

10 Questions Benefits Managers Should Ask Their PBM

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It pays to make an informed decision

Pharmaceutical Benefits Managers are often known simply as “PBMs.” While they are largely unrecognized by most employees -- and even by many benefits managers -- they have a tremendous impact on US health care decision-making because they influence more than 80 percent of prescription drug coverage. The sector is dominated by a handful of very large national players, but there are smaller and regional PBMs as well.

PBMs commonly operate on behalf of employers, insurance companies, and unions; they are also sometimes referred to as “third-party payors.” The original purpose of PBMs was straightforward: issue drug cards for easy ID and account tracking and offer their customer groups cost-effective services as well as reliable claims information.

Over time, however, PBMs have evolved into much more complex organizations. PBMs now take advantage of various strategies associated with rapid growth, including large-scale “block purchases” of drugs and medical products that dramatically lower their wholesale costs — even as PBM fees have consistently increased for customers. Some PBM practices are, in fact, the subject of lawsuits or federal and state regulatory investigations.

So how can you, as a benefits manager, make the best pharmacy decision for your employees? How can you have confidence that your company is receiving optimum PBM value and service? What key questions should you ask your current or potential PBM—or your health insurer contracting with a PBM?

The following 10 questions are designed to help you and other benefits managers select the best PBM for your organizations.

1) Do you use the same average wholesale price (AWP) in calculating price to clients and payments to pharmacies?

Some PBMs realize hidden profits by employing a practice known as “differential or spread pricing.” Differential pricing is when a PBM establishes a discount off the average wholesale price (AWP) for the individual employee filling a prescription, but establishes a different AWP discount for retailers.

Here’s an example of differential pricing in action:

Your employee or group member pays AWP minus 15%

PBM pays retailer AWP minus 18%

PBM pockets the 3% differential

Although PBM revenues derived from differential pricing can run between \$5 and \$8 depending on the type of program served, typical PBM disclosed fees hover at \$1 per prescription. While differential pricing is a common business practice, PBMs should disclose the differential to you or your health insurer.

If you have a plan governed by ERISA, you should keep in mind that the U.S. Department of Labor requires full disclosure of all compensation, fees, and income from a PBM that acts in a fiduciary capacity as an administrator and/or claims payor for an employer with a benefits plan.

Recommendation: Ask to see your PBM's contract with network pharmacies and compare with the PBM's contract with your organization. The reimbursement rates should be the same on both contracts.

2) Do you participate in rebates from drug manufacturers?

PBMs often receive rebates from drug manufacturers in return for placing products on formularies and for working to increase sales volume for these drugs. (Rebates can range from 50 cents to \$1.25 per claim.) Some employers allow PBMs to keep 100 percent of rebates in exchange for lower administrative fees. Alternatively, you may prefer a sharing arrangement, typically 50/50.

Recommendation: Whether you share rebates or exchange rebate dollars for lower administrative fees, ask your PBM to disclose the total amount of rebate dollars collected as a result of the business you represent to the PBM—and ask for supporting documentation that explains how rebate revenue is calculated.

3) What other payments do you get from drug manufacturers besides rebates?

Some PBMs reclassify rebates using categories such as education grants, research, advertising, promotion, access fees, formulary management fees, and data collection fees.

Recommendation: Ask your PBM to report the per member per month (PMPM) cost. This figure is calculated by dividing the total amount of drug cost spent in a month by the number of members enrolled in the program. The PMPM cannot be manipulated and is a true reflection of whether the plan's costs have increased or decreased.

4) Do you have any plans for mandating mail order on any drug or drug category?

A survey by the National Community Pharmacists Association found that while small and medium size businesses commonly offer mail order options through their health plans, most plans do not force employees to purchase their drugs in this way, but allow them to continue to obtain their drugs at local pharmacies. The option of transitioning to mail order only was very unpopular with these employers.

PBMs encourage the use of their own in-house mail order operations by charging reduced co-payments and by offering a 90-day supply of drugs. PBMs deny the 90-day supply option to local pharmacies.

When mail order prescriptions are filled, a PBM receives income from both dispensing and

claims fees. A PBM will, therefore, try to maximize use of mail order. This is not necessarily bad for your company, if the benefit design (co-pays) is established correctly and the best possible mail order rates have been negotiated.

