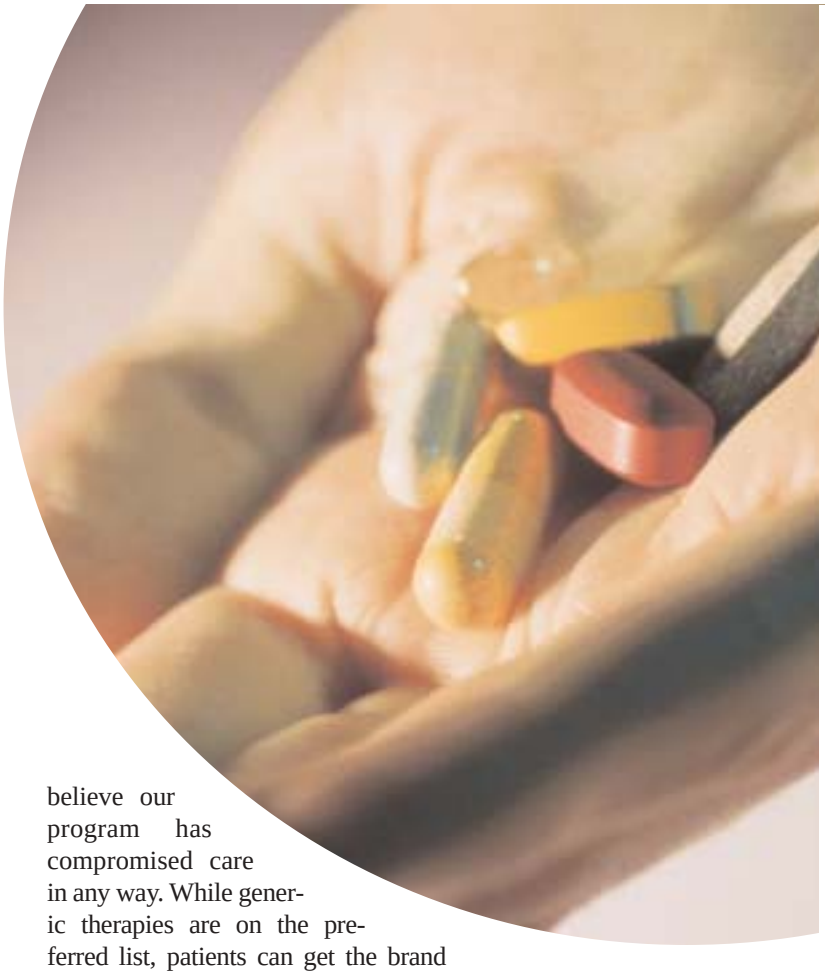
The ABCs of PBMs

New models for managing drug costs

BY SALLY SUE BROWN



Most Americans show up at their local pharmacy, their plastic drug cards in hand, with little idea of how prices and co-payments are determined or how their drug benefit is managed. They know they pay different co-pays for different drugs, but they don't know why. Headlines and rising drug costs over the past few years, however, have captured the attention of average Americans and state officials alike.

States have taken the lead in developing new models to manage drug benefits. In some cases these new models draw heavily from the private sector and in others, they venture into new territory. Grappling with drug-cost growth as high as 18 percent, states have looked at pooling purchasing among agencies or even among states. States have also used their Medicaid buying power to help the uninsured receive prescription drugs at a discount.

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One increasingly common strategy states are examining is banding together to increase their purchasing power. In many cases states have joined together and contracted with a private pharmacy benefit manager (PBM) for services.

The Northern New England Tri-State Coalition, for example, linked executive agencies from Maine, New Hampshire and Vermont to issue a joint request for proposals for PBM services in 2001. While the states negotiated with the same company, each one is establishing a separate contract with the PBM. Through their combined buying power, the states expect to save between 10 percent and 15 percent a year on prescription drugs.

"It's been a very successful program for us and it has saved a lot of money," said Vermont Rep. Pat O'Donnell. "We don't believe our program has compromised care in any way. While generic therapies are on the preferred list, patients can get the brand name if the doctor requests."

