ISSUE BRIEF
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Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans

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ABSTRACT

ISSUE: Large self-insured employers and other health care plan sponsors are concerned about rising prescription drug costs. Formularies developed on their behalf by intermediaries like pharmacy benefit managers (PBMs) and health plans can ensure drug safety and support negotiating with manufacturers. But intermediaries can profit from these negotiations, creating financial incentives to include high-price drugs even if they offer little clinical value.

GOAL: Identify drugs that add waste on employers' formularies, measure savings from removing waste, and identify best practices in pharmacy benefit management.

METHODS: Analyze drug utilization data from 15 self-insured plan sponsors — 13 are members of the Pacific Business Group on Health (PBGH) — to estimate savings from reducing the use of drugs that cost more than their commensurate clinical value as compared to alternatives.

KEY FINDINGS: Reducing the use of high-cost, low-value drugs could lead to $63 million in annual savings across the 15 plan sponsors. This represented 3 percent to 24 percent of overall pharmacy spending, depending on a number of factors.

CONCLUSION: Plan sponsors could lower drug spending and out-of-pocket costs for enrollees by reducing the use of high-cost, low-value drugs on formularies. Savings could be achieved by improving pharmacy benefit design and management.

TOPLINES

- Pharmacy benefit plan sponsors could lower drug spending and out-of-pocket costs for enrollees by reducing the use of high-cost, low-value drugs.
- Better formulary management can help pharmacy benefit plan sponsors provide their workers with access to appropriate and innovative medications at lower overall cost and ultimately improve health outcomes.

The Commonwealth Fund

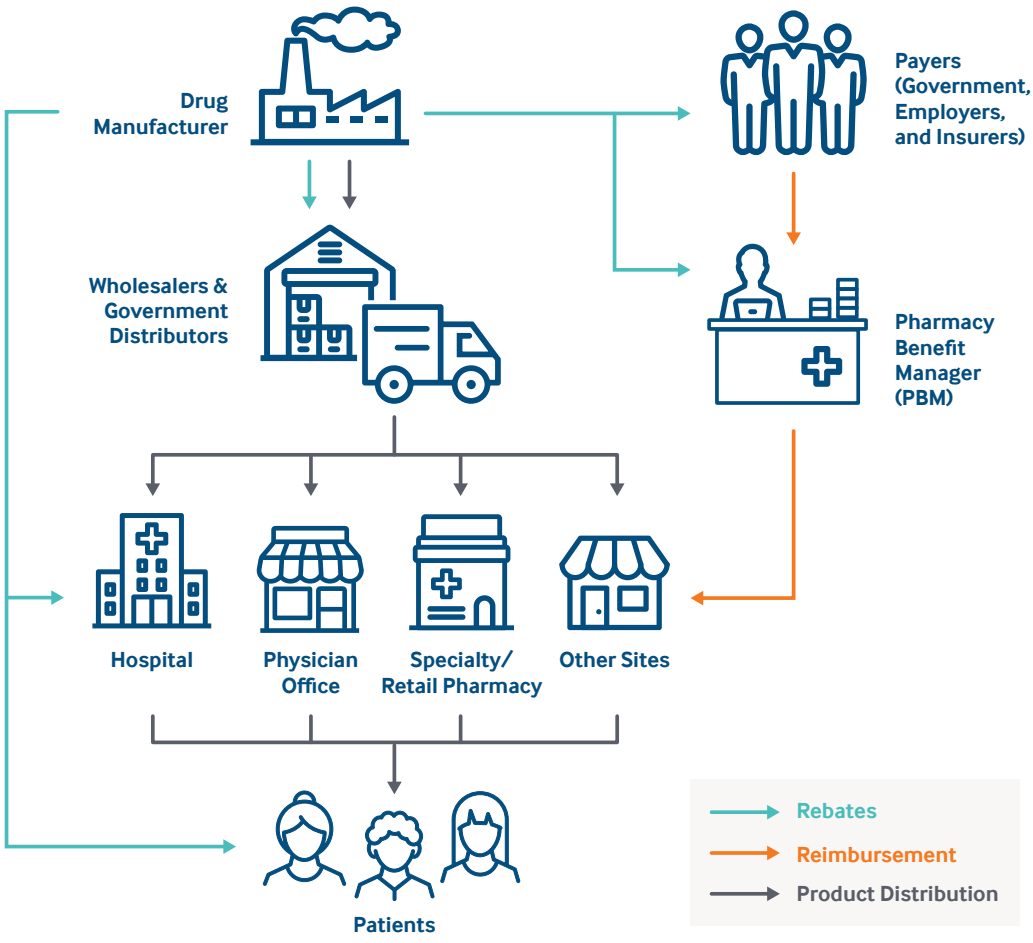
BACKGROUND

The high and growing cost of prescription drugs imposes a financial burden on patients and employers, who sponsor health benefits. Certain costs — for instance, for new and effective therapies — can be justified. But costs also can accrue from products that offer little or no value relative to available alternatives. There are complicated, numerous reasons that this occurs.

