McGraw Wentworth

BENEFIT Advisor

Volume Seven, Issue Ten November 2004

In This Issue

In this tenth issue of the McGraw Wentworth Benefit Advisor for 2004, we will discuss pharmacy benefits. Pharmacy costs are one of the fastest rising component costs in medical plan cost increases. Organizations have made changes in the pharmacy arena to help control rising costs. However, looking into the components of a pharmacy benefit manager contract and negotiating contract terms can have an impact on your claim costs. The focus of this Advisor is to unravel the mystery of Pharmacy Benefit Management and provide useful ideas to help manage pharmacy cost.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

"Optimizing Your Pharmacy Benefit Manager Pricing"

Many organizations choose to self-fund their prescription drug benefit programs. Organizations that choose this route typically hire a pharmacy benefit manager (PBM) to administer their plans. While most PBMs offer discount pricing and utilization management initiatives, a closer look at your contract and plan design may reap significant savings.

Drug benefit cost increases still lead overall medical cost increases. The latest Mercer benefit survey indicates prescription cost rose 16.1% in 2003 for large employers. The increase was 16.9% in 2002 and 17.8% in 2001. Increases are expected to run approximately 14.5% for 2004 and approximately 15% for 2005. Prescription drugs are becoming a larger part of medical plan costs each year.

Organizations are reevaluating their prescription drug plan designs. They are increasing copays and making concerted efforts to steer their employees to more cost-effective prescription therapies. The use of a three-tier copay design increased to 50% in 2003 according to the Mercer survey. In 2002, only 42% of employers offered the three-tier copay. How can your organization manage prescription drug costs as these costs continue to climb? Taking a look at your PBM contract and looking at the plan design are both great places to start.

This *Benefit Advisor* reviews in detail the common components of a Pharmacy Benefit Manager contract. It explains the terms PBMs use and discusses opportunities to secure the best prices. It also discusses plan designs that maximize pharmacy plan benefits and manage claim cost.

PBM Contract Options

PBM contracts seem simple on the surface but they are, in practice, complicated. While it may seem straightforward, for example, a discount of 12% off Average Wholesale Price, you need to look below the surface. What exactly does that mean? PBM contract terms can be confusing. In order to appear competitive in specific situations, PBMs have become creative in their price structures. For example, they may quote a very small administrative fee to appear competitive, but they may keep part of the drug manufacturer's discount to meet their profit targets, instead of passing the discount on to your organization.

Continued on Page 2

Comparing your current PBM to others in the market is not easy. Each PBM will handle each component of your contract in a different way. A higher administrative fee may be more than offset by a very aggressive discount structure. While you need to review each component independently, you must review the combined elements of the price determination as well. In addition, the specific drugs your employees use and the pharmacies they use could have a significant price impact with different PBMs. One of the most effective approaches to review cost is to analyze two to three months of actual claim experience. However, not all PBMs can provide comparative repricing.

Remember that PBM arrangements change over time. A recent study conducted by The Pharmacy Benefit Management Institute, Inc., indicates pharmacy benefit discounts continue to improve:

- In 1995, the average discount off Average Wholesale Price (AWP) for retail use was 12%. By 2002, the discount off AWP was 14%.
- In 1995, the average discount off AWP for mail order was 15%. By 2002, the discount was 20% on average.

PBMs are under intense scrutiny regarding their prices. As a result, they feel pressure to offer better pricing arrangements.

PBM operating arrangements are changing rapidly. An arrangement that is attractive one year may not be as favorable two years down the road depending on changes in utilization and preferred arrangements.

It is important to review many areas when looking at your PBM relationship:

- Generic prescription pricing
- Brand name prescription drug pricing
- Plan design considerations

Generic Prescription Pricing

Many pharmacy plans are designed to encourage people to use generic drugs. It makes sense; generics should cost the plan significantly less. It is estimated that for every 1% increase in generic drug use, plans will save approximately 1-2% in claim cost. However, the exact amount depends on the contract prices for generic drugs.

In general, an aggressive pricing strategy for generic drugs is a Maximum Allowable Cost schedule (MAC list). This schedule is simply a list of generic drugs and their aggressively discounted prices. To determine how favorable your PBM's MAC list is to your plan, either ask your current PBM about what MAC options it offers and/or compare your PBM's MAC options with the options other vendors offer. Make sure the list covers the prescription drugs your employees actually use.

For example, PBM A may have a MAC discount of 67% off the AWP while PBM B pays only 55% off the AWP on its MAC. Of course, PBM A appears to offer the most favorable price on the surface, but you need to dig deeper into the details. PBM A only has 300 drugs on its MAC list and the drugs are not the ones your employees use the most. PBM B, on the other hand, has 600 drugs on its MAC list and those drugs represent 50% of the drugs your employees use. You can see how PBM A looks more favorable on the surface, but PBM B offers a more cost-effective arrangement.

Another important question to ask your PBM vendor is how much the PBM pays the pharmacy. It is not uncommon for a PBM to have one MAC list for the plan sponsor and a different MAC list offering more aggressive discounts for the pharmacy. In short, the PBM may bill the plan at one rate, pay the pharmacy a lower rate and keep the difference, or spread.

