



## How to Peel Back the Onion of PBM Pricing

It's no secret. Every pharmacy benefit management (PBM) company has three primary sources of revenue: administrative fees, rebates, and the spread on drug pricing. Not surprisingly, these sources also receive the most scrutiny during the PBM evaluation process. Therefore, if competing PBMs each provide a proposal that outlines pricing in the three categories, an accurate comparison should be easy, right? Not exactly. Analyzing PBM pricing requires a thorough understanding of the variables in each category before an "apples-to-apples" comparison can be assumed. As with any extensive evaluation, it is important to peel back the layers on PBM proposals so that you can perform a true comparison for your clients. Following are some suggested steps for doing so.

### **Layer One: Evaluate Administrative Fees**

When comparing the administrative fees of competing PBMs, scrutiny should not be limited to the per-transaction fee which often times is low or zero. PBM administrative fees may also include other charges including those for prior authorizations, clinical programs, reporting, etc. All ancillary fees should be taken into consideration with each proposal. Even if a waived administrative fee is touted, it is important to seek clarification on all other fees not explicitly mentioned. Often times, this level of detail is not provided in the proposal and may need to be specifically requested.

### **Layer Two: Ask Questions About Rebates**

As stakeholders continue to seek out the lowest-net-cost prescription drug benefit, rebates continue to play a role. However, the value of rebates should be weighed against the cost savings associated with other strategies, like increased generic utilization. These two cost-mitigating forces are often at odds. It is no secret that the only prescription drug claims that generate rebates are those for brand-name medications. Not surprisingly, groups that earn large drug rebates tend to have lower generic utilization. Decision makers really need to decide what their focus will be – will they seek out the lowest-net-cost benefit that centers on relentless generic promotion at the expense of rebate dollars? Or will they choose the PBM that provides the biggest per-claim rebate whose focus may be more rebate-centric than cost-centric? As national generic utilization rates approach 70% of claims, it is clear that rebates are taking a back seat to other strategies that promote the lowest net-cost benefit. Saying the above, if you are interested in evaluating rebates as part of your comparison of PBMs' pricing proposals, there are a number of points to consider.

Most PBMs keep a portion of the rebates earned as a fee for administering the formulary and billing pharmaceutical manufacturers on behalf of the client. Rebates can be paid out on a per-total-claim basis (on all claims, brand and generic), or only on those claims that actually earn a rebate. Frequency of payout is another consideration. Some PBMs delay payout of rebates until after they have received payment themselves from all the manufacturers. Other PBMs will guarantee payout of rebates routinely even if they have not received all the payments from manufacturers. The diversity in method of rebate pass-through in the industry today necessitates that questions be asked up front to elucidate which PBM really offers the best deal.

Another question to ask is: How are the rebates paid? Are they paid by crediting the account? Or is payment being issued by check? Many prefer the latter as it is easier to track on the books just how much was reimbursed through rebates.

Qualifiers are another point of consideration with regard to rebates. In some cases, PBMs include qualifiers in the contract that guarantee the rebates quoted only if specific contingencies are met. For example, a PBM may require participation in clinical programs to steer utilization of formulary drugs. Another qualifier may involve National Drug Code (NDC) number lock outs that prohibit certain non-formulary drugs from being covered. Clarifying the presence of qualifier contingencies in the proposal process will increase understanding of PBM formulary management and may help mitigate member disruption upon implementation.

### **Layer Three: Understanding Drug Discounts**

The “spread” on prescription drug claims represents the cost difference between what PBMs are contracted to pay the pharmacy versus what PBMs are contracted to charge the client. While PBM contracts with pharmacies are proprietary and confidential, the discounts and/or guarantees presented on a client proposal often warrant additional scrutiny.

With brand name drugs, PBM-to-PBM pricing comparisons are relatively straightforward and can generally be evaluated based on a spreadsheet of data. Currently, PBMs base client brand drug discounts on the nationally-recognized list price called AWP, or the Average Wholesale Price. For the most part, comparison of each PBM’s discount off AWP quoted in a proposal can be taken at face value (with the caveat that contractual disclaimers may exist that exclude some products).

With generic drugs, a fair cost comparison is often difficult to perform at first glance. For retail pharmacy claims, PBMs generally price generics at their maximum allowable cost (MAC). Since the MAC list (and therefore MAC pricing) is proprietary to each PBM and not usually available to clients, pricing may vary considerably.

Owing to these pricing variations, primarily in regard to generics, the very best way to compare PBM pricing proposals is through the exercise of a re-pricing analysis.

