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Pharmacy Benefit Management: Are Reporting Requirements Pro- or Anticompetitive?

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ABSTRACT *The market-based US healthcare system relies on pharmacy benefit managers (PBMs) to control pharmaceutical costs, in contrast to most other countries that regulate drug prices and access. Optimal structuring and regulation of PBM contracts pose significant agency challenges for private and public payers. However, recent reporting requirements for PBMs may be counterproductive and reflect the interests of competitors rather than customers.*

Key Words: Pharmaceuticals; Pharmacy Benefit Management; Insurance; Transparency; Regulation.

JEL classifications: D4; I13; I18; L8.

1. Introduction

Insurance coverage for drugs provides consumer protection but also reduces consumer demand elasticity. This creates both consumer moral hazard (use of low benefit care) and producer moral hazard (producers charge higher prices). US insurers/payers manage pharmacy benefits to restrain these effects, using formularies of covered drugs and patient cost-sharing, negotiating prices charged by drug manufacturers and pharmacies, and processing claims. Self-insured employers and many smaller health plans contract out these functions to specialized pharmacy benefit managers (PBMs), while some large health plans have developed in-house PBMs.

In response to concerns of whether payers have the information necessary to contract efficiently for these services, recent legislation has increased data reporting requirements for PBMs. Reporting of cost data to the government was required for prescription drug plans (PDPs) that perform PBM functions for Medicare Part D, and the Affordable Care Act requires data reporting by PBMs serving health plans in insurance exchanges. Similar requirements have been proposed for data reporting to self-insured employers.

Previous literature on PBM data reporting requirements has questioned the need for data reporting and recognized that in the context of oligopoly,

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transparency of competitor prices may facilitate collusion.[1] This article contributes to this literature by reviewing empirical evidence on concentration in this industry, with the two largest PBMs accounting for 59% of industry revenues in 2013, and the limited extent of competitive entry over the last decade. It also reviews recent survey evidence of employer contracting with PBMs. Competitive dynamics in this industry are complex, because the independent PBMs are both suppliers to large health plans and sometimes competitors with their in-house PBMs. Similarly, because large PBMs operate mail-order pharmacies, they are both customers of retail pharmacies and competitors. Any mandates for data reporting should evaluate the demand from employer customers and also consider potential anticompetitive effects in the market for PBM services and pharmacy services.

In this article, Section 2 outlines the basic business model of PBMs, including their roles as suppliers to health plans and competitors, and as both purchasers from retail pharmacies and competitors, through PBMs' operation of mail-order pharmacies. Section 3 describes the industry structure and evidence on competitive entry. Section 4 discusses survey evidence from PBM customers. Section 5 evaluates proposals for data reporting and concludes.

2. The PBM Business Model

PBMs use a range of strategies to manage and administer pharmacy benefits on behalf of payers/sponsors.[2] These strategies include management of drug utilization and negotiation of rebates on drug prices, by means of formularies with tiered patient cost-sharing and access controls; negotiation with retail pharmacies for discounts on drug prices and dispensing fees, in return for participation in the preferred pharmacy network; claims processing and reimbursement of retail pharmacy claims; and operation of mail-order pharmacy. The basic principle is that PBMs can drive discounts on drug prices and pharmacy fees by restricting patients' choice of drugs or pharmacies, thereby increasing volume for preferred suppliers that accept the discounted prices. Thus, more restrictive drug formularies or pharmacy networks generally obtain larger discounts.

2.1. Strategies

2.1.1 Formulary Structure

PBMs (sometimes in conjunction with a health plan's Pharmacy and Therapeutics Committee) structure a formulary of covered drugs and associated patient cost-sharing. Most formularies now have three or four tiers. The lowest tier covers generics, with average co-pay of $11; the second tier includes preferred brands, with average co-pay of $30; the third tier includes nonpreferred and off-patent brands, with average co-pay of $56 (PBMI 2013). Many plans also have a fourth tier for expensive specialty drugs, often with a co-insurance of 20–30% of drug price. Utilization of nonpreferred and specialty drugs may be further managed through requirements that physicians obtain prior authorization and/or that patients first try less costly alternatives ("step edits"). Large self-insured employers may structure their own formulary, but smaller self-insured employers usually choose one of several standard

