

# KEEPING PRESCRIPTION DRUGS AFFORDABLE: The Value of Pharmacy Benefit Managers (PBMs)



The prescription drug benefit covered by health plans—public and private—is the health insurance benefit most widely used by consumers. In Texas alone there were more than 228 million prescriptions filled at more than 7,000 retail pharmacy settings in 2014, representing \$17.6 billion in prescription drug costs.<sup>1</sup>

Health plans primarily use pharmacy benefit managers, or PBMs, as an efficient, effective way to manage prescription drug coverage and improve health outcomes. Some health plans maintain prescription drug management in-house, while others contract with PBMs outside of their organizations. PBMs help consumers and employers save on the cost of prescription drugs, while using clinically-based services to reduce medication errors and increase compliance with drug therapies. Actuaries from the Centers for Medicare and Medicaid Services (CMS) estimate that PBMs' use of prescription drug management tools, including encouraging the use of generic drugs, helped slow prescription drug spending growth from 5.3% in 2009 to 3.5% in 2010.<sup>2</sup> From 2012 to 2021, PBMs are expected to save employers and consumers almost \$2 trillion—or about 35% in savings—compared with drug expenditures made without pharmacy benefit management.<sup>3</sup>

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*“PBMs also empower businesses to create jobs. When PBMs save employers even 1% in prescription drug costs, businesses can re-deploy that savings to cover the cost of 20,000 jobs.”*

- Pharmaceutical Care Management Association President and CEO Mark Merritt.

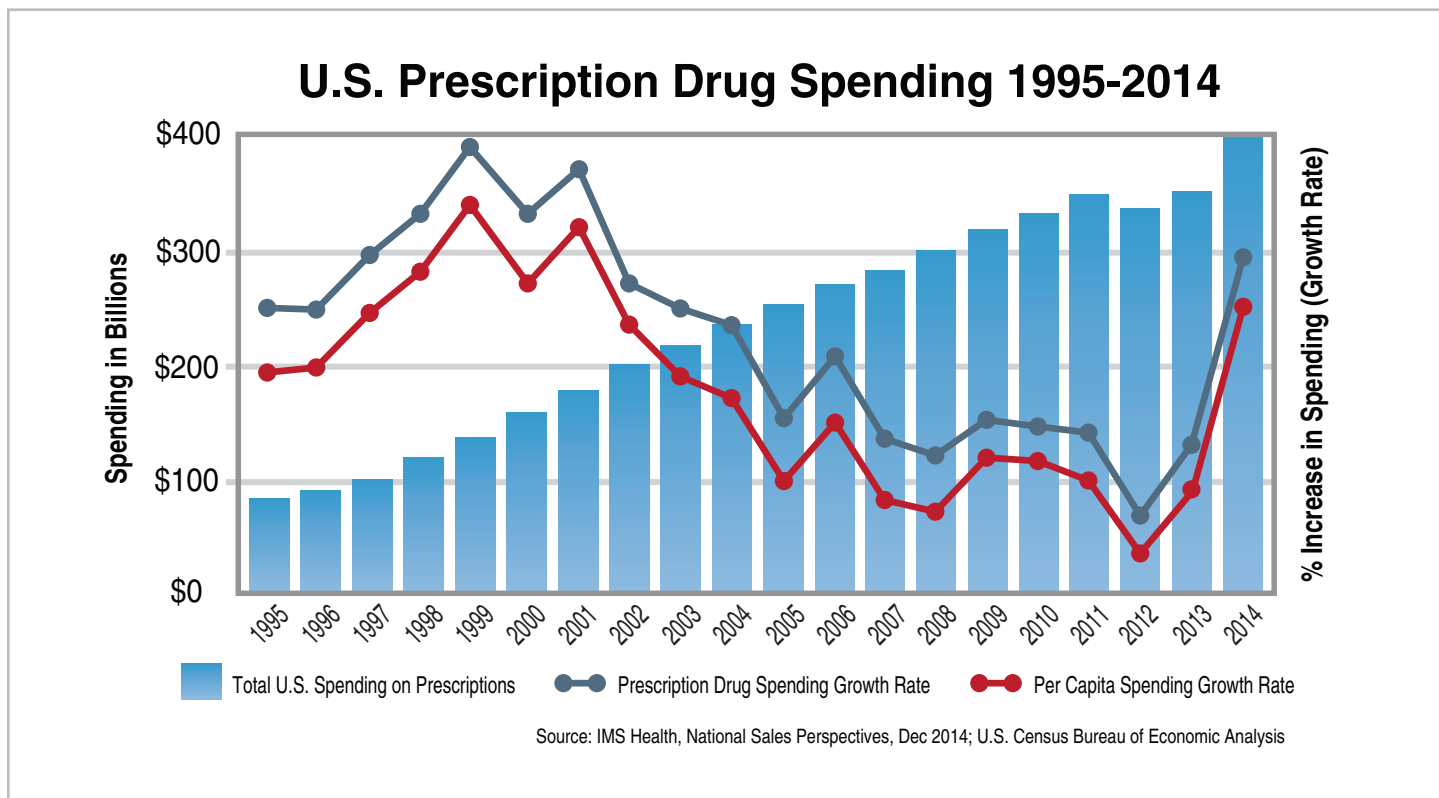
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## **PBMs Keep Prescription Drug Coverage Affordable for Consumers and Employers**

