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Identifying Cost Savings in Pharmacy Benefits

Pharmacy benefits for active employees and Medicare-eligible retirees present an excellent opportunity to drive out unnecessary costs and improve risk management, driven by market dynamics as well as regulatory and tax changes.

Over the next three years**,** $133 billion worth of brand-name drugs will lose patent protection, generating downward pressure on prescription drug costs. Unfortunately for the bottom lines of corporate health-plan sponsors, the savings will be at least partially offset by the increasing use of specialty pharmaceuticals. These new-age drugs frequently cost tens to hundreds of thousands of dollars per year, and they also spur cost inflation for brand drugs prior to their patent expiration.

The goals in optimizing retiree health benefits and pharmacy benefits for active employees are (1) superior clinical outcomes for employees and dependents, and (2) improved financial performance. The strategies and tactics outlined below will help plan sponsors achieve both objectives.

Active Employee Pharmacy Benefits

Many large employers unwittingly leave significant amounts of money on the table in the provision of pharmacy benefits for active employees as well as pre-Medicare retirees on “active” plans. In many cases, active employee pharmacy benefits are accessed through an employer’s contracted health plan. Unbundling or “carving out” the pharmacy benefits presents substantial savings opportunities for plan sponsors.

However, as anyone who has analyzed a pharmacy benefit manager (PBM) contract will attest, these contracts are both complex and opaque. To maximize cost savings and risk management opportunities available through “carving out,” it is essential to understand and clarify all aspects of the contract while also embedding in the contract comprehensive audit rights and the ability to implement appropriate clinical programs.

In a “carved-in” arrangement, the health plan acts as a middleman between the PBM and the plan sponsor. This structure drives up the price of drugs for the plan sponsor, as many health plans are embedding revenue in their pharmacy benefit management contracts as a result of the Affordable Care Act’s minimum-

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loss ratio slated to take effect in 2014. Additionally, health plan contracts are generally silent on drug pricing metrics leaving plan sponsors in the dark over contract discounts, rebates, and administrative fees.

When prescription drugs are “carved in,” plan sponsors often lack the ability to effectively audit drug claims that provide important insights into utilization patterns and provide opportunities to manage costs and clinical outcomes.

While carving out the pharmacy benefit allows for direct negotiation of pharmacy benefits, it is critical to approach this process very deliberately. In order for plan sponsors to maximize their leverage when carving out pharmacy benefits, it is necessary to structure a request for proposal (RFP) that results in a comprehensive contract with clearly defined terms, competitive discounts and rebates, market price checks before the final contract year, and most importantly, a full range of audit rights to ensure that the agreed-upon contract terms are being delivered.

A well-negotiated PBM contract, followed by comprehensive auditing and clinical program oversight, can help improve outcomes for employees and their dependents, while simultaneously reducing excess costs. It is not uncommon for a carved-out health-care plan to yield savings of 12% to 15% in total annual pharmacy spend.

Many health-care plans argue that carving out the pharmacy benefit will negatively affect disease-management programs because it is more difficult for doctors to account for all medications being taken by a patient when some drug claims run through the medical plan and some go through a separate carved-our drug plan. Disease-management programs ostensibly remove cost from both medical and drug benefit plans. That claim is self-serving at best. Plan sponsors can mandate that both providers establish protocol for sharing data to ensure effective disease-management programs, regardless of how prescription drugs are procured.

Retiree Pharmacy Benefits

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) created two federal subsidy programs to offset plan sponsors’ prescription drug costs for Medicare- eligible retirees. One, known as the Retiree Drug Subsidy (RDS), provides a tax-free 28% reimbursement for employers whose

costs fall between $320 and $6,500 per retiree in 2012. The Affordable Care Act changed the tax treatment of the RDS subsidy, making it taxable in 2013. Large corporations receiving the subsidy have already reduced their deferred tax assets to reflect the change.

The other subsidy approach created by the MMA is the Employer Group Waiver Plan (EGWP), often referred to as an “egg-whip” or a Series 800 plan. This structure was not widely embraced by the health-care consulting market, and initially corporations showed little interest because of the plan’s limitations in union environments. Companies also failed to recognize the EGWP’s real benefit: protection against the rising cost of specialty medications.

However, changes in the tax treatment of RDS payments, combined with interpretive guidance from the Center for Medicare and Medicaid Services (CMS) subsequent to the passage of health-care reform, has made the EGWP increasingly attractive to employers. The EGWP has benefitted from the integration of a secondary “wrap” plan, which enables plan sponsors to offload a greater percentage of costs onto brand pharmaceutical manufacturers, and also to match the employer’s original plan design, making the EGWP + wrap suitable for collectively bargained retiree groups.

Without any change in benefit levels or cost sharing, switching from the RDS to the EGWP + wrap will result in plan sponsors lowering their ASC 715-60 (formerly FAS 106) liability by approximately 12% to 14%.

The chart below illustrates how the reinsurance provided by an EGWP can substantially benefit plan sponsors faced with the extremely high costs of specialty drugs. Under the RDS, plan sponsors receive 28% of the costs incurred between $320 and $6,500 in 2012. In the EGWP plan, sponsors benefit from a base subsidy of approximately $657 (as compared to an average RDS reimbursement of $510), plus federally funded 80% reinsurance for “catastrophic” costs, defined as those expenses an individual retiree generates in excess of a CMS set threshold ($6,657.50 in 2013) in a given plan year.

RDS vs. EGWP: A Comparison
How the Retiree Drug Subsidy stacks up against the Employer Group Waiver Plan for holding down retiree drug costs.

Retiree Drug Subsidy	"800-series" EGWP
Does not provide catastrophic coverage	Catastrophic coverage provided through Federal govt. funded reinsurance covering 80% of large claims
Beginning in 2013, RDS will lose its beneficial tax treatment	From 2011 to 2020 the Federal govt. will provide additional coverage eventually filling 75% of the coverage gap in Part D
Public sector employers not allowed to include RDS subsidy when calculating their Accrued Actuarial Liability (AAL) on their financial statements	Public sector employers are permitted to incorporate EGWP subsidy when calculating AAL
Unpredictable cash flow	Predictable cash flow
Pharmaceutical industry discounts do not apply	Allowed to participate in pharmaceutical manufacturer discounts
Does not access Part D improvements	All requirements including formulary enhancements and beneficiary communications have been approved by CMS
Employer responsible for CMS compliance & reporting and subject to CMS audit	The EGWP plan sponsor (typically the PBM or PDP, not the employer) is responsible CMS compliance & reporting
No low-income subsidy payments	Receive low-income subsidy payments
Employer must pass gross and net actuarial equivalence test to qualify for subsidy	No actuarial equivalence tests required

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