

Understanding the Role of Pharmacy Benefit Managers in Healthcare

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Contents

Overview	3
Improve Health Outcomes	4
Design and Manage Networks	7
Reduce Spending and Costs	10
Conclusion	14
Endnotes	15

Key Takeaways

- PBMs work in three primary ways to deliver the prescription drug benefit: improving health outcomes, managing pharmacy networks, and reducing spending and costs.
- Using evidence-based clinical programs, PBMs improve health outcomes. These programs include formulary management, drug utilization review, prior authorization, step therapy, and the enforcement of quantity limits.
- PBMs are cost-effective. They design and manage highly effective pharmacy networks to achieve cost savings for members and utilize other financial strategies to generate savings for the healthcare system.

Overview

Pharmacy Benefit Managers (PBMs) are a critical player in the delivery of the healthcare benefit. They contribute to favorable health outcomes through the use of customized clinical quality tools, increase access to appropriate care, and use financial management strategies to reduce drug spending and costs.

PBMs are companies that administer the prescription drug benefit for health plans and employers. PBMs manage prescription drug plans for more than 266 million Americans—roughly four in five Americans—who have health insurance from a variety of sources, including public and private payers.¹ There are 70 PBMs in the United States today, and they play a crucial role in the drug supply chain, which also includes drug manufacturers, wholesalers, pharmacies, and health plans.²

In addition to processing prescription drug claims, PBMs work in three primary ways to deliver the prescription drug benefit: improving health outcomes, managing networks, and reducing spending and costs.

PBM Benefits

1

Improve Health Outcomes

PBMs can help to improve health outcomes by ensuring members have access to medically appropriate treatments through the administration of evidence-based clinical programs.

2

Manage Networks

PBMs build networks of pharmacies and partner with them to ensure access, quality, and convenience at a cost savings to members.

3

Reduce Spending and Costs

PBMs work to reduce drug costs for health plans, employers, and plan members.

PBMs avoid one size fits all contracts so that plans and employers are able to choose the best benefit and network design at the best price point for them.

PBMs Improve Health Outcomes Using Evidence-Based Clinical Programs

PBMs employ teams of pharmacists and other clinicians to develop, execute, and monitor programs designed to improve health outcomes. Formulary management, drug utilization review, prior authorization, step therapy, and safety programs such as quantity limits are some of the evidence-based tools that comprise PBM clinical programs.

Safety and efficacy are key factors in formulary development.

Formulary Management

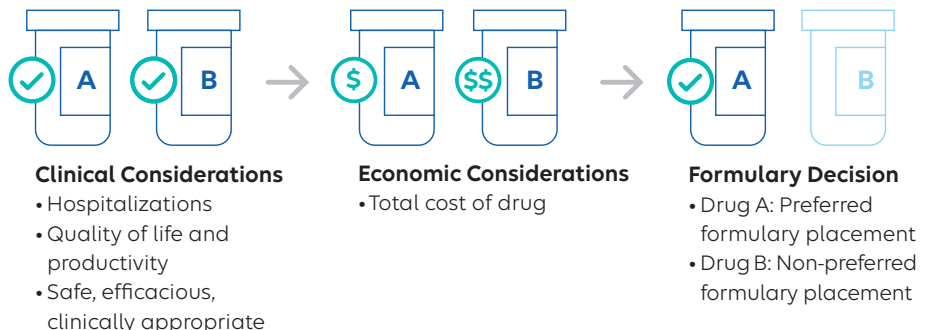
A formulary is a list of covered medications; it may refer to a standard formulary offered by a PBM or one that the PBM customizes specifically for a given health plan or employer.

Safety, efficacy, and clinical appropriateness are key factors PBMs use in determining formulary placement, but when those measures are equal between two drugs, cost may be the determining factor.

PBMs use panels of experts called Pharmacy and Therapeutics (P&T) Committees to determine the most clinically appropriate drugs for a given drug class and indication. These committees are composed of actively practicing primary care physicians (particularly those focused on high-risk areas), actively practicing pharmacists, and other health care specialists covering the clinical needs of the majority of plan members.³ PBMs design their formularies based on P&T Committee recommendations and then factor in a number of cost-saving elements, such as biosimilar availability.

