



# How Pharmacy Benefit Management Programs Can Help Employers Save Significantly on Healthcare Costs



Learn About More Proactive and Progressive Approaches to Managing the Pharmacy Trend to Remain Profitable, Productive and Competitive

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By: Gary Alton

## LEARN ABOUT MORE PROACTIVE AND PROGRESSIVE APPROACHES TO MANAGING THE PHARMACY TREND TO REMAIN PROFITABLE, PRODUCTIVE AND COMPETITIVE

### Pharmacy benefit costs are the fastest growing segment of our national healthcare expenditures...

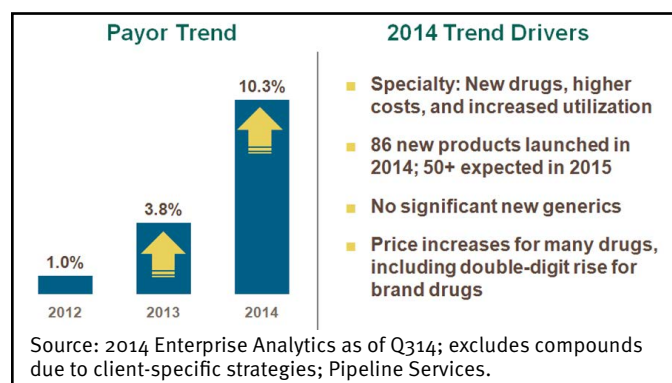
rising at a rate faster than hospital care and physician services combined! In this whitepaper we explore how employers are achieving significant savings via a proprietary pharmacy benefit program, available via their self-funded health plan\*. Additionally, we've included recent case studies demonstrating 10% to 30% savings achieved through this program, plus an overview of the latest trends and new programs that will improve your healthcare program members' Rx utilization while lowering your self-funded prescription expense.

The Partners Group formed a partnership with the experts at RxBenefits in order to better understand the complex world of Pharmacy Benefits and how it affects our clients. What we found out is critical information for self-funded employers. To help you understand why pharmacy is a major key to your employee benefit savings, we start with an overview of the current pharmacy landscape in the marketplace and then address strategies to stay ahead of these growing pharmacy trends.

### Current Pharmacy Landscape & Strategies to Stay Ahead of Growing Trends

Pharmacy is the most complex and fastest growing component of medical benefits expenditures. It currently represents 20-25% of our overall medical spend in the U.S., a percentage predicted to grow in the near future. In the past few years, trend increases have remained very modest in pharmacy. However in 2014 we experienced a big spike.

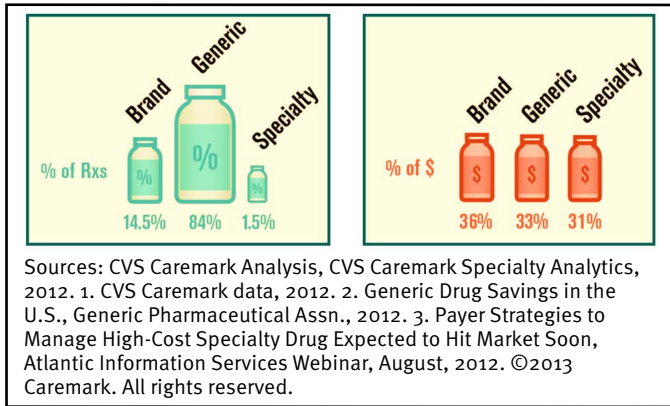
This kind of movement will continue for the next few years due to emerging trends in the marketplace, most noticeably in the specialty drugs category. Over 85 new specialty products were launched last year, and another 50 are expected to launch in 2015.



We've seen the conversion of brand names to generics over the past few years, which has helped us to mitigate the drug trend increase, but that pipeline is quickly dwindling. Unfortunately the cost of both generic and brand prescriptions are increasing and the trend of brand name drugs moving to generics has peaked. Not only are prices rising, but studies show that consumers have been filling more prescriptions as the economy has improved.

### Pharmacy Cost Profile Trends

The breakdown of the three major categories of drugs shows us that while the current allocation of prescriptions is extremely disproportionate, with generics making up 84%, brands 14.5%, and specialty only 1.5%, the cost profile of each is nearly equal, at 33%, 36% and 31% respectively. This model is constantly evolving as the pharmacy landscape changes, and studies predict the rise of the specialty cost profile in the coming years.