One is misaligned incentives in the drug supply chain (Exhibit 1).[1] Pharmacy benefit managers (PBMs) act as the intermediary between health plans and pharmaceutical manufacturers. Self-insured plan sponsors often contract directly with PBMs to manage the pharmacy benefit offered to employees. PBMs negotiate with pharmaceutical manufacturers for price discounts, which are typically paid as rebates based on sales volumes driven by formulary placement. Rebates can reduce the final net price to the plan sponsor and may be passed on to patients. However, in exchange for low administration fees, plan sponsors allow PBMs to keep a portion of the negotiated rebates and other fees.[2] Contracts between PBMs and plan sponsors contain rebate guarantees, perpetuating the demand for high-rebate drugs by encouraging PBMs to maximize rebate revenue, giving preference to some drugs over others on formularies based on rebate revenue rather than their value and final cost to the patient or plan sponsor. Additionally, PBMs earn revenue from "spread" pricing, which is the difference between what PBMs pay pharmacies on behalf of plan sponsors and what PBMs are reimbursed by the plan sponsor. This also encourages PBMs to prioritize higher-cost drugs to allow for a larger spread.

Exhibit 1. An Example of the Pharmaceutical Supply Chain

From pharmacies to hospitals to insurance companies to distributors, many entities are involved in getting a medicine from the pharmaceutical company to the patient. Together, they make up the pharmaceutical supply chain. This chart depicts a typical route a medicine takes from drug manufacturer to patient, including the roles of multiple players that make up the process.



Data: Adapted from Janssen Global Services, LLC, *2018 Janssen U.S. Transparency Report* (Janssen, Mar. 2019), 21.

Privacy agreements have kept these incentives hidden by prohibiting communication about them by manufacturers or pharmacists. Formularies can contain drugs that have little or no additional clinical value. These may include me-too drugs,[3] combination drugs,[4] brand-name drugs rather than their generic equivalents, and over-the-counter equivalents (see text box).

TYPES OF WASTEFUL OR LOW-VALUE DRUGS

- Me-too drugs: Immaterial tweaking of a particular ingredient results in a "new" drug that adds no clinical value and often extends patent protection
- Combination drugs: Drugs that combine two active ingredients into one pill, resulting in costs substantially higher than the costs of the individual ingredients
- Prescription drugs offered when over-the-counter alternatives are available
- Brand-name or higher-priced generic drugs offered when lesser-cost generics are available

Moreover, plan sponsors often allow broad formularies that include wasteful drugs because they are concerned that employees will be disappointed if their prescribed drugs are not covered. Doctors prescribe these drugs because they are often unaware of drug costs. Pharmaceutical manufacturers contribute to these patterns by promoting their products through "detailers" — pharmaceutical salespeople calling on doctors — when less costly alternatives may be clinically appropriate for patients. Plan sponsors have addressed the resulting high spending by increasing patient cost-sharing on lower-value drugs. Manufacturers counteract cost-sharing and formulary management tools by flooding the market with copayment coupons that undermine the benefit structure put in place by plan sponsors.

Pacific Business Group on Health partnered with Integrity Pharmaceutical Advisors to test the feasibility of rooting out formulary waste.[5] The project sought to understand and estimate the impact of plan sponsors adjusting formularies to remove drugs that add cost and have low or no clinical value compared to alternatives. The project sought to answer the following questions:

- Do formularies offered by 15 plan sponsors contain waste that is contributing to high pharmacy costs and trends? What are potential savings from reduced use of wasteful drugs?
- What prevents plan sponsors from adopting a waste-free formulary and instructing their PBMs to change formulary practices?

The study considered a large data set from self-insured plan sponsors and identified meaningful opportunity for plan savings if wasteful drugs were excluded from formularies. The study did not directly measure savings to patients; however, it follows that plan participant savings could be substantial as well. The methods section includes information about the conservative assumption and approach applied to this work (see How We Conducted This Study).

FINDINGS

Savings Estimate

A total of 868 drugs from 71 drug groups making up 6 percent of claims analyzed were classified as wasteful and included in the calculations.

