Beating the PBM Administrative/ Rebate Credit Game

"Smoke and mirrors" is the best way to describe the "Rebate Credit" game. Here is how it works: A third party administrator (TPA) or administrative services only (ASO) carrier offers to give the employer an administrative fee credit in exchange for that employer's agreement to use a certain "PBM," allowing that TPA to retain most or all of the employer's drug rebates. In some circumstances, this can translate to a credit of $20 -$30 per employee per month (PEPM). Sound too good to be true? It is.

While the message from these offers may shout *"Control fixed costs!"* and *"Savings now!",* buried in the fine print you'll discover that that the employer must accept certain terms and conditions.

- The pharmacy benefit manager (PBM**) formulary cannot be modified**, meaning no flexibility, which makes it easier for the PBM and the carrier to push more expensive drugs that generate the largest rebates (which they will be keeping).
- **Early termination "pay back" provision.** Experiencing bad service or higher than promised costs? Leaving earlier than the term of the contract will often trigger a requirement to **"pay back"** the administrative credit – though the PBM or TPA will keep any rebates earned by claims paid up to termination. **You lose, they win.**
- **Sometimes a mandatory mail order program accompanies the offer**; other times employees are driven to mail order with frequent offers of an "opportunity" to receive mail order (i.e., a $50 Amazon gift card as incentive, or even the easy auto-enroll feature). Remember, **the goal of these programs is to sell your members as many drugs from their owned (or partner-owned) mail order pharmacies and generate as much rebates as possible.**

PBMs focus on fixed cost savings to make you think you're saving on prescription costs… but a closer look reveals that you're going to pay significantly more on pharmacy claims.

So the PBM is saying to you, in essence, "Take **our** pharmacy program, pay for the drugs **we** dispense for your employees, and allow **us** to keep the rebates," and **you** get… an administrative fee credit for your self-funded health plan.

This approach has largely evolved out of tremendous channel consolidation in the health insurance market. **All of the major health insurance carriers** (who happen to offer TPA services or ASO offerings) **either own or are owned by** major pharmacy benefit managers *(see chart below)*.

Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2021

SOURCE: Drug Channels

This channel alignment allows for an easier flow of money between entities since the PBM and insurance carrier are in the same corporate structure. **So, now rebates can be earned to offset medical administration fees.**

These carrier/PBM hybrids manage fixed costs by manipulating factors within the claim costs. The concept is not entirely new. Some Blue Cross organizations have retained portions of medical discounts to offset administrative fees in the past. But the rebate approach has begun popping up like mushrooms on a warm spring day. Their message: Sign the agreement and control costs – **fixed** costs.

But what really drives the administrative credit? What is happening when a self-funded employer turns over control of an element of its plan that increasingly makes up between 20% and 25% of claim costs?

First, a reminder of the role fixed costs play in a health plan. On MedBen's block of business, administrative fees make up between 5% and 7% of plan cost. Certainly, they make up a smaller portion of plan costs than pharmacy claims – and using pharmacy claim costs to lower fixed costs is a dangerous tactic for self-funded employers.

Second, employers should understand that brand drugs – particularly expensive brand drugs – generate nearly all rebates earned through plan utilization. In fact, rebates are built into the cost of these drugs, so accepting a drug rebate offer from a carrier or PBM creates a perverse incentive in the contractual relationship, as one entity (the self-funded employer) is writing checks to pay for prescription drugs – including these expensive brand name drugs that generate large rebates – while another entity (the PBM or carrier) controls which drugs appear on the formulary. It takes almost no imagination to understand that the PBM or carrier is highly motivated to encourage coverage for high-rebate drugs – which, in turn, drive up the prescription drug costs under the plan**.**

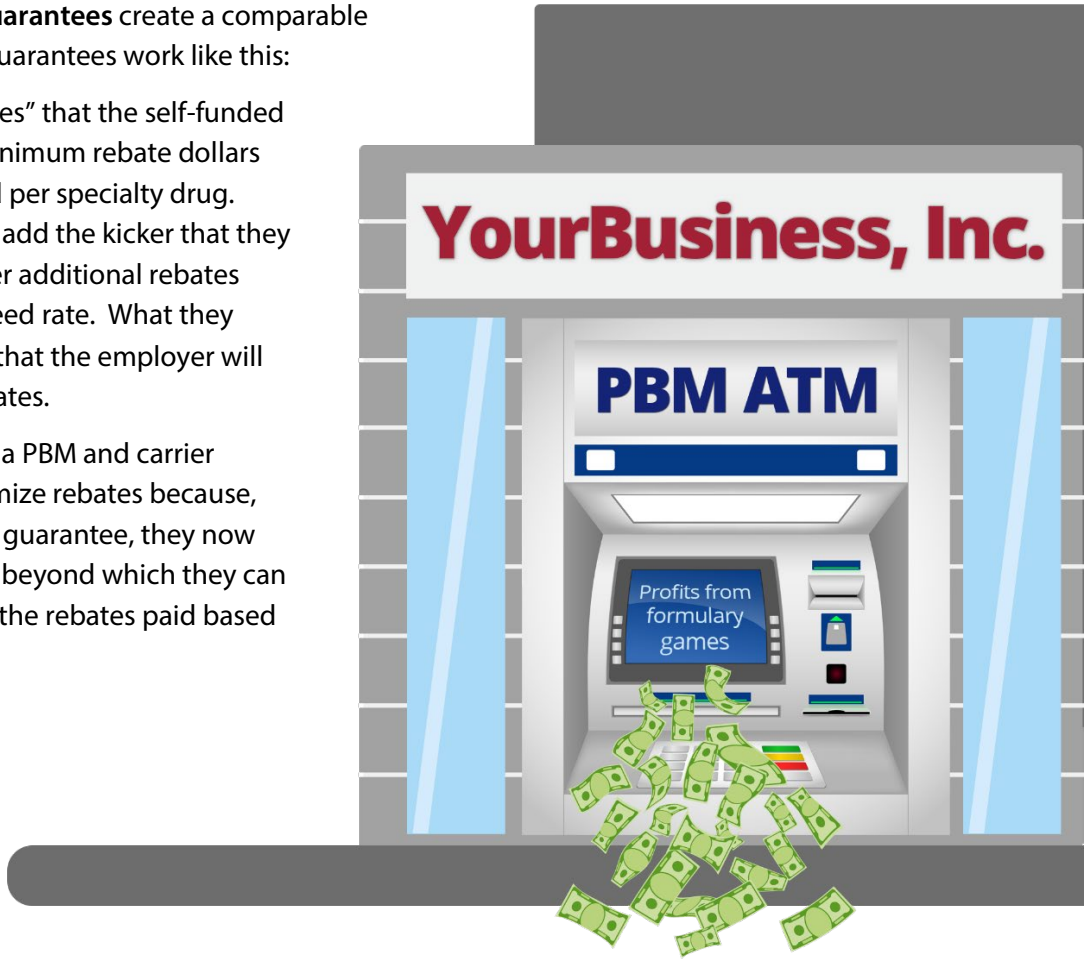
The PBM is assisted in the effort by the drug manufacturers who heavily advertise these expensive, rebate-rich drugs in order to get plan participants to ask for the drugs.