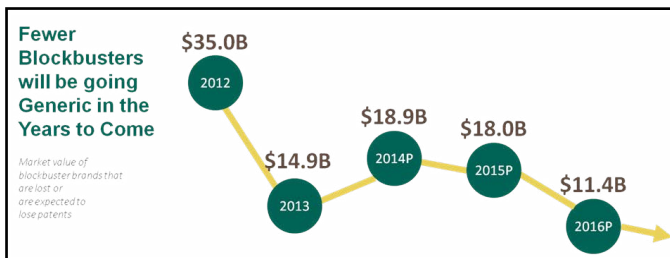


## The Generics Cost Increase Trend

Generics have been able to offset inflation for the past few years, but that opportunity is nearly exhausted now. Manufacturers are pulling out of the generic space, which creates less competition to drive down prices. Additionally, there are shortages in the supply of some active ingredients, all resulting in increased costs. Still, the average price of a generic drug is around \$50, compared to the average cost of a brand name drug at around \$150. Generics are still delivering substantial savings over brand name drugs.

## Increased Difficulty in Shifting From Brands to Generics

In 2012, 35 billion dollars in brand name drugs came off patent, which allowed for the opportunity to take advantage of generic drugs in order to control costs. Yet, as the years go by, fewer and fewer brand name drugs will be coming off patent, making it difficult to control costs by shifting members from brands to generics.



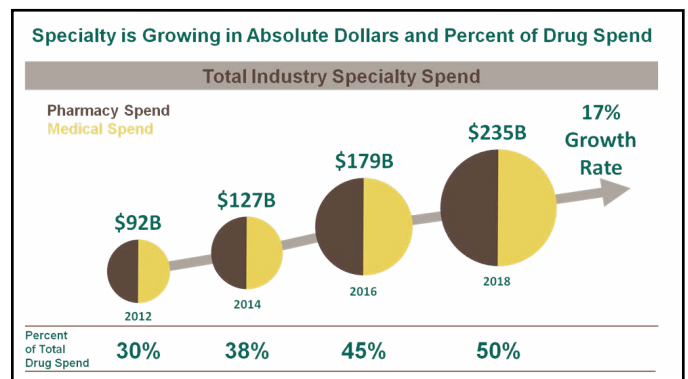
## Specialty Drugs – The Runaway Train

Perhaps the biggest issue though, is the extremely high price point of specialty drugs. The average cost is roughly \$3,000 per month, but the most expensive specialty drug to date, Sovaldi, a new Hepatitis C drug, costs \$84,000 per 12-week regimen.

Specialty drugs are expected to have a growth rate of approximately 17% year over year. In 2012, it represented 30% of the drug cost profile, and by 2018 it's expected to represent 50% of the employer's total pharmacy spend!

## Hidden Specialty Costs

As illustrated below, half of your specialty drug spend is actually represented in the medical plan versus the pharmacy plan. For every dollar that you spend on specialty drugs in the pharmacy channel, there is a corresponding dollar spent on medical. The reason behind this is that many plan sponsors don't realize the significance of the pharmacy claims because they're listed on medical claims reports that show higher cost claims, such as surgeries, so they don't stand out as much. Conversely, on a pharmacy claims report, these specialty drugs stand out as very noticeable.

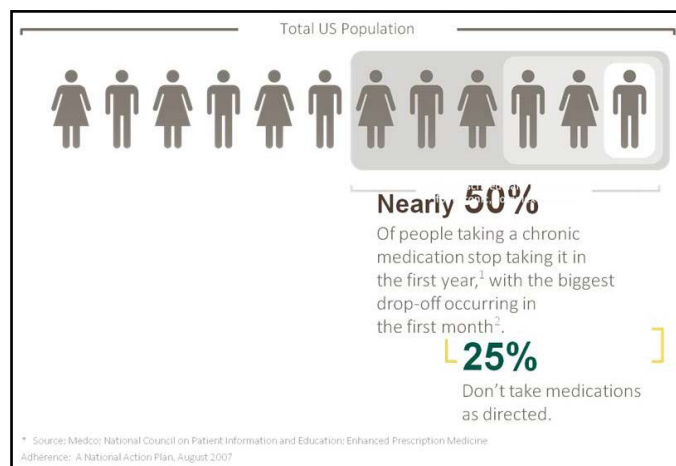


## PHARMACY STRATEGIES: FORMULARY, ADHERENCE, AND CARVE-IN/CARVE-OUT

### Formulary Strategies – Designed for the Safest, Most Effective Medications at the Most Reasonable Cost

Formularies are very specific and strategic, developed by Pharmacy Benefit Managers (PBM) to provide the safest, most effective medications at the most reasonable cost. One strategy is to have tiered co-payments, where members incur a higher co-pay for higher cost drugs, or for drugs listed as non-preferred on the formulary. A more recent strategy PBMs have deployed is to make exclusive agreements with certain manufacturers. These agreements secure greater discounts and rebates in exchange for exclusive formulary rights.

