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ISSUE BRIEF



Pharmacy Benefit Managers: A Model for Medicare?

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A discussion featuring

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Pharmacy Benefit Managers

Overview—*This issue brief uses large employer experiences with pharmacy benefit managers (PBMs) to shed light on their potential as Medicare outpatient drug benefit administrators. PBM management techniques and typical employer approaches are discussed, as well as employer perspectives on PBM strengths and weaknesses and lessons learned. Considerations for Medicare policy are also examined. Information is based on a literature review and conversations and telephone interviews with employers, PBM industry executives, and benefit consultants. This brief builds on previous National Health Policy Forum PBM industry analysis; in particular the October 1999 forum and issue brief “The ABCs of PBMs.”*¹

Pharmacy benefit managers (PBMs) are central to the debate over a Medicare prescription drug benefit. Virtually all the major proposals include PBMs to administer the benefit, with some analysts citing the method as an alternative to price regulation.² But not all PBMs are alike.

The industry, which administers drug benefits for more than 200 million people nationwide, is varied and changing.³ PBMs provide a wide array of services, employ different management strategies, and operate in a very complex pharmaceuticals market. In recent years, the PBM industry has gone through dramatic consolidation.⁴ Now, the three largest firms handle more than three-quarters of retail prescription drug purchases.⁵

Large self-insured employers turned to PBMs during the 1990s to administer the popular drug benefit, manage cost and utilization trends, ensure appropriate use of drugs, and improve care quality. Although most employers are satisfied with their PBM, concern is growing as drug spending continues to climb at double-digit rates. Employer frustration over rising costs and questions about appropriateness of drug use are stimulating interest in PBM contractual relationships, especially financial arrangements with drug manufacturers, and the bearing those relationships may have on PBM performance.

Amidst a growing public discourse about drug spending and affordability, Congress is considering a Medicare benefit. Whether the best practices of private-sector pharmacy benefit management are appropriate for Medicare is uncertain. PBMs rely on utilization controls, especially techniques that promote formulary

compliance, to curb spending growth. Industry supporters argue the controls encourage appropriate drug use, but the public backlash against managed care could spill over to PBMs if they are seen as too intrusive or indifferent to consumer needs. At the very least, a Medicare benefit would encourage closer government scrutiny of PBM practices, a prospect not unwelcome to private purchasers. At the worst, Medicare reform politics could involve the industry in delivering the benefit but take the teeth out of its cost- and quality-management capabilities.

This Forum session will bring together speakers representing large employers, PBM firms, industry analysts, and health policy experts to discuss the strengths and limitations of the pharmacy benefit management model that has evolved in the private sector and its suitability for a Medicare prescription drug benefit.

INDUSTRY SNAPSHOT

PBMs administer prescription drug benefits through contracts with employers, managed health care organizations, and insurance carriers. Today, the top 20 firms manage more than 90 percent of retail prescription drug purchases, and three firms—AdvancePCS, Express Scripts, and Merck-Medco Managed Care—dominate the market.⁶ The oldest began as claims administrators.

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Many newer industry members were started or acquired by health plans, pharmaceutical manufacturers, retail pharmacy chains, or other PBMs to build specific capabilities. Still others were established with a particular niche in mind, such as mail order pharmacy.

A common strength of today's PBMs is use of automated processes and information technology. Electronic communications and real-time claims processing are essential to industry operations. The member takes a prescription to a participating pharmacy, where the pharmacist uses a computer to check member eligibility, the presence of the medication on the plan's formulary, plan rules about generic and therapeutic substitutions, and the member copayment. Other techniques pioneered by PBMs, including standardized claim forms and mail order pharmacy, have helped make the industry a leader in administrative efficiency.

Contractual relationships with retail pharmacies, pharmacists, wholesalers, and pharmaceutical manufacturers are another reason for the industry's growth. PBMs negotiate drug price and dispensing fee discounts with retail pharmacies. They frequently provide incentives to pharmacists to encourage generic drugs and formulary compliance and negotiate price discounts with drug manufacturers and wholesalers for mail order services. The principal sources of net revenue for PBMs are retained rebates and the difference between drug acquisition cost and sales cost for mail service pharmacy, according to industry experts.

Contracts with manufacturers are beginning to come under closer scrutiny, however. PBMs contract with manufacturers for rebates (after sale discounts) based on demonstrated market share utilization shifts. Rebates range between 2 and 20 percent of the drug's average wholesale price, according to Bridget Eber, Pharm.D., who is practice leader, prescription benefits, for Hewitt Associates.⁷ Variance is attributed to competition within therapeutic categories and the type of formulary, among other factors.

Most employers contracting with PBMs receive a share of between 50 and 100 percent of the rebate. But PBMs often receive several forms of income from manufacturers, including unrestricted financial grants and fees for disease management programs, rebate administration, and analysis of drug expenditure data. While industry experts are aware of these arrangements, few details are available because of their proprietary nature. Purchasers are beginning to question whether they are getting sufficient value for the price they pay for PBM services.

