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Law of Averages

New benchmarks for wholesale drug pricing have the health industry scrambling to adapt.

by Brian N. Anderson

Recent federal litigation has prompted a change in calculating the benchmark average wholesale price for prescription drugs, but many health insurers and other payors are uncertain what the change means for them.

These new benchmarks for claims pricing took effect in late September 2009. Now that some time has passed, health plans, self-insured health care plans and pharmacy benefit managers can examine the emerging picture and begin to understand how these changes affect them.

The simple answer is that the average wholesale price has been lowered, but pharmacy benefit managers modified their contracts to create cost neutrality for most organizations and their members. In other words, the revised contracts produce the same expected cost to the plan as before the change.

The more complicated answer, however, is that there is much confusion in the implementation of pricing changes. Payors that work through pharmacy benefit managers would be well-advised to examine the pricing procedures and look closely at exactly how the new benchmarks affect their interests and those of their members.

For large and small plan sponsors, the changes can mean thousands or even millions of dollars, depending

- **The Situation:** A class-action settlement has redefined how average wholesale drug prices are established.
- **The Issue:** Health plans and pharmacy benefit managers must adjust to the changes while maintaining mutual trust and integrity.
- **The Way Ahead:** Eventually, average pricing will give way to newer ways of determining how drug costs impact plan benefits.

Contributor Brian N. Anderson is a consultant with Milliman Inc., based in San Diego. He may be reached at Brian.Anderson@Milliman.com.

on how the new prices are calculated. Even for health plans that handle their own in-house claims processing, it is important to understand the pricing issues. The chart below, "Impact of Average Wholesale Price Changes," illustrates the possible impact on a sample plan sponsor.

In the recent past, the average wholesale prices were dynamic; they fluctuated weekly or even daily, depending on how often the pharmacy benefit managers updated their pricing files. Before October 2009, pharmacy benefit managers relied mainly on average wholesale price benchmarks published by companies such as Medi-Span and First DataBank.

The court, however, ruled in *New England Carpenters Health Benefits Fund et al. v. First DataBank Inc. and McKesson Corp.* that the prices had been inflated artificially during most of the decade after 2000. According to the lawsuit, this in turn increased the prices paid by plan sponsors and their members for prescription drugs.

More specifically, the court determined that price markups of 25% over wholesale acquisition cost—the so-called 1.25 factor, the usual pricing standard for brand name drugs—were unfair and ordered the standard set at a maximum markup of 20% (i.e., a 1.20 factor). According to the court-approved settlement, companies publishing average wholesale prices were to begin using the 1.20 factor as a maximum benchmark whose Blue Book AWP is set based upon a markup to WAC or Direct Price, and discontinue the publication of the Blue Book Average Wholesale Prices for all drugs no later than two years following the date that the price adjustments noted above were implemented.

However, it is the pharmacy benefit manager industry's position that average wholesale price discount levels in place reflected the price markups of 25% over wholesale acquisition costs; therefore, the margins generated today by pharmacy benefit managers are not inflated artificially. In other words, the average discounts received by their customers would be lower than what they had been if the average wholesale price markup over wholesale acquisition costs always had been 20%. Most pharmacy benefit managers will decide on a new benchmark by late 2010.

A New Approach

Long-term solutions to determining average wholesale drug pricing might include:

- Wholesale acquisition cost plus a markup factor.
- Prices based on the manufacturer's sales price or an average manufacturer's price.
- Average sales price.
- The average acquisition cost.
- Suggested wholesale price.
- Direct price.
- A trended average wholesale price set by each pharmacy benefit manager, based on previous average wholesale prices and adjusted dynamically. (Not likely.)

Source: Milliman

What's Next?

If the new benchmarks are determined by a fixed maximum—the 1.20 factor—does this mean the resulting prices will be fair and appropriate? A payor should ask who will be defining or publishing the new benchmark, how it can be audited and whether it currently exists.

Before late September 2009, the pre-settlement average wholesale price provided an easily accessible figure against which a payor could audit claims. Now that some pharmacy benefit managers are using alternative methods to determine their own markup factors to be used to create quasi-average wholesale prices, it is more difficult to evaluate the accuracy of discounts for ingredient costs. Payors need to know how the pharmacy benefit manager arrives at its prices, and to ensure that this price is consistent with what it pays pharmacies and with the contract between the pharmacy benefit manager and the payor. It's a good idea for payors to review their pricing schedule on a regular basis, such as quarterly or yearly, to make sure they're getting the deal for which they contracted.

