Pharmacy Benefit Managers Overview & Background

NAIC PBM Regulatory Issues Subgroup

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Webinar

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

= supply flow
= money flow
= negotiation

Drug Makers

Set Drug List Prices

Drug Makers negotiate with PSAOs to distribute their drugs to Pharmacies

Drug Makers pay Rebates to PBMs per Negotiated Agreements

PBMs

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

PSAO / Wholesaler

PSAOs sell/distribute drugs to their Pharmacy Clients

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

PBMs/Health Insurance Providers pay pharmacy for drugs dispensed

Health Insurance Providers

Health Insurance Providers Cover Enrollee Drug Costs

Pharmacy

Patient pays copays for Drugs

Pharmacy Dispenses Drugs To Patient

Patient

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Generic Drug Supply Chain

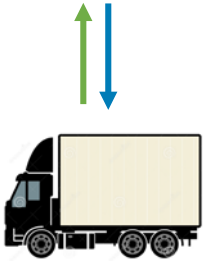
$20 Drug Example

= supply flow
= money flow
= negotiation

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

PSAO/PBM contract determines payment methodology to the pharmacy

PBMs/health insurance providers pay pharmacy for drugs dispensed

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 pays $10 copay for drugs

Pharmacy dispenses drugs to patient for copays

Patient

Copay of $10 to pharmacy.

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Branded Supply Chain

$10,000 Drug Example

= supply flow
= money flow
= negotiation

Drug Maker

Sets Drug List Price

Sets list price of $10,000 (WAC)