PBM MANAGEMENT TECHNIQUES

Basic management techniques include pharmacy network management, formulary management, drug utilization management, and mail service. Many PBMs also provide disease management programs. The extent to which these techniques are used in combination with member cost-sharing affect drug cost and utilization trends. In specifying their prescription drug benefit plans, which are administered by the PBM, employers balance cost-containment opportunities with employee satisfaction, convenience, and access to affordable drug therapies.

Pharmacy Network

PBMs offer a range of broad to narrow retail pharmacy networks. A narrower network concentrates purchasing power by limiting the pharmacies at which members are covered, thereby leveraging greater discounts. Thirty-one states have "any willing provider" laws requiring PBMs to contract with any pharmacy willing to accept their reimbursement rate.⁸

Formulary

The formulary is a fundamental tool for the PBM. It is a list of the plan's preferred drugs within each therapeutic class. Formulary options range from the least restrictive open formulary to the most restrictive closed formulary. Managed formularies combine member cost-sharing incentives with the list of preferred drugs to encourage their use. Three-tier and four-tier cost-sharing structures are becoming popular because they allow for an open formulary while requiring higher member contributions for non-preferred drugs.⁹

Drug Utilization Review

Prospective, concurrent, and retrospective drug utilization reviews are used to ensure safety, improve care quality, and promote compliance with the formulary. Prior authorization is a form of prospective review, conducted before medications are dispensed and, ideally, before they are prescribed. Prior authorization programs target specific drugs and require special authorization at the point of sale for coverage by the plan. Most often, the programs apply to drugs that are high-cost and have off-label uses and a potential for misuse.

Concurrent reviews are done electronically before medications are dispensed. The prescription is checked against the formulary as well as the member's eligibility, prescription record for drug interaction, drug-disease

interaction (when available), appropriate dosage, and other factors. The pharmacist may receive one of two types of alerts (or edits) regarding the transaction. The first does not allow the transaction to proceed. The second allows the transaction to be processed and provides information to the pharmacist. Based on the information, the pharmacist may contact the prescribing physician before proceeding or after the transaction is processed.

Retrospective reviews encourage compliance with the formulary and promote safety by revealing inappropriate prescribing patterns. It can also be used to assess prescribing behavior against best medical practice. Often, physicians who frequently prescribe drugs that are not on the formulary are contacted in writing.

Generic Substitution and Drug Interchange

Substitution of generic drugs for their brand name equivalents is common and cost-effective. Therapeutic interchange is the substitution of one drug for another in the same therapeutic class. The technique encourages formulary compliance. However, physician permission to interchange drugs is required due to differences in drug chemical compounds.

Mail Services

Dispensing medications by mail is cost-effective for maintenance drugs because of discounts negotiated with wholesalers and manufacturers and the absence of retail pharmacy overhead. Member communications and a range of benefit design options are used to encourage members to use mail service when appropriate. Some PBMs own and operate their own mail order pharmacies, while others outsource the service. Many PBMs allow members to refill maintenance medications via the Internet.

Disease Management

Many PBMs provide disease management programs for common and potentially high-cost conditions, such as asthma, diabetes, heart disease, and depression. Often education and disease-specific information are available to members. Sometimes members are encouraged through targeted communications to comply with their treatment regimens and to take an active role in the management of their conditions. Some PBMs are reconsidering their disease management programs due to sensitivity about medical confidentiality; others are reassessing programs as a result of marginal success in reaching target populations.

LEADING-EDGE PBM PRACTICES

Leading-edge practices use the industry's technology and data management competencies to put information and tools into the hands of physicians and consumers. One example is the recently announced RxHub LLC, a joint venture of AdvancePCS, Express Scripts, and Merck-Medco Managed Care to create an electronic exchange and encourage more physicians to prescribe electronically.¹⁰

The venture addresses three major health policy concerns: safety, quality, and consumer service. It attempts to enhance safety by reducing errors introduced by reading handwritten prescriptions. Quality is addressed by making available to physicians the PBM's database and its quick access to information such as drug interactions. And it targets consumer inconvenience by providing information to physicians at the point of care instead of catching problems, such as noncompliance with the formulary or incorrect dosage, at the pharmacy. The program is currently being tested with physicians. The three PBMs plan to introduce the exchange in late 2001 or early 2002.

To be sure, physician acceptance and connectivity will be necessary for the exchange's success. Many doctors use the Internet now, although primarily for administrative transactions and clinical research.¹¹ Fewer than 5 percent prescribe electronically, according to the RxHub venture partners.

