

A stylized illustration of a woman's profile in white, facing right. A large, dark purple circle is superimposed over the top of her head, containing the main title and subtitle in white and light blue text. The background is a light beige color.

Prescription Coverage Savings

Easy to Find if You Just Look for Them

by | **Linda Cahn**

A health plan sponsor can dramatically reduce its prescription costs if it excludes—or disfavors—high-cost drugs, pays attention to and changes its PBM contract terms and guarantees, excludes high-cost pharmacies from its retail pharmacy network and takes advantage of manufacturer coupons.



Newspapers are filled with stories about Martin Shkreli's \$750 per pill Daraprim®, Mylan's \$600 per package EpiPen® treatments and projected double-digit prescription price increases for 2017. But if you think it's impossible for your health plan to decrease its prescription coverage costs, think again.

All you need do is look for—and take advantage of—multiple savings opportunities to dramatically decrease total plan costs. The examples that follow make it clear that finding savings opportunities is as easy as finding an elephant hiding under a chair.

Stop Covering High-Cost Drugs That Have Lower Cost Equivalents

Your plan likely is spending a small fortune for high-cost brand drugs when it instead could cover only chemically identical, lower cost generic or over-the-counter (OTC) equivalents.

It's virtually certain a list of your plan's 50 most costly drugs includes brand drugs that have far less expensive alternatives:

- Crestor® (substitute rosuvastatin)
- Abilify® (substitute aripiprazole)
- AndroGel® 1.62% gel (substitute androgel 1% gel)
- Nexium® (don't cover at all or cover only OTC Nexium).

Dig a bit deeper, and you'll see many more possibilities: Lipitor® (atorvastatin); Diovan® (valsartan); Cymbalta® (duloxetine hcl); Celebrex® (celecoxib); and Fortamet® and Glumetza® (generic metformin hcl ER). Two more brand drugs—Zetia® and Seroquel XR®—also will soon have far lower cost generic substitutes.

Given your plan's likely financial pressures, it's reasonable to tell participants your plan can't afford to spend several hundred dollars per script instead of \$10 or \$20 for a chemically identical drug. You may be surprised at how few complaints you receive if participants understand why you're acting.

If you review your claims data and identify all high-cost drugs with far lower cost substitutes available, you'll likely also be amazed at how much your plan can save. For small plans, the difference could aggregate to hundreds of thousands of dollars in savings; large plans could save millions.

Require Pass-Through Pricing for Every Drug Dispensed

There are two different structures a pharmacy benefits manager (PBM) can use to charge your health plan for drugs:

1. *Pass-through pricing:* The PBM invoices your plan with the PBM's actual reimbursement to the pharmacy.
2. *Spread pricing:* The PBM reimburses the pharmacy at one cost but charges your plan a different (usually higher) cost, creating a profit "spread" for the PBM.

To uncover this hidden elephant of high costs, you need to review your PBM contract and determine the pricing it allows. Your PBM or consulting firm may have stated you have pass-through pricing, but a careful review of your contract may reveal the contrary. Here's why:

- Your contract may contain contradictory provisions. While one section may say you have pass-through pricing, elsewhere the contract may allow spread pricing. Any contradiction leaves the PBM free to select the provision it will apply.
- Typically, if you look at the contract section that contains your pricing terms and guarantees, you can determine how your PBM actually invoices your plan. If that section contains a fixed price (for example, average wholesale price (AWP) minus 15.5% for retail brand drugs), you don't have retail pass-through pricing. After all, no PBM reimburses every pharmacy—for every brand drug—with the identical discount. If your contract states your PBM will invoice your plan for each drug based on its actual cost to the PBM, then you likely have retail pass-through pricing.
- Pass-through pricing for drugs dispensed through a PBM's mail-order pharmacy and/or specialty drug pharmacy falls into two categories—real and fake pass-through pricing. You have the former if your contract explicitly requires your PBM to pass through its actual acquisition costs. However, it's more likely your contract says nothing about acquisition costs and, therefore, implicitly allows your PBM to pass through its "negotiated rates" with its own subsidiary mail-order and specialty pharmacies. Obviously, any PBM that negotiates with its own subsidiary pharmacies can build into its negotiated rates large profit spreads above the pharmacies' acquisition costs. Thus, if your contract allows your PBM to pass through negotiated rates, you're no better off than you'd be with a spread pricing structure.

