Reducing Drug Costs for Employees of Not-for-Profit Hospitals: Tight Management of Prescription Benefit Management (PBM) Vendors

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Overview

Prescription drugs represent the most complicated segment within the US's $3.5 trillion healthcare market, and this is due in large part because of the convoluted role that Prescription Benefit Managers (PBM) have created for their *own benefit*. This document illustrates one hospital client's experience to:

- Describe the current situation regarding drug employee costs
- Identify implications for hospitals as employers, and specify key action steps
- Explore how hospitals can leverage their "provider capabilities" to manage drug costs
- Specify an action plan for PBM vendor management.

Our client is a 2-hospital, not-for-profit health system with 850 employees that, until recently, contracted with a national PBM on the recommendation of its benefit consultant. Our focus here is on the hospital's role as an employer that has its own pharmacy, thereby allowing critical accounting insights (true transparency) into some of the tactics that PBMs use.

The bottom line for our client: an *average annual $500,000 savings ($600 per employee).*

Current Situation

A. Prescription Drugs vs. Medical Services (Drugs are Very Different)

Unlike medical *services*, prescription drugs:

a. Are typically protected by patents.
b. Have minimal variable cost (and conversely offer extremely high contribution margins).
c. Are prescribed by providers but then typically dispensed by vast networks of other entities (e.g., retail and specialty pharmacies).
d. Are the typical mainstay treatments for chronic medical conditions, where patient medication adherence is a serious care management issue.

Over the past decade, specialty medications (loosely-defined as drugs that cost more than $750 per dose) have accounted for virtually all growth in drug expenditures and are unsurprisingly both the most-advertised drugs on TV and have the highest margins for manufacturers.

Also unlike medical services, coverage for medications is split between medical and pharmacy benefits. Traditionally, infusion therapy medications are most often covered by the medical benefit, while all other medications are covered by the drug benefit and dispensed in pharmacies. Financially, for over two decades, dispensed medications have been adjudicated on a real-time basis (setting aside prior-authorization for specialty meds), unlike medical claims.

B. What PBMs Do for Employers (and Health Insurance Carriers)

PBMs provide these core services:

A. Process claims per contract terms
B. Provide an accessible pharmacy network
C. Manage care (e.g., provide and follow a formulary, administer prior-authorization and step therapy programs)
D. Negotiate rebates (that are paid to employers after receipt by the PBM)

The role of PBMs has grown over the years. Initially, PBMs value had two components:

1. Contract rates on thousands of drug/dosage/strength SKUs with pharmacies across the country ("maximum allowed charge")
2. Ability to adjudicate claims on a real-time basis at the point-of-sale at those pharmacies

As clinical options have expanded (e.g., brand versus generic), PBMs began guiding the selection of the optimal drug for a specific patient via the usage of formularies and prior-authorization. Given this role, drug manufacturers will negotiate with "buyers" to increase usage of their highly-profitable products. By control of the formulary and prior-authorization, PBMs "act" as the buyer. However, they cannot reduce the price paid by the retail pharmacies, as those pharmacies buy from distributors. Instead, PBMs obtain rebates from drug manufacturers, and the ultimate payers (health plans and self-insured employers) usually expect to receive most of the rebate amounts via payment from the PBM. Those rebates (and other incentives) totaled $153 billion in 2017, or roughly 30% of total prescription drug expenditures.[i] The core issue is the portion retained by PBMs (versus being refunded to the self-insured employers).

C. PBMs are Very Profitable Entities

PBMs generate an attractive profit margin of 6% of net revenues (FY17 financials):

Financials of Top PBMs
in $billions

	CVS / Caremark	Express Scripts	OptumRx (United)	Total
PBM services only				
Gross profit	$5.90	$8.51	$3.12	$17.53
Net revenues	$119.96	$96.51	$63.76	$280.23
Profit margin	**5%**	**9%**	**5%**	**6%**

These economics drove two key acquisitions during 2018: CVS/Caremark's acquisition of Aetna and CIGNA's acquisition of Express Scripts. Net revenues include funds from customers ("claims paid" plus explicit fees) and drug manufacturers (rebates and other incentives).

D. Costs to Self-insured Employers: Medical Benefit versus Prescription Drug Benefit

For self-insured employers, each employer's cost for *medical benefits* is the summation of:

a. Actual claims paid by the carrier, plus
b. Administrative service fee (e.g., *simple* $30 Per Employee Per Month)

Let's contrast this simplicity with the drug benefit under a typical, difficult-to-follow, employer-PBM agreement:

