PERSPECTIVE

Pharmaceutical Benefit Management: An Alternative Approach

Rather than adopting a regulated-monopoly approach to PBMs, why not try a competitive model first?

by Patricia M. Danzon

HAIDEN HUSKAMP and her colleagues believe that any Medicare drug benefit should be managed, which, for traditional Medicare, means using pharmacy benefit managers (PBMs). I share that view. However, their Medicare PBM model is constrained by regulations that could have far-reaching and unintended consequences. The authors propose that PBMs would bid periodically for an exclusive, regional Medicare franchise. Each monopoly Medicare PBM would offer an open formulary; use therapeutic reference pricing (their "incentive pricing") based on the Health Care Financing Administration's (HCFA's) classification of drugs; and pay HCFA-regulated prices of new drugs until these are included in reference pricing.

An alternative approach is a competing-PBM model, which would offer seniors a choice between alternative, approved PBMs, analogous to alternative, qualifying plans under Medicare+Choice. Approved plans would be subject to certain coverage requirements but would compete on formulary design, cost sharing such as triple-tier copayments, and other service dimensions. Therapeutic reference pricing could be adopted if it proved to offer value for money, but current private-sector evidence suggests that it does not.

The authors dismiss this competing-PBM model on grounds of adverse selection, citing the selection bias experienced by Medigap plans that offer drug coverage. Adverse selection is a concern for Medigap insurers, which are fully at risk for enrollee costs. Adverse selection also raises Medigap premiums paid by enrollees. However, adverse selection risk would be much reduced once drug coverage for seniors is made virtually universal by being heavily subsidized. Moreover, if PBMs are reimbursed for costs plus an administrative fee, this implies almost perfect ex post risk adjustment of premiums, except for risk sharing capped at 5 percent of total costs. With PBMs only minimally at risk; per patient costs limited to, say, $2,500 per patient per year (50 percent of $5,000); and open enrollment, neither adverse selection nor cream skimming seems a sufficiently large threat to warrant the regulatory fix of regional monopolies and reference pricing.

The disadvantages of monopoly PBMs are not simply the familiar monopoly problem of weak incentives to deliver value for money to captive customers, who cannot vote with their feet. Less obvious but potentially more serious are the consequences of reference pricing, which is not an incidental addition but a logical component of the monopoly PBM model. A monopoly PBM model leads to an open formulary, since monopoly PBMs could exploit undue monopsony power if empowered to select drugs for preferred formulary status. But since the open formulary robs PBMs of their leverage in bargaining with drug manufacturers, reference pricing follows

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to restore the PBMs' price-setting clout.

Reference pricing is sometimes rationalized as being procompetitive, because the payer reimburses the same reference price for all products within each class, leaving the patient who wants a higher-price product to pay any excess. This is fair competition if the drugs in a class are in fact perfect substitutes. But it easily becomes inappropriate competition if classes include different compounds (therapeutic substitutes), as the authors propose, rather than just generic substitutes.

Efficient incentives for drug utilization and for research and development (R&D) require that prices for different drugs reflect their relative effectiveness. Patent protection is intended to permit originator prices to exceed the production costs incurred by generics, to cover R&D costs. The proposed reference-pricing system would reimburse all drugs in a class at the price of the least expensive, presumably the least effective or a generic. Payers have incentives to define broad classes. But broader classes include more heterogeneous drugs and hence result in greater distortions in relative prices. In theory, patients could pay a surcharge for a superior product, but physicians may be reluctant to spend the time (unreimbursed) to explain the differences. Evidence from other countries indicates that brand prices typically drop to the reference price, which under the authors' proposal would typically be a generic. Thus, reference pricing effectively eliminates patent protection for new drugs as soon as a generic becomes available for any drug in the same product class, because the generic price becomes the reference price, which in turn becomes a price ceiling on other drugs in the class.

The reduction in brand prices to generic levels would spill over to other private and public buyers in the United States and possibly abroad, who presumably would refuse to pay more than the Medicare reference price. Thus, the Medicare reference-pricing system would drive prices nationwide to the lowest price in the class, usually a generic, regardless of patent status. For classes that initially do not include generics, brand-name drugs' prices may rise for private plans, as has occurred under Medicaid best-price provisions.

While the reference-pricing system will on average probably reduce prices for on-patent products, payers likely will pay more for generics. Once the reference prices had been set for the year, any discounts given by generic manufacturers to pharmacists to induce them to dispense their products would accrue to the pharmacists, not the payer/taxpayers, who would continue to pay the reference price, as has occurred in the Dutch reference-pricing system.

By contrast, competing PBMs design their own formularies, which usually include multiple compounds with preferred status in each class, possibly reimbursed at different prices reflecting their different effects. With triple-tier copays, patients face only a limited surcharge for nonpreferred drugs, hence have better insurance. This should lower the administrative cost of appeals and preserve incentives for manufacturers to develop improved drugs in established classes. Competing PBMs could capture for consumers the savings from generic competition, by reducing reimbursement to pharmacists as generic prices fall. Whereas the authors' regulated-monopoly PBMs would compete primarily by controlling volume, without regard to costs generated elsewhere, competing PBMs that compete for enrollees would be forced to consider patient satisfaction.

Any Medicare drug benefit design will be an imperfect compromise. Huskamp and colleagues downplay the disadvantages of their monopoly-PBM approach. Ideally, the political process would select and monitor the monopoly PBMs, design an appropriate classification scheme, and set prices for new drugs to achieve the socially preferred balance of efficiency and equity. But the political process may lack the information and/or incentives needed to make unbiased choices. It seems worth trying the competing-PBM option before moving to a regulated-monopoly model.