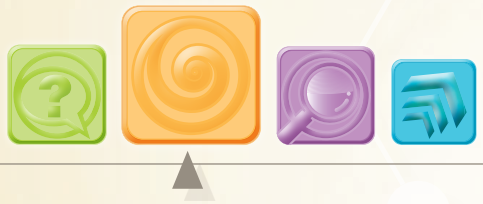

Now or Later: Rebate Considerations for Plan Sponsors

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In the era of high deductibles and co-insurance, what plan sponsors do with rebate dollars generated from brand drug utilization has come under more intense focus. Today, many plan sponsors utilize rebate dollars received from the Pharmacy Benefit Manager (PBM) to offset total plan costs, thereby factoring into the rate-setting methodology and/or offsetting contributions made by employees towards the total cost of care. In this arrangement, all participants under a group health plan realize a benefit from these rebates through lower premium contributions. Now, with patients taking on larger portions of the cost, should plans consider applying rebates at the pharmacy counter to lower the utilizing participant's cost share for brand name drugs?

Before discussing why or why not a plan sponsor would consider sharing rebates with plan participants, let's review a few key conceptual points about rebates:

- Rebates are negotiated by the PBM with brand drug manufacturers as additional discounts off the price of a pharmaceutical product. These negotiations take place outside the normal buy and sell prices negotiated within the supply chain by manufacturers, wholesalers and pharmacies.

- The portion of rebates shared with an individual plan sponsor is negotiated within the PBM contract between the PBM and the plan sponsor. The definition of "rebate" can vary among PBMs and the guaranteed amounts may take the form of a flat dollar per branded script, a percentage of rebates collected,

a per member per month (PMPM) credit, a credit to administrative fees (primarily in carve-in arrangements) or a combination of the above. Note that actual rebates are rarely disclosed on a drug-specific, claim-specific basis due to confidentiality clauses desired by both the PBM and the pharmaceutical manufacturer.

- Rebates are paid retrospectively by manufacturers to PBMs after utilization data have been aggregated, validated and evaluated against contractual terms, such as market share targets, formulary positioning or price protection guarantees. Accordingly, many plan sponsors receive rebates somewhere between 60 and 270 days after the quarter in which the claim was processed.

- After consideration of the safety and efficacy of a pharmaceutical product, the value of rebates typically determines the positioning of a branded pharmaceutical product on a PBM's formulary. Most recently, rebate negotiations have also included the intensity of clinical management criteria permitted in order to maximize rebate value.

To make the best decision for your plan, understanding the above concepts and how your PBM contract addresses rebates is helpful. In addition, these considerations should help plan sponsors determine their best option:

- **Premium Contributions**: Most plan sponsors recognize the balance between a competitive employee contribution, taken from paychecks, and affordable limits to variable out-of-pocket costs associated with the utilization of health care services. Since many plan sponsors factor rebates into the rate setting formula today, providing those rebates at the point-of-sale will require an adjustment to either premiums or out-of-pocket limits. Multiple studies[1] show that the average plan sponsor would have to adjust premiums for pharmacy coverage roughly 3 to 4 percent or approximately 0.75 percent to 1 percent for total health care premiums. The decision whether or not to raise premium contributions may be impacted by the demographics and average

1 https://www.phrma.org/report/point-of-sale-rebate-analysis-in-the-commercial-market
https://payorsolutions.cvshealth.com/insights/consumer-transparency

salaries of individuals a plan sponsor is looking to attract and retain.

- **Drug Mix**: Plan sponsors historically have tried to dissuade participants from using brand medications in favor of generic medications through higher out-of-pocket cost sharing for brands. This strategy, when applied broadly across all medications, has some drawbacks in that the same higher cost share is applied to brands used to treat chronic conditions with few, if any, lower cost therapeutic alternatives as those used to treat "lifestyle" conditions, expensive combo products or other high cost, low value brands with adequate alternatives. Applying brand rebates at the point of sale across all brands, regardless of value, may undermine the intent of plan design and ultimately cost the plan more. Hence, plan sponsors may look for opportunities to:

  (a) employ a chronic drug list that bypasses the deductible in lieu of point- of-sale rebates,
  (b) determine whether the application of rebates at the point-of-sale can be administered on a subset of brands used to treat chronic disease, or
  (c) adopt a more tightly managed formulary with low-value brand drugs excluded from coverage.

- **Contracting**: Applying rebates at the point-of-sale falls outside the normal timing for rebates and thereby creates a situation where the PBM is "floating" money to the plan and its participants. Obviously, this often results in some tradeoff and can create an opportunity for negotiation. A few key questions one must address include:

  - What value will be applied at the point of sale? Is it the negotiated rebate guarantee? Is it the actual drug-level rebate? Is it an estimate of the drug-level rebate?
  - How is the rebate value applied at the point of sale reconciled to the rebates actually collected by the PBM on behalf of the plan sponsor and guaranteed in the contract between the two (e.g. 100 percent rebate pass-through)?

- Is there an interest charge or fee to account for the time-value of the upfront rebate dollars? What percentage of the total rebates expected will be captured by the point-of-sale rebate?

- **Max-Out-Of-Pocket (MOOP) / Deductible Limits**: The limits that the plan sets on its deductibles and MOOP will also be impacted by a point-of-sale rebate model. A plan should determine how many of its participants hit the deductible and MOOP limits, and also determine how this might change under the new model. It would be expected that administering rebates at the point-of-sale would slow an individual participant's progression through the deductible and post-deductible/pre-MOOP phase of the plan. If the number of participants hitting the deductible limit is unchanged, and the plan has flat copays post-deductible, then the point-of-sale rebates may have limited impact. A similar logic would follow based on the number of participants hitting the MOOP, since coverage for the participant is 100 percent for expenditures above that limit. A plan might also decide to adjust its deductible or MOOP limits to make up for the shift in rebates to the point-of-sale.

Many opinions about point-of-sale rebates come from those trying to alleviate some of the scrutiny pharmaceutical manufacturers have come under for drug price inflation. They position the idea as a "no-brainer" for employers and other plan sponsors; however, the decision does require further consideration than many admit. Whether it's the right strategy for any individual plan sponsor will hinge on that plan sponsor's unique situation and its consideration of multiple factors, including those raised above.

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