An effective pharmacy benefits plan includes four key strategy areas.

Pharmacy benefits plans in the employer marketplace have the potential to play an important role in positively affecting the health and well-being of their plan participants. Designed and used appropriately, pharmacy benefits can provide cost-effective and efficient treatment. In addition, these plans can help reduce absenteeism and, in turn, improve worker productivity. If not managed appropriately, they can represent a constantly growing drain on employer financial resources that undermines the return on investment of an employer’s entire health-care benefits program.

Decisions to implement cost-effective pharmacy benefits plans need to be made within the context of the rapidly changing pharmaceutical landscape,
including the following major developments that are under way:

- Ongoing consolidation of the pharmacy benefits manager (PBM) marketplace, which has created a “buyer’s market” of PBM services for employers
- Recent expiration of blockbuster brand drug patents and expected patent expirations during the next four years, which present major savings opportunities through increased use of low-cost generic drugs
- Emergence of specialty (biotechnology) drugs as a major cost driver of pharmacy benefits plans

Employers that have designed their pharmacy plans to encourage generic drug use are achieving generic dispensing rates of 75 percent or more.

Poor drug adherence by patients with chronic diseases can result in expensive hospital care, higher medical and disability plan costs, and increased absenteeism. This article discusses pragmatic strategies to help employers manage their pharmacy benefits plans effectively by capitalizing on opportunities created by the rapidly changing pharmaceutical landscape. These strategies focus on four key areas:

- Plan design
- Clinical programs
- PBM pricing
- Specialty drug cost, usage and clinical patient management.

Plan Design

Today, employers that have designed their pharmacy plans to encourage generic drug use are achieving generic dispensing rates (GDRs) of 75 percent or more, and will likely exceed 80 percent over the next two or three years. (GDR is the percent of total drugs dispensed as generics during a specified time period.) Three years ago, these rates were in the 60 percent to 65 percent range.

As pharmacy plan costs have risen and the economy has deteriorated, many employers have made significant changes in their pharmacy benefits plan designs. Two key plan design trends have emerged during the past five years, which were validated in the findings of Buck Consultants’ “2011 Prescription Drug Benefit Survey Report:”

1. A shift from two-tier to three-tier cost sharing to incent plan participants to use lower-cost generic drugs and formulary brand drugs.
2. A shift from flat-dollar co-pays to co-insurance to minimize cost shifting to the employer plan as drug costs rise.

Strategic Decision Point

Employers need to set employee cost-sharing policy based on their plans’ specific claim and usage experience, in addition to industry-specific benchmarks and internal company considerations, such as corporate budgets, benefits philosophy and objectives. This requires employers to evaluate their current employee cost sharing empirically to determine:

- The appropriate approach going forward (i.e., flat-dollar vs. co-insurance)
- The percentage of pharmacy plan costs that employees/retirees and their dependents should pay for generic, formulary brand and nonformulary brand drugs.

This approach enables employers to structure their plan designs based on specific plan participant cost-sharing targets and facilitate budgeting pharmacy benefits plan costs more precisely for the upcoming year.

Clinical Management Programs for Traditional (Nonspecialty) Drug Therapy

Sound clinical programs are critical to managing pharmacy benefits costs effectively by helping to minimize unnecessary drug use and waste. The overriding objective of clinical programs is to ensure that members receive the right drug for the right condition at the right dose at the right time.

Key elements of a clinical program strategy:

- Mandatory generic substitution of patent-expired brand drugs
- Prior authorizations (PAs) for drugs in selected classes
- Quantity limits on certain drugs to meet FDA guidelines for safety and to minimize fraud and abuse
- Step therapy to require a participant who has not previously used a drug in specific drug classes (e.g., cholesterol-lowering drugs) to try a less expensive therapeutic alternative before using a more costly brand drug
- Exclusion of certain drug classes with over-the-counter (OTC) versions
- Programs to improve member drug adherence that can lead to improved health and lower
medical plan costs and mitigation of disease complications.

PBM Pricing

Today’s employer marketplace is a buyer’s market for PBM services because of the ongoing consolidation of the PBM marketplace. PBMs currently cover more than 220 million lives under their plans. The only way a PBM can generate significantly more revenue in the employer marketplace is to take away business from another PBM, usually through competitive bidding, or acquire another PBM, as several PBMs have done during the past five years.

Plan consolidation presents important savings opportunities for employers by enabling them to leverage their plans’ usage and drug spend to negotiate improved financial terms in a shrinking PBM marketplace. Just three years ago, there were few opportunities for employers with 10,000 or fewer covered lives to negotiate with the PBMs. Today, the intense competition among the PBMs for employer business has resulted in greater opportunity for these employers to negotiate financial and nonfinancial terms with the PBMs.

For larger employers, PBM competitive bidding and follow-up negotiations have enabled them to achieve even greater savings than they could achieve previously. As a result, virtually all financial and nonfinancial terms are negotiable. The key to successful negotiations with the PBMs is to retain knowledgeable consultants or other advisors who have in-depth understanding of the economics of the PBM marketplace, how the PBMs make money, the nuanced language that is contained in their contracts with employers, and pricing benchmarks for employers of comparable size and in the same industry. For example, some PBMs offer high-dollar guaranteed rebates (e.g., $20 guaranteed rebate per brand drug dispensed at retail and $60 or more at mail order). However, in a footnote to these guarantees or under the pricing assumptions listed elsewhere in the PBM’s proposal or contract, the PBM may state that such high-dollar guaranteed rebates assume the plan will have an average days’ supply at retail of 30 and 90 at mail order. If the average days’ supply is less than these levels, the guaranteed dollar rebates would be prorated downward. In reality, these are impossible thresholds to meet. Such “stealth” pricing terms need to be identified and eliminated from a PBM’s pricing offer for employers to achieve optimal contract savings.

