Pharmacy Benefit Managers (PBMs): The Good, The Bad, and The Truth

Daniel E. Buffington, PharmD, MBA, FAPhA

Louisiana Pharmacists Association
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Disclosure of Conflicts

- No conflicts or disclosures.
- Neither I, nor any of my immediate family members, have a conflict of interest within the last twelve months regarding a vested interest in or affiliation with any corporate organization offering financial support for this educational event.
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Learning Objectives

1. Outline the history of pharmacy benefit managers (PBMs)
2. Diagram the electronic claims adjudication process that conveys drug benefit design and transmits prescription claims data
3. Illustrate the problems and concerns associated with PBMs in today’s market
4. Recognize methods utilized by PBMs to control costs and revenues
5. Design strategies to collaborate with impacted parties to diminish the negative effect of PBMs on patient care and clinical practice

Pharmacists & Pharmacy Technicians

**Pharmacist Objectives:**
- Explain the process of electronic claims adjudication
- Compare the prescription transaction and clinical services provided by PBMs
- Demonstrate how PBMs utilize contracted distribution channels and clinical management for specialty drugs

**Pharmacy Technician Objectives:**
- Explain the role of a pharmacy technician for PBMs
- Describe the use of drug formularies and formulary restrictions by PBMs
- Illustrate how a patient’s prescription drug benefit information is provided to pharmacies by PBMs
What are Pharmacy Benefit Managers (PBMs)?

- Third party administrator contracted by health plans, self-insured employer groups, and government entities to help manage and administer their prescription drug benefit programs to their insured patients
- Goals:
  - Facilitate the process of communicating the plan’s drug benefits for their patients
  - Develop and provide contracted pharmacy networks as a point-of-access
  - Process prescription drug claims from the pharmacy to the health plan
  - Control of medication-related costs for health insurer and patient

PBM Market Place

**Outline**

1. **Good**
2. **Bad**
3. **Truth**

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**History of Pharmacy Benefit Managers**

- **1968** Pharmaceutical Card System was the first Pharmacy Benefit Manager or “PBM” (PCS, later AdvancePCS). PCS invented the patient portable drug benefit card (plastic).
- **1970s** PCS was a fiscal intermediary using paper-based fiscal intermediaries by adjudicating prescription drug claims by paper.
- **1980s** PBMs were hosting computer-based “electronic claims adjudication”.
- **1990s** Diversified Pharmaceutical Services (DPS) was one of the earliest examples of a PBM which came from within a national health maintenance organization United HealthCare (now United Health Group).
- **1999** Express Scripts acquired Diversified in April 1999 and consolidated itself as a leading PBM for managed care organizations.
- **2002** Wall Street Journal article on how PBMs had “steered doctors to cheaper drugs, low-cost generics and away big pharmaceutical companies” from 1992 through 2002.
  - PBMs quietly evolved into aggressive price controls for pharmacy network contracts, marketing expensive brand name drugs, and processing specialty medications.
- **2007** CVS acquired Caremark. PBMs changed “prescription claims processing and focused on trying to control pharmacy benefit design for health plans, negotiating “drug discounts with pharmaceutical manufacturers”, and providing “drug utilization reviews and disease management.”
- **2012** Express Scripts and CVS Caremark transitioned from using tiered formularies to models that excluded specific drugs from a formulary.
Pharmacy Benefit Managers (PBMs) are 3rd party administrators of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans. According to the American Pharmacists Association, “PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims” Work directly with health plans to design drug benefits to maintain or reduce the pharmacy expenditures. PBMs operate outside of integrated healthcare systems, as a “middleman” between health plans and the point of care (i.e., pharmacies or physicians) By 2016, PBMs were managing pharmacy benefits for 266 million Americans By 2017, the largest PBMs had higher revenue than the largest pharmaceutical manufacturers. 3 major PBMs (i.e., Express Scripts, CVS Health, and OptumRx of UnitedHealth Group) are ~80% of market

With the inception of the Medicare Part D Program in 2006, and the Affordable Care Act in 2010, insurers became more interested in outsourcing management of prescription claims and client services As coverage expanded, PBMs stepped in to lighten the load
It’s All About Perspective

Toll Collectors in the Prescription Drug Benefit Process

Originally to submit an Rx Claim, now multiple charges
Paper Claims / 3rd Party Administrators

Electronic Claims Adjudicators

1960s – 1980s

1980s - Present

The Good
PBM Scope of Services

- Real-Time Electronic Claims Processing
- Drug Utilization Review
- Drug Plan Formulary Development
- Develop Networks of Contracted Pharmacies
- Payment Policies
- Improve Medication Access
- Mail Order Medications
- Specialty Pharmacies
- Medicare Part D
- 340B

Electronic Claims Adjudication

Responsibilities of a PBM
The U.S. Pharmacy Distribution and Reimbursement System for Patient-Administered, Outpatient Prescription Drugs

Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.


