Pharmacy Benefit Managers and Unique Customer Segments: Large Employers

by Gene Jay

Employers have, over the past several decades, increasingly offered prescription drug coverage as a benefit for employees. Often, large employers contract directly with pharmacy benefit management companies (PBMs) for these services.

PBMs have existed since the early 1980s. Initially mail service pharmacies or claims adjudicators, PBMs grew rapidly in the late 1980s–early 1990s as they leveraged purchasing power with drug manufacturers to garner financial rebates. At the same time, PBMs made huge investments in information systems to not only adjudicate and house claims, but also to drive powerful rule-based clinical programs, and administer formularies at the point of prescription purchase.

PBMs have adapted their products and services for diverse market segments, including large and small employers. Retail networks can be customized, mail service utilization can be optimized in many ways, formularies can be customized, prior authorization programs and point of service limitations (on a per prescription basis, or quantity over a period of time basis) have become very

sophisticated, and reporting has become much more customized to the specific needs of the employer. Given the extent of this flexibility, and the ability of PBMs to offer these services à la carte, most employers can take advantage of PBM services. Employers now play a much greater role in deciding how their prescription dollars are spent, rather than just paying the bill.

Fortune 500 employers are the largest of the large employers, and have additional requirements. Because of their large number of employees, these employers are able to negotiate with PBMs for deeply discounted pricing; customized and aggressive clinical programs; dedicated account teams consisting of account managers, clinical pharmacists, financial analysts, specially-trained customer and client service units; and other services tailored to their needs.

■ Prescription Benefits and Medical Benefits

Employers generally provide health maintenance organization (HMO) and indemnity health plan choices for employees' medical benefits. The HMO

plan may offer a prescription drug benefit that is often administered in whole or in part through a PBM. The indemnity medical benefit is typically offered through a medical carrier, and may include a prescription drug benefit.

Alternatively, the employer may carve out the pharmacy benefit directly to a PBM. Active employees generally tend to opt for less-expensive HMO medical plans, whereas retirees are often predisposed to indemnity plans because they are more familiar with such plans and want flexibility in selecting physicians.

Traditional indemnity options became less and less popular in the 1990s.¹ Employers will often offer a prescription benefit for members in a point-of-service plan directly through a PBM.

It is beyond the scope of this article to detail the regulatory oversight that employers need to consider when designing pharmacy benefits, other than to mention that specific regulations must be considered when designing clinical programs (especially when appeals criteria are important). More information on this topic can be found in the employer benefits literature.²

Author

GENE JAY, Pharm.D., is Associate Director, Clinical Services, at Merck-Medco Managed Care in South Windsor, CT.

AUTHOR CORRESPONDENCE: Gene Jay, Merck-Medco Managed Care, Rosewood Bldg., 435 Buckland Rd., South Windsor, CT 06074. Tel: 860-648-5949; Fax: 860-648-5901; E-mail: gene.jay@merck.com

Copyright © 2000, Academy of Managed Care Pharmacy, Inc. All rights reserved.

Clinical Management Tools for Large Employers

Managing prescription drug benefits for large employers requires a portfolio of programs, services, and management techniques that can match the employers' benefit philosophy and needs.

Utilization Management Programs

Utilization management programs (e.g., retrospective drug-utilization review [DUR], prior authorization, point-of-service or online edits) are generally required by large employers, but they vary in how aggressively they want to manage the plan. Some are very aggressive and able to manage a good deal of

addition to drug-drug, drug-gender, and drug-disease interaction alerts. Lastly, logic programs that apply point-of-service concurrent edits for dose-duration, quantity dispensed per copayment and step therapy rules are becoming increasingly popular.