Yet, despite the potential for improved safety and efficiency, the venture is raising concerns among chain and independent pharmacies. They believe RxHub will shift patients from retail pharmacies to the partners' mail order and Internet services. The PBM partners maintain RxHub is merely a standardized electronic platform for prescription writing. Physicians will be able to transmit prescriptions to the patient's pharmacy of choice. Another concern of some smaller pharmacies is a burdensome investment in information technology in order to receive prescriptions electronically.

New PBM consumer tools can tap into the power of the Internet for convenient, customized access to health and prescription drug information. Two-thirds of employers with 20,000 or more employees use Internet/intranet applications for medical benefits.¹² PBMs are following suit by providing plan members with online information and tools to help them effectively use their prescription drug benefits and manage their health.

PBMs are also dedicating more resources to clinical consulting. Their pharmacists meet face-to-face with

physicians and other health care professionals to provide clinical information about prescription drugs and treatment protocols. Often, clinical consultants can work from a profile of the physician's prescribing practices to tailor the consultation.

Finally, leading PBMs are positioning themselves as comprehensive health management organizations providing a wide range of research and health improvement services. One example is the Center for Healthy Aging and Drug Safety at AdvancePCS. The firm is dedicating staff and resources in a "holistic approach to promoting safe and cost effective health care by adding the consumer as an active participant in his/her own health care," according to Renwyck Elder, R.Ph., vice president for strategic business consulting. The center researches aging and drug safety issues and educates consumers, physicians, and pharmacists. Its mission is to influence the overall cost of care by facilitating reductions in direct and indirect costs.

EMPLOYER-SPONSORED PLANS

Forty-eight percent of employers with more than 10,000 employees contract directly with a PBM, according to a recent survey by consulting firm William M. Mercer.¹³ Each employer's prescription drug plan is different with respect to coverage and elements such as utilization controls and disease management. However, employers interviewed for this brief expressed similar expectations of their PBMs: smooth plan administration with advanced use of technology and good internal controls; best practice clinical management programs, including provider initiatives and effective drug utilization review programs; favorable financial terms; excellent customer service; and PBM willingness to partner on areas of need or interest.

Contracted Services

Large employers contract with PBMs for a fairly similar set of pharmacy benefit management services: administrative services, pharmacy network management, formulary management, rebate services, drug utilization management, and mail service. In contrast, health plans may contract with PBMs for administrative services and drug utilization review but manage their own formularies and negotiate their own discounts.

Most PBMs contracting with employers forecast expenditures and consult with employers on plan design. Employers make basic decisions about the restrictiveness of the formulary and the degree to which

prescription drug management techniques are used to promote formulary compliance.

Administrative services usually include maintaining eligibility files, issuing identification cards, member services, reporting, and processing claims consistent with plan design by adhering to coverage rules, such as formulary and prior authorization, and member cost-sharing in the form of deductibles, copays, coinsurance, and benefit maximums.

In addition to concurrent and retrospective reviews, drug utilization management often encompasses implementation of best practice clinical management programs, health and disease management programs, case management, physician initiatives, and member education and outreach programs.

With a growing number of breakthrough drugs coming to market and increased direct-to-consumer advertising, more employers are asking their PBMs to provide them a formal clinical review of new drugs. The review includes recommendations for placement in the formulary and for encouraging appropriate utilization through controls such as prior authorization, retail edits, quantity limitations, and member cost-sharing.

Typically, large employers contract with only one PBM because discounts and administrative fees are based on projected group utilization. Generally, they opt for a broad pharmacy network, and contracts usually cover a three-year term. The various criteria employers consider in choosing a PBM are summarized in Table 1.

Table 1
Choosing a PBM:
Employers' Administrative, Service,
and Financial Criteria

- Bidding requirements (e.g., eligibility file maintenance)
- Firm profile and stability
- Operational and administrative procedures
- Network management
- Utilization and cost management
- Financial terms
- Performance guarantees
- Miscellaneous administrative requirements
- References

Source: Bridget Eber, Hewitt Associates

Financial Terms

The typical payment arrangement for employers contracting with PBMs is a fee-per-claim basis. Administrative fees have been declining in recent years, averaging between 10 cents and 60 cents per claim. Financial terms considered during the bid process include administrative and dispensing fees, rebates, and price discounts on drug average wholesale price and maximum allowable cost, a reimbursement schedule for generic drugs. Base rate administrative fees often do not include fees for customized programming of systems administering utilization controls such as prior authorization programs. Contracts often contain provisions prohibiting employers from discussing negotiated fees and discounts with other employers.

Performance Evaluation and Financial Guarantees

Contracts usually specify performance on several factors. For example, dispensing indicators may address mail service rate, timeliness, accuracy, and generic drug rate. Customer service indicators may include telephone accessibility, response time on written inquiries, and timely and accurate issuance of identification cards.