- PBMs save consumers an average of **35% on prescription drugs**.
- PBMs will save employers and consumers **\$2 trillion on prescription drugs over a decade (2012-2021)**.
- PBMs have increased the use of **lower cost generics by 32% (2003-2013)**, saving over **\$200 billion in 2012 alone**.
- Employers can create **20,000 jobs for every 1% PBMs save in prescription drug costs**.
- PBMs' use of mail-order pharmacies will save employers and consumers more than **\$60 billion over a decade**.
- PBMs' use of specialty pharmacies will save employers and consumers more than **\$250 billion over a decade**.

## PBMs Keep the Cost of Prescription Drugs in Check

In recent years Americans have seen a sudden spike in the price of prescription drugs—due in large part to the skyrocketing costs of specialty drugs—making the role of PBMs increasingly important in keeping drug costs manageable. Spending on specialty drugs is becoming a bigger share of U.S. prescription drug spending and is growing at a rapid and unsustainable rate. In 2014 alone, U.S. prescription drug spending increased by 13.1%—the largest annual increase since 2003—and was largely driven by a 30.9% increase in the cost of specialty drugs.<sup>4</sup> Because of the rapid increase in prescription drug costs, the job of managing pharmacy benefits has become even more critical. Left unmanaged, prescription drug costs would rise at even faster rates with the ultimate result of reduced benefits and higher costs to consumers and employers. As prescription drug spending increases nationwide, PBMs continue to play an important role in saving consumers money on drug coverage.



## What is a PBM?

A pharmacy benefit manager, or PBM, is a third-party administrator that manages the prescription drug benefit of individual health plans, employer-sponsored plans, and government-sponsored health plans such as Medicaid and Medicare. Currently, more than 215 million Americans receive pharmacy benefits provided through PBMs.

PBMs' main responsibilities include:

- **Negotiating the most competitive prices with drug manufacturers;**
- **Negotiating and contracting with pharmacies to develop networks of pharmacies willing to provide the most value for consumers' dollars;**
- **Developing and maintaining prescription drug formularies;**
- **Processing and paying prescription drug claims; and**
- **Clinical drug management (prior authorizations, medication adherence programs, step therapy).**

## How PBMs Work for Consumers

When a patient receives a prescription that is covered by a prescription drug benefit, the patient goes to a retail pharmacy to have it filled, and the PBM system allows electronic processing of a prescription in real-time.

