Tripping Over Savings to Pick Up Rebates

By L.G. Hanzel Principal & Vice President, RxResults
Featuring a Conversation with Cheryl Larson
President & CEO, Midwest Business Group on Health
A research report by the Pharmacy Benefit Management Institute emphasizes the top struggles of plan sponsors and members in the face of drug costs:* 

- Managing drug trend remains the top priority for plan sponsors 
- Members are feeling more financial stress about higher, unpredictable out-of-pocket costs 

The research report also indicated that 83% of plan sponsor respondents reported they received rebates on traditional (non-specialty) drugs.

According to a study conducted by Benfield on behalf of the National Pharmaceutical Council, a majority of employers—69%—indicated that they would welcome an alternative to rebates.

*Source: Pharmacy Benefit Management Institute 2018 Trends in Drug Benefit Design Report*
About rebates and formularies*

**A rebate is the return of part of the purchase price by the seller to the buyer.** Rebates are used by a wide array of manufacturers, such as automakers, electronics companies, and pharmaceutical manufacturers, to drive demand for their products. Prescription drug rebates are generally paid by a pharmaceutical manufacturer to a PBM, who then shares a portion with the health insurer. Rebates are mostly used for high-cost brand-name prescription drugs in competitive therapeutic classes where there are interchangeable products (rarely for generics), and aim to incentivize PBMs and health insurers to include the pharmaceutical manufacturer’s products on their formularies and to obtain preferred “tier” placement.

**A formulary is the list of prescription drugs that a health insurer will cover;** it assigns particular products to one of several tiers (typically two to four in commercial formularies) with different member cost sharing. These formularies are generally developed by PBMs, which negotiate contracted prescription drug prices and rebates with pharmaceutical manufacturers on behalf of their clients, the health insurers. Formulary tiers are often designed to promote low-cost prescription drugs; for example, a low-cost generic prescription drug may require a $5 copay, a preferred brand prescription drug with a rebate may require a $20 copay, and a non-preferred brand prescription drug without a rebate may require a $50 copay.

*All content on page sourced directly from: Milliman (2018) A primer on prescription drug rebates: Insights into why rebates are a target for reducing prices*
Rebate contract terms are trade secrets and vary widely among brands, pharmaceutical manufacturers, and health insurers, but tend to be highest for brands in therapeutic classes with competing products. This secrecy makes cost comparisons of competing brands on the basis of price alone very difficult (if not impossible) to estimate. Rebates therefore create a “black box” in the prescription drug distribution chain—the patient (and often the commercial health insurer) does not know how much the pharmaceutical manufacturers are paying in rebates, and how much of the rebates PBMs are keeping before passing the remainder to the health insurer. While average rebates are close to 20% of the price, some brands have no rebates and others are believed to offer rebates of over 60%.

To understand rebates, it is important to recognize the key stakeholders in the prescription drug distribution chain. There are generally six stakeholders in the supply and demand of prescription drugs: pharmaceutical manufacturers, health insurers (including self-insured employers), pharmacy benefit managers (PBMs), pharmacies, wholesalers, and patients.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role</th>
<th>Example Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceutical Manufacturer</td>
<td>Develop and market prescription medications</td>
<td>Genentech, Pfizer, Sanofi</td>
</tr>
<tr>
<td>Health Insurer (Including Part D Plans)</td>
<td>Provide insurance products that cover healthcare services, including prescription drugs</td>
<td>Aetna, Cigna, Employers, Center for Medicare and Medicaid Services (CMS)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Dispense pharmaceutical drugs to patients</td>
<td>Walgreens, Rite Aid, Duane Reed, CVS, Mail Order</td>
</tr>
<tr>
<td>Pharmacy Benefit Manager</td>
<td>Intermediary between the health insurer and the pharmacy. Develop and maintain formularies for health insurers, negotiates rebates and discounts.</td>
<td>Caremark (Part of CVS) Express Scripts, Prime Therapeutics</td>
</tr>
<tr>
<td>Wholesaler</td>
<td>Distributes pharmaceutical drugs from the pharmaceutical manufacturer to the pharmacy</td>
<td>Amerisourcebergen, Cardinal Health, McKesson</td>
</tr>
<tr>
<td>Patient</td>
<td>End user of a prescription drug</td>
<td></td>
</tr>
</tbody>
</table>

