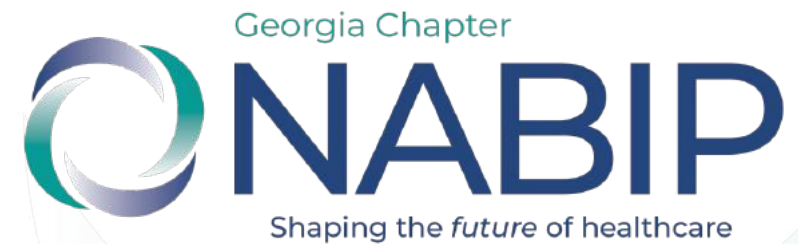




# Pharmacy Benefits: A Primer



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LinkedIn: [davidcurtissmith](#)

# Disclaimer

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- Content Acknowledgment:
  - David Mordo, REBC • Senior Compliance Analyst, BenefitMall
  - David C. Smith JD, REBC • Senior Vice President, eBen Benefits
  - Stephanie Berger LPRT • President, Centered Insurance Solutions and 2021-22 Professional Development Council Chair

ASK QUESTIONS  
CONTRIBUTE  
CHALLENGE

The best way for  
us all to learn and  
take something  
away from this  
learning  
experience



# Sharing the Wealth

Here is how profits are shared from a brand-name drug with a list price of \$300\*. Of the middlemen involved in the process, a pharmacy benefit manager gets the biggest gross profit of \$18.

**Start**

**\$ Payment**

**\$ Gross profit\*\***



**Plan sponsor**  
(Health insurer or employer)

**-\$185**



**Patient**  
Out-of-pocket

**-\$35**



**Pharmacy**

**\$16**

**Pharmacy-benefit manager**



Helps design benefit plans and negotiates rebates from drugmakers, sharing them with other middlemen.

**\$18**



**Wholesaler**

**\$3**



**Drugmaker**

**\$137**

Lists drug for \$300

\*No one pays the full list price because of rebates and incentives that are negotiated by the pharmacy benefit manager and paid out by the drugmaker.  
\*\*The amount of the payments don't add up to the gross profits in part because of various markups and discounts taken during the filling of a prescription.

# Drug Categories and Classifications



# Brand Name Drugs



- A “brand-name” drug is one that is marketed with a specific name by the company that manufactures it, usually the company which develops and patents it.
  - There are rules that apply to developing the brand name for medications. The name can’t make an overt claim about what it does, nor can it be promotional.
- Nearly every new drug in America is first marketed exclusively under a patent by its discoverer/owner and the manufacturer with an exclusive right to control the retail sale of the medication

# Drug Patents



- Patents are good for 20 years after the discovery of the unique chemical/biologic compound, but obviously has delayed “market” protection because of the time to get approved by FDA.
- Many larger pharmaceutical companies file several patents on the same drug, aiming to extend the 20-year period and block generic competitors from producing the same drug.

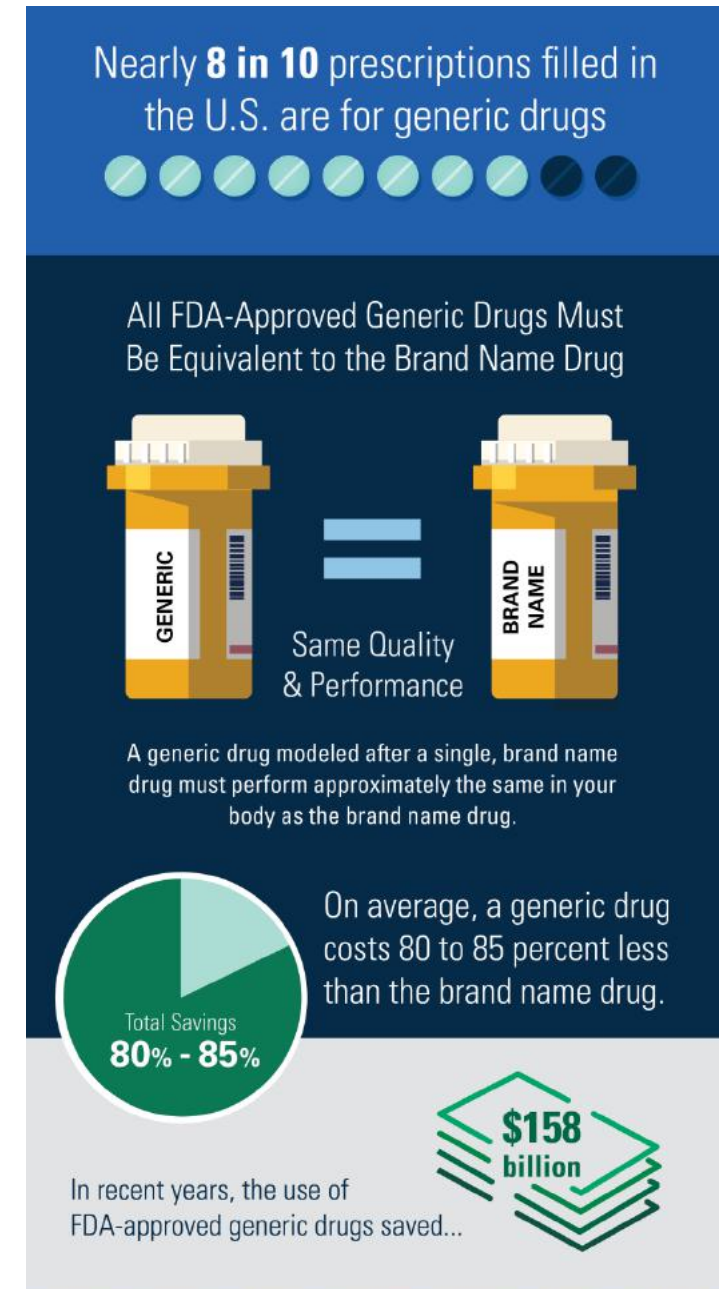
- When a pharmaceutical company challenges a generic drug manufacturer in court, the FDA must mandate a 30-month freeze on the approval of the generic drug.
- Generic drug makers, in turn, file lawsuits to invalidate these additional patents. This is just how the carousel of brand-name versus generic drug makers works in a legal forum.

# Generic Drugs

A generic drug is a medication created to be chemically identical as an existing brand-name drug in dosage form, safety, strength, quality, performance characteristics, and intended use.

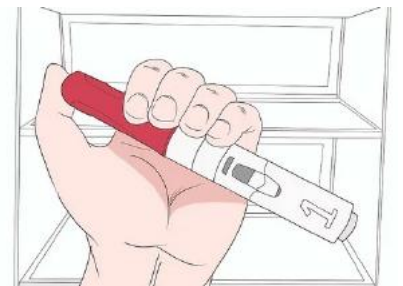
These similarities help to demonstrate bioequivalence, which means that a generic medicine works in the same way and provides the same clinical benefit as its brand-name version.

You can take a generic medicine as an equal substitute for its brand-name counterpart.



# Specialty Drugs

- Specialty drugs, which account for at least 33% of the total US drug spend, are high-cost oral or injectable medications used to treat some rare chronic conditions. They are typically highly complex medications that structurally mimic compounds found within the body.
  - Treats rare or orphan disease indications
  - Requires additional patient education, adherence, and support beyond traditional way that drugs are delivered and used
  - Can be oral, injectable, inhalable, or infusible drug product
  - Usually have specific storage or shipment requirements, such as refrigeration
  - Ordinarily not stocked at most retail pharmacies
- What is a specialty drug? Definitions vary...
  - If negotiated cost of the drug is more than \$670 per month, Medicare defines it as a specialty drug.
  - Academy of Managed Care Pharmacy (AMCP) defines specialty drugs as requiring intense clinical monitoring, frequent adjustments in dosage, and/or specialized training for handling and/or administration



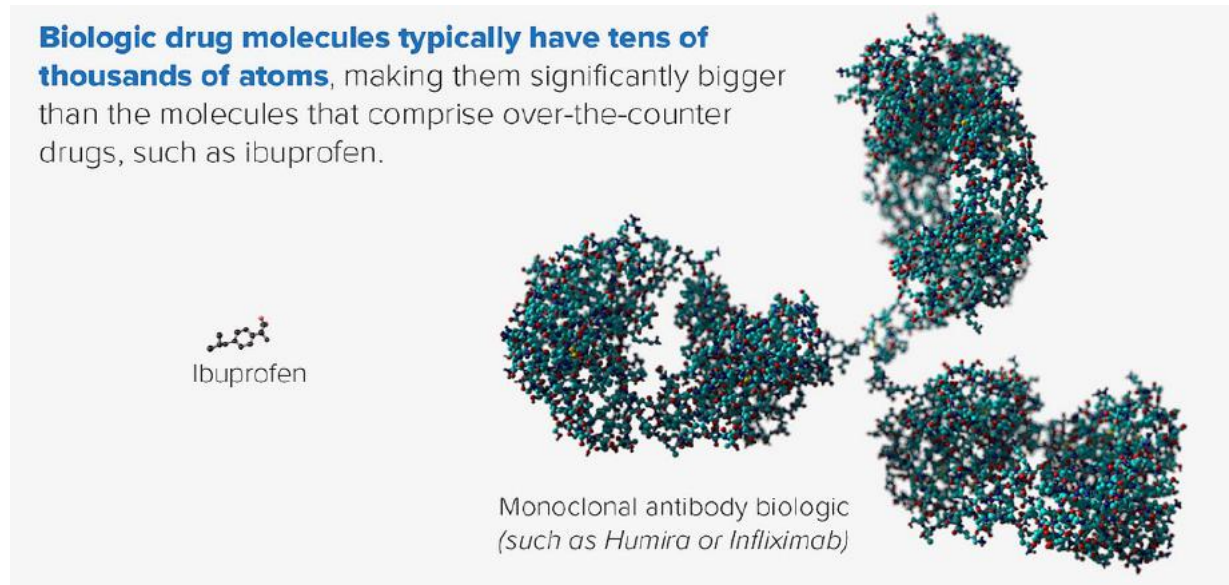
# Trends in Specialty Drugs

- Spending on specialty drugs in 2021 was \$284.9 billion for all sectors, which was 49.4% of total prescription expenditures, increasing 8.7% vs. 2020.
- Three biggest sectors accounted for 88.8% of spending on specialty drugs:
  - mail-order pharmacies (\$130.3B, 45.7%)
  - Clinics, including physician offices and outpatient clinics (\$84.2B, 29.5%)
  - retail pharmacies (\$38.5B, 13.5%)