Recommendation: Check reimbursement rates to ensure they are competitive. Shop around for the best rate. Ask for manufacturer rebates on mail order prescriptions.

5) Does your formulary limit drugs that will be covered?

A formulary is a list of “preferred drugs that pharmaceutical manufacturers discount to employers and other groups in exchange for volume usage.” The most effective formularies optimize and balance quality, effectiveness, and costs.

Check to see if your health plan has to pre-approve a medication before plan members can get their prescription filled. Many plans require physicians to get prior authorization of medications before the plan will cover the drug. That means physicians or pharmacists must call the health plan or PBM for permission to write or fill certain prescriptions. Some plans also require members to try a less expensive medicine first, before they will cover the one recommended by the member’s physician.

Recommendation: Make sure that any switching of drugs is constructed to save you money and not the PBM. Check with your plan to understand its authorization process so members are not surprised when they arrive at the pharmacy. And, be sure to learn how to appeal requirements and decisions when your members have complaints.

6) How often do you change your formulary?

In most states, even though medications may be covered when the health plan is selected, a PBM may change its list of approved medicines at any time throughout the year. If a medication is removed from the formulary without prior notice, the individual patient must either pay out-of-pocket or accept a medication that the PBM prefers.

Recommendation: Check with your PBM for policies related to formulary changes. Will you receive notice of formulary changes in writing? If not, ask for notification.

7) How are co-payments set?

Most health plans require a co-payment for each prescription. Some plans have a single, uniform co-payment — for example, \$10 for any prescription. Other plans have different levels of co-payments for different medications, a system known as “tiered co-pay.” A PBM can shift medications from one tier to another at any time, leading to — much like arbitrary formulary changes — potentially unpleasant surprises for employees presenting prescriptions at pharmacies.

Recommendation: Ask about how you and plan members will be notified when the PBM makes

a tiered co-pay change for a medication.

8) Are you currently the subject of any lawsuits or investigations relating to your business practices?

The New York attorney general's office reported that it had subpoenaed the records of Express Scripts, a large PBM, after an audit by the state comptroller found that it had repeatedly overcharged a state employees' drug plan. Express Scripts said it had repaid \$613,000 and changed its system to prevent future errors. Attorneys general in more than 20 states are investigating the business practices of Medco Health Solutions and Caremark (AdvancePCS), under consumer protection laws and pharmacy professional standards.

Some large employers, health plans, and states are hiring outside auditors to review PBM transactions.

Recommendation: Research lawsuits or government investigations against PBMs that are public knowledge. Ask about PBM practices for reporting fraud and abuse and for external audits.

9) Can you provide a detailed explanation of your health plan's fee schedule and specifically the cost of clinical programs?

Be sure to compare "apples to apples" when evaluating a financial proposal from a PBM. Inexpensive claims processing fees may be less attractive if you are "nickel and dimed" on everything else. Clinical programs are an area where fees vary widely. For example, a prior authorization (PA) program establishes protocols for prior approvals of expensive, non-formulary drugs. A PA program is one tool, among many, that keep costs under control. However, PA program fees vary widely, ranging from \$2 to \$40 per PA.

Recommendation: Ask for detailed disclosure and explanation of a PBM's fee schedule. If policies related to prior authorization systems are not clearly explained — ask.

10) What is your policy on selling pharmacy data?

In the business of health care, information equals revenue. Every drug manufacturer would like to know about your plan members' demographics and utilization patterns. You have the right to demand that your company's proprietary information not be sold by your PBM to the highest bidder. And, that all PBM practices are in compliance with the privacy regulations established under the Health Care Portability and Accountability Act (HIPAA).

Recommendation: Ask the PBM to include a paragraph covering the sale of data in your contract. If you have no objection to aggregate data being sold, you should still require disclosure of the sales. Also consider the value of your company's data and whether or not to ask for some form of compensation from the PBM.

Much of the information contained in this guide for benefits managers comes from the 1998

white paper, “Do You Really Know Your PBM? Tell Your PBM to Show You the Money!” authored by Gerry Purcell, managing partner with Pharmacy Partners, an Atlanta company that assists health plans in selecting and contracting for the best PBM arrangement.