From a plan response perspective, many groups are moving toward high deductible plans. High deductible plans on the pharmacy side are financial models, rather than clinical models, which is problematic because short-term members are identifying these plans as more cost conscious. Yet studies show that in the long run, these plans actually lead to reduced office visits and lower prescription drug adherence, with an increase in emergency room expenses. It's critical that each group understands their breakeven point when evaluating plan designs.



## Case Study: Sovaldi— Utilizing Formulary Strategies to Influence Pharmacy Costs

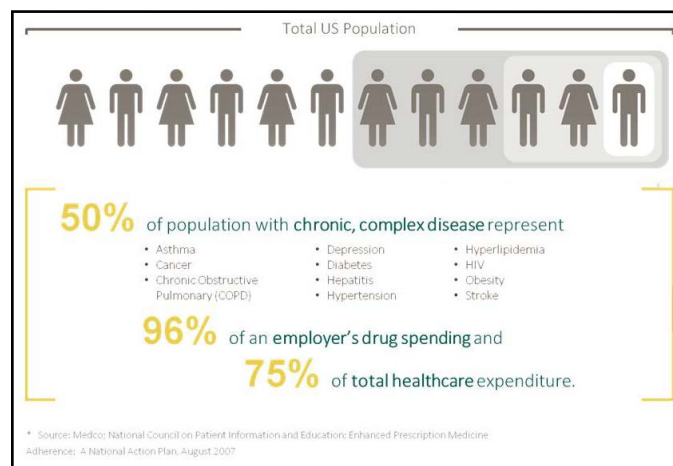
An example for how exclusive arrangements between PBMs and manufacturers can influence pharmacy costs is Sovaldi, a Hepatitis C medication which costs \$84,000 per 12-week regimen. There are other drugs on the market, made by different manufacturers, which are equally as effective as Sovaldi with a 95% cure-rate for Hepatitis C. Express Scripts, a pharmacy benefit manager (PBM), made a deal with Viekira Pak, an equivalent drug made by a different manufacturer, to be their preferred brand name drug for Hepatitis C.

Express Scripts negotiated the cost of the drug and the cost increase per year on the basis that they would make Viekira Pak their preferred option, excluding Sovaldi and others from their formulary. Sovaldi manufacturers then approached CVS Caremark and made a similar deal, sensing the threat of marketplace exclusion. The bottom line is that PBMs are able to create pressure in the marketplace,

ultimately driving down costs, especially with highly expensive specialty drugs.

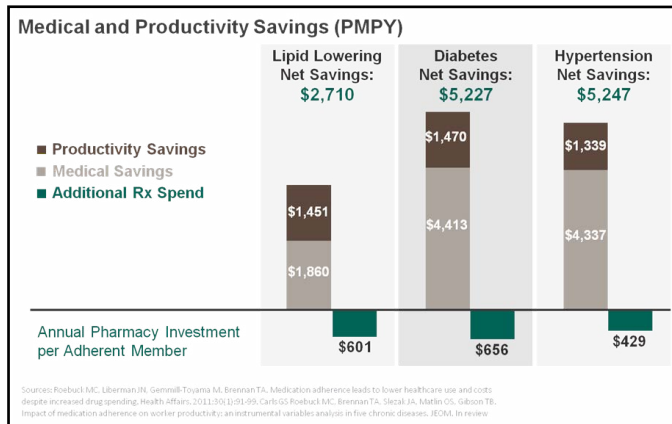
## Improving Medication Adherence as Another Solution for Reducing Costs

Medication adherence is another place employers could look to cut costs. Members who are not adherent or compliant with their doctor recommended medication regimen result in higher costs for the plan. Of a typical population, over 50% of the members are chronically ill in some form. These individuals represent 96% of an employer's drug spend and 75% of the overall healthcare spend. Approximately half of those individuals are not compliant with their drug regimen. Improving adherence to medication may increase an employer's drug spend, but it will also reduce costs related to an ER visit or other acute encounters, which are ultimately much more expensive. The problem becomes leveraging the PBM and all of their clinical tools and resources to get all members to a compliant state.



