



New breed of PBMs are poised to address transparency in healthcare

Specialty pharmaceuticals, generic drugs and Part D help feed the need for pharmacy benefit administrators to offer transparency

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WHEN CULTURES ENTER Renaissance periods, new learning and ideas create transition. Heightened interest in the workings of pharmacy benefit management and subsequent changes in business philosophy represent a Renaissance for managed care. All key stakeholders will feel the ripples of change: payers, physicians, pharmacists, patients and pharmaceutical companies.

Since their creation in the early 1990s, pharmacy benefit management companies (PBMs) have lowered the unit cost of prescription drugs by obtaining discounts from pharmacies and rebates from drug companies. Savings have been significant. While unit cost discounts remain important, healthcare purchasers' needs have changed. Currently, improving patients' pharmaceutical utilization and drug-related outcomes is imperative. Now, contractual relationships with physicians and patients will be needed. Health plans and disease management companies are better established with these target audiences, however, to influence outcomes, health plans and disease management companies will need sophisticated decision support tools. PBMs must reposition themselves to address these needs.

In the 1990s employers perceived receipt of now controversial PBM-generated brand name drug rebates as a true value. Although there are numerous types and definitions of "rebate," one revenue model—using costlier brand name drugs to generate larger rebates—has been widely criticized. Some audits of PBM claims data revealed a negative impact on total drug costs, and affected employers perceived some practices were misleading or fraudulent. These misaligned priorities included redefinition of rebates as administrative fees, data fees, or detailing fees re-

tained by the PBM, not passed on to the health plan. Lawsuits sometimes followed.

Marketplace opportunities shifted; larger PBMs with established customer relationships became less attractive to employers, and new and/or smaller PBMs developed a market edge. Hence, pharmacy benefit administrators (PBAs)—PBMs with a transparent business model—were born and pass-through pricing has become an essential business offering (see Table 1, page 48).

SPECIALTY PHARMACEUTICALS

The subset of drugs and biologics dubbed "specialty pharmaceuticals" (see Table 2, page 48) represent great discoveries akin to those that changed life in the Renaissance; their value is unquestionable. (Often referred to as "large molecules," these agents are complex sugars or proteins, not chemicals like most traditional drugs.) The specialty pharmacy market has traditionally addressed high-maintenance biologics and other high-cost medications. The small number of patients currently using specialty pharmaceuticals (less than 0.5%) has kept them below most payers' radar screen. Specialty pharmacy represents a \$40 billion market, and estimates approach \$75 billion by 2008. This rapid market growth of about 20% annually makes specialty pharmaceuticals attractive to PBMs and will have payers paying closer attention to the high per-member-per-year costs of these agents. The fact that 150 new specialty pharmaceuticals are in the Food and Drug Administration's (FDA) approval channels mandates involvement in this market segment for survival.

With retail and traditional mail service

Table 1. Some PBMs with transparency*

Catalyst RX	www.catalystrx.com
Envision Rx Options	www.envisionrx.com
Health Trans	www.healthtrans.com
MedImpact	www.medimpact.com
Navitus Health Solutions	www.navitus.com
Partners Rx	www.partnersrx.com
RxEDO	www.rxedo.com
ProCare Rx	www.procarerx.com
Sun Rx	www.sunrx.com

* This chart reflects examples and is not a comprehensive list

Source: The Pharmacy Group LLC

pharmacy unable or unwilling to handle these agents because of challenges with inventory, product knowledge and administration tools, PBMs need new cost management paradigms. Since these drugs are often administered in a physician's office or by a home health company, the claims payment has almost always been covered as a medical benefit. However, coverage is transitioning to the pharmacy benefit to take advantage of cost and utilization management tools. When PBMs become involved, they must establish consistent guidelines for managing the benefit.

Administration and distribution may occur via physician offices, specialty pharmacies or community pharmacies, and PBMs will need to determine the best, but least restrictive, site of care. Claims administration and coding issues need to be resolved. Issues such as discounts, physician service fees, rebates, and formularies have to be addressed in a transparent fashion, and utilization management (prior authorization programs) must not impede access for needy patients.

Specialty pharmaceuticals are most often used to treat HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, infertility, Crohn's Disease, rheumatoid arthritis, and growth hormone deficiency.

Table 2. Characteristics of specialty pharmaceuticals

SPECIALTY PHARMACEUTICALS HAVE SOME OR ALL OF THE FOLLOWING CHARACTERISTICS:

- Expensive with high medical cost potential
- Produced using biotechnology mechanism
- Usually administered by injection or infusion
- Associated with complex clinical management
- Require close patient monitoring
- Distributed through restricted provider network with unique shipping requirements
- No generic substitutes available

Source: The Pharmacy Group LLC

These patients require special management, often chronically. Payers have considerable interest in improving several aspects of patient care: appropriate distribution to prevent waste, correct administration, adherence monitoring, coordination of care for comorbidities, and ongoing counseling. They also want good information management. In short, they will want personalized services for patients.

Antineoplastics represent a subset of specialty drugs, and increasingly, many cancer patients are being treated as outpatients and with oral therapies. Although payers want cost-effective oncology treatment programs, specialty pharmacy has a limited role. The best solution to managing oncology is the community-based oncologist (CBO). However, CBOs will need better data reporting capabilities and reimbursement models that are based on services, not drug price mark up.

GENERIC DRUG MANAGEMENT

Generic drugs' proven value will expand as the patents for several blockbuster drugs expire. PBM programs must emphasize use of generic medications. Payers also must be diligent to ensure they are purchasing these generic drugs for the best possible price, as there can be significant differences in pricing from one PBM to another.

While generic drug sales typically account for less than 20% of a payers' dollars spent on prescription medications, they

contribute approximately 50% of the profits for most retail and mail service pharmacies. In order to ensure that payers do not overpay for generic drugs, it is critical to utilize a Maximum Allowable Cost (MAC) pricing structure.

The goal of this pricing structure should be to define reasonable and fair maximum reimbursement rate for the top 90% of drugs dispensed that have an available AB-rated generic equivalent that is listed in the FDA's Orange Book.

MMA, MEDICAID REIMBURSEMENT

The Medicare Modernization Act (MMA) represents more change in thinking, this time on the part of the federal government. For physicians, changes to Part B reimbursement will eliminate or reduce profits from drug sales. As the nation implements the Medicare Part D drug program in 2006, Medicare-eligibles (mainly the elderly) will be introduced to PBM services designed to improve prescription drug access.

Efforts to address the impact of Part D on the 2006 federal budget will more than likely result in elimination of the average wholesale price discount formulas traditionally used for pharmacy reimbursement establishing average manufacturer price as the new pricing baseline. This change in the reimbursement formula significantly will impact independent pharmacies possibly affecting retail pharmacy access in rural areas. MHE