Questions and Answers about Pharmacy Benefit Companies and the Services They Offer

How do pharmacy benefit companies save money for health plan sponsors and patients?

According to research, pharmacy benefit companies save health plan sponsors and patients $1,040 per person per year. Much of this direct savings comes from the rebates and discounts that pharmacy benefit companies negotiate from drug companies. But pharmacy benefit companies do far more than just negotiate rebates. Pharmacy benefit companies provide at least $148 billion in value for the health care system every year. In addition to negotiated drug company rebates, pharmacy benefit companies also negotiate pharmacy discounts, facilitate mail delivery of prescriptions, accelerate the pace of new drug innovation, promote the use of cheaper generic drugs, help patients stay on their drugs to reduce overall health care expenditures, and reduce health care related tax distortions.

What are pharmacy benefit companies doing to help patients afford their medications?

Pharmacy benefit companies provide affordable access to prescription drugs for 275 million people every year, which is over 3.6 billion scripts filled annually. Without pharmacy benefit companies, the savings they negotiate, and prescription drug coverage, patients could pay list prices – sometimes incredibly high list prices – for their prescriptions. Pharmacy benefit companies have programs to help patients who face high cost sharing, including those in their deductible phase. Pharmacy benefit companies encouraged the U.S. Department of Treasury to expand the list of preventive care for health savings account (HSA) participants to include a wider range of drugs used to treat chronic conditions like asthma and heart disease. The U.S. Department of Treasury now allows preventive care prescriptions, including insulin, to be covered at no or low cost sharing ahead of an enrollee meeting the deductible in high deductible health plans.

What are formularies and why do pharmacy benefit companies use them?

A formulary is a continually updated list of prescription drugs approved for reimbursement by the pharmacy benefit company's payer clients. In coordination with clinical experts on a pharmacy and therapeutics (P&T) committee, pharmacy benefit companies typically develop a recommended formulary for payers, who may customize it. Prescription drug formularies give patients financial incentives to use the most clinically effective and cost-effective generic and brand drugs. When there are multiple drug options that are equally effective at treating a medical condition, pharmacy benefit companies are able to use formulary placement to encourage manufacturers to offer price concessions, typically by lowering cost sharing for the less expensive drug to encourage its use over costlier drugs that provide no meaningful additional clinical benefit.

Can patients access drugs that are not on their plan formulary?

Pharmacy benefit companies do not make decisions about what drugs a patient can access or prevent access to a drug. Pharmacy benefit companies recommend drugs for insurance coverage based on clinical evidence and health plan sponsors design benefits accounting for those recommendations. Health care providers have the final say on what to prescribe to patients. Typically, health coverage includes appeals mechanisms for drugs that may be

excluded from coverage for a given patient. If, after the appeals process has been exhausted, a drug is not covered by a patient's health plan, the patient can purchase the drug outside of the plan. Options exist to help with the cost of drugs purchased with or without insurance.

Why are brand drugs sometimes recommended for formulary placement over generics?

In very rare instances, brand manufacturers discount their drugs to a degree that places their cost below that of competing generics. When the first generic competitor comes to market, it has six months where it competes exclusively with the brand product. Because competition is still very limited during this period, first-to-market generics typically arrive at a higher price than subsequent generic products, and brand manufacturers offer significant rebates to undercut the generic and retain market share. Pharmacy benefit companies seek to save patients and plan sponsors money by recommending the lowest net cost drug for formulary placement.

How do pharmacy benefit companies encourage generic drugs?

Generic drugs offer significant cost savings to health plan sponsors, so pharmacy benefit companies recommend formularies that give patients incentives to use generic drugs instead of more expensive competing brand drugs. Thanks to these incentives, the generic dispensing rate in the US is 90%, and when they are available, generic drugs are dispensed 97% of the time.

What are utilization management (UM) tools and why do pharmacy benefit companies use them?

The most common utilization management (UM) tools are prior authorization (PA) and step therapy (ST), which promote use of clinically appropriate, cost-effective medications. PA ensures that a medication being dispensed is clinically appropriate, safe, and cost effective for the patient. ST encourages trying proven, more affordable therapies before drugs that cost more. The Government Accountability Office (GAO) has found that use of UM tools was associated with cost savings and improved health outcomes. These tools do not prevent access to a therapy. Prescribers can submit PA requests electronically to speed the approval process, and there are additional exceptions processes available that prescribers can choose in certain circumstances.

What happens to drug company rebates on insulin?