Closed and Customized Formularies

Closed and customized formularies traditionally have not been feasible for large employers to manage because employers do not have a pharmacy and therapeutics (P&T) committee. The PBM must have a P&T committee to make formulary decisions, be able to notify members of changes in the formulary, and have an

plan. Some do, however, maintain a separate plan design for retirees, or separate business lines (such as subcorporations or different corporations of a merger). Most common are plan designs in which prescription drugs are covered, with selected exclusions such as oral contraceptives, smoking deterrents, cosmetic drugs, injectables, vitamins, and appetite suppressants.

Controversial today is coverage of quality-of-life (QOL) drugs, or so-called life-enhancement drugs. Employers are looking to the PBM industry to define which products belong in the category of life-enhancement drugs, and how they should be covered. As Sevon and Mitrany point out, the answers to these questions lie beyond clinical and economic analysis, and must consider ethical and social issues as well.⁴ Most PBMs define this category to include erectile dysfunction drugs, cosmetic agents, infertility agents, and oral contraceptives, but many other drug categories, such as smoking deterrents and weight-loss medications, could also be included. In general, most employers would like employees to pay a higher share of the cost of these drugs compared with traditional prescription drugs like antibiotics and cardiovascular medications.

Health-Management Programs

Most large employers are interested in health-management programs and embrace the concept of offsetting medical costs by instituting a health-management program, even if a program may increase drug costs. Of particular interest to employers is the workplace impact of disease burden, especially depression. One recent article illustrates how employees with major depression have three times higher disability costs compared with other employees.⁵ One PBM recently published a paper on its experience with a depression health-management program, showing improvement in detection and treatment of depression.⁶

In competition with the PBMs for enrollment in these programs are health plans' own programs, specialty disease-

Managing prescription drug benefits for large employers requires programs, services, and management techniques that can match the employers' benefit philosophy and needs.

member reactions to these tools, whereas others have very little tolerance for strong member reactions.

Employers must realize that there is a tradeoff between cost savings and member reaction to intensive pharmacy-management techniques. Usually a balance can be maintained where the employer can take advantage of a utilization program that promotes appropriate drug therapy and saves dollars on drugs, while maintaining member satisfaction with the prescription plan.

Therapeutic classes usually chosen for closer management through a retrospective DUR program include gastrointestinal drugs, nonседating antihistamines, antidepressants, calcium channel blockers, nonsteroidal antiinflammatory drugs and narcotics. Given the large number of retirees in many large employers' plans, concurrent DUR programs (real-time point-of-sale management edits) should include specialized edits for geriatrics, in

appeals process set up for members.

In general, however, most of the employees in a carve-out drug plan are in an indemnity insurance plan, and may be very resistant to such an approach. One controversial study alleged the potential for restrictive formularies to lead to higher costs and lower quality of care if not properly designed.³

Three-tier copayment structures that offer financial incentives to employees to select preferred formulary products are becoming increasingly popular. Tiered copayments are often more attractive to an employer than a closed formulary because they do not restrict member access to drug products and offer savings to employers by increasing formulary rebates.

Drug Inclusions and Exclusions

Drug inclusions and exclusions vary widely among employers, but individual employers usually use only one plan design to cover employees in a carve-out

management vendors, and pharmaceutical manufacturers' programs. Areas of interest for health-management programs include asthma, diabetes, cardiovascular disease, depression, gastrointestinal diseases, smoking cessation, and others.

In summary, large employers are able to leverage their size and prescription volume to get premium pricing, demand dedicated account-management teams and access to other resources, and implement utilization, formulary, and/or health-management programs. The PBM needs to provide these programs and services as turnkey, including member appeals, and up-front notification to members regarding program changes.

Case Studies

Two hypothetical case studies will illustrate common challenges large employers encounter, and the tools PBMs can use to resolve them.

