Pharmacy Benefit Companies 101: A Primer

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- Rx Research Corner

Given all the recent attention around pharmacy benefit companies and prescription drug costs, I thought it would be helpful to create a primer of what exactly a pharmacy benefit company is and does. A lot of people aren't too sure what roles pharmacy benefit companies play in the drug supply chain, and I'm hoping to clear some of that ambiguity up with a Q&A.

What is a pharmacy benefit company?

A pharmacy benefit company is an entity that is responsible for pharmacy benefits – the way you gain access to your prescription drugs – function well for more than 275 million people nationwide, allowing us all to access our drugs easily. Pharmacy benefit companies help the entire healthcare system by driving down drug costs, saving money for patients and health plan sponsors – those that hire pharmacy benefit companies, including public and private sector employers, government programs like Medicare and Medicaid, health insurers, and labor unions.

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How do pharmacy benefit companies save money for health plan sponsors and patients?

According to research, pharmacy benefit companies save health plan sponsors and patients $1,040 per person per year, adding up to $1 trillion over the next ten years. Much of this direct savings comes from the rebates and discounts that pharmacy benefit companies negotiate from drug companies and pass back to plan sponsors, who can choose to use the savings to make benefits more affordable or lower patient out-of-pocket costs. Rebates function, in effect, as volume-based discounts that can best be negotiated when there is competition among drug companies. The use of the savings is fully at the discretion of the employer or plan sponsor. But pharmacy benefit companies do far more than just negotiate rebates. Pharmacy benefit companies provide at least $148 billion in value for the healthcare system every year. In addition to negotiating drug company rebates, pharmacy benefit companies also reduce costs and improve health by negotiating lower costs and higher quality from pharmacies, facilitating convenient mail delivery of prescriptions, promoting the use of less costly yet

equally effective generic drugs, and helping patients stay on their drugs, thereby avoiding serious and costly medical events.

What are pharmacy benefit companies doing to help patients afford their medications?

Pharmacy benefit companies provide affordable access to prescription drugs for 275 million people every year, which means helping patients, clinicians, and pharmacists navigate more than 3.6 billion prescriptions filled annually. Without pharmacy benefit companies, the savings they negotiate, and prescription drug coverage, patients could be forced to pay drug companies' list prices – sometimes incredibly high list prices – for their prescriptions. Pharmacy benefit companies have programs to help patients who face high cost sharing (i.e., out-of-pocket costs), including those patients who are in their deductible phase of coverage. This program covers a wide range of drugs used to treat chronic conditions like diabetes, asthma, and heart disease. For example, many pharmacy benefit companies cap the cost of insulin at $25 for a 30-day supply.

How do pharmacies negotiate with pharmacy benefit companies?

Pharmacies of all sizes work with pharmacy benefit companies and contract with pharmacy benefit companies for agreed-upon reimbursement rates for prescription drugs. These rates are based on drug acquisition costs, taxes, and other fees charged by the pharmacy. While independent pharmacists can choose to negotiate their contracts directly with pharmacy benefit companies, the vast majority choose to join a pharmacy services administrative organization (PSAO), which has scale and collective bargaining power. The PSAO marketplace is dominated by the big three wholesalers: AmerisourceBergen, Cardinal Health, and McKesson. Over 75% of independent and small-chain pharmacies contract with a PSAO owned by one of these wholesalers. PSAOs are powerful corporate entities, operating with virtually no state or federal regulation or oversight.

Why do pharmacy benefit companies use pharmacy networks?

Pharmacy benefit companies build pharmacy networks to allow patients access their prescriptions at discounted rates. Pharmacies negotiate to be in networks, offering discounts in exchange for network status to attract customers. They also are held to performance metrics that enable a high-quality experience for patients; for example, encouraging generic drug dispensing and patient medication adherence. Keeping pharmacies accountable for providing lower-cost drugs and high-quality service is an important tool pharmacy benefit companies use to keep the rising costs of prescription drugs down for patients and taxpayers. In Medicare Part D, where the use of pharmacy

networks is extremely common, pharmacy benefit companies are able to negotiate 1.9% to 2.3% lower drug prices.

Do pharmacy benefit companies force independent pharmacies to close?