While different P&T Committees' procedures may vary, a multi-step review is commonly used to ensure the clinical benefits and possible side-effects of drugs are assessed first. Clinical efficacy and safety inform any subsequent decisions on formulary placement. Patient satisfaction, adherence, and convenience are also considered. Finally, total costs are factored into formulary placement. Together, clinical evaluation and overall value are used to decide which medications are on the drug list, and on which tier, or level of coverage.

PBM Formulary Review Process



Development and maintenance of formularies is an ongoing activity.

Formulary strategies are designed to promote drugs that lead to better outcomes for plan members. When reviewing drugs and drug classes, a holistic view is taken. This means considering factors such as quality of life and productivity impacts as well as the total cost of the disease. For instance, a more expensive medication may be more cost-effective overall if it leads to improved health outcomes, reduced emergency room visits, and fewer hospitalizations.

Formularies are continually updated to keep pace with newly introduced therapies, the availability of generics or biosimilars, and new or evolving evidence from the literature supporting removal or inclusion of a drug.

Formulary designs that encourage generic substitution improve value by reducing costs for equivalent quality medications. The benefit of generic substitution extends to all parties as generic prescriptions are almost always the better choice for plans in terms of overall cost, and the member's out-of-pocket share is almost always lower as well.⁴ Higher out-of-pocket costs are a known barrier to member adherence.⁵

An Archives of Internal Medicine study found that patients who initiated treatment with generics had 62% greater odds of achieving adequate adherence compared to those who received branded, nonpreferred medications.⁶

Drug Utilization Review and Management

Drug utilization review (DUR) is a structured, ongoing review of the prescribing, dispensing, and use of medication against predetermined standards.⁷

Medicaid programs use DUR to help reduce the risk of adverse drug outcomes.

DUR may result in changes to drug therapy when those criteria are not met. DUR includes an appraisal of patients' prescription and medication data before, during, and after dispensing to ensure appropriate therapeutic decision-making and favorable patient outcomes. DUR programs also provide ongoing prescriber feedback and evaluations.⁸

Through their PBMs' retrospective DUR efforts, state Medicaid programs alert prescribers if they determine potential adverse effects with certain identified prescribing patterns.⁹ DUR programs are key to helping PBMs evaluate and improve the prescribing, administration, and use of medications. DUR enables the identification of trends in prescribing within groups of patients, such as among individuals with asthma, diabetes, or high blood pressure, or by drug-specific criteria such as therapeutic duplication, interactions, or contraindications.

PBM pharmacy staff can then, in collaboration with prescribers and other members of the health care team, initiate action to continually improve drug therapy for patients. Currently, the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services (CMS),¹⁰ and many other government agencies mandate that drug reviews be performed to ensure appropriate drug therapy.¹¹

Additionally, PBMs employ utilization management tools to reduce adverse drug events associated with the use of multiple medications concurrently, reduce potential for overuse and waste, and manage drug costs effectively.

PBMs succeed at implementing these programs because they have real-time access to patients' pharmacy claims data and are able to develop models that can identify patients at high risk for non-adherence or unsafe utilization (e.g., drug-drug interactions). Pharmacy data is also typically provided on a real-time basis by the PBM to the health plan, facilitating care coordination, utilization management, and care coordination efforts contributing to whole person health.

PBM Management Tools



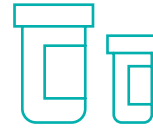
Prior Authorization

provides an opportunity to suggest lower-cost or clinically superior alternative medications.



Step Therapy

ensures that medically sound and cost-effective medications are prescribed appropriately.



Quantity Limits

for certain drugs ensures safer access to therapies and protects against inappropriate use and waste.

Pharmacy data can be provided on a real-time basis by the PBM to the health plan.

Prior Authorization (PA) Programs. The PA process helps to avoid the use of inappropriate or unnecessarily costly therapies. PA programs allow the prescriber the opportunity to demonstrate the therapeutic need for the specific prescribed medication. Prior authorization can also help members avoid potentially dangerous medication combinations or those that may be addictive. For example, opioids are among the more commonly misused drugs, with an estimated 3.2 million misusers reported in 2017.¹² PA may require submission of appropriate diagnoses or attestation from the prescriber in cases of duplicative opioid therapy or concurrent opioid and benzodiazepine therapy, especially in cases of multiple prescribers. One state Medicaid program documented a decrease in overall opioid use and costs following the implementation of targeted PA tools.¹³

Step Therapy. This process involves exploring a less expensive (but still clinically efficacious) option before “stepping up” to a drug that costs more. There is usually a first line drug that is tried and then a more costly second line drug that will be approved if the first line drug is not effective or tolerated by the patient. A physician may request an exception to the step therapy process if they determine that the first line drug is not medically appropriate for the member.