Case Study One

A large employer in a service-based industry has recently merged with another Fortune 500 company. Each of the partners has several operating companies. Although both companies contract with the same PBM, each has a different drug coverage plan; two of the operating companies have a tiered copayment structure; three companies have quantity restrictions on different therapeutic categories. Although it has not been decided who is going to emerge as the risk manager with responsibility for the drug benefit, both companies agree that:

- financial and drug-benefit plan designs must be consistent across all operating companies;
- utilization-management programs must be consistent across all operating companies, but must be sensitive to the individual cultures of the operating companies;
- the contract with the PBM must be restructured to leverage the newly combined size;
- health-management programs must be coordinated with medical vendors' ini-

tatives;

- double-digit drug spending increases must be controlled; and
- consolidation into a single drug benefit must be immediate.

Action plan. The individual plan designs must be analyzed and a common plan developed. The incentive, three-tier copay structure in place is providing cost savings for two operating companies with very little member reaction. Therefore, an incentive formulary should be implemented across all business lines. A mandatory generic program needs to be implemented across all business lines as well. A managed prior authorization program could be implemented for selected drugs, based on a forecasting model that estimates how many members would be affected, and what cost savings could be achieved. Point-of-service edits could be put in place for selected medications (e.g., influenza drugs, erectile dysfunction drugs, migraine drugs) to limit quantity dispensed per month. Lastly, a new contract might need to be negotiated to set pricing for such things as mail-service prescriptions, retail claims adjudication, clinical programs, etc. Also, performance standards and guarantees may need to be revisited.

These activities would achieve the goal of integrating several operating companies under one plan, with minimal member disturbance. Utilization programs could be expected to save about 6%–7.5% of drug spending each year, while the incentive formulary and mandatory generic program might result in an additional 6%–8% savings of drug spending for each operating company, based on experience in similar situations.

Other programs that could be considered for this client include health-management programs, step-therapy edits at point of service, and additional drugs for prior authorization.

Case Study Two

A large employer recently changed its PBM in an effort to offset rising drug costs, especially in its very large retiree population. Members covered under the

PBM-managed plan include those in the indemnity and point-of-service plans. Members are accustomed to a very rich medical and pharmacy benefit. Mail-service utilization is very low, despite the fact that members can get a 90-day mail-service prescription supply for the same copay as retail. No utilization-management programs are in place.

The employer has indicated recruitment and retention of employees is critical. Therefore, the employer is very sensitive to member complaints. Also, employees have asked that an oral contraceptive benefit be added to the drug plan.

Action plan. The initial approach of the account team might be to properly align retail and mail-service copays. The employer might consider copays for mail-service prescriptions set at two times the retail copay for a 90-day supply. Retail benefits should be restricted to a 30-day supply. This would give members further incentive to use mail service, and the employer benefits from deeper mail-service pricing discounts.

Next, utilization-management programs should be implemented. After a financial and member impact analysis is performed, decisions need to be made to require prior authorization for drugs in different therapeutic categories, ranging from myeloid and erythroid stimulants, to growth hormones, to erectile dysfunction, and others. Prenotification letters should be sent out to members on these medications, informing them of the change in coverage and of the criteria for approval. Patients should be encouraged to take the letters to their physicians and apply for prior authorization before the change takes effect.

The employer should implement a formulary compliance program, which would significantly enhance formulary rebates for the employer. Oral contraceptives could be added as a covered benefit to respond to employee demand. However, to better manage costs (estimated spending for oral contraceptives is about 2% of total costs) the benefit could be limited to mail service only.

Continued on page 346

Because of the large retiree population, a full range of senior-specific concurrent drug-utilization review edits should be implemented. Lastly, point-of-service management edits can be put into place in selected drug categories to limit the quantity of drug dispensed over a month.

The formulary, copay, and utilization-management initiatives described above could save about 11% of total drug costs. The oral contraceptive benefit made available through mail service may add an additional 0.25% to drug spending. Overall, these initiatives would most likely be widely accepted by members. Unfortunately, some members accustomed to many years of a rich pharmacy benefit might voice their dissatisfaction when that benefit moves to a more contemporary management model. This can be minimized by up-front member education.

