SHINING THE LIGHT ON NON-TRANSPARENT PBM CASH FLOWS

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ILLUSTRATION: STEPHANIE CARTER

An overview to assist pharmacists in explaining PBM industry nuances to plan sponsors

The prescription drug benefit is one of the fastest growing segments of our health care bill. With that said, this is perhaps the ideal time to reflect on the pharmacy benefit management (PBM) industry. The PBM industry is made up of several business entities, performing many services that may or may not be in the best interest of the health care purchaser, which in many cases is the employer. Furthermore, it has been our experience as industry consultants and academics, that many employers are unaware of some of the practices of this complex industry.

This article will describe the PBM industry, and will also discuss two cash flows to the PBM: spread pricing and PBM-owned mail order pharmacy. Although PBM cash flows are largely understood by pharmacists, these cash flows may not be readily apparent to the non-insider, and employer groups may find this discussion informative. The goal here is to help pharmacists communicate with their local employer groups.

WHAT IS A PBM?

The PBM industry is the generic term referring to those entities that administer the sponsor's prescription card. Most self-insured plan sponsors in corporate America lack the in-house expertise to manage the pharmacy benefit. Other plan sponsors, such as managed care organizations, have substantial expertise and require only certain components, such as claims processing. Therefore, the PBM provides a valuable service by offering "one-stop shopping" for some clients, while providing only needed components for others.

PBM convenience can come at a high price, especially when the PBM takes cash flows not readily apparent to the employer. For convenience, we call those PBMs that take undisclosed cash flows "non-transparent," as opposed to a full-disclosure, or "transparent" PBM. The cash flows to non-transparent PBMs arise from subtleties in contract language and the basis of pricing drugs. To assist the practicing pharmacist in explaining PBM industry nuances to plan sponsors, we will provide a basic overview that will describe two broad PBM functions. These are:

- Pharmacy network formation and contracting
- The basis of pricing in the industry

Our experience indicates that understanding these basic elements of the PBM industry are well worth the effort required on the part of the employer.