When you review generic pricing, you should also consider the PBM's discount on generic drugs not on the MAC list. Typically these drugs are covered at a discount off Average Wholesale Price (AWP). For generics, the Average Wholesale Price is not particularly competitive. Your plan will save money with a MAC list that covers the drugs your employees use most and has a relatively high discount off AWP for non-MAC generics.

Continued on Page 3

NOTABLE THOUGHTS

A BUDGET IS JUST A METHOD OF WORRYING BEFORE YOU SPEND MONEY, AS WELL AS AFTERWARD.

ANONYMOUS

Brand Name Prescription Drug Pricing

Brand name prescription drugs, in general, are more expensive than generics. However, an employee may need a brand name drug to treat a specific condition.

The brand name drug price is often expressed as discount off Average Wholesale Price (AWP). When you review your contract's brand name pricing provisions, consider the following:

- Either the plan's contract or the pharmacy's contract with the PBM can determine the amount the plan pays the pharmacy for a brand name drug. It is common for the PBM to have one discount arrangement for the pharmacy and another for the plan.
- How is the brand pricing discount expressed in the contract? Is it a set discount or a discount that allows "the lower of the plan's contract or the pharmacy contract price"? Compare the plan's contract discount with the pharmacy contract discount. If the pharmacy contract discount seems more aggressive, you will often find it better to seek a "lower than cost" arrangement. Ask your PBM which options offer the most aggressive brand name price discounts.

Also, consider rebates. Rebates are often available on specific brand name prescription drugs. Rebates can affect overall cost, although they may not always decrease costs. Generally, PBMs offer rebates on brand name medications when at the end of the plan year they get a "kick back" based on volume purchasing from drug manufacturers. While re-

Continued on Page 4

TERMS TO KNOW

- **Generic Drug** – A drug that is no longer protected by a patent. These drugs can be manufactured and distributed by different companies and must be approved by the Food and Drug Administration.
- **Brand Name Drug** – A patented drug generally manufactured and sold by the developing firm. On occasion, cross licensing will occur and in these instances, you may see more than one firm producing a brand name drug. These are called co-branded drugs.
- **Dispensing Fee** –An additional fee a pharmacy adds to the cost of a prescription. The fee represents the professional charge for the pharmacists' services which includes cost for overhead expense, profit and cognitive services.
- **Formularies** – A formulary is a list of drugs compiled by an institution (including pharmacy benefit managers, insurance carriers and even the government) that needs special handling. Drugs on a formulary list generally are deeply discounted or must meet special conditions before the prescription can be filled.
- **HCFA Federal Upper Limit Price** – The price established by the Health Care Financing Administration as a target payment amount for state Medicaid programs. It typically relates to drugs available from multiple sources, such as generics, and is not considered a very aggressive discount arrangement.
- **Maximum Allowable Cost (MAC) Pricing** – The highest amount a third party will pay a pharmacy for dispensing specific multiple source drugs (drugs for which generic equivalents exist). Public programs and private prescription drug programs primarily use MAC pricing. There are no standard MAC drug lists. The lists are developed by the pharmacy benefit manager and are different for different vendors and can change throughout the course of the contract.
- **Rebate** – An amount the drug manufacturer reimburses a health plan or pharmacy benefit manager for each unit of a specified drug dispensed under a plan. Manufacturers offer rebates to drug plans, including Medicaid, HMOs, insurers and pharmacy benefit managers. These arrangements are "after market" events because the rebate is not based on an individual sale but on total prescriptions filled. Rebates may be calculated only on preferred drugs and are often contingent on meeting minimum sale targets or by restricting coverage for some drugs within a therapeutic class.
- **Average Wholesale Price (AWP)** – Surprisingly, this price does not represent an average or a drug's wholesale price. This is a baseline price determined by the pharmaceutical manufacturer based on drug and package size.

bates may defer a portion of the cost, the drugs on the formulary may not be the lowest cost therapy available. Although they may not be the most pivotal aspect of a PBM contract, rebates do affect some costs. Key questions regarding your rebates include:

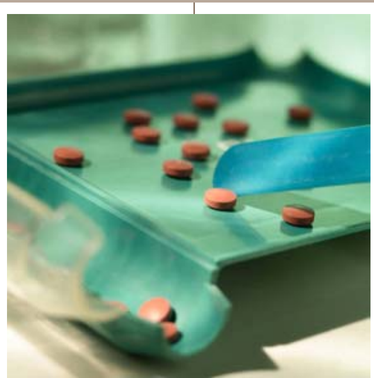
- How are rebates calculated? Are they quoted for each claim or for each branded formulary claim? Rebates can take many forms, so it is important to understand your plan's rebate arrangements.
- If rebates are based on a list of specific prescriptions (called the formulary), how many of those drugs do your employees actually use? How many claims would be eligible under the arrangement and how can the plan estimate potential rebate savings?
- Will the PBM guarantee that the plan will receive the greater of either a percentage share of rebates or a quoted Brand Formulary Claim (BFC) amount? Again, exactly how are the rebates calculated? Once you know, you can apply the options to your specific claim base to estimate rebate revenue.
- Will a full accounting of rebates be provided? Certain PBMs will balk at providing this accounting. Your plan should push for a complete disclosure of the rebates the PBM receives. Typically, the plan will receive a percentage of the rebates and the PBM will retain a percentage. Ask whether the PBM will allow the plan to audit the rebate calculation.