### **Learn the Inner Truth through Re-pricing**

Even after all the layers of contractual language have been peeled back and all the right questions asked, comparing overall drug costs is still complicated. Often times it’s necessary to look beyond the simple spreadsheet of discounts to obtain the clearest picture on pricing. In these cases the most effective way to accurately compare proposal pricing is to ask each PBM to perform a re-pricing analysis.

To conduct a re-pricing analysis, claims data from a set time period is provided (typically one quarter or six months of data) to all competing PBMs who re-price the claims using their proposed discounts. From the standpoint of pricing, the preferred vendor will be determined from this exercise if the same data is provided to all finalists and they perform the analysis correctly.

Evaluating pricing by eliminating the variables simplifies the process. However, basing the decision on pricing alone does not always lead to the best outcome for the client. Service, flexibility, and the willingness of a PBM to cater to varying needs are key points of consideration as well.

### **Service: Another Key Consideration**

In addition to the valuable exercise of re-pricing and the evaluation of administration fees and rebates, service to you and your plan members should also be considered when determining the PBM that has a true advantage over the others.

One service quality to look for in a PBM is its flexibility with plan design. No two clients are exactly alike so beware of PBMs that try to apply a standard, boilerplate plan design for your group. A PBM should take time to get to know your group, understand your business and craft a plan that meets your specific benefit management objectives. Also, how willing is the PBM to incorporate your input into the plan design? Do you have the option to opt in or out of clinical programs? Can you dictate drug inclusions or exclusions? And remember, whatever needs you’re working to meet when first building the plan design may change – you need a PBM that understands that and is willing to accommodate.

**Account Management.** Another point to look for in a PBM is its ability to provide you with more than a single point of contact for questions or requests, but also a single point of accountability. Every PBM will assign your business an account manager. Unfortunately, many of those managers are only in the position to triage issues and pass along problems to the next person or department. An account manager that is empowered with the authority and support of management to make decisions is more likely to take ownership in responding to your questions or requests and expedite issue resolutions. Having an account manager who is involved with your business from day one of discussions and who takes a proactive, consultative role in the relationship is also important. Look for this person to be your eyes and ears about industry trends and to help you understand how those trends impact your plan design, proposing recommendations for improvement if necessary.

**Reporting.** The service of providing information is also a key factor to consider when choosing a PBM. Many PBMs wait for their clients to request an analysis prior to the plan renewal in hopes that the request won’t happen, contracts automatically renew, and business will continue as usual. Again, look for a proactive

PBM that presents an analysis of your plan's performance well before your renewal date so you have time to evaluate and implement recommendations for improvement.

Directly related to reporting is the issue of data access. How quickly can you get your hands on your data? Do you have online access to creating your own reports, either for the purpose of executive summary or more in-depth claims analysis? Most PBMs provide standard reports on a monthly or quarterly basis and ad hoc reports on an as needed basis. But with ad hoc reports, how quickly are they turned around and at what cost? Also, how well is the data explained? Raw data is all well and good if you have the time and desire to pour through it, but a good PBM will put it in a format that is easy for you to understand and will have an account manager willing to explain it clearly.

**Member Service.** There is also the matter of how well the PBM provides service to its plan members. Keep in mind, a PBM shouldn't just talk of "service" as it relates to the responsiveness of their call center. In these days of consumerism, service to members means being proactive in giving them the tools and education they need to better manage their prescription care. For example, a PBM that's web site empowers members to perform tasks such as compare the costs of prescriptions, quickly find a participating network pharmacy, or research a drug's side effects is certainly to be perceived as a strong service provider, resulting in far less member complaints. And for those who like the convenience of web services, a phone call to customer service is likely considered a hindrance. However, the call center is still important as there are certainly times human intervention is most appropriate. As you evaluate PBMs customer service aspect, remember that some PBMs require members to call different phone numbers to speak with different customer service units based on whether the member used mail or retail services. Look for a PBM that simplifies the process with only one phone number that will direct them to service representatives who are empowered to handle and resolve all member issues. Ultimately, the better service plan members receive, the less noise you will hear from them.

All of the above offerings are important points to keep in mind the next time you have the opportunity to comparison shop for a PBM. Just remember that it is only after the layers of each offering are peeled back will the PBM representing the best fit be determined.

#### ***About the Author***

Sharon Murillo is President of Serve You – Custom Prescription Management, Inc., based in Milwaukee, Wisconsin. Sharon has more than 20 years of PBM experience, the last 10 spent at Serve You. Prior to Serve You, she worked for a PBM software developer, as an independent consultant focused on evaluation of PBM systems and operations, and for a national managed health care company, where she played a central role in developing their PBM product offering.