

Process of Prescription Drug Rebates and the Role of Pharmacy Benefit Managers (PBMs)

Last week, we spoke about the history behind drug rebates in the pharmaceutical industry and why they exist. This week we are going to expand on that a little bit and speak about the process of rebates and how pharmacy benefit managers (PBMs) are involved in the rebate process. PBMs have been a hot topic in the pharmaceutical industry due to their involvement in a multitude of processes in the world of pharmacy. That in mind, their true role and utility in the pharmacy world is frequently under scrutiny with certain practices being questioned.

First, let's talk a bit about the role of PBMs and why health plans/employers (insurers) contract with them. PBMs are often hired by insurers to handle pharmacy services, including managing the plan's drug formulary, negotiating with drug manufacturers and pharmacies, processing drug claims, etc.¹ The insurer relies on the PBM to complete these services and provide information back to the insurer about how to improve based on trends and information the PBM aggregates. Less commonly, some insurers do not use PBMs and handle pharmacy services on their own. For ease of understanding, throughout this paper we'll be referring to the more common model where PBMs work on behalf of the insurer.

Now that we understand the role of PBMs in the pharmaceutical industry, let's take a look at how they're involved in the process of rebates for prescription drugs and who all they communicate with; Figures 2 and 3 can be referenced as a visual. Initially the PBM signs a rebate agreement with a drug manufacturer, generally for a brand drug². Then, once pharmacies fill a prescription for a medication, the pharmacy bills the PBM for that medication². The PBM then pays the pharmacy and bills the insurer for that payment which is subsequently paid². The PBM also aggregates paid claims data and invoices the drug manufacturer for rebates quarterly². The drug manufacturer then analyzes those invoices and sends rebate payments to the PBM². Finally, the PBM either pays rebates to the insurer in a self-funded arrangement or retains the rebates to keep premiums down in a fully-insured arrangement².

With so many entities involved in the drug rebate process, it can be a complex operation. One of the key players in this operation is the PBM, who plays a role in every step of the rebate process. Their robust position in this operation has always kept them under the insurers' microscope, largely due to considerable secrecy surrounding their monetary intake¹. Concealed profits by PBMs can occur in a traditional model where the PBM charges zero or greatly reduced administrative fees to the insurer and shares in rebates/discounts with the insurer, but is not fully transparent with the insurer regarding rebates/discounts³. The alternative model is known as a pass through or transparent model, where contracts are fully disclosed and transparent, the insurer pays an administrative fee to the PBM, the PBM passes along all discounts/rebates to the insurer, and the insurer has greater control over pharmacy spending³.

While the traditional model is the most popular, it has led to the ongoing discussion of whether PBMs are holding onto excess profits, because their income is not transparent.

These excess profits for the PBM are thought to be caused by an increase in drug list price, leading to higher rebate prices, compared to the previous year. Let's take a look at a simple example and keep in mind these numbers relate to each drug claim, so the profits would be multiplied by the number of drug claims; Figure 1 can be referenced below as a visual. That in mind, if a drug costs \$5 in year 1 and the PBM has negotiated a 20% rebate with the manufacturer, they would earn a \$1 rebate. During year 1, the PBM also negotiated a \$0.25 rebate payment to the insurer, leaving the PBM with a total rebate profit of \$0.75. Now, let's say in year 2, the drug costs \$7; therefore, the PBM would earn \$1.40 off the same 20% rebate. In addition, the PBM has negotiated a \$0.30 rebate payment to the insurer; despite the increase in payment to the insurer, they are still left with a higher rebate profit of \$1.10 in year 2. This is the key to how PBM's increase their profits from year to year, drug costs are increasing at a higher rate compared to the PBM's rebate payment to the insurer. Table 1 below shows a scenario, more closely related to a real-world example, of how a rise in AWP (drug cost) and rebates simultaneously can change profit numbers for the PBM compared to the insurer.

Figure 1. Changes in AWP Compared to Changes in Rebates and Revenue for PBM versus Insurer