Employers typically approach PBM performance evaluation in a three-step process. First, they identify areas of importance, such as customer service, generic rate, or mail service timeliness and accuracy. Next, they consider financial incentives. Usually a percentage of the administrative fee (20 to 50 percent) guarantees performance. Sometimes a limited risk-sharing arrangement is used so that PBMs and employers share any savings. Finally, they structure the financial guarantee by establishing targets and defining measures and incentive/penalty arrangements.

Audits

Audits are used to formally verify PBM performance. The audit provides oversight, ensuring that the PBM meets its contractual agreements, as well as information on utilization and PBM operations and performance. A recent survey found that 68 percent of employers have audit rights in their contracts, but only 30 percent audit their PBMs.¹⁴ PBM audits are becoming more frequent, however, and employers are incorporating more detailed audit language into their contracts. New provisions more clearly define audit rights, such as choice of auditor, time frame for responding to requests, and ownership and use of data. As part of the process, PBMs must audit participating pharmacies at their own cost.

EMPLOYER PERSPECTIVES AND LESSONS LEARNED

A recent survey of employers by the International Society of Employee Benefits Specialists reported that 91 percent of respondents said they were satisfied or very satisfied with their PBMs.¹⁵ Discussions with employers and benefit consultants provide more detail on employer perspectives about PBM strengths, areas for improvement, and lessons learned. Although employers acknowledge PBMs have different management strategies and strengths, they articulate some common themes about performance.

Strengths

Administrative Services. Employers report PBMs efficiently and economically manage a high volume of claims with relatively few problems for beneficiaries. For example, one large employer interviewed for this brief reports that 400,000 prescription drug claims are processed annually. AdvancePCS, one of the three largest firms, manages 450 million pharmacy claims annually, representing \$18 billion in drug expenditures.¹⁶ Nowhere else in the health care delivery system is such a large volume of claims processed in real time so efficiently.

Negotiated Discount Pricing on Drugs and Networks. PBMs are effective at negotiating rebates from manufacturers and lower prices from retail pharmacies (drugs and dispensing fees) for plan members than are available to cash-paying customers.

Drug Utilization Review. PBM databases are comprehensive. They provide real-time safety controls and the potential to continually improve efficiency and care quality.

Mail Service. Audits of mail order services reveal they are efficient and secure. Plan members, rather than sponsors, are usually the primary beneficiaries of savings associated with mail service due to the deep discounts offered to encourage their use. For example, the retiree drug plan might have a 20 percent coinsurance for a 30-day supply at retail and \$10 generic/\$20 brand copays for a 90-day supply by mail. Employers are reexamining plan design to ensure it does not overemphasize mail service and result in wastage of medications and unnecessary spending. They want to avoid problems such as a beneficiary's buying a 90-day supply of a maintenance drug only to have problems with side effects and never finish the course of medication. Some employers require at least two prescription fills through retail before allowing or requiring the prescription to be processed by mail.

Areas for Improvement

Client-Focused Infrastructure and Reporting. A number of employers express dissatisfaction with PBM reporting, saying they have difficulty understanding the data. Employers also want reports tailored to specific interventions. Generally, PBMs will not customize reports without charging additional fees. For their largest clients, the cost of customized systems and reporting is usually included in the bidding process.

A related issue employers raise is member service. Especially during the first quarter of a plan year with new coverage rules, employers report that members are frequently directed back to them rather than having issues resolved by the PBM. As large corporations reduce the size of their benefits staff, the problem is becoming more pronounced. Employers want PBMs to use more sophisticated information and reporting systems so that member service representatives can readily reference coverage rules and reports can be customized. They also want better handling of member inquiries, especially when delivering unwelcome messages, and better execution of appeals processes.

Industry leaders are aware of employer concerns and are responding in a variety of ways. For instance, some PBMs are experimenting with electronic venues to customize reports. Employer-clients would have a database available to them and could customize their own reports. PBMs are also distilling data into actionable information and creating reports consistent with plan objectives, rather than reporting a lot of data that may be meaningless to the client. PBMs and their clients are continuing to work together to improve reporting and customer service.

Proactive Programs. Employers want PBMs to more actively address physician prescribing patterns and pharmacy performance to encourage best clinical practice. The lack of proactive account management relative to cost management and quality improvement opportunities is a common employer complaint.

For example, Verizon Communications, working with Omnicare, Inc., a geriatrics health care company, found a significant number of Verizon's Medicare-eligible retirees were being prescribed cisapride, a gastroesophageal reflux disease medication with adverse side effects for many seniors.¹⁷ They also found their PBM did not have a drug utilization review protocol to caution against cisapride use in seniors, even though there are alternatives with significantly less risk. Omnicare pharmacists consulted with prescribing physicians in an effort to reduce the risk of cisapride-

associated problems in plan members with medical and drug risk factors. The effort resulted in cisapride being discontinued in 78 percent of identified cases.

