

A high-angle photograph of three business executives in a meeting. A man in a light blue shirt and dark tie is on the left, pointing at a document. A woman in a striped shirt is on the right, looking at the document. A third person is partially visible at the bottom, writing on a document. The table is covered with various business documents, including charts and graphs, a laptop, a tablet, a smartphone, and a notebook. The background is a dark wooden floor.

BEYOND THE REBATE

How Executives Can Better Manage Pharmacy Spend

Business leaders must look past unit costs to
achieve long-term predictability and sustainability.

The Big Picture:

- ✓ **Prioritize “Drug Mix” Over Unit Cost:** Traditional procurement focusing on discounts and rebates accounts for only 30% of future costs. Managing the “drug mix” drives the remaining 70%.
- ✓ **Demand Clinical Accountability:** Employers should evaluate pharmacy benefit managers (PBM) based on formulary appropriateness (efficacy and safety before total costs), clinical program rigor, including prior authorization success rates and refill logic, to prevent significant waste.
- ✓ **Use Transparent Pricing Indices:** Shifting from the volatile world of Average Wholesale Price (AWP) and Maximum Allowable Cost (MAC) Lists to acquisition-cost-based benchmarks, such as National Average Drug Acquisition Cost (NADAC), allows employers to have visibility into actual drug prices so not to be enveloped in ERISA lawsuits due to inflated benchmark pricing and capture deflationary trends in drug pricing, thereby avoiding market arbitrage.

Introduction

The landscape of employer-sponsored healthcare is experiencing continued inflationary pressures largely driven by misaligned vendor incentives and the stratospheric rise in pharmacy spend. As high-cost specialty medications and GLP-1 agonists for an everexpanding list of indications become more prevalent, traditional methods of evaluating PBMs are failing to provide accurate estimates of future drug spend that plan sponsors and payers need.

The industry standard for procurement has focused almost exclusively on unit costs: the depth of discounts and the size of rebate checks. This approach inevitably obscures the true drivers of plan performance.

Executives responsible for healthcare spending need to refocus on their pharmacy benefit strategy, shifting from “chasing rebates” to a model centered on total costs driven by clinical guarantees from drug mix management.

A deeper investigation of the interplay between pricing indices, clinical oversight, and risk-transfer models can allow business and finance professionals to create genuine predictability in their healthcare budgets. A more rigorous, clinically focused approach can help address the challenges associated with understanding drug spend drivers while also ensuring plan sponsors feel more prepared to assess total future pharmacy costs during their next RFP process.



Kristin Begley, PharmD
Chief Commercial Officer

“Only ~30% of future drug costs come from discounts, admin fees, and rebates. The other 70% comes from drug mix and utilization, where real cost pressure begins.”

- Kristin Begley, PharmD



Michael Miele, FSA, MAAA
Senior Vice President,
Insured Services



CONTENT SPOTLIGHT:

[PMPM vs Clinical Guarantees: A Pharmacist and an Actuary Explain How to Create Predictability Around Pharmacy Spend](#)

The Fallacy of the Rebate-First Strategy

In traditional PBM procurement models, success is often measured by the rebate check and meeting guarantees. While these payments are tangible, they can distract from the plan's escalating total cost. In fact, a perverse relationship ensues: industry data suggests that for every \$1 earned in rebates, a plan sponsor typically spends \$3.50 on ingredient costs.

This ratio highlights a critical truth: rebates are often used to incentivize the use of high-cost brand-name drugs over more affordable, clinically equivalent alternatives. Additionally, PBMs who white label high Wholesale Acquisition Cost (WAC) biosimilars enjoy the greatest rebates, but they help drive the highest baseline ingredient costs for plan sponsors and payers.

The disparity between unit cost and total spend is stark. Analysis shows that discounts, administrative fees, and rebates only account for approximately 30% of a plan's

