Choosing a PBM: Is Your Plan Asking the Right Questions?

Changing the factors considered when choosing a pharmacy benefit manager could help plan sponsors better control drug cost increases.

by | **Kenneth B. Berry**

Most benefit plans select their pharmacy benefit managers (PBMs) after issuing a request for proposals (RFP) and evaluating the costs. But this "spreadsheet" approach may fall short of the goal of saving money, since it does not really tell employers which PBM can provide them with the lowest prescription drug cost.

In some cases, this approach actually could increase total spending on drugs because it fails to capture the differences in clinical programs among PBMs. To get a complete understanding of prescription drug costs, the RFP process should also include factors such as denial rates on key therapeutic classes of drugs and other ways a PBM manages an employer's prescription drug spending.

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Although some say that there isn't a good way to perform this type of evaluation, the author believes that in some cases the way a PBM manages prescription drug spending results in lower overall drug costs even when an initial RFP projects higher costs.

The most important metric plan sponsors can measure is what has actually been spent on prescription drugs. Using a measure called *per employee per month (PEPM) cost* takes into account every dollar spent, including all of the discounts, rebates, administrative fees and, most importantly, the unnecessary prescriptions that were filled. The cost of unnecessary prescriptions is *not* taken into account in the initial evaluation process.

Challenges

The proliferation of prescription drug advertising on television has completely changed the supply-and-demand dynamics of purchasing prescription drugs. Direct-to-consumer (DTC) advertising by pharmaceutical companies is known to have a positive return on investment (ROI). Depending on the study one reads or which drug is targeted, a pharmaceutical company's ROI can range from $1.60 to $8.00 in increased sales for every $1 spent in advertising.

Because of these ads, patients now go into the doctor's office demanding to get that miracle drug. Yet those advertised prescription drugs typically are the most expensive option, and lower cost options are available that will provide the same result.

For example, Prilosec®, a brand-name drug that controls acid reflux, recently lost its patent. A 45-day supply of the generic drug omeprazole was sold at a big box store for $17. The U.S. Food and Drug Administration (FDA) has determined the drug is safe enough to be sold over the counter without a doctor's prescription. However, the manufacturer tweaked the omeprazole molecule and got a new patent for the drug Nexium®, which is heavily advertised as "the purple pill." The cost for a 30-day supply of Nexium is $180 at the same big box store. A very strong argument could be made that omeprazole works just as well as Nexium, so why pay $163 more? The answer is simple: the power of advertising.

Formularies are supposed to take care of these differences but, with the ubiquitous nature of pharmaceutical manufacturer copayment assistance, patient costs for these new brand-name medications could be lower for them than a $10 generic. Unfortunately, the member copayment is a relatively small amount compared with the overall cost of the medication, and the plan ends up incurring higher costs than necessary.

Cost-Containment Programs

To counteract the advertising push by pharmaceutical companies, all prescription drug programs need to include cost-containment programs, such as step therapy and prior authorization. Many do, but the problem is that not all PBMs enforce their cost-containment programs at, or near, the same level.

Step therapy requires a patient to try a lower cost alternative before being prescribed a higher cost drug. In the case of Nexium and omeprazole described previously, a participant would be required to try omeprazole before using the more expensive drug, Nexium. The participant would be allowed to use Nexium only after it has been shown that the lower cost alternative failed to provide the desired result.

Prior authorization requires participants to obtain approval from the drug plan before a drug claim will be approved for payment. Pharmaceutical manufacturers have labeled the process of prior authorization as "arbitrary and capricious" because their goal is to have their medication included in the PBM's preferred formulary. Manufacturers work with the PBM to promote the FDA-approved indication and limit attempts to control costs. Manufacturers

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spend millions of dollars to promote their latest and greatest medication and can't afford for PBMs to control spending on a new therapy.

Before turning to how to measure how effectively PBMs manage a plan's prescription drug spending, a few terms should be defined.

It's important to differentiate between the terms *therapeutically equivalent* and *chemically equivalent.*

Using the previous example, omeprazole and Prilosec are chemically equivalent. When a pharmaceutical manufacturer loses its patent on a brand-name drug, other manufacturers can make a generic (or chemically equivalent) drug, and the pharmacist can, without approval from the physician, substitute the brand-name drug for a generic drug.

Prilosec and Nexium (a brand-name drug) are therapeutically equivalent. They don't have the same chemical structure, but they treat acid reflux in the same way.