Source: National trends in prescription drug expenditures and projections for 2022 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9383648/>

# Biologics

- Biologics are often what is truly referred to as a specialty drug
- A biologic is manufactured in a living system such as a micro-organism, or plant or animal cells
- Biologics manufacturers must tightly control the source and nature of starting materials, and consistently employ hundreds of process controls that assure predictable manufacturing outcomes
  - That is why there are no “generics” per se since essentially each “replica” must go through the same FDA approval process to be a bio-similar



# Drug Compounding

- Drug compounding is the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient
  - Patient has allergy to certain dye and needs a medication to be made without it
  - Elderly patient or a child who cannot swallow a tablet or capsule and needs a medicine in a liquid dosage form
- Compounded drugs as a unit are typically not FDA-approved, but the practice is allowed under federal rules
- Ongoing concerns about the risk and safety of compounding exist, raising the likelihood of increased regulatory oversight
- Also, the concern about the cost of certain drug combinations, mixing generic drugs together to create a higher-cost medication
- Example: Zegerid is a compounded drug that combines Prilosec with baking soda
  - Retail cost when released: \$14,000 for three-month supply
  - Ingredient costs: less than \$24

# Other New Terms to Know

An **orphan drug** is a drug used to treat, prevent, or diagnose an orphan disease (a rare disease or condition that affects fewer than 200,000 people in the United States).



**Gene Therapy drugs** are a new class of medications that are designed to treat or prevent disease by correcting the underlying genetic problem. Often discovered to address a serious medical condition (e.g., hemophilia) but carry a very high price tag (Roctavian is expected to cost up to \$2.1M).

### Highest Orphan Drug Prices

Four orphan drugs cost more than \$70,000 per month this year. There are 33 orphan drugs that cost at least \$28,000 per 30-day supply.

2016 Price Per 30-Day Rx	Brand Name	Primary Indication
>\$70K	CEPROTIN	Protein C deficiency
	STRENSIQ	Hypophosphatasia
	VIMIZIM	Mucopolysaccharidosis IVA (enzyme deficiency)
	MYALEPT	Leptin deficiency in lipodystrophy
\$50-\$70K	RUCONEST	Hereditary angioedema
	NAGLAZYME	Mucopolysaccharidosis IVA (enzyme deficiency)
	XURIDEN	Hereditary orotic aciduria
\$40-\$50K	CINRYZE	Hereditary angioedema
	IMPAVIDO	Leishmaniasis
	YERVOY	Metastatic melanoma

Source: Express Scripts

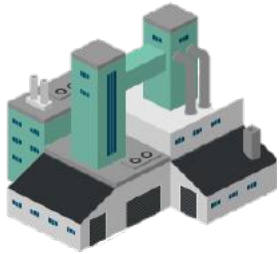
# **FUNDAMENTALS**

of Pharmacy Benefits

# Key Terms

- AWP—The average wholesale price is the price published by MediSpan which PBMs use to discount the cost of drugs
- WAC—Wholesale Acquisition Cost
- Medispan—The only commercially published drug pricing guide by Wolters Kluwer
- MAC—Maximum Allowable Cost determine the price assigned to generic drugs by your PBM and can differ by day, by client, by line of business
- NADAC—Published by CMS, a database of acquisition prices
- National Drug Code (NDC)—11-digit code that identifies the Manufacturer, Drug, Strength and Package Size of every drug (Rx and OTC) for sale in the U.S.

# Understanding “Price” in Prescription Drugs



## Wholesale Acquisition Cost (WAC):

List price paid by a wholesaler, distributor and other direct accounts for drugs purchased from the wholesaler's supplier. the price charged by the manufacturer before any rebates, discounts or allowances are offered by the supplier of the product.

“Cost to Manufacturer, Market, R&D”



## Average Wholesale Price (AWP):

“Sticker Price” that includes rebates and other incentives for prescriptions. meaning it is an elevated drug price that is rarely what is actually paid. This price is not government regulated, does not include other discounts and can be manipulated by manufacturers.

No relationship to retail cost (what’s shown as the cost at the pharmacy) or to what the employer/payer actually pays for that drug as claim cost...

Note: Medicare relies on NADAC listing, which reflect the cost of acquisition, which may be lower than WAC or AWP

# Key Terms: Types of PBM Models

## Traditional (Spread):

- PBM charges plan sponsor a contracted price with specific network pharmacy discounts while paying the dispensing pharmacy a different price (aka “spread” pricing).
- The difference is retained as revenue for the PBM versus charging the plan sponsor an administrative fee (no admin fee).

## Pass-Through:

- Price charged by pharmacy for medication (according to PBM agreement) is passed through to plan sponsor.
- PBM charges a per-claim or per-member administrative fee, but may also charge additional fees, such as network audit fees and rebate administration fees.

## Acquisition Cost Plus:

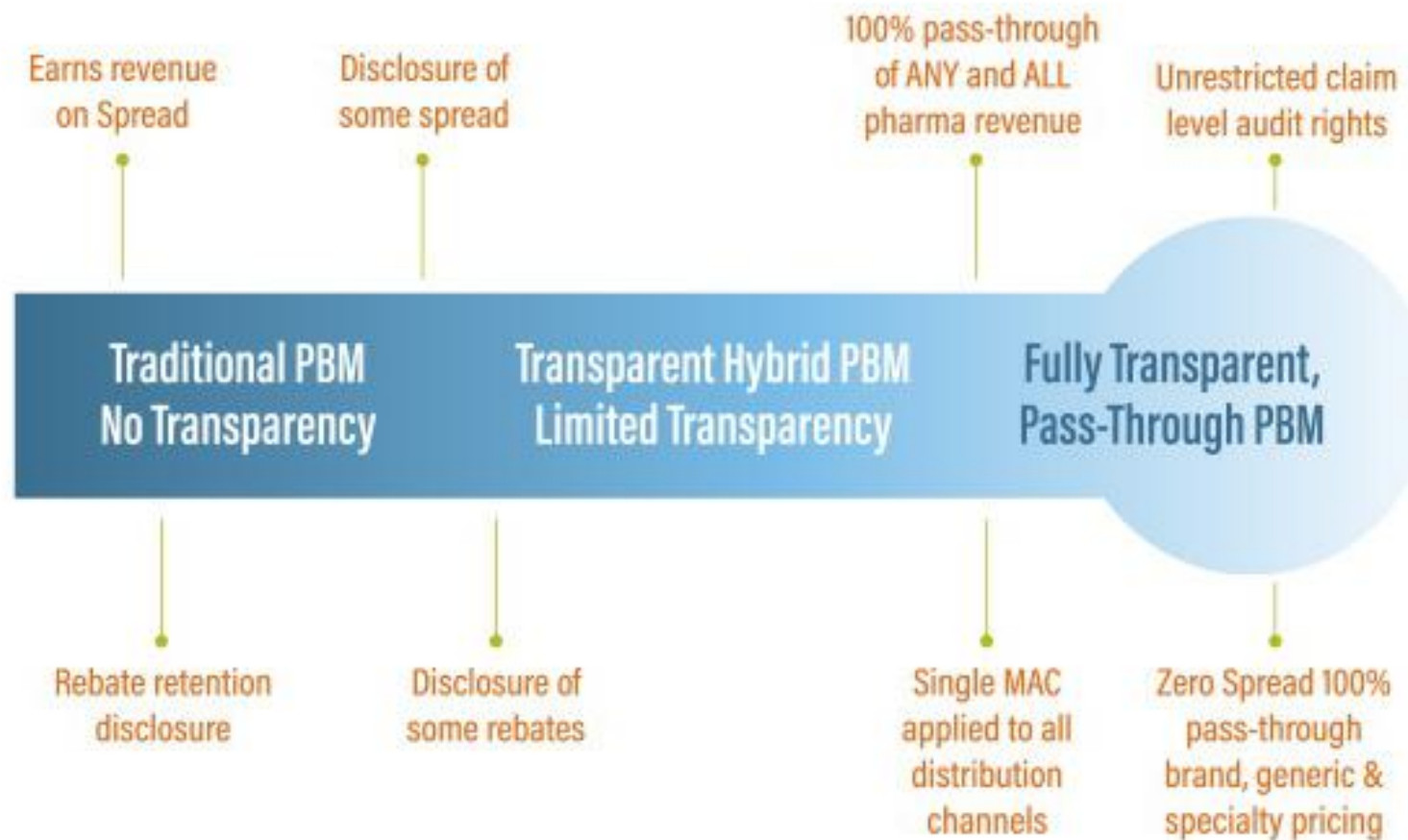
- Newer pricing model where PBM charges plan sponsor the acquisition cost of the drug, a dispensing fee, and a per claim administrative fee.
- With this model, the cost of generic drugs may be significantly higher due to the add-on costs. Important to minimize negative impact on members to ensure generic drug utilization remains high.

