

Access Based Network Design

A new approach to significantly reducing prescription drug benefit costs.

Payers and their benefit consultants and PBMs are continually seeking ways to bend the cost curve on prescription drug spending. There has been some success in this area as plan and formulary designs have increased the use of generic drugs and the introduction of \$4 prescription drug programs put downward pressure on costs.

But it's not enough. New ways of combating rising costs are desperately needed and CFOs are pressuring Benefit Directors to find ways to rein in health care spending while still ensuring that employees receive the care they need.

Access Based Network Design will play a major role in controlling these costs. It doesn't just slow the cost increases, it actually creates a break in the cost curve and slows future cost increases by applying downward pressure on cost drivers.

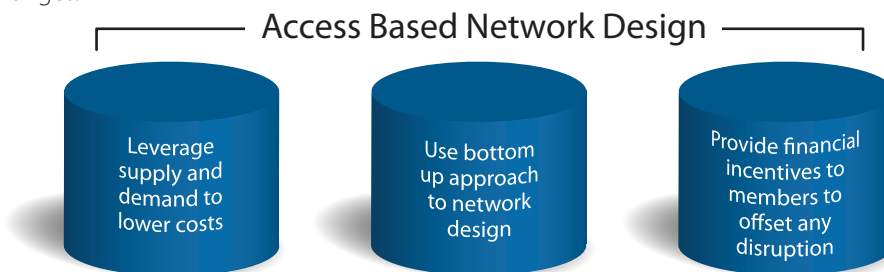


Pillars of Access Based Network Design

Access Based Network Design is a process of structuring pharmacy networks in which the goal is to **minimize costs while achieving predetermined access standards**. Most payers are unknowingly operating under a different goal of **maximize access at any cost**.

Access Based Network Design is based on three pillars.

1. Leverage supply and demand to create competition among pharmacy providers resulting in lower costs.
2. Use a 'bottom-up' rather than 'top-down' approach to network design by building a network based on the number of pharmacies you need rather than the number of pharmacies there are.
3. Provide financial incentives to plan members to offset any disruption or inconvenience created by network changes.



Let's address each of these pillars separately.

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The First Pillar

Leveraging Supply and Demand

Consider how your company purchases virtually everything. You determine exactly what it is you need and when you need it and you have vendors compete for your business. Let's say you're selecting a vendor for office supplies. You define what types of products you need and determine performance standards such as delivery requirements. Then, you let vendors compete for the business.

And it's not just office supplies. You force vendors to compete on price and other metrics whether your company is purchasing raw materials, janitorial services, hiring an accounting firm, or repaving the parking lot at your corporate office. You're leveraging the fact that there are multiple vendors who all want your business and you force them to compete to get it. Nobody doubts that competition helps reduce costs.

So why doesn't your company buy prescription drugs this way? You might answer that you have Pharmacy Benefit Management companies (PBMs) compete against each other for your business and you then leave it up to the one you hire to negotiate with pharmacies on your behalf. In other words, you're outsourcing vendor negotiations to a PBM. That's fine – hiring experts in areas where you don't have internal expertise makes a lot of sense. But it's your company's money. You're the one that's paying that exorbitant prescription drug bill twice a month. As the payer, you should insist that your PBM apply the same competitive bidding approach in their pharmacy negotiations as your company uses in purchasing other things, such as office supplies. In other words, you need to leverage supply and demand.

Supply: There are over 60,000 pharmacies in the U.S. That's close to twice the number of supermarkets and five times the number of McDonald's restaurants. It seems there's a pharmacy on almost every corner. That's great news for payers because when the supply of vendors is larger than demand, prices can be forced down.