## Research Shows: Investing in Adherence, Improves Outcomes

As portrayed in the middle column below, for every dollar spent on diabetes medication, roughly seven dollars are saved in medical spend. This type of saving is also evident with high cholesterol and high blood pressure medication. Medication adherence keeps members out of hospitals, which impacts medical costs. While investigating pharmacy costs is important, understanding how pharmacy programs relate to overall medical costs has the potential to cut expenditure as well.



## Key Issues Affecting Adherence

Several barriers to medication adherence have been identified:

- **Cost** is the number one problem we've identified.
- How easy is it for the member to refill a prescription? The easier it is, the more likely they will stay adherent to the medication regimen.
- **Human error** or forgetting to take the medication according to regimen creates a third barrier.
- **Side-effects**, such as flu-like symptoms, can discourage a member from continuing usage of the drug.

Whatever the cause, the drug goes to waste if not used properly, incurring more cost to the plan either by a more serious medical problem resulting in hospital care, or having to start the drug regimen from the start again.

## Different plans can be deployed to support adherence.

For example, the use of 90-day drugs, either via mail or retail prescriptions, will make it more convenient for members to fill their prescription because they won't have to do it as often as every month. Guiding members toward the lower cost generic drugs to make them more affordable will help with adherence as well. PBMs can extend support for members by issuing refill reminders or offering counseling for members using specialty medications with adverse side-effects. If the members know what to expect as far as side-effects, they are more likely to carry out the entire regimen.

## Carved-In vs. Carved-Out

As a self-insured plan sponsor, you have options for designing your pharmacy plan, whether it's a carved-in arrangement or carved-out.

- **In a carved-in arrangement**– the medical carrier or the third-party administrator (TPA) holds the pharmacy contract with the PBM, which is bundled with the medical contract.
- **In a carved-out arrangement**– pharmacy is separated from the medical carrier and a direct relationship with the PBM is formed. The benefit to a carved-out method is that your contract with the PBM is fully transparent and auditable and you can hold the PBM accountable to the terms of that contract.

## Pharmacy contracts can be very misleading.

It's helpful to have a firm like The Partners Group, especially in partnership with RxBenefits, to be able to assist you in reviewing these contracts. If you have a carved-in arrangement with a medical carrier, the carrier holds that pharmacy contract, leaving you in the dark as to what kind of a deal or discounts you're getting. The carrier may provide you with a high-level overview of the discounts off of the average wholesale price, (AWP), by drug type and distribution channel, but in reality, the PBMs and carriers typically use clever optics to make the contract look more attractive on paper than it actually performs.

**Carving-out allows you more control over your pharmacy spend and more transparency** with your contract. The majority of large employers and the most sophisticated buyers are carving-out.

## Who exactly is carving-out pharmacy?

- 85% of Fortune 500 employers
- 90% of Fortune 250 employers
- 94% of Fortune 100 employers

These massive companies recognize the value in carving-out, because they have the size and scope to negotiate very aggressive discounts and the PBMs will cater to them from a service perspective.

"It is not uncommon for a carved-out healthcare plan to yield savings of 12% to 15% in total annual pharmacy spend" - CFO.com, March 14, 2013

## What About Mid-Size Companies Carving-Out?

In the mid-market segment, only about one in five employers is carving-out pharmacy. It's easy to understand why this trend differs from larger employers. When mid-sized companies go directly to the big PBMs, such as Express Scripts, CVS Caremark, or Optum, they tend to get lost in the shuffle from a pricing and service perspective. Mid-sized companies miss out on the savings that Wall-Street-sized accounts are able to secure because they are catering to their larger accounts, the 500-life group, 1,000-life group, or even 5,000-life group.