Available at: [http://drugchannelsinstitute.com/products/industry-reports/pharmacy](http://drugchannelsinstitute.com/products/industry-reports/pharmacy)

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Employers feel stress over drug costs but are not standing still

<table>
<thead>
<tr>
<th>Use of traditional trend management tools holds steady:</th>
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</thead>
<tbody>
<tr>
<td>94% Prior authorization</td>
</tr>
</tbody>
</table>

Deductibles becoming the new normal?

- 61% with HSA: A majority of employers offer a high-deductible health plan (HDHP)
- 18% with HSA

Offering HDHPs with good intentions

- 47% use them as an effective way to manage overall drug trend and save money
- 58% say they are an effective way to help consumers make better decisions

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Managing drug benefit trend remains the top priority for plans

- 83% are self-funded and earn 51% share of loss reinsurance that includes prescription drugs

- 38% reported four or more tiers, and 48% have a separate tier for higher-cost generics

- 44% have a pharmacy deductible, either alone or shared with medical
Prescription Drug Formulary

- List of approved drugs that a health plan covers, basis for prescription drug benefit.
- Goal is to provide high-quality care using the most cost-effective medications.
- Often includes two to five groupings of drugs (“tiers”) at different levels of patient copayments.
  - Lowest tier will have the smallest patient cost-sharing, while the drugs in the highest tier will have the highest patient cost-sharing.
  - Generic drugs – medications that are essentially copies of brand name drugs with similar dosage, intended use, and side effects – are often assigned to the lowest tiers, with brand name and specialty drugs populating the higher tiers.

Drug Formulary

<table>
<thead>
<tr>
<th>What your drug formulary WILL tell you</th>
<th>What your drug formulary will NOT tell you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each medicine considered to be covered</td>
<td>Actual cost of that medication action filled at a pharmacy</td>
</tr>
<tr>
<td>“Tier” that is placed on</td>
<td>Non-flexible out-of-pocket responsibility related to that tier of the drug</td>
</tr>
<tr>
<td>Indications for use (disease state management)</td>
<td>Information on your pharmacy’s contractual obligations</td>
</tr>
<tr>
<td>Prior Authorization (PA)</td>
<td>Benefits identified or generic alternative</td>
</tr>
<tr>
<td>Alternative therapies on or off formulary</td>
<td>Co-prescriptions of mail order vs. retail pharmacy</td>
</tr>
<tr>
<td>Information may vary by</td>
<td>Authorization by your provider</td>
</tr>
<tr>
<td>Medications contained in a generic medications when prescribed as a specific or non-specific dose</td>
<td></td>
</tr>
</tbody>
</table>

*Note: This is a simplified representation of a drug formulary. Actual formularies may vary.*
A drug formulary is a list of prescription drugs (generic and brand) used to assist practitioners in selecting the drugs that offer the greatest overall value.

A committee of independent, actively practicing physicians and pharmacists design & maintain the drug formulary.
Controversial revenue strategies
  - Fees from supply chain
  - Rebate programs with manufacturers
    - Rebate details and savings sharing is often confidential and not clear on how the savings are actually distributed amongst PBMs, payers, health plans, etc.
  - Pharmacy spreads
    - The difference between what they pay for drugs from a pharmacy and what they get paid by the insurer
  - Concentrated market shares, stemming from recent mergers and acquisitions
    - Restricted pharmacy networks
The Bad

- Free from regulation
- Lack of transparency
  - Particularly with rebate agreements, allocation, and chargebacks
  - May not be choosing the most cost-effective drugs
  - Formulary tier priority assigned to drugs with the highest rebate
  - Profits for firms that own PBMs and distributors increased between 2011 and 2016 from $9.9 billion to $15.7 billion for PBMs and from $3 billion to $5.2 billion for distributors

Direct and indirect remuneration (DIR Clawback Fees), or post-sale payment return, is commonly used by Medicare Part D and private employer-based plans and based on sales volume or product preferences

Unfair (Below Cost) Pricing Models of the medication is less than the copayment or coinsurance determined by PBM, excess funds are returned from the pharmacy to the PBM

Impacts on Medicare:
  - Increases drug costs at point-of-sale
  - Accelerates transition to catastrophic benefit
  - Benefits the Part D plan sponsor because rebates are disproportionately distributed to reduce plan liability
  - Secretive pricing
Different Perspectives
No One is Totally Happy