## Reference-Based

- Hybrid model that uses established reference source (cost-plus or NADAC) for certain commonly used drugs to determine what plan will pay.
- Model allows for member flexibility in drug choice but has the potential to negatively impact a member's finances since the allowed amount may be less than what is charged by the pharmacy.

# Transparent PBMs

## The Difference Between Traditional & Pass-Through PBMs



# Formulary



- At its most basic level, a formulary is nothing more than a list of medicines
  - Continually updated list of prescription drugs approved to be covered by the group health plan/payer, with variation based on tiers (what is paid by member)
  - Formularies are developed by PBMs and offered to payers, which ought to include involvement of medical professionals to determine the clinical appropriateness of different medications for each condition
  - The negotiated price for certain drugs, high cost of new medications, rebates, and PBM compensation all play a role in setting what is “on formulary”

# Formulary



- Ultimately up to the payer client to decide on the exact formulary that will be used in conjunction with its benefits plan, as well as the techniques (e.g., copays for different tiers, limited network for some drugs) to encourage formulary compliance.
- Formularies will often change when new medicines enter the market, or generic versions become available -- usually changes are effective at the beginning of a calendar quarter
  - It is vital that you periodically review the most up-to-date list of medications on formulary and communicate impact to members when there are changes

# Formulary: Related Terms











- Tier - level of copayment/cost that a member will pay for drugs on that list

	Previously	Now
Tier 1	Generic	Could mean anything... there may be a brand drug in Tier 1 and a single-source generic in Tier 4 so the old definitions don't fit any more...
Tier 2	Preferred Brand	
Tier 3	Non-Preferred Brand	
Tier 4	Specialty	
Tier 5/6		Preferred/Non-Preferred Specialty

- Plan exclusions: drugs that are not covered at all (e.g. medications for weight loss drugs, sexual problems, cosmetic use)

# Formulary Types

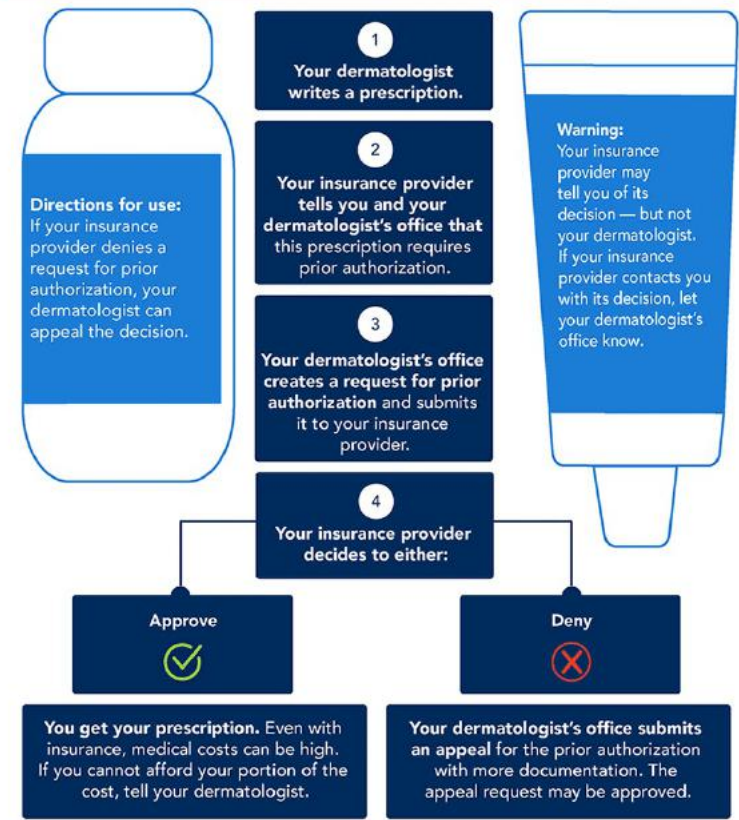
	OPEN	CLOSED		VALUE-BASED
WHAT IT IS	All drugs on an approved drug list are covered	Some drugs on an approved drug list are covered; you choose the access level		Drugs are assigned to tiers based on their true value, or safety + effectiveness + cost
WHAT YOU GET	Convenience for your employees	Primarily generic medications: Maximum amount of cost savings	Access to select brand-name drugs: Less disruption for your employees	Long-term investment in your employees' health
RELATIVE COST				
DRUG ACCESS				

## PRIOR AUTHORIZATION

### What is prior authorization?

To get insurance coverage for certain medications, tests, and other medical care, your health insurance provider must approve (authorize) the care before (prior) you receive it. Without prior authorization, you may end up paying the entire cost or be denied the care.

Here's an example to show you what happens during the prior authorization process:



# Prior Authorization

- Prior authorization is approval from the insurance company or PBM (not physician) to decide if they will pay for certain medicines.
- Prior authorization is put in place to make sure drug use is clinically appropriate for the patient and cost-effective for the payer.
- Insurers claim these prior authorizations save money by bypassing unnecessary or expensive treatment options when other equally effective options exist.
- Pharmacists says that excessive number of required prior authorizations are bad for patients and the process

# Prior Authorization

- It is not unusual for prior authorization to be requested for:
  - Brand-name drugs that have a generic alternative.
  - Drugs that are intended for certain age groups or conditions only (Aduhelm for Alzheimer's)
  - Drugs used only for cosmetic reasons (e.g., Botox which can be used for migraines in specific situations).
  - Drugs that are neither preventative nor used to treat non-life-threatening conditions.
  - Drugs that may have adverse health effects, possibly dangerous interactions, and/or risks for abuse or misuse.
  - Drugs that are not covered by insurance but are deemed medically necessary by the doctor (e.g., formulary exceptions like Armour Thyroid).

# Step Therapy

## Step Therapy

Insurance companies have policies, such as step therapy, that are designed to help control costs but sometimes block patients' access to medications and limit the decision making of patients and physicians<sup>1</sup>

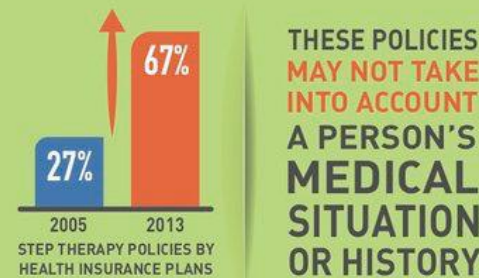
### STEP THERAPY requires patients to:



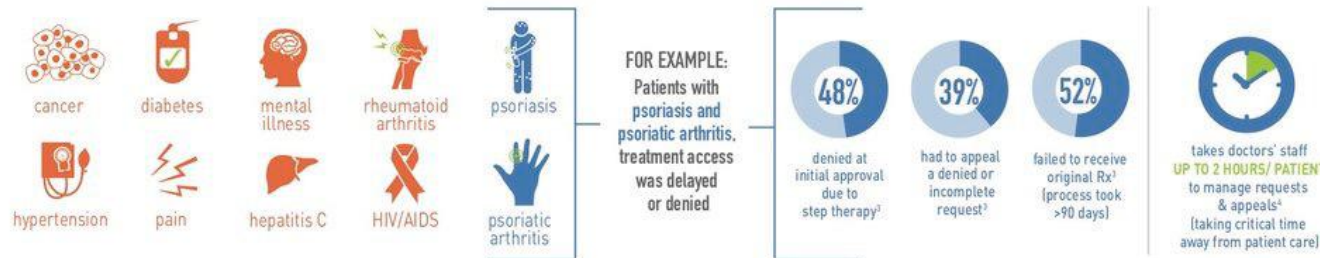
In some cases, patients must step through FDA branded boxed warning drugs before being prescribed FDA branded non-boxed warning drugs<sup>2</sup>

**WARNING**

### STEP THERAPY is on the rise:



### Major health conditions affected by STEP THERAPY:



If you or a loved one has been affected by step therapy, speak with an advocacy group in your disease area. Visit [www.prescriptionprocess.com/steptherapy](http://www.prescriptionprocess.com/steptherapy) for more information/tips and to share your story.

REFERENCES:  
 1. Nayak, R., Pearson, S. The Ethics Of 'Fail First': Guidelines And Practical Scenarios For Step Therapy Coverage Policies. *Health Affairs*. 2014; 33(10): 1779-1785.  
 2. Branning, G., Schaars, R., Hourning, J., et al. Formulary Management of Branded Boxed Drugs and Non-Boxed Warning Drugs within Therapeutic Categories. Abstract 40204. Data presented at the International Society for Pharmacoeconomics and Outcomes Research 20th Annual International Meeting, May 16-20, 2015, Philadelphia.  
 3. Covance. *Otezla Support Plus*. February 2015.  
 4. Dermatology Nurses Prior Authorization Advisory Board. Macon, GA, Feb 2015.

