Drug Costs: Perspectives from the Pharmacy Benefit Managers

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The Role of PBMs

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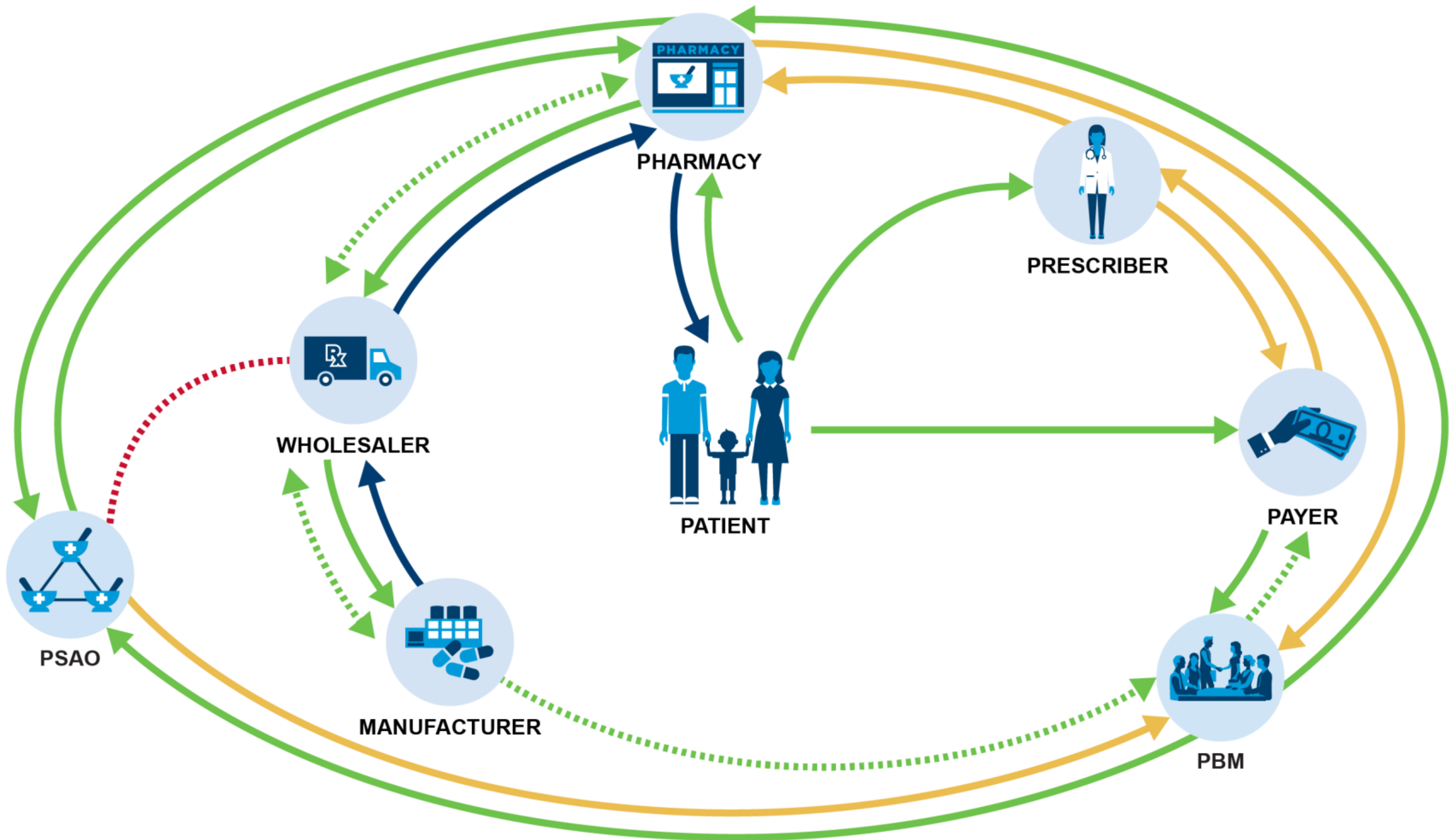
Flow of Goods, Transactions & Services



