Negotiating Pharmacy Benefit Contracts: Strategies for Health Plans and Employers

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Moderator: Lauren Flynn Kelly, editor of AIS's Drug Benefit News.

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WEBINAR PROGRAM
• Introductions/Administrative Reminders
• 60-Minute Panel Discussion
• 30-Minute Q&A Session

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WEBINAR OUTLINE
Part 1: Topics for Discussion
• Exploring the different types of PBM contracts available to health plans and employers
• Defining “transparency”
• Demystifying PBM fees and services
• Contracting strategies to reduce costs and improve transparency
• Drug pricing methodologies
• Ensuring that plan sponsors are getting 100% of rebate revenue
• PBM auditing
• Making sure the contract reflects what the PBM proposed

Part 2: Questions and Answers
Negotiating Pharmacy Benefit Contracts:
Strategies for Health Plans and Employers
Negotiating Pharmacy Benefit Contracts: Topics for discussion

Topic #1

What are the different types of PBM contracts available to health plans and employers (e.g., traditional, pass-through)? Which are most appropriate under what circumstances?
Negotiating Pharmacy Benefit Contracts:  
Topics for discussion

**Topic #2**

How do you define the term “transparency”?  
How can plan sponsors and PBMs reach an agreement that reflects both parties’ interpretations?
Topic #3

What fees do PBMs typically charge, and what is included in those payments?
What additional fees may be charged and for what kinds of enhanced services?
Negotiating Pharmacy Benefit Contracts: Topics for discussion

Topic #4

What contracting strategies can be used to reduce costs and improve transparency?
Negotiating Pharmacy Benefit Contracts: Topics for discussion

Topic #5

What are the commonly used pricing methodologies to determine ingredient costs, and how are they evolving?

What pricing schemes or changes in the market could prompt payers to update their contracts?
Negotiating Pharmacy Benefit Contracts: Topics for discussion

Topic #6

How do plan sponsors know they’re getting 100% of rebate revenue resulting from their groups’ drug utilization?
Negotiating Pharmacy Benefit Contracts: Topics for discussion

Topic #7

How can plan sponsors negotiate the right to audit in their contracts?

What can the PBM provide to the plan sponsor on an ongoing basis to avoid a full audit?
Negotiating Pharmacy Benefit Contracts: Topics for discussion

Topic #8

How can plan sponsors ensure that the contract reflects what the PBM proposed?
Questions?

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Payers See Acquisition Cost Data as Next Step Toward New Drug Pricing Benchmark


Now that CMS has finally released its first round of retail pharmacy survey results — intended to provide state Medicaid agencies with a pricing benchmark that reflects actual market prices — payers have an unmatched set of data at their disposal as they consider average acquisition cost (AAC) as a basis for pharmacy reimbursement. The files also allow health plans and employers to gain new insight into pharmacy spread, or the difference between what they’re paying PBMs and what the pharmacies are getting paid. But the data are very green at this point, and are marked by certain limitations, industry insiders warn.

“These data series will be game changers,” declares Adam Fein, Ph.D., president of Pembroke Consulting, Inc. “Payers have great interest in these data because they have limited transparency into the pharmacy channel. It’s almost unprecedented that the government would provide this level of detail on information about a particular part of our health care system.”

CMS on Oct. 5 posted the first set of data based on its Survey of Retail Prices, which is divided into two parts:

(1) The collection of National Average Retail Price (NARP) data — which contains the combined prices paid for drug ingredient costs; payments made by cash-carrying consumers, Medicaid or third-party insurance; and dispensing fees — as authorized in the Affordable Care Act; and

(2) The collection of purchase prices of all covered outpatient drugs from retail community pharmacies, also referred to as the National Average Drug Acquisition Cost (NADAC) survey. Specialty pharmacies are not included in the survey.

Both efforts are intended to create publicly available pricing files that state Medicaid agencies can use to compare their own pricing methodologies and payments as they move away from average wholesale price (AWP), which is based on manufacturer-reported data and does not necessarily reflect actual market prices for drugs, especially generics. AAC, which is already used by several state Medicaid agencies, can serve as the basis for both generic and brand pricing, and is believed to be a closer approximation to market prices.