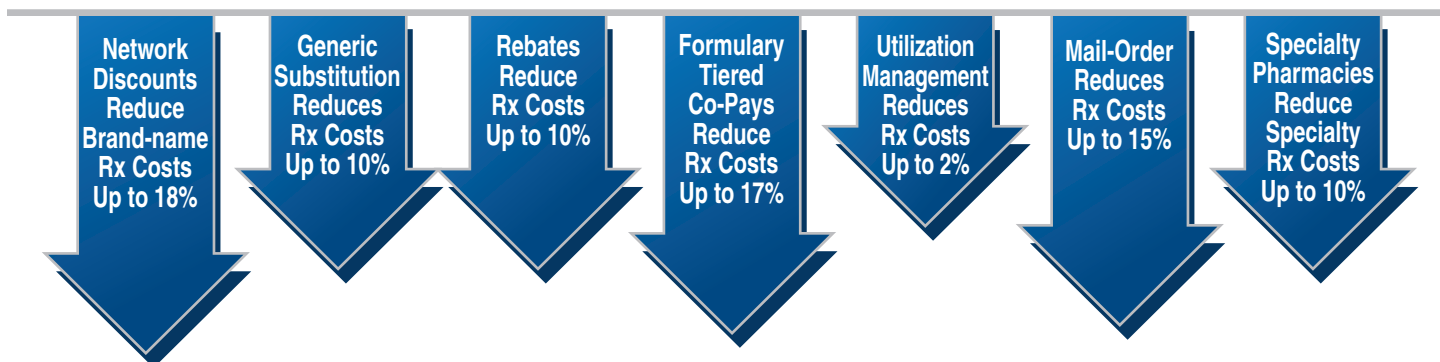
In a matter of seconds, the PBM establishes patient eligibility, formulary compliance, copay or coinsurance amounts, utilization review requirements and pharmacy reimbursement. At the same time, PBMs apply clinical tools aimed at reducing inappropriate prescribing, reducing medication errors, improving consumer compliance and yielding better health outcomes.

## How PBMs Keep Prescription Drug Coverage Affordable

Health plans and PBMs have a difficult mission: increasing prescription drug access while reducing costs. Health plans and PBMs use a number of drug management tools to reduce drug costs and keep prescription drug coverage affordable for consumers and employers. In most instances, it is the plan sponsor (usually the employer) that makes decisions on how pharmacy benefits are managed, including determining formulary

coverage, co-payment tiers, utilization management, and types of pharmacy options (including mail order). Plan sponsors weigh many factors, including clinical quality, cost, and member satisfaction when making these choices. PBMs produce prescription drug savings, ranging from 20% to 50%, depending on the extent a plan sponsor decides to use a PBM's best practices and drug management tools.<sup>5</sup>

# PBM Drug Management Tools & Best Practices Reduce Rx Costs by 20% to 50%—an Average of 35%



Source: Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante, Prepared for PCMA, September 2011 and Mail-Service and Specialty Pharmacies Will Save more than \$300 Billion for Consumers, Employers, and Other Payers Over the Next 10 Years. Visante, Prepared for PCMA, Sept 2014.