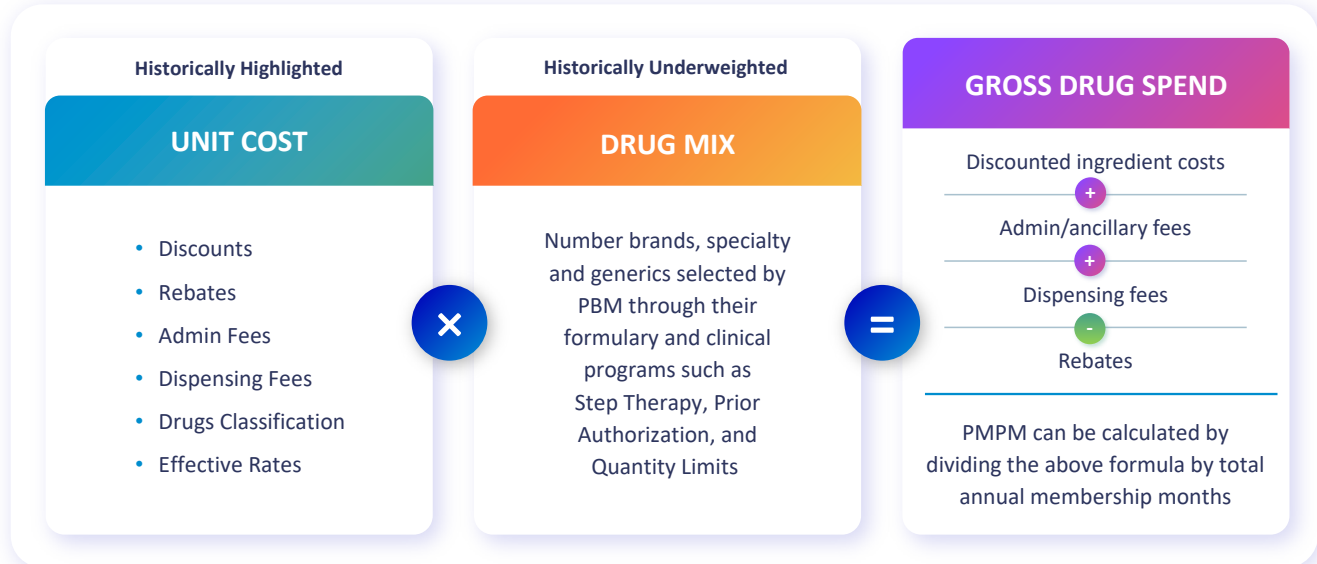
future drug costs. The remaining 70% is determined by the drug mix – which drugs are being dispensed and how often. If a health plan has a low generic dispensing rate (GDR), it may be because the PBM favors brands that carry higher rebates. The end result is a larger rebate check and inflated ingredient costs – i.e., higher total net costs.

Traditional PBMs also have lots of levers they can pull to improve the optics around their programs and make spreadsheets appear more favorable during the procurement process. A common tactic involves the reclassification of medications. For instance, a PBM might move a drug such as Dupixent® from the specialty category to the brand category. This maneuver impacts the rebate guarantees in both buckets, misleading consultants and plan sponsors about the actual financial value of the contract.

To combat this, finance professionals must look beyond the “guaranteed” rebate and demand transparency regarding how drugs are categorized and how those categories affect the bottom line.

Drug Mix Matters

The two cost drivers that matter most in calculating total drug costs are:



Drug mix – The highest predictor of total plan drug spending and represents the types of drugs dispensed based on the formulary, clinical program approvals, and the number of pills shipped or refilled per person.

Unit cost – Represents how to classify a drug (e.g., brand, generic, or specialty) and how much each drug costs, inclusive of discounts, rebates, and administrative and dispensing fees.

Decoding Pricing Indices and Clinical Levers

Achieving predictability requires a transition to more stable and transparent pricing benchmarks. Most PBMs rely on (AWP), a metric experts often criticize due to its lack of correlation with actual market acquisition costs.

AWP is prone to arbitrage, where the starting price of a drug remains high, even as its market value drops. In contrast, the NADAC is a deflationary index based on a survey of what retail pharmacies actually pay wholesalers. Used by 40+ states for Medicaid reimbursement, NADAC provides a “cost-plus” transparency that reflects the real-time downward trend of generic prices.¹

¹NADAC data is used by 40 states for Medicaid to ensure pricing aligns with actual retail acquisition costs.

NADAC Avoids Egregious Price Gouging

DRUG NAME, mn	AWP DOLLARS	NADAC DOLLARS	OTHER PBM COST BEFORE COPAY	JUDI RX COST BEFORE COPAY
Imatinib Mesylat 100mg	\$9,720	\$160.18	\$972.75	\$170.18
Abiraterone Acetate 250mg	\$2,912	\$30.29	\$291.97	\$40.29
Teriflunomide 14mg	\$29,252	\$62.40	\$5,850.75	\$72.40



Josh Golden

Senior Vice
President, Strategy

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Want to learn more about drug pricing indices?
[Listen to our podcast episode with Josh Golden.](#)