## A Solution for Providing Greater Buying Power to Mid-Sized Companies

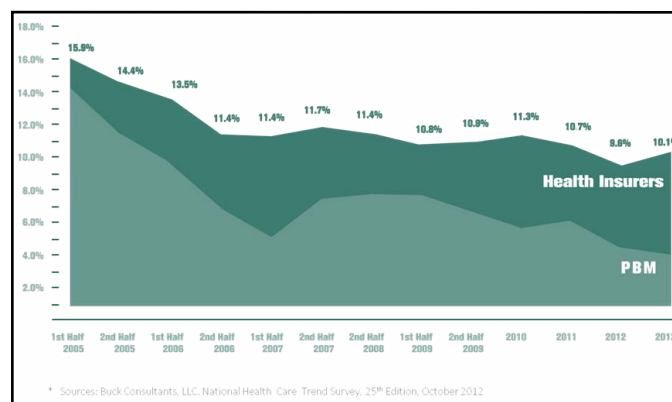
C2 Solutions was developed as a solution to help provide greater buying power to mid-sized employers. The Partners Group and four other independent consulting firms throughout the United States have formed an equity-owned partnership called C2 Solutions. The five firms in the partnership have gone to these PBMs as C2 in order to bring the size and scope of their combined books of business to negotiate contracts that allow their midmarket clients to purchase like much larger organizations. For example, the 500-life company can purchase like a 50,000-life company. Additionally, C2 provides oversight of the contract to make sure PBMs are performing to the terms given and that there are no gaps in service. C2 is now the fifth largest employee benefit independent consulting firm in the nation, with over 3.3 billion dollars of premium under management.

## It's Vital to Stay on Top of the Rising Pharmacy Cost Trend

Carved-out PBMs offer 100% of their resources toward pharmacy management. Carving-out pharmacy puts you in a direct relationship with the experts, where their only focus is pharmacy. In a health plan arrangement, pharmacy tends to take a backseat to medical, but statistics show that pharmacy costs are only going to continue to increase, which makes that intense focus vital in the coming years.

## Carved-Out Model Drives Better Overall Cost and Trend Management

Trends in a carved-in or health insurer model versus a carved-out or PBM model show an increasingly large gap over the years. At the end of the years 2013 and 2014, the health insurer pharmacy trend was upwards of 10 – 12%, whereas the carved-out arrangement was 3 – 4%. This gap between the two models is projected to increase. **With pharmacy expenditures at 20 – 25% of your health care spend and growing, it's important to know how to stay ahead of these trends. The PBMs have many different programs that can be put in place to control costs, but understanding your population, utilization, and purchasing effectively is critical.**



## Rising Cost Trends are Making a Pharmacy Focus Critical

**Partnering with an expert dedicated to and focused on Pharmacy Benefits is becoming critical in a world where pharmacy constitutes 20-25% of an employer's medical spend each year, a number projected to increase in coming years. Our job is not just to find areas where we can cut costs for our clients, but to examine and address the topics employers will need to consider in the future to maintain a sustainable, profitable business.** In addition to lowering cost basis and negotiating greater discounts each year, RxBenefits predicts how pharmacy trends will affect expenditure in the future, which allows us to put programming in place to mitigate costs. The C2/Rx Partnership gives clients an exceptionally focused effort on 20-25% of their total medical spend, resulting in a possible 10-30% projected savings for the employer.

## Available Audit Process to Compare Your Plan's Current Performance Verse How it Could Be Performing

The Business Consulting division at The Partners Group has partnered with RxBenefits to create a data analytics program that allows us to capture a group's pharmacy data and calculate their pharmacy spend as it would have looked if it was in a C2 contract with Express Scripts or CVS Caremark. We can then run their current pharmacy contract through the same system and get a true apples-to-apples comparison for the two plans. This audit is performed at no cost to the employer. It is an easy way to see how the current plan is performing verse how it could be performing with the efficiencies gained from incorporating the pharmacy benefit plan.

### Case Study

This case study demonstrates the value of the analytics that TPG and RxBenefits provide for TPG clients, especially for those presently in a carved-in model. The report gives insight into the current arrangement and how it's performing today, while also recalculating claims as if they were processed through the carved-out arrangements negotiated by the C2/Rx Partnership. This allows employers to see how their current deal compares to the marketplace.

This case study was an actual self-funded group in Portland. They are a 400-life group and have been self-funded for eight to nine years. The group believed their situation was about as good as it could get: they were with a large, well-known carrier, their generic utilization was at 86%, and they had a great plan design. Overall, they were a great performing group, but there were still substantial savings TPG's analysis was able to produce. Of course, there were a few things the HR team, CFO, and CEO worried about concerning the implementation of a new model.