*All content on page sourced directly from: Milliman (2018) A primer on prescription drug rebates: Insights into why rebates are a target for reducing prices*
BETTER GUIDANCE
A conversation with Cheryl Larson

Cheryl Larson is President and CEO of the non-profit Midwest Business Group on Health (MBGH)—an employer coalition of 130 mid, large and jumbo self-funded, public and private companies that represent more than 4 million lives.
A conversation with Cheryl Larson

What do employer/plan sponsors need to know about the traditional PBM model?

CHERYL: Some PBMs have evolved into giant organizations that are sophisticated, organized, well-represented by industry groups and frequently lobby Washington to protect their marketplace position and revenue stream. Shareholders have come to expect high single- and double-digit profits as a result. One problem is that PBMs can influence a significant portion of the cost of drugs and for employers, who serve as the real “payors” of healthcare, this can lead to significant price increases. In fact, PBM contracts often lack transparency, which has led many stakeholders to question how they function, how their deals are cut, how revenue is generated and what specific services are performed.

Are there potential misaligned incentives between the plan sponsor and a traditional PBM?

CHERYL: PBM profits can be impacted if the price of a drug is not high enough because some of their revenue comes from retaining a percentage of the drug price or through a discount or rebate. Employers still believe that their PBM is managing all the costs in the value chain, yet there are significant issues with the current economic model that result in higher costs, without equivalent value for employers.

Are there potential conflicts of interest between the plan sponsor and a traditional PBM?

CHERYL: PBMs began as the broker and claims payer in the middle, negotiating the best price and service on the employer’s behalf. Many became pharmacies by offering mail order services and some developed relationships with retail pharmacy chains. This created a channel conflict—with some PBMs pushing patients to preferred networks, formularies and their own mandatory mail order programs, which also drove their profit.
What is your call to action for the employers?

**CHERYL:** With all the mergers, acquisitions and changes that have taken place in the pharmacy benefit marketplace over the past 7+ years, just how have employers fared? One could argue that the consolidation has created more consistent, relatively efficient pharmacy benefit models—which is still in question—but it has not resulted in lower costs. In fact, PBM economic models create incentives to drive the price up and this consolidated power has resulted in employers quietly losing a lot of leverage because they are a highly fragmented buyer. In addition, they can’t see the economic models between middlemen in the value chain because they are not party to these contracts. Each contract in the value chain contains a confidentiality or non-disclosure clause that precludes transparency. It may seem like pennies on the dollar but when you add up all the pennies, you realize there are a lot of dollars to be made in the middlemen space. Our call to action is to be truthful to employers about how these middlemen are increasing costs and provide them with clear guidance on new and innovative approaches. This is especially important in light of the requirement that employers, as plan fiduciary, have a responsibility to beneficiaries to ensure they purchase the best benefits at the best price. They can only do this if they eliminate the many loopholes in their PBM contracts.

What can employers do?

**CHERYL:** To start, they need to think differently about how to manage the pharmacy benefit and take action to address these excess costs caused by PBM and other middlemen. Waste in healthcare is a huge cost driver for employers. Ethical and philosophical decisions will arise over what a drug is worth and their ability to pay, so it’s critical to make sure dollars are used efficiently. Players in the value chain are preparing for this and many PBMs will continue to find ways to preserve the revenue they have now. Pressure to increase prices will not change as publicly traded companies must deliver profits to shareholders. This model continues to significantly impact employers, who already bear the brunt of paying for low-value care, waste and misuse in healthcare and pharmacy benefits. Some of our innovative employer members are taking a bold step and integrating **EmployeeRxEvolution (ERxE)**, a fully-vetted pharmacy benefit service offered by MBGH and key partners. ERxE helps them optimize their PBM contracts and formularies, enables direct contracting with retail pharmacies and uses evidenced-based clinical criteria prior authorization for specialty drugs. Transparency, truth and collaboration is what’s needed to fix pharmacy benefits today and we want to help employers get there. This is giving our employer members more control and significant cost savings. This is our stake in the ground!
Managing pharmacy risk vs managing pharmacy benefits

