now Centers for Medicare and Medicaid Services or CMS) predicted that seniors will spend $1.5T on prescription drugs over the next ten years and that drug expense will rise from 4.4% of personal spending to 16% by 2010. There are many reasons for this rapid increase, some of which are unavoidable; namely, an aging population, new and more expensive medications, a population that uses more drugs, and multimedia drug advertising to consumers.

While these drivers of drug spend are un avoidable, many are not without remedy. For example, the increase of drug spend due to the aging of the population has frequently been offered as a given without any mitigating circumstances. However, government policies to increase the age of retirement and managed care efforts to improve health care maintenance can result in larger numbers of workers to pay for aged populations, as well as lower utilization. Further, direct-to-consumer advertising (DTCA) is subject to the same competitive influences as consumer products, such that both payers and employees are forced to discriminate between competing options for drugs the same as they would for food and lodging.

Since pharmacy benefits are complex and require special expertise, payers have outsourced the management of the benefit to various contractors (e.g., pharmacy benefit managers or PBMs, health plans and third-party administrators or TPAs), which we will collectively refer to as "PBMs." Most payers have now had at least three to five years of experience with PBMs and in the face of a depression and double-digit increases in pharmacy benefit expenses, they are demanding relief Therefore, all areas are under consideration for cost reductions including benefit changes, lower prices for medications, and PBM performance. Essentially, they are focusing on the "M" or "management" function of pharmacy benefit management.

Medication Therapy

From a global perspective, what can medication therapy manage, and what is beyond the scope of medications? There are certain individual risks that implicate a person's health, productivity and absenteeism from work. The National Center for Health Promotion identified that for every 100 employees in the workplace: 60 are sedentary (i.e., don't get sufficient exercise), 25 smoke, and 20 are 20% overweight,

While there are medications to assist with smoking and weight problems, they are not curative and represent only one approach to augment behavioral therapies. These prob-

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lems must be addressed on a personal level and by "wellness" programs directed to health care maintenance.

In the same study, for every 100 employees in the workplace:

- 27 have active cardiovascular disease.
- 50 have high cholesterol (a risk factor for cardiovascular disease).
- 24 have high blood pressure (a risk factor for cardiovascular disease).
- 10 have diabetes.
- 50 are distressed or depressed.

Medication therapy is a critical component for treating these problems and is a major focus of new drug research by pharmaceutical companies. As a consequence, pharmacy benefits are designed to include the treatments for these problems and the benefit expense is subject to the cost and utilization of medications to treat them. It is no surprise, therefore, that many of the medications that drive the benefit expenses are common to most plans and include therapies to:

- Lower cholesterol (e.g., Lipitor, Zocor, Pravachol)
- Lower blood pressure (e.g.,Norvasc,Vasotec, Cardizem CD)
- Treat diabetes (e.g., Rezulin, Glucophage)
- Treat depression (e.g., Zoloft, Paxil).

From a cost perspective each of the issues listed above impact total health care expenses to a different degree. Sedentary lifestyles add an estimated 10% to total health costs, while smoking and obesity each add about 21% to total expenses. *(Business & Health,* 1998).The following medication-susceptible problems increased total health care expenses as indicated:

- Depression 70%
- High stress 46%
- Diabetes 35 %
- Hypertension 21 %

It is imperative, therefore, that these problems be addressed aggressively by the health care system, and that pharmacy benefits assist individuals with covering the expense of their treatment.

Complicating this situation, however, is a mix of medications that participate in driving benefit expenses higher. Among these medications are symptomatic treatments for allergies (e.g., Claritin, Zyrtec, Allegra) and heartburn (e.g., Prilosec, Prevacid, Pepcid). These medications are heavily dependent on media advertising for their popularity. A further complication is the introduction of medications that affect "lifestyle" choices (e.g., oral contraceptives, Viagra). Lifestyle drugs force us to consider what should be covered under insurance. For example, as insurance the pharmacy benefit is designed to form a collective pool to mitigate personal expense beyond an individual's capability to pay. The plan must decide which personal needs (if any) should be included,

Design of Pharmacy Benefits

Prudent business practice suggests that pharmacy benefits answer four fundamental questions:

1. Are members receiving *effective medications* at competitive prices?
2. Are *benefits comparable* to similar offerings within their respective industry(s)?
3. Are payers and their members receiving *value* for their pharmacy benefit dollar?
4. Have all *unnecessary expenses* been avoided, including potential fraud and abuse?

The first concern for answering these questions is: What do members want, and what do they need? Several national studies indicate that members go to doctors for general symptoms of fatigue, back pain, headaches, dizziness and anxiety for which there is frequently no readily identifiable medical cause. In addition, retirees and seniors *choose* health plans for pharmacy coverage and networks including their primary physicians, but they *stay* in these plans for customer service and the ability to get appointments with specialists.