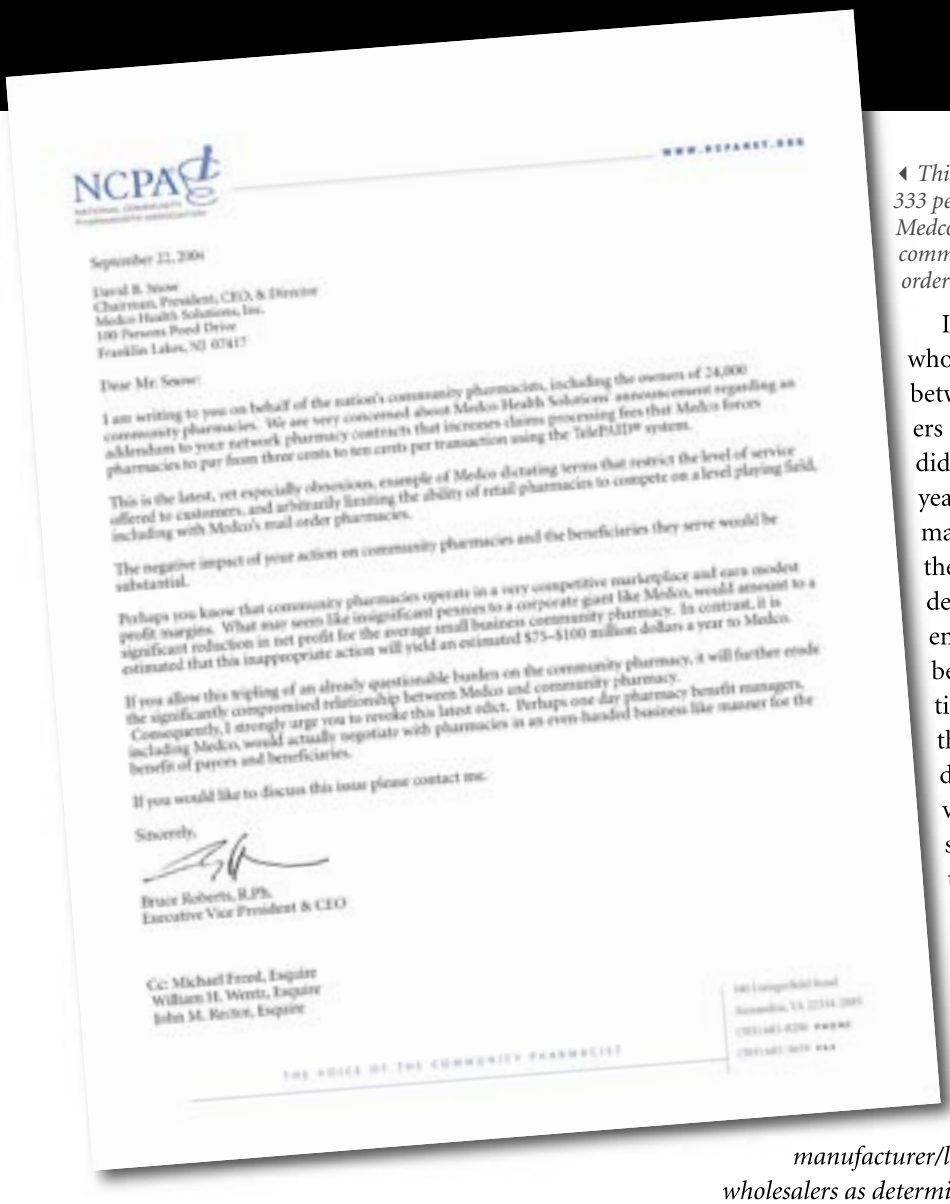
THE PHARMACY NETWORK AND THE BASIS OF PRICING IN THE PBM INDUSTRY

Almost all PBM companies have an extensive pharmacy network that generally allows for plan members to fill prescriptions conveniently. The PBM executes contracts with chain and independent community pharmacies to provide a network of pharmacies for the sponsor's employees.

The PBM is able to obtain network pharmacy participation at deep discounts when contracting because network participation gives the pharmacy potential access to more patients. The PBM offers contracts to the network pharmacies based on a discount off the average wholesale price (AWP minus a percentage [%]) reimbursement for drug products dispensed plus a professional fee. Table 1 (page 23) presents the two components of the pharmacy reimbursement. The pharmacy is reimbursed for the drug ingredient cost as a discount off AWP (for example, AWP minus 15%) and is paid a professional dispensing fee (usually between $1 and $3 per prescription) to compensate the pharmacy for the required resources to dispense the medication (such as pharmacist counseling, technician assistance, inventory management, and other operational resources within the pharmacy).

In performing the middleman function between employers and pharmacies, the PBM forms two contracts: one which specifies how much the PBM will pay the pharmacies for each prescription transaction, and another with the sponsor that specifies how much the sponsor will be charged for each prescription transaction. The sponsor is billed for ingredient cost as a discount off AWP (AWP minus %).

Because the PBM enters into separate contracts with network pharmacies and employer groups, the opportunity for differential pricing exists. This differential pricing has been call the "AWP spread" or simply the "spread." The spread refers to billing the employer a higher price for the drug ingredient than is paid to the network pharmacy. The spread can provide a significant cash flow to the PBM and can be highly variable across medications.



NCPA

September 22, 2004

David B. Snow
Chairman, President, CEO, & Director
Medco Health Solutions, Inc.
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

Dear Mr. Snow:

I am writing to you on behalf of the nation's community pharmacists, including the owners of 24,000 community pharmacies. We are very concerned about Medco Health Solutions' announcement regarding an addendum to your network pharmacy contracts that increases claims processing fees that Medco forces pharmacies to pay from three cents to ten cents per transaction using the TelePASS® system.

This is the latest, yet especially obnoxious, example of Medco dictating terms that restrict the level of service offered to customers, and arbitrarily limiting the ability of retail pharmacies to compete on a level playing field, including with Medco's mail order pharmacies.

The negative impact of your action on community pharmacies and the beneficiaries they serve would be substantial.

Perhaps you know that community pharmacies operate in a very competitive marketplace and earn modest profit margins. What may seem like insignificant pennies to a corporate giant like Medco, would amount to a significant reduction in net profit for the average small business community pharmacy. In contrast, it is estimated that this inappropriate action will yield an estimated $75–$100 million dollars a year to Medco.

If you allow this tripling of an already questionable burden on the community pharmacy, it will further erode the significantly compromised relationship between Medco and community pharmacy. Consequently, I strongly urge you to revoke this latest edict. Perhaps one day pharmacy benefit managers, including Medco, would actually negotiate with pharmacies in an even handed business like manner for the benefit of payors and beneficiaries.

