



# Cleaning Out the Medicine Cabinet in Your Health Plan

by Dan LaRock & Suzie Tolzin

*“It is easy to get a thousand prescriptions, but hard to get one single remedy.”*

*– Chinese Proverb*

Unfortunately, this adage identifies one of the stark realities that contributes to today’s escalating prescription drug costs. Sometimes physicians and pharmacists simply don’t know which drug will work - which one will be the “remedy” - so they prescribe several until they find the proverbial “silver bullet.” Any parent with young children can undoubtedly tell stories about how it has taken more than one antibiotic to clear up their child’s ear infection. While the total volume of drug prescriptions may be a factor in the rising cost of pharmaceuticals, it is certainly not the only culprit.

Many sponsors of group health plans are seeing the rising tide in pharmaceutical pricing and have tried numerous methods to help control costs. Some groups simply raise copays in their prescription plans, while others are lowering the generic copay or adding a fourth tier. Because copays are costs we see directly, they are often the first to be affected and adjusted when times get tough.

It can be easy to overlook the other moving parts of a prescription drug plan. This article will help identify some of those parts and encourage plan sponsors to ask the right questions to ensure their prescription plans are set up properly.

## Know the elements of your prescription drug plan

The typical buzz words surrounding pharmacy benefit management include formulary rebates, AWP discount, dispensing fees, retail, mail-order, MAC pricing, transparency and PBM, just to name a few. In self-funded health plans, these are important terms with which you should be familiar.

In fully-insured plans, it is important to know and understand the terms because money spent on prescription drugs can account for approximately 15-20% of total claims dollars within a health plan. You need to make sure your carrier has

contracted with a PBM who implements a prudent pricing structure so that the drug dollars spent do not inadvertently escalate your loss ratios.

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With that said, let’s start the cleaning process by learning what’s in the medicine cabinet.

## Terms

**Average Wholesale Price (AWP)** This term refers to the average sticker or list price at which wholesale vendors sell drugs to physicians, pharmacies and other customers. Charges are typically based on the AWP, minus some percentage or discount.

The AWP (discount) is another important factor to consider when calculating the cost of your prescriptions. The following is a typical pricing set-up:

Brand AWP Discount	15%
Generic AWP (MAC) Discount	45%
Brand Dispensing Fee	\$1.95
Generic Dispensing Fee	\$2.05
Mail-Order Brand AWP Discount	21%
Mail Generic AWP Discount	52%

*All rebates are retained by the TPA/Carrier*

An alternative pricing model could consist of a three-tier copay structure with a minimum \$15 difference between the Formulary Name Brand Drug and the Non-Formulary Name Brand Drug copay. For example:

Brand AWP Discount	16.75%
Generic AWP (MAC) Pricing	50%
Brand Dispensing Fee	\$1.70
Generic Dispensing Fee	\$1.70
Mail-Order Brand AWP Discount	24%
Mail Generic AWP Discount	55%
Formulary rebates	\$3 per retail claim and \$9 per mail service paid claim

Moving to a PBM that yields deeper discounts in pricing (AWP) and shares some form of rebate can reap great benefits. The illustration shown above was for a group with a majority of retail prescription drug claims and approximately 4,400 paid claims annually (1,818 Brand and 2,582 Generic). The estimated savings within the first year of this illustration totaled nearly \$30,000 and continues to rise annually.

**Maximum Allowable Cost (MAC)** This term refers to a product's price. These prices set the upper limits that a plan will pay for generic drugs and brand drugs that have a generic version available (multi-source brands). Generic drugs often have a huge range of AWP's and the MAC prices are needed to reconcile the difference between an inflated AWP and the price the pharmacy actually pays. PBMs research the prices pharmacies pay for drugs to approximate each drug's acquisition cost. A well-run MAC program will allow the pharmacy to receive a reasonable markup on each product/drug which, in turn, allows it a reasonable amount of margin to promote the use of generics whenever possible. For most programs, a generic should always be dispensed, if available, unless the physician adds the phrase DAW (Dispense as Written) to the prescription, which means that the pharmacist cannot dispense anything other than the prescription written. A PBM should research and price the MAC of each drug accordingly so that it isn't inflated and will allow the pharmacy to remain in operation.

**Dispensing fee** The dispensing fee is a payment made to the pharmacy for dispensing a prescription or product. This fee helps pay for store operations, salaries, packaging, compounding (mixing the drug if necessary), consulting with the patient, education and computer time and systems. The pharmacy will typically receive a set fee per prescription to offset operating expenses. When filling a mail-order prescription, there is typically no load on the price for

dispensing the drug. In other words, the PBM is not making any additional money. Therefore, the decision to buy in bulk could certainly pay off.