A similar effort was launched through a Pharmacy Working Group made up of several state employee purchasing agencies that had previously contracted with separate PBMs for their employee health benefits. In 2002, four states – West Virginia, Maryland, Missouri and New Mexico – issued a joint request for proposals. West Virginia and Missouri subsequently selected a single pharmacy benefit manager, and the other two states were able to renegotiate existing PBM contracts at lower rates. West Virginia estimates that the process will save the state $25 million over three years. The multistate PBM was one of the winners of CSG's 2003 Innovations Awards.

In February 2003, Michigan and Vermont announced a plan to work together on Medicaid drug purchasing; Wisconsin and South Carolina quickly joined them. Other states have also expressed interest but each will have to develop or adopt a similar preferred drug list in order to work together.

In May 2003, the Centers for Medicare and Medicaid Services, the federal agency that oversees Medicaid, announced it would allow and provide states with guidance on multistate purchasing arrangements for Medicaid.

In addition to multistate purchasing programs, several states have pooled covered populations within their state agencies to negotiate better prices. For example, in Georgia, the Medicaid program and state employee health benefits plan jointly purchased PBM services and are using a common preferred drug list. Similarly, the Texas Legislature created an interagency council to develop methods for bulk purchasing in hopes of saving $13 million over the next two years. And Michigan created a common preferred drug list for all state programs that purchase pharmaceuticals and has contracted with a PBM to negotiate prices.

How does pharmacy benefit management work? PBMs apply private sector best practice techniques to manage drug costs and access. Their basic functions are to negotiate best prices with manufacturers based on volume, develop a formulary or preferred drug list to encourage patients to use only certain drugs, manage the drug benefit on behalf of purchasers, and contract with pharmacies to create a network for patients to use.

As states have looked at developing new models for drug purchasing, many have followed the private sector's lead and have used private PBM companies to manage their drug benefits. As of July, 22 states had contracted directly with a PBM company to manage drug purchasing and distribution on their behalf, according to the National Academy for State Health Policy.

Since the early 1990s, PBM companies have acted as middlemen between purchasers and pharmacies, promising to cut costs for employers and health plans. The savings come through bulk purchasing as PBMs use their mass buying power to negotiate discount prices on behalf of their clients. Such arrangements also provide convenience for patients, who can have prescriptions filled and only pay the co-payment at the pharmacy. For health plans and employers, PBMs offer specialized expertise in drug management, higher savings and less hassle because the company handles claims processing and reimbursement.

State contracts with pharmacy benefit managers have brought both questions and concerns. PBMs are for-profit companies and have received increased scrutiny by the media and health care analysts in recent years. Some critics contend that PBMs make excessive profits off programs designed to cut costs.

There are three ways PBMs make money: charging administrative fees, collecting a percentage of the cost of each drug dispensed, and taking advantage of manufacturer rebates. Over the years, the fees PBMs charge for their services have actually decreased as the profit potential in drug ingredient costs and rebates has increased. When the PBM industry started out, administrative fees were about $1 per transaction. Now, increased competition and the ability to make money in other aspects of the business have caused fees to plummet to about 19 cents per transaction.

PBMs can profit when a prescription is filled. For example, a PBM may contract with a drug manufacturer to pay $10 for a prescription, but then bill the payer $13. The purchaser is generally glad to pay less than the regular $20 selling price and assumes that $13 represents the best cost savings the company can negotiate. What purchasers sometimes may not realize is that the PBM made a profit of $3. In a health care system where every penny counts, some customers may be frustrated that the price they pay is not the lowest negotiated price.

"Much of the controversy is based on misunderstandings," said Robert Garis, assistant professor of pharmaceutical and administrative sciences at Creighton University. "Most employers think they are charged the actual price that is negotiated and are shocked to discover that these companies are profiting in the process of generating savings."