On the other hand, the expense of the pharmacy benefit is driven by medications to

treat heartburn, high cholesterol, depression, allergies, diabetes and high blood pressure. There is clearly a disconnect between member expectations for service and access, and the medical emphasis on treating symptoms and chronic disease. In order to align expectations and medical necessity while also managing cost, policy makers focus on increasing member involvement in decisions about their therapy and its comparative cost, Practically, this strategy translates into benefit changes directed to increasing copays, coinsurance and deductibles.

While the cost and utilization of medications continues to rise, consumers have continued to pay less out of pocket (82% in 1970 to a low of 25% in 2001) for their share of medication expense. As a result, PBMs and payers are focusing on reversing this trend by shifting more of the expense back to the member. The concept is that members who must pay a significant share of their health care expense will become more informed consumers. The difficulty with this concept is that information must be balanced with ability to pay so that essential medications are not withheld and alternative medical services overutilized. These are benefit design issues that are currently being addressed by three-tier and higher copay structures, preferred drug lists with lower copays, and formularies that differentiate value among various medications. The trends are clearly to three-tier and higher copays.

The tiered copays are based on categories of medications that have the same therapeutic effect and the same relative risk of adverse effects. Each category has several brand-name options at varying costs. The goal is to offer lower copays for the brand-name medications with the lowest costs. For example, the average amount paid per prescription by PBMs is $51.66 for brand-name medications, and $11.21 for generics. The goal of three-tier copays is to increase the percentage of brand-name medications filled at the lower first and second tiers that cost less than the third-tier alternatives. There is considerable evidence building that the lower copays for the first and second tiers are accounting for about 85-90% of claims with copays between $8 and $16. This is a good deal for members who would have to pay about $52 at retail, and also results in decreasing the average cost per claim paid by PBMs.

However, changing copays is not possible for many payers involved in collective bargaining agreements or long-term employment contracts, so benefit design changes cannot react as quickly to forces driving the pharmacy benefit expense. As a result, besides benefit changes, emphasis is being placed on the administration of the pharmacy benefit by PBMs and the effectiveness of the various tools that are being used to manage the benefit.

As a general rule, design of the pharmacy benefit can be based on cost, the number of claims utilized, or on integrating the pharmacy with the medical benefit,

Cost Models. Copays, coinsurance, deductibles, and exclusions/restrictions currently provide the greatest impact on benefit cost. Specifically, lowering drug cost can be achieved through the use of generic medications (at a cost of 40-50% of branded alternatives), more restrictive formularies, and therapeutically substituting comparable medications that reach the same results with similar risk and at a lower cost. However, the generic utilization rate (currently at about 43%) is relatively flat for most payers that do not have significant copay differences between brand and generic medications. Benefit restrictions have provided the most cornplications, because they frequently require some prior authorization procedures. Both physician and pharmacy providers and members have bitterly complained about the disruption of care incumbent in prior authorization procedures implemented by PBMs and payers, such that the current trend is to limit the number of medications covered under these programs. The high cost of these programs is also at issue, whether performed internally or outsourced to PBMs, since upward of 80% of requests for prior authoriza-

tions are approved. As a separate issue "stop loss" and reinsurance policies have also been scrutinized to include pharmacy costs for members reaching more than $10,000 per year. Finally, fraud and abuse by providers is monitored by PBM audits. The effectiveness of these audits has previously not been subject to payer scrutiny. However, the current climate for contractor oversight is leading some payers to insist upon results and recovenes similar to benchmarks in Medicaid and other auditors of the same providers.

Utilization Models. These are the worst possible construct. Previous efforts to limit the number of prescriptions per member (i.e., utilization management) have resulted in poor control of medical conditions and have led to an increase in emergency department and hospital admissions.

Integrated Pharmacy and Medical Models. The processes of care and information technology have not progressed to the point where medical and pharmacy activities can be integrated and cooperatively managed. As a resuit, these models await future developments.

There are some other novel ideas. Some payers that are close to Canada or Mexico are considering sending their employees and retirees over the borders to purchase their medications. These payers have identified legitimate pharmacies where they can be assured of receiving potent medications at significant discounts of 60-80%. These efforts are in their infancy and require extensive research to ensure that legal and appropriate clinical oversight is achieved.

With all of this emphasis on cost, where is the "value"? From a quality standpoint, drug utilization review programs must identify potential clinical problems and act as the stimulus for more evidence-based approaches to treatment that provide a minimum level of care and less variation in the treatment of patients with similar problems. These evidence-based approaches include communication of information through provider profiling and education; online hard edits for important drug interactions, and dosage problems that can lead to adverse drug effects; and regular and ongoing patient education. Emphasizing these efforts to increase the quality of the benefit, and thereby reduce cost, is similar to the emphasis and impact made by quality programs introduced by Deming and others to product and service industries.