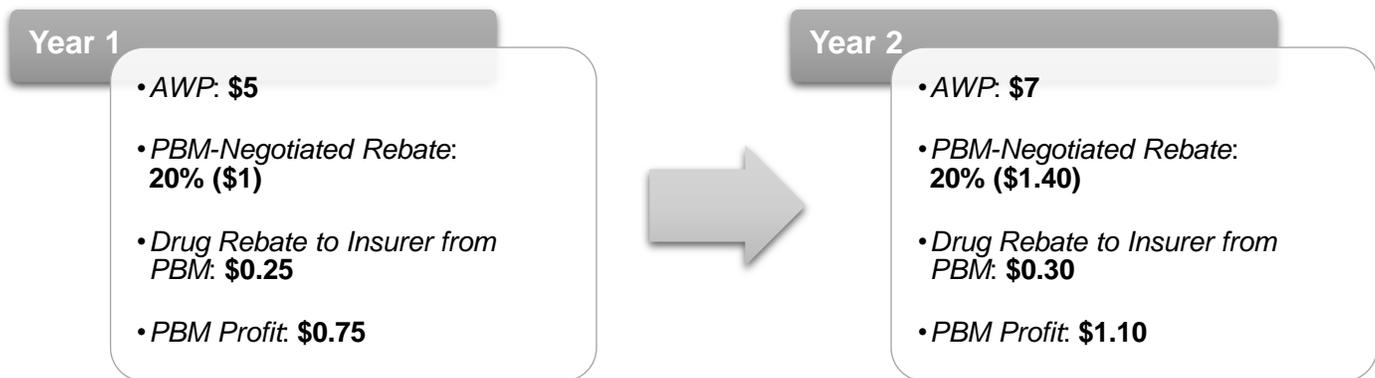


Table 1. Changes in AWP Compared to Changes in Rebates and Revenue for PBM versus Insurer in Example Drug*

	Year 1	Year 2
1 AWP	\$5,400/claim	\$6,300/claim (~14% increase)
2 PBM-Negotiated Rebate Percent from Drug Manufacturer	25%	25%
3 PBM-Negotiated Rebate from Drug Manufacturer (row 1 x row 2 = row 3)	\$1,350/claim	\$1,575/claim
4 Drug Rebate to Insurer from PBM (contract negotiated)	\$1,300/claim	\$1,400/claim
5 PBM Profit (row 3 - row 4 = row 5)	\$50/claim	\$175/claim
6 Findings	250% increase in profits for the PBM from Year 1 to Year 2, despite an increase in dollars to the insurer and an increase in AWP	
	~7.7% increase in profits for the insurer from Year 1 to Year 2	

*Real world numbers may vary

On average, a \$1 increase in rebates is associated with a \$1.17 increase in a drug's list price, especially important to think about when manufacturers are continuing to raise their average wholesale price (AWP) about 12% annually⁴. One analysis showed that manufacturer rebates paid to PBMs increased from \$39.7 billion in 2012 to \$89.5 billion in 2016; however, the PBMs say despite this increase in rebate dollars, they are passing on a comparable share to insurers⁵. This is corroborated by another study that showed the share of rebates PBMs passed through to insurers increased from 78% in 2012 to 91% in 2016⁵. It is also important to note that despite a higher percent of rebate money being passed onto insurers as a whole by PBMs, smaller insurers state that they are not collecting this share of savings⁵.

With this information in mind, we can appreciate the complex nature of the rebate process with a multitude of players involved. The drug manufacturer works with the PBM, the pharmacy works with the patient and the PBM, and the insurer works with the PBM. All of these relationships work together to ultimately get drug rebates from the drug manufacturer to the insurer to lower overall drug costs and support patient safety with efficacious drugs on the insurer's formulary, as we spoke about last week. However, you can see the PBM is a key player in the middle of all of these rebates, a powerful position for them. This central placement in the rebate process has led to continued investigations surrounding their income, especially when operating under a traditional model which leaves true earnings confidential.

*Written by: Brenae Wilson, PharmD Candidate 2021
University of South Carolina College of Pharmacy
Current as of May 28, 2020*

