



## Three Strategies for Controlling Pharmacy Benefit Costs

By Ritu Malhotra and Sean M. Brandle

Effective auditing, innovative plan design, and increased focus on controlling aspects of member behavior can set the stage for reducing future cost trends in pharmacy plans.

As public-sector health plan sponsors struggle with increasing pharmacy plan costs, effective auditing, innovative plan design, and increased focus on controlling aspects of member behavior can set the stage for reducing future cost trends. Most health plan sponsors work with a pharmacy benefit manager (PBM) that processes their pharmacy claims and assists them with other administrative aspects of offering a pharmacy benefit (i.e., plan design application, clinical programs, formulary development, providing mail-order pharmacy access). As the market evolves, PBM capabilities present both challenges and opportunities for plan sponsors. Effective auditing techniques can help ensure that plan sponsors and members pay competitive market prices for drugs and eliminate excessive PBM profits. Innovative plan design seeks to eliminate financial barriers to drug therapies that have been shown to provide therapeutic value and be cost effective. Examining potential fraud and abuse patterns within a population fulfills a fiduciary responsibility and may improve overall member health and productivity in instances where corrective measures and counseling can be put in place.

### EFFECTIVE AUDITING

Electronic claim audits of PBM data are the cornerstone of an effective pharmacy benefit management program. A plan sponsor should use these audits as opportunities to measure the

financial performance of its PBM and to update contract language to remove hidden PBM profit drivers that can increase plan costs. One such opportunity, which can deliver savings to both plan sponsors and members, is the language used to define generic drugs, which is discussed below.

The evolving nature of the PBM industry demands frequent examinations of data and financial terms to facilitate PBM negotiations and contractual updates. As part of a thorough audit process, a plan sponsor must carefully review and scrutinize its PBM's financial contract terms and compare them with existing benchmarks and standards to ensure they are receiving the maximum cost benefits from items such as generic drugs. Due to the complicated and somewhat mysterious manner in which generic versions of brand-name medications enter the marketplace, murky PBM contractual definitions of brand versus generic medications can have a profound impact on plan and participant costs.

The primary reason for much of the confusion is the six-month exclusivity period provided to the first generic drug manufacturer that successfully challenges a brand drug manufacturer's patent. This rewards the manufacturer with the sole right to distribute its generic equivalent for six months, in essence preventing competition — and typically makes the price of the generic drug only slightly lower than that of

the brand drug. After the exclusivity period, other generic manufacturers usually enter the market and prices often plunge, creating savings opportunities for both plan and participant. Most PBMs refer to generic drugs within their six-month exclusivity period as “single-source generics” and specifically exclude them from their generic discount guarantees, or worse, include the single-source generic claims in the brand discount guarantee, which can artificially inflate the calculated discount.

Lack of a consistent, industry-standard method of coding medications as brands or generics, the six-month exclusivity period, and loosely defined contract terms are the crux of the problem. As more brand-name medications lose patent protection, these issues become increasingly prevalent and contribute to the confusion in pharmacy benefit pricing. Plan sponsors should consider installing contractual revisions that are designed to isolate and separately guarantee costs and discount levels for this growing list of medications.

All PBMs are quick to tout their ability to effectively convert participants to generic versions of medications that were previously patent-protected. They routinely provide plan sponsors with lists of brand-name medications that are losing their patent protection, by year and with the associated potential for savings. These same lists can become the basis for revised contractual drug price guarantees.

Because PBMs estimate that close to \$100 billion in brand-name drugs are coming off patent between 2009 and 2015, a plan sponsor needs to closely question its PBM about the pricing that is applicable to the generic versions of

these medications, to ensure that both participants and the plan realize the full financial benefit of generic drugs. One solution is to negotiate separate pricing guarantees for all the drugs on the patent expiration list during the term of the agreement.

Meaningful changes to arcane PBM contract language can produce valuable savings for plan sponsors if auditing is thorough and performed by auditors who have deep knowledge of the PBM industry and pricing practices. A qualified auditor will:

- Perform electronic auditing using a nationally recognized drug pricing source and prices determined on a date-sensitive basis.
- Re-price and audit 100 percent of electronic claims.
- Independently determine the brand versus generic status of each claim based on a logical, date-sensitive algorithm.
- Review, analyze, and suggest changes to all contractual pricing and verbal definitions of drug classification and categorization for discount measurement.

## PLAN DESIGN EVOLUTION

Although prescription drug costs continue to increase, shifting costs to employees or members is no longer considered the only effective strategy plan sponsors can use to control health-care benefit costs. A number of studies of prescription drug cost sharing have shown that increases in the patients’ cost burden can result in a decrease in drug adherence, and that a decrease in drug adherence for drugs used to treat chronic conditions can result in a worsening of the condition. The likely result is increased overall health-care costs

to the plan, in addition to the adverse health outcome for the employee. The correlation between an increase in cost sharing and an increase in overall health-care costs has been extensively studied, but definitive results have been difficult to obtain. However, based on the available research and the theory that cost containment strategies in a silo will not result in lowering the health-care cost trend, many plan sponsors are beginning to examine strategies designed to control overall health-care benefit costs.