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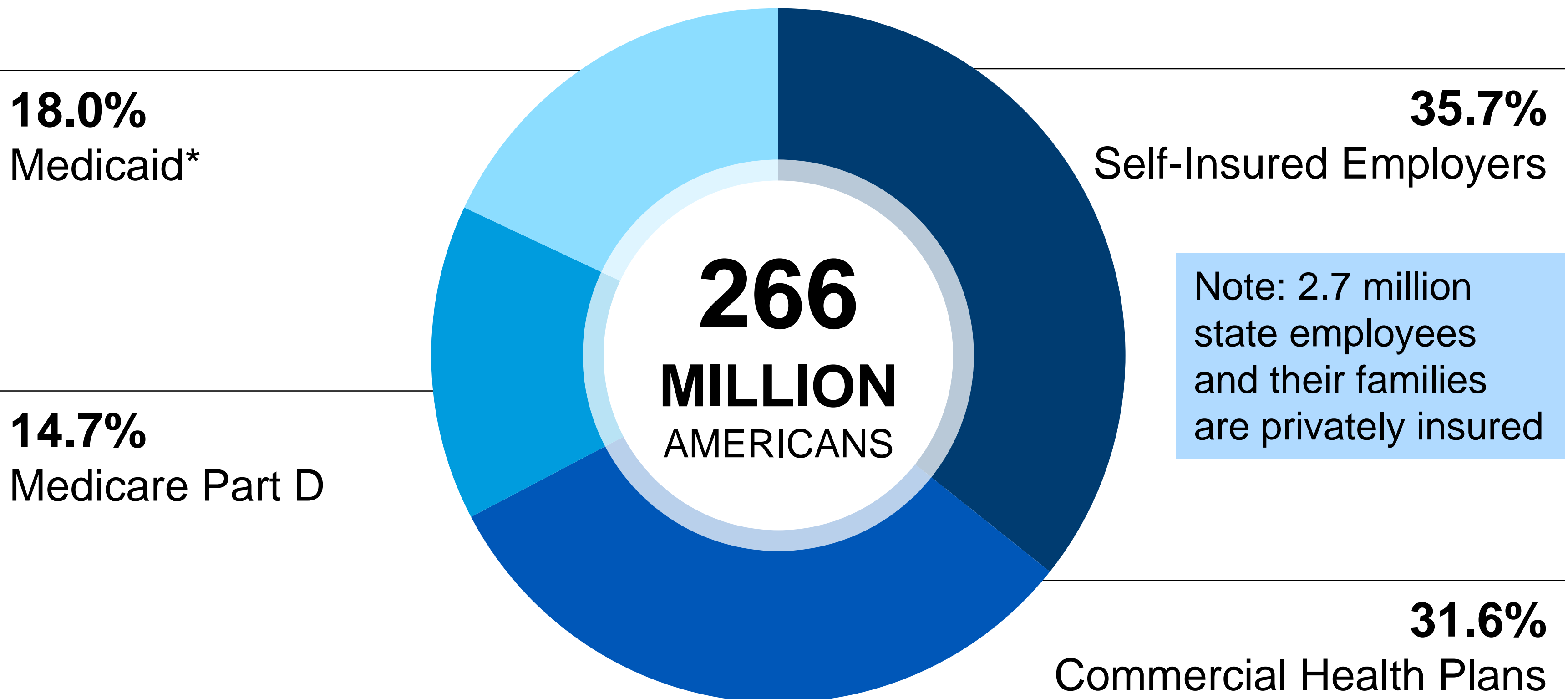
PBMs Serve Public and Private Programs

More than **266 million Americans** receive pharmacy benefits provided through PBMs



*Excludes Medicare-Medicaid Dual Eligibles where drugs are covered by Medicare Part D.
Source: Visante estimates prepared for PCMA, 2016.