Quantity Limits. Put into place for certain drugs, these limits ensure safer access to therapies and protect against inappropriate use and waste. They are generally developed to be consistent with Food and Drug Administration drug labeling. For instance, PBMs have limits in place for certain drugs intended for short-term use only, such as sedatives used to treat insomnia or opioids for acute pain management.

PBMs Design and Manage Pharmacy Networks

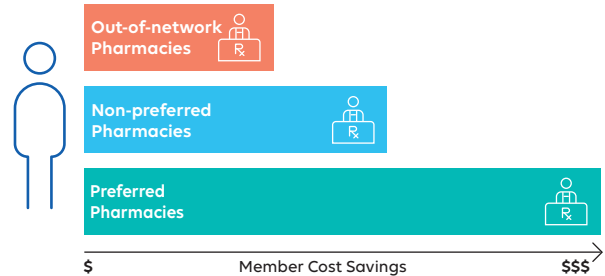
Pharmacy networks are groups of pharmacies that a specific health plan, through their PBM, contracts with to provide convenient access to medication and care at a discounted price. They can include large retail chains, small independent pharmacies, and mid-sized regional chains.

PBMs work with plans to consider factors when deciding the size and scope of pharmacy networks, including: membership size, geographic area, financial and clinical goals, and medication fills or utilization patterns.

Just as cost savings are usually experienced when members receive care within designated physician and provider networks, member savings are achieved by choosing a pharmacy within the pharmacy network to fill prescriptions.

Pharmacy Networks and Savings

Member savings are achieved by choosing a preferred pharmacy within the pharmacy network to fill prescriptions.



Medicare plans with preferred pharmacy networks were 17 percent less expensive than those without them.

Taken a step further, *preferred* pharmacy networks are used by health plans to create even more affordability for their members. PBMs establish preferred pharmacy networks by contracting with a subset of pharmacies within the existing pharmacy network under specific conditions for participation. Preferred pharmacies must meet established quality standards and are also willing to contract at a lower reimbursement rate than non-preferred pharmacies. Pharmacies may choose to contract under these preferred terms because they benefit from greater customer volume. That is, they usually see a higher volume of prescriptions than their non-preferred counterparts, as more members will choose a network's preferred pharmacies in order to realize savings at the point of sale from lower member cost sharing.

The Federal Trade Commission has argued that measures prohibiting preferred pharmacy networks lead to higher drug prices and higher premiums, hence removing an effective means of cost control from the system.¹⁴ One study found that Medicare plans that used preferred pharmacy networks were 17 percent less expensive than those that did not.¹⁵

Specialty Pharmacies

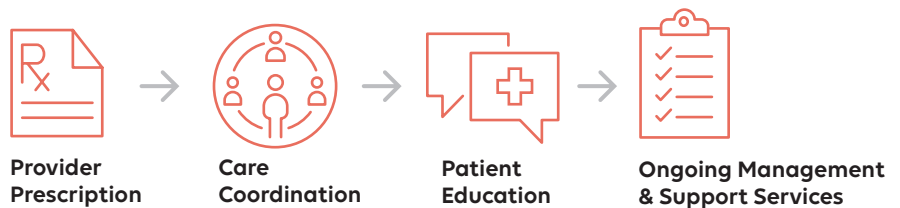
Specialty pharmacies are differentiated from retail pharmacies by their role in safely storing and delivering complex, often injectable or infused, medications.

Specialty pharmacies have tools to support individuals experiencing complex medical conditions.

These drugs are generally more expensive, may require constant refrigeration or other handling protocols that only certain facilities are equipped to provide, and therefore must be managed differently. PBMs have dedicated specialty pharmacy case managers that work with patients to ensure they have access to specialized clinicians, are monitored proactively, and receive trusted information. And because PBMs increasingly have the ability to integrate medical and pharmacy claims data, they are also able to identify the most cost-effective and convenient site of service for provider administered specialty drugs, without compromising quality of care.

