

# Designing and Negotiating Affordable Pharmacy Benefits

by **Edward Kaplan** | *Segal*

**T**remendous gains in science and technology have led to significant breakthroughs in pharmaceutical therapies. They can be the most effective option for treating diseases and can save, extend and improve the quality of life. However, these therapies can be tremendous cost burdens for many group health plan sponsors. Today, nearly one-quarter of all health benefit claims incurred by sponsors of group plans are for prescription drug therapies. Per-participant prescription drug cost trends are increasing at a double-digit annual rate. Only inpatient hospital claim expenses represent a larger piece of the health care spending pie for the average plan.<sup>1</sup>

A concerted effort to lower the prices of prescription drugs and lower the utilization rates of high-cost, low-value drugs is underway in both the public and private sectors. This article discusses various strategies and approaches for getting the most plan sponsors' pharmacy benefit dollars while still meeting the health needs of plan participants.

## Benefit Coverage Design

A well-designed strategy for covering prescription drugs is critical to affordable long-term spending.

When I started my career as a benefits consultant in the 1980s, most group health plan sponsors offered drug treatment coverage as part of comprehensive medical benefits. Plans generally had a small annual deductible for all eligible services (e.g., \$200 per year) and 20% coinsurance for all eligible medical procedures, drugs and supplies. Plan participants paid out of pocket and submitted paper claims for allowed medical expenses, including drugs or assigned benefit payments, to the medical provider.

When pharmacy benefit managers (PBMs) came on the scene, they promoted a “carve-out” approach to plan design

with no prescription drug copayment. Plan participants swiped their PBM card at the pharmacy and paid no cash up-front. Many loved the change, and pharmaceutical sales took off. Prescription drug claims accounted for typically 4% of total plan spending in the 1980s.

Over time, as costs grew, plan sponsors added nominal, fixed-dollar copayments for participant convenience. However, this approach removed the cost of drugs from the decision. In some cases, high-cost, brand-name drugs were dispensed that were no better than inexpensive and effective generic drug treatments.

When direct-to-consumer (DTC) pharmacy ads were made legal in 1992, drug companies began the marketing onslaught, and a growing number of prescribing physicians embraced writing prescriptions for treatments.

The low copayments and promotion of drugs fueled a cost growth that has lasted decades. Many plans have

## AT A GLANCE

- The high cost of prescription drug coverage is a growing financial burden for plan sponsors. A new tiered approach to cost sharing can yield savings while ensuring that participants continue to have access to the drugs they need most at a price they can afford.
- Other opportunities to manage the cost of pharmacy benefits are available through negotiated contract terms with pharmacy benefit managers (PBMs). Examples include service guarantees, minimum percentage rebates, value-based formularies, step therapy and prior authorization.
- Ongoing monitoring and audits of pharmacy benefits are also important aspects of cost management.

gotten away from coverage designs that keep the patient in the loop to drive more rational utilization. Fixed-dollar copayments eroded in value over time, adding to the inflationary trends for plan sponsors. Fixed-dollar copayments also insulate drug companies from competing on price and efficacy and for setting market-competitive pricing for their drugs.

To get back to more sustainable coverage design, plan sponsors should consider embracing cost sharing that shows the costs of competing drug treatment options and recognizes that not all treatments are created equal in their effectiveness and health value. A coinsurance approach results in the patient and prescribing physician being invested in the cost of their options. It keeps costs transparent and may put pressure on drug company price setting.

Of course, for life-saving therapies that have no therapeutic equivalents, patients have little leverage and should be protected from their high prices. For these treatments, plans can consider affordable maximum participant copayments.

For quality-of-life treatments that have many effective low-cost generic drug options or even over-the-counter (OTC) drug alternatives, percentage copayments with no maximums may be prudent.

A coverage design that preserves high coverage levels for major conditions can be funded by lesser coverage levels for minor conditions with low-cost treatment options. Insurance was initially designed to protect policyholders from catastrophic losses and not to pay for predictable and affordable expenses that don't require protection. Most participants are likely to accept that approach for prescription drug coverage. This approach can be used with or without high-deductible health plan (HDHP) coverage strategies.

The table on page 26 illustrates an example of a new, rebalanced drug coverage design that better rations limited benefit dollars, creates greater cost transparency, would drive out some low-value drug therapies that can be treated with low-cost generics or OTC drugs, and would ultimately lower plan sponsor costs significantly. Finally, this percentage coinsurance model keeps pace with drug price inflation and doesn't have to be reset every few years.