If you would like to discuss this issue please contact me.

Sincerely,

Bruce Roberts, R.Ph.
Executive Vice President & CEO

Cc: Michael Freed, Esquire
William H. Wentz, Esquire
John M. Rector, Esquire

This letter from NCPA to Medco, reacting to a 333 percent increase in the claims processing fee Medco charges, illustrates how PBMs disadvantage community pharmacy competitors to their mail order operations.

We will present the reader with two potentially significant cash flows to the non-transparent PBM. These cash flows are spread pricing, and PBM-owned mail order pharmacy services. Both of these cash flows rely on the AWP, which is the basis of drug ingredient payment in the PBM industry.

TWO CASH FLOWS IN THE PBM INDUSTRY

Spread Pricing

Differential terms of the contracts the PBM executes with pharmacies and employers present opportunities for spread pricing. This differential contracting is complicated because AWP is not a standard price, as many pharmacy benefit purchasers have been led to believe.

In actuality, AWP is neither average nor wholesale. Potential fluctuation of AWP between the amounts charged to employers and the amounts paid to pharmacies did not attract much attention in the early years of the PBM industry, because pharmacy spending was a small percentage of the total health care bill. Only in the last decade have pharmacy costs been a large enough part of the overall health care benefit to demand systematic investigation. The sponsor needs to be aware of the variability in AWP prices for each drug product. There is no externally validated standard for AWP prices. Instead, the AWP is the price reported by the manufacturer or other entity with the appropriate license. The AWP is defined as follows in Medi-Span's AWP publication, *Price Alert*:

"The average wholesale price (AWP) is either the published suggested wholesale price obtained from the manufacturer/labeler or the price commonly charged by wholesalers as determined by survey."

As previously described, the spread is the difference between the amount paid to the pharmacist for the drug ingredient and the amount that the plan sponsor is billed for the drug ingredient for the same prescription. See Table 2 (page 23) to augment the following explanation of the spread.

The contract the PBM negotiates with the employer is to provide the generic drug, Enalapril 20 mg #100, that has an AWP of $153 for the reimbursement of (AWP minus 40%), and for the same drug the PBM has a contract to reimburse the pharmacy at the maximum allowable cost (MAC) of $80. In our example, the sponsor's contract specifies the sponsor will pay the PBM (AWP minus 40%) for an ingredient cost of $91.80. Additionally, the PBM has a contract to pay the

Table 1: Two Components of Pharmacy Payment
For a Prescription Filled on a PBM Contract

Drug Ingredient Cost	+	Professional Fee	=	Total Pharmacy Payment
Discounted AWP Price ("AWP minus %") Reimbursement for the Drug Used to Fill the Prescription	+	Costs of Dispensing $2 Per Prescription Filled	=	Total Pharmacy Payment

pharmacy $80 for the same ingredient. These contract terms created a spread of $11.80 on this transaction. In our experience, the employer quite often believes its contract price, in this case $91.80, is the amount the pharmacist received for the ingredient cost of that prescription. It seems reasonable that the nature of the spread taken by the PBM be revealed to the employer by the pharmacist.

Community pharmacists, with generally good professional relationships with employers in their trade area, can serve a valuable educational role to employers on the business practices of the non-transparent PBMs. We believe that the collaboration of the pharmacist and the plan sponsor is key to raising awareness of PBM cash flows. The pharmacist may want to educate the sponsor about the prices of generics and the existence of MAC prices. The Centers for Medicare and Medicaid Services (CMS) MAC price is public and reasonably replicates the MAC price in most proprietary MAC lists. The sponsor may need the pharmacist's help to navigate the sponsor's transaction records. Our research group has found collaboration with plan sponsors to be a very enlightening experience as we attempt to educate the market on PBM business practices.

MAIL ORDER PHARMACY AFFILIATED WITH THE PBM

Because the AWP is not a standard price, an opportunity exists to manipulate AWP without the purchaser's knowledge. Drug pricing can be particularly deceptive in a mail order PBM pharmacy affiliated with a PBM. That is, if a pharmacy wants to buy a container of 10,000 tablets from a drug manufacturer and break up that container into bottles suitable for dispensing (for instance, 30 tablets per bottle), they may do so if they have a Food and Drug Administration (FDA) "Repacker" license. Repackaged products (the bottles of 30 tablets) will have a new national drug code (NDC) number and, as a consequence, the repacker may assign the drug product a new AWP.