Strategic decisions that impact PBM pricing include:

- **Broad vs. narrower retail pharmacy networks.** Where member access is not compromised, employers have an opportunity to achieve additional price savings by moving to a narrower network.

- **Appropriate drug channel management — retail, mail order or specialty pharmacy.** Acute, maintenance and specialty drugs need to be dispensed in the appropriate channel to achieve optimal pricing and savings.

- **Plan design.** PBM pricing is directly related to a plan’s member cost-share structure, with optimum pricing achieved with a three-tier cost-share structure that has appropriate cost-share differentials between retail and mail order generic, formulary brand and nonformulary brand drugs.

Specialty Drugs

There are more than 700 specialty drugs in development, targeted to treat a range of cancers, as well as common chronic diseases, including diabetes, neurological conditions and cardiovascular disease. It is expected that eight out of 10 new drugs approved by the FDA during the next five years will be specialty drugs, according to reports from Express Scripts and Medco Health Solutions. These drugs currently average more than $2,000 per 30-day supply. The cost of some of these drugs exceeds $100,000 per year. Today, specialty drugs represent 15 percent or more of an employer’s annual drug costs, according to reports from CVS Caremark, Express Scripts and Medco Health Solutions. Annual specialty drug trend — the rate of increase in specialty drug cost measured on a per-member-per-month basis — exceeded 17 percent in 2010, compared with annual trend for traditional (nonspecialty) drugs of less than 4 percent.

Because of the robust developmental pipeline of specialty drugs, estimates from Medco Health Solutions show that by 2015 specialty drugs could represent 47 percent of annual employer drug costs provided through the medical and pharmacy plans combined (see Figure 1). Typically, 50 percent or more of an employer’s specialty drugs cost is generated by the medical plan. Over the next three years, two-thirds of

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**Figure 1** Breakdown of Annual Drug Spend: 2010 vs. 2015

<table>
<thead>
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<th></th>
<th>2010 (actual)</th>
<th>2015 (estimated)</th>
<th>% Point Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Drugs</td>
<td>76%</td>
<td>53%</td>
<td>-23</td>
</tr>
<tr>
<td>Specialty Drugs Through Medical Plan</td>
<td>14%</td>
<td>26%</td>
<td>+12</td>
</tr>
<tr>
<td>Specialty Drugs Through Pharmacy Plan</td>
<td>12%</td>
<td>21%</td>
<td>+9</td>
</tr>
</tbody>
</table>

Source: Express Scripts Book of Business; Express Scripts analysis of the Thomson Reuters MarketScan Scripts Commercial Database.
The key to managing specialty drug costs is to implement a strategy that includes proactive patient management to help members manage their conditions.

Employers need to understand the magnitude and immediacy of the specialty drug cost issue and develop a comprehensive strategy now to manage their rapidly rising specialty drug costs. Otherwise, they will find that their pharmacy plans will soon be unaffordable.

Two key elements of a specialty drug strategy to consider are:

1. Carve out self-injectable and orally administered specialty drugs from both the medical and pharmacy plans for dispensing through a specialty pharmacy
2. Implement proactive clinical management programs through the specialty pharmacy

Employers use different approaches to plan design for specialty drugs. Many have applied retail co-pays for traditional generic, formulary brand and nonformulary brand drugs to specialty drugs. Others have added a fourth tier with higher flat-dollar co-pays or applied co-insurance to specialty drugs.

The cost of specialty drugs is very high. Above a certain participant cost-share threshold, many specialty patients may not be able to afford these drugs and will stop using them, according to a 2006 Express Scripts study. These patients also use multiple traditional drug therapies for the same condition or related conditions, which presents an added financial barrier for them.

Driving up member cost share for these drugs is counterproductive. If patients stop taking specialty drugs, their condition will likely worsen and will require expensive hospitalizations, which, in turn, will drive up employer medical plan costs. The key to managing specialty drug costs is to implement a strategy that includes proactive patient management to help members manage their conditions and drug side effects, and ensure appropriate use of these drugs for the right condition at the right time and at the right dose.

Conclusion

Pharmacy benefits plans have the potential to play an important role in the health and well-being of plan participants if these plans are designed appropriately. Otherwise, they can be a growing drain on employer budgets.

To have a positive impact on the health and well-being of participants, employers need to develop a strategy that actively manages the pharmacy benefit so that members have access to quality drug therapy and, at the same time, the plan ensures drug safety, eliminates waste and achieves appropriate usage. Key elements of this strategy include:

1. Plan design that provides financial incentives for members to use low-cost generic drugs and formulary brand drugs
2. Clinical coverage rules, such as prior authorization and step therapy, to ensure appropriate usage
3. Identification of members with high-cost chronic conditions who have poor drug adherence and client-specific PBM or other vendor programs to help improve drug compliance
4. Drug channel management to ensure that acute-care, maintenance and specialty drugs are dispensed through the most cost-effective and efficient pharmacy delivery channel — retail, mail order or specialty pharmacy
5. Aggressive negotiation of financial and nonfinancial contract terms to capitalize on today’s buyer’s market for PBM services
6. Specialty drug carve-out and proactive clinical management programs to ensure optimum pricing, appropriate usage and avoidance of high-cost hospitalizations that drive up medical plan costs.

Marketplace forces at play create challenges for plan sponsors to manage their pharmacy benefits plans effectively. These forces also present savings opportunities for employers, provided realistic strategies are developed and implemented effectively.

Robert W. Kalman is principal and co-leader of the National Pharmacy Practice at Buck Consultants in Washington, D.C. He can be reached at robert.kalman@buckconsultants.com.

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