A third important term is *therapeutic class of drugs.* Both Prilosec and Nexium are in the therapeutic class of drugs known as *proton pump inhibitors.* Here is a partial list of proton pump inhibitors:

- Lansoprazole (Prevacid®, Prevacid®IV, Prevacid®24HR)
- Dexlansoprazole (Dexilant, Dexilant SoluTab)
- Rabeprazole (AcipHex®, AcipHex® Sprinkle™)
- Pantoprazole (Protonix®).

As previously described, a step therapy program would require a participant to try one of the lower costing generic proton pump inhibitors before a brand-name alternative would be approved. And, to improve upon savings even more, there are other programs that have elements of reference-based pricing, step therapy and prior authorization to ensure the participant is getting the lowest cost generic drug, since there are many manufacturers of a generic drug and the costs among manufacturers can vary greatly.

Evaluating PBMs

How can the effectiveness of a PBM in managing prescription drug spending be evaluated? The PBM should monitor its denial rates for each therapeutic class of drugs and must know the average cost of drugs that are approved in a particular therapeutic class of drugs.

An example is the therapeutic class of drugs that treat hepatitis C. The cost of the drugs in this class varies widely, and some can cost as much as $113,400 for a 12-week course of therapy. All PBMs have a pharmacy and therapeutics committee that develops protocols for what drugs should be used in different situations. Factors such as how effectively a certain drug treats a particular condition, its potential side effects and the cost go into the decision of when a drug would be appropriate for use.

Here is a possible scenario in which a PBM's costs of a hepatitis C drug may look attractive in the RFP process, but an evaluation of other factors would reveal that the PBM's actual costs may be higher than those of another PBM.

A PBM might ask the manufacturer of Harvoni®, the $94,500 (based on wholesale acquisition cost) drug to treat hepatitis C, for a greater discount on the acquisition cost of the drug in exchange for the PBM relaxing its step therapy or prior authorization approval process. The PBM provides information on this discount to the plan sponsor but doesn't disclose the additional cost the prescription drug program will incur as a result of more Harvoni prescriptions being approved.

If one assumes that this hypothetical PBM (PBM 1) can get the deal on Harvoni, its quote in the RFP results in a $500,000 savings over a different PBM (PBM 2). But because PBM 1 has relaxed the approval process for Harvoni, PBM 1 is going to see more hepatitis C drugs being dispensed than PBM 2. The table makes some further assumptions on the use and cost of all prescription drugs in the therapeutic class

takeaways

- The traditional process of selecting a PBM through an RFP process and evaluating the costs may not provide plan sponsors with a complete picture of drug costs.
- Plan sponsors should use a per employee per month (PEPM) cost measure to better evaluate what is being spent on prescription drugs.
- Cost-containment programs such as step therapy and prior authorization are important elements of a cost-containment program, but not all PBMs enforce these programs at the same level.
- Plan sponsors should ask PBMs that submit RFPs to provide denial rates on step therapy and prior authorization programs along with the average cost of a prescription drug approved for the top five therapeutic classes of drugs.
- Participants must be educated on how step therapy and prior authorization programs work to improve acceptance and limit negative perception.

TABLE

Comparing PBMs

	Denial Rates	Average Cost of Prescriptions Approved	Number of Prescriptions	Total Cost of Prescriptions Approved	Additional Cost
PBM 1	11%	$22,000	89	$1,958,000	$1,400,000
PBM 2	69%	$18,000	31	$558,000	N/A

of hepatitis C drugs, assuming that 100 patients had a request submitted for a hepatitis C drug.

The table shows that the denial rates for PBM 1 are very low because it is allowing more Harvoni prescriptions than normal. Because this prescription is so expensive, it's pushing up the average cost of drugs approved in this therapeutic class. Lastly, this analysis shows that if the plan sponsor looked only at the current RFP results, PBM 1 would show $500,000 more savings. However, adding in this new analysis, PBM 2 would actually have $900,000 in lower net costs because it has stricter prior authorization or step therapy programs.

Another practice that would be exposed if PBMs reported the average cost per therapeutic class is when a PBM does not take the branded drug off of its preferred formulary list after the brand-name drug goes off patent. There are very few situations in which a branded drug costs less than its generic equivalent, even if it's a *single-source generic,* which is a drug produced by a single manufacturer that has the exclusive right to produce the drug for the first six months it is off patent.

A perfect example of this practice is outlined in the Express Scripts 2015 *Drug Trend Report,* in which Nexium is ranked eighth among the ten best-selling brand-name drugs in 2015. This seems unlikely because the FDA approved the marketing of esomeprazole, a generic for Nexium, in January 2015. One reason may be that Nexium manufacturer AstraZeneca offered large rebates prior to Nexium losing its patent. That might have meant that more Nexium prescriptions were filled through PBMs, which would increase the PBMs' rebate dollars (and PBM profits) and allow them to quote a higher rebate number in their RFPs.