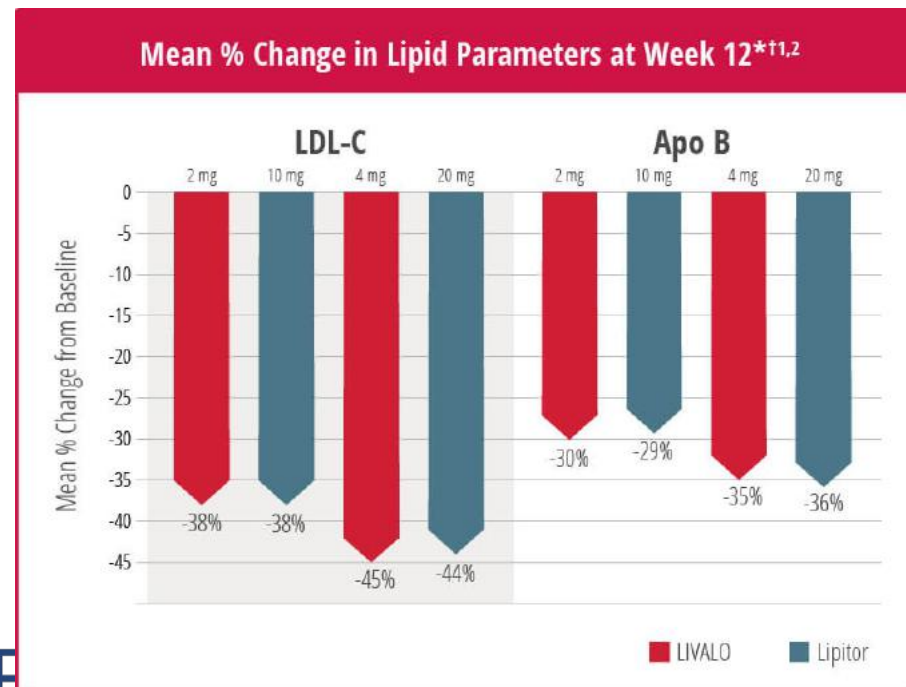
- Step therapy is a type of prior authorization, requiring patients to use a less expensive drug first to treat a medical condition.
- Designed to keep Rx price impact on premium lower while preserving appropriate access to medications.
- If the lower-price drug proves to be effective, step therapy will help save money in terms of premium and claim costs.
- Conversely, going straight to the more expensive medication, will result in insurance not covering the full cost, leading to higher out-of-pocket expense for the patient.

# Step Therapy



## Lipitor (atorvastatin) vs. Livalo (pitavastatin)

- HMG-CoA reductase inhibitors (“statins”) used to treat elevated total cholesterol, LDL, triglycerides, and to elevate HDL cholesterol
- 30-day supply of generic Lipitor is \$18 vs. \$386 for Livalo (which has no generic)



As a result, many plans put Livalo on step-therapy because for most patients, Lipitor is just as effective as Livalo for treating high cholesterol and is 95% less expensive.

# Dispense As Written (DAW)



- DO NOT SUBSTITUTE: Prescriber's instructions to:
  - Limit authorization for substitution with generic equivalents
  - Ordering of the specific prescribed medication with instructions on the prescription to dispense the specific prescribed medication
- Providers often cite the fact that the “fail first” concept means a patient must suffer before they can receive the recommend treatment first prescribed by the provider.
- Also used as a step-therapy override, some states have instituted protections to given prescriber authority to countermand the step-therapy protocol in favor of coverage of the selected prescription drug of the prescribing health care provider because certain conditions have been met.

# Preventive Medication Adherence

- Increasingly, plans are looking to lower the cost of preventive medications so that patients/members take those regularly in order to reduce the likelihood of a high-cost medical episode
- Studies (seventy-nine individual studies assessing the cost of medication non-adherence across 14 disease groups) found that lower levels of medication adherence generally resulted in higher total health care costs for that individual
  - Annual disease-specific economic cost of non-adherence per person ranged from \$949 to \$44,190

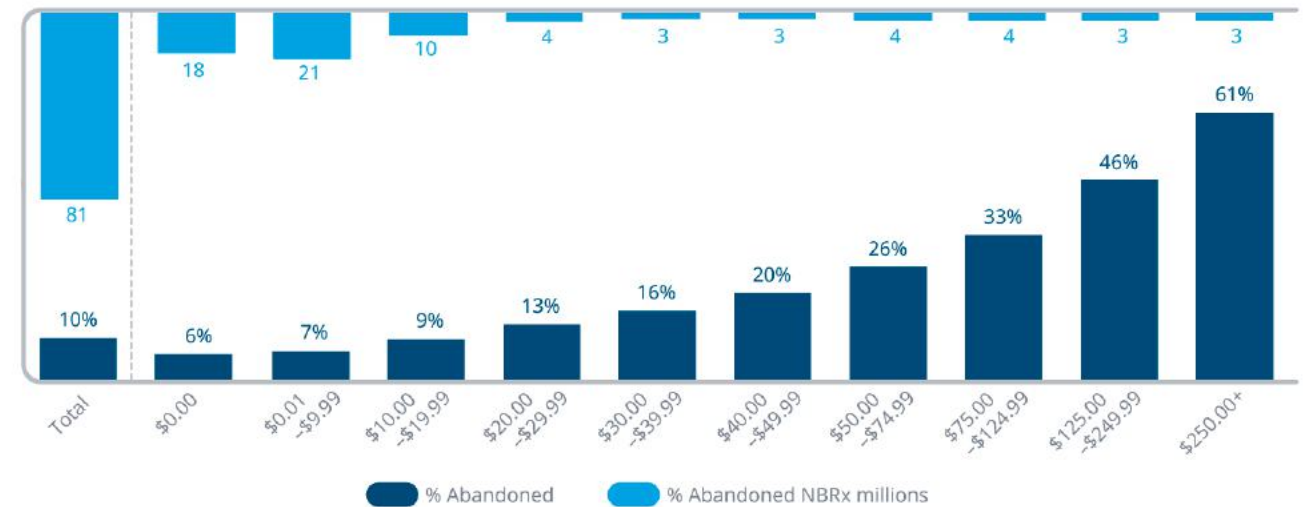


# Preventive Medication Adherence

Affordability is a key concern as to why people do not take their medications as prescribed. 2019 KFF Health Tracking Poll found that 25% adults finds cost to be a driving factor in not taking their medication:

- 19% do not fill their medication
- 18% take an over-the-counter drug instead
- 12% cut their pills in half or skip doses

14-day abandonment share of new-to-product prescriptions by final out-of-pocket cost in 2021, all payers, all products



Source: IQVIA National Prescription Audit: New to Brand, LAAD Sample Claims Data, Dec 2021.

Notes: New to product prescriptions are those where patients have not had a prescription for the specific brand or generic drug within the prior year. Pharmacies in the sample provide information on prescriptions which were prepared for dispensing and whether they were dispensed, with abandonment defined as the prescription in question not being dispensed to the patient within 14 days of the initial fill. Analyses on a sample of claims projected to national totals, where a similar analysis in prior reports were not projected and thus not comparable in terms of total abandoned new prescriptions. Report: The Use of Medicines in the U.S.2022. IQVIA Institute for Human Data Science, April 2022.

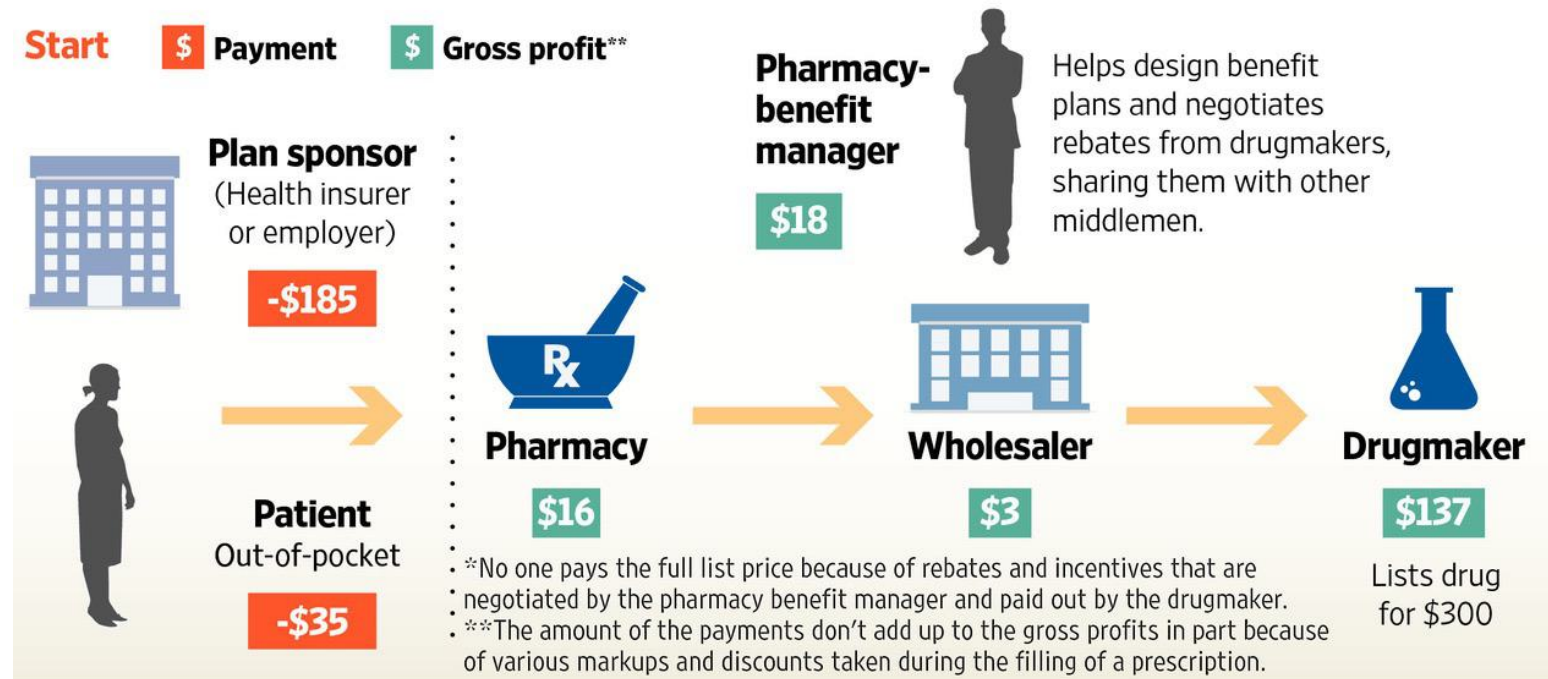
# The Secrets of Prescription Drug Cost and Impact on Health Care Spending



# The Core Problem with Drug Costs: Hidden Profit

## Sharing the Wealth

Here is how profits are shared from a brand-name drug with a list price of \$300\*. Of the middlemen involved in the process, a pharmacy benefit manager gets the biggest gross profit of \$18.

