How Pharmacy Can Help Optimize Employee Prescription Drug Benefits

- Analyze clinical and financial data
- Contribute to PBM contract negotiations

Unexpected Growth in Drug Spend Prompts Financial Review

Pepper Health, a pseudonym for a six-hospital health system in the Northeast, is one health system that benefitted from involving their pharmacy leaders in reviewing pharmacy benefits.

The system hired a leading PBM to help reduce rising medication costs for their 12,000 employees and beneficiaries. In initial conversations between Pepper's benefits team and the PBM, the PBM projected lower cost growth representing significant cost savings for Pepper Health's $12 million dollar employee medication spend.

However, after three months, leaders found that the health system was not realizing these promised savings; rather, drug spending was increasing significantly.

Despite this rise in spend, the PBM assured the system that it was still, in fact, saving money. Skeptical, the health system outpatient pharmacy director decided to look more closely into the data to determine the underlying cause of the increase in spend.

Pharmacy Leads Analysis of Contracted PBM's Work

PBM Transition at Pepper Health Yields Unsatisfactory Results

Promised savings…

Organization hires PBM to manage rising employee drug spend

$760K

Cost savings in first year projected by PBM prior to signing contract

…led to unexpected costs

Three months into contract, spend analysis reveals unexplained rising costs

$1.3M

Estimated annual drug **spend increase** following PBM switch, based on growth in first three months

Pharmacy leader steps in to conduct root cause analysis using retail, industry expertise

Case in Brief: Pepper Health

- Not-for-profit health system located in the Northeast, consisting of six hospitals and over 50 locations for ambulatory, surgical, and urgent care
- After three months with new contract, system leaders identified a rise in employee drug charges; after analysis, the system estimated an annual increase of $1.3 million
- A health system pharmacy director used his pharmacy expertise to investigate claims data and contract terms to identify root cause of rising costs; he identified substantial spread and overcharges
- When their PBM contract ended, the organization chose to move to a transparent PBM and saved $2 million in the first year

Source: Pharmacy Executive Forum interviews and analysis.

Pharmacy Leader Conducts Financial Analysis

To determine if Pepper Health's incurred costs were reasonable, the pharmacy director compared the amount the PBM charged them, as the employer, to the amounts the PBM paid to the health system's pharmacy. The difference between these two numbers is called "spread" (explained on page 11).

Like all PBM customers, the health system had access to claims data to determine the amount charged to the system for each employee prescription. Unlike other employers, Pepper Health had an in-house pharmacy that was paid by the same PBM for many prescriptions for other patients treated within the system. They could use these two data sources to determine the spread that the PBM was generating from the health system's employees.

This analysis revealed many instances where the difference was more than $60 for a single prescription.

Although many employers consider spread a reasonable and expected part of doing business with a PBM, it also undeniably contributed to Pepper Health's rising drug costs.

Spread is a Key Contributor to Spend Growth

Combined Data Sources Enable Spread Analysis at Pepper Health[1]

PBM-Provided Data + *In-House Pharmacy Data* → *Spread Identification*

Amount charged to employer per prescription

Payment received from PBM for prescriptions filled

Difference between charge to employer and payment to pharmacy

Example from Single Five-Day Generic Antibiotic Prescription

$26.87 — Amount PBM billed to health system

$5.19 — Amount PBM paid to in-house retail pharmacy

= $21.68 — Spread generated by PBM on single employee prescription

1) Pseudonym.

Source: Pharmacy Executive Forum interviews and analysis.

Claims Evaluation Reveals Compliance Issues

After identifying the excessive spread generated off of generic antibiotics, Pepper Health's[1] pharmacy leader wanted to verify that the PBM was honoring the terms of its contract.