Another example is an effort led by General Motors (GM) to improve treatment compliance and drug effect through dosing optimization. GM's director of pharmacy, health care initiatives, Cynthia Kirman, PharmD., has met with hospitals, health plans, PBMs, medical societies, employers, and drug manufacturers to stimulate awareness and education about the quality and cost implications of once- versus twice-daily dosing. GM is working with Merck-Medco Managed Care on developing a pilot program to improve optimal dosing for maintenance drugs obtained through mail service.

Employers recognize that payment on a per claim basis does not provide PBMs an incentive to improve clinical practice. Some are exploring more aggressive risk-sharing arrangements such as performance-based pharmacy networks. Others are excluding rebate guarantees from their contracts to reduce incentives driving utilization toward specific drugs.

Lessons Learned

Employers interviewed for this issue brief generally agree that they would offer the following advice to others considering contracting with PBMs.

Recognize that not all PBMs are alike. Most PBMs evolved with a focus on a particular market segment and therefore developed specific management strategies and strengths. For example, a PBM may present excellent financial terms but not have a strong reputation for service to pharmacists and physicians. Open reporting of rebate agreements and processes may be a management approach for one firm, but not another. One PBM may have successful disease management programs, while another is relatively ineffective in demonstrating participation by target populations. Although there is a fairly uniform level of administrative services provided by industry members, employers must consider a number of financial, operational, and special program issues during the bidding and selection process.

Clearly define objectives and contract terms. As employers gain more experience with PBMs, they are less likely to use standard PBM contracts. Many employers are undergoing a comprehensive review of contract terms to improve clarity. For example, new contracts clearly define how measures will be calculated and reported and how penalties will be assessed. They thoroughly describe audit rights and what constitutes a rebate. Financial terms are being renegotiated with

greater use of incentive/penalty arrangements. More employers are working with consultants familiar with PBM operations in order to improve their knowledge and position prior to contracting.

Formally review performance. Although it can be expensive, more employers are auditing their PBMs. Occasionally, audits find errors such as incorrect fees or discounts programmed at set-up that result in financial charges to the PBM. Some employers report that an audit revealed a PBM practice they did not track in routine reports, such as therapeutic substitutions at mail service. The Segal Company, an actuarial and consulting firm, finds formal PBM reviews and audits often “provide encouraging news about PBMs,” such as higher than expected generic substitution rates and larger discounts than required by the contract.¹⁸

Actively communicate with plan members. Leading employers believe the more informed employees and retirees are about their prescription drug benefit, the less likely they will have problems. At a minimum, members should understand the objectives of the prescription drug plan and know what drugs are on the formulary and what techniques are used to promote formulary compliance.

Changes in coverage or processes present special communication challenges. Drug price changes are especially difficult to communicate in a timely way. Employers devote significant resources to benefits communication. They actively educate employees and retirees through a variety of venues about their benefit plans, navigating the health care system, and health promotion/disease management. PBMs, through contractual agreements, are also responsible for educating plan members. They use multiple media to reach out to members and respond to their inquiries. They also prepare network pharmacies to answer plan member questions.

Growing Concerns about Manufacturer Relationships

As prescription drug spending continues to climb at double-digit rates, more employers have questions about the effects of PBM/manufacturer relationships. Speaking candidly, they worry that manufacturer pricing and rebate agreements may inappropriately drive formulary and drug switching decisions and excessive use of drugs. There is no objective evidence linking rebates to inappropriate volume increases or drug substitutions to consumer harm or benefit. But PBMs do not disclose details of rebate negotiations and other revenue from manufacturers, fueling speculation

about the actual effects of those agreements. Jim Astuto, regional manager with the healthcare management group at Verizon Communications, speaks for many employers when he asks, “Are we getting discount prices while driving increased volume?”

Until recently, few employers were interested in drug formulary management. Employers are reluctant to involve themselves in areas where they have little expertise. After making basic decisions about formulary restrictiveness and enrollee cost-sharing, they rely on the PBM and its pharmacy and therapeutics (P&T) committee to recommend a quality formulary. The P&T committee usually comprises physicians and clinical pharmacists and is often independent of the PBM. Their recommendations are based on evaluations of drug efficacy, safety, and relative cost. Drug side effects and their relationship to physician visits, clinical monitoring, and patient functioning are considered when determining relative cost.

Many P&T committees use what Joanne Sica, assistant vice president of Aon Consulting, refers to as a “bucket strategy.”¹⁹ The first bucket contains “must have medications.” The second bucket contains “no need to have medications.” These drugs either have no clinical advantage over others in the same therapeutic class or have safety or efficacy profiles that are not comparable to others in the class and/or have a higher price. The third bucket contains “could have medications.” These have similar safety, efficacy, and relative cost as other drugs in the therapeutic class and are good clinical alternatives for many patients.