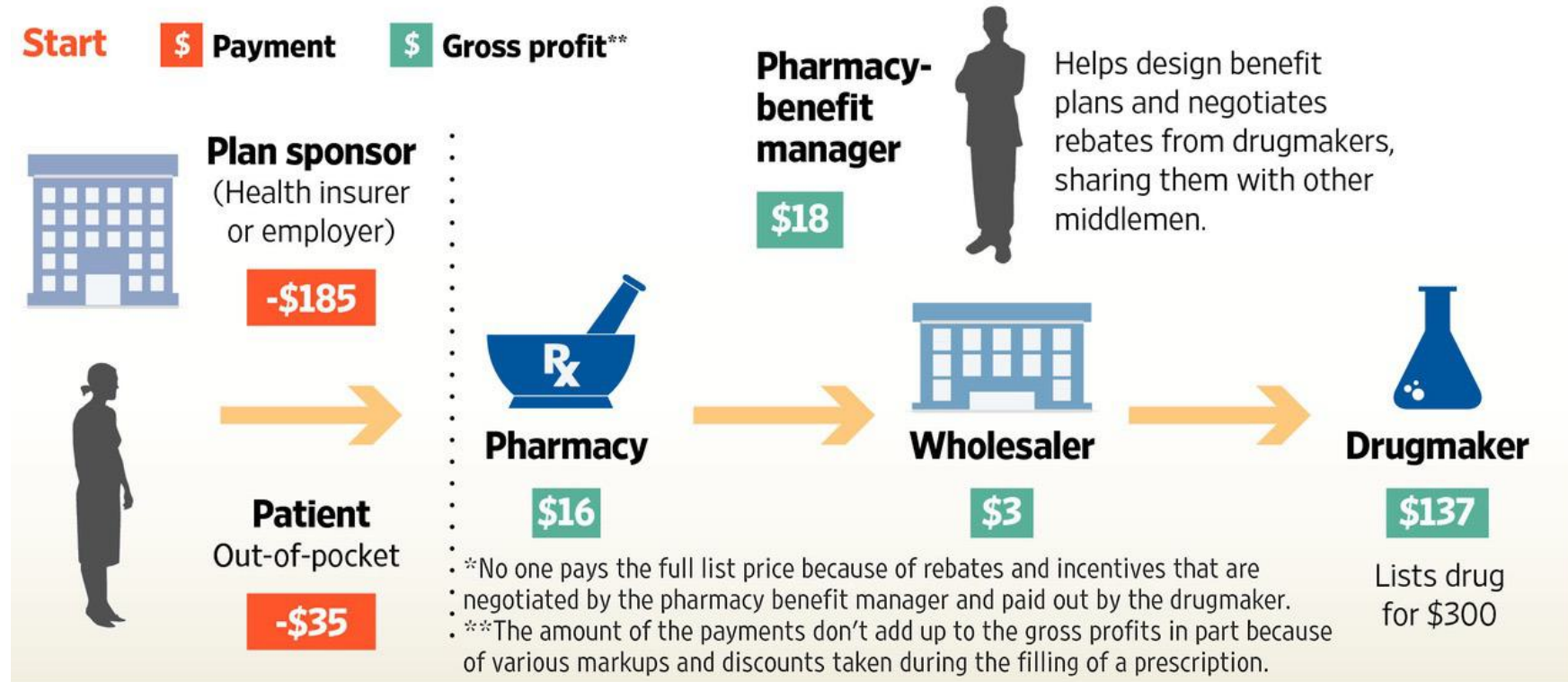


Sources: Pembroke Consulting; WSJ staff reports

THE WALL STREET JOURNAL.

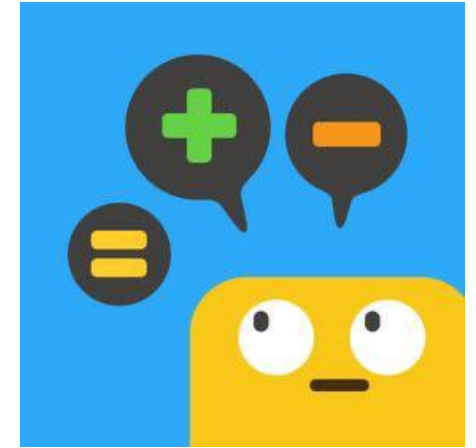
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THE WALL STREET JOURNAL.



## Let's Do Math

DRUGMAKER	\$137
WHOLESALE	\$3
RETAILER	\$16
PBM	\$18
<b>TOTAL</b>	<b>\$174</b>

ALLOWED	\$220
- Plan/Insurer	\$185
- Member Copay	\$35



## WHAT ABOUT THE MISSING \$46

- Rebates
- Spread pricing
- Manufacturer Admin Fees
- Other forms of hidden revenue



# Rebates

- A rebate is the return of part of the purchase price by the seller to the buyer by the manufacturer. Pharmaceutical manufacturers use rebates to drive demand for their products.
- Rebates are often a major deciding factor when health insurers or PBMs choose how to cover a drug, and how much a patient should pay for it. Rebates have been targeted as a tool to lower prescription drug prices.
  - Prescription drug rebates are generally paid by a pharmaceutical manufacturer to a PBM, who then shares a portion with the health insurer.
  - Rebates play a key role in deciding whether to include a drug on an insurer's formulary and in which tier.



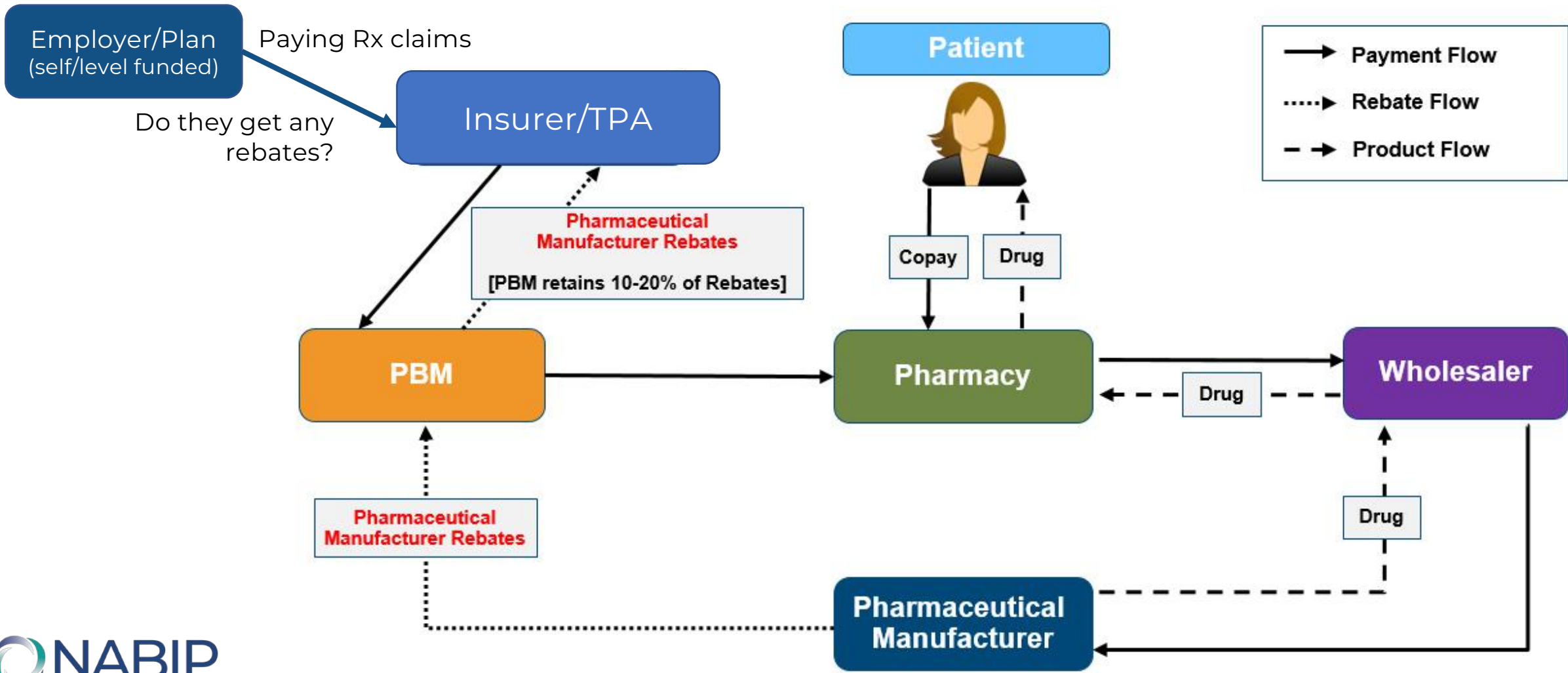


# Rebate Negotiation

- PBMs negotiate manufacturer rebates with drug companies on drugs (usually brand-name) in exchange for placing that particular drug on PBMs' drug formulary or on a specific cost-share tier.
- Rebates negotiated between manufacturers and PBMs are typically calculated as a percentage of the list price. Additional rebates may also be paid if the total number of prescriptions dispensed, relative to other medicines in the therapeutic class, exceeds a predetermined threshold.
- How much in rebates that are actually paid is determined retroactively, based on utilization data submitted to the manufacturer from the PBM (how many were bought).
- PBMs also negotiate price protection provisions with manufacturers as a standard feature of contracts. Under these arrangements, manufacturer price increases in excess of predetermined thresholds result in increased rebates to the PBM