### Member Disruption

Member disruption was a major concern for the case study group. How will this impact our employees and their families? What will have to change in order to enter a new contract? With a change in contract comes an unavoidable change in routing codes and the issuing of new cards to members. When

changing PBMs completely, members may have to deal with a change in formularies, which may or may not affect some of them. For example, if a group is with Optum, but finds out through the analysis that Express Scripts would save them 17%, they may deal with minor disruptions regarding formularies if they switch over. Members may find that the preferred brand name drug they used with Optum is now in the non-preferred brand name category with Express Scripts. A handful of members will see a drug changing from Tier II to Tier III, while others will see their Tier II drug move up to Tier I with the new PBM.

This impact is something TPG looks at in each analysis. For the case study group, we noted 25 members who saw their co-pays go from a \$20 brand name drug to a \$40 non-preferred brand name drug. Yet, over fifty members experienced the opposite. There was also a rescue inhaler, used by about 10 members, that was an excluded drug on the new formulary. However, there were five or six other options in both the preferred and non-preferred category which members could shift to.

Another consideration we had was prior authorizations. If members had already been preapproved to take a drug, we obtained that list and automatically coded it, meaning members didn't have to get reapproved for a drug, saving a lot of member disruption.

### Billing Implementation

Typically in a self-funded plan, there are two bills an employer pays: monthly fixed expenses and weekly or bi-weekly claims. When an employer carves-out pharmacy, they still have the fixed fees charged by the TPA, but the medical and pharmacy claims are billed separately. As long as implementation and set up is done correctly, ongoing impact to the employer is minimal, and TPG helps oversee this process.

### Audits

If a group chooses to have an audit done by TPG and RxBenefits, they may get some pushback from the carrier, the TPA, or the PBM, but as a self-funded group, it's their data and they have a right to view it. It's important to understand that pharmacy is a profit center for most carriers. This isn't necessarily a bad

thing, but it's something employers should be aware of. Carriers may negotiate a 75% discount off of AWP, but they're only passing along 65% of that discount to the employer, meaning they keep the 10% spread as profit.

## Multi-Year Contracts

Usually the longer a group can get a rate guarantee on their medical plan, the better. Unfortunately, in the pharmacy world, it's only a good deal for the PBM. PBMs continually negotiate lower costs with pharmacy manufacturers. Plus any new drug that comes into the marketplace is expensive regardless, so they pass those expenses on. Any of the negotiated savings over a two or three-year contract become profit for PBMs because they're still adhering to the terms of the old contract and the original discount. They may be improving that discount year over year, but they're not passing it on to the groups. There were cases when we did the analysis for certain groups and determined that the group needed to wait a year because the penalty to get out of the contract was far too high. Again this isn't a bad thing, but it's something to be aware of.

## Integration Fees

If an employer does choose to carve-out the PBM, the TPA will charge a per employee/per month integration fee, because they're working with an outside vendor versus having it bundled together. Some TPAs may only charge 45 cents and others will charge six dollars per employee, per month. A reasonable fee is between two and three dollars.

## Executive Summary of Case Study/Audit Process

The 400-life group featured in this case study was performing very well. Their spend per claim was very low with CVS Caremark. In order to perform the audit, TPG looks at 12 months of actual Rx claims data and runs it through the C2 contract in order to figure out what the cost would have been had the group used the C2 contract with either a direct CVS Caremark or Express Scripts contract.

When TPG compared the group's contract, which was direct with the TPA, to the C2 contract with both CVS Caremark and Express Scripts, they found approximately 30% in savings. This group was

spending about 600,000 on pharmacy a year, and would have saved \$190,000 with the C2 contract. Of course there are still the considerations about member impact, disruption, and implementation, but the high level savings were impressive.

## Financial Analysis Comparison—Current PBM vs. C2 RxPartnership –CVS Caremark

While a group's contract may say they receive 16% off AWP for retail brand name drugs, it takes more analysis to determine whether they're actually receiving what they've been promised. TPG does a deeper analysis of the discounts to find the actual effective rate, and compares it to the effective rate of the proposed C2 RxPartnership contract. For example, the case study group was receiving a 15% discount on retail brand name drugs with their current contract. When compared to the cost under CVS Caremark with the C2 contract, the discount was only slightly higher, at about 16%.

