Pharmacy Benefit Managers
Overview & Background

NAIC PBM Regulatory Issues Subgroup

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Who is AHIP?

America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage and health-related services that improve and protect the health and financial security of consumers, families, businesses, communities and the nation.
Agenda

• The Drug Supply Chain
  − Illustrating the various entities
  − Differences between branded and generic drugs

• Carriers Utilization of PBMs
  − Services provided by PBMs
  − Carrier Payments to PBMs for Services
  − Rebates

• Next Steps:
  − NAIC Background
  − State Considerations

• Q & A

• Appendix:
  − Milliman Analysis on Prescription Drug Rebates
  − Copay Coupons
Drug Supply Chain
Drug Supply Chain

**Drug Makers**
Set Drug List Prices

Drug Makers negotiate with PSAOs to distribute their drugs to Pharmacies

**PSAO / Wholesaler**

PSAOs sell/distribute drugs to their Pharmacy Clients

**PBM**

Negotiate Discounts with Drug Makers on Behalf of their Health Plan Clients or Large Employer Clients

**Health Insurance Providers**

Health Insurance Providers Cover Enrollee Drug Costs

**Pharmacy**

Pharmacy Dispenses Drugs To Patient

**Patient**

Patient pays copays for Drugs

Drug Makers pay Rebates to PBMs per Negotiated Agreements

PSAOs Negotiate Drug Reimbursement on Behalf of their Pharmacy Clients with PBMs

PBMs/Health Insurance Providers pay pharmacy for drugs dispensed

= supply flow  
= money flow  
= negotiation

(set drug list prices, negotiate discounts with PBMs, health insurance providers cover enrollee costs, pharmacy dispenses drugs to patient, patient pays copays for drugs, drug makers pay rebates to PBMs per negotiated agreements, PSAOs negotiate drug reimbursement with PBMs, PBMs pay pharmacy for drugs dispensed)
Generic Drug Supply Chain
$20 Drug Example

**DRUG MAKERS**
Sets Drug List Price
Wholesale Acquisition Price (WAC) varies $15-$25, from multiple generic drug makers

**PSAO / WHOLESALER**
PSAO sells/distributes drug to their pharmacy client for discounted price off the Average Wholesale Price; AWP = $18

**PHARMACY**
Pharmacy buys for $18; charges patient $10 copay

PBM
Depending on contract, PBM pays:
* FFS $8 ($18 minus $10 copay)
* avg. price/MAC $10 ($20 minus $10 copay)
PBM charges insurance $11.50 ($20 avg price plus $1.50 dispensing fee, minus $10 copay).

**HEALTH INSURANCE PROVIDER**
Generic drug has $10 copay, insurer pays full amount $11.50, (minus copay of $10).

**PATIENT**
Copay of $10 to pharmacy.

= supply flow
= money flow
= negotiation
Branded Supply Chain
$10,000 Drug Example

**Drug Maker**
Sets Drug List Price
Sets list price of $10,000 (WAC)

**PBM**
PBM pays pharmacy $10,925;
Negotiated $2000 rebate with Drug Maker, keeps $100, sends $1900 to health insurance provider

**Health Insurance Provider**
Pays PBM $10,925;
receives $1900 rebate from PBM; records total drug spend of $9,025.

**Patient**
Patient pays $75 copay
Pharmacy dispenses drug to patient for copay

**Pharmacy**
Pharmacy charges $11,000; charges patient $75 copay

**PSAO / Wholesaler**
PSAO buys drug at $10,000 WAC;
sells/distributes drug to their pharmacy client for $10,500 AWP

**Drug流**
Drug makers pays rebate to PBM per negotiated agreement

PBM negotiates drug reimbursement on behalf of their pharmacy clients

PBM / health insurance provider pays pharmacy for drug dispensed
Carriers Utilization of PBMs
Why Curbing Drugs Costs Is Critical

- Prescription Drugs: 23.3¢
- Doctor Services: 22.2¢
- Office & Clinic Visits: 20.2¢
- Hospital Stays: 16.1¢
- Taxes: 4.7¢

Other Fees & Business Expenses: 3.3¢
Customer Engagement: 1.8¢
Finance, Claims, & Special Investigations: 1.6¢
Care Management: 1.6¢
Technology & Analytics: 1.6¢
Administration: 0.7¢
Provider Management: 0.5¢
Net Profit: 2.3¢

Source: https://www.ahip.org/wp-content/uploads/2017/03/HealthCareDollar_FINAL.pdf
Carriers Utilize PBMS to Provide a Variety of Services:

- Negotiate with drug manufacturers on price: lowest net price goal
- Process drug claims
- Handle mail-order pharmacy
- Drug formulary management
  - can also include P&T Committees
- Pharmacy networks, including specialty pharmacies
  - to meet our network adequacy requirements
- Drug utilization review
- Manage drug adherence & disease management programs
Carriers Pay PBM in Various Ways:

- **Administrative Fees**: A charge for each service provided (i.e., per member per month, monthly service charge, or other fee-based service charge).

