

WHITE PAPER



Top Seven Provisions in a PBM Contract That Will Reduce Your Drug Spend

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Introduction

The contract between a plan sponsor of a prescription drug benefit program and a pharmacy benefit manager (“PBM”) is the most important component for determining the cost and drug spend in the program. The four most dangerous words in the PBM lexicon are “It’s standard industry practice.” This is the answer that is given too frequently by many PBMs when challenged regarding the wording in their contracts.

The standard PBM version is always full of imprecise language and opportunity for the PBM to interpret its adherence to contract provisions in the broadest way possible. The standard contract typically allows discretionary authority by the PBM to choose and change pricing references, change the formulary and alter final cost as they see fit.

It is one of the rare contractual arrangements where the buyer doesn’t know the cost of what they are purchasing and relies on the “seller” to let them know how they are performing! There’s no question that if the plan sponsor accepts the PBM “standard” contract language, the plan and their members will pay significantly more for prescription drugs than is necessary.

Most plan sponsors (and some consultants) are only familiar with a handful of PBMs. There are actually over 60 PBMs in operation today. This competition has enabled an expansion of more “client-centric” pricing and terms. Full-service PBMs offer comprehensive prescription drug management services to plan sponsors. These services generally include the following:

- Claims processing and adjudication
- Retail pharmacy network contracting and management
- Mail service pharmacy
- Specialty pharmacy management
- Contracts with manufacturers for incentives and rebates
- Utilization review
- Clinical programs
- Communication services to plan members and physicians
- Formulary creation and management
- Medicare Part D services
- Management reports

In exchange for these services, PBMs charge fees that can take shape in many forms. Various types of financial incentives from manufacturers, rebate sharing, pricing spread differentials, and administrative fees per scrip or on a per member per month basis, are some of the variations in business practices that PBMs may utilize to generate revenue. These variations make a fair comparison difficult. Unfortunately, many plan sponsors depend on consultants who try and compare financial offers from competing PBMs by providing a superficial analysis. They simply spreadsheet the submitted proposals and compare brand and generic drug discounts off of average wholesale price (“AWP”), administrative fees, dispensing fees and guaranteed rebates. This methodology may tell little as to which offer is actually lowest cost.

Re-pricing a claims file using the formulary, drug mix, generic substitution and therapeutic interchange, driven by the key contract definitions to establish an accurate cost basis for each competing PBM is the more effective process for providing a comparison. It is these key contract provisions that are the focus of this paper.

The Seven Key Provisions

#1 - Business Model

There are three basic business models (Traditional; Transparent; and Full Pass-Through) currently deployed in the PBM industry. Each one can have a dramatic difference in the financial impact on the plan sponsor.

Traditional is the most common and has been the model that started the industry. It is the one that operates in complex secrecy and provides a minimum of disclosure. It's only been relatively recently that PBMs have felt compelled (through litigation settlements) to provide more insight into their financial operation and how they may enhance their client value through better discounts and sharing of cash flows.

Transparent is the second model, and as mentioned above, is the attempt by the industry to be more forthcoming with their financial contracting on behalf of their clients. Unfortunately, transparent for most PBMs actually means translucent, since they really don't fully share all of the cash flows that are generated. The PBM may disclose to the client that they exist, or that they are willing to share some percentage of a specific category of cash flows, but they do not provide complete, unfettered access to the dollars that many plan sponsors feel, are rightfully theirs.

Full Pass-Through is the third model. As the name implies, this one provides total disclosure and payment to the plan sponsor. The PBM charges an administration fee, which is typically either a flat dollar charge per claim, or quoted on a per member per month ("PMPM") basis. All cash flows pass-through to the client, so pricing spreads are eliminated and improvements in acquisition costs or reductions in pharmacy transaction costs are credited to the client. Also, all rebates and manufacturers incentives are passed through to the client.

Note that not all PBMs that advertise that they operate as "full pass-through" are in fact, offering true acquisition cost pricing. Most will reserve some form of an AWP discount that is more than the acquisition cost that they receive for mail service generics.

Some PBMs will also offer both traditional and transparent pricing proposals. They claim that it doesn't matter to them which option the client chooses, since they will adjust their administrative fees and rebates to reflect the same net profit margin per script under either option. We believe this "dualism" is incompatible with the premise of transparency. In our opinion, a PBM should either follow the traditional pathway, or commit to a service model that clearly identifies their fees, and where subsequent cost savings accrues to the benefit of their client.

#2 – Spread Pricing

The selection of the type of business model proposal generally dictates whether spread pricing is created. In traditional offers, the PBM contracts with a pharmacy to pay them a price for a prescription as determined by a contract discount. The PBM then charges the plan sponsor a higher amount as reimbursement. For example, The PBM pays the pharmacy \$80 for a particular prescription and they charge the plan \$95. The \$15 “spread” is kept by the PBM and is not disclosed to the client. Some transparent offers disclose that spreads may occur, but typically do not allow the client to review the details of the contractual arrangements between the PBM and pharmacies. Full Pass-Through offers disclose the arrangements and will generally let the client see the retail contracts.

