PBM news

Pricing Landscape Grows in Complexity

A keynote session at PBMI's 10th annual conference in April discussed the methodologies for reporting reference pricing used for adjudicating drug claims.

This article is based on information presented by Matthew R. Pike, clinical manager of US product files for Medi-Span/Wolters Kluwer Health; Stephen W. Schondelmeyer, PharmD, PhD, professor and director of the PRIME Institute at the University of Minnesota; and Terry Torgler, RPh, Vice President of Customer Support Services at Argus Health Systems, Inc.

Historically, pharmacies and PBMs based their prices on average wholesale price (AWP). AWP prices are published by several national drug information companies including First Databank (Hearst Corporation), Medi-Span (Wolters Kluwer Health), and Red Book (Thomson Healthcare).

Table 1 on page 2 shows how each of these companies derive the drug price reference fields commonly used in the industry. Because of methodological differences, the AWP price for a specific drug published by each company may vary. Industry experience shows that the AWP prices from these three different sources are normally the same for 80% to 85% of legend drugs used in outpatient settings.

First Databank and Medi-Span announced in March that they will change the way they will calculate drug reference pricing for new listings to their databases. New listings may be for new drugs, new manufacturers, and or companies created through merger and or acquisition. Neither company is retrospectively changing pricing calculations for products already listed in the databases. These changes are being implemented because drug manufacturers and wholesalers have changed their

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PBMI Calls for 2006 Speakers

The Pharmacy Benefit Management Institute (PBMI) is calling for speaker presentations on drug benefit management topics for its 11th annual Prescription Drug Utilization Management Conference. Conference attendees are most interested in these topics:

- Coordination of benefits at point of sale
- Evidence-based formularies
- Medicare Part D implementation and early experience
- PBM pricing transparency
- Specialty pharmacy
- Union negotiation strategies

As an independent organization dedicated to educating employers, union groups, health plans, self-insured organizations, and third party administrators about drug benefit management, PBMI hosts the nation's premier meeting dedicated to drug benefit design and administration.

PBMI wants proposals from articulate industry experts that:

- Educate employers, health plans, union groups, and third-party administrators about cost-effective management of the drug benefit;
- Focus on case studies of successful solutions to drug benefit challenges;
- Discuss cutting-edge ideas; and
- Quantify results and outcomes.

Submit presentation proposals with a copy of speaker resume and a conference presentation recently developed by the speaker at www.pbmi.com/PresentationSubmission.asp. Proposals must be submitted by Aug. 26.

Speakers will be notified by Oct. 14. Presentation submissions will be reviewed by PBMI and its advisory councils. Final selections are made solely by PBMI. ●

Save the Date for 2006 Conference

PBMI's 11th annual Prescription Drug Utilization Management Conference will be held **April 26-28, 2006** at The Scottsdale Plaza Resort in Arizona.

Volume 10 No. 3
Summer 2005

Michael H. Deskin, President
PO Box 27831
Tempe, AZ 85285-7831
Tel: 480-730-0814
Fax: 602-241-6914
pbmi@pbmi.com

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reporting of pricing information to drug publishing companies.

First Databank has created the alternative benchmark price (ABP) for prescription drugs which is equal to wholesale acquisition cost (WAC) + 25% or direct price (DP) +25%, depending on which value–WAC or DP–is supplied by the manufacturer. The standardized markup of 25% adopted by First Databank is based on a historical analysis of its own Blue Book AWP data for 2001 to 2004, according to a customer letter posted on the company Web site at www.firstdatabank.com/customer_support.

For new listings in its drug database, Medi-Span will report AWP as either suggested wholesale price (SWP) or WAC + 25% or DP + 25%, depending on what information is supplied by the manufacturer. Medi-Span's reporting guidelines are on the Web at www.medispan.com.

Understand Source of AWP

"It is critical for plan sponsors to understand that not all AWPs are equal," said Matthew R. Pike, clinical manager of US product files for Medi-Span/Wolters Kluwer Health in Indianapolis. "It's important to understand the source of the AWP used in drug benefit contracts and how it was derived. Plan sponsors should write contracts so they know what they are paying," he added. Medi-Span's drug information database supplies an AWP indicator code to let users know if the AWP supplied was derived by applying a mark-up factor to a manufacturer-reported WAC or DP, or if AWP is the same value as SWP.