This plan design described in the table requires PBM support to categorize therapies and should be updated annually.

Plan savings over current low fixed-dollar copayments will come from all of the following.

- Higher generic drug dispensing rates
- Greater drug price transparency among competing drug options
- Greater use of OTC drugs
- Less waste from stockpiling costly brand-name drugs
- Modest cost shifting over current copayment levels
- Less erosion of fixed-dollar copayment values

Savings over typical fixed-dollar copayment designs are estimated to be 10-15% in incurred claim costs before rebates are considered.

Plan sponsors that don't want to make this dramatic change have other options. For example, they could apply a percentage coinsurance coverage design across all brand-name drugs and keep a fixed-dollar copayment for generic drugs.

## PBM Contracting

Over the years since PBMs entered the health care system, contracting has become increasingly complex. As a result, it can now cost more than six figures in legal fees to negotiate a PBM contract.

Negotiating competitive discounts and rebate guarantees, cost trend risk sharing and lower administrative fees depends on volume and market share. Plans are now going beyond pricing terms and looking to secure PBM contract terms that align incentives, increase transparency and develop effective partnerships.

## Conventional PBM Pricing Terms

Conventional PBM pricing terms include minimum discounts on drug claims costs minimum rebate guarantees and administrative fees. Here are three tips to consider when negotiating a PBM contract under a conventional contract.

### 1. Minimum Discounts on Drug Claim Costs

Discounts are commonly structured as a percentage off the average wholesale price (AWP). However, discounts can be expressed as a percentage of wholesale acquisition cost (WAC); prices paid by Medicaid (national drug acquisition cost (NADAC)); and even other indexes, such as average sales pricing. For generic drugs, it's even pos-

TABLE

### A New Tiered Drug Coverage Design for Prescription Drug Therapies

| Drug Tier and Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Retail                                                                                                                                                                                           | Retail 90-Day Supply or Mail Order                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1: Preventive Therapies</b><br><b>(those included on the Affordable Care Act (ACA) list)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$0 participant copayment                                                                                                                                                                        | \$0 participant copayment                                                                                                                                                                         |
| <b>Tier 2: Major Therapies</b><br>This includes potentially life-saving drugs that treat conditions such as: <ul style="list-style-type: none"> <li>• Viruses</li> <li>• Asthma</li> <li>• Cancer</li> <li>• Cystic fibrosis</li> <li>• Diabetes</li> <li>• Heart disease</li> <li>• Hemophilia</li> <li>• Mental illness</li> <li>• Multiple sclerosis</li> <li>• Rheumatoid arthritis.</li> </ul>                                                                                                                                             | 10% copayment generic maximum \$10 per prescription<br>10% preferred brand name with \$75 maximum copayment per 30-day supply (10% penalty nonpreferred)<br>\$2,500 annual out-of-pocket maximum | 10% copayment generic \$20 maximum per prescription<br>10% preferred brand name with \$150 maximum copayment per 90-day supply (10% penalty nonpreferred)<br>\$2,500 annual out-of-pocket maximum |
| <b>Tier 3: Minor Elective Therapies</b><br>Potential treatment categories and medications include: <ul style="list-style-type: none"> <li>• Cough and cold</li> <li>• Pain: Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, Celebrex® and naproxen)</li> <li>• Allergies: Antihistamines (e.g., Claritin®, Allegra® and Zyrtec®)</li> <li>• Dermatology (e.g., conditions such as psoriasis)</li> <li>• Weight loss (e.g., Wegovy® and Zepbound®)</li> <li>• Gastrointestinal: (e.g., proton pump inhibitors (PPIs))</li> </ul> | 25% copayment preferred brand name and generic, no out-of-pocket maximum                                                                                                                         | 25% copayment preferred brand name and generic, no out-of-pocket maximum                                                                                                                          |

sible to set prices on lists of prospective prices per unit by drug. Although uncommon, some payers set prices of generic drugs based on a maximum allowable charge (MAC) list by drug.

Setting a MAC list price list by generic drugs may be cleanest way to set price guarantees.

Since generic drugs typically have multiple suppliers with varied list prices,

a percentage discount off the AWP is flawed. What generic drug supplier is the PBM and retail network pharmacy using to apply their percentage discount guarantee? An 85% discount off

the highest priced generic drug supplier may be more expensive than an 80% discount off another generic drug maker's lower list price.