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Tackling High Drug Costs

- **Health plans and PBMs do not have any control over the price the manufacturer sets for a drug** — but PBMs have some tools to drive down drug costs
- Patient cost-sharing often represents only a small fraction of the total cost of the drug
- Brand drug manufacturers establish prices within a monopoly established by federal patent law
- Until other drugs are approved for the same disease or condition, manufacturers have little incentive to reduce their prices

Pharmacy Benefit Management Services

Claims Processing

Price, Discount and Rebate Negotiations with Pharmaceutical Manufacturers and Drugstores

Formulary Management

Pharmacy Networks

Mail-service Pharmacy

Specialty Pharmacy

Drug Utilization Review

Disease Management and Adherence Initiatives

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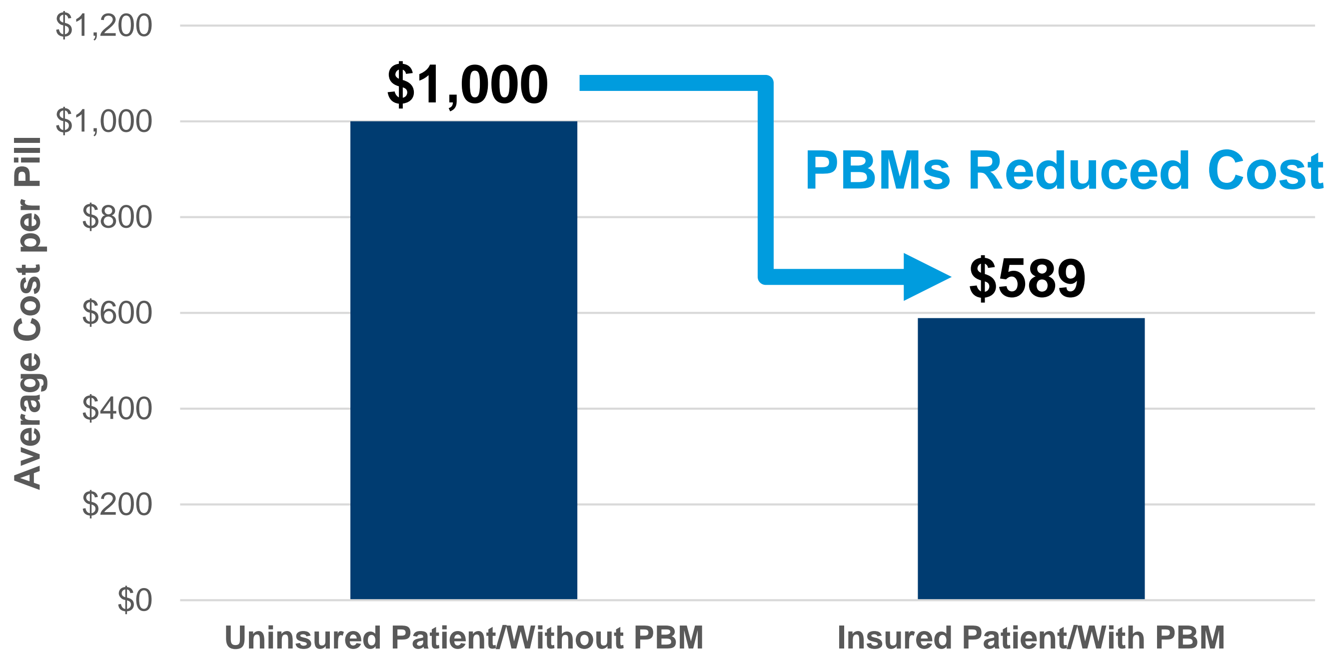
PBMs Harness Competition

PBMs use competition among drugs that are therapeutically substitutable to negotiate rebates with manufacturers



Source: Visante, prepared for PCMA. February 2016.

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PBMs Pass Through Rebates

- In Medicaid, states may negotiate above 23.5% statutory rebates and collect supplemental rebates
- In private insurance, disposition of rebates is up to the client
  - 29 percent of employers negotiate to keep all rebates*
  - On average, 90 percent of rebates are passed through to clients**
- Use of rebates by client depends on plan design
  - Most use rebates to reduce premiums, cost sharing
- Some insurers offer no- or low-drug-deductible plans

* Pharmacy Benefit Management Institute, “2016 Trends in Drug Benefit Design Report,” 2016
** Drug Channels, “Solving the Mystery of Employer-PBM Rebate Pass-Through,” 2016.