If you analyze your PBM contract and choose the most favorable provisions, you may be able to reduce your drug costs. This strategy may have no impact on your employees' out of pocket costs, but it can have significant effect on your bottom line.

Plan Design Considerations

In the last decade, most plans have made changes in plan design. The flat copay was a common plan provision ten years ago. A decade of double digit increases in pharmacy costs has prompted creative plan designs.

At a minimum, most organizations offer a two-tier prescription plan, one copay for generic drugs and another one for brand name drugs. Other possibilities to consider include:



- **Pharmacy Network Options**: Most PBMs offer more than one pharmacy network. Often, a slightly more restrictive network can reduce claim costs. Find out which network options your PBM offers and whether these options can affect your claim cost. Determine how many employees would lose access to their current pharmacies and whether there are network pharmacies available in their area.
- **Review Coverage Limits**: Most PBMs can give you a detailed list of how the plan covers each type of drug. Ask your PBM about the medical necessity of the various covered items and your options as a plan sponsor. For example, are you covering prescriptions for lifestyle medications, such as Viagra? If every claim dollar counts, perhaps your plan will decide not to cover it. Sometimes medications can come in different formats or dosage levels. Is your PBM ensuring your employees have access to the most cost-effective, therapeutically equivalent forms and doses?
- **Copay Options**: PBMs offer several copay strategies to help plan sponsors steer employees to the most cost-effective pharmacy therapy. For example, a flat copay for generic drugs and coinsurance for brand name drugs with minimum and maximum copay limits could encourage employees to use generic drugs. A cutting edge strategy is reverse copays. In a reverse copay, the plan pays a fixed amount for generic and brand name drugs and the plan participant pays the remaining portion.
- **Mandatory Mail Order**: GM now requires employees to fill certain maintenance medications by mail order. However, this option may not be attractive for all plans. The higher your plan's copay for mail order prescription, the less likely your copay loss will be off set by the more aggressive discounts offered by mail order pharmacies.

Most plan sponsors have investigated new plan designs. However,

Continued on Page 5

the design options available today are far different from the ones offered even five years ago. In reviewing plan design options, remember to consider the effect the change will have on your employees.

Full Disclosure

PBM contracts often have very complicated underlying arrangements. Measuring the true cost/benefit of a specific PBM is difficult because PBMs rarely reveal all revenue sources within each contract arrangement. In order to select the contract best suited to your organization, weigh the cost/benefit of various vendors. Ask each vendor to fully reveal discount arrangements and how those discounts and rebates would operate in your plan environment. PBMs are often reluctant to reveal these contract details because this information may limit their ability to negotiate aggressively on behalf of your plan.

PBMs receive revenue from both your plan and pharmaceutical manufacturers. Many recent lawsuits have questioned whether PBMs are acting in a plan's best interest or their own best interest as they negotiate discounts, offer rebates and construct formularies. PBMs are disclosing more information now because of market pressures.

Currently, no federal mandates control PBM pricing practices. However, the Office of the General Inspector of the Department of Health and Human Services recommends that fully disclosing contract provisions on rebates can prevent lawsuits against pharmaceutical manufacturers and pharmacy benefit managers.

Some PBMs fully disclose prices in transparent contracts. However, a transparent arrangement may not necessarily be the most cost effective. It depends very much on how your current PBM collects revenue and on how favorably your demographics and participant purchase patterns coordinate with the PBM's preferred arrangements with manufacturers.

Conclusion

Over the last decade, pharmacy benefit manager pricing has become somewhat of a shell game. Behind–the-scenes deals are not disclosed to a plan sponsor. The more your organization understands contract terms and how to interpret them, the more successfully your organization will be able to negotiate more favorable terms.

Remember, the stated discount may not always be the best deal. The best arrangement often depends on your plan's prescription claims and how favorably your own plan experience compares with a PBM's preferred arrangements with key manufacturers. To evaluate various vendor options, analyze your plan's actual claim experience. Some PBM's can offer the data you'll need to perform this analysis and others cannot. After a detailed review of your contract and a check of the market, you may be able to revise your contract to reduce prescription drug costs for your organization and maintain competitive prescription drug benefits for your employees. Opening these discussions may also help your plan operate more efficiently.

If your plan has negotiated aggressive, favorable contract terms, consider plan design options to help meet budget targets. Make sure your plan is designed to steer participants to the most cost-effective therapy for their medical conditions.

Please contact your McGraw Wentworth Account Director for more information on PBM pricing practices and analyzing your PBM's contract. MW

Notable Thoughts

A person usually has two reasons for doing something; a good reason and the real reason.

Thomas Carlyle

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McGraw Wentworth
3250 West Big Beaver Road, Suite 500
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
www.mcgrawwentworth.com