Pharmacies are important partners with pharmacy benefit companies, who help make drugs accessible and affordable for patients. Rather than being in decline, the independent pharmacy market is stable and profitable. According to National Council for Prescription Drug Programs' (NCPDP) data, over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5%. Over the last five years, the number of independent pharmacies has increased 0.5%, indicating a stable marketplace. In fact, this is not just NCPDP's data showing this; the National Community Pharmacy Association (NCPA), the lobbying group for independent pharmacists, agrees. In their annual 2022 Digest Report, they report that the number of independent pharmacies increased by 0.4% in the last year, stating that the "independent pharmacy category was essentially flat."

Additionally, independent pharmacies' financials have also been stable. From 2016 to 2020, the average per prescription gross profit margin for independent pharmacies ranged from 20.8% to 21.1%, showing little fluctuation. This market's strength and stability allows pharmacy benefit companies more opportunities to partner with independent pharmacies to achieve our shared objectives of increasing access to affordable medications and helping patients stay on their prescribed medications.

How competitive is the pharmacy benefit marketplace?

The pharmacy benefit marketplace is highly competitive, with 70 full service pharmacy benefit companies operating in 2021. And this number is increasing, with nearly 10% more pharmacy benefit companies in 2021 than in 2019. Pharmacy benefit companies differentiate themselves through product innovation and client services. For example, they can offer employers and health plan sponsors the ability to include medication adherence programs, patient support programs, and customized low or zero cost sharing in the prescription drug benefits they offer to their employees and plan members.

Do pharmacy benefit companies support transparency?

Pharmacy benefit companies are strongly in favor of transparency that provides usable information for plan sponsors, prescribers, and patients. Technology like real time benefit tools (RTBT), electronic prior authorization (ePA), and electronic prescribing (eRx) reduce burdens and provide actionable information. Pharmacy benefit companies also provide plan sponsors with financial data on savings they've secured on

prescription drugs, fees and payments, aggregate data on drug utilization and plan enrollees, and details about how much will be paid for each drug filled under the plan. This information helps plan sponsors make the best plan choices for them and the people they enroll in prescription benefit coverage. Pharmacy benefit companies also submit to regular, contractually required, plan-sponsor audits. Misguided "transparency" proposals that require disclosure of proprietary information would encourage drug companies to offer fewer price concessions once they realized competitors weren't discounting as deeply. This tacit collusion by drug companies would result in higher drug costs.

How are pharmacy benefit companies paid?

In addition to making final decisions on benefit design and coverage, employers, and health plan sponsors (i.e., payers) also choose how they would like to pay for the services and programs pharmacy benefit companies deliver to them. There are two main choices that employers and health plans make when hiring a pharmacy benefit company:

Risk Mitigation Contracting

- The employer or health plan pays their pharmacy benefit company a set reimbursement amount for each drug, regardless of where the patient fills the prescription. If the patient's pharmacy charges the pharmacy benefit company more than that set reimbursement rate, the pharmacy benefit company takes a loss. If the patient's pharmacy charges less than the set reimbursement rate, the pharmacy benefit company earns a margin (i.e., the spread). Smaller employers often choose what are referred to as "spread contracts" because of the pricing predictability and savings they derive.
- Alternatively, the employer or health plan may choose to pay the pharmacy benefit company a fee to administer the claims and pay the pharmacy benefit company whatever the pharmacy charges (based on the pharmacy/pharmacy benefit company contract). Many large employers prefer this compensation model over a risk mitigation (spread) model because they have the scale to absorb reimbursement variability.

Rebate Contracting

- Employers and health plan sponsors may also choose to allow the pharmacy benefit companies to keep a small portion of the drug company's rebates, or discounts, as a way to incentivize pharmacy benefit companies to negotiate

deeper discounts. While this aligns incentives toward deriving cost savings, it is a less common payment model.

- Alternatively, employers and health plan sponsors may choose to keep 100 percent of the rebates and pay the PBM fees for negotiating rebates and setting up a formulary.

What happens to drug company rebates?

For brand drugs for which there is therapeutic competition, pharmacy benefit companies negotiate rebates, which are price concessions on drug company list prices, from drug companies in exchange for placement on drug formularies. Once rebates are negotiated, they are usually "passed through" from the pharmacy benefit company to the health plan sponsor. According to the Government Accountability Office (GAO), 99.6% of rebates in Medicare Part D are passed through to plan sponsors. In the commercial market, 91% of rebates are passed to plan sponsors. Plan sponsors choose what to do with those rebate dollars, which typically includes lowering premiums and cost sharing and enhancing benefits.

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