Drug makers pays rebate to PBM per negotiated agreement

PBM

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

PSAO negotiates drug reimbursement on behalf of their pharmacy clients

PBM/ health insurance provider pays pharmacy for drug dispensed

PSAO / Wholesaler

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

Health Insurance Provider

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

Pharmacy

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

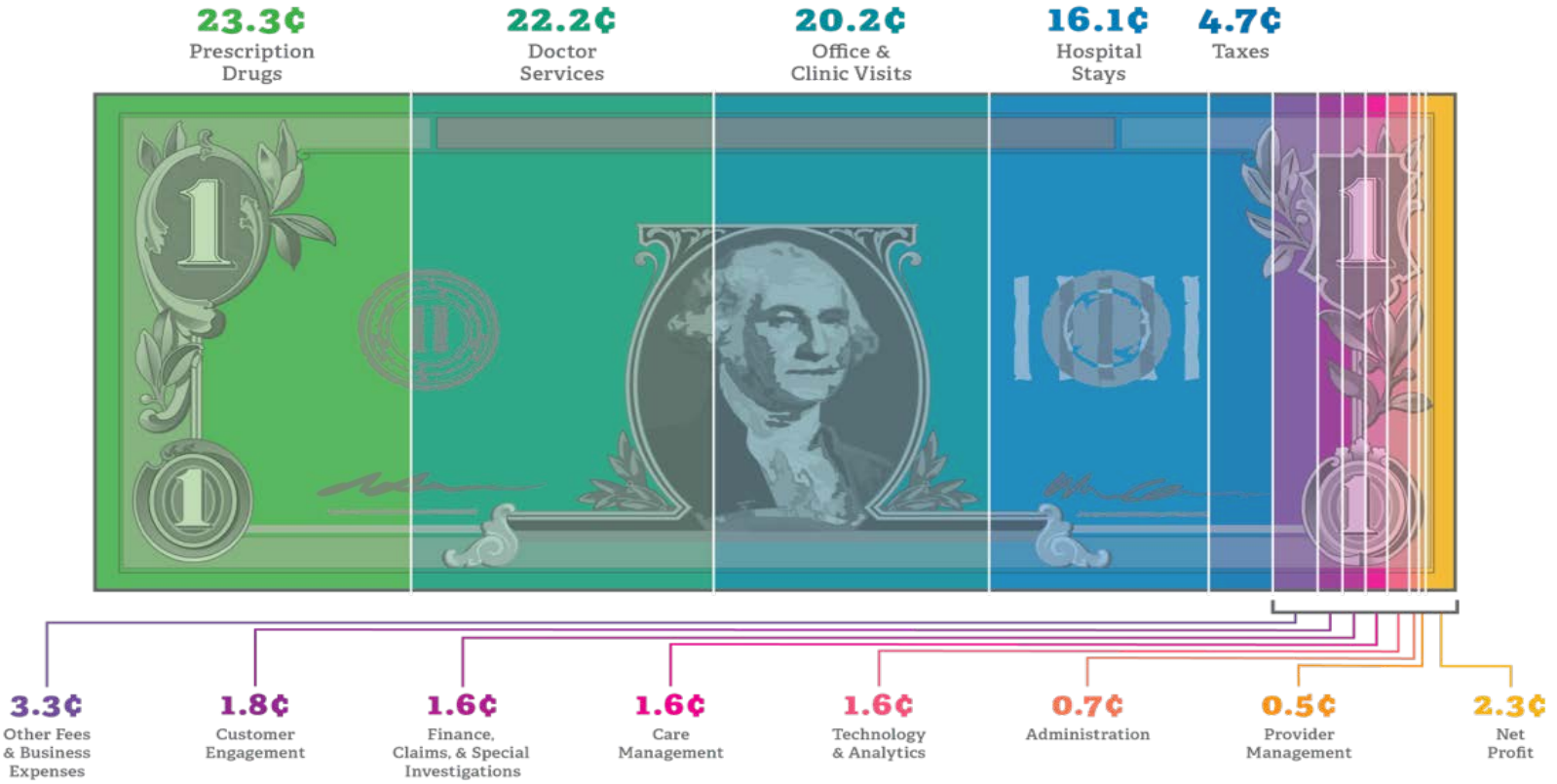
Patient pays $75 copay

Pharmacy dispenses drug to patient for copay

Patient

Carriers Utilization of PBMs

Why Curbing Drugs Costs Is Critical



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

	Drugs without Significant Rebates				Drugs with Significant Rebates	Total
	No Rebates		Some Rebates			
	Brand	Generic	Brand	Generic	Brand	
% of Scripts	2%	87%	1%	0%	10%	100%
% of Drug Count	34%	46%	5%	0%	15%	100%