Sparked by cost sharing research, many large plan sponsors have begun to look at the impact on their overall health-care costs of reducing prescription drug cost sharing. One well-documented approach was taken by Pitney Bowes, which in 2002 chose to reduce copayments for all drugs used to treat asthma, diabetes, and hypertension. The two-year results were fewer emergency room visits for participants with diabetes, savings on short-term disability for diabetic patients, and an overall decrease in the total annual health-care costs for the diabetic and asthmatic patients. In addition, the company reported a decrease in average pharmacy costs for the same diabetic and asthmatic individuals, which it attributes to a decrease in the drugs used to treat complications of the diseases.<sup>1</sup>

The strategy of providing enhanced benefits for drugs with established high value is commonly referred to as value-based design. This focuses on stratifying member cost share based on the established clinical effectiveness research and/or on a drugs’ ability to halt or delay chronic disease progression. Most plan sponsors that have implemented value-based designs focus on four major conditions: dia-

betes, asthma, hypertension, and high cholesterol. Uncontrolled, each of these conditions can lead to high medical costs. Plan sponsors that use value-based designs are careful not to establish excessive cost-sharing levels that reduce members' adherence to drug therapy because research shows that, if properly adhered to, these drugs can keep the conditions from worsening.

### **CLINICAL PROGRAMS CAN SAVE MONEY AND LIVES**

PBMs offer their clients an exhaustive list of clinical programs that can be implemented, and they typically present the programs as part of a cost-containment strategy. These programs vary from point-of-sale adjudication edits, such as quantity limits and prior authorizations, to retrospective reviews of claims for drug interactions or overuse. Many plan sponsors shy away from implementing these programs because they are not interested in cost-containment controls, which cause member disruption. However, clinical programs should not simply be viewed as ways to save money, but should also be considered an effective strategy for plan sponsors to build safety checks into their prescription drug benefit. Clinical programs offered by PBMs are designed to provide another level of safety monitoring to ensure that patients receive the right drug for the right duration and in the right dose.

In the current health-care environment, doctors are requested to write multiple prescriptions for patients to treat both their chronic conditions and whatever ailment brought them into the office that day. They are not always given enough time to think strategically and prescribe the drugs according to industry-accepted FDA approval guide-

lines. The next health-care professional in the process is the pharmacist, who is often under the same time constraints as doctors. Pharmacy systems are built to help pharmacists get prescriptions out the door as fast as possible and will typically allow a pharmacist to bypass or override system messages about safety.

The plan sponsor and/or PBM, however, can have the final say on whether or not the prescription gets dispensed by restricting coverage at the point of sale. Clinical point-of-sale edits that are designed to stop a claim from being processed provide the doctor with a second chance to critically evaluate a patient's need for the drug being prescribed. Because the PBM is the only health-care vendor in the process with the whole picture of what an individual member is being prescribed, a plan sponsor should work closely with its PBM to ensure that only "safe" claims are processed through the benefit.

### **CONTROLLING ABUSE**

Most public-sector health plans have yet to take notice of the rising health-care costs associated with prescription fraud and abuse by employees or members. Drug diversion — deflecting prescription drugs from their original medical purpose to the illegal market, the primary type of prescription drug fraud — costs U.S. health insurers an estimated \$72.5 billion per year, in total.<sup>2</sup>

According to the Drug Enforcement Administration, nearly 7 million Americans abuse prescription drugs,<sup>3</sup> and a 2009 Centers for Disease Control survey reported that one in five high school students had taken a prescription drug (e.g., Oxycontin, Percocet,

Adderall, Ritalin or Xanax) without a doctor's prescription.<sup>4</sup> When asked how they obtained the medication, the most common response was "from a friend or relative for free." Almost 10 percent of all hospital admissions for substance abuse in 2008 involved painkillers, up from 2.2 percent in 1998. Tragically, a growing number of prescription drug overuse cases result in fatal consequences. In almost a third of U.S. states, accidental drug poisoning now causes more deaths than traffic accidents do.