What appears to be a cost-saving offer turns the self-funded pharmacy plan into a virtual ATM machine for the PBM and carrier.

Similarly, **rebate guarantees** create a comparable dynamic. Rebate guarantees work like this:

The PBM "guarantees" that the self-funded plan will receive minimum rebate dollars per brand drug and per specialty drug. And they will often add the kicker that they are willing to deliver additional rebates above the guaranteed rate. What they **don't** guarantee is that the employer will receive *all* paid rebates.

The result, again, is a PBM and carrier motivated to maximize rebates because, having set a rebate guarantee, they now have a target to hit beyond which they can begin to gain from the rebates paid based on the formulary.



What they fail to explain is that they are now highly motivated to encourage members to use more expensive brand and specialty drugs so they can hit the rebate guarantee target and begin sharing in the rewards created by the employer paying for more expensive drugs.

Another force is also at play in both of these scenarios. In both offerings, the plan target has shifted; in the first case, the target has shifted from controlling pharmacy costs, which can make up between 20% and 25% of the plan spend, to lowering administrative fees, which in most cases are less than 10% of plan costs. **The self-funded plan has given up control of a sizeable portion of their plan spend to manage a much smaller portion of plan costs.**

In the second case, the focus has shifted from the cost of the pharmacy plan to the value of the rebates. The measure of success, incorporated as a guarantee to be reviewed as part of plan performance, is a rebate guarantee, although achieving that target very often requires placing drugs on the pharmacy formulary that will drive up pharmacy costs. And what do self-funded plans actually write checks for? Rebates? Absolutely not.

Self-funded plans write checks for the drugs used by the plan.

So, what *should* plans be looking at?

How about discounts? Discounts are a better measure BUT be certain that the PBM is not motivated to manipulate discounts by categorizing some generic drugs as brands or even some specialty drugs as brand (or brands as specialty) depending on the discount available. There are lots of definitional ways to manipulate discounts.

More important: Make sure **all** discounts and paid rebates come back to the plan. **How are discounts calculated?** Are they based on an Average Wholesale Price (AWP), which can be easily manipulated or inflated to make smaller discounts look larger? AWP is an arbitrary number and is **NOT** the price the pharmacy pays for a drug. Make sure rebates come back to the plan in order to ensure that the PBM isn't motivated to push high-cost drugs.

Is the PBM actually a giant mail order pharmacy or pharmacy chain that stands to gain from the buying habits of members with automatic refills to drive up purchase volume and price? **Or is the PBM not part of the supply chain** and paid on a transaction basis in order to remove the perverse incentives from the system?

Finally, the plan should focus on lowest net cost. **What will be done by the PBM and pharmacy partners to ensure that the most cost-effective drugs go to members** rather than the drugs that drive the largest rebate revenue?

The savings that self-funding delivers to employers should come from a focus on dollars, not discounts or rebates. **What can be done to manage the dollars paid out under the self-funded plan so they can be used to provide even better benefits for plan participants?**

These questions must be taken under consideration when deciding on a PBM. It's easy to get caught up in the allure of an immediate reduction in fixed costs. But for you to realize true savings on your pharmacy plan, you first need to look beyond the smoke and mirrors.

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*To learn more about how MedBen Rx can help you beat the PBM administrative credit game, please call the MedBen Marketing Department at **(888) 627-8683**. We would welcome the opportunity to discuss how our innovative pharmacy solutions can benefit your business.*

MedBen Rx puts you in control of your pharmacy plan, not the PBM. We save you money by offering drugs at the lowest cost and eliminating the pricing guesswork. And we bring evidence-based research and employers together to find the most clinically effective drugs at the best cost.

MedBen has been a Midwest leader in benefits management since 1938.