2019 MARKET CHECK

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The pharmacy benefit management marketplace is facing more public scrutiny than ever. Over the past several months, the news media exploded with stories concerning the business practices of pharmacy benefit managers (PBMs). Some stories focus on the rebates PBMs receive from drug manufacturers or the unexplained spikes in the list price of certain drugs. Other stories focus on PBMs requiring pharmacies to collect from patients the full amount of a patient's cost share, even when the actual cost of the drug is less than the patient's full cost share. And, to be sure, there are many other stories that question other PBM business practices.

These stories often assert that certain PBM business practices allow the PBM to profit in an underhanded way at the expense of pharmacy benefit plan sponsors and patients. At the minimum, these stories at least imply that these practices increase overall pharmaceutical costs, and they cast doubt on whether PBMs provide any value.

The truth of the matter is, there is at least some element of truth in these stories. The PBM industry is one that sounds like it should be very straightforward, but in reality, is extremely complex. Unfortunately, this dichotomy leaves many pharmacy benefit plan sponsors vulnerable to business practices that may have a significant impact on the amounts they and their plan enrollees pay for drugs, whether they know it or not.

Of course, PBMs have their side of the story. PBMs generally contend that they have nothing to do with the list price of any drug. Rather, they say, it is their job to reduce the cost of drugs, to the extent possible, through efficiencies, clinical oversight and purchasing power given the plan design they are asked to administer. The reality is, there is at least some element of truth in the PBM stories as well.

The press generated by PBM business practices has spurned a number of proposals for new regulations and legislation concerning some PBM business practices. For example, the U.S. Department of Health and Human Services recently proposed regulation changes governing the safe harbors for rebates paid to PBMs and health plans, and a bill is working its way through the U.S. Senate entitled the "Patient Right to Know Drug Prices Act" (S. 2554) to address the amount a patient should pay at the pharmacy counter. Whether either of these efforts will come to fruition, whether they truly address the issues, and whether they are even a good idea in the first place is still a subject of debate. More importantly, the result of these efforts is largely outside of the control of a pharmacy benefit plan sponsor.

What a pharmacy benefit plan sponsor can do

to help ensure that its overall drug spend is being managed appropriately is align itself with a PBM program that rigorously monitors market dynamics and proactively adjusts for them. For years, **Employers Health has used its collective purchasing power** to avoid PBM gamesmanship through a process called a "market check".

A market check is a process through which Employers Health, on an annual basis, renegotiates the terms and conditions related to the PBM services provided to its members. Much of this process involves renegotiating pricing terms to ensure that Employers Health members enjoy the lowest possible drug cost while maintaining high-quality patient care. But, the process also includes amending contract provisions to avoid PBM gamesmanship.

As an example, over a decade ago, Employers Health incorporated terms into its PBM agreements that required pharmacies to collect from patients no more than the lowest of the patient's cost share, or the pharmacy's cash price, or what the pharmacy's cash price should be (a.k.a. Maximum Allowable Cost, or MAC). Until recently, this provision got little attention. But over the years, collectively, it has saved plan enrollees countless dollars that otherwise would have been unknowingly spent.

A more recent example concerns rebates. Since its inception, Employers Health has had a keen focus on ensuring that its member organizations receive the maximum possible rebates. In the past, rebates were relatively straightforward and easy to administer, but over the years, payments from drug manufacturers started to take different forms. Employers Health has stayed abreast of these industry dynamics. Through the market check process, Employers Health has ensured that its members benefit from drug manufacturer payments to the greatest extent possible. As a result, since 2014, the rebate guarantee for a retail brand prescription has increased over 600 percent, and Employers Health is generally known for having industry leading rebate guarantees. This, in turn, helps our member organizations combat out of control increases in the list price of many drugs.

Turning our eyes toward the future, much has been done already in anticipation of 2019. The pricing terms for 2019 have been renegotiated to maintain our industry leading standard. In addition, Employers Health has taken steps to ensure that specialty drugs are priced appropriately as more and more generics are given a specialty designation, and the specialty class continues to grow in importance. For most Employers Health members, these efforts will result in significant improvements compared with their current industry-leading terms.

As the complexity of the PBM marketplace continues to increase, the need for pharmacy benefit plan sponsors to be market savvy is greater than ever. As the buzz grows louder on certain PBM business practices, Employers Health is proud to have addressed many of these issues years ago and looks forward to continuing to serve its membership into the future.

A MARKET CHECK
IS A PROCESS THROUGH WHICH EMPLOYERS HEALTH, ON AN ANNUAL BASIS, RENEGOTIATES THE TERMS AND CONDITIONS RELATED TO THE PBM SERVICES PROVIDED TO ITS MEMBERS.