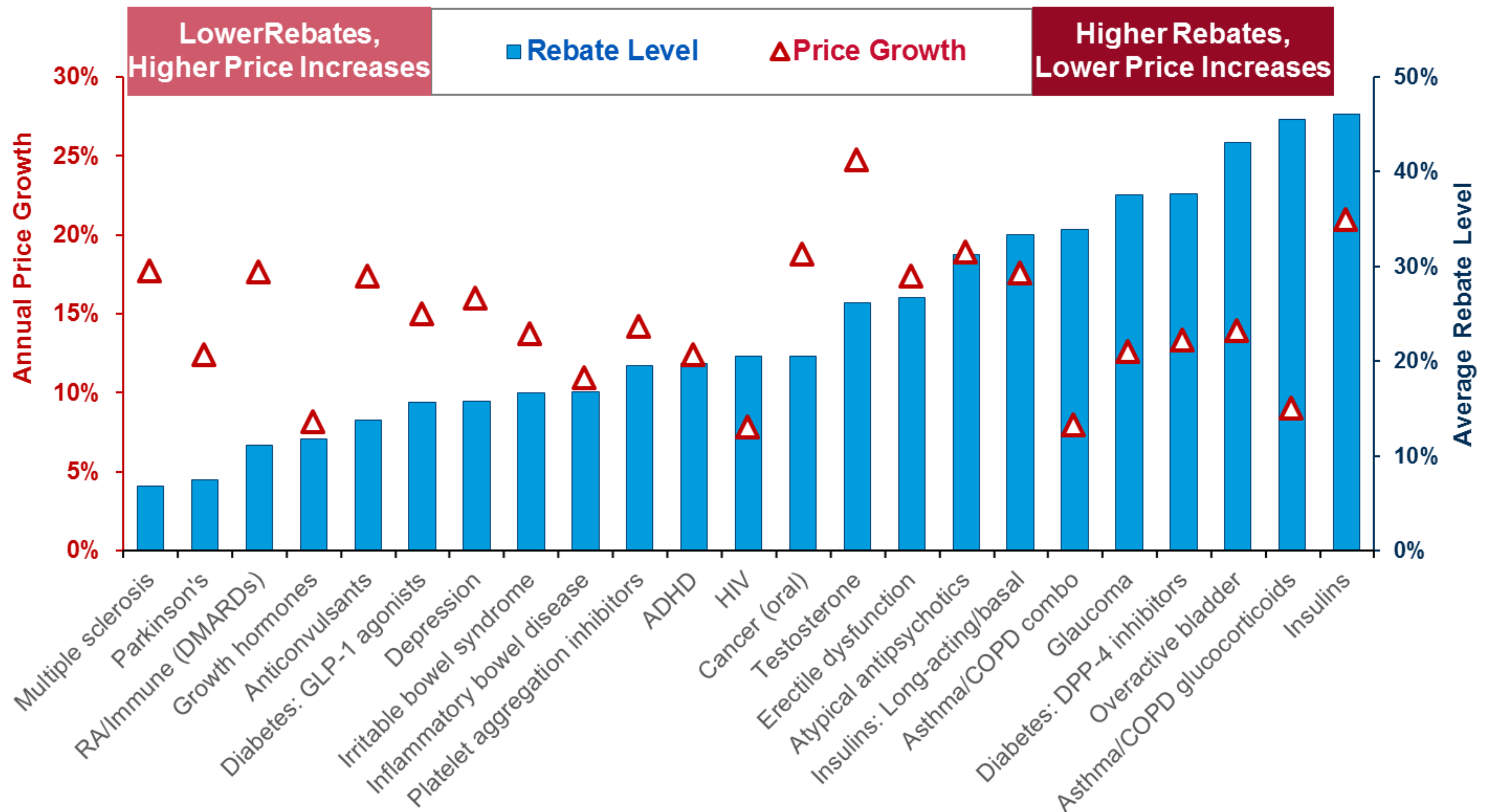
No Correlation Between Rebates and Prices

Using commercially available data on gross and net sales for the top 200 self-administered, patent-protected, brand drugs in the United States, Visante estimated annual rebate levels over the 2011-2016 period and compared these against manufacturer list price levels and increases over the same time period.

Major findings:

- No correlation between the size of rebates and price increases
- High price increases in drug categories with low rebates
- Lower price increases in drug categories with high rebates
- Drug prices increasing regardless of rebate levels

Drug Price Growth Varies Widely Across Drug Categories Regardless of Rebate Levels



Source: Visante estimates and analysis of SSR Health data, 2017.