What does this mean for the plan sponsor? One, it serves to underscore the reality that AWP is not a standard price and that any contract based on a fictitious price would necessarily leave a lot of room for interpretation. Two, if an affiliate of the PBM is a repacker, the sponsor could be charged a new (and potentially higher) AWP for certain drug products. An example of a repacker and a PBM being affiliated is demonstrated in a PBM that has an "in house" mail order pharmacy.

The PBM that owns a mail order pharmacy can easily obtain a repacker license from the FDA. With the repacker license, the mail order pharmacy can set a new AWP price for any drugs it repackages. From this perspective, it becomes clear how some PBMs can offer an "in-house" mail order option with apparently very large percentage discounts off AWP. The AWP value is artificially inflated before the discount is calculated.

Now, let us compare the prices for the same prescription filled at a retail pharmacy and the PBM's mail order pharmacy that has a repacker license. Table 3 (page 24) shows payment terms of "(AWP minus 13%) + $2.50" for retail pharmacy prescriptions and "(AWP minus 20%) + $1" for mail order prescriptions. Because of AWP manipulation, this comparison might not be as straightforward as it seems.

Table 2: The "Spread" in the Pharmacy Benefit

Amount Paid to Pharmacy	Amount Charged to Sponsor
Contract Terms of the Participating Pharmacy: MAC Reimbursement for the Generic Drug Enalapril 20 mg #100 MAC = $80	Contract Terms of the Sponsor: (AWP minus 40%) for the Generic Drug Enalapril 20 mg #100 AWP = $153
$80 Paid to the Pharmacy	($153 minus 40%) = $91.80 Charged to the Sponsor
"Spread" = $91.80 minus $80 = $11.80	
The PBM made $11.80 on this Prescription via the "Spread"	

Table 3: Retail Pharmacy Versus Mail Order Pharmacy With Repacker License

Retail Pharmacy	Mail Order Pharmacy Affiliated With the PBM (Pharmacy has Repacker License)
Sponsor's Prescription Terms for a Prescription at a Network Retail Pharmacy (AWP minus 13%) + Professional Fee of $2.50 AWP = $85/100 Tablets	Sponsor's Prescription Terms for a Prescription at the PBM Mail-Order Pharmacy (AWP minus 20%) + Professional Fee of $1 AWP = $125/100 Tablets
($85 minus 13%) + $2.50 = $76.45 Total Price of the Prescription	($125 minus 20%) + $1 = $101 Total Price of the Prescription
Mail-Order Prescription is $24.55 ($101 minus $76.45) higher Sponsor May Have a Lower Copay for Mail-Order Prescriptions to Take Advantage of the "Seemingly Larger" Discount off AWP	

In our example, we see that the mail order pharmacy sets a higher AWP price on the drug product it repacked. In our example, the drug manufacturer AWP is $85/100 tablets, and the repacker-determined AWP is $125/100 tablets. The sponsor would pay $24.55 more for a prescription from the mail order facility, despite the apparently larger discount off the AWP price. Additionally, because the mail order option appears to be more economical for the sponsor, members are often motivated to use mail order service. The incentive for the member is typically a lower copayment if they use the mail order option.

Table 4 (page 25) presents a sample of audit results from a client with some members in a PBM-affiliated mail order service and some members in the PBM's community pharmacy network. We present the drug ingredient cost charged to the employer by the mail order facility and contrast that amount to the drug ingredient cost charged by a retail pharmacy for the same employer from the same PBM. It shows that the total price for the 22 drugs from the mail order facility was $1,491.12, and the retail pharmacy charge would have been $1,229.14. The difference in price mail and retail was $261.98, or $11.91 per prescription higher from the mail order pharmacy. It appeared from the sponsor's invoice that the sponsor was being charged AWP minus 50%, instead of a much lower MAC price that many PBMs use in a retail pharmacy network. We can compare AWP minus 50% pricing with MAC pricing in Table 4 for Atenolol 50 mg (difference = $26.60), Fluoxetine 20 mg (difference = $67.08), Synthroid 125 mcg (difference = $7.28), and Zocor 80 mg (difference = $15.78).