### *Establishing Competitive Networks: Negotiating Discounts from Pharmacies*

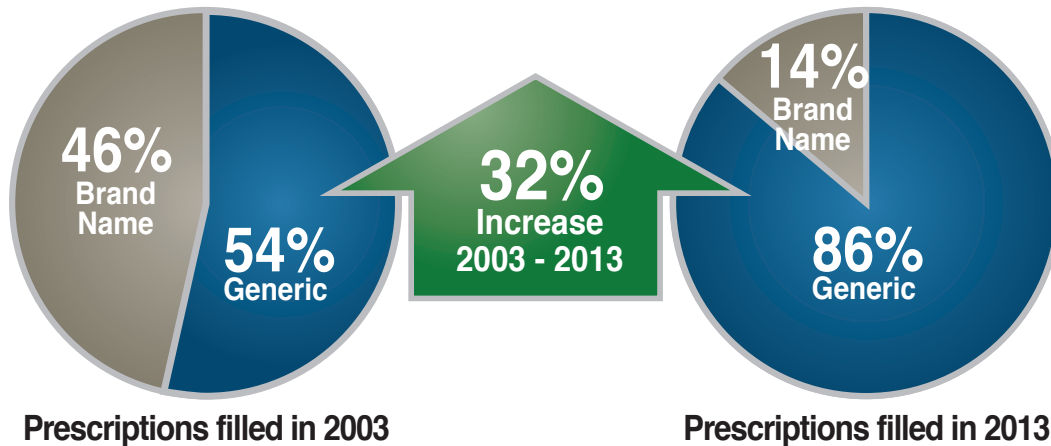
PBMs are employed by health plans or employers to provide health plan members with greater access to affordable medications. PBMs achieve this by establishing a network of pharmacies—including mail-order pharmacies—that compete to be in a health plan's network. Pharmacies agree to negotiated discounts for health plan members in order to be in a network. Nationally, PBM networks include nearly all chain pharmacies, and the majority of PBMs contract with 90% of pharmacies in the regions they serve. This allows patients the ability to fill their prescriptions at a wide choice of pharmacies.



## *PBMs Encourage Use of Lower-Cost Medications*

PBMs encourage the use of lower cost generic drugs to keep prescription drug coverage affordable. Over the past 10 years, the generic dispensing rate (GDR)—the percentage of prescriptions dispensed with a generic drug instead of a brand-name drug—grew by 32 percentage points, from 54% in 2003 to 86% in 2013.<sup>6</sup>

### Percentage of Rx Dispensed as a Generic vs. Brand-Name Drug



Source: Medicine Use and Shifting Costs of Healthcare: A review of the use of medicines in the United States in 2013, IMS Institute for Healthcare Informatics, April 2014.

**Generic drugs on average cost 85% less than identical brand-name counterparts.** According to a recent study, generic drug use saved the U.S. health care system over \$1.2 trillion from 2003 to 2012, with \$217 billion in savings achieved in 2012 alone.<sup>7</sup> **Generic drugs make up more than 80% of the prescription drug volume but only 27% of total prescription spending.**

Generic drugs become available when patents on brand-name drugs expire. A generic drug must have identical chemical composition and be therapeutically equivalent to its brand-name equivalent, and it must meet the same government standards. A generic drug's life cycle typically begins with a 180-day period of marketing exclusivity granted to the first generic approved by the FDA. During this period, this first-approved generic competes only with the brand-name version of the drug. If only one generic is available during the 180-day period, pharmacies can typically acquire the drug for about 20% less than the brand price. Once the 180-day period has come to a close, the market is open to any FDA-approved generic, and dramatic savings often result. For example, after the 180-day period for the first generic of the anti-depressant Lexapro ended, 11 additional generics were approved by the FDA. The additional competition drove the price down 94% within a month.



### *Negotiating Rebates and Savings from Drug Manufacturers: Reducing the Net Cost of Drugs*

PBMs help achieve additional cost-savings by negotiating rebates and savings from drug manufacturers. PBMs can use formulary tiers to negotiate these discounts. In most instances, there are multiple prescription drug options, developed by different manufacturers, that are identical or are therapeutically comparable (expected to have the same clinical impact on a patient). Because PBMs negotiate on behalf of many health plans and employers and represent a large customer base, manufacturers must compete for placement on the health plan's covered formulary (a list of drugs the health plan covers). Drug manufacturers compete with each other to be on a PBM's formulary by offering rebates and discounts that reduce the net cost of the drug. In return, the PBM and health plan encourage consumers to use these lower cost drugs through formulary tiers.