Once determinations are made on “must have” and “no need to have” drugs, the committee may provide guidance on the “could have medications” and the number of choices physicians should have within a therapeutic class. Otherwise, their work is complete. The PBM then negotiates price and rebate agreements on the “could have medications.” Whether those drugs end up on the formulary may be due more to the capabilities of the PBM’s rebate contracting department than to clinical significance, according to some industry experts.

Some PBMs report a somewhat different P&T committee process. Among others, the Merck-Medco Managed Care P&T committee does not use cost as a factor in its considerations. Drug price is negotiated by the PBM based on its ability to move market share. It does not enter into P&T committee deliberations.

Rebate negotiations seem to be getting more complex. Negotiating a rebate for one drug often necessitates having other of the manufacturer’s drugs on the

formulary. Manufacturers may also require demonstrated market shifts to qualify for rebates. The PBM's use of the formulary to shift utilization gives them better leverage to negotiate prices and rebates from manufacturers. But there are numerous questions about that strategy, such as whether drug switching decisions are in the best interest of individual consumers and how physicians view therapeutic substitution requests and other, perhaps numerous, PBM formulary advisories.

Employers play a part in the problem by accepting discounts and using rebate performance guarantees. In this competitive environment, however, most employers are reluctant to give up rebates when everyone else benefits from them and there is no hard evidence of detrimental utilization effects.

CONSIDERATIONS FOR MEDICARE

As Congress considers expanding Medicare benefits to include outpatient prescription drugs, large employer experiences highlight important considerations for Medicare policy.

Expenditure Trends and Patient Affordability

Prescription drug costs as a percentage of total health care expenditures will continue to rise and older Americans will continue to account for a disproportionate share of drug spending. In 2000, drug spending rose by 19 percent to almost \$132 billion. A recent study by the Health Care Financing Administration predicts prescription drugs will be a major driver of annual health care spending increases averaging 13 percent over the next decade.²⁰ Medicare beneficiaries will spend an estimated \$686 out-of-pocket on drugs in 2001, and 20 percent of them will spend more than \$1,100.²¹

Employer experiences bear out these data. The drug benefit is the fastest rising component of retiree medical plan costs. A survey of large employers predicts retiree drug costs will increase 23 percent in 2001, compared to a 13 percent rise in total retiree medical plan expenditures.²² One employer interviewed for this brief reports that Medicare-eligible retirees use an average of 34 prescriptions per year, while the average for active enrollees is 11 percent.

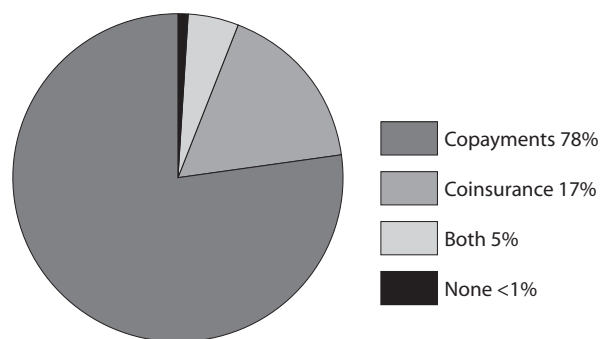
More work is needed to understand PBMs' capability to affect drug prices, expenditures, and trends. A 1997 U.S. General Accounting Office study of the Federal Employees Health Benefits Plan estimated significant savings from PBMs, although much of the

savings came from "lower prices paid to pharmacies rather than rebates offered by drug manufacturers."²³

Private employer experiences show PBMs exert more control over expenditures and trends than an unmanaged system does, but on the whole are unsuccessful in slowing spending growth. PBMs counter they could further slow spending if permitted to use more aggressive pharmacy management strategies, but employers are unwilling to do so.

Nevertheless, after almost a decade of annual double-digit growth in prescription drug expenditures, employers are increasing copays for brand and generic drugs. And more employers are considering shifting consumer cost-sharing from a copay to a coinsurance design. As shown in Figure 1, copayment accounts for more than three-quarters of current cost-sharing structures. The copay design, a flat fee paid by plan members for a prescription, such as \$5 for generic and \$10 for brand drugs, has resulted in employers' paying an increasing share of drug costs as prices have increased. The coinsurance design requires plan members to pay a percentage, usually 20 percent, of the prescription cost. Coinsurance designs automatically index member out-of-pocket spending to the drug's cost and may make consumers more aware of prices for different brand and generic drugs.

Figure 1
Employer/Employee Cost-Sharing Structures



Source: International Society of Employee Benefit Specialists, Survey Results, December 2000.

The Role of the PBM

The way the PBMs' role is defined and the flexibility they are given to use techniques such as formulary management and drug utilization review will likely

determine their effectiveness in containing costs and improving the way patients use and physicians prescribe drugs. However, just as there is a public backlash against managed care, there may be problems if PBMs are perceived by consumers and physicians as being too intrusive.