**Barriers to Action.** The fraud and abuse problem has not received the critical attention it deserves because of two key reasons. The first is that most PBMs encourage their clients to focus on areas of the pharmacy benefit that affect the payer's cost trend and are at the same time profit centers for the PBM.<sup>5</sup> This has resulted in a serious lack of investment in time and finances in establishing effective fraud and abuse programs. Moreover, the PBM is often the only single entity with access to all a patient's claims since patients may use multiple prescribers and pharmacies. Because PBMs are armed with this data and have access to real-time pharmacy claims, they would be able to offer the most effective fraud and abuse programs. Another barrier to approaching the problem is that there is no uniform definition of what constitutes fraudulent or abusive behavior. A determination often cannot be established based on pharmacy claims alone. Pain medications, the most highly abused medications, are the most difficult to monitor because of the different degrees of dosing required for each individual patient. For this reason, PBMs have historically shied away from recommending clinical programs for pain medications. Implementing

any limits on quantity or requirements for prior authorization of pain medications is likely to affect individuals with legitimate pain problems (e.g., cancer patients) in addition to the fraudulent or abusive users.

**Identifying the Problem.** The most effective strategy for detecting fraudulent or abusive use of prescription drugs starts with identifying who has unusual usage patterns. An electronic evaluation of pharmacy claims can identify:

- Members who received prescription drugs by multiple pharmacies.
- Members who received prescription drugs prescribed by multiple prescribers.
- Members who have other pattern(s) of potential abuse or misuse (e.g., duplicate therapy, excessive days supply, etc.).

Once the evaluation has identified individuals with red-flags, the PBM or medical vendor should further investigate the unusual usage patterns. The first step is to contact the prescriber or prescribers to determine the medical rationale for prescribing the high abuse-potential medications or to establish coordination of care among many prescribers. The pharmacist, as the last line of defense against fraudulent or abusive activities, might also be able to provide valuable information on the individual's behavior. Once the investigation is complete and fraud or abuse is established, the health plan sponsor, the PBM, and local authorities should address the potentially dangerous and/or illegal activity.

**Preventing Fraud and Abuse.** A health plan needs to work closely with its PBM to implement controls and review processes to identify the potential for fraud or abuse in its plan. Most

PBMs offer both prospective and retrospective drug utilization reviews for their clients, but not all of these programs contain criteria that are sophisticated enough to identify prescription drug fraud or abuse. A health plan sponsor that has concerns about active fraud or abuse can direct its PBM to implement more targeted clinical edits such as quantity limits on medication classes that have high potential for abuse. The drawback of these edits is that they may temporarily inconvenience some patients who have legitimate medical reasons for using these medications, until their prescriber can provide the PBM with the rationale for the prescription. The more advanced PBMs can exclude individuals who are likely to have unique pain relief needs (e.g., cancer patients) from these edits, based on their previous prescription histories.

Despite the implementation of clinical edits or drug utilization reviews, health plans still need to conduct regular evaluations of pharmacy claims to identify potentially fraudulent claims or abusive individuals who might have slipped through the cracks. Once the identification and investigations are complete, a health plan sponsor has options for controlling how a problem employee or member uses his or her pharmacy benefits. The individual can be restricted to using a single pharmacy or prescriber for drugs with high abuse potential. The plan sponsor should discuss this strategy with a specific pharmacist and/or the prescriber to ensure that they are willing to participate in the process. The professional judgment of these individuals can be crucial to ensuring that the individual does not continue to obtain fraudulent claims or continue to abuse prescription drugs.

## CONCLUSIONS

Effective auditing, innovative plan design and increased focus on controlling fraudulent and abusive member behavior can help public-sector health plan sponsors that use PBMs control their pharmacy plan costs. In addition to controlling pharmacy costs, these strategies can enhance the member experience and encourage members to use their pharmacy benefits more safely and effectively. ■

### Notes

1. J.J. Mahoney, "Benefit-based copays in the real world: the employer perspective," *The American Journal of Managed Care*, 2006, 12(13).
2. Coalition Against Insurance Fraud, "Prescription for Peril," December 2007.
3. U.S. Drug Enforcement Administration, "Fact Sheet — Prescription Drug Abuse — A DEA Focus," available at [http://www.justice.gov/dea/concern/prescription\\_drug\\_fact\\_sheet.html](http://www.justice.gov/dea/concern/prescription_drug_fact_sheet.html).
4. Centers for Disease Control National Youth Risk Behavior Study, 2009
5. PBMs tend to encourage their clients to focus on the cost-cutting potential of mail-order pharmacy services, generic drug dispensing, and formularies (preferred drug lists). Although these areas will save money for public-sector health plans, they also generate profits for the PBM.

---

**DR. RITU MALHOTRA** is a vice president and clinical pharmacy consultant in the Chicago office of The Segal Company. Malhotra provides clinical consulting, analysis, support, and strategic direction. She can be reached at 312-456-7919 or [malhotr@segalco.com](mailto:malhotr@segalco.com). **SEAN M. BRANDLE** is a vice president and leader of the National Rx Consulting Practice in the New York Office of The Segal Company. He focuses on the valuation of PBM services, prescription plan design strategies, and overall PBM measure development. He can be reached at 212-251-5148 or [sbrandle@segalco.com](mailto:sbrandle@segalco.com).