#3 – MAC Manipulation

Maximum Allowable Cost (“MAC”) is a pricing benchmark applied to generic drugs that is used as the maximum cost reimbursement that a PBM will pay a pharmacy for each generic drug that appears on the PBM’s MAC list. MAC prices were created because the cost of identical generic drugs may differ between distributors. It is typically set at the lower end of a pricing scale of available generic alternatives in a therapeutic category. Many PBMs claim that their MAC lists are proprietary and will not share the list or pricing with clients. Others have an “open book” and will readily present their MAC.

The MAC list can change regularly and usually at the discretion of the PBM, with no prior authorization or disclosure to the client. Many PBMs maintain multiple MAC lists, each with a different number of drugs and different pricing. One list may extend MAC pricing to 300 drugs while a second list from the same PBM may cover 1,500 drugs. A pharmacy may be presented the broad list where the deeper discounts apply while the client receives an abbreviated list, thereby being invoiced a higher charge, due to the particular drug not appearing on the abridged list.

Comparison of AWP with Deep Discount vs. MAC

Drug	Quantity	AWP-60%	MAC Pricing	Savings with MAC
Atenolol 50 mg.	100	\$ 33.33	\$ 10.50	\$ 22.83
Alprazolam .5 mg.	100	\$ 36.28	\$ 11.95	\$ 24.33
Captopril 25 mg.	100	\$ 29.33	\$ 19.00	\$ 10.33
Cephalexin 500 mg.	28	\$ 17.04	\$ 11.50	\$ 5.54
Fluoxetine 20 mg.	100	\$106.40	\$ 25.00	\$ 81.40
Glyburide 5 mg.	60	\$ 17.44	\$ 16.95	\$ 0.49
Lorazepam 2 mg.	100	\$ 50.28	\$ 25.50	\$ 24.78
Ranitidine 150 mg.	100	\$ 61.78	\$ 49.89	\$ 11.89

Some PBMs will use MAC pricing at retail pharmacies, but not use it at mail, thus creating a bigger pricing spread on mail order generics. This channel is generally the most lucrative for the PBM and is one of the main reasons they encourage plan sponsors to promote it to their employees or members. This is usually accomplished by creating a plan design that reduces the number of co-pays in the mail channel that a member must pay. They can receive a 90 day supply for two co-pays instead of the three co-pays that would be required when filling three 30-day prescriptions at retail. The pricing differential can be significant. We recently saw an example where a plan member using retail would pay \$30 (three co-pays of \$10 each) and the plan would be charged a total of \$28 for the three Rx's that had MAC pricing; vs. a \$20 charge (two co-payments of \$10 each) by the member and a total non-MAC charge to the plan of \$188 for the 90-day supply at mail. This represented \$160 greater cost to the plan by having the member use mail!

#4 – Package Quantity / Repackaging

To fully decipher drug utilization and cost, a plan sponsor must be able to see a claim file or utilization report with prescribed drugs identified using an 11-digit National Drug Code (“NDC”). Each set of numbers in the code represents a different identifier, such as the labeler (manufacturer or re-packer), the product (name of the drug and dosage strength) and the last two digits are saved for the packaging/quantity. Some PBMs exclude the last two numbers from the report, because they are paying the wholesaler a greatly reduced per pill quantity price (maybe based on 5,000 units for example), repackaging the pills into smaller quantities, creating a new NDC number, and are billing the plan sponsor at a higher per pill price, based on a 50 or 100 pill count. This practice is known as a 9-Digit NDC Switch.

Many PBM contracts will define the quantity pricing as based on the 50 or 100 pill count and defer questions that this “is standard industry practice.” The plan sponsor should require that the actual pill count purchase size is used if receiving a transparent or pass-through proposal. If traditional, the sponsor should recognize that pricing spreads are being created for the PBM and consider other pricing concessions that they can negotiate.

Example – Retail Pharmacy vs. Mail-Order with Repackaging
“How better discounts and lower dispensing fees sometimes cost more.”

Retail Pharmacy	Mail Oder with Repackaging
Plan’s prescription terms for an Rx at Network Retail Pharmacy (AWP -13%) plus Dispensing Fee of \$2.50	Plan’s prescription terms for an Rx at the PBM’s Mail-Order (AWP minus 20%) plus Dispensing Fee of \$1.00
AWP = \$85/100 tablets	AWP = \$125/100 tablets
(\$85 minus 13%) plus \$2.50 = \$76.45 Total Price of Rx	(\$125 minus 20%) plus \$1.00 = \$101 Total Price of Rx
<p>Mail-Order with Repackaging is \$24.55 higher (\$101 - \$76.45 = \$24.55)</p> <p>Mail-Order buys in larger quantities but repackages into dispensing amount And prices per pill at the 100 count rate. Retail Pharmacy passed along a lower cost per pill.</p>	

#5 – Defining Generics

Most PBMs use very nebulous terms to identify and define what is included as a generic drug. Multi-source brand drugs can be presented to the pharmacy as a generic, thus receiving the highest discounts, particularly if subject to MAC. Many PBMs try to take advantage of any ambiguity by treating an eligible drug as a multi-source brand for billing purposes, but will treat it as a generic when applying the generic fill rate (“GFR”) calculation in order to meet the GFR guarantee (many contracts quote a minimum guarantee for generic substitutions). For example, the contract may state that the PBM guarantees that at least 45% of all prescriptions will be filled as generics.