Note too: If your contract provides pass-through pricing for retail drugs, your PBM can still not provide its lowest available costs to your plan. After all, virtually all PBMs negotiate several different reimbursement rates with each chain pharmacy (ranging from lower to far higher rates). This means your PBM can choose from among several possible rates when invoicing your plan.

It's not hard to imagine PBMs assign their lowest reimbursement rates to clients with spread pricing contracts, since doing so results in the largest profit spreads for the PBMs. But for clients with pass-through pricing contracts, the PBMs apply their higher contracted retail reimbursement rates, because PBMs can't make any profits under pass-through pricing contracts.

Bottom line: When negotiating your next contract or conducting your next request for proposal (RFP), you should insist on pass-through pricing contracts, and you should simultaneously force your PBM to pass through its lowest rates by imposing aggressive price guarantees.

Retail and Mail Guarantees for Brand and Generic Drugs

A review of your retail and mail price guarantees may reveal the next hidden elephant. In fact, it's very likely your contract's guarantees aren't worth the paper they are written on.

Take a look at your contract, and you'll undoubtedly find very different guarantees for "brand drugs" and "generic drugs" (say, AWP -15.5% for retail brands and AWP -80% for retail generics). It's clear your contract must pin down definitions for *brand drugs* and *generic drugs* lest your PBM shift

drugs between categories and eviscerate the usefulness of guarantees. Here's how your PBM does so:

- Let's say your contract requires your PBM to satisfy the above retail average annual guarantees.
- PBMs pay for most retail generic drugs at discounts ranging from AWP -80% to AWP -95% but pay for others at far weaker discounts (like AWP -25% or AWP -45%).
- Let's say there are new generics for which the PBM reimburses retail pharmacies at discounts of around AWP -25%.
- If your PBM accurately categorizes those drugs as generic drugs when calculating its satisfaction of your contract's retail generic drug guarantee of AWP -80%, your PBM will be forced to fully pass through all its strong discounts to satisfy its guarantee.
- However, if your PBM inaccurately categorizes the -25% generics as brand drugs, it will no longer be forced to blend in the

weak -25% discounted generics with all its steeply discounted generics and will be able to charge you more for the latter generics.

- Meanwhile, PBMs pay for most retail brands at discounts of AWP -15% to AWP -17%. Since your PBM has shifted the -25% new generics into the brand category, your PBM can charge your plan more for the other brands and still satisfy its brand guarantee of AWP -15.5%.

In short, if your contract doesn't pin down the definitions for brand and generic drugs, your PBM can easily shift drugs between categories and overcharge you for all drugs.

How do you know if your contract contains pinned-down definitions?

If your definitions allow your PBM to use its own "proprietary algorithm" to determine how to categorize drugs, you've obviously given your PBM the right to shift drugs whenever it wants. The same is true if your contract states your PBM can "categorize drugs

takeaways

- Plans can achieve big savings by covering only chemically identical, lower cost generic or over-the-counter (OTC) equivalents of brand-name drugs.
- PBMs should be asked to use pass-through pricing for all drugs dispensed, and plan sponsors should carefully examine their PBM contract to uncover loopholes.
- Contract definitions for brand drugs and generic drugs should be pinned down so that drugs can't be shifted between categories, which can make pricing guarantees useless.
- Plans should have tight controls over specialty drug pricing and make sure to control prices on new-to-market drugs.
- If drug company rebates are labeled as something else in a PBM contract, the PBM may be able to avoid passing rebates along to the health plan.
- Plans may want to consider creating a limited or preferred retail pharmacy network to avoid higher costs charged by some of the largest pharmacy chains.
- Plan participants, who probably are aware of high drug costs, may be surprisingly willing to accept pharmacy cost-control steps.

(brand/generic . . .).” An enormous number of PBM-client contracts contain exactly those terms. Check the definition section of your contract to see if yours is among them.

Less obviously, if your contract allows your PBM to categorize drugs using First DataBank’s categorization, you’ve also given your PBM complete discretion to shift drugs between categories. First DataBank does not have any “information field” that categorizes drugs by whether they are brand or generic. Instead, First DataBank offers numerous other “information fields” that the PBM is free to assemble in whatever way it chooses, creating essentially its own proprietary algorithm. So check for this language, too, because it also is in numerous contracts.

In addition to ambiguous brand/generic definitions, your PBM contract likely contains other loopholes that eviscerate guarantees’ utility. For example, your contract may contain explicit language stating certain drugs—like specialty drugs dispensed through retail pharmacies—won’t be included in your retail contract guarantees. This means your PBM can exclude numerous drugs from your retail guarantees and charge whatever prices it wants for all such drugs.