- ***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

https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf

Brand Drugs, Rebates, and Competition

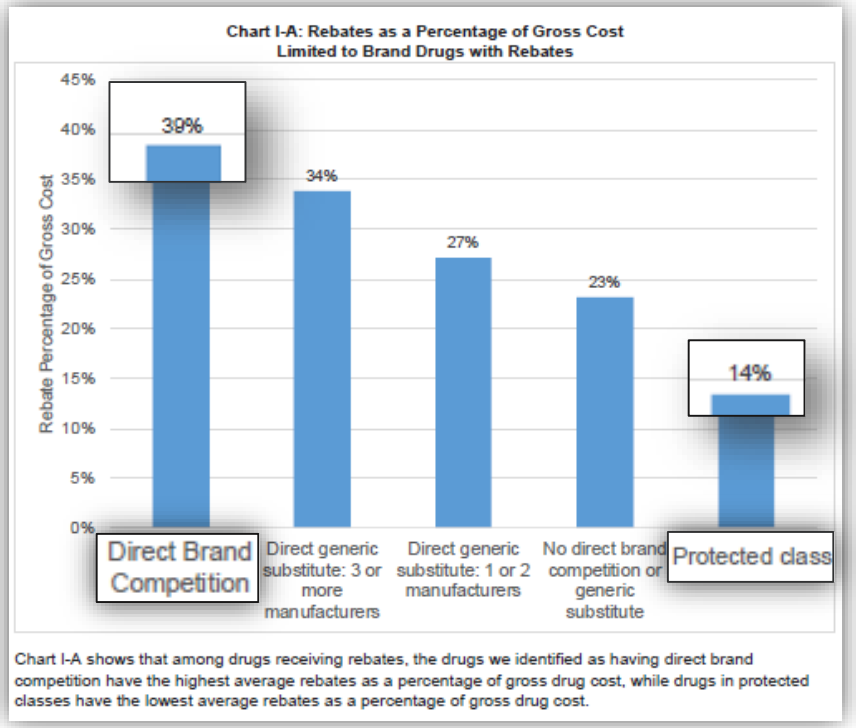


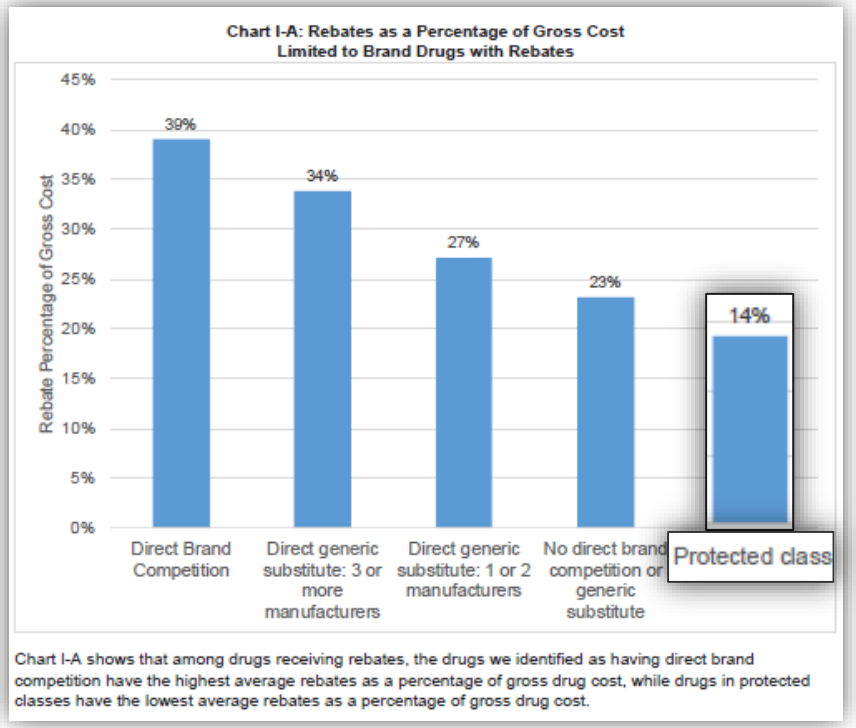
Chart I-A shows that among drugs receiving rebates, the drugs we identified as having direct brand competition have the highest average rebates as a percentage of gross drug cost, while drugs in protected classes have the lowest average rebates as a percentage of gross drug cost.

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***

https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf

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)

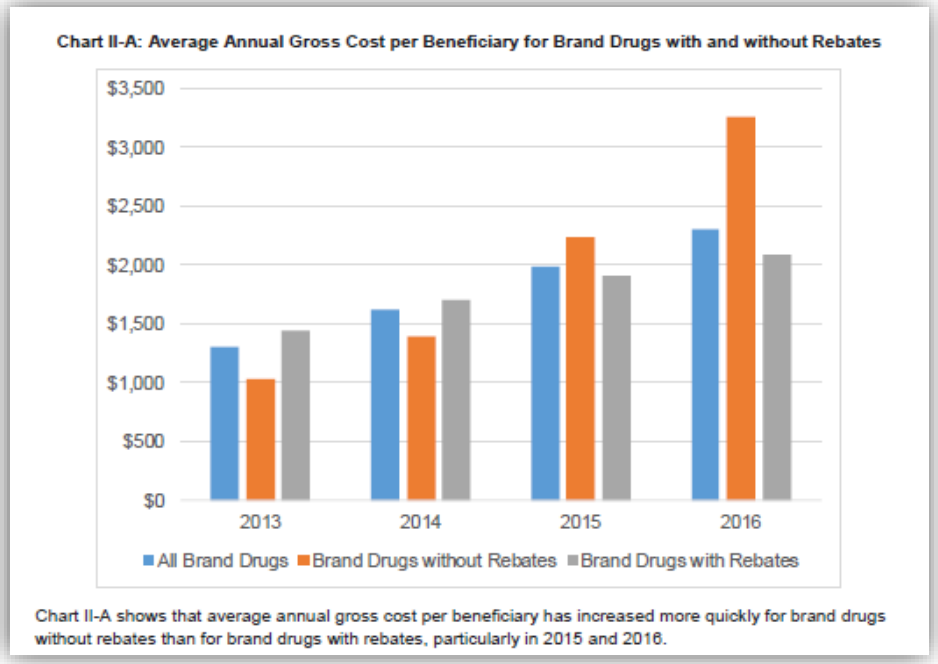
https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf

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.



https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf

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

Chart II-B: Average 2016 Annual Gross Drug Cost, 2016 Rebates and 2013 to 2016 Price Trend By Percentage (of Gross Cost) Manufacturer Rebate Quartile Limited to Brand Drugs with Rebates

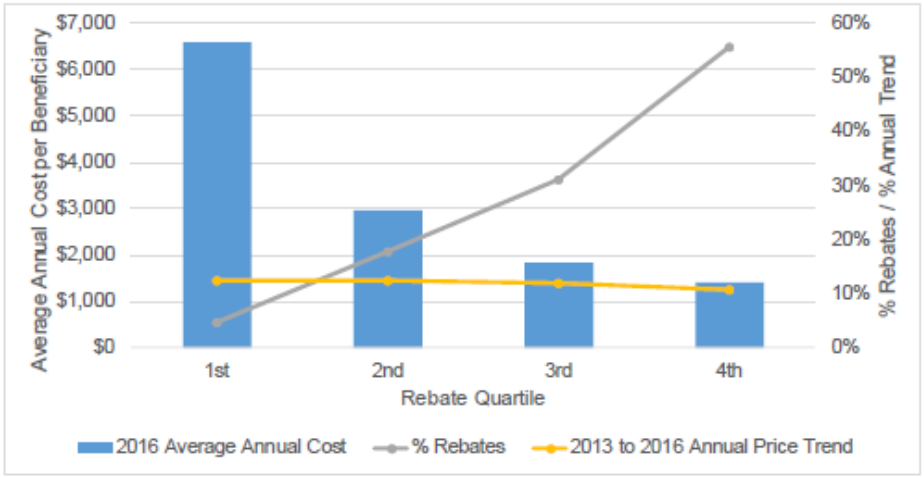
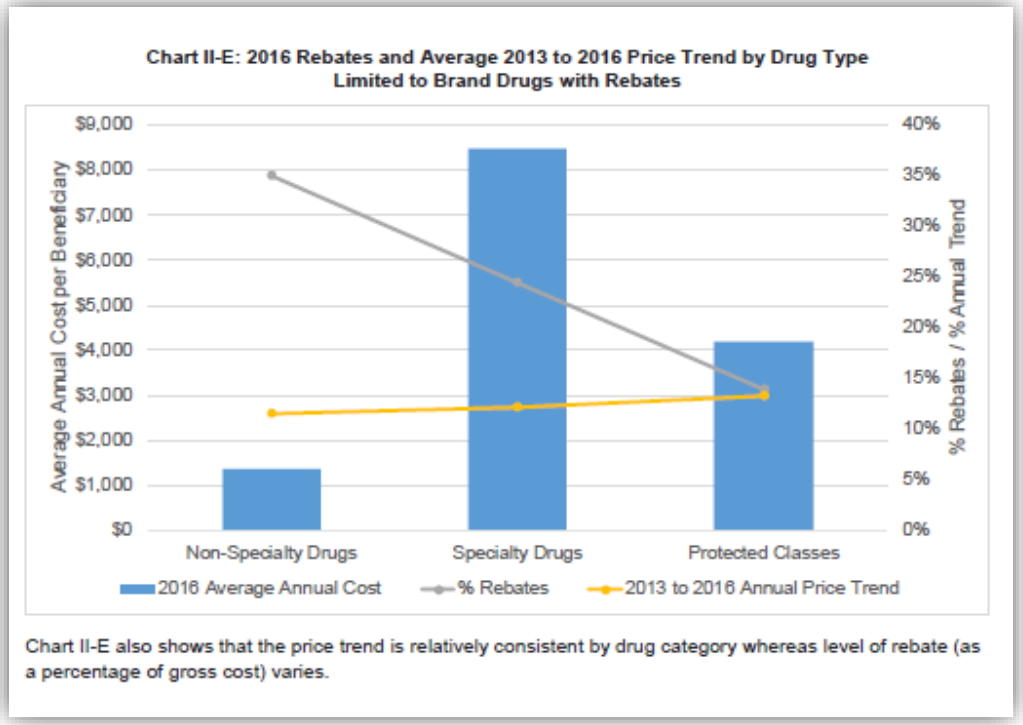