## *PBMs Develop Formularies to Encourage Consumers to Use Lower-Cost Drugs*

A formulary is a list of medications covered under a health plan. The purpose of a health plan's formulary is to steer patients to the best value and least costly medications that are clinically effective for treating their health condition.

Under Texas Law (Texas Insurance Code sec. 1369.051), a formulary is defined as "a list of drugs" for which a health plan provides coverage, payments, physicians, or incentives.

The PBM develops the formulary based on recommendations from a Pharmacy and Therapeutics Committee (P&T) composed of pharmacists and physicians from various medical specialties. Health plans and PBMs review the medications in all therapeutic categories based on safety, effectiveness, and cost, and selects and recommends the most cost-effective drugs in each class. The formulary reflects the overall value of drugs. PBMs maintain formularies by taking into consideration regular reviews by P&T committees on new and existing medications to ensure that the PBM's formulary remains responsive to the needs of health plan members. Drugs on a formulary are usually grouped into tiers, which determine the consumer's coinsurance or co-payment amounts.

**A typical drug formulary includes three tiers, but the increasing use of emerging specialty medicines has led many health plans and employers to add a fourth tier.**

- **Tier 1** has the lowest co-payment and usually includes generic medications.
- **Tier 2** has a higher co-payment than Tier 1 and usually includes preferred brand-name medications.
- **Tier 3** has the highest co-payment and usually includes non-preferred brand-name medications. A PBM or health plan may place a medication in Tier 3 because it is new and not yet proven to be safe or effective. Or, a medication may be in Tier 3 because there is a similar drug on a lower tier of the formulary that may provide consumers with the same benefit at a lower cost.
- **Tier 4** tends to be specialty medicines or the highest cost medicines that require specialized delivery, storage and administration, and come at considerably higher costs.



*Overall, consumers are paying less for prescription drugs. Out-of-pocket expenses for prescription drugs for consumers have been steadily declining since the 1960's. In 2013, consumers' out-of-pocket costs decreased \$558 million, from \$46.5 billion in 2012 to \$45.9 billion in 2013.<sup>8</sup>*

## *Prescription Drug Utilization Management – Reducing Waste and Improving Adherence*

PBMs offer tools that tend to reduce unnecessary and inappropriate drug utilization. Drug utilization review programs improve quality and safety by preventing drug duplication, drug interaction, and drug overuse. They include the use of quantity limits and prior authorization for certain drugs. PBMs also use tools to increase appropriate utilization through improved adherence to drug therapy for chronic diseases. This includes dispensing prescriptions that last 90 days, instead of 30 days, through mail order or at retail pharmacies for chronic diseases. Utilization management can reduce the cost of prescription drugs by up to 2%.<sup>9</sup>

Formulary  
Tiered  
Co-Pays  
Reduce  
Rx Costs  
Up to 17%

Utilization  
Management  
Reduces  
Rx Costs  
Up to 2%

## Offering More Affordable Pharmacy Options - PBMs Encourage Use of Mail-Order Prescriptions and Specialty Pharmacies to Reduce Rx Costs

**Mail-Order Pharmacies:** One highly effective cost-cutting measure employed by PBMs is processing prescriptions through mail-order pharmacies. **Mail-order pharmacies save an average of 16% on prescription costs compared to retail pharmacies.**<sup>10</sup> Not only are mail-order pharmacies more affordable, they also increase medication adherence for consumers, which leads to stronger health outcomes and reduced hospital and ER admissions.<sup>11</sup> Typically, using mail-order pharmacies helps automate the process and reduces the number of steps and people required to fill ongoing medication needs, which reduces overall costs. For example, if a consumer takes a medicine for a chronic condition—like cholesterol control—a PBM will most likely suggest a 90-day mail-order prescription, as compared to the typical 30-day supply issued at retail pharmacies. A PBM will also encourage consumers with chronic conditions to have their prescriptions filled automatically to maximize efficiency, and may contact the doctor on a consumer's behalf when the prescription needs to be refilled. Typically, mail-order programs require lower co-payments than those that apply to prescriptions filled at local pharmacies to encourage consumers to use this lower cost option. **Mail-service pharmacies will save an estimated \$5.1 billion for U.S. consumers, employers, and other payers in 2015, and \$59.6 billion over the 10-year period 2015-24.**<sup>12</sup>