"In light of recent price reporting changes, plan sponsors should consider changing PBM contract language to their benefit," said Craig Stern, RPH, PharmD, MBA, FASCP, FICA, FLMI, and principal of Pro Pharma Pharmaceutical Consultants. "With an increasing number of pricing fields available from drug information companies, PBM contracts with plan sponsors need to specify which pricing source and which price field will be used to price claims. Because most PBMs buy multiple pricing sources, plan sponsors should require the best drug price irrespective of pricing source."

Historically, the difference between AWP and WAC for brand drugs has averaged 20%. This provided the pharmacists with roughly a 5% margin on the price of drugs, assuming the average 15% discount reported by respondents to PBMI's *2005 Prescription Drug Benefit Cost and Plan Design Survey Report.* In the past few years, the spread between the pharmacies' acquisition cost and AWP for brand-name drugs migrated from 20% to 25% because of marketplace changes.

"The spread between WAC and AWP for generics has ranged from 20% to 6000% in the past," said Terry Torgler, RPh, Vice President of Customer Support Services at Argus Health Systems, Inc. "Manufacturers set high AWPs for generic drugs while keeping low WACs to increase sales to pharmacies. A generic drug with a low WAC and a high AWP is more profitable for the pharmacy," explained Torgler. "That's why maximum allowable cost (MAC) lists were created, to address these large spreads."

The recently reported changes will be implemented for both brand and generic drugs. It is important to discuss generic drugs separately because of the impact this pricing change may have on PBM contracts with plan sponsors and pharmacies.

Implications of Fixed Spread on Generics

A fixed spread between WAC and AWP for generic drugs may have a significant impact on plan sponsor-PBM contracts and PBM-pharmacy contracts. Currently, some PBMs report they lose money on brand drugs while making up this loss through their pricing of generic drugs. This works for the PBMs and the pharmacies because of the large difference between the generic drug WAC and AWP. This contracting strategy gives incentives to the pharmacies and PBMs to encourage generic drug use. PBMs that have followed this contracting strategy may need to renegotiate their contracts with the pharmacies and with the plan sponsors.

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Understand the Acronyms

The industry's robust list of drug pricing acronyms is getting longer. Here's a quick reference of drug pricing terms organized alphabetically by acronym or common terminology.

ABP– Alternative Benchmark Price is a new drug pricing field to be supplied by First Databank.

AWP–Average Wholesale Price represents the average of prices wholesalers publish for their customers. AWP does not represent the actual cost of drugs to pharmacies. This is a reference price PBMs and pharmacies have traditionally used for pricing prescriptions, with PBMs typically negotiating discounts off of AWP for their plan sponsor customers.

ASP– Average Sales Price is submitted quarterly by manufacturers to the U.S. Center for Medicare and Medicaid Services. It is currently used to price Medicare Part B drugs administered in physician offices.

DP–Direct price represents the price the manufacturer has reported it sells the drug to non-wholesalers. DP does not reflect discounts, rebates or other price reductions that may be extended to non-wholesalers.

MAC–Maximum Allowed Cost is the unit price that has been established for a generic drug. The same MAC price applies to all versions of identical generic drugs. MAC prices were created because the cost of identical generic drugs may differ significantly from distributor to distributor. Although some plans and PBMs use the CMS Federal Upper Limit Prices, many develop their own MAC lists to augment or replace the CMS MAC list.

WAC–Wholesale Acquisition Cost is the reported cost that wholesalers pay to a manufacturer for drug products. WAC, reported by manufacturers, may not represent actual acquisition price because wholesalers may obtain discounts through volume purchases or special deals.

RBP–Reference Based Pricing is a fixed dollar amount paid for any drug in a specified therapeutic class. Example: $80 for any proton pump inhibitor.

SWP–Suggested Wholesale Price is the manufacturer's suggested price for drugs to be sold by wholesalers to their customers. Wholesalers determine the actual sales price to their customers.

Source: "Understanding Drug Pricing Methodologies" presentation given by Matthew R. Pike, RPh, Clinical Manager, US Product Files for Wolters Kluwer Health; and Terry Torgler, RPh, Vice President of Customer Support Services at Argus Health Systems, Inc.