Other programs that could be considered for this employer include a three-tiered incentive formulary, a mandatory generic program, and health-management programs for diabetes and cardiovascular disease.

In summary, case one illustrates the opportunities and challenges of integrating a merger between two large companies, a growing trend in the late 1990s that is expected to continue in the near future. The second case study illustrates that significant cost savings can be achieved through utilization-management and formulary programs while providing a safety net for the elderly on many medications. However, the employer will need to be prepared for some initial dissatisfaction in its member population.

■ Implications for Managed Care Pharmacy

Large employers need to be serviced by account teams consisting of financial analysts, account management staff with various levels of responsibility, and a clinical pharmacist. Pharmacists in account management must have good analytical skills, presentation skills, business acumen, and communication skills in addition to clinical skills.

Pharmacists who work for PBMs must demonstrate a wealth of technical and clinical experience. Many also have academic or hospital administration backgrounds. While not required, many have a doctorate in pharmacy (Pharm.D.). In many cases, managed care organizations will request that the PBM provide a clinical pharmacist with a Pharm.D. degree. Clinical skills required are an ability to evaluate the medical literature, keeping current with changes within medical care, and experience in implementing and maintaining clinical programs. Additionally, clients look to their PBMs as the "drug experts," so the clinical pharmacist must be able to respond to drug information requests, handle complex customer service issues related to drug therapy, and act as a consultant to the employer.

With the growth in prescription drug spending, plan sponsors demand forecasts of the impact of new drugs on their drug costs. While the actual forecasting is beyond the scope of the clinical pharmacist and requires the efforts of the entire organization, it is up to the clinical pharmacist to understand the forecasting models in detail, and present the information to the client in a format that will meet its particular needs.

Necessary business skills include the ability to analyze financial drug data, create a vision and strategy for different clients, balance company objectives with client objectives to create a win-win environment and articulate clinical programs to clients. While the clinical pharmacist usually does not negotiate the contract with the payor, he or she must ensure that programs are in place to meet stated guarantees and expectations. Predicting how a given clinical program will impact membership is a critical component of managing the client's expectations and the agreed-upon contract. Technical skills such as spreadsheet manipulation and database management are also required.

■ The Future

The explosive growth of the Internet offers an opportunity for improving programs

and services to members and clients in a variety of ways. For mail-service delivery, the Internet streamlines the process of getting the prescription to the pharmacy from the member's home. By ordering their own refills, members are in control of the process, which often reduces customer-service phone calls.

Clinically, the potential is also vast. Already formularies are available on Web sites so that when a member logs in, his or her plan's formulary can be viewed, with an overview of the benefit plan. Health-management program information can also reside on the Web site. Members should expect the Web site to be easy to navigate, provide health information specific to their individual interests, and offer them a better understanding of how to manage their health and fully utilize the pharmacy benefit.

In summary, to provide customized services to large employers PBMs must offer an array of programs and services to manage drug costs, and provide useful reporting and forecasting of drug expenses. The PBM must be able to provide a portfolio of utilization management capabilities that fit an employer's specific needs, and offer health-management programs that educate members on how to become more involved in their own care.

References

1. Health Insurance Association of America. Source book of health insurance data, 1999-2000. Washington: HIAA, 2000.
2. Focus on ERISA-25 years later. Employee Benefit Plan Review 1999; Sept: 48-57.
3. Horn SD et al. Intended and unintended consequences of HMO cost containment strategies: results from the managed care outcomes project. Am J Managed Care 1996; 2: 253-64.
4. Sevon MC, Mitrany D. Quality-of-life drugs: framing the issue. JMCP 1999; 5: 185-190.
5. Birnbaum HG et al. Workplace burden of depression: a case study in social functioning using employer claims data. Drug Benefit Trends 1999; 11(8): BH6-12.
6. Fulop G et al. Opportunities for depression disease management: a pharmacy benefit manager's experience. Depression and Anxiety 1999; 10: 61-7.