The “M” in Pharmacy Benefit Management

Having exhausted benefit remedies, other management tools must be employed to provide incremental cost improvements and quality enhancement. What is being done to manage the increase in pharmacy benefit cost? In the face of double-digit increases in pharmacy benefit cost, payers are demanding cost cuts from PBMs. Where can we achieve these cuts? Fundamentally, PBMs limit cost by:

- Negotiating discounts with pharmacies
- Providing electronic adjudication of claims to ensure eligibility and benefit compliance
- Providing deeper discounts through their wholly owned mail-order/Internet pharmacies
- Rebating some of the savings achieved by contracts with drug manufacturers,

On the other hand, since PBMs make money by claim adjudication, filling mail-order prescriptions, maintaining a percentage of rebates collected from manufacturers (and collecting additional fees from drug marketing programs), payers have taken a greater interest in ensuring that PBM incentives are aligned with their goals. Some large payers have chosen to adjudicate claims internally and contract directly with pharmacies in order to ensure that they are not adversely harmed by the PBM's incentives, and that they can decrease their costs by eliminating the "middleman." These payers have also discounted their fees by eliminating the "spread" between what the PBMs charge to the payers and what they pay the pharmacies. Internal management of the pharmacy benefit has not become a major movement as of yet, mostly due to the fact that it re-

quires significant expertise and large member counts to achieve volume discounts. In addition, market pressures have discounted claim adjudication fees and drug average wholesale price (AWP) discounts to the point that they are commodities and trade within pennies between payers.

Market pressures on PBMs and the maturing of the marketplace over the last year have led to very aggressive discounting of fees and forced PBMs to offer larger rebates just to maintain their current market share. For example:

- Pharmacy discounts are reaching 16% off the average wholesale price (AWP).
- Dispensing fees to pharmacies are decreasing to $1.50 per prescription.
- Administrative fees for adjudicating claims are dropping by half, and to zero for very large clients.
- Rebates are doubling. (Benchmarks for rebates are the HCFA rebates of 15.1% for prescription medications and 11.1% for over-the-counter medications. Further discounts are on a per payer basis and can reach as much as 85% for some Medicaid programs.)
- PBMs are offering deeper mail-order discounts.

Most of this is due to the demand for "management" of double-digit benefit increases. PBMs are able to offer these discounts by achieving greater rebates and marketing incentives from drug manufacturers with three-tier and higher copay programs, which lead to greater market share for certain drugs. They are also extracting deeper discounts from pharmacies, but balancing some of the "pain" of the discounts by allowing the pharmacies to collect entire copays (called "zero balance billing") even when the medications cost less. The PBMs are facing a more difficult contracting environment, however, because chain pharmacies and food market pharmacies control an increasing share of the market (about 61%) so they are more able to resist price discounts without some balancing revenue. The PBMs do offer greater mail-order discounts in efforts to shift more market share (currently 14.6%) to their wholly owned entities where they keep the revenue and can presumably offer better clinical oversight. They can balance these counts by the volume purchasing available when tiered copays help move market share to specific branded medications.

While PBM contracts have usually covered three-year terms, the influence of market pressures indicates that future contracts should include options to readjust fees yearly by utilizing "market-to-market" clauses. Such clauses would ensure that payers are not fixed in higher cost contracts when the market falls and unable to participate in lower fees.

Value-added programs, disease management programs and other offerings by PBMs have not been highly popular. Many of these programs, while seemingly adding to the value proposition for the benefit, have not been shown to be highly effective or to have returns-on-investment (ROI) of greater than 1.5:1. (A benchmark for these programs is the typical ROI of 3-4:1 expected for any capital program.) As a result, payers have generally requested these programs, but have been reluctant to pay for them. Several national quality organizations, e.g.,NCQA, are developing accreditation tools for PBMs and various states are considering legislation for PBM oversight. As a result, it is expected that PBMs will have greater oversight and a requirement for offering more robust quality programs over the next three to five years, Some larger payers are enhancing their oversight of PBM administrative policies and demanding performance improvement as well as improved performance in the compliance with benefit hard and soft edits. These improvements are targeted to administration of the benefit, and not to benefit changes or the cost of drugs. There is a realization that the same performance oversight expected from a manufacturer or service provider should be applied to PBMs, TPAs, insurers or health plans. Cost savings from process oversight should approximate the savings seen from Six Sigma programs and at least 7% of total benefit expense.

Where Is the "M"?

The future will show that the health care benefit, and the pharmacy benefit in particular, will continue to cover a larger share of discretionary spending for all employees, retirees and their dependents. The pharmacy benefit is an expense and, therefore, it must be managed the same as any other business or personal expense. Whether it is managed internally or outsourced to a PBM, the payer and the member must demand measurable value for each dollar. And, payers will demand even more management ("M").

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