Bottom line: Your plan needs effective price guarantees to decrease and control its drug costs. And almost no contracts contain such guarantees. Take a few minutes to examine your contract to find the hidden elephant that’s easily discoverable. Or ask a lawyer to review your contract. Meaningless contract guarantees leave your plan vulnerable to paying far more than you would otherwise pay.

Ensure Your Specialty Drug Pricing Is Competitive and Also Guaranteed

Specialty drugs are approximately 1% of all drugs dispensed but are projected to account for 35% of total costs

in 2017. It’s obvious you must have tight controls over their costs. A quick examination of your contract will almost certainly demonstrate you don’t.

Here’s what to look for to discover why you’re overspending and what you need to do to decrease your costs:

- **Identify specialty drugs.** Since the term *specialty drug* is laced throughout your contract, it’s imperative you identify which drugs are actually specialty drugs. But your contract likely defines the term by identifying the drugs that “may” or “might” be included—a dead giveaway that your lawyer or consulting firm failed to pin down the term. To clearly identify the drugs that are specialty drugs, create a list of all 1,000+ specialty drugs and cross-reference your definition to that list. Also, make clear in your definition that specialty drugs include new-to-market drugs the parties mutually agree to add to your list.
- **You need a price control over every existing specialty drug.** You can control the costs of specialty drugs dispensed from retail pharmacies by making sure they are included in your retail guarantees. But most specialty drugs will be dispensed from your PBM’s specialty drug pharmacy. Since different specialty drugs have vastly different discounts available, you need to require your PBM to provide a drug-by-drug price guarantee for every existing specialty drug. That means 1,000+ competitive contract guarantees. If your contract contains drug-by-drug guarantees but lists only a few hundred drugs, your PBM can charge whatever it wants for the hundreds of drugs that aren’t listed. Another dead giveaway you’re squandering money on specialty drugs: If your contract contains only one guarantee (say, AWP -16%) for all specialty drugs, you’re overpaying for dozens of high-cost drugs, since many should be dispensed with discounts of AWP -30% to AWP -80%.
- **You need a price control over all new-to-market specialty drugs.** The Food and Drug Administration approves several dozen new specialty drugs every year. You need a “control” over their prices too. But almost no health plan in the country—even the largest health plans—has any price control over any new-to-market specialty drug. Your contract should contain a “default discount guarantee” for every specialty drug that enters the market during the life of your contract. If you

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Education

Overview of Prescription Drugs

Visit www.ifebp.org/elearning for more information.

From the Bookstore

Pharmacy Benefits: Plan Design and Management

F. Randy Vogenberg. International Foundation. 2011.

Visit www.ifebp.org/books.asp?6962 for more details.

insist on such a guarantee when you negotiate your next contract or conduct your next RFP, you'll be amazed at just how high a guarantee you can obtain from some PBMs.

- **You need a “right to renegotiate” to improve your price controls.** Since the discounts on existing drugs change over time—and you'll want to improve on your default discount guarantee whenever higher discounts become available—you need a “right to renegotiate” any specialty drug guarantee on at least a quarterly basis. If you obtain and exercise that right, you'll ensure that your specialty drug prices remain competitive throughout the life of your contract.
- **You need a “carve-out right” to gain negotiating leverage.** To ensure you have leverage to obtain competitive pricing when you exercise your “renegotiation” right, you need a right to carve out drugs so you can turn to another specialty drug pharmacy whenever necessary.

These specialty drug requirements probably seem obvious (as obvious as an elephant hiding under a chair). But it's reasonably likely your contract doesn't contain *any* of these provisions. Without all of them, you can't—and won't—control your specialty drug costs.

End PBMs' Rebate Games

When PBMs were created, their great promise was they would aggrandize and leverage their clients' purchasing power and negotiate cost reduc-

tions from manufacturers. However, PBMs' purported efforts to reduce clients' costs often increase them instead. Here are three different rebate problems and what you need to do to address each one.

First, your PBM contract undoubtedly obligates your PBM to pass through only a certain type of money—typically, rebates. But when your PBM negotiates secret contracts with manufacturers, it can label the money manufacturers pay the PBM with any label the PBM wants—*rebates*, but also *administrative fees*, *health management fees*, *data sales fees*, *prompt payment discounts*, etc. For example, some PBMs are collecting as much as 5% of a manufacturer's total AWP value sold as purported “administrative fees.”