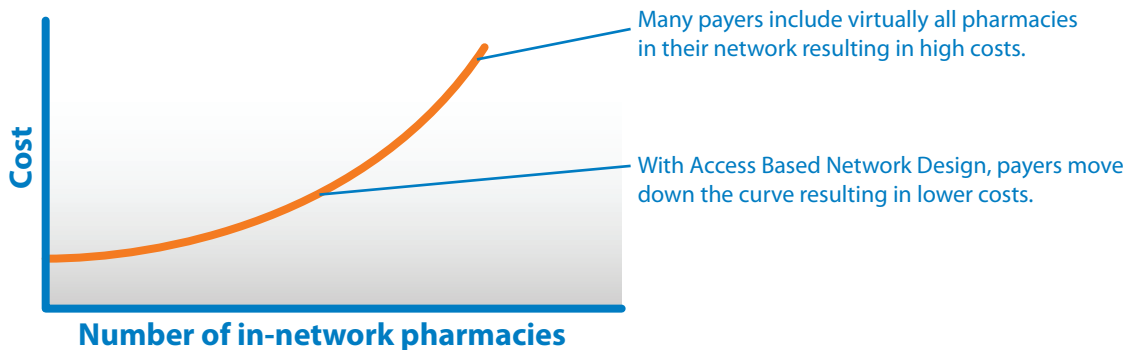
Demand: This is where payers and PBMs are missing the boat. In the self-funded market, most national employers have pharmacy networks that have virtually all 60,000 pharmacies in-network. The large supply of pharmacies is not being leveraged to drive down costs.

The common approach used by PBMs in building a pharmacy network is to allow any pharmacy that agrees to meet certain rate requirements and other conditions of participation to be allowed in the network. What if we applied this same approach to our office supplies example? In that case, you would announce to all office supply vendors that they could get a portion of your business if they agreed to a certain cost per item that you established in advance. If the rate you're offering is attractive enough, you might get every office supply distributor within 200 miles to accept your offer. In fact, the rate you're offering will have to be quite attractive because office supply vendors have to assume that they'll be one of many that accept the offer. If the potential is that they'll only get a small percentage of your total business, they have to take that risk into consideration when determining whether or not to accept your offer.

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With Access Based Network Design, payers in the self-funded market leverage the fact that there are many pharmacies that want their business, which forces competition and drives down costs as shown in the graph below.



Aligning of Interests

When PBMs negotiate rates with pharmacies today, the incentive of the pharmacy is to keep prices as high as possible without getting kicked out of the PBM's network. This is a very important point and a key reason drug prices are high. Pharmacy networks contain virtually all pharmacies and co-pays are the same at all pharmacies in the network so pharmacies have absolutely no incentive to reduce the amount they charge your company for prescription drugs. If there's no upside to providing lower costs, vendors will not provide lower costs.

Let's compare how Walmart's incentives differ for its pharmacy operation versus other departments in the store. The Walmart merchants responsible for electronics, apparel, grocery, and virtually every other area of the store have a single minded focus. They buy quality products at the best possible price, distribute those products as efficiently as possible, and sell them for less than their competitors. They know that if they can sell those products for less, many people will choose to buy them at Walmart stores.

Compare that to the incentive of Walmart pharmacies. The out-of-pocket cost to members is set by you as the plan sponsor. And, assuming you use co-pays, you set the same out-of-pocket cost at all pharmacies, so the out-of-pocket cost to your members is fixed and does not differ by pharmacy. Pharmacies therefore have less incentive to compete against each other on prices to you, and plan participants have no incentive to shop at a pharmacy offering your company lower prices for prescription drugs. The incentive system is broken and Access Based Network Design has been developed to fix that.

Summary of The First Pillar – Leveraging Supply and Demand:

- Leverage the fact that there is a large supply of pharmacies. By creating competition among pharmacy vendors, costs go down.
- Align the interests of the pharmacies with your company's interests. Just like any other vendor, if pharmacies have the opportunity for upside, they'll compete aggressively to get it.



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The Second Pillar

Incorporate a 'bottom-up' rather than 'top-down' approach to network design

It was noted earlier that there are about five times more pharmacies in the country than there are McDonald's restaurants. And nobody would argue that it's difficult to get a Big Mac. So, we've determined that there is plenty of supply when it comes to pharmacies. The next question to address in Access Based Network Design is:

"How many and which pharmacies do I need to ensure good access for my plan participants, yet still force competition in order to lower prices"

Said another way, you want to determine how far you can move down the curve that is shown in the graph on the previous page. The goal is to move down the curve to the point at which you maximize the savings opportunity while still meeting access standards for your employees.