# The "Rebate" Factor



# “Rebate Pumping”

When PBMs favor a higher-cost drug because higher cost medications tend to be associated with higher manufacturer rebates. By including medications with high manufacturers’ rebates on their formulary, PBMs can generate more profits.

- Drugs released in 2017 to cure Hepatitis C:

- Mavyret



- Covered more conditions (approved to treat chronic HCV genotypes 1, 2, 3, 4, 5 or 6 infection in patients without cirrhosis or with compensated cirrhosis)
    - Cost: Without discounts, \$27,580.60 for an 8-week supply

- Harvoni, Epclusa, Sovaldi



- Only approved to treat genotypes 1, 4, 5, or 6 of Hep C
    - Cost: 12-week supply costs \$76-94,500 without discounts.

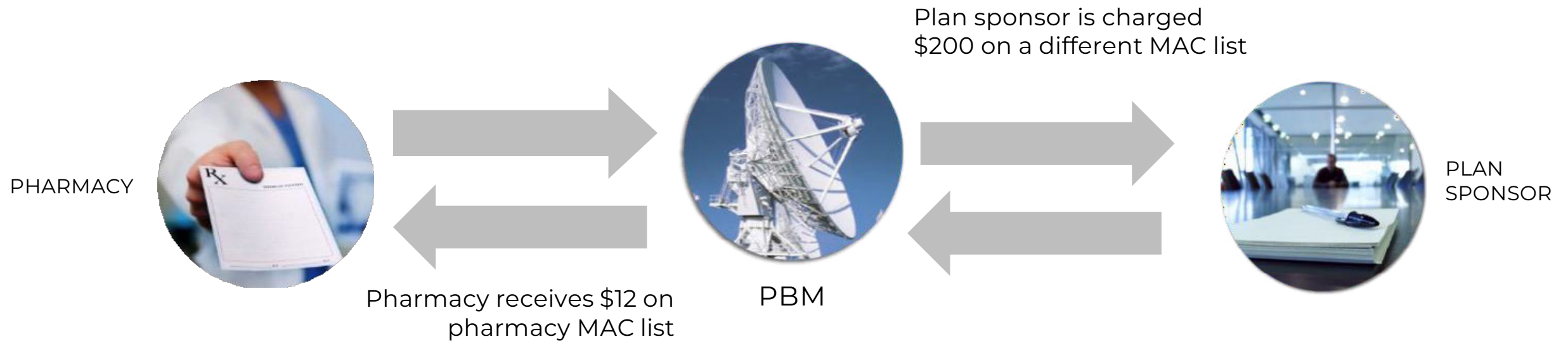
After first three years, Harvoni and its higher cost competitors were more often filled and given preferential formulary treatment because they paid a significant rebate for each script filled

- For example, Express Scripts updated its 2019 formulary list and made changes to its Hepatitis C category excluding Mavyret.

# Spread Pricing

Example:  
ATORVASTATIN

- In managing the prescription drug benefits for health plans, PBMs often engage in “spread pricing” where the PBM charges the payer more than it reimburses the pharmacy for a certain drug and retains the difference.
  - Spread pricing is the predominate way clients pay for pharmacy benefits -- it’s why PBM services are “free” but allows for deviation in cost from pharmacy to pharmacy.



Atorvastatin script PBM spread: \$188

# Spread Pricing: Look at the Contract

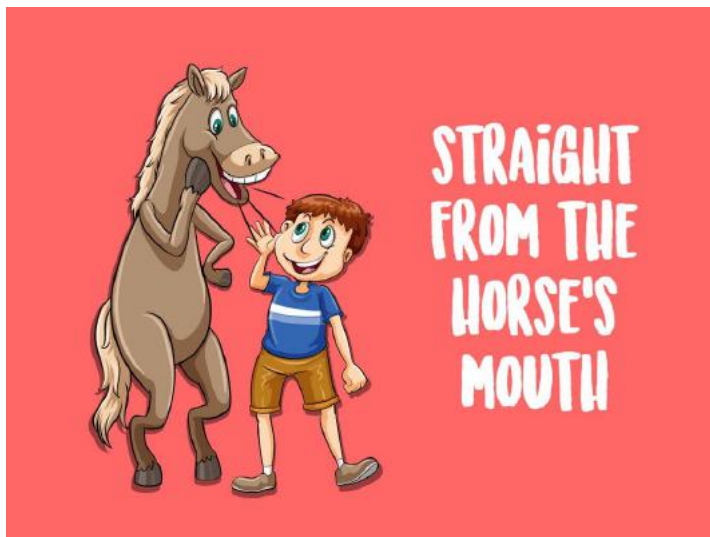
- Why is Spread Pricing even a thing?
  - Plan sponsors contract with PBM to pay a certain amount for prescription drugs (AWP-15%)
  - PBMs contract with pharmacies at another level FOR THE SAME TRANSACTION (AWP-18%)
  - The PBM is making the 3% difference between what they paid the pharmacy (AWP-18%) vs. what they got paid by the payer/insurer (AWP-15%)
- It's all about the contract...
  - What is a brand, generics and specialty drugs is defined differently in each contract
  - What is on or off a MAC list may vary by client
  - Pricing terms are different and PBM is meeting the financial performance for both the chains/independents and plan sponsors... and neither know there is a difference
  - Because attorneys that review PBM contracts do not know what to look for and allow spread pricing to happen even for large state governments (Ohio) that contract with large PBMs (like CVS and Optum)

# PBM Revenue Streams

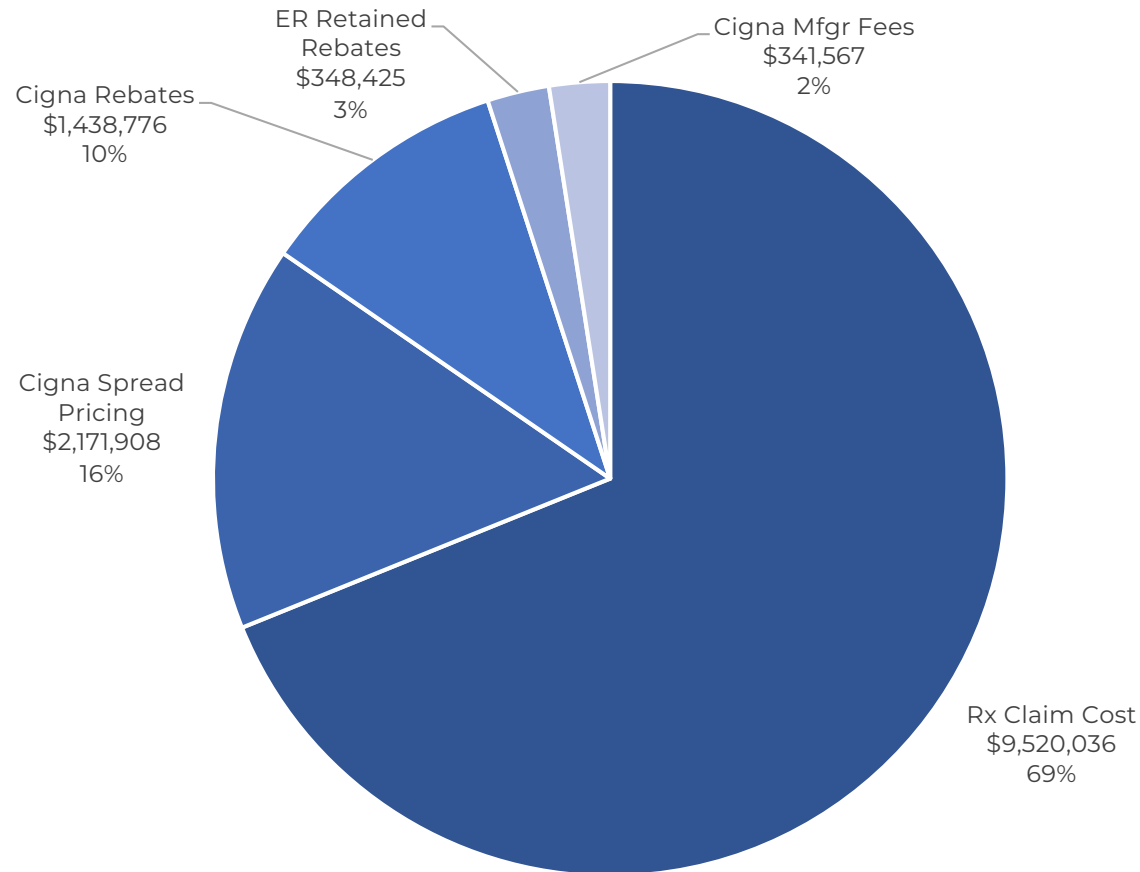
- Manipulate Favored Nations Pricing
- Manipulate Reversed, Rejected, Non-Plan OTC Claims
- Manipulate 340B Claims
- Manipulate Device Claims
- Manipulate Vaccine Claims (including charging admin fees)
- Manipulate Compound Claims
- Create Spread on Repackaged NDCs