Traditional pharmacy benefit agreements essentially trade volume for price. Rebate Maximization has been the prevailing strategy for far too long. Plan sponsors across the country know their plans are paying for drugs that are wasteful and in many cases not cost effective. Expensive and branded drugs are not always the clinical superior drug. And, I think it’s safe to say that many plan sponsors…benefit directors, CFOs and benefit consultants included…have become addicted to simply maximizing their quarterly rebate checks.

If the plan sponsor really wants to manage their trend, at some point they have to manage utilization. Evidence-based pharmacy risk management provides an independent clinical perspective that allows the plan sponsor to ensure access to medications proven safe and effective while providing cost and utilization control. An effectively managed pharmacy benefit plan drives both plan and member savings. It does not simply continue to shift more cost to the plan participants. Cost shifting to the plan participants is creating another big concern in the form of medication adherence. When plan participants can’t afford their medications…they quit taking their meds.

Plan sponsors understand that employees value health and drug benefits and want to be able to continue to offer them. However, the tradeoff is often that members are responsible for a larger share of costs.


Patient Out-of-Pocket Cohort Note: sample limited to new patient approvals across Top Brands, which span over 25 traditional and specialty therapeutic areas

Source: IQVIA Formulary Impact Analyzer dataset (2013-2017); IQVIA analysis
Examples of Plan Sponsors Tripping Over Savings to Pick Up Rebates...

**EXAMPLE 1**

A Guidebook developed in conjunction with the Johns Hopkins Drug Access and Affordability Initiative points out that there is a financial incentive for PBMs to prefer drugs with high prices and large rebates or large spreads, which often results in having wasteful drugs on the formulary.* The guidebook gave a couple of real world examples.

In Example 1, the branded drug Oracea 40mg has a list price of $886 for a 30-day supply. The generic doxycycline 20mg has a list price of $46 for a 60-day supply. The rebate percentage needed to offset the savings is 96.7%.

<table>
<thead>
<tr>
<th>Wasteful Drug</th>
<th>Therapeutic Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oracea 40mg (doxycycline 40mg) extended release capsules</td>
<td>Generic Doxycycline 20mg tablets</td>
</tr>
<tr>
<td>30 pills</td>
<td>60 pills</td>
</tr>
<tr>
<td>$886.80</td>
<td>$46.20</td>
</tr>
<tr>
<td>$802.07</td>
<td>$26.54</td>
</tr>
<tr>
<td>$561.45</td>
<td>$26.54</td>
</tr>
<tr>
<td>$248.60</td>
<td>$26.54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Discounted Price$ (no rebates)</th>
<th>Price with 42% combined discount &amp; rebate</th>
<th>Price with 74% combined discount &amp; rebate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wasteful Drug Oracea 40mg (doxycycline 40mg) extended release capsules</td>
<td>30 pills</td>
<td>$886.80</td>
<td>$561.45</td>
<td>$248.60</td>
</tr>
<tr>
<td>Therapeutic Alternative Generic Doxycycline 20mg tablets</td>
<td>60 pills</td>
<td>$46.20</td>
<td>$26.54</td>
<td>$26.54</td>
</tr>
<tr>
<td>Savings per 30-day claim at each price</td>
<td></td>
<td>$840.60</td>
<td>$534.91</td>
<td>$222.06</td>
</tr>
<tr>
<td></td>
<td>% rebate needed to offset savings—96.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Removing Waste from Drug Formularies Guidebook
EXAMPLE 2

Example 2, Duexis, is actually one of my favorite target drugs. And, while many people reading this eBook, might say...we all know about Duexis. We know it needs to be excluded. The fact is I still see Duexis show up several times a month in our Pharmacy Risk Analyses that we run for plan sponsors and benefit consultants. RxResults has been targeting Duexis via exclusion or reference-based pricing for almost 10 years now.