This leads us to the second pillar of Access Based Network Design which is to insist that your PBM build your pharmacy network from the bottom-up rather than the top-down. In conjunction with your benefit consultant or PBM, you determine what access standard you desire and then, based on that access standard, determine how many pharmacies are needed to achieve it.

Medicare for example, has established the following access standards for Medicare Prescription Drug Plans:

Medicare Pharmacy Access Standards

Urban – On average, at least 90% of Medicare beneficiaries who live in an urban area have access to a network pharmacy within 2 miles of their residence.

Suburban – On average, at least 90% of Medicare beneficiaries who live in a suburban area have access to a network pharmacy within 5 miles of their residence.

Rural – At least 70% of Medicare beneficiaries have access to a network pharmacy within 15 miles of their residence.

The relevant question in building a network is not "How many pharmacies are there?"

It's "How many pharmacies do I need?"

You may decide to have less aggressive access standards than what Medicare requires – after all the average age of a member on a Medicare prescription drug plan is around 72. Once you've determined what access standard is appropriate, a PBM can build a network that meets these standards. And chances are you'll be shocked at how little the access for your employees' changes, even when you maximize savings by reducing the number of in-network pharmacies. The Medicare access standards shown above can be achieved for virtually any large national employer with a national pharmacy network of less than 20,000 pharmacies.¹

¹ Source: Express Scripts Network Pharmacy Accessibility Analysis. May 4, 2010.

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Maximizing savings

Some large employers that are adopting Access Based Network Design are asking pharmacies to provide pricing directly to the employer. Others are outsourcing price negotiations or bidding to their PBM. Whatever the approach, it's critical that the pharmacies that are competing have access to the information they need to allow them to bid aggressively. Identifying upfront the maximum number of pharmacies that will be allowed in-network and the term of the agreement is critical. So is ensuring that rates are known and fixed. If there is unknown downside risk due to a PBM's pricing methodology, pharmacies will have to take that risk into account in their pricing which will drive up costs.

For example, pharmacies might be asked to compete to gain entrance to a national network that contains a maximum 20,000 pharmacies for a minimum period of three years. Effective rate guarantees or cost-plus pricing would be in place so that pharmacies are not at risk of the PBM unilaterally reducing reimbursement. By tightly defining the 'prize', pharmacies can calculate their upside, know that their downside risk is minimized, and bid extremely aggressively for the business. Again, this is no different from the way vendors compete for other things your company purchases.

Finally, don't forget to take a pharmacy's generic conversion capabilities into consideration. Some pharmacies are better at others at moving people from expensive brand drugs to low cost generic drugs. That should be taken into consideration as your PBM builds this network since this will result in additional cost savings.

Continued downward price pressure

Not only does Access Based Network Design deliver immediate and ongoing savings, it also provides additional downward pressure on long-term costs. As noted previously, the way pharmacy networks are built today, the incentive for pharmacies is to keep their prices as high as possible without getting kicked out of a network. That puts upward pressure on costs. With Access Based Network Design, pharmacies that did not bid aggressively enough to gain access to the network will have a strong incentive to bid more aggressively when the contract renews. And pharmacies that are already in the network will need to assume that their position is at risk which puts downward price pressure on those pharmacies also.

Summary of The Second Pillar

Use a 'bottom-up' rather than 'top-down' approach to network design.

- Determine what access standards you require in your network. For example, 90% of employees must live within 6 miles of a network pharmacy.
- Have your PBM determine how many pharmacies are needed to meet your access standard.
- Force pharmacies to compete against each other to be allowed in this network.

Is Access Based Network Design right for your company?

Pose the following question to your company's CFO:

"Today, 90% of our employees live within 5 miles of a network pharmacy. If I changed that to 90% living within 6 miles of a network pharmacy, but that resulted in a 10% immediate reduction in our prescription drug benefit costs, would you want to do it?"

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The Third Pillar

Provide financial incentives to encourage plan members to support and embrace Access Based Network Design.

Access Based Network Design allows payers to realize significant cost savings in exchange for insignificant changes in geographic access for their employees.