Moving to a prospective list of maximum prices per unit of generic drugs (a MAC list guarantee) and applying that requirement to all PBMs may be the cleanest way to compare PBM pricing offers on generic drugs. Equally as important as the stated minimum discount percentage is the presence of pricing exclusions and the PBM's ability to offset a shortfall in one area of pricing performance (e.g., retail or mail order) with overperformance in another area of claims. Neither should be allowed. Plan sponsors should pay attention to these contractual adjustments, and they should be normalized across competing PBMs.

## 2. Brand-Name Drug Rebates

Rebates have become a major part of the economics of U.S.-based drug pricing. Removing them from the cost equation will allow plan sponsors to see the direct/complete cost of two competing drugs that treat the same disease/condition without the black box of drug-specific rebates.

Rebates are typically paid by drug manufacturers as a percentage of the WAC or AWP, generally on brand-name drugs where there are multiple competing drug treatment options that treat the same disease or condition. For some therapy classes, such as oncology and potentially HIV, rebates are not material, but for therapy classes such as glucagon-like peptide-1 (GLP-1) receptor agonists for diabetes and weight loss, drug companies compete for market share and use rebates as leverage to drive more sales to their products. Since drug company payments are not limited to rebates, plan sponsors should recognize that if they are getting 100% of all rebate payments passed through to them, that does not mean the PBM is not earning and retaining other forms of pharmaceutical payments.

Most PBM contracts today set rebate guarantees as a minimum fixed amount per brand-name drug dispensed. Exclusions and day-supply definitions play a major role in the value of competing PBM rebate offers. Requiring the PBM to underwrite a rebate as a minimum dollar amount per brand-name prescription dispensed puts them under tremendous pressure. As a result, PBMs now quote minimum

rebate guarantees per brand-name prescription that include retroactive adjustments, called *rebate credit adjustments*, that eliminate the reliability of these rebate guarantees. A PBM may state that it can make these adjustments due to, for example, government-imposed price changes, such as those under the Inflation Reduction Act, or drug manufacturer price changes. A PBM could quote unrealistic minimum rebate guarantees and just claw back a substantial portion of these offered guarantees in the following year via this rebate credit adjustment, which is really a clawback nullifying quoted rebate guarantees.

During contracting and competitive bidding, plan sponsors should consider rejecting or greatly constraining PBMs' ability to claw back rebate guarantee commitments. These guarantees undermine the commitment to a minimum percentage rebate on allowed brand-name drugs dispensed. Instead, plans can move away from a per-brand prescription dispensed guarantee to a minimum percentage approach to rebates, which provides the PBM with natural protection against both drug company price reductions and federal action that reduces brand-name pricing. If the PBM contract has a minimum percentage rebate guarantee instead of a dollar amount, the rebates will automatically adjust if drug makers lower or increase list prices. In addition, moving the rebate guarantee to minimum percentage of brand AWP dispensed amounts eliminates the need to worry about PBMs redefining brand-name drug day supply bucketing of claims as well as whether a drug is a nonspecialty or specialty drug. Taking this a step further, future PBM contracts could prohibit all rebates and just apply the value of those rebates as part of the drug claims cost discounts.

## 3. Next-Generation Contracting: Risk Sharing, PMPMs, GDRS and Formulary Limits

A move is beginning to replace conventional PBM contracts and their minimum discounts and rebate guarantees. Increased scrutiny by federal and state policy makers on drug pricing schemes, opaque rebates and high list prices, and unsustainable prescription drug benefit plan costs are pushing PBMs to offer new ways to contract. PBMs are being asked to take on drug claim cost risk in several ways, including quoting per member per month (PMPM) capitation rates, shar-

ing in the excess plan costs above national benchmarks or putting a portion of their administrative fees at risk.

PBMs are also being asked to quote minimum generic drug dispensing rates (GDRs) by therapy class to increase the use of generic drugs where appropriate. Generic drugs not only cost a fraction of their brand-name counterparts but have modest price increases.

Larger plan sponsors should take a close look at these new pricing guarantee arrangements, which move away from the conventional spread pricing arrangements that misalign PBM incentives with plan sponsor incentives. However, contractual loopholes attached to these new arrangements must continue to be scrutinized.

### **Drug Formulary Management and Clinical Strategies**

Another area that warrants attention is the preferred drug formulary and drug utilization management protocols that plan sponsors implement. In closed-model health maintenance organizations (HMOs), PMPM spending on outpatient drug claim expenses tends to be substantially lower than drug costs under broad, open drug formularies associated with self-insured preferred provider organization (PPO) medical plans. HMOs and their prescribing physicians apply a more disciplined approach to dispensing drug therapies.