Specialty pharmacies provide effective patient education, monitoring, and support for individuals with complex conditions. While consultations in traditional retail pharmacies last an average of two minutes, specialty pharmacy clinical consultations average 15 to 18 minutes for patients with serious diseases, such as rheumatoid arthritis, hepatitis C, and cancer.¹⁶

A Patient's Journey through Specialty Pharmacy



To be included in a PBM's network, specialty pharmacies must undergo formal reviews by independent accrediting bodies to demonstrate their ability to meet predetermined standards and ongoing measures. Accreditation measures and standards include specific requirements concerning call center performance, distribution and dispensing accuracy and handling, prescription turnaround time, and consumer satisfaction.¹⁷

Mail-Service Pharmacies

PBMs' pharmacy networks include mail-service pharmacies that offer safe and cost-effective home delivery of medications.

Mail-service pharmacies offer scale, typically leading to deeper discounts than retail pharmacies, which are passed onto members in the form of lower cost sharing. Mail-service pharmacies encourage the use of generics and have been shown to increase adherence by offering a 90-day supply of maintenance medications and medications for chronic conditions. Improved adherence in turn contributes to better health outcomes.¹⁸

Mail-service pharmacy dispensing processes are highly accurate resulting in virtually zero medication errors.

Computer-controlled quality processes and dispensing practices enable tremendous accuracy in mail-service pharmacies, reducing potential medication errors to virtually zero.¹⁹ A study of the preparation and dispensing processes by one high-volume mail-service pharmacy yielded only 16 errors in over 21,000 prescriptions that were prepared and dispensed, translating to a 0.075 percent error rate.

In addition to promoting access, accuracy, and convenience for members, mail-service pharmacies are highly cost-effective. A recent study published by the National Bureau of Economic Research (NBER) used economic modeling to estimate that mail-service pharmacy utilization results in \$3 billion in value annually to plans.²⁰ This in turn translates to greater savings for members, as cost share is almost always lower when mail-service pharmacies are chosen.

Mail-Service Pharmacy Benefits



Accessibility

24/7 access to pharmacists often available.



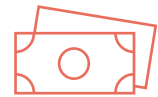
Accuracy

State-of-the-art dispensing with quality checks for safety and accuracy.



Convenience

Medications are delivered right to the member's home with no additional cost.



Cost-Effective

Members save money with fewer refills and lower out-of-pocket costs.

Digital Capabilities Support Prescribing Decisions

As costly products continue to enter the market, the ability to align the medical and pharmacy benefit in real time is increasingly important.

With real time benefit checks, PBMs and plans are able to provide current, accurate prescription cost information to the provider at the point of prescribing, including cost differences by pharmacy network channel (e.g., retail, 90-day supply, mail order, specialty pharmacy). In addition to providing immediate insight into the most cost-effective location for the fill, real time benefit checks can also break down patient out-of-pocket costs and deductible information. Real time benefit checks may also present alternative drug choices that have preferred formulary status or incur lower cost to the patient, all through the electronic health record.²¹ In short, real time benefit checks support access to the right medication at the right price.

PBMs Reduce Spending and Costs

Nationwide spending on prescription drugs increased tenfold in the last four decades, from \$30 billion in 1980 to \$335 billion in 2018.²² This has led to significant public interest in identifying the underlying causes behind this increase, as well as creating a demand for solutions to make drugs more affordable.

Brand-name drug list prices often increase at a higher rate than inflation.

Manufacturers set list drug prices. When there is a lack of sufficient competition due to patent protections or extensions, drug prices can go unchecked. Drug wholesalers, the entities that distribute drugs to pharmacies, usually construct their service agreements as a percentage of a drug's list price and are not typically engaged in negotiating discounts for plans, employers, or consumers. Studies have demonstrated that brand drug list prices often increase faster than the concurrent rate of inflation. A 2022 analysis found that 75 of the 100 brand-name drugs with the highest Medicare Part D spending in 2020 saw their list prices increase in January 2022; none experienced a decrease. The average increase was 5 percent, with some drug prices (12 of 75) growing by nearly 8 percent.²³

In 2016, PBMs passed 99.6 percent of rebate dollars received from manufacturers through to Part D plan sponsors.

PBMs reduce prescription drug spending for plans by negotiating with pharmaceutical manufacturers to secure discounts off of the list price in the form of rebates. Rebates lower net brand drug prices and make drugs more accessible and economical for patients. Rebates also encourage marketplace competition by incentivizing manufacturers of comparable products to negotiate deeper discounts with PBMs. Health plans generally use rebates and other discounts to lower brand drug costs and/or lower the costs of providing prescription drug coverage for all of their members.