Another related criticism of PBMs is that they may make formulary decisions based on the potential for greatest profit rather

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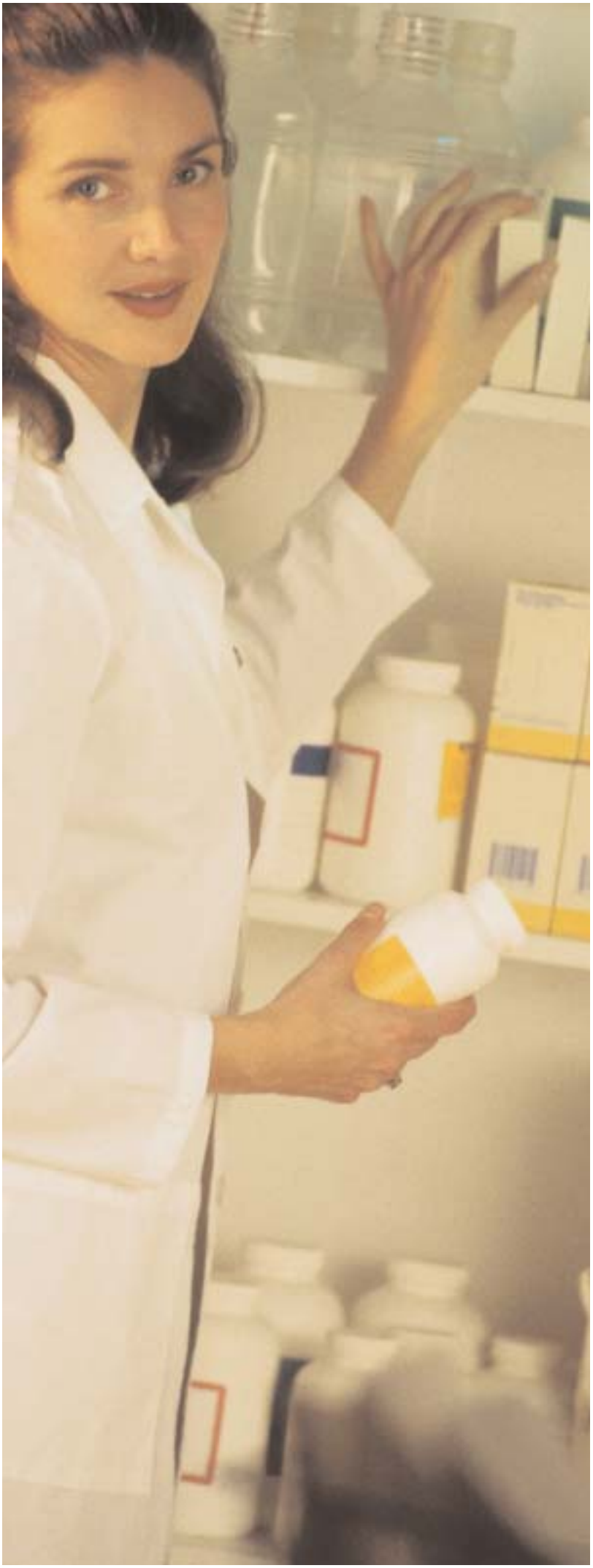