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Generic Drug Reimbursement

- A maximum allowable cost (MAC) list specifies the maximum amount a PBM will reimburse a pharmacy for a particular generic drug
- Every manufacturer has its own price for a particular generic drug and these prices can differ extensively by manufacturer
- MAC lists standardize the reimbursement amount for identical products from various manufacturers, regardless of each manufacturer's price

Generic Drug Reimbursement

- PBMs develop and maintain their own confidential MAC lists, based on proprietary methodologies that include a number of factors, such as survey of existing wholesale prices in the marketplace
- MAC lists help PBMs fairly compensate pharmacies while providing cost-effective drug benefits to their health plan and employer clients

Value of MAC Lists

Recent research* has shown that
restrictions on MAC lists could:

Increase costs by
31% to 56% for affected
generic prescriptions.

Increase expenditures
nationally by up to
$5.5 billion annually.

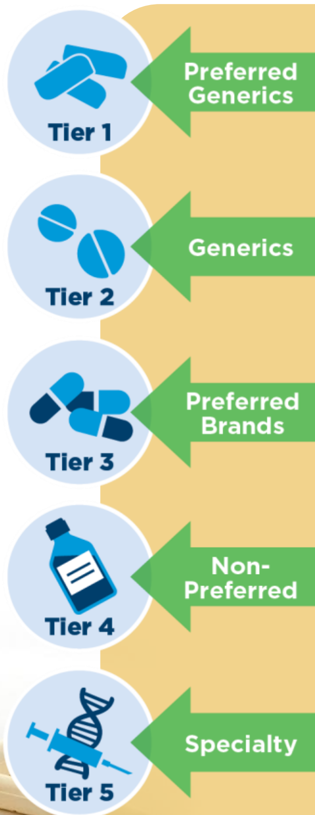
Source: Visante, prepared for PCMA. January 2015.

COPAY CAPS DON'T SOLVE THE PROBLEM OF HIGH DRUG PRICES

Drug Costs Continue to Inflate, but Copay Caps Are Not the Answer

Brand manufacturers are deflecting blame for skyrocketing drug costs by falsely claiming that high costs are a "coverage" problem that requires copay caps and other restrictions on plan design.

By capping patient out-of-pocket expenses, doctors and patients will inevitably choose *more expensive* brand drugs over equally effective lower-cost generics. This will feed the cycle of price increases.



Smart benefit design stretches the health care dollar[1]

Through the use of drug tiers, health plans generally require higher out-of-pocket costs for more expensive drugs.

Copay caps disrupt the sound decision-making process plans use to provide patients with access to lower-cost — but equally effective — alternatives, including generics.

Copay caps profit brand manufacturers

Copay caps are government-set price controls that benefit brand drug manufacturers at the expense of patients and employers.

These mandates prevent payers from effectively managing drug costs, and force the public to pay more in health premiums and overall health care costs.