A 2019 report published by the Office of the Inspector General found that rebates for brand-name drugs in Part D substantially reduced the growth in spending from 2011 to 2015. Specifically, total gross Part D reimbursement for brand-name drugs increased by 19 percent, or from \$55 billion to nearly \$65 billion, from 2011 to 2015. Rebate-adjusted reimbursement for these drugs increased by only 4 percent, or from \$46 billion to \$48 billion.²⁴ (Figure 1)

Figure 1

Total Part D Reimbursement

- Not Rebate-Adjusted Reimbursement
- Rebate-Adjusted Reimbursement



Source. Office of the Inspector General. (2019). Rebates for Brand-Name Drugs in Part D Substantially Reduced the Growth in Spending from 2011 to 2015.

Rebate savings contribute to lower premiums and reduced cost sharing for members.

A commonly cited concern with the use of rebates to lower drug prices is the potential for PBMs to retain rebates as profit and not pass savings to health plans and members. However, data from a 2019 GAO report showed that PBMs passed 99.6 percent of rebate dollars received from manufacturers through to Part D plan sponsors in 2016. Those savings are passed along to patients in the form of lower premiums and reduced cost sharing. In fact, Part D rebates resulted in \$34.9 billion in beneficiary premium savings from 2014 to 2018.²⁵

Similar to the savings experienced in the Part D program, a Pew Trust survey found that PBMs passed through 91 percent of manufacturer rebates across all plan types in 2016.²⁶

Traditional vs. Pass-Through Pricing Contracts

Health plans and employers compensate PBMs for their work to administer the prescription drug benefit using two primary approaches known as traditional (or “spread”) pricing and pass-through pricing.

PBM Compensation Models



Traditional Pricing

The PBM and plans agree to negotiated guaranteed rates for brand and generic drugs.



Pass-through Pricing

PBMs pass along retail discounts in full to health plans and employers and charge an administrative fee.

Traditional Pricing (also known as spread pricing). In this model, the PBM’s compensation is equal to the difference between its negotiated reimbursement rate with the plan and the PBM’s negotiated reimbursement to the pharmacy. This is often the approach chosen for contracts in the commercial health insurance market.

There are usually no separate administrative fees associated with traditional pricing arrangements, or they are far less than in other PBM contracting models. Traditional pricing aligns incentives and encourages PBMs to negotiate aggressively to get lowest net cost. PBMs then use their compensation via the traditional pricing model to fund core PBM services and clinical programs.

Traditional Pricing Model



A traditional pricing model tends to offer employers and health plans greater predictability.

Employers and health plans often choose to use a traditional pricing model in their contract agreements with PBMs because of their greater predictability. This is because more cost risk resides with the PBM due to drug price fluctuation. And as a result, the PBM has greater accountability to provide a cost-effective network of pharmacy providers that meets the access needs of the payer.

Consider an overly simplistic example of a single drug, without regard for other fees, rebates, or quality programs: the PBM incurs a loss if their reimbursement to the pharmacy for the prescription exceeds the negotiated rate between the plan sponsor and the PBM. Conversely, if the pharmacy reimbursement is less than the PBM's contracted rate with the plan sponsor, the PBM retains the difference as its compensation for services.

Pass-Through Pricing. In a pass-through pricing model, PBMs pass along retail discounts in full to health plans and employers. PBMs receive administrative fees as compensation for their services. Pass-through pricing may be viewed as more transparent than the traditional pricing approach, as the payer is charged the same amount per claim as the PBM pays the pharmacy. Plans and employers will often request bids from PBMs on both pricing models, but ultimately choose a traditional pricing arrangement much of the time, giving greater weight to the overall cost predictability of the pharmacy benefit versus the manner in which the PBM is compensated for services.

Value-Based Payment

Value-based payment in healthcare refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use.²⁷

Today, Medicare performance-based programs are in place for physicians, hospitals, nursing facilities, home health, and pharmacies.