**Specialty Pharmacies:** The main driver for a recent spike in prescription drug costs is the skyrocketing price of specialty drugs. While there is no universal definition for specialty drugs, they are typically brand-name or generic drugs for patients undergoing intensive therapies for chronic, complex illnesses, which are much more costly than traditional prescription drugs.

To ensure that consumers can afford specialty drugs when needed, PBMs contract with and sometimes own specialty pharmacies to supply and coordinate the complex delivery and treatment associated with specialty drugs. These contracts incentivize pharmacies to compete to earn specialty status and in turn, to earn a health plan's business. This stiff competition drives prices down for the consumer and increases the standards for clinical outcomes.

These pharmacies have specialized capabilities to monitor and track the use of specialty drugs, and the necessary training and expertise to handle their distribution. Specialty pharmacies also employ dedicated teams of health care specialists who can help patients understand how to manage their medication and ensure that these drugs are administered at the most appropriate site of care.

**Specialty pharmacies have demonstrated average savings of 10% on drug costs and substantial savings on non-drug medical costs compared to retail pharmacies.**<sup>13</sup> Specialty pharmacies will save an estimated \$13.5 billion for consumers, employers, and other payers in 2015, and are expected to save \$251.5 billion over the 10-year period 2015-24.<sup>14</sup>

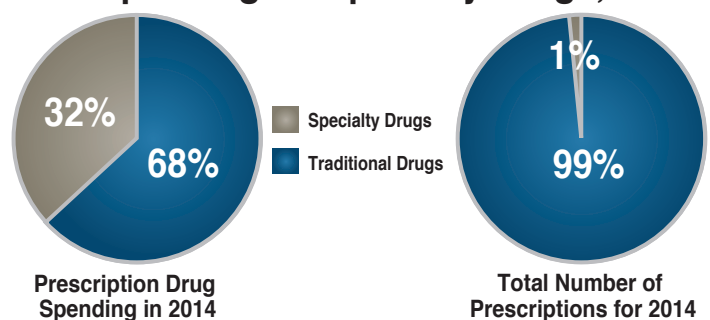


### More on Specialty Drugs

As stated, specialty drugs tend to be much more expensive than traditional prescription drugs. They also require greater patient education and monitoring, and usually treat smaller populations (rare disease/disorder). Most specialty drugs are biological specialty drugs that are so complex that they lack generic alternatives, and can only be substituted with a biosimilar. Spending on specialty drugs is rising much faster than spending on traditional drugs. In 2014, U.S. spending on prescription drugs totaled nearly \$379 billion—almost a third of which was spent on specialty drugs. Specialty drugs currently represent only 1% of all U.S. prescriptions but make up more than 31% of drug spending, and are expected to increase to 44% of overall drug spending by 2017.<sup>15</sup> Key drivers of this anticipated increase in spending on specialty drugs include the introduction of an increased number of new drug products to the market, increased specialty drug utilization (of current and new products), and the much higher rate of inflation for these products.

Specialty drugs currently account for about 17% of the average employer's overall pharmacy costs and are estimated to make up 40% of an employer's total pharmacy spend by 2020.<sup>16</sup> Specialty drug spending per member per year is anticipated to increase from \$290 in 2012 to \$845 by 2018.<sup>17</sup>

### U.S. Spending on Specialty Drugs, 2014



Source: The Express Scripts 2014 Drug Trend Report, March 2015.