Manufacturers don't care which label is used. After all, money is money. So manufacturers don't insist when contracting with PBMs that their payments are labeled as rebates (which manufacturers could do). However, PBMs do care how manufacturer money is labeled in their manufacturer contracts. If PBM contracts with clients require that PBMs pass through only rebates, PBMs can retain money labeled as something other than rebates.

Accordingly, your savings opportunity is obvious: Make sure your PBM contract requires your PBM to pass through to your plan “all third-party financial benefits,” not just rebates.

Second, it's reasonably likely your PBM contract obligates your PBM to pass through only retail and mail rebates but not specialty drug rebates. That means that even if your PBM has labeled the enormous price reductions

it negotiated with hepatitis C manufacturers as rebates, your PBM probably is not passing those reductions through to your plan. The same is true for all other price reductions your PBM negotiates for specialty drugs. Clearly, your plan can save large sums if you make your PBM pass through “all third-party financial benefits” for *all* drugs, including all retail, 90-day supply retail, mail and specialty drugs.

Third, most PBMs market “standard” formularies that exclude multiple drugs, and most PBMs run “standard” prior authorization and step therapy programs. Assuming your plan is relying on your PBM's “standard” formulary and programs, your PBM probably claims that its formulary exclusions and programs reduce your costs given the rebates that your PBM has negotiated.

However, PBMs' “standard” approaches often favor higher cost products over lower cost products. Moreover, when PBMs insist on large payments from manufacturers, they create marketplace forces for manufacturers to raise their prices, which manufacturers can easily do. PBMs' rebate ploys ultimately are driving up the list prices of many drugs.

To counter these practices, larger health plans with greater resources should reject PBMs' standard formularies and programs and insist on customized formularies and programs. Such plans should also insist their PBMs disclose the net cost of drugs (factoring in all rebates) so the plans can determine which drugs should be excluded, included or favored. Smaller plans without the resources to perform customization tasks may want to consider joining a coalition but should be

sure the coalition is actually customizing formularies and programs for its members.

Also, all health plans should move toward generic-centric formularies and programs that exclude or disfavor brand drugs except when generic alternatives aren't available. Such formularies and programs are available and will increase if more plans require them.

Create a Limited—or Preferred—Retail Pharmacy Network

When PBMs enter into contracts with retail pharmacies, the largest chains have far greater negotiating leverage than other pharmacies. It's likely your health plan's costs for drugs dispensed from the large chain pharmacies are higher than costs for the same drugs when they're dispensed from other pharmacies. In fact, generic drugs from high-cost pharmacies often are twice as high as those from low-cost pharmacies.

It may make sense for your plan to exclude entirely at least one high-cost pharmacy from your retail network. If your participants mostly live in metropolitan areas with multiple pharmacies, you may even be able to exclude more than one large chain pharmacy and still provide excellent pharmacy access.

To determine what's feasible, conduct a claims data analysis and identify your cost of drugs at each pharmacy. Then conduct a geo-access analysis to determine the extent to which you can exclude the high-cost pharmacies you identify.

When you've completed both analyses, ask your PBM to contact all identified high-cost pharmacies and tell them that unless they are willing to provide competitive prices, you intend to exclude them. It's likely that at least some pharmacies will respond by offering far lower pricing.

If they do, you can retain those pharmacies in your network and boot only those that won't significantly reduce their prices. If no pharmacies respond, you'll still be positioned to take action and exclude as many high-cost pharmacies as feasible, given the results of your geo-access study.

Note: Instead of excluding pharmacies, many PBMs encourage plans to create preferred pharmacy networks. To do so, PBMs tell plans to impose lower brand and generic copays for drugs dispensed from lower cost pharmacies and higher brand and generic copays for drugs dispensed from higher cost pharmacies. While the higher copays will offset

some of a plan's excessive costs from high-cost pharmacies, this approach is less effective than excluding high-cost pharmacies for at least two reasons.

Often, the pharmacies the PBMs are favoring are not actually lower cost pharmacies. Any plan that is relying on a preferred pharmacy network should ask an independent entity to evaluate pharmacy costs.

Also, this approach relies on beneficiaries to voluntarily use lower cost pharmacies. Many won't do so, especially because many are evading their copays by using coupons.

Address the Coupon Problem

To steer participants to use lower cost drugs, your plan may have put in place a three- or four-tier formulary that imposes increasingly higher copays in each tier. Brand manufacturers have responded to health plans' improved formularies by marketing coupons or discount cards that entirely eliminate copays or reduce them to very small amounts (like \$5). In other words, brand manufacturers have devised a means to "end run" your copay structure.