- Health Plans
- Patients
- Pharmacies
- Prescribers
- Pharmacists
- Manufacturers
- Wholesalers
- Pharmacy Benefit Managers

Drug Benefit Design

<table>
<thead>
<tr>
<th>TIER</th>
<th>DRUG TYPE</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preferred Generic</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>Generic</td>
<td>$$</td>
</tr>
<tr>
<td>3</td>
<td>Unpreferred Brands</td>
<td>$$$</td>
</tr>
<tr>
<td>4</td>
<td>Non-PREFERRED</td>
<td>$$$$</td>
</tr>
<tr>
<td>5</td>
<td>Specialty</td>
<td>$$$$$</td>
</tr>
</tbody>
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PATIENT SAFETY
We missed a critical opportunity to build the tools to serve us, instead they are being developed by others and thrust upon us...strangulating pharmacists/pharmacies in an effort to a) control health plans drug benefit spend and to b) maximize PBM profits by skimming in the middle

**It’s time to take our profession back...This is Sparta**
Where We Are Today

- PBMs are out of the realm of regulation and have minimal transparency and/or visibility
- DIR fees
- Prescription Discount Cards
- Controversies surrounding the potential misalignment of the financial incentives of PBMs with health plans, pharmacies, and patients
- Amazon’s potential plan to forego the involvement of pharmacy benefit managers
- New Legislation: Anti-Kickback Statutes
- Passing on discount to patients

The Truth About the Future
Our Collective Challenges

- Discerning between Good vs Bad PBMs
- Identifying Functional PBM Alternatives
- Forcing PBMs to be regulated by State-based Insurance Commissioners
- All parties working together to hold PBMs accountable and diminish their roles
- Transparency
- Industry based alliances
- Enhanced Pharmacy Benefit Administrator (monitoring of PBM activities)
- Vertical Integration of Health Plans and PBM functions
Examples of PBMs

- Express Scripts
- CVS Caremark
- OptumRx
- Humana
- Aetna
- RxPreferred Benefits
- Choice Rx Solutions
- True Rx Management Services

Monopolize the Market

PBMs who’ve pledged to conduct a transparent model

The Biggest Players

PBM Market Share by 2017 Total Equivalent Prescription Claims Managed

- Express Scripts: 25%
- CVS Caremark: 16%
- OptumRx: 22%
- Humana Pharmacy Solutions: 4%
- Aetna: 7%
- RxPreferred Benefits: 4%
- Others: 24%

Percentages may not equal 100% due to rounding.
### PBM Growth & Consolidation

#### 5 Top Insurers and Their PBM Partners

<table>
<thead>
<tr>
<th>Insurers</th>
<th>PBM Partners</th>
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</thead>
<tbody>
<tr>
<td>UnitedHealth Group</td>
<td>OptumRx (in-house); CatamaranRx (purchased 2015)</td>
</tr>
<tr>
<td>Anthem</td>
<td>IngenioRx (launching in-house in 2020)</td>
</tr>
<tr>
<td>Aetna</td>
<td>CVS/Caremark (purchase under review)</td>
</tr>
<tr>
<td>Cigna</td>
<td>Cigna Pharmacy Management (in-house); Express Scripts (purchase under review)</td>
</tr>
<tr>
<td>Humana</td>
<td>Humana Pharmacy Solutions (in-house)</td>
</tr>
</tbody>
</table>
Pharmacy Practice Settings

Community  Hospital  Health Plans & Mail Order  Innovative Practice Models

Opportunities in the Profession

Develop National (non-PBM) Networks  Customized Contracts

Simplified, Fair, and Functional  Innovative Contacts & Pricing Models
High Cost Medication Models

- Specialty Drugs
- Orphan Drugs
- Biologics
- Oncology

Critical Concern – The Cost of Specialty Drugs

Specialty drug costs have been the top concern every year since the inception of this report, and this year is no exception.

Large costs for small populations...

61% of respondents list management of specialty drug costs as their number one priority.

...with no end in sight

Specialty drug spending under the medical benefit has increased 35% since 2014, and double-digit average specialty trend under the pharmacy benefit has been the norm since 2000.

Employers Caught in the Middle

87% of workers report health and drug benefits as extremely or very important. Employers know these benefits are important to recruit and retain key talent and that healthy employees are more productive.

$52,486 AVERAGE TREATMENT

The average annual cost of treatment with a single specialty drug was $52,486 in 2015.

$48,665 MEDIAN TREATMENT

Median wage in 2015 was $24,380, and median household income in 2015 was $53,021.