This process can be complex because there are other issues that also affect drug costs, such as drug-mix changes and inflation. This type of review should be completed on a retrospective basis and included in

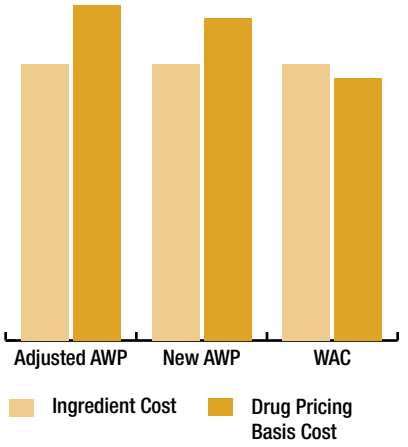
Impact of Average Wholesale Price Changes

($ thousand)

	Ingredient Cost	Drug Pricing Basis Cost	Average Discount		% Impact of Total Cost	$ Impact on Total Cost
			Brand	Generic		
Experience Data Priced at Pre-settlement AWP	$10,340	$14,880	17%	70%	0.0%	$-
New AWP, Unchanged Contractual Discounts	$10,000	$14,450	17%	70%	-3.3%	-$340
Pre-settlement AWP, Unchanged Contractual Discounts	$10,340	$14,880	17%	70%	0.0%	$-
New AWP, Restated Contractual Discounts	$10,340	$14,450	14%	70%	0.0%	$-

Source: Milliman

Brand Name Drugs Relative to Pricing Basis



Source: Milliman

the annual reconciliation process or during an audit.

The graph above shows the differences between the drug pricing basis and ingredient cost for a hypothetical brand-name drug, and how the drug's pricing basis varies when compared to a drug's ingredient cost in the cases of cost neutrality. (There is still uncertainty on which method is best. However, effective management and controls can help contain cost increases.)

Pharmacy benefit managers appear to be addressing the new pricing requirements in different ways. Some are reducing their average wholesale price discounts; some are adjusting the published price to reflect pre-settlement markup factors; and some are using alternative pricing terms, such as wholesale acquisition costs times a factor, instead of average wholesale price times the discount factor. Last August, Milliman's online *Health Perspectives* posted three methods in use by pharmacy benefit managers to address the court-required pricing changes.

But in the longer term, the average wholesale price will no longer be the benchmark and pharmacy benefit managers will have to decide exactly how to determine their pricing.

It is possible that, in the future, each pharmacy benefit manager will create its own basis for pricing, as is the case now in the generic drug market. Today, about 80% of generic drugs are priced on some basis other than the average wholesale price, most often on maximum allowable cost. In the generic market, each pharmacy benefit manager has its own maximum allowable cost lists and, in many instances, determines its own maximum prices, which the pharmacy benefit manager updates from time to time.

Thus, the picture could become one of many different pricing structures for both brand-name and generic prescription drugs. The future pricing structure may vary from pharmacy benefit manager to pharmacy benefit manager, or be based on an industry standard.

What's a Payor to Do?

In this changing environment, payors who contract with pharmacy benefit managers should practice careful oversight to make sure that they understand how drug prices are determined, including how the prices change over time. It is also important to know how often the list of drugs changes, not only in prices but also in additions and removals of specific, covered drugs. Such issues are fair game in negotiating a pharmacy benefit manager contract.

"Other issues also affect drug costs, such as drug-mix changes and inflation."

For pharmacy benefit managers, consistency and transparency are important. Payors expect clarity in pricing structures and auditing procedures, and to be kept abreast of changes as they occur. Payors should work closely with their pharmacy benefit managers and consultants in reviewing drug expenses by creating a partnership with an open dialogue.

In summary, health plans and plan sponsors should be able to ask themselves the following questions and feel satisfied with the answers:

- Do we understand the methodology by which our prices are determined, and are we comfortable that the method has been implemented correctly?
- Do we monitor and audit our plan's pricing regularly, and are we satisfied with the results?
- Are the results what we expected from the contract terms we signed?

These are the partnerships that will result in successful, longer-lasting relationships with pharmacy benefit managers. BR