- Negotiate Rebate Then Supply Drug From Their In-House Pharmacy
- Negotiate Rebate Using Early Refill Rules to Increase More Yearly Refills
- Sister Companies Collect Other Rx Monies
- No Pass-through U&C Claims
- Reclassify Generic as Brand
- Fields Removed from System Access
- Selecting Higher AWP
- Dispute Rebateable Drugs
- Clawbacks
- Multiple MACs
- Spread Pricing
- Drug Reclassification
- Audit Recovery Retention
- NDC Switch

- NDC Switch
- Selling Your Data
- Marketshare Fees
- Management Fees
- Mail Autofill
- Repackage AWP
- Mail Copay Waiver
- Rebate Manipulation & Retention
- Collect Rebates on OTC, Insulin, non-formulary drugs
- Collect Diabetic Supply Rebates
- Charge Reversed Claim Admin Fees
- Only Provide Portion of POS Rebates
- Multiple MAC Lists
- Remove Refill Too Soon at Mail
- Gag Orders on Pharmacies
- Dispense 90 Days But Charge for 100 Days



# And the data reveals all...



## 2019-2021 Cigna ESI Data

- \$15.66M in Rx claims
- \$1.83M in member cost-sharing
- \$13.8M in net Rx claims paid by clients

## Net claims paid by Employer: \$9.17M

- Employer Rebates: \$348K

## CIGNA/ESI Earnings from Rx: \$3.95M

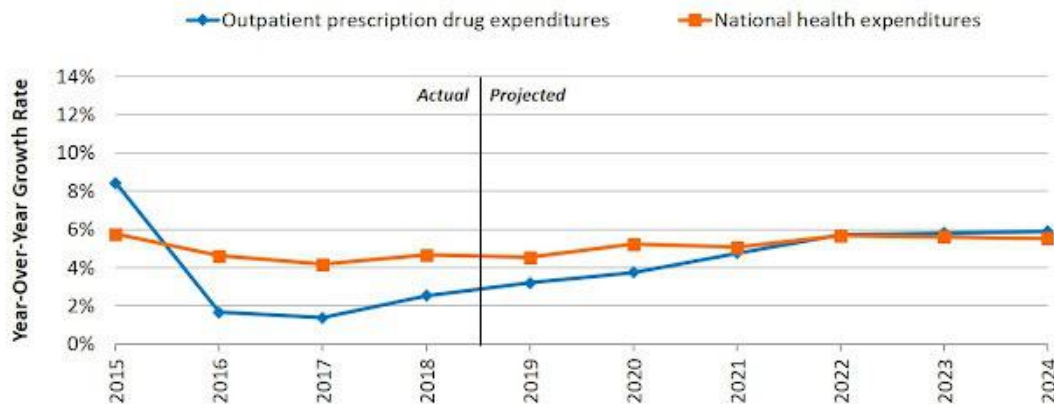
- Spread Pricing: \$2.17M
- Cigna Retained Rebates: \$1.44M
- Cigna Retained Mfg Fees: \$342K

# Being Your Best Benefit Consultant



# Healthcare Spending REALITY.

Projected Growth Rates in National Health and Outpatient Prescription Drug Expenditures, 2015 to 2024



First projected year is 2019.

Source: Drug Channels Institute analysis of National Health Expenditure Accounts, Office of the Actuary in the Centers for Medicare & Medicaid Services, March 2020. Outpatient prescription drug data exclude inpatient prescription drug spending within hospitals and nearly all provider-administered outpatient drugs.

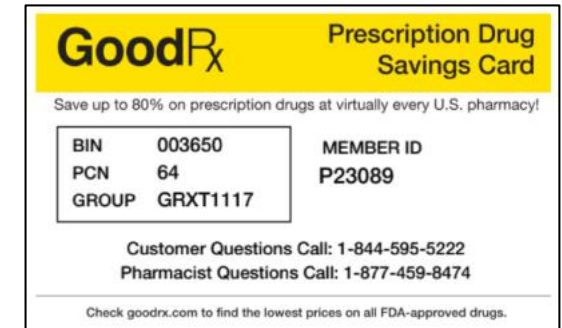
Published on Drug Channels ([www.DrugChannels.net](http://www.DrugChannels.net)) on April 7, 2020.



- CMS projects that from 2019 to 2024, total health spending will grow at an average rate of 5.3%, while prescription drug spending will grow more slowly, at an average rate of 4.8%.
- Prescription drug spending will decline as a portion of overall U.S. healthcare expenditures.
- CMS projects that prescription drugs spending will account for 8.9% of 2024 national healthcare expenditures, compared with 9.2% in 2018.

# Drug Coupon Cards

- Prescription drug discount cards are seen as a reasonable alternative to assist with the cost element but do not always work well with benefit plans or Medicare/Medicaid.
  - These cards act like coupons, bypassing insurance altogether meaning that the patient/member pays 100% of the cost
  - This means that when someone uses a discount card (or pharmacy discount program), what they pay for the drug fill does not count toward OOP limits or deductibles... and there's no claims data to go with it.



**GoodRx** Prescription Drug Savings Card

Save up to 80% on prescription drugs at virtually every U.S. pharmacy!

BIN	003650	MEMBER ID	
PCN	64		P23089
GROUP	GRXT1117		

Customer Questions Call: 1-844-595-5222  
Pharmacist Questions Call: 1-877-459-8474

Check [goodrx.com](http://goodrx.com) to find the lowest prices on all FDA-approved drugs.



**★FREE DRUG CARD.US**

Coupon ID Number: 38386C267F  
RxBIN: 610709  
RxGroup: FDCUS2R

**Rx Pharmacy Coupon**

PATIENT INSTRUCTIONS: This card/coupon is pre-activated and can be used immediately. Present this card/coupon to any participating pharmacy to receive a discount on prescription medications.  
PHARMACIST INSTRUCTIONS: Submit as a primary claim (cannot be processed as secondary) using the following pharmacy processing information. For processing questions and comments please call the Pharmacy Helpline below.

Pharmacy Helpline | 800-223-2146 | Customer Service | 877-321-6755

Savings can be as high as 80%. This coupon has no expiration date and is reusable on Brand and Generic Rx's.  
This program is not insurance. This is a point-of-sale discount program.



**IntegrityRx**

**U.S. RX SAVINGS CARD**

ID	PCCARD	BIN	610312
GRP	NXAACC	PCN	01

For use at your local U.S. pharmacy. This card is active for all prescribed family and pet medications. This card is not insurance and never expires.

Pharmacist and Patient Services: 1-800-796-6064



**Rx.com** PRESCRIPTION DRUG SAVINGS CARD

BIN	610312	Show this discount card at your pharmacy to save up to 90% on your prescriptions.
PCN	01	
ID	RXCOM	
GROUP	RXCOM	

Have Questions? Call Us At 1-866-447-9266

# Drug Coupon Cards

- These programs usually don't cost anything to join
- There may be some limitations as far as participating pharmacies and...
- Cost for each drug will differ based on the pharmacy
  - Why: leveraging discounts off the AWP price



- But buyer beware...
  - GoodRx and their competitors are often owned by companies who are using the data gleaned from using their discounts to buy medications to sell to third parties for marketing other products and services
  - Read the fine print...