Pharmacy benefit companies negotiate rebates from drug companies in exchange for placement on drug formularies. Rebates on insulin tend to be higher than in other drug classes. Once rebates are negotiated, they are usually "passed through" the pharmacy benefit company to the health plan sponsor. According to GAO, 99.6% of rebates in Part D are passed through to plan sponsors, not kept by the pharmacy benefit companies. In the commercial market, 91% of rebates are passed to plan sponsors. Plan sponsors choose what to do with rebate dollars, which includes lowering premiums and cost sharing and enhancing benefits.

Why do pharmacy benefit companies keep specific rebate levels confidential?

Rebates are proprietary contractual information. Given the sensitive nature of the information, pharmacy benefit companies do keep them confidential. If rebate amounts were made public, manufacturers that discovered they were giving greater price concessions than competitors

would stop doing that, which would increase costs. (This is considered tacit collusion). The Federal Trade Commission (FTC) has repeatedly warned against policies that require rebate disclosure as leading to tacit collusion, lower rebate levels, higher drug prices, and represent a significant threat to competition, a position also taken by the Congressional Budget Office (CBO). Additionally, The Department of Justice (DOJ) has noted the dangers of improper transparency and how it often leads to tacit collusion.

Do pharmacy benefit companies support transparency?

Pharmacy benefit companies are strongly in favor of transparency that provides usable information for plan sponsors, providers, and patients. Tools like real time benefit tools (RTBT), electronic prior authorization (ePA), and electronic prescribing (eRx) reduce burdens and provide actionable information. Pharmacy benefit companies also provide plan sponsors with financial information savings they've secured on prescription drugs, fees, and payments made as part of the contract, aggregate data on drug utilization and plan enrollees, and details about how much will be paid for each drug filled under the plan. This information helps plan sponsors make the best plan choices for them and the people they enroll in prescription benefit coverage. They also submit to regular contractually required audits conducted by plan sponsors. Misguided transparency proposals that require disclosure of proprietary information will lead to tacit collusion by drug companies and higher drug prices.

How do pharmacies negotiate with pharmacy benefit companies?

Pharmacies negotiate reimbursement rates with pharmacy benefit companies. These rates are based on drug acquisition costs, taxes, and fees charged by the pharmacy. Pharmacy benefit companies require pharmacies to be appropriately licensed, in compliance with state and federal laws, and able to perform the duties for which they have been contracted. While independent pharmacies can choose to directly negotiate their contracts with pharmacy benefit companies, most – 83% – choose to join a pharmacy services administrative organization (PSAO). PSAOs are collective bargaining groups that leverage their member pharmacies to negotiate contracts with pharmacy benefit companies. The PSAO marketplace is dominated by the big three wholesalers: AmerisourceBergen, Cardinal Health, and McKesson. Over 75% of independent and small-chain pharmacies contract with a PSAO owned by one of these wholesalers. PSAOs operate as black boxes, with virtually no state or federal regulation or oversight. Independent pharmacies on average negotiate higher reimbursement rates than chain drugstores.

Do pharmacy benefit companies force independent pharmacies to close?

Pharmacies are important partners for pharmacy benefit companies, who help make drugs accessible and affordable for patients. Rather than being in decline, the independent pharmacy market is stable and profitable. Over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5%. Over the last five years, the number of independent pharmacies has increased 0.5%, indicating a stable marketplace. In fact, independent pharmacies' financials have also been stable. From 2016 to 2020, the average per prescription gross profit margin for independent pharmacies ranged from 20.8% to 21.1%, showing little fluctuation.

How has the FTC historically viewed the pharmacy benefit industry?

Over the last two decades, the FTC has repeatedly looked at pharmacy benefit companies. Each time they have concluded that the industry is competitive and lowers drug costs for consumers. For example, the FTC has sent letters to lawmakers in various states arguing that proposed state laws would have anticompetitive effects and would lead to higher drug costs, and that concerns about conflicts of interest were "not prevalent."

How competitive is the pharmacy benefit company marketplace?

The pharmacy benefit company marketplace is highly competitive, with 70 full service pharmacy benefit companies operating in 2021. And this number is increasing, with nearly 10% more pharmacy benefit companies in 2021 than in 2019. Companies differentiate themselves through product innovation and client services.

How does Costco provide good prices on drugs to their members?

Costco members are offered Costco Member Prescription Program (CMPP), which is a direct-to-members savings program administered by Costco Health Solutions, Inc. and Ventegra, Inc., both of which are pharmacy benefit companies. Costco fully owns Costco Health Solutions, Inc., which also offers pharmacy benefit services to small- and medium-sized businesses. Ventegra, Inc. is a small pharmacy benefit company that bills itself as offering innovative cost-saving solutions. In addition to owning Costco Health Solutions, Inc., Costco has also owned since 2020 a minority stake in Navitus Health Solutions, another pharmacy benefit company that defines itself in the marketplace as an industry disrupter.