States' estimated and actual phase II distributable amounts for 1999-2001

STATE	1999		2000		2001		Total	
	Estimated	Actual	Estimated	Actual	Estimated	Actual	Estimated	Actual
Alabama	$190,000	$190,000	$140,000	$124,059	$200,000	$180,434	$530,000	$494,493
Florida	4,294,000	4,294,000	3,164,000	2,803,727	4,520,000	4,077,805	11,978,000	11,175,532
Georgia	22,230,000	22,230,000	16,380,000	14,514,871	23,400,000	21,110,761	62,010,000	57,855,632
Indiana	4,408,000	4,408,000	3,248,000	2,878,162	4,640,000	4,186,065	12,296,000	11,472,227
Kentucky	112,708,000	112,708,000	83,048,000	73,591,636	118,640,000	107,033,362	314,396,000	293,332,998
Maryland	2,356,000	2,356,000	1,736,000	1,538,328	2,480,000	2,237,380	6,572,000	6,131,708
Missouri	1,596,000	1,596,000	1,176,000	1,042,093	1,680,000	1,515,644	4,452,000	4,153,737
North Carolina	144,210,000	144,210,000	106,260,000	94,160,573	151,800,000	136,949,296	402,270,000	375,319,869
Ohio	5,168,000	5,168,000	3,808,000	3,374,397	5,440,000	4,907,801	14,416,000	13,450,198
Pennsylvania	1,634,000	1,634,000	1,204,000	1,066,905	1,720,000	1,551,731	4,558,000	4,252,636
South Carolina	26,372,000	26,372,000	19,432,000	17,219,351	27,760,000	25,044,219	73,564,000	68,635,570
Tennessee	28,766,000	28,766,000	21,196,000	18,782,491	30,280,000	27,317,685	80,242,000	74,866,176
Virginia	25,004,000	25,004,000	18,424,000	16,326,128	26,320,000	23,745,095	69,748,000	65,075,223
West Virginia	1,064,000	1,064,000	784,000	694,729	1,120,000	1,010,430	2,968,000	2,769,159
TOTAL	**380,000,000**	**380,000,000**	**280,000,000**	**248,117,450**	**400,000,000**	**360,867,708**	**1,060,000,000**	**988,985,158**

Source: U.S. General Accounting Office

MSA: Five years later Continued from page 16

CSG estimates that between 2003 and 2010 states could lose between $10.1 billion and $15.6 billion in cigarette excise taxes from Internet sales. This figure does not include sales taxes, which would make these revenue loss estimates even bigger.

There are hundreds of Internet cigarette retailers, and very few of them comply with the Jenkins Act that requires retailers to submit to states their purchase records so that states can collect appropriate taxes. Few Internet retailers comply because violation of the Jenkins Act is only a misdemeanor and the federal government does not actively enforce the law. Another problem is that buying cigarettes off the Internet is relatively easy for underage smokers because few Internet retailers verify the age of their customers. While OPMs must fund programs to prevent youth smoking as part of the MSA, Internet cigarette sales are undermining these efforts.

Looking back and looking forward

In the five years since the MSA was signed, states have received billions of dollars in settlement money. These settlement funds, however, have been adjusted downward because of the declining volume of cigarettes manufactured and sold in this country. Some tobacco farmers have gone out of business, but many have survived through these years of declining demand. The original participating tobacco manufacturers that signed the MSA remain relatively sound financially, but companies that did not sign the MSA are gaining market share. And there is some evidence that declining tobacco sales have hurt small tobacco retailers.

If current trends continue and tobacco consumption declines, tobacco-related illnesses should also decline. This is good from both a public health and a financial perspective for the states. The financial health of tobacco farmers and major tobacco companies, however, may not fare as well. MSA-related costs in addition to other factors may combine to decrease the profitability of many small tobacco farms, mostly in the South. And the future of many large tobacco companies may depend, in part, on the actions states take to address issues related to the rising market share of companies that have not signed on to the MSA. The economic impacts of the MSA will continue to play out over the next several years.

— Melissa Taylor is chief research analyst and Irakli Khodeli is a research intern at The Council of State Governments.

States' use of tobacco settlement funds

Fiscal year	Budget shortfall	Tobacco control	Assistance to tobacco growers and economic development	Health	Education and social services	Tax reductions	Infrastructure	General purposes/ reserves	Unallocated
2000-2001	NR*	6.8%	5.6%	41.3%	9.3%	3.6%	2.5%	10.6%	20.2%
2002	14.4%	5.2%	4.1%	48.0%	9.6%	0.5%	2.0%	9.8%	6.5%
2003	14.5%	5.1%	5.0%	50.7%	9.8%	1.4%	1.5%	8.6%	3.5%

Source: U.S. General Accounting Office *Not Reported