# Generics: Competition is Important



## Single Source Generics (SSGs)?

- “Single source generic” status is assigned to generic manufacturer who receives an exclusive approval to market as first time generic for a 6-month exclusivity period
- In a typical contract, instead of the SSG drug getting a deep generic discount (74%), they get a typical discount of 35%

## EXAMPLE: Lipitor

- November 30, 2011: Lipitor’s patent expired, making way for pharmaceutical companies to offer a generic version.
- One of the first companies to do this is Ranbaxy, who as a single-source generic manufacturer, began producing atorvastatin, the generic of Lipitor



- First generic competitor resulted in a reduction in monthly brand-name atorvastatin fills by 50%, there was no meaningful difference in monthly out-of-pocket spending was found between brand-name and generic atorvastatin during first six months.
- After full generic competition, estimated monthly out-of-pocket spending for generic atorvastatin (median \$5.10), authorized generic atorvastatin (median, \$5.52) was substantially lower than that for brand-name atorvastatin (median, \$30.00)

# Shopping for PBMs



- In today's market, there are lots of options...
  - You know what to expect from the largest PBMs, but you need to first focus on what makes each PBM unique
  - Nearly everyone is going to tout “transparent and pass-through” (but you need to make sure you understand what that means – read the contract)
  - Take a drug claim run and give “raw data” to vendors (remove the discounted rates paid currently and ask them to reprice)
  - Then understand why “they” are cheaper -- it's not better contracts always
  - What alternative programs are they providing?
    - International sourcing
    - Manufacturer assistance programs
    - Mail order or other solutions

# Shopping for PBMs

- and occasionally no option at all...
  - Many of the traditional PBM sources are tied to TPA or ASO arrangements so shopping for alternatives may not always be viable
    - e.g., Cigna self-funded is going to use Express Scripts
- But you can still do your job
  - Move away from spread pricing
  - Understand what rebates and compensation the PBM and TPA are exchanging... by knowing what drugs folks are taking
  - Hire a pharmacy consultant to help negotiate better PBM rebate credits



# Drug Importation & Reimportation

- Increasingly plans and patients are looking for lower cost alternatives to US prices for medications and turning to importation/reimportation vendors
  - Importation: Drug manufactured outside of the US and shipping into the US
  - Reimportation: Drug manufactured in US, shipped to foreign country and then reimported back to US
- Seen as a significant cost savings but approach with caution...
  - Humira Example
    - Drug manufactured in Canada, imported to US - current cost was \$5500 per month for 40 mg/ml, cost after importation from Canada: \$2414 for 80 mg/ml dosage (annual savings \$40,000 for health plan)
  - Arimidex Example
    - Reimport from Turkey for US patient - US cost is \$542 for 90 supply, reimported cost is only \$80
- Be mindful of where drug is manufactured (Class A countries - UK, Canada, Australia & New Zealand) and how shipped (increasingly have cold pack shipping options available from multiple vendors) as well as FDA safety requirements

# Specialty... Read the Contract



- How is specialty drug defined?
  - Too broad or focused on biologics and orphan drugs only?
  - Why important? What is called “specialty” or not will change the allowed amount (and what the PBM will make on the transaction)
- Pay close attention to how specialty drugs cost is determined
  - In some contracts, will be based on discount off AWP vs. NADAC
  - AWP pricing will inflate costs when manufacturers increase prices.
- PBM requiring exclusive use of their preferred or exclusive specialty vendor rather than open competition
  - Competition and inclusion of retail options may lower specialty drugs cost
- White bagging: A provider purchases medication already prepared for the patient from a specialty pharmacy.
- Brown bagging: The patient receives medication from the pharmacy and is then responsible for transporting it to a provider for administration.



# Specialty... Read the Contract

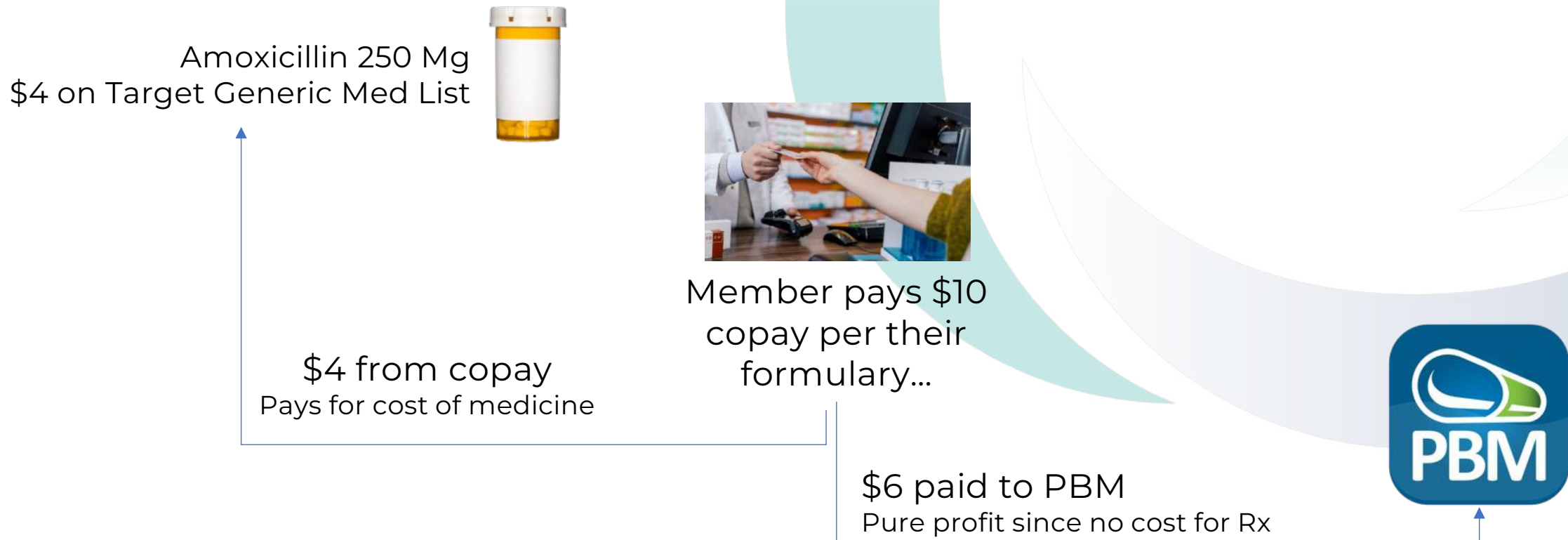
- How are manufacturer coupons applied?
  - May lower costs to member but increase use of specialty products when patients have no incentive to use lower cost non-specialty drugs
- Does your PBM encourage Foundation/Patient Assistance programs, and if so, how will it work operationally?
  - These may, like coupons, provide no incentive for patient to use lower cost drugs. How does this impact OOP cost?
- Are the “right drugs” covered and/or excluded as medical or pharmacy benefits?
  - Leaving some drugs to be paid only as a medical benefit which could instead be purchased by patients in a pharmacy can increase costs. Would “brown bag” requirements help?

# Zero Balance Logic/Zero-Based Cost

- Zero Based Claims (ZBC) - claims where the member cost share (copay) pays the full cost of the prescription drug claim, and the plan/insurer pays nothing... because the pharmacy's cash price is less than copay
- But a word of caution: ZBL is important to watch out for two reasons:
  - Makes the PBM's performance vs. contract look better since they will use an AWP-100% discount on ZBL claims instead of the actual discount, the overall discount performance is inflated therefore helping them meet their guarantees.
    - Practice Point: Exclude ZBL claims from average Rx cost calculation

# Clawbacks

As instructed by PBM, pharmacy charges member the assigned copay for a drug even if the entire cost of the drug is less than the copay, resulting in the PBM making money on the claim entirely from the member co-pay.



- New entrant to the market, focusing on disrupting the manufacturing side of pharmaceuticals where single-source has resulted in much higher costs for some drugs
  - Cuban has promised that his company will manufacture certain drugs (currently 1000 generic drugs) and then sell directly to consumers (for now) at cost plus 15% and a pharmacy fill fee
  - Like Civica, this may prove that competition can improve price in this market and give the consumer more choices:
    - BEFORE: With limited manufacturing for an existing drug, the cost goes up because there is no competition: The only person who makes something can set the price wherever they want.
    - What Cuban and even Civica are doing is saying, “OK... we’ll create our own manufacturing” so that price can be improved since cost and profit motivations are reduced.
  - Who is most advantaged? Consumers should not have to worry about affording a drug when a child or loved one is sick and employers can share that there are reasonable and less expensive alternatives so that no one denies themselves the need to take their meds due to cost



**MARK CUBAN**  
**CostPlus**  
**DRUG COMPANY**

# How Drug Cost Impact Renewals

- Medical Loss Ratio Reports are misleading...
  - Comparing premium paid vs. claims incurred or paid
  - Counting full cost of certain medications on the claims side of calculation...
  - Not including the revenue the carrier earns on that group's unique Rx spend as a part of "premium" in MLR calculation

## EXAMPLES

### Rolling Twelve Month Medical Loss Ratio

Premium Received	1,099,887
Incurred Claims	1,272,920

**MEDICAL LOSS RATIO: 115.7%**

results

*"You're having a bad year... so here's the 25% increase for health insurance for next year since our target MLR is 85%."*



# Analyze and Advocate

01

Does not include the revenue generated by the carrier for rebates and other incentives from manufacturers and/or PBMs for this group's drug fills

## Rolling Twelve Month Medical Loss Ratio

Premium Received

1,099,887

Incurred Claims

1,272,920

**MEDICAL LOSS RATIO:**

**115.7%**

02

This is NOT claims spent... it's an estimate of what claims have been paid and what they believe/guess is outstanding to be paid

03

Does not exclude any claims reimbursed to the carrier based on stop-loss (or pooling points) for claimants exceeding \$85,000

# Analyze and Advocate



## Specifics

Employee taking Stelara for psoriasis and psoriatic arthritis, at an average cost of \$24,440 per month

**\$293,284** annual cost

### Rolling Twelve Month Medical Loss Ratio

Revenue	Premium Received	1,196,119
Net Paid	Incurred Claims	1,064,636

**MEDICAL LOSS RATIO: 88.7%**

## Conclusion

When you add in likely rebates, exclude amounts above \$85,000 and consider alternative plan designs (e.g., manufacturer programs or international sourcing), would self-funded make more sense for the group?

# Be smarter....

- Ask questions, look for alternatives
- Give good information to your client... they see you doing the work, and see you as a trusted adviser.
- Argue with underwriters and insurers -- do not simply take their numbers
  - Use the information you have to get the right renewal and options for each employer
- Find good partners -- a pharmacy consultant, PBMs you trust and data analytics to equip you to help your client

# QUESTIONS?



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