The cost differential between the low-value drugs and the drugs that were at least as effective and less expensive ranged from 25 percent to 99.9 percent per drug. We estimate a total annual savings of $63.3 million for the plan sponsors evaluated. For a subset of plan sponsors for whom total PBM-channel drug spending information was available, this represented 3 percent to 24 percent of total PBM-administered pharmacy spend.[6] The variation is related to the degree to which plan sponsors already design their formulary to exclude wasteful drugs and more closely manage pharmacy benefits, in addition to variation in demographics and utilization patterns.

Estimates are annual direct cost savings for nonspecialty drugs and do not include additional savings from better clinical outcomes, indirect productivity and member satisfaction, or better contracting practices and network arrangements.

In addition, the study showed that:

- wasteful prescriptions represented 3 percent to 12 percent of total claims per plan sponsor evaluated, or 6 percent across all data, with an average savings of $413 per script
- brand-name drugs made up 42 percent of wasteful prescriptions, generating an average savings of $682 per wasteful brand script
- generic drugs made up 58 percent of wasteful scripts, generating an average savings of $212 per wasteful generic script
- specialty drugs made up 0.1 percent of wasteful scripts, which generated an average savings of $2,221 per wasteful specialty script.

Ten drug groups accounted for 72 percent of total savings (Exhibit 2); eight drugs accounted for 21 percent of total savings (Exhibit 3). (Additional lessons learned from this study are summarized in the Appendix.)

Potential for Plan Sponsor Adoption

The savings created from removing wasteful drugs from formularies should be a powerful motivator for employers and other plan sponsors to do it. However, benefit design decisions on pharmacy practices vary by plan sponsor and depend on multiple factors, including cost (or savings opportunity); members' experiences, including concerns about negative health consequences; and administrative "lift." Companies use this framework to make decisions around employer-sponsored pharmacy benefits and it shows why benefit designs can vary across companies. Despite a clear opportunity for savings, plan sponsors will consider their larger health benefit strategy when considering steps to reduce use of low-value drugs and wasteful spending.

Exhibit 2. Ten Drug Groups Account for 72 Percent of Savings

Drug group	Percent of wasteful prescriptions	Percent of savings
Dermatologicals	23.7	24.9
Ulcer drugs	9.1	7.9
Antidiabetics	1.2	7.1
Antidepressants	2.2	6.5
Analgesics — anti-inflammatory	0.9	5.2
Anticonvulsants	1.4	4.6
Nasal agents — systemic and topical	19.5	4.4
Migraine products	2.6	4.1
Vasopressors	1.1	3.9
Tetracyclines	1.6	3.6

Data: Author's analysis.

Exhibit 3. Eight Drugs Account for 21 Percent of Savings

Drug	Percent of savings
Metformin Hcl ER (MOD + OSM)	5.5
Dexilant	3.6
Duexis	2.6
Mometasone furoate	2.1
Absorica	2.0
Solodyn	2.0
Esomeprazole magnesium	1.6
Jublia	1.5

Data: Author's analysis.

Other Potential Barriers to Adoption. Plan sponsors cite concerns about PBM business practices when considering the value of the drugs included on their formularies. These concerns can be an obstacle to uptake (see text box).

PBMs provide a range of services including formulary development, clinical care management, utilization management (including preauthorization), negotiations with pharmacies for drug price discounts, negotiations with manufacturers for rebates, and claims adjudication and payment. Plan sponsors use services depending on their individual models and preferences; administrative fees are assessed accordingly. Services with the potential to increase revenue streams to the PBM may lower administrative fees; for example, formulary design that allows PBMs to select "profitable" drugs in terms of rebates and pharmacy spread might be accompanied by reduced administrative fees. Plan sponsors have made unfavorable and often uninformed trade-offs for reduced administrative fees to PBMs.[7]

Plan sponsors negotiate with PBMs to receive some or all of the rebates negotiated with manufacturers. They add rebate audits and guarantees to PBM contracts to ensure these transactions. However, PBM practices that curtail rebate pass-through, including categorizing manufacturer fees as something other than rebates, have become widespread. As a result, plan sponsors should consider alternatives to rebate-driven formularies.

But reliance on rebate revenue can also be an obstacle to adoption. Plan sponsors have become accustomed to receiving rebate checks and often budget accordingly to utilize those payouts despite an overall higher total cost of care. Moreover, those funds are often used to reduce costs of the entire plan, including premiums for all enrollees. This dynamic can be troubling — some patients pay the higher list price and then rebates are returned to benefit all enrollees. Some plan sponsors utilize a point-of-sale rebate policy, which returns the portion of the rebate paid by the patient directly to that patient. This practice is growing in popularity but currently used by only a minority of the plans.