What are Medicare Star Ratings and how do they apply to pharmacies?

The Centers for Medicare & Medicaid Services (CMS) created the Medicare Part C and D Star Ratings metrics to give Medicare beneficiaries important (and standardized) information about the quality and performance of their plan choices. Medicare plans are rated on a 1-to-5-star scale for each measure. There are five measures that relate to prescription drug use, all of which have been endorsed by the Pharmacy Quality Alliance (PQA). Participation in these metrics by all Part D plan sponsors is required by CMS, and to meet those metrics, plans rely on their contracted pharmacy benefit companies, which also contract with their network pharmacies to help meet the metrics. These metrics include:

- Medication Adherence for Diabetes Medications;
- Medication Adherence for Hypertension (RAS antagonists);
- Medication Adherence for Cholesterol (Statins);
- MTM Program Completion Rate for Comprehensive Medication Review (CMR); and
- Statin Use in Persons with Diabetes.

Are pharmacy benefit companies regulated by state and federal governments?

Pharmacy benefit companies are subject to regulations promulgated by the Department of Health and Human Services (HHS), the Department of Labor, the Department of the Treasury, and states. pharmacy benefit company practices are overseen by state Medicaid agencies, state-based consumer protection agencies, private accreditation organizations, and their own

clients – health plan sponsors. Pharmacy benefit companies are also directly regulated by state departments of insurance or other state agencies.

Several federal departments and agencies require extensive reporting from various health care entities on drug pricing, which require input from pharmacy benefit companies. Pursuant to requirements in the Affordable Care Act (ACA), CMS requires reporting by pharmacy benefit companies for Exchange plans and Medicare Part D of data on generic dispensing rate (by pharmacy type); the aggregate amount and type of rebates, discounts, or price concessions that are attributable to patient utilization, those that are passed on to the plan sponsor; the total number of prescriptions that were dispensed; and the difference between the amount the health plan pays the pharmacy benefit company and the amount that the pharmacy benefit company pays retail and mail order pharmacies. Part D plans and the pharmacy benefit companies that administer them must also implement real-time benefits tools to give patients and prescribers cost sharing and benefits information at the point of prescribing.

Medicare Part D plans must submit Prescription Drug Event (PDE) records, a summary of Part D claims activities for each drug dispensed to CMS. When plans submit PDEs to CMS for payment, they include any pharmacy dispensing fee. As part of the bid and reconciliation processes, pharmacy benefit companies (via the Part D plans) must report estimated pharmacy and manufacturer Direct and Indirect Remuneration (DIR), including rebates and other price concessions.

The Departments of the Treasury, HHS, and Labor and the Office of Personnel Management require pharmacy benefit companies to report:

- The 50 most frequently dispensed brand prescription drugs;
- The 50 costliest prescription drugs by total annual spending;
- The 50 prescription drugs with the greatest increase in expenditures from the previous year;
- Prescription drug rebates, fees, and payments by drug manufacturers in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates; and
- The premium and out-of-pocket cost impact of prescription drug rebates, fees, and other payments.

Pharmacy benefit companies may report these data directly to the government or to their clients. The clients (plan sponsors, issuers, and the FEHB program carriers generally) are required to submit this information aggregated at the state/market level, rather than separately for each plan. The tri-agencies are required by statute to issue a report on trends biannually.

Beyond government reporting requirements, much of the pharmacy benefit company's operational specifics are available to plan enrollees through other provisions of the ACA and Social Security Act including the Summary of Benefits and Coverage, Medicare Plan Finder, and real-time benefit tools that provide current information on prescription drug benefits. The Securities and Exchange Commission (SEC) also requires publicly traded health plans and pharmacy benefit companies to report quarterly and annual financial information to the SEC.

What are benefit consultants and who pays them?

Benefit consultants are organizations hired by plan sponsors – employers, unions, retirees, etc. – to provide information about how to optimize the dollars they have available to provide benefits to their employees, members, or participants. These benefits usually include health insurance, prescription drug coverage, dental and vision plans, employee assistance plans, retirement plans, and paid leave, but can include myriad other incentives.

Benefits consultants typically oversee the request-for-proposal (RFP) process that self-funded employers use to select their pharmacy benefit company, including establishing the key parameters employers should consider in selecting a pharmacy benefit company, evaluating the RFPs received from pharmacy benefit companies, and recommending finalists for their clients' consideration.