The average cost of healthcare in 2017 for a family of four was $15,604. 37% is paid by the employer.
Tough Choices: Tactics to Manage Specialty Trend

Balancing premiums with member out-of-pocket costs

33% - The prevalence of high-deductible health plans continues to increase, rising from 28% in 2014 to 33% in 2019.

Balancing member access with network management

65% - Of respondents reported that their contract requires the use of a designated specialty pharmacy.

31% - Significantly fewer reported different cost-sharing designs by site of care.

57% of employers use prior authorization to encourage use of lower-cost sites of service.

44% have reduced cost-sharing amounts at preferred sites of service.

Sharing costs and managing trend

Cost-sharing and trend management are two of the most common specialty benefit plan strategies.

56% of respondents in 2017 reported a separate cost-sharing tier for specialty drugs under the pharmacy benefit, compared to 24% in 2016.

And excluding some drugs altogether

58% - Of respondents reported using formulary exclusions for specialty drugs.

62% - Of all employers agree that formulary exclusions are an effective way to manage specialty trend.

41% - #1 CHALLENGE

Member discrimination is the top challenge associated with pharmacy benefits, linked by clinical variation.

24% - #2 CHALLENGE

Orphan Drugs: Providing Hope ... Creating Concerns

Rare diseases are not so rare

They affect nearly 30 MILLION Americans — compared to the 143 million with a history of cancer and the 137 million who have a stroke or heart attack annually.

Of the new drugs approved in 2015, 41% were orphan drugs used to treat a rare disease or condition.

Only 5% of rare diseases have treatments available.

Drug cost is a primary concern to employers

55% - With the high price tags associated with new orphan drugs, it is unsurprising that over half (55%) of respondents rated drug costs as their top concern.

71% do not feel the current prices of orphan drugs are sustainable.

But other concerns abound:

- “Lack of information on efficacy.”
- “How much we don’t know about them and what’s out there that could at some point devastate our healthcare cost budget.”
- “Patient/provider demand — even though a drug may not be overwhelmingly effective, if it is the ONLY treatment option for that disease, patients and providers demand it and insist that the plan must cover it.”
- “There is going to reach a point at which the market is not going to be able to support additional cost.”
Orphan Drugs

In response to concerns, employers have put programs in place to manage orphan drugs:

- 82% have prior authorization
- 62% implemented clinical care management programs
- 59% limit orphan specialty drugs to 30-day supply
- 53% require use of specific specialty pharmacy

Vertical Integration
**PBM Revenue Structure**

- **Rebates**: Discount on a medication the drug manufacturer gives a PBM and in return the PBM agrees to cover their product.
- **Spreads**: The dollar difference between what the PBM pays the pharmacy to dispense the medication and what the PBM charges the plan sponsor.
- **Direct and Indirect Remuneration Fees**: Retrospective revenue from community pharmacies based on prescription sales.

**Market Share & Encroachment**

- Due to their expanding involvement in the prescription drug industry, PBMs pull in profits from several different directions.
  - Industry experts surmise that, as baby boomers age, health care and prescription drug spending will continue to rise, meaning more revenue for these claims processing giants.
  - According to a 2015 Applied Policy Report, the top three PBMs in the country manage the drug benefits of 78% of the U.S. population, or 180 million people.
  - Pending the approval of the Aetna-Caremark and Cigna-Express Scripts deals, these giants would be linked to three colossal insurers.
  - When looking at prescription claims managed, OptumRx (22%), Caremark (24%), and Express Scripts (25%) dominated the market in 2017.
  - The pending mergers could propel Cigna and Aetna to surpass UnitedHealthcare in PBM market share, providing the number of claims processed by each of the companies remains about the same in the future.
Vertical Integration: Health Plans & PBMS

- October 2017, Anthem announced that it would not renew its contract with Express Scripts, but instead, launch its own PBM, IngenioRx, in 2020.
- December 2017 - Aetna stated its intention to have a PBM with its merge with CVS Health in a $69 billion deal.
- Cigna disclosed its agreement to purchase Express Scripts for $52 billion.

Mergers & Acquisitions

- A major reason why Anthem will allow its contract with Express Scripts to end at the close of 2019 is it believes Express Scripts withheld billions in savings and overcharged them for services.
- Modern Healthcare reports PBMs have been criticized for keeping their rebate deals with drug makers guarded by nondisclosure agreements.
Mergers & Acquisitions

- According to insurers, employers want drug pricing to be more transparent.
- With more oversight of PBMs, insurers could provide their clients with this increased transparency and streamline and further integrate their members' care.
- In turn, this could lead to lower prescription drug costs for consumers — but there's a good chance it won't.