POTENTIAL BARRIERS TO ADOPTION OF A WASTE-FREE FORMULARY

- Contract restrictions imposed by PBMs.
- Increased administrative fees imposed by PBMs. Case studies confirm that savings from reduced waste will compensate for increased administrative fees.
- Current conventional procurement processes involves consultants comparing administrative fees, rebates, and discounts instead of the reduced per-member per-month drug spend that can result from an appropriate drug mix.
- Attachment to current rebate payouts will require financial and budgetary adjustments, despite an overall decreased per-member per-month drug spend.
- Concern for member experience if prescribed drugs are excluded.
- Ensuring the highest-value drug mix might demand a specialized consultant, which may create an administrative burden.
- Popular consultants have a stronghold and may be conflicted by PBM revenues themselves.

Even with rebates passed through, other PBM revenue streams (such as spread pricing) can result in low-value drugs being placed on formularies. If plan sponsors take steps to remove low-value drugs, PBMs could increase their administrative fees to replace lost revenue. However, administrative fees charged to plan sponsors are transparent and require justification by PBMs. In addition, PBMs would have to contend with other competitors on transparent fees and services. This would be a significant change from today's approach in which PBM revenue streams remain hidden.

While this analysis demonstrates savings from waste-free formularies can be substantial, employers will need to exercise due diligence with regard to their formularies, data analysis, and vendor contracts. PBMs may seek other avenues to replace lost income from removal of high-rebate drugs. Insisting on transparency and informed contract terms with PBMs will bolster employers' ability to retain savings from the type of formulary changes reflected in this study.

Plan sponsors may face other barriers. For example, health benefit consultants that work with plan sponsors might have interests that conflict with the goals of optimized pharmacy benefit management, particularly if they are working with organizations within the supply chain.

CONCLUSION

Large self-insured employers and other plan sponsors can save 3 percent to 24 percent of outpatient pharmacy costs managed by PBMs by removing high-priced drugs with low or no added clinical value from their formularies. These savings are compelling, given the relatively low administrative barrier to implementation. Nevertheless, adoption may be slow; plan sponsors make benefit decisions based on factors that might trump cost reduction. Better formulary management — including elimination of wasteful spending — can help plan sponsors provide their workers with access to appropriate and innovative medications at lower overall cost and ultimately improve health outcomes.

HOW WE CONDUCTED THIS STUDY

All of the 15 plan sponsors used one of the following PBMs: Express Scripts (4), CVS Caremark (8), OptumRx (3).

The data sets analyzed represented claims data from 2017 through March 2018. The data sets did not include prices or rebate information, patient demographics or health status, formulary and benefit design information, or information about the universe of covered lives for each plan sponsor. Total costs were imputed based on conservative assumptions about this information. Excluded from the analysis were specialty drugs and drugs where PBMs and manufacturers negotiated rebates based on competitive drug offerings, resulting in lower net prices of one brand over another.

In identification of waste, clinical studies of alternative lower-cost drugs were carefully evaluated to fully understand any clinical value that might be derived from the higher-cost, higher-rebate alternatives. In some cases, if a potential clinical advantage might be derived by a more expensive drug for a patient subset, a preauthorization protocol is recommended to assure that FDA clinical indications and clinical study findings are followed. For this analysis, any recommendations where clinical judgements may be considered controversial were eliminated.

Assumptions Supporting This Study

Estimated discounts from average wholesale price (AWP) were applied to all dispensing channels based on the size of the data donor. AWP discount guarantees across all dispensing channels vary depending on contractual terms and the method by which they are measured and administered. The AWP estimated discounts, by dispensing channel with ranges based on plan sponsor size, are:

- Brand at retail: AWP minus 16% to 18%
- Brand mail order or 90-day fill: AWP minus 26% to 28%
- Generic at retail: AWP minus 82% to 84%
- Generic mail order or 90-day fill: AWP minus 83% to 86%.

AWP and all drug classifications were determined based on the transaction date of each claim via the Medi-Span database.

A presumed maximum allowable cost list was generated for each of the three PBMs based on offerings made to similarly sized plan sponsors.

An estimated rebate amount was assigned to each drug eligible for rebates over the six-month period and it was assumed that the plan sponsor received 100 percent of those rebate funds.

Alternative utilization assumptions were applied for conversions from each targeted wasteful drug to less expensive, equally effective alternatives (i.e., it was not assumed that all current users would switch to highest-value alternatives).

