What a PDAB Means for State Employee Plans

State employee benefit plans, like other employer-sponsored health plans, obtain some amount of manufacturer discount on many of the drugs in their benefit plans. These discounts or "price concessions" are transmitted from manufacturer to employer through rebates. The amount of the rebate depends on the amount of a drug dispensed to enrollees/employees and the unit amount of the rebate. The rebate is billed by the health plan or its pharmacy benefit manager (PBM) and paid by the manufacturer, after the drug has been dispensed and the health plan/PBM has reimbursed the pharmacy for its acquisition cost of the dispensed drug. The rebate reduces the health plan's net cost of the prescription. As with other employer-sponsored health plans, the rebate does not directly lower costs for the enrollee and does not affect how much the pharmacy paid to stock the drug.

If a PDAB were to establish a statewide, all-payer, upper payment limit (UPL) on a drug, pharmacies and other providers in the state would acquire a UPL drug at that upper payment limit through their normal supply channels (which also must comply with the UPL requirement). The state employee plan (and all other health plans) would reimburse providers at their acquisition costs – the UPL – plus a dispensing fee. And, pharmacy benefit managers, acting on behalf of health plans, would not use a national average cost formula (i.e., some percentage of the whole sale acquisition cost or WAC) to reimburse pharmacists for a UPL drug since the UPL is the state specific acquisition cost which is public and required.

There are two aspects of savings for the state employee plan (and other health plans).

One aspect is the amount a health plan/PBM reimburses providers for the provider's cost to acquire/stock a drug (the acquisition cost). That reimbursement for retail drugs is typically based on some percentage of wholesale acquisition cost (WAC) or average wholesale price (AWP). If a UPL for a drug lowered provider acquisition costs to say to WAC-30%, that would be a significant reduction in the amount of money plans spend to reimburse providers ("claims payment").

The second way to think about plan savings is comparing a plan's net cost of a drug (after rebates) to the UPL. If a plan's net cost for a drug before a UPL is WAC-10% and WAC-30% after the UPL, there is a savings there too. If the health plan was already netting WAC-30% after rebates, there is no additional net savings for the plan. The plan savings moved from rebates to savings on pharmacy reimbursement. The move from rebates to on-invoice discounts also help consumers and pharmacists in ways that rebates do not.

So, if the UPL cost is greater than the plan's net cost after rebates, the health plan would still pursue manufacturer rebates, but the cost of paying pharmacy claims would be reduced to the level of the UPL. If the UPL lowers the plan's net cost after rebates on a drug, the health plan benefits even more.

Health plans that consult with the state PDAB in establishing UPLs could derive significant net savings.

As an example, Humira and Enbrel are two widely prescribed treatments for rheumatoid arthritis and other autoimmune disorders. The retail price for these drugs was about $65,000/year two years ago. At that time, the average rebate in the private market was estimated to be between 30-40% and is probably higher today. If the UPL could be 35% off the list price ($42,250), state employer plans could estimate potential savings using two calculations: cost of claims paid calculation and net cost calculation. First, to estimate savings on cost of claims paid, state employer plans could calculate

pharmacy claims payments for these drugs and assume a 35% reduction. To estimate net cost savings, the employee plan should compare its net (post rebate) cost of these drugs relative to a UPL of WAC-35%.

Consider also possible savings for the newer diabetes insulins, Lantus and Levemir, which retailed at about $200 and $400/pen two years ago. The average private market rebate was estimated to be 60-70%. If the UPL dropped the acquisition cost of these products by 70%, that would be a significant savings in claims payments, a significant savings in the supply chain and a significant savings for consumers at the pharmacy counter. A UPL at this level could be a significant net cost savings to state employee plans.

A UPL of even 10%-12% below WAC for newer cancer drugs would be significant when manufacturer rebates are scarce in the market. A UPL of WAC-25% for costly multiple sclerosis drugs could make a large impact on state employee plans and consumers. A PDAB could also decide to capture deeper price concessions as needed to expand patient access. A PDAB could be well positioned to evaluate the range of discounts in setting UPLs to manage affordability and increase access to costly drugs in the state.

These types of back of the envelop estimates should encourage state employee plans and other health plans in a state to work with the PDAB so that the UPL creates net cost savings for the plans.