Such sentiment is evident in New Jersey, where new regulations effective July 1, 2001, prohibit health maintenance organizations from using a closed formulary or denying coverage for drugs not on their preferred list. The new rules also limit plan member and physician incentives to choose preferred drugs.²⁴

Citing such examples, policy experts speculate about the appropriateness of the current private-sector model for Medicare. Coverage decisions and processes in a Medicare benefit would need to be more public and subject to greater scrutiny. Some industry experts propose a fairly regulated approach to PBMs administering Medicare benefits, with open formularies, reference (or incentive) drug pricing, and periodic bidding for regional monopoly contracts. Others recommend a more competitive model, whereby seniors would choose among approved PBMs in their market.

Still others, such as the National Association of Chain Drug Stores (NACDS), question the scope of patient care and cost management responsibilities assigned to PBMs in Medicare drug proposals under consideration. NACDS would limit the PBM role to administrative functions, saying they have not been effective care managers and actually add cost to the system.²⁵

Depending on the structure of a Medicare PBM market, the formulary itself could be a critical sticking point in designing a workable benefit. Private employers make important decisions regarding the restrictiveness of the formulary and member cost sharing. Will Medicare play a similar role? If so, how will formulary decisions be made, and what are the implications of excluding drugs from the Medicare formulary? On the other hand, formulary design and compliance incentives are the key tools for containing costs. How would program spending be managed with an open formulary and few rules or incentives for preferred drugs?

PBMs and Financial Risk

Typically, PBMs contracting with employers are paid by a fee-for-service arrangement. They generally do not guarantee drug spending trend or take capitated risk. They do, however, negotiate financial guarantees for certain aspects of the plan, such as generic dispens-

ing rates and rebates. In recent years, PBMs experimented with capitated arrangements. These were quickly abandoned for a variety of reasons: PBMs are not insurers, they have not been able to accurately project cost trends, and they do not have contractual relationships with physicians and therefore have little ability to influence prescribing. Generally, proposals to shift Medicare's insurance risk for pharmacy to the PBM industry through full capitation have met with a cool reception. But, since the Medicare prescription drug bill passed by the House last year was based on capitation, the issue of risk assumption by PBMs has continued significance.

Marketplace Relationships and Dynamics

Finally, Congress must consider how a Medicare benefit administered by PBMs affects marketplace relationships and dynamics. For example, retail pharmacies say increased PBM market share disproportionately targets them for cost containment through low reimbursement rates. Another competitive issue they raise is the redirection of consumers to mail order and Web-based pharmacy services. While mail order and online pharmacies may be a convenience for consumers, the long-term impact on retail pharmacies is unknown.

THIS FORUM SESSION

Speakers

Bridget Eber, Pharm.D., who leads Hewitt Associates' national prescription drug consulting practice, will begin with an overview of the PBM industry and a discussion of the principles and "rules of the road" that generally guide large-employer contracting decisions. Before joining Hewitt, Eber was a regional pharmacy director for a large national HMO, where she was responsible for administrative and cost management programs. She has also practiced as a clinical pharmacist.

Cynthia Kirman, Pharm.D., director of pharmacy, health care initiatives, at General Motors, will discuss GM's experience with pharmacy benefit management and outline current GM pharmacy initiatives, with a focus on retiree issues. In her role at GM, Kirman, a registered pharmacist, works with insurance carriers, unions, and community leaders to improve prescription drug value and quality. Her previous professional experience includes serving as director of pharmacy programs for a health maintenance organization and as director of clinical information services for a pharmacy benefit management company.

Bruce I. Taylor, director, benefits planning, health and welfare plans, at Verizon Communications, will discuss the firm's experience with pharmacy benefit management as well as important considerations for Medicare's use of PBMs. At Verizon, Taylor is responsible for the strategy and management of the firm's health care and other welfare employee benefit plans. He is actively involved in national health care issues and holds leadership positions in the Washington Business Group on Health, the Employer's Managed Health Care Association, and the Leapfrog Group for Patient Safety, among others.

Jeff Sanders, senior vice president, strategic initiatives, at AdvancePCS, will focus on the operational issues PBMs face in providing services to large-employer customers and how these issues would play out in a Medicare environment. Before joining PCS in 1993, Sanders served three years as director of the Office of Legislation and Policy at the Health Care Financing Administration; he has also held posts with the Congress and the Office of Management and Budget.

Independent health policy consultant **Lynn Etheredge** will conclude with reactions to the speakers' presentations, raising key questions about the use of PBMs to implement a Medicare prescription drug benefit. Etheredge's career includes several stints at the Office of Management and Budget; he currently works with the Health Insurance Reform Project at the George Washington University and has authored numerous policy studies about Medicare reform and prescription drug coverage.