Would point of sale rebates save money in Medicare Part D?

The Congressional Budget Office (CBO) estimated that the 2020 rebate rule, which would require point-of-sale (POS) rebates in Part D, would cost taxpayers $177 billion over ten years. The rule was also expected to increase premiums by an average of 25% and to provide drug manufacturers with a $40 billion windfall. Implementation of the rule has been delayed until 2032.

Why would it be inappropriate to name pharmacy benefit companies as fiduciaries?

An entity with a fiduciary duty must act in a way that will benefit someone else financially. To execute this duty, the fiduciary would need decision making authority. Pharmacy benefit companies do not hold such authority. Pharmacy benefit companies recommend and administer benefits, but they do not make decisions on behalf of plan participants. Plan sponsors are responsible for those decisions. In addition, pharmacy benefit companies contract with plan sponsors, and if they had a fiduciary duty, it would need to be to the plan sponsor as the party with which they contracted. Naming them as a fiduciary for patients as well as for the plan would be a conflict as the pharmacy benefit company could not owe a financial duty to both parties.

What is DIR and how did CMS change it?

Direct or Indirect Remuneration (DIR) is a term specific to the Medicare Part D program, although some use this term more widely. DIR covers both manufacturer and pharmacy price concessions paid to either a Part D plan sponsor or its contracted pharmacy benefit company, and it includes direct and indirect discounts, rebates, coupons, incentive payments, and other price concessions. Pharmacy DIR includes price adjustments between the pharmacy benefit company and the pharmacy that serve to change the final cost of the Part D drug. Payments that meet CMS's definition of DIR must be reported to CMS by June of the following year. These amounts are used by CMS in determining Part D plan payments to help reduce beneficiary premiums.

Point of Sale (POS) pharmacy price concessions are retrospectively reconciled based on value-based benchmarks (e.g., generic dispensing rates, patient refill (adherence) rates, medication therapy management services, counseling services, and volume-base price concessions based

on pharmacy foot traffic) agreed to in pharmacy benefit company-pharmacy contracts. Pharmacy payments can be increased or decreased based on pharmacy performance. DIR is not a retrospective "fee" assessed to pharmacies. Price reconciliations are based on performance in accordance with the contract.

In 2022, CMS revised the rules around DIR. In 2024 the term "negotiated price" will change to mean the price upon which pharmacy benefit companies must calculate cost sharing. The new rule requires that beneficiary cost sharing must be based on the lowest amount the pharmacy would be paid after accounting for any pharmacy DIR adjustments, which should reduce beneficiary cost sharing to some degree. When the rule was proposed, CMS acknowledged that pharmacy reimbursement based on the lowest possible reimbursement would reduce direct pharmacy payments by about $40 billion over the 2023-2033 period. Pharmacies submitted comments in support of this reduction. With respect to pharmacy contracting, it is unclear exactly how Part D plans will implement the new requirement; more will be known when the plans for 2024 are finalized.

How are pharmacy benefit companies paid?

In addition to making final decisions on benefit design and coverage, employers and health plan sponsors (i.e., payers) also choose how they would like to pay for the services and programs pharmacy benefit companies deliver to them. There are two main choices that employers and health plans make when hiring a pharmacy benefit company:

Risk Mitigation Contracting:

- The employer or health plan pays their pharmacy benefit company a set reimbursement amount for each drug, regardless of where the patient fills the prescription. If the patient's pharmacy charges the pharmacy benefit company more than that set reimbursement rate, the pharmacy benefit company takes a loss. If the patient's pharmacy charges less than the set reimbursement rate, the pharmacy benefit company earns a margin (i.e., the spread). Smaller employers often choose what are referred to as "spread contracts" because of the pricing predictability and savings they derive.
- Alternatively, the employer or health plan may choose to pay the pharmacy benefit company a fee to administer the claims and pay the pharmacy benefit company whatever the pharmacy charges (based on the pharmacy/pharmacy benefit company contract). Many large employers prefer this compensation model over a risk mitigation (spread) model because they have the scale to absorb reimbursement variability.

Rebate Contracting:

- Employers and health plan sponsors may also choose to allow the pharmacy benefit companies to keep a small portion of the drug company rebates, or discounts, as a way to incentivize pharmacy benefit companies to negotiate deeper discounts. While this aligns incentives toward deriving cost savings, it is a less common payment model.

- Alternatively, employers and health plan sponsors may choose to keep 100 percent of the rebates and pay the PBM fees for negotiating rebates and setting up a formulary.