

Who Covers What? Untangling the Intricacies of Administering Prescription Drug Benefits with Professor Amanda Starc

Amanda Starc, **Pavel Darling**, and **Christopher Ody** — 5 MIN READ

*Professor **Amanda Starc** – Associate Professor of Strategy at the Kellogg School of Management at Northwestern University – has studied the workings of the US health care system for many years. Analysis Group Managing Principal **Pavel Darling** and Vice President **Christopher Ody** had the opportunity to chat with Professor Starc about the roles that payers play in administering prescription drug benefits, and the competitive implications of this from an economist's perspective.*

To start, why is it so difficult to understand prescription drug pricing in the US?

Every prescription depends on a large and complex supply chain. Going to the pharmacy seems as simple as going to the grocery store, but we finance prescription drugs and groceries very differently. When a customer who's covered by an insurance plan pays for their prescription at the pharmacy, they're only paying a portion of the cost (if anything) at the time of the transaction. The rest of the cost is paid for indirectly by other parties, such as insurance companies or the federal government in the case of Medicare, for example.

To manage the process, several entities interact behind the scenes: pharmacy benefit managers [PBMs], drug manufacturers, pharmacies, and wholesale drug distributors. These interactions affect drug pricing and access to cost-efficient options.

How does this complex ecosystem affect pricing and coverage?

Which drugs are available to individual consumers at what price, and who pays what portion of the full cost, depends on negotiated contracts. Of course, consumer choice shapes these negotiations.

For example, as I've seen in some of my own research on Medicare programs, a Medicare Part D plan may use preferred pharmacy networks to lower retail drug prices. This means that enrollees for whom price is a deciding factor may be willing to sign up for a less expensive Medicare Part D plan and drive further to fill their prescriptions.

Others may value convenience over cost and sign up for a more expensive Medicare Part D plan that allows them to get their drugs from pharmacies closer to their homes. It depends on what's most important to the specific enrollee.

What roles do specialized firms like PBMs play in this system?

PBMs are intermediaries between insurers and drug manufacturers. Insurers can contract with them, among other things, to develop drug formularies, which can guide insurers toward covering – and steer patients toward using – certain treatments.

In developing these formularies, PBMs may negotiate discounts, known as rebates, on behalf of the insurers from manufacturers and pharmacies alike. Those negotiations could ultimately influence which drugs are available to patients and what prices they may pay.

And how could interactions between PBMs and insurers affect health care spending?

The answer to that question is specific to the parties involved. We would need to understand how the relationship is structured between the particular PBM and insurer involved.

Compare, as an example, Medicare Advantage and Medicare Part D programs. While the former provides members with both health insurance and drug coverage, the latter only provide members with drug coverage. Because Medicare Advantage plans are on the hook for their enrollees' total health care spending, they have an incentive to encourage their members to use drugs that lower overall spending. Medicare Part D plans, on the other hand, have incentives to control prices at the individual drug level because traditional Medicare covers the medical spending. This can actually lead to higher total spending in some cases.



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> AMANDA STARC

That said, insurers and PBMs have incentives to promote coordinated care, so this pattern might not generalize outside of Medicare Part D and traditional Medicare. One reason for that could be the benefits of specialization. PBMs specialize in administering prescription drug benefits, which might give them certain competitive advantages in doing so. For instance, the scale that comes from this specialization could potentially give PBMs the ability to negotiate lower drug prices. How much an insurer would benefit from working with a PBM would depend on how effectively that insurer could fulfill these specialized roles itself.

So, what does all of the complexity in this system mean for the prices of drugs?

Well, for one thing, it means that there is no such thing as a single price of a drug. Price means different things to parties at different stages of the supply chain, and prices often differ even for parties at the same stage of the supply chain.

That is because prices are subject to changes based on many factors, including – but not limited to – negotiated discounts between the parties; consumer contributions affected by copayments, coinsurance, deductibles, and out-of-pocket maximums; and even features such as stop-loss insurance, which can transfer some of the cost to additional entities.

For instance, decisions by PBMs and insurers can affect the uptake of generic and biosimilar products, which may affect patient expenses for those products and their branded and biologic counterparts.

From the perspective of patients, whether and how much cheaper certain drugs could be can depend on the specific negotiations between the different parties.

How could changes in this system – such as supply disruptions or shifts in competitive conditions – affect drug prices?

Given the complexity of both the data and the interactions between the various parties, there is quite a bit of nuance to consider here. For example, defining the relevant price for any particular participant in a transaction requires extensive knowledge of how the economics of the supply chain works. Economic frameworks can provide footholds to answer these kinds of questions.

Accounting for changes in market behavior given discounts and third-party payments requires both industry knowledge and solid economic frameworks. In my experience, this makes economists who study competition and have knowledge of both health care and pharmaceutical markets particularly well positioned to study drug prices. ■