2.1.2 *Negotiating Drug Rebates with Pharmaceutical Manufacturers*

Restrictive formulary structures enable PBMs to "shift market share" to preferred drugs with relatively low patient cost-sharing and possibly other access controls. PBMs may enhance share shifting by encouraging pharmacies to call the patient's doctor to authorize switching to preferred drugs.[3] PBMs' ability to shift share enables them to negotiate discounts/rebates off list prices from branded drug manufacturers, in return for preferred placement and increased market share for their drugs. PBMs' ability to shift share and thereby negotiate rebates is greatest in therapeutic classes with several drugs of very similar efficacy, such that physicians and patients accept restrictions on their choice and are sensitive to modest cost-sharing differentials. Drug price rebates are typically paid by electronic transfer from the drug manufacturer to the PBM, on evidence of preferred formulary status and/or increased drug utilization. The pass-through of the drug rebates by PBMs to plan sponsors has been a contentious issue, but recent evidence suggests that most sponsors capture most of the rebates (see below).

2.1.3 *Contracting for Discounted Pharmacy Costs*

When pharmacies dispense drugs to patients, they add a mark-up to the ex-wholesaler price at which they purchased the drugs, to cover their inventory and other costs, and a dispensing fee for their time. An important source of PBMs' cost savings for payers is the negotiation of discounts on pharmacy mark-ups and dispensing fees. Under pressure from retail pharmacy associations, many states have enacted Any Willing Provider laws that require PBMs to contract with any pharmacy willing to accept their fees.[4] Theory and evidence suggest that such laws lead to higher costs to consumers, by limiting PBMs' ability to contract selectively in return for discounted fees (FTC 2014).

2.1.4 *Processing Pharmacy Claims*

PBMs provide convenience for pharmacies and patients by providing IT services that enable pharmacies to verify at point-of-sale whether a drug is covered by the patient's plan and their co-payment. The pharmacy then collects the co-pay from the patient and bills the PBM for the remaining drug cost and dispensing fee, at agreed rates.

2.1.5 *Mail-Order Pharmacy Dispensing*

All major PBMs operate their own mail-order pharmacies that dispense medications through the mail. PBMs offer patients lower cost-sharing on drugs dispensed through the mail, to encourage acceptance of mail dispensing.

2.1.6 *Other Functions*

In addition to these basic services, large PBMs offer a range of other services, including drug utilization review, compliance and therapy management, and specialty pharmacy services such as home infusion.

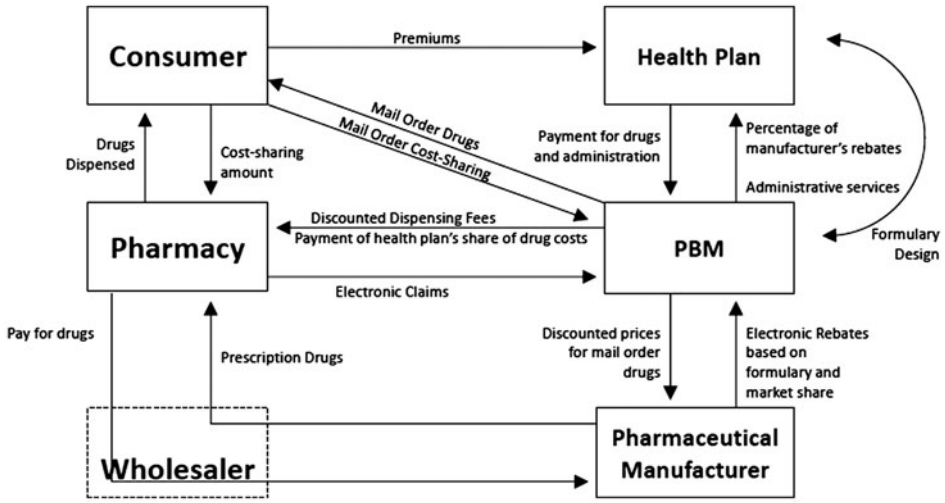
Figure 1 shows the flow of money and goods in pharmacy benefit management. Pharmaceutical manufacturers typically sell their drugs to wholesalers that distribute the drugs to pharmacies, including PBMs' mail pharmacies. PBMs contract with and collect rebates from drug manufacturers, contract with and reimburse retail pharmacies, and dispense drugs through their mail pharmacies.