1. "Claims paid" are fictional. PBMs usually promise employers a discount off "Average Wholesale Price" (AWP). Although one may assume this is similar to a health plan offering a "discount off hospital charges" for medical claims, PBMs actually reimburse pharmacies at rates lower than discount-from-AWP (by using a second payment structure with pharmacies called "maximum allowable charge" (MAC)), and PBMs usually retain any difference between the two figures. We have seen this **arbitrage** explicitly described in a PBM's agreement, so while this practice is misleading, it is not fraudulent.
2. Drug manufacturers drive PBM behavior via the payment of **rebates** and other incentives. In 2016, these financial arrangements totaled $128 billion[1], or roughly 30% of total drug spending at invoice level. Rebates (and other incentives) are paid to ensure that (a) a drug is included in a PBM's formulary as a preferred product and (b) the PBM performs medication therapy management to boost patient adherence. Scale matters, as manufacturers pay higher rebates to larger entities; for these reasons, many PBMs in turn contract with "rebate aggregators", who negotiate actual rebates with manufacturers. Due to these complexities (and an industry-wide "best interest" in opacity), rebates and other incentives paid to the PBM on behalf of an employer are impossible to audit, and hence are rarely fully passed-on to the employer.
3. Definitions are meaningless as PBMs have designed their contracts to game matters to their advantage. For example, they can decide whether or not a specific drug is "generic." This means that typical PBM claims of guaranteed rebates per brand prescription are useless. We have even found "formularies" useless, as our clients have seen their PBMs approve, without prior authorization from the employer, extremely high-cost medications that are off-formulary (from the PBM's own formulary published online) and concluded that rebates drove the PBM's decisions.
4. The PBM is also able to force members to use its own specialty and mail-order (in network) pharmacies. This, in turn facilitates (a) higher-than market rates (e.g., overpaying for mail-order via the PBM choosing drugs with higher AWPs (and hence dollar margin per script)) and (b) minimizes the use of programs that could reduce an employer's net cost (e.g., not offering the patient assistance program for high-cost specialty medications offered by drug manufacturers).

E. One Employer's Experience

Reviewing an actual case study is instructive. Our client has 850 covered employees and 1,700 covered lives. We analyzed 22 months of drug claims data (at the "NDC11" level). In CY 2017, medical claims paid totaled $5.54 million and drugs costs were $2.14 million ($2.35 million with co-pays). These amounts increased 11.4% and 25.7% from the previous year, respectively. Our findings include:

1. Large "mark-up" assessed on "claims paid." Because this employer is a hospital, and its pharmacy dispensed the majority of scripts (83% of scripts representing 68% of pharmacy claims costs), we had enough claims data to compare both the employer and pharmacy views of "claims paid." A 100% sample of claims paid in one month (1,777) revealed that the hospital's own pharmacy was paid $111,000 by the PBM while the PBM charged the hospital's HR department $137,000 for those same dispensed medications. This $26,000 monthly markup equates to $310,000 annualized (equal to 15% of total claims paid) or $14.77 per claim. This $15 per claim arbitrage explains how PBMs can offer a low administrative fee (such as $0.65 per claim) and generate 5-9% profit margins on their revenues (which include payments from employers for "claims paid" and administrative fees *plus* rebates).
2. A relatively small figure for rebates was credited to the employer: only 8% of paid claims. Recall that, nationally, rebates and other incentives averaged 28% of total drug expenditures. For our client, the difference between these rates would have been $490,000 in CY18.
3. A clinical review of the claims database revealed:
    a. 80 members (of 1,700) who were treated by a specialty medication accounted for 42% of all drug expenditures (20 members accounted for 30% of all drug spend).
    b. Of the 5 highest-cost cases, 3 had expensive *off-formulary* drugs, and one of these was deemed by an independent physician to be a prime example of polypharmacy.
    c. Patient assistance programs were available from drug manufacturers for some high-cost drugs but not offered to patients by the PBM (and its in-house specialty pharmacy). Such a program would have saved this employer over $70,000 annually on just one member.

In total, the employer expects to save $500,000+ annually (or $600+ per employee) when it switches its PBM vendor for CY19.

Implications for Hospitals (as Employers)

Hospitals are different from most employers because they can:

1. **Operate** their own **retail pharmacies;**
2. **Reduce procurement costs** to levels 10-30% below those of typical retail pharmacies via accessing their "own-use" ("acute care") discounts, for their own employees/dependents and hospital patients; see endnotes regarding 340B;[2]
3. **Offer a worksite clinic** at a far lower cost than typical employers, via leveraging existing facilities and clinical staff. The majority of large employers utilize such services,[3] and hospitals can easily expand the scope of these clinics, as needed, to manage medications;
4. Leverage their own **care management programs** to assist the 3-5% of the enrolled lives that drive most drug expenditures;
5. Develop **condition-specific clinical programs and clinics** (e.g., diabetes, heart failure) whose central purpose is essentially medication management.