Chart II-B shows that among brand drugs with rebates, the average annual cost per beneficiary decreases (blue bars) as the average rebate (as a percentage of gross cost) increases (gray line). However, the average 2013 to 2016 price increases (yellow line) are similar for all four quartiles of rebate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

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

https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf

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***

https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf

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

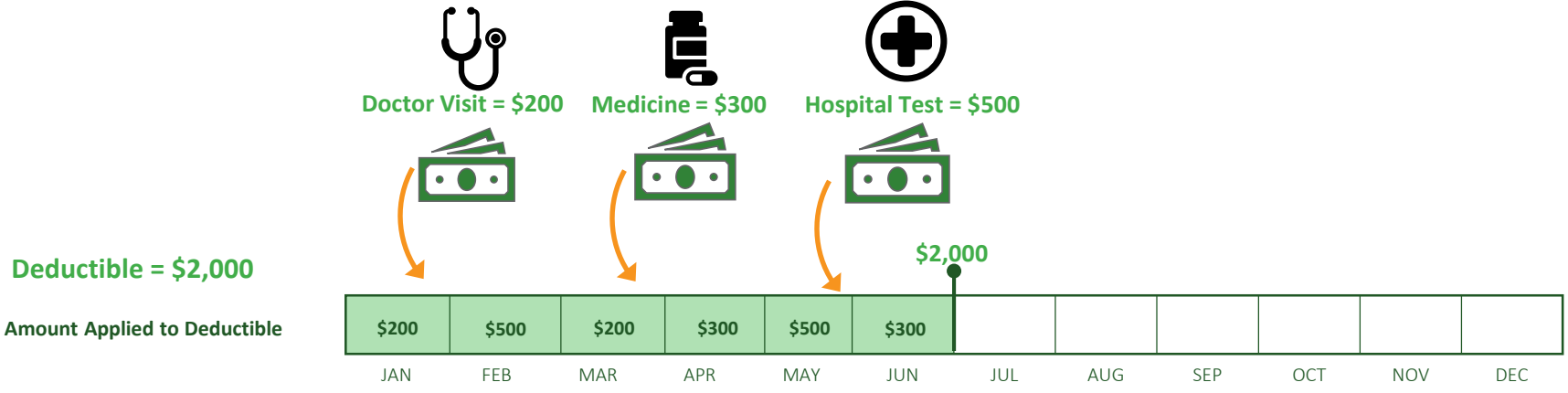
In a 2017 study on copay coupons, the researchers took neighboring states that had differing approaches to copay coupons to analyze the impact coupons have on generic utilization and drug spending.†

	Massachusetts	New Hampshire
Coupons Allowed?	**NO** - Massachusetts banned the use of coupons statewide	**YES** - New Hampshire allows coupon use in non-federal programs
Drugs Not Offering Coupons	When branded drugs did not offer coupons, **use of generic alternatives was equivalent** in both states	
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.



How Do Copay Coupons Work?

