
DRUG BENEFIT NEWS

Report: PBMs Could Improve Specialty Pharmacy, Disease Management Services

While many plan sponsors say they are satisfied overall with their PBM, there are still a few areas that could use some improvement, according to a recent Pharmacy Benefit Management Institute (PBMI) report. PBMs could shore up their specialty pharmacy and disease management services, as well as their transparency efforts, particularly in contract language in requests for proposals (RFPs), said respondents. Ultimately, says Bill Sullivan, principal consultant at Specialty Pharmacy Solutions, LLC, the *2009 Pharmacy Benefit Manager Customer Satisfaction Report* should serve as a cautionary tale for plan sponsors. The findings, he says, indicate “that payers are overly dependent on the PBMs because bringing program services and pharmacy management in house is hard work for typically understaffed pharmacy departments.”

The report profiled the nine PBMs receiving 10 or more completed surveys from 358 U.S. employers. In overall service and performance, the companies ranked, from best to worst on a 10-point scale, as follows:

- (1) *Envision Pharmaceutical Services* (8.9)
- (2) *CIGNA Pharmacy Management* (8.8)
- (3) *Catalyst Rx/Walgreens Health Initiatives* (tie) (8.5)
- (4) *Aetna Pharmacy Management* (8.1)
- (5) *Medco Health Solutions, Inc.* (7.9)
- (6) *Express Scripts, Inc.* (7.7)
- (7) *CVS Caremark Corp.* (7.5)
- (8) *WellPoint NextRx* (6.6)

Respondents were asked about specialty pharmacy services for the first time in this survey, which is in its 15th year. They ranked customer service highest among specialty pharmacy activity, but rated PBMs lowest on delivering promised savings on specialty drugs.

“It’s still early on with companies actively managing specialty drugs,” says PBMI President Dana Felthouse, author of the report. Because of this, there is a basic lack of knowledge about the specialty market, says F. Randy Vogenberg, Ph.D., co-founder of pharmaceutical consulting firm Employer-based Pharmaceutical Strategies, LLC, including an understanding of “the relative costs associated with products, along with high

expectations/perceptions about what specialty contracting could do akin to traditional pharmacy benefit management.” Elan Rubinstein, Pharm.D., founder and principal of consulting firm EB Rubinstein Associates, notes that “specialty pharmacy pricing to payers is not as competitive as is PBM pricing to payers for retail and mail-order pharmacy.” Although nonspecialty drugs are placed on varying tiers, most specialty therapies are just placed on the highest tier of drug formularies. And even the lack of an accepted industrywide definition of “specialty drug” can lead to problems, says Michael Jacobs, a principal at Buck Consultants.

Sullivan points out that unlike traditional nonspecialty drugs, savings on these expensive drugs can be gotten through only two approaches. “Unit cost savings via a deeper discount” can be realized in the first year of a contract, he says. “After that, it takes hard work through proactive efforts with prescribers and patients to ferret out other savings.” And problems arise when payers don’t want to pay for medication therapy management, he says, which forces specialty pharmacies owned by PBMs to cut back on these important, but costly, services. “All too many publicly traded companies believe they have a primary responsibility to their stockholders,” he says. With plan sponsors not paying for these services, “one has to wonder what high-touch services will actually be delivered,” says Rubinstein.

Plans Question Paying for Disease Management

The same problem with payers not wanting to pay for these services also plagues disease management programs, he says. Some companies are “only able to sell stand-alone disease management programs on a risk basis — in other words, payers aren’t willing to buy disease management programs on a fixed-fee basis, and payment is dependent on results achieving targets,” explains Rubinstein. According to Felthouse, survey respondents have never rated disease management well, although the average rating has slowly improved since 1995. “Managing disease requires a whole comprehensive approach” that can include not only drugs adjudicated on the pharmacy side, but also ones adjudicated on the medical side, ancillary care, lab tests and

X-rays, she points out. And PBMs' disease management services can vary greatly from client to client, depending on the services each one purchases, she tells *DBN*.

"Demonstrating a return on investment on health improvements is very difficult," maintains Jacobs. "It's difficult to quantify." And because improvements are really determined over years, not weeks, disease management "drives up costs in the short term" when people are encouraged to take medications, get testing done and go to the doctor, he says. "A key component of disease management is compliance monitoring," agrees Sullivan. "And higher compliance actually translates into higher utilization, which costs more — not less — dollars." For these reasons, "perceived value remains controversial for disease management among employer human resources management," asserts Vogenberg. One potential solution, says Jacobs, is portable electronic medical records, which could help with tracking improvements in health.

Respondents also were asked about the RFP process for the first time in this survey. They ranked PBMs' responsiveness to RFP questions highest among four attributes of the process, but they rated clarity of contract language the lowest. The issue gains even more perspective considering that "clarity of contract language

has the strongest correlation to overall service and performance" among the RFP findings, Felthouse says. The finding, though, did not seem surprising to industry insiders who spoke with *DBN*. "These contracts are getting more and more complicated and less and less clear," Jacobs tells *DBN*. According to Vogenberg, "Contract offers are notoriously opaque and convoluted.... Paragraphs conflict with one another and others supersede previous paragraphs." For example, based on a recent assessment of contracts, Rubinstein notes that all of the contracts said they had maximum allowable costs, "but none explained how MACs are built and maintained."

Jacobs says plan sponsors should keep an eye out for terms that limit their rights to their own data, including the ability to audit those data. Vague contracts "always work to the advantage of the vendor," says Sullivan. He tells *DBN* that payers need to develop comprehensive terms and conditions for performance. "A payer that fails to hammer out the details up front gets what they deserve," he contends.

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