#6 – Rebate Language / Rebate Guarantees

A rebate is a payment made from a manufacturer to the PBM as an incentive to help “move” a particular drug. Approximately 25-33% of branded drugs dispensed are eligible for a rebate. The manufacturer typically divides rebates into three components:

- **Utilization rebates** for increased market share and actual prescriptions filled
- **Access fees** for placement on a PBM’s formulary as a preferred drug
- **Incentive fees** for clinical programs, switching programs and data administration

Many PBMs will only count utilization rebates as the basis of their calculation for sharing this revenue with a plan sponsor. It has been disclosed by one major PBM that historically, they had retained 45% of the rebates they had received from manufacturers. If a plan sponsor’s contract

says that they are to receive 80% of the rebates, they may actually only be receiving 80% of 55% of the total rebates available.

Careful language needs to be included in your contract to make sure the plan sponsor is receiving ALL manufacturer incentives. Many times payments from manufacturers are not identified as “rebates” but are referred to as incentives, prompt pay discounts, data fees and grants. All of these payments are technically rebates and should be incorporated into the definition so that plan sponsors can receive their fair share.

#7- Audit Rights

The best contract in the world is of little value if adherence to the negotiated terms is not required. Auditing performance is the necessary follow-up to a well-thought and effective procurement process.

The audit process validates the contract pricing, guarantees and performance of the plan, and holds the PBM accountable for their results. There are several types of PBM audits including contract terms (discounts, fees, guarantees);, plan design (deductibles, co-payments are being applied correctly); rebates (guarantees, timing, total amount); operations (procedures, fraud, waste & abuse); Quality (member services, errors); eligibility (who is receiving benefits?).

PBMs are usually reluctant to support auditing. They will include restrictive language regarding who can perform an audit (usually a Big-4 CPA firm). They will typically require that the auditor must be someone that the PBM approves. Many times, the boutique auditing firms that have demonstrated success in recovery or litigation, will not be acceptable to the PBM. The PBM will also usually create stringent confidentiality requirements (sometimes, the auditor can't share the actual results with the client).

A Big-4 CPA firm may not be as familiar with PBM operations as a specialized boutique auditor. They may also represent the PBM as a tax and accounting client, which presents a very real potential for conflict if hired by the plan sponsor to audit the PBM's performance. The accounting firm may be reluctant to be as critical of their client's performance as would an independent auditor..

We believe that an experienced and qualified auditor, who is willing to sign reasonable confidentiality agreements and who is not in competition with the PBM, should be available to the plan sponsor without PBM approval. These rights all are points that need to be negotiated.

Conclusion

The PBM contract has been carefully crafted and refined over the years. It was designed to provide the PBM with maximum flexibility in order to create the pricing adjustments necessary to meet the PBM's financial objectives and performance guarantees. The business practices and market conduct exhibited by many PBMs has demonstrated that the PBM industry has been able to operate in an environment that did not require much disclosure. Plan sponsors have had little recourse until recent years, when litigation has brought to light many of these practices.

Today, a new climate exists for those plan sponsors who know where to look and what to ask. Many PBMs still do not volunteer contract concessions that would otherwise, be deemed fair and appropriate when viewed through the plan sponsor's prism. Market competition has created a number of qualified PBMs jockeying for market share, thereby supplying plan sponsors with alternatives for receiving more favorable terms and pricing options.

Be cautious however, if you select a consultant to help you through this process. Many of the consulting "specialists" who concentrate on PBM reviews, have entered arrangements to receive commissions in the form of a per script fee from the PBMs they are reviewing. Many times it is without disclosure to the plan sponsor. They will be paid by a fee from the plan sponsor and receive a commission from the PBM selected. We believe that this type of arrangement creates terrible conflict of interest issues. Additionally, it may limit the number of viable options made available to the plan sponsor. We have seen examples where other PBMs who do not agree to these payments, will not be invited to bid by the consultant. A plan sponsor can mitigate this risk by requiring the consultant to disclose all compensation arrangements received from the PBMs being reviewed.

A plan sponsor may be well-served to engage a consultant who understands the nuances of PBM contracting and can represent the best interest of the plan by providing in-depth analysis of competing PBM offers and without compromising the objectivity of their analysis.