# Why Over-Regulation Restricts PBMs' Ability to Save Consumers Money

PBMs have and will continue to play an important role in keeping drug costs manageable. There are currently a number of efforts on the federal and state level to impose stifling regulations on drug plans that would prevent PBMs and health plans from using best practices and effective drug management tools to keep drug coverage affordable and improve

health outcomes. While regulation is an important tool to protect consumers and taxpayers, over-regulation limits free-market negotiations and can increase the cost of prescription drug coverage for consumers and employers. It can also hamper health plan and PBM efforts to promote quality care. Regulations that have been proposed in states include:

## Banning Preferred Pharmacy Networks (“Any Willing Provider” Laws)

- Drug plans have experimented with exclusive or “preferred” pharmacy networks as leverage to negotiate lower drug prices from pharmacies competing to become preferred network drug providers.
- Any willing pharmacy (AWP) mandates restrict private market negotiations by forcing health plans to contract with any willing pharmacy—regardless of whether it is the best candidate available, whether there is already enough patient access, or whether adding the pharmacy will increase the cost of health care for consumers and businesses.
- Network pharmacies compete on service, price, convenience, and quality to attract consumers within a particular plan.
- The Federal Trade Commission (FTC) has stated that policies that restrict health plans’ ability to create pharmacy networks that meet their needs “*result in higher health care expenditures.*”

## Limiting Mail-Order Pharmacies

- Proposals that are intended to protect local pharmacies from having to compete with highly efficient mail-order pharmacies in fact limit cost-saving opportunities for the consumer.
- These proposed restrictions often prohibit drug plans from offering members a financial incentive (lower cost-sharing) for using a health plan’s preferred pharmacy or its cost-saving mail-order option.
- Mail-service pharmacies save an average of 16% on prescription costs compared to retail pharmacies.
- Not only are mail-order pharmacies more affordable, they also increase medication adherence for consumers, which leads to stronger health outcomes and helps prevent hospital and ER admissions.<sup>18</sup>

## Inhibiting Specialty Networks

- Highly advanced specialty drugs and biological agents are supplanting the pills, capsules and elixirs Americans relied on during the past century. Specialty drugs are very expensive, costing thousands to tens of thousands of dollars per month—creating a gold rush among firms vying to provide these lucrative services.
- Well-managed, exclusive specialty pharmacy networks allow manufacturers to track drugs that require specific or complex dosing and laboratory monitoring. FDA monitoring requirements favor tightly controlled networks for safety reasons.
- The FTC agrees that exclusive networks are an effective means of cost control. Regulations that inhibit drug plans from establishing highly-efficient, preferred specialty networks also make it more difficult to ensure the integrity and safety of these drugs.

## Obstructing Competitive Bidding

- With the cost of advanced therapies growing to previously unimaginable levels, health plans and PBMs have increasingly turned to competitive bidding in order to negotiate better deals with drug makers and retail pharmacy chains.
- In a healthy marketplace, competition for a coveted place on a formulary encourages bidders to offer their best deals to avoid the loss of potentially lucrative business.

## Sources

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- <sup>2</sup>Sean P. Keehan et al., “National Health Spending Projection Through 2020: Economic Recovery and Reform Drive Faster Spending Growth,” Health Affairs, Volume 30, NO. 8, 2011.
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- <sup>5</sup>Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante, Prepared for PCMA, September 2011.
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- <sup>7</sup>Generic Drug Savings in the US, Generic Pharmaceutical Association, Fifth Annual Edition: 2013
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- <sup>9</sup>Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante, Prepared for PCMA, September 2011.
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- <sup>16</sup>Herr, J. “Employers Becoming More Savvy About Specialty Pharmacy, but Need More Cost Controls.” Midwest Business Group on Health. February 2013.
- <sup>17</sup>“The Growing Cost of Specialty Pharmacy—Is it Sustainable?” American Journal of Managed Care. February 2013.
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## About TAHP

The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas. As the voice for health plans in Texas, TAHP strives to increase public awareness about our members’ services, health care delivery benefits and contributions to communities throughout the state.

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