- **Spread Pricing**: An arrangement where the plan sponsor (health plan or self-funded employer) pays the PBM a set price for a drug, which can differ from what the PBM pays to the pharmacy;
  - Any added fee to a drug dispensed covers the services provided by the PBM.
  - Any losses are assumed by the PBM.

- **Shared Savings**: PBM keeps part of the rebates/discounts that are negotiated with brand drug manufacturers.
Rebates

**Shared Savings (PBM and Plan)**

- Carrier pay for a PBM’s service through a portion of the rebates negotiated by the PBM.
- For example, if a PBM negotiates a $200 discount from retail cost, the PBM can keep 5% of the rebate negotiated ($10).
- Incentivizes the PBM to negotiate for the lowest net cost for drugs, inclusive of the rebate amounts.
- Total rebates are used to lower premiums (lower net drug costs).
- The carrier reports rebates on the MLR annual report.

**Point of Sale (Consumer)**

- The rebate is estimated and factored into the consumer’s cost-share at the pharmacy (at the point of sale).
- Estimations will need to be reconciled periodically to ensure all rebates have been properly accounted.
- No rebates are factored into premium, therefore overall drug cost spend will likely be higher.
PBM Rebates Are Not The Issue

- Over 300 million medications* are prescribed annually:
  - 82% generic drugs
  - 18% brand name drugs

- Only **2.4% of brand drugs** would be eligible for a discount at the pharmacy counter (i.e. point-of-sale rebate)
  - 11.5% brands paid with flat copays (not eligible for “Point-of-Sale” rebate)
  - 2.4% brands paid with coinsurance (affected by a for “Point-of-Sale” rebate)

* Commercial data only

Source: Internal AHIP analysis of REDBOOK™ drug pricing data, February 2018
Next Steps
NAIC Background

• NAIC: Health Carrier Prescription Drug Benefit Management Model Act #22
  - Applies to all health carriers who provide prescription drug coverage
  - Designed to protect consumers related to drug benefits
    • Requirements for formularies (development, maintenance, review)
      - Formalization of P&T committees with specific clinical review criteria
      - Notice of changes to formularies
    • Information to providers, enrollees, and prospective persons regarding drug coverage
      - Easily accessible formulary information including cost sharing
      - Medical management information (including formulary changes)
    • Medical appeals/exceptions processes
    • Record keeping and regulatory reporting
    • Oversight and contracting responsibilities

• NAIC: Network Adequacy Model Act #74
  - Added “Pharmacy” to the list of providers needed in an adequate network
Considerations for State-Based Regulation

**Regulations Should**

- Allow regulators to know who is operating as a PBM in their state
- Provide regulators with information on the organizational structure and basic information of PBM entities operating in their state
- Have the authority to enforce PBM-related laws passed in their state
- Protect consumers

**Regulations Should Not**

- Determine payment amounts for drugs
- Hamper negotiations or prohibit tools that provide opportunities to decrease drug costs or improve quality for consumers
- Protect certain businesses from competition
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Q&A
Appendix
Milliman Analysis: Prescription Drug Rebates and Part D Drug Costs

Analysis of historical Medicare Part D drug prices and manufacturer rebates
Most Prescribed Medications Are Not Rebated By Drug Makers

- **89% of prescriptions** written in 2016 had no rebates
- **81% of all Part D drugs analyzed** did not have rebates from drug makers in 2016, and **64% of brand drugs analyzed** did not have rebates

[Table]

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<table>
<thead>
<tr>
<th>Drugs without Significant Rebates</th>
<th>Drugs with Significant Rebates</th>
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</thead>
<tbody>
<tr>
<td>No Rebates</td>
<td>Some Rebates</td>
</tr>
<tr>
<td>Brand</td>
<td>Generic</td>
</tr>
<tr>
<td>% of Scripts</td>
<td>2%</td>
</tr>
<tr>
<td>% of Drug Count</td>
<td>34%</td>
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Among brand drugs with manufacturer rebates, rebates as a percentage of total drug spending were on average:

- **Highest** for drugs with direct brand and generic competition
- **Lowest** for protected classes drugs

Protected Class Drugs, Rebates, and Competition

- Among brand drugs with manufacturer rebates, rebates as a percentage of total drug spending were on average **lowest for protected classes drugs**
- **Only 13%** of the 2016 protected class drugs analyzed **had manufacturer rebates**
- The rebates for protected class drugs with rebates **averaged 14% of drug spend** – significantly lower than rebate levels for drugs with direct brand competition (i.e., 39% of drug spend)

Average Annual Gross Cost per Beneficiary: Brands with Rebates vs Brands without Rebates

For 2016, brand drugs with manufacturer rebates had lower average annual gross cost per beneficiary than brand drugs without rebates.

Relationship Between List Price Trends, Rebate Levels, and Average Annual Drug Costs for Brand Drugs with Rebates

Among brand drugs with rebates from drug makers, drug price increases were similar across different rebate levels.