HOW CAN THE PHARMACIST AND EMPLOYER COLLABORATE?

The sponsor can do much to improve its pharmacy benefit purchasing efficiency by working with the community pharmacist and by keeping in mind our discussion of the spread and AWP manipulation in mail order pharmacy pricing. For instance, the pharmacist can provide an employer with CMS MAC prices, allowing the employer to check its generic drug pricing. Also, the employer might need the pharmacist's help in reading the transactions on its billing statement. With some orientation from the pharmacist, the employer could look at common drugs and quantities filled both in the PBM mail order plan and in the PBM community pharmacy network. The results of this investigation provide the type of information found in Table 4.

There are certainly Health Insurance Portability and Accountability Act (HIPAA) issues, about which the plan sponsor and the pharmacist are well aware. There is also proprietary information in the billing documents and both the pharmacist and the sponsor will have to keep such information confidential. There remains a great deal of information that can be shared between the pharmacist and the plan sponsor. This sharing between provider and payor can work to remove much of the misunderstanding that has for many years been associated with the pharmacy benefit.

CONCLUSION

A number of articles have commented on the PBM spread in recent years. Interest in spreads was heightened in the first quarter of 2003 with a front page story in the *Wall Street Journal* and litigation by a large public employee union, in part, over the spread taken by four well-known PBMs. Although these cash flows can accrue to some PBMs, there are others that do business on a full-disclosure arrangement with the plan sponsor.

The sponsor should be prepared for a greater upfront PBM administration fee in exchange for total disclosure of cash flows. These full-disclosure models avoid the "bargain basement" administration fees of 10 cents to 20 cents that

may be forcing some non-transparent PBMs to generate cash flows that are not readily apparent to the sponsor. The full-disclosure model PBM may not actively promote a mail order pharmacy facility, because with no manipulation of AWP and a fair MAC for both the pharmacist and sponsor, the PBM has no economic advantage. Without a clear financial advantage to the sponsor, there may no longer be a need to actively promote mail order pharmacy to the members.

The perception of many plan sponsors is that "AWP minus discount" and a "low cost mail order option" are the two key components in evaluating the PBM proposal. Given the competition in the PBM industry and the potential for undisclosed cash flows, we believe that pharmacists and plan sponsors can use the information in this article to their advantage in selecting and monitoring their PBM. From our experience, the plan sponsor should take the time to investigate the cash flows to the PBM. The time invested in PBM selection can return significant cost savings on future pharmacy benefit costs. ■

Table 4: Ingredient Costs* Charged to the Plan Sponsor in a PBM-Owned Mail Order Pharmacy Compared With a Retail Pharmacy Price Within the Same Plan

Quantity	Drug	Strength	PBM-Owned Mail Order Pharmacy	Retail Pharmacy**
90	Alprazolam	1 mg	$44.28	$9.84
90	Atenolol	50 mg	$37.50	$7.90
90	Bisoprodolol/ HCTZ	5/6.25 mg	$51.20	$47.10
90	Clonazepam	1 mg	$38.55	$14.40
90	Doxepin	25 mg	$21.07	$9.59
10	Duragesic		$97.39	$102.89
16	Flonase	50 mcg	$53.81	$56.66
90	Fluoxetine	20 mg	$121.06	$53.98
180	Furosemide	40 mg	$15.84	$11.93
180	Gemfibrozil	600 mg	$111.88	$49.12
180	Generic Darvocet N	100	$60.45	$63.05
15	Humalog		$97.39	$102.89
60	Levoxyl	100 mg	$20.00	$19.25
90	Prednisone	10 mg	$9.04	$8.20
180	Propranolol	40 mg	$63.20	$48.29
60	Synthroid	125 mcg	$32.53	$25.25
90	Toprol XL	100 mg	$84.23	$91.18
90	Trazodone	50 mg	$18.75	$7.49
360	Trim/HCTZ	37.5/25	$20.00	$17.83
100	Ultracet	37.5/325	$81.93	$88.29
90	Verapamil	240 mg	$72.93	$40.14
90	Zocor	80 mg	$338.09	$353.87
Totals			$1491.12	$1229.14

* All above prices are for drug ingredient cost only. There are no professional fees or PBM administrative fees included.

** The retail pharmacy prices were taken from the same employer for an identical prescription filled in the same date range

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