Without Copay Coupon Tracking (i.e. *"copay coupon accumulator"*)

EXAMPLE

MANUFACTURER:
Abbvie

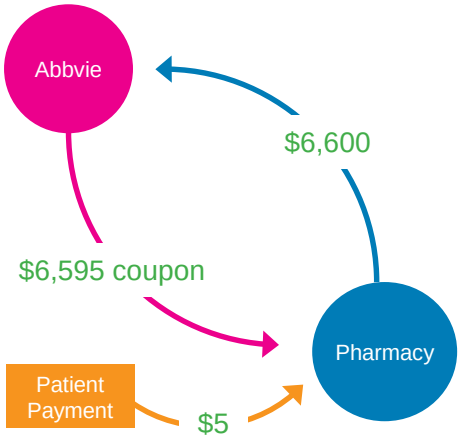
DRUG:
Humira

DRUG PRICE:
$6,600

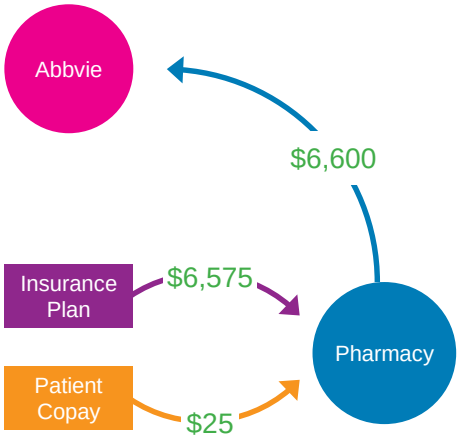
COUPON AMOUNT:
$6,595 (Typically 1 Month, Assuming Deductible is Reached)

PATIENT'S DEDUCTIBLE:
$2,000

MONTHS 1



MONTHS 2-12



Deductible = $2000

$6,600 Total Price Applied to Deductible (and Annual Out-Of-Pocket Maximum Limit)

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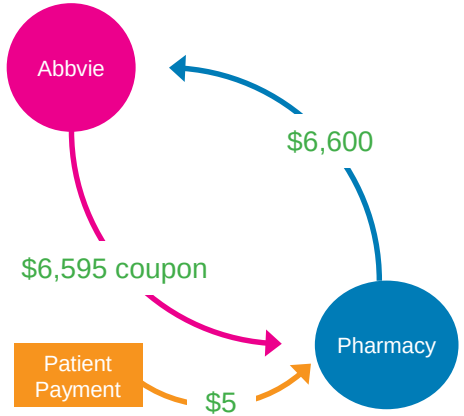
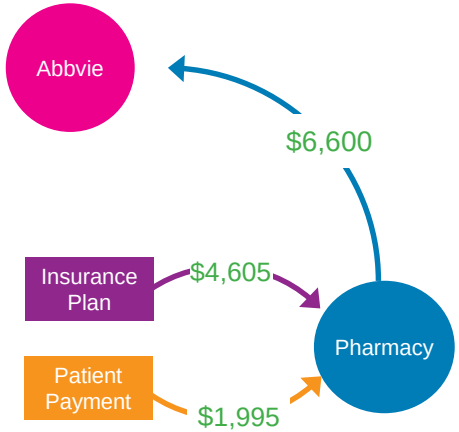
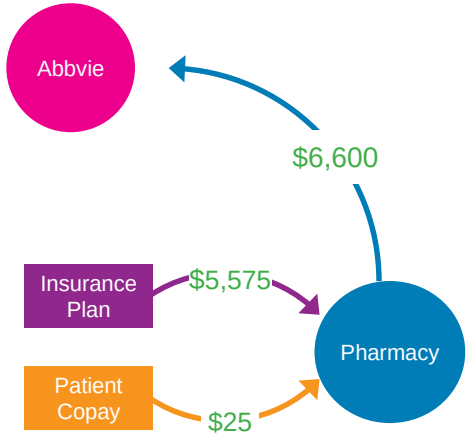


MONTH 2



MONTHS 3-12



Deductible = $2000

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

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