Key Questions

Among the questions to be considered by the speakers are the following:

- How effective are rebates for cost containment? And to what extent do purchasers actually pay the average wholesale price? If PBMs manage most of prescription drug purchases, can they all be getting discounts from the "average" price?
- What would be the role of PBMs in a Medicare benefit? By what process will Medicare as the buyer make cost containment, utilization management, and formulary decisions? If PBMs were given little latitude to apply utilization management techniques, how would costs be managed?
- How should the Medicare PBM marketplace be structured, that is, one PBM per area or competing PBMs?
- How would a Medicare benefit administered by PBMs affect marketplace dynamics and relationships among PBMs, retail pharmacies, manufacturers, and health plans? How would the benefit affect competition for PBM services, considering there are other companies with similar management capabilities, such as the Blues plans and EDS?
- What are the Medicare specific concerns, such as implementation and administrative challenges related to Medicare population characteristics (for example, older, sicker, lower average income; integration of Part A and B systems with PBM operations; and restructuring of medigap options)?
- In designing the benefit, how can Congress capitalize on industry information management capabilities to improve drug safety and efficiency?

ENDNOTES

1. For more information on industry evolution and a glossary of terms, see Robin J. Strongin, "The ABCs of PBMs," Issue Brief No. 749, National Health Policy Forum, October 27, 1999.
2. Mark McClellan, Ian D. Spatz, and Stacie Carney, "Designing a Medicare Prescription Drug Benefit: Issues, Obstacles, and Opportunities," *Health Affairs*, 19, no. 2 (March/April 2000): 26-41.
3. Anna Cook, Thomas Kornfield, and Marsha Gold, "The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit," a report by Mathematica Policy Research, Inc., for the Henry J. Kaiser Family Foundation, January 2000.
4. Strongin, "ABCs of PBMs," and Lynn Etheredge, "Pharmacy Benefit Management: The Right Rx?" Health Insurance Reform Project at the George Washington University, April 1995.
5. Cook et al., "Role of PBMs."
6. For a detailed overview of PBM origins and ownership, see Cook et al., "Role of PBMs."
7. Bridget Eber, "The Employer/Purchaser PBM Perspective," presentation for Hewitt Associates at the National Health Care Purchasing Institute Advanced Purchaser Workshop, Academy for Health Services Research and Health Policy, November 17, 2000.
8. Cook et al., "Role of PBMs."
9. A three-tier structure has different copayments for generic, brand, and nonpreferred brand drugs. In 2000, 29 percent of large employers used a three-tier plan with an

average copayment of \$29.00 for nonpreferred brand drugs, according to consulting firm William M. Mercer. Some of the new four-tier structures are based on cost and efficacy rather than whether the drug is a generic or brand. For example, a high-cost generic may be in tier two, while a low-cost brand name drug may be in tier one. Self-injectables, gene therapy drugs, and new biotech products are placed in tier four, with the highest copay or no coverage provided by the plan, although consumers may benefit from a price discount due to group purchasing.

10. Ann Carrns, "Trio of Big Pharmacy-Benefit Managers Announce Plans for Electronic Exchange," *Wall Street Journal*, February 23, 2001.

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13. Blaine Bos, briefing for Capitol Hill staff and media, based on Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans: Key Findings for 2000, April 18, 2001.

14. International Society of Certified Employee Benefit Specialists (ISCEBS), "Employer-Sponsored Prescription Drug Benefits—A Closer Look: Survey Results," Brookfield, Wis., December 2000.

15. ISCEBS, "Survey Results."

16. AdvancePCS, Fact Sheet, January 2001.

17. Jim Astuto, Regional Manager, Healthcare Management Group, Verizon Communications, Inc., telephone conversation with author, April 16, 2001, and National Health Care Purchaser Award Nomination Form, National Health Care Purchasing Institute.

18. The Segal Company, "A Prescription for Treating the High Cost of Drug Coverage: PBM Reviews and Follow-up," *Government Employees Benefits Update*, June 2000.

19. Joanne Sica, telephone conversation with author, May 30, 2001.

20. Stephen Heffler et al., "Health Spending Growth Up in 1999; Faster Growth Expected in the Future," *Health Affairs*, 20, no. 2 (March/April 2001): 193-203.

21. Kaiser Family Foundation., "Medicare and Prescription Drugs," Fact Sheet, March 2000; accessed January 30, 2001, at <http://www.kff.org/content/2000>.

22. Watson Wyatt Worldwide and Washington Business Group on Health, "Projected Employer Health Care Spending in 2001," survey, 2000.

23. U.S. General Accounting Office, "Pharmacy Benefit Managers: FEHBP Plans Satisfied with Savings and Services, but Retail Pharmacies Have Concerns," GAO/HEHS-97-47, February 21, 1997.

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25. National Association of Chain Drug Stores, "Assuring a Quality, Cost-effective Pharmacy Benefit for America's Seniors," Issue Brief, April 2001.