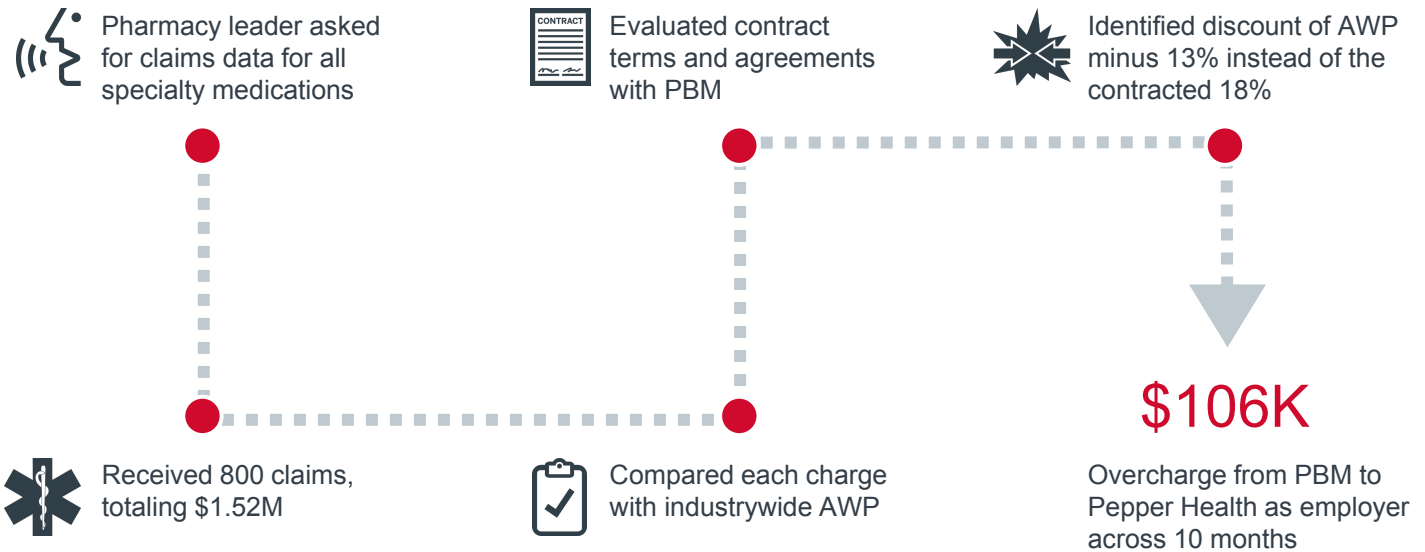
The pharmacy director requested access to additional claims data to evaluate charges. He first looked at the data for specialty medications, an area where the employee drug spend was rising rapidly.

In this first evaluation, the pharmacist compared the charges to the industry standard AWP[2] to determine what discount the system was receiving. This investigation revealed that the discount the system was receiving was only AWP minus 13%, whereas they contracted for AWP minus 18%.

This 5 percentage point overcharge led to a total of $106,000 in excess spending by the health system over a 10 month period. While this error may have been an honest mistake, it would have been overlooked if the pharmacy leader had not conducted the financial analysis.

There May Be Value in Taking a Fine Tooth Comb Through Data Sets

Pharmacy-Led Financial Analysis Identified Overcharges



1) Average wholesale price.
2) Pseudonym.

Source: Pharmacy Executive Forum interviews and analysis.

Pharmacy Analysis Also Identifies Clinical Opportunities

We recommend that pharmacy leaders conduct ongoing financial analyses similar to that detailed in the previous case study alongside a review of clinical data, as detailed below. For most organizations, both should be completed quarterly.

The first component of the clinical review is reviewing trends in "vital sign" indicators that may show developing issues or potential areas for cost savings. Changes in these indicators should prompt further investigation and action to address root causes. For example, if the data indicates changes in generic dispensing rate, the pharmacy leader can investigate which physician prescribing patterns are changing and encourage physicians to use generics when possible.

In addition, leaders should closely evaluate the top 400 drugs used by beneficiaries to identify opportunities to implement formulary modifications or clinical programs such as step therapy[1] and prior authorization.

While not all PBM contracts will allow for formulary or clinical program modifications, organizations should at least inquire about the potential for changes. At a minimum, this utilization analysis can provide data to inform future contract negotiations.

Data Monitoring and Critical Formulary Evaluation Lead to Cost Savings

Components of Pharmacy Benefit Compass[2] Quarterly Clinical Claims Review

1

Monitor Key Indicators:

"Vital Sign" Metrics
Scripts per member (annualized)
Total scripts
Generic dispensing rate
Average cost per brand Rx (incl. specialty)
Average cost per generic Rx
Rebates
Member contribution as % of total spend

2

Perform Clinical Analysis:

Review top 400 drugs used, by plan cost, to assess opportunity for changes to clinical plan design

Modifications may include:

- Implementing clinical programs, such as step therapy or prior authorization requirements
- Formulary removal
- Brand-to-generic swaps

1) Step therapy requires patients to try a more cost-effective drug first if one is available for a patient's condition, rather than moving directly to a more expensive drug.
2) Pharmacy Benefit Compass is a former Advisory Board membership that was provided in collaboration with a transparent PBM. Through the membership, an Advisory Board pharmacist monitored pharmacy claims data and advised health systems on opportunities to reduce costs and improve care through changes to drug benefit design.

Source: Advisory Board, Pharmacy Benefit Compass interviews and analysis; Pharmacy Executive Forum interviews and analysis.