Hospitals can leverage their "provider capabilities" to manage their employee drug costs:

Key aspect	Benefit design	PBM terms	Hospital operations
1. Hospital's own pharmacy	Incentivize patient usage; require usage for all specialty meds	Require "claims paid" to match amount paid to pharmacy; or inform PBM that it no longer needs to send funds to hospital pharmacy for own employees (i.e., use "journal entry")	Ensure that the retail pharmacy is "retail-focused" and can dispense all needed medications
2. "Own Use" drug procurement	Modify formulary based on cost (as some brands' costs drop substantially)	Set allowable at Own Use cost plus explicit dispensing fee	Implement separate / virtual inventories in the pharmacy to handle 2^+ cost structures
3. Worksite clinic	Waive co-pays on visits (industry norm)	Have the PBM provide tools to clinic for medication cost comparisons	Leverage clinical pharmacist for targeted usage in clinic
4. Care management	Cover medication therapy as a service	Tightly review formulary; require PBM to obtain approval for any off-formulary usage; Transfer prior-auth to hospital	Add prior-auth to care team's tasks; leverage own clinical pharmacists (rather than PBM's)
5. Condition-specific clinics	Waive co-pays for usage of such clinics	Use clinics for care management rather than remote PBM-provided staff; get access to PBM's protocols and tools	Develop clinics, with employees as first patients

We recommend the following action steps to **manage your PBM** vendor relationship:

A. Evaluate PBMs on the basis of *total cost* instead of solely on *administrative fees*. Our example client previously evaluated its PBM on the basis of a very low administrative fee ($0.65 per claim) Fees totaled only $16,000 per year for $2.1 million in "paid claims", or 0.7% of paid claims. Our client was amazed to learn about the quantified $300,000 arbitrage and another $300,000 in potential rebates.

B. Obtain complete claims data files monthly, for periodic analysis by independent analysts.

C. Audit prescriptions dispensed to your employees by your own pharmacy, to quantify any arbitrage margins generated by the PBM.

D. Request annual cost quotes from competing PBMs (before committing to a PBM for the next plan year). That is, have various PBMs calculate what their paid claims and credited rebates, plus fees, would have been, for the previous 12 months, based on your own data.

E. Create an independent medical director function (part-time), to review plan performance.

F. Contractually require the PBM to obtain approval before it can authorize any off-formulary usage throughout the year.

G. Use a rebate aggregator directly, as opposed to the PBM, to handle rebates.

Hospitals should (re)negotiate their PBM contracts to (a) ensure true transparency, (b) co-manage formularies, (c) leverage their own care management services to help optimize beneficiaries' chronic condition management, and (d) lower drug acquisition costs via focusing all dispensing to the hospital's pharmacies (for "own use" discounts) and using patient assistance programs.

Summary

Employee drug costs are a likely source of cost pressure to hospitals, but they may also help hospitals develop capabilities that could be leveraged for all patients.

As an employer, each hospital should manage its PBM vendors armed with knowledge of their typical tactics and how to address them. Hospitals, *as the core of a health system*, also have a set of capabilities to further reduce drug costs. Deploying those capabilities on behalf of employees/dependents may help finance new clinical programs while improving care.

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[i] See Adam Fein, "A System Without Rebates: The Drug Channels Negotiated Discounted Model", August 2, 2018, from https://www.drugchannels.net/2018/08/a-system-without-rebates-drug-channels.html, accessed 1-17-19. See also Adam Fein, "Don't Blame Drug Prices on 'Big Pharma,'" The Wall Street Journal, February 4, 2019 and "A Primer on prescription drugs rebates: Insights into why rebates are a target for reducing prices", May 2018, from Milliman http://www.milliman.com/insight/2018/A-primer-on-prescription-drug-rebates-Insights-into-why-rebates-are-a-target-for-reducing-prices/, accessed 1-17-19. Milliman stated that "in recent years, pharmaceutical manufacturers have reported actual revenue of 50% to 60% of gross sales due to rebates and discounts."

[2]340B eligibility only applies to patients of the hospital and for prescriptions written in the outpatient hospital setting. Hospital employees and dependents are not 340B-eligible *merely* due to their employment status. Rather, we view hospital employees/dependents as one attractive patient segment for 340B Covered Entities to pursue as part of a comprehensive 340B strategy.

[3] See: https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/mercer-worksite-clinic-survey.html

Appendix: Market Value of PBMs versus Hospitals

A consolidated market capitalization of $116 billion (for PBM portion of the firms):

Financials of Top PBMs
in $billions

	CVS / Caremark	Express Scripts	OptumRx (United)	Total
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Net revenues	$119.96	$96.51	$63.76	$280.23
Profit margin	**5%**	**9%**	**5%**	**6%**
Market cap (3/16/18)				
Total firm	$67	$43	$221	
PBM-services share of total margin	39%	100%	21%	
PBM-services only (attribution)	$26	$43	$46	$116

By means of comparison, this market capitalization is three times larger than the consolidated value of four for-profit hospital chains, comprising almost 400 hospitals:

	Market cap (3/16/18)	Hospitals (per websites 3/16)
HCA	$36.0	177
CHS	$0.5	127
Tenet	$2.5	69
Lifepoint	$2.0	23
	$40.9	396