You can and should respond to manufacturers' obvious coupon ploy. In doing so, you need to understand that your ability to act differs in connection with retail drugs (where pharmacies process coupons without your PBM having any knowledge of coupon use) vs. mail and specialty drugs (where, assuming the PBM operates its own mail and specialty drug pharmacies, the PBM itself is processing coupons).

For retail-dispensed drugs, there's no effective method for your plan or your PBM to stop retail pharmacies from processing coupons. To fight back, all you can do is end coverage for certain high-cost brand drugs that have generic substitutes. Alternatively, you can "cap" the amount your plan will spend for certain drugs at the cost of the available generics and let your beneficiaries still buy brands using coupons, knowing you'll limit your costs. Neither of those solutions is perfect since they don't apply to all drugs with coupons. But they will eliminate the impact of at least some coupons.

For mail- and specialty-dispensed drugs, you're in a far better position to address the coupon problem. Tell your PBM it can't process any coupons at its subsidiary pharmacies other than those coupons you specifically authorize. Then, assuming you can get your PBM to cooperate, turn manufacturers' coupons against them in the following way:

- Determine the drugs the plan is spending the most money on.
- Look up the coupons available for each drug.
- Increase your beneficiaries' copays for each such drug by roughly the amount of the coupon.
- Tell your PBM to process a coupon for each such drug and re-adjust the copay to a reduced amount.

By taking these actions, you'll reduce your plan's costs by the approximate value of the coupons, as reflected in the following example:

The new hepatitis C drugs—Sovaldi® and Harvoni®—likely are costing your plan about \$80,000 for a 12-week treatment or about \$26,600 per four-week treatment. Both have coupons that reduce a user's copay to \$5 per four-week treatment, up to a maximum of 25% of the catalogue price.

If your current copay for a four-week treatment is, say, \$100, your plan pays the total cost of the drug, minus the \$100. But if you raise the copay to, say, \$5,000 and tell your PBM to coupon the drug for each hep C patient, your plan will instead pay the total cost of the drug minus \$5,000. In other words, your plan will save almost \$5,000 per five-week treatment. And after your PBM applies the coupon to the \$5,000 copay, your beneficiaries will pay only the \$5 required by the coupon (far less than the \$100 copay that would otherwise be required by your plan).

There are hundreds of coupons available for drugs, including very large coupons for many of the specialty drugs

that are dramatically increasing your costs. For example, all the new hepatitis C drugs (not just Sovaldi and Harvoni, but also Viekira Pak®, Zepatier™ and Epclusa®), rheumatoid arthritis drugs (like Enbrel® and Humira®) and multiple sclerosis drugs (like Tecfidera®, Copaxone® and Gilenya®).

If your PBM is unable or unwilling to apply coupons to copays, you may want to find one that will. Or you should take advantage of your new "carve-out" rights and ask an alternative specialty drug pharmacy that runs a coupon program to process some of your high-cost specialty drugs that offer coupons. Your potential savings from a well-structured coupon program are simply too great for your plan to ignore.

Transform Your Beneficiaries Into Allies

Many plans are aware of at least some of the savings opportunities this article describes but fail to investigate and take advantage of them for fear of

triggering employee irritation. Such a concern is understandable but probably unnecessary and unwise.

Your beneficiaries are your natural allies. Virtually all of them are aware that prescription drug costs are soaring and want to avoid drug costs being shifted to them.

Tell them you need them to work with you to control their costs and yours. Explain that together you can impact and change the marketplace if they'll only start paying attention to the prices of drugs. Urge them to ask their doctors to prescribe lower cost generics or OTC drugs whenever possible. And ask them to shop at lower cost pharmacies, and identify the specific pharmacies they should use.

Finally, whenever you act to exclude or disfavor high-cost drugs, explain why you are doing so and identify the money your plan and your beneficiaries will save.

Large savings are available, if your plan will only look for and take steps to access them. 📌

bio



Linda Cahn is an attorney and the founder and CEO of Pharmacy Benefit Consultants, a nationwide consulting firm that analyzes claims data, negotiates contracts with PBMs and conducts PBM RFPs. She is also the executive director of the National Prescription Coverage Coalition, which provides continual drug monitoring and support services to corporations, unions and municipal health plans that join the coalition. Cahn also writes the Rx Drug Alerts blog at <http://nationalprescriptioncoveragecoalition.com/category/rx-alerts>. Cahn received a bachelor's degree from Princeton University and a law degree from Hofstra Law School.



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