Mergers & Acquisitions

- If drug manufacturer rebates become more transparent, the drug manufacturers themselves could then use information about their competitors to minimize their rebate amounts.
- This would make drug manufacturers more competitive, which would lead the overall price of drugs to go up, not down.
- For the average joe to see lower prescription drug prices from these mergers, insurers would have to pass on the rebate savings they negotiate to beneficiaries.
- Right now, it's likely companies are more interested in claiming a "rich" slice of the pie before it's gone.
As for Humana, at the end of March, The Wall Street Journal reported that massive retailer Walmart Inc. is “in preliminary talks” to purchase the insurer. Such a deal would be similar in nature to CVS Health’s acquisition of Aetna, Rite Aid Corp’s 2015 acquisition of PBM EnvisionRx Plus, and Albertsons Cos. proposed acquisition of Rite Aid Corp.

Humana and Walmart already have a co-branded drug plan together, so it wouldn’t be a surprise if they chose to further their existing partnership. Creating a stronger bond with Walmart could get Humana more customers. Additionally, combining with Humana would give Walmart another way to stay competitive with Amazon. Speculation that the online retail behemoth will expand into prescription drug sales may have influenced many of the health care related merger proposals we’re seeing today.

The CVS-Aetna, Cigna-Express Scripts, Albertsons-Rite Aid, and potential Walmart-Humana mergers will all need to be reviewed and approved by the Antitrust Division of the Department of Justice. If they do, insurers should have more control over drug pricing, but it’s not clear as to whether shoppers will see decreased provider options or increased savings from insurers.

In early March, UnitedHealthcare committed to passing rebate savings on drugs to its fully insured group health members on an individual basis at the point of sale beginning in 2019. Aetna has also said it will pass negotiated drug discounts on to about three million of its members next year. Others could follow suit, but that’s anybody’s guess.

Lawmakers in the federal and state governments are also examining PBMs and introducing regulation attempting to reform some of their more questionable practices.
Legislation Introduced

  - Improves pharmacy choice for seniors and strengthens Medicare Part D through increased pharmacy competition
- H.R. 1316: **Prescription Drug Price Transparency Act**
  - Increases transparency in generic drug payments in taxpayer-funded federal health programs and preserves patient’s access to local pharmacies
- H.R. 1038: **Improving Transparency and Accuracy in Medicare Part D Spending Act**
  - Prohibits pharmacy direct and indirect remuneration fees from being applied after the point-of-sale for prescriptions to Medicare beneficiaries

Legislation – Enacted Into Law

- S. 2554: **Patient Right to Know Drug Prices Act**
  - To ensure that health insurance issuers and group health plans do not prohibit pharmacy providers from providing certain information to enrollees
  - Essentially eliminates “gag clauses”
Alternatives to PBMs

- **Transparent PBM Model**
  - A PBM who takes a flat administrative fee for each prescription

- **Pharmacy Benefit Administrator**
  - Oversee administrative services for the plan sponsor such as claims processing and data reporting, while the plan sponsor handles other functions such as formulary management, rebate negotiations, and contracting with pharmacies for network participation

- **Self-insured Organizations**
  - Organizations create their own network
  - Example: Health Transformation Alliance

Opportunities for Integration Into CMS & CMMI Initiatives

- **Hospital Engagement Networks (HEN)**
- **Transforming Clinical Practice Initiative (TCPi)**
- **Alternate Payment Models (APM)**
- **National Opioid Crisis: CMS Medication Management Opioid Initiative**
- Who We Are

The Pharmacy Benefit Management Institute (PBMI) is the nation's leading provider of research and education that informs, advances, and influences the industry on drug cost management. Our insights enable evidence-based, actionable decision making in a complex and evolving pharmaceutical marketplace.

Learn More

Your independent analysis of the PBM market is appreciated.

— President of a TPA

The Future of Pharmacists' Reimbursement

- Evolution of Pharmacists' Practice Models
  - Practice Management Strategies & Tools
  - Collaborative Practice Agreements
- Health Information Technology Resources
  - Dynamic Patient Profiles
  - Pharmacist-specific Therapeutic Analytics
  - Practice Metrics (blending both pharmacy and medical data)
  - Practice-based Outcomes Reporting Tools (patient and organization)
  - Align Pharmacists Services "ROI" with "Value-based" Payment & Reporting Systems
- Public & Payer Relations
  - Enhance Market Awareness and Understanding of pharmacists' impact
  - Evolve current Comprehensive Medication Management
  - Incorporation into "standard medical benefit"