NOTES

1. Janssen Global Services, LLC, *2018 Janssen U.S. Transparency Report* (Janssen, Mar. 2019), 21.

2. The Burchfield Group, *The PBM Insider: A Guidebook for Gaining Control Over Your Pharmacy Benefit Manager and Prescription Drug Costs* (Burchfield, 2017).

3. Bruce Friedman, "How Pharmaceutical Companies Fool Consumers with Me-Too Drugs," *Lab Soft News* (blog), Pathology Education Consortium, Jan. 7, 2013.

4. Sharon Orrange, "You're Paying Too Much for These 10 Expensive Combination Drugs," *GoodRx* (blog), Dec. 13, 2016.

5. Pacific Business Group on Health commissioned the assistance of Integrity Pharmaceuticals Advisors (IPA) as a technical and clinical partner on this work. Learn more about IPA here: integritypharmaceuticaladvisors.com.

6. Pharmacy spend for plan sponsors can be categorized as "PBM" spend, similar to Part D in the Medicare space or "medical channel," similar to Part B in the Medicare space. This project addressed PBM-channel spending only.

7. Henry C. Eickelberg, *The Prescription Drug Supply Chain "Black Box": How It Works and Why You Should Care* (American Health Policy Institute, 2015).

8. Alex Jung, "Employer Actions to Reduce Pharmacy Costs," EY-Parthenon, n.d.

9. Dave Chase, "8 Steps That Could Save Employers $500 Billion and Boost Education," *Forbes,* June 22, 2015.

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Appendix. Additional Lessons Learned from Waste-Free Formulary Analysis

1. Recognize the misaligned incentives innate in the pharmacy benefit manager (PBM) business model.
2. Optimize PBM contracts, which may require hiring experienced (and clinical) staff or identifying an independent expert consultant.[8]
    a. Be sure any consultant has your interest as their business objective and is not receiving revenues from any external sources. Enforce this by contract.
    b. Consider carving formulary development out of the PBM contract to an external independent consultant or internal clinical expert. Other PBM services might be outsourced as well. In all cases, assure that incentives are aligned for best financial and clinical outcomes objectives.
3. Evaluate data to get a preliminary sense of the opportunity for savings. Purchasers can undertake initial efforts themselves, request specific answers from their vendors, or commission external support to identify waste in existing pharmacy utilization.
4. Categorize and prioritize waste clean-up based on cost-per-patient and condition type. Establish a work plan and timeline for multiple types of interventions.
    a. For very high-cost drugs (high per-patient waste factor), consider engaging a clinician (M.D. or Pharm.D.) to contact prescribers and discuss a prescription change by sharing information on clinical studies and drug costs.
    b. Identify drugs for some chronic conditions to "grandfather," and make changes for new prescriptions only.
    c. Consider direct mailings to patients on certain chronic drugs notifying them of the opportunity for savings to patient and plan and announce the timeline for formulary change.
    d. Consider engaging a consumer-facing transparency tool to help patients make better and higher-value drug decisions.
    e. Consider whether a shared-savings program with individual patients might be a culture fit to encourage those patients' selection of higher-value drugs that might otherwise, depending on benefit design, bring them moderate savings while bringing the employer substantial savings.
5. Engage employed populations in sharing the fruits of a successful initiative by virtue of reduced or consistent premium trends.
    a. For some corporate cultures, employee partnerships for altruistic uses of health care savings has positive impact on member receptivity to the change.[9]
6. Make benefit design changes that support better formulary management.
    a. Allow coverage for select over-the-counter drugs.
    b. Consider reference pricing or coinsurance plans and exclude coverage for blatantly wasteful drugs.
    c. Implement coupon accumulator programs to adhere to benefit designs. This ensures equity across conditions within a population. Employers should be mindful that high cost share can impact drug adherence resulting in poor health outcomes and higher health care costs. Benefits should be designed to assure affordable access to high-value drugs and other medical care.
    d. Consider options for other programs to counter or take advantage of copayment coupons.
7. Adopt point-of-sale rebate practices to reduce cost burden on less healthy populations and to promote a degree of transparency about rebates and actual drug cost.
8. Identify provider groups treating large proportions of your population and partner with them to reduce wasteful prescribing, including the promotion of effective point-of-care prescribing support.
9. Utilize a PBM that keeps no rebates, other pharmaceutical manufacturer revenues, or spread (pass-through model) and insist on stringent auditing rights.
10. Involve corporate finance and accounting leadership in modeling total cost-of-care savings so that they understand that a reduction in periodic rebate payouts will be accompanied by a reduction in total cost of care because higher-value drugs will be used.

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The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.