2.2. How PBMs Make Money

Although the survival and growth of PBMs suggests that on balance they offer net savings to plan sponsors on essential claims processing, management of drug utilization and prices and management of pharmacy dispensing costs, nevertheless concerns have been raised over how far PBMs pass through the savings realized and whether sponsors have the information needed for informed contracting. In particular, the following components of PBM revenues are at issue:

2.2.1. Spreads on Retail Pharmacy-Dispensed Drugs. PBMs capture the spread between the prices at which they are reimbursed by sponsors and the prices they pay to pharmacies for dispensed drugs. These contractually agreed prices are typically expressed as a percentage of a widely available list price benchmark, most commonly average wholesale price (AWP). For example, the PBM may reimburse pharmacies for drugs at AWP minus 18% plus a $1 dispensing fee. The PBM contracts for reimbursement from the sponsor at a somewhat smaller discount off AWP, say AWP minus 16% plus a $2 administration fee per script. The difference between the sponsor's payment to the PBM and the PBM's payment to the pharmacy (the "retail spread") is a significant source of PBMs' net revenue.

These payment rates from PBMs to pharmacies and from pharmacies to wholesalers are complex and not generally known to plan sponsors.



Manufacturers of on-patent brand drugs typically sell their drugs to wholesalers at the manufacturer's list price or wholesale acquisition cost (WAC), net of any discounts for prompt payment and so on. Manufacturers also supply their list price(s) to third party database companies such as Medi-Span that calculate and publish the AWP. AWP is generally based on the standard formula (WAC + 20%), but if manufacturers also list a suggested wholesale price (SWP), Medi-Span sets AWP at the manufacturer's SWP.[5] Thus, for on-patent brand drugs AWP is a list price that is usually higher than and roughly but not strictly proportional to the price the wholesaler actually paid. Wholesalers distribute drugs to pharmacies, adding their own margin, and retail pharmacies add their own mark-up to the drug price plus a dispensing fee. In a cash transaction to a self-pay patient, this marked-up retail price would be charged in full to the patient. PBMs reduce costs for sponsors by negotiating discounts on the pharmacies' customary drug mark-ups and dispensing fees.

2.2.2. *Generics.* Managing generics has been a major source of PBM savings for payers. Under most state substitution laws, pharmacies are authorized to substitute any bio-equivalent generic for the brand, even if the physician prescribes the brand, unless the physician explicitly notes "brand required." PBMs incentivize patients to accept generic substitution, by offering much lower cost-sharing on generics. PBMs also incentivize pharmacies to substitute low priced generics by reimbursing pharmacies for generics using a maximum allowable cost (MAC). The MAC is the same for all generic versions of a drug, and is based on the PBM's estimate of generic acquisition cost to pharmacies. MAC reimbursement incentivizes pharmacies to use the lowest cost generic available as the pharmacy captures the spread between the MAC and its acquisition cost. MAC reimbursement thus also incentivizes generic suppliers to offer price discounts to pharmacies. Over time, PBMs revise down their MAC, based on actual pharmacy acquisition cost for generics, thereby capturing (some of) the savings from competitive discounting by generic manufacturers to pharmacies. Unlike AWP, which is a list price schedule set by third party database companies, each PBM sets its own MAC reimbursement prices for pharmacies (Eberle and Van Amber 2008). The majority of PBM contracts with plan sponsors (75%) bill for generics based on MAC pricing, and the remainder bill for generics using discounted AWP (PBMI 2013). PBMs earn a spread on generics dispensed through retail pharmacies, as they do on brand drugs. However, retail pharmacies retain significant discounts on generics.[6]

2.2.3. *Mail-Order Pharmacy Business.* Mail dispensing substitutes the PBM's own dispensing costs for those of retail pharmacies. Mail dispensing may also enhance a PBM's ability to ensure patient adherence and formulary compliance, because the PBM can ensure that their in-house pharmacist calls physicians to switch patients to preferred drugs and contacts patients with reminders for prescription renewal. PBMs' enhanced ability to influence

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