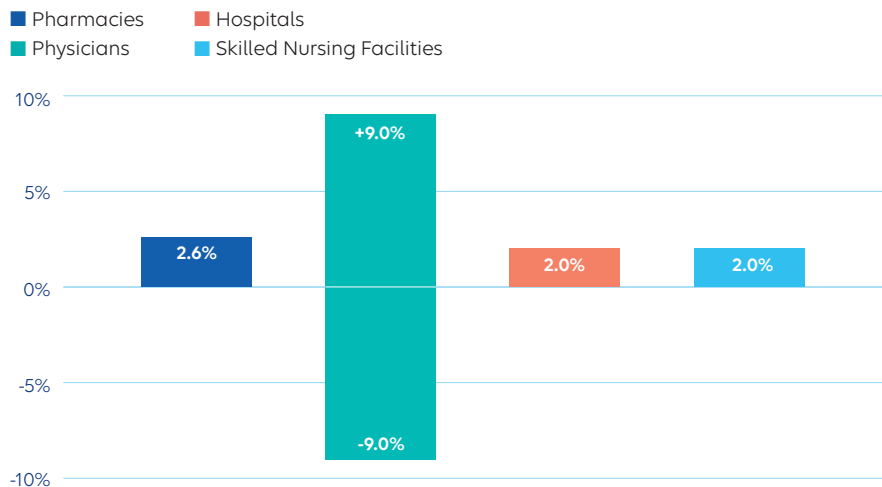
Value-based performance measures can allow for comparison across organizations or systems and can be used in contracts with providers, public reporting, and pay-for-performance programs.

CMS implemented its first value-based payment model for select providers in 2012. Today, there are Medicare performance-based programs in place for physicians, hospitals, skilled nursing facilities, home health, and pharmacies.

Direct and Indirect Remuneration (DIR). This term of art refers, in part, to performance-based payments to pharmacies in the Medicare program. DIR is part of a national movement toward value-based health care, wherein quality measures and outcomes on those measures contribute to pharmacies' payment structure. Pharmacy DIR reflected 2.6 percent of total Part D plan payments to pharmacies in 2020, which is in line with the at-risk reimbursement of other Medicare pay-for-performance programs. (Figure 2)

Figure 2

Value-Based Payments At-Risk in Medicare, 2020



Source. Centers for Medicare & Medicaid Services program data.

Commercial plans are increasingly extending value-based payment contracts to pharmacies as well. PBMs design their contracts to include these kinds of performance measures to incentivize pharmacies, with higher performance on the measures resulting in higher reimbursement.

Extending value-based payment arrangements to pharmacies recognizes the important role that pharmacists play in contributing to patient-centered quality care.



Pharmacy performance measures may include:²⁸

- Medication adherence
- Appropriate medication use
- Medication safety metrics
- Medication management services
- Indicators to address the opioid epidemic
- Preventable hospitalizations
- Patient outcomes

Pharmacy value-based payment reflects pharmacists' role in patient care.

Increasingly, pharmacy performance-based measures that track social determinants of health (SDOH) are being considered. The Pharmacy Quality Alliance has begun work to promote ways in which pharmacies and pharmacists can contribute to breaking down identified barriers to care, which may include measures related to pharmacist SDOH screening and training to triage for appropriate subsequent referral.²⁹ Examples of pharmacy performance measures include STARS (Medicare) medication adherence, formulary compliance, comprehensive medication review completion, and statin use in persons with diabetes (SUPD).³⁰

Savings Realized Through PBM Services

Through the utilization of the above referenced tools, the NBER estimates that PBMs generate at least \$148 billion in savings for the healthcare system annually. These savings come from PBM-negotiated rebates and discounts, combined with lower expenditures on other health care services from increased drug utilization and adherence.³¹ Additionally, PBMs deliver a significant return on investment (ROI). For every \$22 billion of resources used by PBMs, they return \$168 billion to the system, a 7:1 ROI for the healthcare system.³²

Conclusion

PBMs partner with health plans and employers to increase access to safe and efficacious medications for individuals while simultaneously reducing drug costs. The successful delivery of the prescription drug benefit requires weaving together sound financial, network management, and clinical programs customized for each population. PBMs exist expressly to fulfill these needs while contributing positively to overall member health, and as such fulfill a critical role in the healthcare system.

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About Us

Elevance Health Public Policy Institute

The Public Policy Institute (PPI) was established to share data and insights that inform public policy and shape the healthcare programs of the future. PPI strives to be an objective and credible contributor to healthcare transformation through the publication of policy-relevant data analysis, timely research, and insights from Elevance Health's innovative programs.

ElevanceHealthPPI.com

Elevance Health

Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. The company supports consumers, families, and communities across the entire care journey—connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve more than 118 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions.

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