1 Not all health plans are designed the same way.

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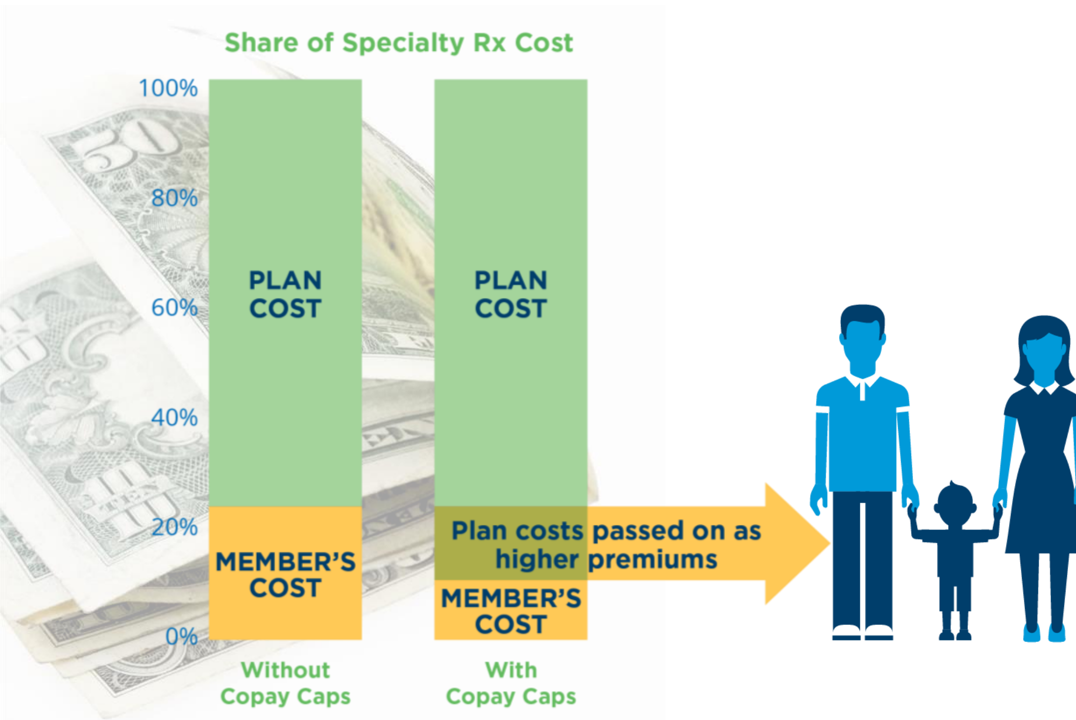
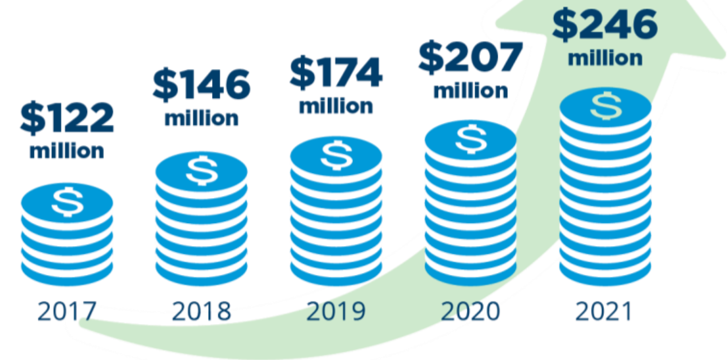
Shifting costs = higher premiums

Significant changes in benefit design can affect the overall cost of a health plan, which in turn affects consumers' premiums.

Capping cost-sharing shifts cost from patients to health plans. This requires plans to increase premiums to compensate for higher costs. **Eventually, all members bear these higher costs through higher premium rates.**





State-mandated copay caps escalate health care costs

Example: The Kentucky Department of Insurance found that copay caps would add approximately **$13.4 million** to private market insurance premiums annually. For an average family with health coverage these price controls would mean nearly **$150 a year** in increased premiums.[2]

Example: In the state of Washington, an independent analysis found that a $250 copay cap per 30-day script would shift costs to health plans and consumers by **$900 million** over five years.[3]

2 Kentucky Department of Insurance. (2015). Available at: http://www.lrc.ky.gov/record/15RS/SB31/HM.pdf
3 Oliver Wyman analysis for PCMA. (2016).
4 Ibid.

PBM-Pharmacy Gag Orders

- At least 26 states have enacted laws prohibiting the use of gag orders in pharmacist-patient interactions.
- Whether the cash price or copay, PCMA always supports patients paying the lowest possible price at the pharmacy counter.

What Can Policymakers Do?

Federal Solutions
Eliminate “pay-for-delay” agreements.
Promote accelerated FDA approval of both “me too” brand and generic drugs.
Reduce innovator biologic exclusivity to seven years.
Eliminate the tax deduction for direct-to-consumer (DTC) drug ads that mention a specific product.
Remove Part D’s protected classes.
Create a safe harbor for value-based drug price negotiations from Medicaid Best Price.

State Solutions
Promote increased access to lower-cost biologics.
Support private negotiations between pharmacies (both chains and independents), PSAOs, and PBMs.
Preserve the ability of PBMs to use their full range of cost-saving tools, including networks, utilization management, and formulary management.

Conclusion

- Manufacturers are increasing drug prices for both brands and generics
- PBMs play a unique and central role in **driving adherence**, **holding down costs**, and **increasing quality**
- PBM tools **deliver savings** for plan sponsors and consumers, underscoring the success of the competitive marketplace