Greater use of step therapy, prior authorization and efficient preferred drug formularies reduces the use of low-value, high-cost, “me-too,” brand-name drugs that have little clinical evidence of managing diseases than other, lower cost brand-names and generics. Plans that have adopted “value formularies” often experience excellent results in the form of cost savings, higher generic drug use and lower long-term cost trends than plans with broad, unmanaged formularies. Properly managing the drug formulary without compromising overall efficacy and medical outcomes likely requires deeper clinical consulting support but can result in a 5-10% reduction in prescription drug benefit costs.

PBMs also offer other effective clinical programs, such as opioid management, Medicare adherence and advocates for patients with rare diseases. These services can improve clinical outcomes for participants and achieve higher rates of satisfaction. Some plan sponsors outsource this function to an expert third party to remove it from the core PBM, which

may have some inherent conflicts of interest, in order to embrace custom, client-specific solutions. Custom formulary or clinical programs may result in fewer rebates earned and paid to the plan but ultimately produce a lower overall pharmacy benefit cost.

For some larger groups that are spending tens of millions of dollars in prescription drug claims annually, hiring a clinical pharmacist has proven to be another effective strategy to better manage the plan and monitor their PBM’s clinical decisions.

### **Other PBM Contracting Issues to Consider**

Other elements of a pharmacy benefit that also need to be addressed include the following.

#### ***Copayment Assistance***

These copayment programs, which are indirectly funded by drug manufacturers, were initially designed to help patients with no coverage for prescription drugs afford high-cost, brand-name, specialty medications. The rationale was likely to get patients on the brand-name medications before they later become covered by Medicaid, Medicare or some other third-party organization. Over time, these programs were adapted to be integrated with high-deductible, high-cost-sharing insurance and third-party group plans.

PBMs register these covered patients and use the value of the copay assistance funds to reduce or eliminate the plan participants’ copayments and out-of-pocket expenses. They can be seen as another form of discount to take advantage of manufacturer coupons as long as they are still available. Typically, for these types of programs, fees are a percentage of savings. There may be an opportunity to look at other administrative fee costs, such as a fee per claim processed through the copayment assistance. Note that the cost of the medication and the associated savings have no impact on the administrative costs to manage these programs.

#### ***Coverage of GLP-1s for Weight Loss***

These relatively new drugs have proven to be effective in managing diabetes and A1C levels and lowering weight in obese individuals. The problem for plan sponsors is twofold: the cost and the fact that there are really no other conditions

that potentially impact more than 40% of a covered population. The liberal Food and Drug Administration (FDA) target population makes the potential patient pool and claim liability enormous. No other drug therapy comes close to having a patient population this wide.

To cover these drug treatments in a fiscally responsible manner, plan sponsors need to drive the price per treatment down and focus coverage on the highest risk patient population. Some of the ways that plan sponsors are attempting to cover and manage these costly brand-name drugs are raising the body mass index (BMI) levels for eligibility, introducing higher percentage coinsurance, and requiring participation in weight-loss coaching and nutrition programs.

### ***Increasing the Use of Biosimilars***

Biosimilars are lower cost treatment options to original biologic specialty drugs. They're therapeutically delivering similar efficacy and safety to the original brand-name drug at substantially reduced cost to the payers. Formularies that add biosimilars and promote their use can produce plan savings.

### ***Patient/Participant Support Service Performance***

PBM contracts should also include service performance guarantees that hold the PBM accountable for responsive call center performance, timely refills, timely and accurate prior authorizations, stable retail pharmacy networks, and timely and accurate annual reconciliations of all financial commitments.

### ***Avoiding Disease Progression***

Investing in better nutritional habits and physical activity can help keep plan participants healthy and, for those employees that can commit to change, avoid the onset of preventable chronic disease. Funding wellness programs and potentially promoting medication therapy adherence pro-

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grams for your population can pay off in the long run for groups that have low turnover.

### ***Quarterly Monitoring and Annual Audits***

It's important for plan sponsors to actively monitor and manage prescription drug benefits given the costs, complexities and activity involved. Developing ongoing reporting and actively reviewing it can catch pricing mistakes and potential important outliers early.

### ***Conclusion***

Complex but valuable prescription drug benefits are a big part of an employer's overall health benefit offerings. Plan sponsors that want to get the most from these benefits for their plan participants and their overall drug spending should implement a pharmacy strategy that focuses on plan design, PBM contracting, appropriate drug utilization management, effective clinical interventions and monitoring. 

### ***Endnote***

- 1 SHAPE, Segal's proprietary health data warehouse.