How to Choose the Right Pharmacy Benefits Manager

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Group employee benefits managers are often pulled in two different directions. They’re under pressure to create an increased level of employee satisfaction while simultaneously keeping costs under control. This is obviously not easy; if you’re reading this you probably already know how difficult it can be to accomplish both objectives.

Pharmacy benefits are typically the most utilized benefit by plan members and one of the fastest-growing in terms of cost. Consequently, selecting the right pharmacy benefit manager (PBM) is a critical decision in managing a plan and supporting member satisfaction with that plan.

There’s a level of frustration among employers and group employee benefits brokers with regard to transparency among PBMs. One way some PBMs have tried to combat this frustration is through transparent pricing, meaning they don’t markup prescription prices. Instead, the PBM will charge an administration or processing fee, but this doesn’t necessarily create cost relief for the employer. Another problem with so-called transparency pricing is that net cost is far more important. In other words, transparent pricing doesn’t guarantee it’s the lowest price. Furthermore, pricing doesn’t matter if you’re not managing the plan properly. Clearly, it’s difficult to navigate this maze of pricing and value.

To help combat the inherent challenges, group employee benefits managers should take a much deeper review of potential PBM partners. Below are questions you should be asking of your PBM:

- What are the discounts for each year of the agreement?
- What is the pricing per pill?
  - Does the PBM provide lists of most utilized prescriptions using the appropriate national drug codes?
- What is the trend on the PBM’s entire book of business – not just for its top 300 prescriptions?
- What is their generic fill rate, or the plan for transitioning to generics?
- What are their plan management capabilities and recommendations?
- What do their reports look like?
  - You should expect strong reporting capabilities. The PBM must be able to deliver accurate and detailed information so that you
can see how the plan is performing and so you can identify areas of opportunity.

- What level of coverage do they provide for the management of medications to treat chronic conditions?
- What are their mail order and retail maintenance medication capabilities?
- Do they offer risk-sharing arrangements?
- What is their specialty pharmacy management offering?

When choosing a PBM, there are three primary options:

1. Bundling the PBM with your medical insurance carrier.
2. A “third party carve-out,” in other words, using a PBM that is separate from your medical insurance carrier.
3. A third party carve-out through a consortium arrangement. This could be through a broker or it could be an industry cooperative.

PBM Bundled with Carrier

**PROS** – This approach is easy to administer. You’re only dealing with one carrier, one contact and one service team. Additionally, the carrier provides consolidated reporting with all information in one place. Carriers, who obviously have some bias here, claim that they can administer medical management better when they have everything under one roof. Studies seem to vary on the validity of such claims, although at least one national carrier will include performance guarantees around total trend and management of chronic conditions if the pharmacy is bundled with their medical.

**CONS** – Bundling reduces your flexibility. You don’t control the terms of the agreement with the PBM, and you don’t have control of things such as formularies, contract terms, preferred drug lists, etc. The medical carrier has the freedom to change their PBM partner, which could be disruptive to the plan participants.

Third Party Carve-out

**PROS** – When an employer chooses a stand-alone PBM, there is more plan design flexibility. The third-party approach provides greater control over the terms of the contract, and the employer often saves money by cutting out the middleman. Interestingly, most carriers who bundle medical and prescription management use a third-party PBM.

**PROS** – You’re dealing with a separate administrator, which means you have to manage another vendor and relationship. Some carriers will charge you for not using their PBMs, applying line items such as reporting fees, connection fees, or increased administration fees, etc. With this approach, you lose the ability for some bundled servicing. For instance, your carrier’s service representative may not have access to prescription data and cannot get a total picture if there is an issue. Additionally, these arrangements are often multi-year contracts, so they should not be entered into lightly.

Third Party Carve-out Through a Consortium

**PROS** – When you sign on with a consortium-based PBM you receive increased buying power, which should translate to better rates. You also have a well-informed expert that’s helping to negotiate and oversee the plan.
CONS – By going through a consortium, you’ve put the middleman back in play, meaning you have reduced flexibility. While the consortium-based PBMs push cost-savings hard in their sales process, it doesn’t always play out for the employer. Specifically, you lose control over the terms of the agreement with the PBM, and you don’t have control of formularies or other parameters of the plan. Adding to this lack of flexibility, commitments are usually multi-year contracts. Lastly, some employers utilizing consortium-based third parties question the objectivity when purchasing services through a consultant or broker.

At Corporate Synergies, we’re neutral on a preferred approach. In our opinion, every employer is different and needs to adopt a PBM solution that best suits their specific situation. The key is going in with eyes wide open.

For more information, please call 1.877.426.7779