Duexis is a combination drug. DUEXIS contains two medicines: ibuprofen, a nonsteroidal anti-inflammatory drug (NSAID), and famotidine, a histamine H2-receptor blocker medicine.

In Example 2, the branded prescription drug Duexis has a list price of $2,979 for a 90-day supply. A 90-day supply of over-the-counter ibuprofen runs approximately $17. The rebate percentage needed to offset the savings is 99.39%.

<table>
<thead>
<tr>
<th>Example 2. DUEXIS = (Ibuprofen + Famotidine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-day claims</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Wasteful Drug</td>
</tr>
<tr>
<td><strong>Duexis</strong> (Ibuprofen 800mg + Famotidine 26mg)</td>
</tr>
<tr>
<td>Therapeutic Alternative</td>
</tr>
<tr>
<td><strong>Ibuprofen</strong> 800mg</td>
</tr>
<tr>
<td><em>Savings per claim at each price</em></td>
</tr>
</tbody>
</table>

% rebate needed to offset savings — 99.39%
The guidebook points out that there are more than 800 drugs that can be considered wasteful. It goes on to note that, given the need to evaluate the clinical value of drugs and given the very complicated pricing structure within the pharmaceutical supply chain, it is likely that specialized, independent consultants will be required. It is important to have non-conflicted independent consultants to assure objectivity and alignment with the plan sponsor.

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Your expense is their revenue

Employers need to remember, in a traditional PBM model, the plan’s expense is the PBM and the Pharmaceutical company’s revenue. Employers and their benefit consultants have to ask…is the PBM’s preferred drug list really the employer’s preferred drug list as well?

Leveling the playing field

Pharmacy risk management is changing the benefits landscape. A pharmacy risk manager doesn’t replace a PBM. It serves to enhance a PBM model as an advocate for the plan sponsor and its plan participants.

Evidence-based pharmacy risk management directly meets the challenge of ensuring access to medications proven safe and effective while providing cost control.
Cheryl Larson is President and CEO of the non-profit Midwest Business Group on Health (MBGH). She oversees all coalition activities including advocacy, membership, administration, research projects and educational activities, working closely with MBGH’s employer-led Board of Directors to establish the strategic direction of the coalition. She also leads MBGH’s National Employer Initiative on Specialty Drugs—the first major purchaser-driven research project that supports employers in managing the higher costs of biologic and specialty drugs by helping them make critical and informed decisions. Cheryl is also a nationally recognized speaker and currently serves on multiple boards and committees representing the purchaser perspective.

Click here to connect with Cheryl Larson on LinkedIn
Click here to visit the Midwest Business Group on Health website

L.G. Hanzel, a pharmacy risk management strategist, has more than 25 years experience in healthcare, benefits, managed care and technology. L.G. has an extensive background in and knowledge of the self-insurance industry and healthcare informatics. L.G. is actively involved in the Self-Insurance Institute of America, Health Care Administrators Association, the National Business Coalition on Health and other regional business health coalitions.

About RxResults: RxResults, a joint-collaborative with the nationally recognized University of Arkansas for Medical Sciences, continuously reviews the latest studies and research on drug outcomes and leverages proprietary informatics, clinical expertise and business processes to identify trends, highlight concerns and formulate actionable insights. RxResults’ core competencies include Specialty Drug Management and Formulary Risk Management.

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Impact of an Evidence-Based Pharmacy Risk Management Strategy: Download the Case Study Here

MONEYPILL: a series of industry related articles by L.G. Hanzel

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VOLUME 2 The Formulary for Success Is an Evidence-Based Preferred Drug List
VOLUME 3 Risky Business: Specialty Drugs Impact on the Self-Insured Market
VOLUME 4 Tripping Over Savings to Pick Up Rebates
For Additional Information

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