10 Questions Company Benefits Managers Must Ask Their PBM

It pays to make an informed decision

Pharmacy Benefit Managers, often known simply as "PBMs," are largely unrecognized by most employees — and even by many benefits managers. But they have a tremendous impact on U.S. health care decision-making because they influence more than 80 percent of drug coverage. The sector is dominated by two large national players, but there are smaller and regional PBMs, too.

PBMs commonly operate on behalf of employers, insurance companies, and unions; they are also sometimes called "third-party payers." The original purpose of PBMs was straightforward: issue drug cards for easy ID and account tracking and offer their customer groups quality cost-effective services, as well as reliable claims information.

Now PBMs are much more complex. They use various strategies to attempt to control costs even as they frequently raise fees to customers. Some PBM practices are, in fact, the subject of lawsuits or federal regulatory investigations.

So how can you, as a benefits manager, make the best drug benefit decision for your employees? How can you have confidence that your company and its employees are receiving the agreed on value and service? What key questions should you ask your current or potential PBM — or your health insurer contracting with a PBM?

The following 10 questions, designed to help you select the best PBM for your organizations, are provided by the National Community Pharmacists Association.

Q: Do you use the same average wholesale price (AWP) in calculating price to clients and payments to pharmacies?

A: Some PBMs realize hidden profits by employing a practice known as "differential pricing." Differential pricing is when a PBM charges the employer more for a prescription than it pays the pharmacy. Here's an example of differential pricing in action:

- Your employee or group member pays AWP minus 15%
- PBM pays pharmacy AWP minus 18%
- PBM pockets the 3% differential

Although PBM revenues derived from differential pricing can run between $5 and $8 depending on the type of program served, typical PBM disclosed fees hover at $1 per prescription. While differential pricing is a common business practice, PBMs should disclose the differential with you or your health insurer.

If you have a plan governed by ERISA, you should keep in mind that the U.S. Department of Labor requires full disclosure of all compensation, fees, and income from a PBM that acts in a fiduciary capacity as an administrator and/or claims payer for an employer with a benefits plan.

Recommendation: Ask to see your PBM's contract with network pharmacies and compare it with the PBM's contract with your organization. The reimbursement rates should be the same on both contracts.

Q: Do you participate in rebates from drug manufacturers?

A: PBMs often receive rebates from drug manufacturers in return for placing products on formularies and for working to increase sales volume for these drugs. (Rebates can range from 50 cents to $1.25 per claim.) Some employers allow PBMs to keep 100 percent of rebates in exchange for lower administrative fees. Alternatively, you may prefer a sharing arrangement, typically 50/50.

Recommendation: Whether you share rebates or exchange rebate dollars for lower administrative fees, ask your PBM to disclose the total amount of rebate dollars collected as a result of the business you represent to the PBM — and ask for supporting documentation that explains how rebate revenue is calculated.

Q: What other payments do you get from drug manufacturers besides rebates?

A: Some PBMs reclassify rebates using categories such as education grants, research, advertising, promotion, access fees, formulary management fees and data collection fees.

Recommendation: Ask your PBM to report the "per member per month" (PMPM) cost. This figure is calculated by dividing the total amount of drug cost spent in a month by the number of members enrolled in the program. The PMPM cannot be manipulated and is a true reflection of whether the plan's costs have increased or decreased.

Q: Do you have any plans for mandating mail order on any drug or drug category?

A: A survey by the National Community Pharmacists Association found that, while small and medium size businesses commonly offer mail order options through their health plans, most employees choose to obtain their drugs at local pharmacies. The option of going to mail order only was very unpopular.

PBMs encourage the use of their own in-house mail order operations by charging reduced co-payments and by offering a 90-day supply of drugs, while contractually limiting local pharmacies to dispensing a 30-day supply.

When mail order prescriptions are filled, a PBM receives income from both dispensing and claims fees. A PBM will, therefore, try to maximize use of its wholly-owned mail order.

Recommendation: Check reimbursement rates to ensure they are competitive. Shop around for the best rate.

Q: Does your formulary limit drugs that will be covered?

A: A formulary is a list of "preferred drugs that pharmaceutical manufacturers discount to employers and other groups in exchange for volume usage." The most effective formularies optimize and balance quality, effectiveness, and costs.

Check to see if your health plan has to pre-approve a medication before members can fill a prescription. Many plans require physicians to get prior authorization of medications before coverage, so physicians or pharmacists must call the health plan or PBM for permission to write or fill certain prescriptions. Some plans also require members to try a less expensive medicine first before covering the one recommended by the physician.

Recommendation: Check with your plan to understand its authorization process so members are not surprised at the pharmacy. And, be sure to learn how to appeal requirements and decisions when your members have complaints.

Q: How often do you change your formulary?

A: In most states, a PBM may change its list of approved medicines at any time. If a medication is removed from the formulary without prior notice, the individual patient must either pay out-of-pocket or accept a medication that the PBM prefers.

Recommendation: Check with your PBM for policies related to formulary changes. Will you receive notice of formulary changes in writing? If not, ask for notification.

Q: How are co-payments set?

A: Most health plans require a co-payment for each prescription. Some have a single, uniform co-payment — for example, $10 for any prescription. Other plans have different levels of co-payments for different medications, a system known as "tiered co-pay." A PBM can shift medications from one tier to another at any time, leading to unpleasant surprises for employees when they go to their pharmacies.

Recommendation: Ask about how you and plan members will be notified when the PBM makes a tiered co-pay change of a medication.

Q: Are you currently the subject of any lawsuits or investigations relating to your business practices?

A: The New York attorney general subpoenaed the records of Express Scripts, a large PBM, after an audit by the state comptroller found repeated overcharges to a state employees' drug plan. Express Scripts said it had repaid $613,000 and changed its system to prevent future errors. Attorneys general in more than 20 states investigated the business practices of another PBM, Medco Health Solutions, under consumer protection laws and pharmacy professional standards. Medco entered into a settlement with those states to correct many anti-consumer practices. The U.S. Attorney General has an ongoing investigation.

Some large employers and health plans are hiring outside auditors to review PBM transactions.

Recommendation: Research lawsuits or government investigations against PBMs that are public knowledge. Ask about PBM practices for reporting fraud and abuse and to review external audits.

Q: Can you provide a detailed explanation of your health plan's fee schedule and specifically the cost of clinical programs?

A: Be sure to compare "apples to apples" when evaluating a financial proposal from a PBM. Inexpensive claims processing fees may be less attractive if you are "nickel and dimed" on everything else. Clinical programs are an area where fees vary widely. For example, a prior authorization (PA) program establishes protocols for prior approvals of expensive, non-formulary drugs. A PA program is one tool that can help keep costs under control. However, PA program fees vary widely, from $2 to $40 per PA.

Recommendation: Ask for detailed disclosure and explanation of a PBM's fee schedule. If policies related to prior authorization systems are not clearly explained — ask.

Q: What is your policy on selling pharmacy data?

A: In the business of health care, information equals revenue. Every drug manufacturer would like to know about your plan members' demographics and use patterns. You have the right to demand that your company's information not be sold by your PBM.

Recommendation: Ask the PBM to include a paragraph covering the sale of data in your contract. If you have no objection to aggregate data being sold, you should still require disclosure of the sales. Also consider the value of your company's data and whether or not to ask for some form of compensation from the PBM.

Much of the information contained in this guide for benefits managers comes from the 1998 white paper, "Do You Really Know Your PBM? Tell Your PBM to Show You the Money!" authored by Gerry Purcell, managing partner with Pharmacy Partners, an Atlanta company that assists health plans in selecting and contracting for the best PBM arrangement.