	INCUMBENT - CVS Caremark through TPA	Effective Rates	C2 RxPartnership CVS Caremark	Effective Rates
	06/01/2012-5/31/2013		06/01/2012-5/31/2013	
Gross Claim Amount Paid by Employer	\$271,967		\$509,847	
Less Member Copay	-\$102,060		-\$102,060	
Claims Amount Paid by Employer	\$569,907		\$404,787	
Plus Administrative/Transaction Fees*	\$5,250		\$21,731	
Less Rebate Credits from PBM	-\$32,913		-\$47,967	
Net Amount Paid by Employer	\$542,244		\$378,551	
Brand Name Ingredient Cost	\$216,405	15.15%	\$213,667	16.25%
Generic Ingredient Cost	\$237,004	55.64%	\$115,004	78.33%
Specialty Ingredient Cost	\$5,931	13.50%	\$5,662	16.00%
Dispensing Fees	\$8,567	51.13%	\$6,502	50.30%
Total Retail Paid	\$467,946		\$341,634	

What differentiates the two plans the most is the discount on retail generic drugs, where the TPA contract shows a 55% discount, while the C2 RxPartnership contract shows 78%. Regardless of what kind of discount is described in the contract, the financial analysis comparison finds the actual effective rate, and the exact amount an employer is paying.

Another thing the analysis checks for is rebates. If a group is self-funded, they're probably receiving a quarterly rebate check, but it's worth asking, how much are they receiving? In some cases we found that Administrative Services Only (ASO) carriers were keeping 100% of the rebates. This analysis helps determine how much a group should be receiving in rebates and figures out if they are actually receiving that amount. C2 contracts guarantee a rebate per script, so it's easy to know the dollar amount a group

should be receiving back. TPG and RxBenefits audit the contract, and find places where the PBM missed a rebate.

The Partners Group factors in any additional administration fees to the analysis. Overall, the case study group wanted to minimize the disruption to their members, so they moved from their bundled or carved-in contract with CVS Caremark to a C2 CVS Caremark contract. They had to reissue their cards, but otherwise, all preauthorization and formularies stayed the same. They were projected to save 30%.

## Reverse Re-Price Summary

On a quarterly and annual basis, The Partners Group audits the plan to figure out if projected savings are met and if the effective rate is holding true to contract. After the case study group's first year on the new plan, TPG broke it down by retail, specialty, mail, dispensing fees, administration fees, and rebates to determine if the discounts all came through as contracted. TPG projected just over 30% in savings for 2014 based on historical claims data, and the actual amount was just short of 32% with little impact to the employer and the employees.

The goal of the audit, at no fee to the group, is to give one of two results. Either the group will find that they are getting a good deal through their current PBM, or that there are additional savings to be secured.

Every group will be different depending on size and utilization, but reverse re-pricing illustrates how much they could save.

## Optional Programs – C2/Rx Partnership – CVS Caremark

Saving 10% to 30% on pharmacy spend is excellent, but what's next? As a group adds more lives to the plan and as pharmacy trend continues to grow, how can the group manage their pharmacy spend in the future? TPG helps determine other programs that are appropriate based on a group's people, culture, and appetite to add more cost control.

## One program TPG is Reviewing is a Mandatory Mail Order or a Maintenance Choice Program

For the case study group, it could save them another 5% on their spend, meaning approximately \$30,000.

That may not seem like a huge number, but it equals out to another full-time employee they could then afford to hire. These programs aren't just about keeping healthcare costs low, but allowing the group to reallocate those dollars more strategically.

## Conclusion – Pharmacy has Been a Neglected Topic, but It Needs to be One of Our Main Focuses

Healthcare is complex, and pharmacy is on a whole other level. People are just starting to understand things like how physicians are paid, how hospitals are paid, what kind of discounts they are getting, and what kind of results we are seeing. The marketplace is just beginning to go down that path, but pharmacy has been a neglected topic. It's easy to assume if you're with a large carrier, you're getting the best possible Rx deal. However, while you may have a fantastic plan, it may not always be your best option. Given the multitude of specialty drugs coming out, and the growth in pharmacy we are about to experience, pharmacy should be one of our main focuses. We don't want to just lower your cost basis up front; we want to continue to manage it for you, to ensure you're getting the best deal possible every year.

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\* **Self-funded** health care is a self insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds. To find out more about how you can become a self-funded employer, please [contact The Partners Group](#).

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### **Bottom Line**

We create strategies that benefit your financial position as well as your employees' well-being. Our clients call this client-centered approach exceptional. We call it being a good partner.

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