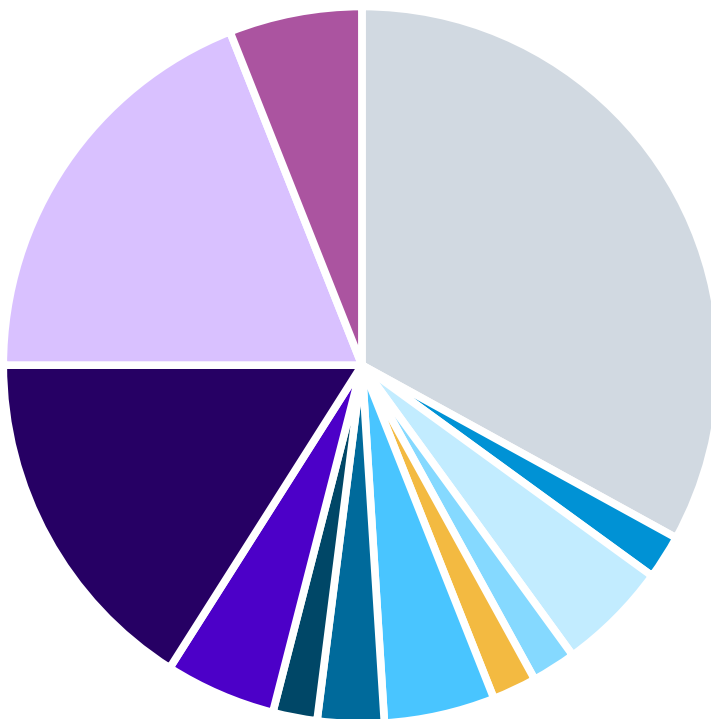


Putting the 'M' Back in PBM

Beyond pricing indices, the most powerful tools for cost containment are clinical levers. These include prior authorization (PA) protocols and refill logic. A common source of waste is auto-refill programs that allow members to accumulate excess medication. In one case study involving the drug Otezla®, a lack of oversight allowed a member to accumulate 82 extra days of therapy over a year, costing the plan an additional \$13,000 for just one member. By implementing smart technology that limits refills until a member has only 14 days of supply remaining, plan pay would be reduced to \$1,500 or less for that same member, and plan sponsors can drastically reduce waste overall (without impacting member health).

Clinical rigor is also needed. While some PBMs approve 90% of prior authorization requests, a clinically appropriate model can operate between 60% - 70% without negatively impacting plan members. This ensures that highcost brand or specialty drugs are used when medically necessary if lower-cost alternative options have been explored. With modern technology and an attentive clinical care team working collaboratively with providers, members have access to the safest clinically appropriate medication, and this approach saves the plan and often the member money.

The Full Picture of What Drives Total Costs for Payers



Spend may be higher or lower based on legacy contract and existing drug mix.

- Unit Cost Values
- White Label/Repackaging/Wholesaler
- Baseline Trend (AWP vs NADAC)
- AWP vs NADAC vs Actual Costs
- High WAC vs Low WAC
- Pass Through Full Rebate Value
- Coupon Program Fees
- Ancillary Program Fees
- Refill Logic
- Formulary
- Prior Authorization (PA)
- Clinical Programs Outside of PA

Navigating New Guarantee Models and Risk Transfer

As the industry moves beyond simple discount guarantees, several new models have emerged to provide employers with greater budgetary certainty. These range from utilization guarantees or all-in Per Member Per Month (PMPM) targets to clinical savings guarantees and truly insured benefits. Understanding the nuances of these structures is essential for finance leaders who are ultimately responsible for the plans' fiduciary health.

Model	What it Does
Utilization Guarantee	PBM commits to a specific dollar amount of savings generated through clinical programs (e.g., PAs, appropriate refills, formulary management), shifting members to biosimilars, or reducing specialty drug use. Generally easier for consultants to track and measure because it holds PBMs accountable for clinical oversight.
PMPM Arrangement	Should be considered a “good-faith estimate,” rather than a true risk transfer – PMPM arrangements are not insurance contracts, nor are they paid to take on risk transfer. If claims exceed the target, the PBM should only be risking their administration fees or will be violating insurance laws. Ultimately, this will come with caveats such as RFP data being an accurate representation of current spend for the PBM to underwrite, and the plan sponsor could still be responsible for the excess claim costs should there be material breach of those caveats.”
Level Funded	Offers a true risk transfer for organizations seeking maximum protection. In these models, the PBM or a reinsurer absorbs the cost of claims above a certain threshold. While these programs will carry higher administrative or “risk” charges that PMPM or Utilization Guarantee offers do not include, they provide a hard ceiling on liability, which is valuable for smaller groups or public entities with fixed tax revenue budgets.

Conclusion

Evaluating PBMs solely on the basis of rebates and discounts is a fool's errand. As pharmacy costs continue to consume a larger share of corporate budgets, business and finance leaders must adopt a more sophisticated approach to procurement.

The evidence makes things clear: Managing drug mix through clinical rigor and leveraging transparent pricing indices like NADAC offers a far more effective path to sustainability than chasing rebate checks.

Want To Learn More?

Contact the Judi Health team today to learn about our transparent, financially aligned approach to pharmacy benefit management.

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