Figure 2. Prescription Drug Rebate Timeline

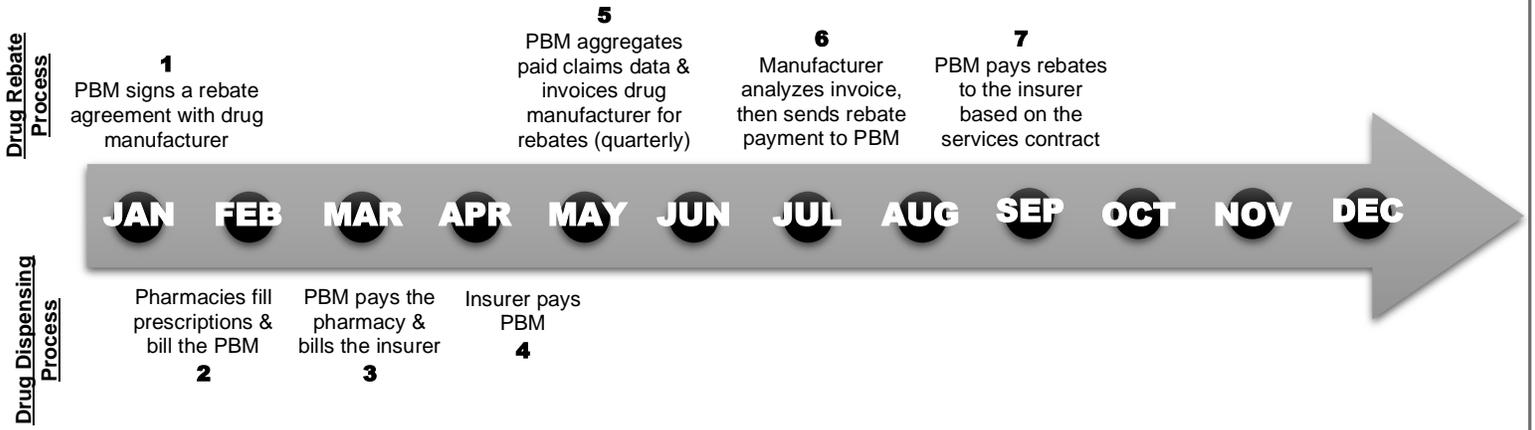
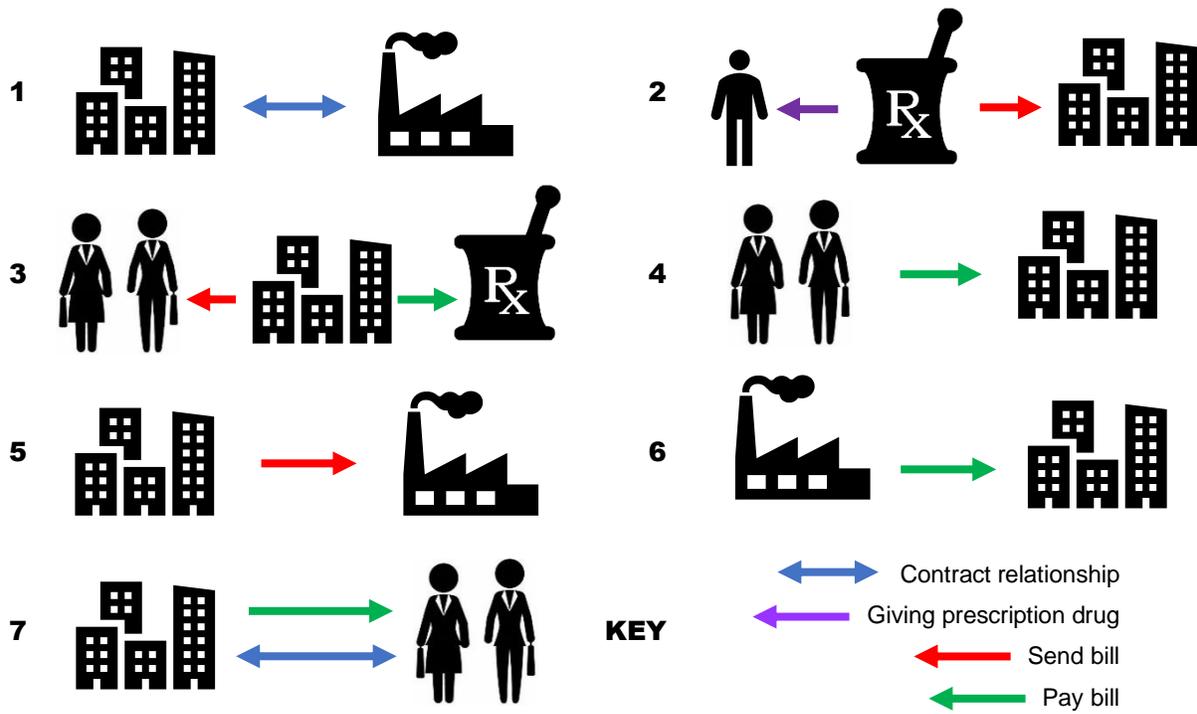


Figure 3. Prescription Drug Rebate Timeline in Pictorial Form



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References

1. Chan A, Schulman K. Examining Pharmaceutical Benefits in the United States-A Framework. JAMA Network Web site. <https://jamanetwork.com/channels/health-forum/fullarticle/2763175>. Published March 13, 2020. Accessed May 22, 2020.
2. Maintaining the Affordability of the Prescription Drug Benefit. AMCP Web site. <https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/Maintaining-the-Affordability-of-the-Prescription-Drug-Benefit>. Published July 18, 2019. Accessed May 20, 2020.
3. Alberico T. Pharmacy Benefits: Pass Through vs. Traditional. Assurance Web site. <https://www.assuranceagency.com/blog-post/pharmacy-benefits-pass-through-vs-traditional>. Published March 19, 2018. Accessed May 28, 2020.
4. Sood N, Ribero R, Ryan M, Van Nuys K. The Association Between Drug Rebates and List Prices. USC Schaeffer Web site. <https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/>. Published February 11, 2020. Accessed May 22, 2020.
5. Bishop S. Pharmacy Benefit Managers and Their Role in Drug Spending. The Commonwealth Fund Web site. <https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending>. Published April 22, 2019. Accessed May 22, 2020.