On-line Resources

More information about drug pricing information can on the drug information company Web sites:

First Databank: www.firstdatabank.com/customer_support/drug_pricing_policy

Medi-Span: http://www.medispan.com/products

Redbook: www.micromedex.com/products/redbook

TABLE 1: DRUG PRICE REFERENCE FIELD CALCULATIONS

PRICING FIELD	CALCULATION USED FOR PRICING FIELD		
	FIRST DATABANK	MEDI-SPAN	REDBOOK
WAC	Manufacturer-reported reference price (before discounts) at which wholesalers purchase drug	Manufacturer-reported reference price (before discounts) at which wholesalers purchase drug	Manufacturer-reported reference price (before discounts) at which wholesalers purchase drug
Traditional AWP for Brands	WAC + manufacturer-specified markup OR if not released WAC + 20% to 25%	WAC + manufacturer-specified markup OR if not released WAC + 20% to 25%	AWP reported by manufacturer OR WAC + manufacturer-specified markup OR if not released WAC + 20%
Traditional AWP for Generics	AWP reported by manufacturer OR WAC + manufacturer-specified markup OR if not released WAC + Variable %	AWP reported by manufacturer OR WAC + manufacturer-specified markup OR if not released WAC + Variable %	Same as brands
Future AWP for Brands experiencing marketplace changes[1]	N/A	SWP[3] OR WAC + 25% OR DP + 25%	No change
Future AWP for Generics experiencing marketplace changes[1]	N/A	SWP[3] OR WAC + 25% OR DP + 25%	No change
ABP for Brands[2]	WAC + 25% OR DP + 25%	N/A	N/A
ABP for Generics[2]	WAC + 25% OR DP + 25%	N/A	N/A

N/A: Not applicable

[1] Beginning in March 2005, methodology changes for reference prices were announced by First Databank and Medi-Span for new listings in drug databases.

[2] First Databank created the alternative benchmark price field in March 2005 with a formal plan for phasing out the AWP field on its database products.

[3] Suggested wholesale price represents the price manufacturers suggest wholesalers such as retail pharmacies, hospitals, and physicians should charge for their products.

NEWS BRIEFS

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"As the spread between the WAC and the AWP for generic drugs moves toward a fixed percentage, we will see PBMs and pharmacies rewriting mail-order contracts to account for the fixed spread," said Torgler. "We also may see health plans and pharmacy chains working out WAC plus fixed-price deals."

Searching for Benchmark

Schondelmeyer pointed out several problems with AWP pricing as historically calculated. It is unclear who really sets AWP. The relationships of AWP to WAC, and AWP to actual pharmacy cost also are unclear. These complex relationships have changed over time as well as across products, manufacturers, and classes of trade.

"An ideal drug price benchmark would be accurate and reliable, accountable and auditable, transparent and accessible, widely available to providers and pharmacists, current and up-to-date, and provide accurate compensation to providers and pharmacists," said Schondelmeyer. The industry is making changes that try to address some of these issues.

While the derivation of the most commonly used drug pricing fields on drug information databases is changing, the perfect benchmark has yet to emerge. ●

Employer Input Needed

PBMI began fielding the 2005 PBM Customer Satisfaction Survey this month. Plan sponsors who have not received this survey and who would like to participate should contact PBMI at (480) 730-0814 or send an email to pbmi@pbmi.com for a copy of the one-page, fax-back survey. Respondents automatically receive a copy of the survey report and are entered in a drawing for a free pass to PBMI's 2006 conference.

Enjoy Rewards of Becoming a Member of Pharmacy Benefit Management Institute

Join PBMI for research-based information on designing and managing pharmacy benefit programs. PBMI membership is open to plan sponsors, pharmacy benefit managers, and the organizations involved in supporting drug benefit delivery. Some of the many benefits of PBMI membership include:

- Discounted registration to largest U.S. conference dedicated to drug benefit issues
- Annual trend reports on PBM performance and drug benefit plan design
- Subscriptions to *PBM News*

Join today by visiting www.pbmi.com or calling 480-730-0814.

Save the Date:
PBMI's 2006 Conference will be held from April 26-28, 2006

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