In rare cases, keeping a brand-name drug on the preferred formulary can result in overall lower costs because the *total* rebate guarantee outweighs the additional cost of the brand-name drugs being dispensed. The PBM consultant should analyze which situation results in the lowest cost for the prescription drug plan.

The author believes that PBMs should be asked in the RFP process to provide denial rates on step therapy and prior authorization programs, along with their average cost of a prescription drug approved for the top five therapeutic classes of drugs (that make up approximately 70% of the prescription drug spending for an average plan). Based on industry knowledge, the author estimates that total annual drug spending would vary from one PBM to the next by as much as 15%.

These are the diseases treated by the top five therapeutic classes of drugs the author believes should be tracked by PBMs and included in the RFP process:

1. Hepatitis C
2. Multiple sclerosis
3. Diabetes
4. Cardiovascular disease
5. Inflammatory conditions.

As touched on earlier, rebates are a major source of revenue for PBMs. They also are a significant factor reported during the current RFP process. In fact, the amount of rebate money can make the difference in one PBM getting hired over another PBM. However, as mentioned, chasing rebate dollars can result in overall higher costs and provide justification for using new approaches in evaluating PBMs.

PEPM Costs

Another way to make PBMs more accountable for how well they manage prescription drug spending is to require them to commit to a maximum PEPM cost in the RFP process for at least the first year of the quote. All PBMs have very powerful software that takes into account what month a drug will be losing its patent protection and the cost impact of that change. They also know when new drugs will become available, what the drugs will cost and what impact that change will have on the plan's overall prescription drug spending. PBMs typically receive information on the previous two years of prescription drug utilization by a plan as part of the RFP process and can use this information along with what they know about future trends to develop a cost projection for the next 12 months.

What PBMs don't know is what new drugs will be prescribed for new or existing participants eligible for coverage.

And if a drug like Harvoni were prescribed and approved for a participant on the plan, it would have a significant impact on the overall PEPM cost for the group. Therefore, the PBM consultant designing the bidding parameters for the RFP should have a listing of drugs that, if newly prescribed, would be excluded from the calculation of the PEPM average cost.

The best scenario is for the PEPM cost to be guaranteed, but most PBMs are not insurance companies and, therefore, can't guarantee a cost (this would constitute an insurance product). However, they could put some of their fees at risk if the target is not met.

There have been attempts to identify stop-loss carriers that would be willing to provide an aggregate stop-loss contract for this PEPM cost guarantee. This would allow a self-funded prescription drug program to enjoy the lower cost structure of a self-funded plan (versus a fully insured product with much higher internal costs), but to date the author has not been able to find a stop-loss company interested in taking on this risk.

PBMs will be successful only if they receive support from the prescription drug plan to educate members on the importance of cost containment within their pharmacy benefit. Prescription drug plan sponsors should provide more education to participants about why step therapy and prior authorization programs are so necessary to control future costs.

Participants must understand how these programs work before they go to the pharmacy to fill their prescription. The programs will lose credibility, and participants will have a negative perception if they don't understand how the programs work and are getting turned away at the pharmacy because their prescriptions do not meet the step therapy protocols or require prior authorization.

Specialty medications, which now make up 30% of the total PEPM cost for drugs, are projected to become 50% of total drug spending by 2018. With no increase in the cost of nonspecialty drugs, that means overall prescription drug spending will increase by 40% in 2018.

Here's how the math works out: Assume the current average PEPM cost for the prescription drug plan is $100, with $30 of that spent on specialty medications and $70 spent on nonspecialty drugs. If the nonspecialty costs do not increase (which is unlikely), the cost of specialty drugs will go to $70 PEPM if estimates that they will represent 50% of costs are accurate. That means the overall spending on drugs will go from $100 PEPM to $140 PEPM—a 40% increase.

Conclusion

Without proper cost-containment programs administered effectively by a plan's PBM, it's going to be very difficult to maintain a reasonable year-over-year increase in the cost of a prescription drug program.

That's why plan sponsors should include criteria in the RFP for how well the PBM manages prescription drug spending. Although tracking denial rates and average costs per drug dispensed in the five therapeutic classes is not part of the RFP process at this point, many PBMs and pharmacy consultants are starting to track these metrics. At a minimum, plan sponsors should ask their pharmacy consultant to provide them with denial rates and average costs per drug dispensed by the five therapeutic classes for their current PBM and a comparison of those findings with other PBMs in the industry.

Plans may find that, just with the proper enforcement of a step therapy program, they could reduce their current prescription drug spending by as much as 15%.

bio

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