Chart II-B shows that among brand drugs with rebates, the average annual cost per beneficiary decreases (blue bars) as the average rebate (as a percentage of gross cost) increases (gray line). However, the average 2013 to 2016 price increases (yellow line) are similar for all four quartiles of rebate levels.

Relationship Between List Price Trends, Rebate Levels, and Average Annual Drug Costs for Brand Drugs with Rebates

Among brand drugs with rebates from drug makers, drug price trends (per unit) were similar for specialty, non-specialty, and protected class drug.
Copay Coupons

Informational Explanation of How Drug Copay Coupons Work
What Are Copay Coupons?

- Drug makers will provide a coupon to a patient so they can receive a discount on a specific brand drug.
- Drug makers use coupons as an incentive for patients to use branded drugs instead of less expensive generics, as insurance providers still pay for the drug.
- Insurance providers are considering not having the price of a drug used with a coupon go towards their deductible and out-of-pocket maximums to stop the practice if there is a generic equivalent.
Copay Coupons

- Coupons increased brand drug makers’ revenue by $700 million to $2.7 billion, an average windfall of $30 to $120 million per drug.
- Coupons reduce the use of generic drug competitors and increase brand drug sales by more than 60%.
- Coupons are prohibited in federal health care programs like Medicare and Medicaid (Considered a “kickback”, as they induce a patient to take a certain drug).

*When Discount Raise Costs: The Effect of Copay Coupons on Generic Utilization.*
Massachusetts vs. New Hampshire

In a 2017 study on copay coupons, the researchers took neighboring states that had differing approaches to copay coupons to analyze the impact coupons have on generic utilization and drug spending.†

<table>
<thead>
<tr>
<th></th>
<th>Massachusetts</th>
<th>New Hampshire</th>
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<tbody>
<tr>
<td><strong>Coupons Allowed?</strong></td>
<td>NO - Massachusetts banned the use of coupons statewide</td>
<td>YES - New Hampshire allows coupon use in non-federal programs</td>
</tr>
<tr>
<td><strong>Drugs Not Offering Coupons</strong></td>
<td>When branded drugs did not offer coupons, use of generic alternatives was equivalent in both states</td>
<td></td>
</tr>
</tbody>
</table>
| **Drugs Offering Coupons to All Patients** | • When branded drugs offered coupons, use of generic alternatives was 3.4% LOWER  
• This amounted to $700 million more in drug spending – $2.9 billion over five years | |
| **Drugs That Offer Coupons Among Patients <65 yrs** | • When branded drugs offered coupons for this age group, use of generic alternatives was 6.3% LOWER  
• Increased spending could reach close to $6 billion | |

† *When Discount Raise Costs: The Effect of Copay Coupons on Generic Utilization.*
How Health Insurance Deductibles Work

• Patients pay doctors, hospitals and pharmacies directly to get treatment. Those amounts are tracked by the insurance provider and counted towards a deductible.

• Once the patient pays the deductible amount, the insurance provider begins to pay for medical treatments. The patient usually pays a small copayment for services, and the insurance provider pays the rest of the bill.

• Insurance providers do not count coupons or other third-party payments towards the deductible. For example, coupons are paid by the drug company (or other third-party entity), and those amounts are not kept by the insurance provider.

Deductible = $2,000

<table>
<thead>
<tr>
<th>Amount Applied to Deductible</th>
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<tbody>
<tr>
<td>JAN</td>
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<tr>
<td>$200</td>
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How Do Copay Coupons Work?
Without Copay Coupon Tracking (i.e. “copay coupon accumulator”)

**EXAMPLE**

**MANUFACTURER:** Abbvie

**DRUG:** Humira

**DRUG PRICE:** $6,600

**COUPON AMOUNT:** $6,595 (Typically 1 Month, Assuming Deductible is Reached)

**PATIENT’S DEDUCTIBLE:** $2,000

**MONTHS 1**

- **Abbvie**
  - $6,600
  - $6,595 coupon
  - Pharmacy
  - Patient Payment: $5

**MONTHS 2-12**

- **Abbvie**
  - $6,600
  - Insurance Plan: $6,575
  - Pharmacy
  - Patient Copay: $25

*Deductible = $2,000*

*Amount Applied*:

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<tr>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
</table>

*$6,600 Total Price Applied to Deductible (and Annual Out-Of-Pocket Maximum Limit)*
How Do Copay Coupons Work? With Copay Coupon Tracking (i.e. “copay coupon accumulator”)

MONTH 1

- **Manufacturer:** Abbvie
- **Drug:** Humira
- **Drug Price:** $6,600
- **Coupon Amount:** $6,595 (Typically 1 Month, Assuming Deductible is Reached)

**Patient's Deductible:** $2,000

**Amount Applied:**
- JAN: $5
- FEB: $1,995
- MAR: $25
- APR: $25
- MAY: $25
- JUN: $25
- JUL: $25
- AUG: $25
- SEP: $25
- OCT: $25
- NOV: $25
- DEC: $25

**Deductible:** $2,000

$5 and $1,995 Patient Payment Applied to Deductible