**Pharmacy Benefit Manager (PBM)** Not only are PBMs responsible for processing payments for prescription drug claims, they also manage contracting with pharmacies, as well as negotiating discounts and rebates with drug manufacturers. According to AIS Market Data Source (Atlantic Information Services, Inc.), the following were the top 5 Pharmacy Benefit Management Companies as of the second quarter of 2007:

1. CVS/Caremark RX, Inc.
2. Medco Health Solutions, Inc.
3. Express Scripts/CuraScript
4. ICORE Healthcare, Inc.
5. Wellpoint NetRX

**Rebates** Drug manufacturer rebates are commonly paid to the PBM by the drug manufacturer and are typically for formulary name brand drugs. In order for PBMs to maximize rebates, they will often make sure to place the drugs that receive high rebates on their "formulary listing" of drugs in order to increase utilization. Rebates can result in a 4-20% savings off the average manufacturer's price.

There are 2 common rebate contracts. Flat rebates are known as first-dollar rebates because the PBM is paid a reimbursement on every unit of product used. Performance rebates provide a PBM higher compensation for higher utilization by patients whose benefits are administered by the PBM. This can all become very convoluted and confusing, as it may be difficult to know how the top 5 receive their rebates from the manufacturers. It is important to understand whether or not rebates are being shared with PBM customers, since the employees/families of those customers are the ones using and/or purchasing the drugs.

In recent years, PBMs have come under heavy scrutiny for failure to disclose the amount of rebate dollars and/or not passing the rebates on to the payer. Payers, often a third-party administrator (TPA), should disclose the process by which they handle these rebates on an annual basis. For example, some carriers keep rebates in order to offer a lower administrative fee, others are split between the carrier and plan sponsor (very common) and in other arrangements 100% of rebates are returned to the health plan sponsor, sometimes resulting in higher administrative fees. There are many ways to handle rebates in your pharmacy benefit relationship, and



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it is the health plan sponsor's responsibility to understand how they are being handled, and to make them become transparent.

Insurance advisors should be able to affirm that you are positioned in the best place with your carrier/PBM on this back room (or back of the medicine cabinet) component of the drug plan. Critics of rebate contracts say that the current rebate structure utilized by PBMs could represent as much as 10% of the amount Americans spend on drugs each year.

**Specialty drugs** These medications are high-cost prescriptions used to treat various complex and rare medical conditions. Often, these drugs are self-administered or self-injectable. The cost of a specialty drug is typically greater than \$500 per treatment. Some conditions for which a specialty drug might be used include Multiple Sclerosis and Rheumatoid Arthritis. Because these are high-cost drugs, many groups have created a fourth tier to their prescription drug plan designs. It is essential to investigate how many individuals utilize these high-cost drugs and to strategically review the timing when adding a fourth-tier structure.

It is also important to review generic medications. If current generic utilization is below 60%, a comprehensive review

of your plan design set-up needs to be performed. Many companies are lowering their generic copay, while some are waiving it for a period of time or eliminating the copay if the consumer receives a generic instead of the name brand.

#### How do we begin to sort it all out?

Consider having your consultant conduct a Request for Proposal (RFP) for your prescription benefit plan. This could mean that you will need to transmit your own group census detail every month or have online access to eligibility at the PBM. Depending on group size, this should not be a difficult process. Many times, your TPA will allow you to contract separately and they will transmit your eligibility information on a weekly basis for a small administrative fee.

The following "housekeeping" checklist can help keep you on track:

- Check Administrative Agreements on Rebate Disclosure.
- Ask your TPA/Carrier for the pricing set-up on your drug plan.
- Verify that you are receiving your rebates (typically quarterly) if the agreement is for you to retain them.
- Evaluate your plan design to make sure you have a minimum of three tiers and possibly consider adding a fourth tier for specialty drugs. Your PBM can provide estimates of savings on each plan design change that you might make.
- Consider a mandatory mail-order program for maintenance drugs, remembering that this takes lead time to communicate to your employees
- If you are dissatisfied with the responses, talk to your account manager/consultant about the options available to you to review PBM service and best practices. Keep in mind, however, that some carriers may not allow an all out change in PBM unless the plan sponsor performs "all eligibility standalone". This means that the health plan sponsor would have substantial and direct reporting requirements with a new PBM – typically the services currently handled by a carrier for eligibility, changes in status, additions & terminations.

It is important to understand the many moving parts of your group health plan – including the PBM arrangement. SilverStone Group Managers are all well versed in the review and analysis of pharmacy benefit relationships, and monitor it closely for our clients. Should you have any questions about your pharmacy specific set-up, feel free to contact us. You have a right to transparency and disclosure.