While the business logic for Access Based Network Design may be irrefutable – your company might realize a 10% or greater reduction in drug spend while your employees may, on average, have to drive a few more blocks to access a network pharmacy – there is always some employee push back when it comes to plan changes. As any Benefits Director can confirm, even minor changes in health plan design invariably create some disruption for members and HR departments.

This brings us to the third pillar of Access Based Network Design which is to offset any employee disruption caused by network changes by giving your employees the opportunity to have lower out of pocket costs on prescription drugs. A financial incentive makes any short-term inconvenience easier to swallow.

Incorporating a financial incentive into your Access Based Network

To maximize savings to your company, you want pharmacies to compete to provide this incentive. To do this, simply have your PBM solicit two rates from pharmacies that are competing for network access – one to gain access to the network and a second if the pharmacy were to be granted a small co-pay advantage versus other pharmacies in the network. Allow the pharmacy that is willing to be most aggressive on rates to have a small co-pay advantage versus others in the network thereby providing your employees the option of saving money if they select that pharmacy.

For example, if you currently have a plan design with a \$10 co-pay on generic drugs, you would keep that co-pay in place under your Access Based Network, but because pharmacies competed for access, your company is paying significantly less. To help offset any inconvenience to those employees that need to select a new pharmacy, you reduce the co-pay at the preferred pharmacy from \$10 to \$7. While those employees may be inconvenienced by needing to switch pharmacies, they now have the option of paying less if they choose to select the preferred pharmacy. You're able to offer this savings to your employees at little or no cost to your company since the preferred pharmacy's more aggressive pricing will offset the reduced copayment amounts.

Summary of the Third Pillar

Provide a financial incentive to members to offset any disruption.

- Have pharmacies submit two bids to be included in the network; one to gain access to the network and a second that allows preferred pharmacies to have a small co-pay advantage versus other pharmacies in the network.
- Communicate to your employees that the new pharmacy network will include preferred pharmacies which will give your employees the opportunity to pay lower co-pays at these preferred pharmacies.

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Implementing Access Based Network Design

Setting up an Access Based Network is easy. A PBM that can administer this type of network can do virtually all the implementation. Some PBMs are building turnkey solutions for payers so it doesn't have to be built from scratch for every employer.

- 1. Determine your access standards.** For example, 90% of employees must live within 6 miles of a network pharmacy.
- 2. Determine the number of pharmacies** needed to achieve your access standard. For example, a maximum of 20K pharmacies are needed across the nation to meet the access standard.
- 3. Define the prize.** Let pharmacies know the maximum number of in-network pharmacies allowed and the co-pay advantage that would be granted to preferred pharmacies. Ensure that pharmacies know their downside risk by basing reimbursement on effective rate guarantees or a cost-plus pricing methodology.
- 4. Compete.** Have pharmacies compete against each other to get into the network. Allow pharmacies to submit a second, more aggressive bid in order to be a preferred pharmacy granted a small co-pay advantage versus other pharmacies in the network.
- 5. Communicate.** Let your employees know you're managing health care costs by forcing pharmacies to compete in order to participate in the new network. Announce the network and let employees know that you're also lowering co-pays at the preferred pharmacies in that network.
- 6. Save.** Your company begins realizing significant savings immediately. You've created a break in the cost curve as is shown on the first page of this white paper. At the end of the initial term (2 - 3 years for example) pharmacies compete again for network access which puts further downward pressure on costs.

Summary

Access Based Network Design is a simple solution to significantly reduce prescription drug benefit costs. It applies many of the principals you use today when purchasing from vendors and applies this same proven methodology to your company's purchasing of prescription drugs. It creates competition among pharmacies by leveraging the fact that there is a very large supply of pharmacies. It bases your pharmacy network design on the number of pharmacies you need to reach pre-determined employee access standards, rather than basing the network on the number of pharmacies there are. And it provides a financial incentive to your employees to offset any inconvenience caused by network changes. The result is a break in the cost curve resulting in immediate savings and continued downward pressure on rates.

Michael Struhs is Director of Business Development for Walmart's Health and Wellness business unit. To learn more about Access Based Network Design and PBMs that provide it, contact Michael at 877-234-8662 or Michael.Struhs@wal-mart.com.