Whereas plans usually pay AWP minus a discount percentage, under an AAC or “cost-plus” model, the pharmacy is reimbursed based on a computed measure of its acquisition cost for a drug plus an additional amount to cover the pharmacy’s overhead and profit margin, according to Fein’s 2011-12 Economic Report on Retail and Specialty Pharmacies.

“The AAC model is saying, ’We’re going to go to the pharmacies and find out what they’re really paying’” for drugs purchased from wholesalers, explains Patrick Lupinetti, senior vice president at First Databank, Inc., which stopped publishing AWP data in 2011 after several lawsuits alleged that drugmakers inflated and/or produced misleading data. “And instead of paying a minimal dispensing fee of $2 or $3, [plans] would pay a reasonable dispensing fee on top of the actual cost of the drug to the pharmacy. In theory, it sounds good and it is less susceptible to gaming the system, but you have to get people to cooperate with the survey and respond truthfully.”
The new data provided by CMS allow anyone to compute average per-prescription pharmacy profit margins for more than 3,000 generic and single-source brand drugs at the National Drug Code (NDC) level by combining the pharmacy reimbursement with the acquisition cost data, explains Fein. On his Drug Channels blog, Fein calculated the per-prescription gross profits and per-prescription gross margins by payer type for the common dosages of popular brands Abilify (aripiprazole), Nexium (esomeprazole) and Singulair (montelukast), which all face generic competition in the coming years, using NARP and NADAC figures. At a NARP of $593.31, for example, pharmacies dispensing 15 mg tablets of Abilify to Medicaid patients made $32.24 per prescription, or a gross margin of 5.4%.

“It’s a measure of the spread, including the dispensing fee,” he tells DBN. “In theory, a health plan or an employer that hires a PBM to manage their pharmacy benefit could use these data to start estimating whether they are overpaying or underpaying a pharmacy. A health plan could also start using these data to evaluate the spreads that a PBM could be earning for operating a retail pharmacy network, to see if they’re getting an appropriate deal.”

Uncertainties Surround AAC Data, Too

Nevertheless, the data have certain limitations. For one, the NADAC survey is voluntary. CMS polled about 2,500 pharmacies and received roughly 850 responses. “I’m not a statistician but whether that’s a statistically valid sample is a good question,” says Lupinetti. Adds Jenna Stento, a manager in the health reform practice at Washington, D.C., consulting group Avalere Health LLC, “I think CMS felt like they had a sufficient sample, but we don’t know anything about that sample in terms of geographic distribution, chain versus independent, etc.”

Moreover, the data series only includes what’s on the invoice, not taking into account rebates and other discounts that a pharmacy receives. “Those off-invoice discounts and rebates can be very large, especially for multisource or generic drugs,” explains Fein. “So acquisition cost is probably inflated in the data the government is reporting, but it does give the payer a sense of what the pharmacy actually purchased the drug for. In other words, it’s another tool that a payer could use to compute an estimated acquisition cost.”

“It is out for public consumption as an additional data point for drug prices,” concurs Stento. “But the NADAC data is really new and there’s still a healthy skepticism around how accurate it is, how sound the data collection methods are. So I think in terms of the broader payer perspective, before anybody really jumps on this and starts to use NADAC and other AAC-based methodologies, they’re going to want to look at the data and analyze it, become comfortable with it and watch it over time to see how much it fluctuates to see what sort of abnormalities are in the data.”

States Were Early AAC Adopters

Several states already are using AAC for reimbursement, including Alabama, Idaho and Oregon. “I do think that the states are going to look very carefully at the NADAC and that this may accelerate some of the transition away from AWP towards AAC [for Medicaid reimbursement] because it alleviates the individual states having to do their own data collections process,” predicts Stento. “I think in theory they could adopt NADAC-based reimbursement and use it.”
But Lupinetti suggests that the state-derived data may be more reliable, as states like New York and California — which have passed legislation to move to AAC-based Medicaid reimbursement and are in the implementation stages — mandate the participation of pharmacies in the state surveys and intend to include all off-invoice rebates or discounts in their data collection.

First Databank will eventually publish AAC data gathered from a variety of sources in addition to the clinical information it already shares with health care professionals. For now, non-Medicaid payers may want to use the available data simply for comparison purposes. “This information is still in its infancy and it’s a little bit ragged, but it will get better and you will have a new standard,” advises Lupinetti, who expressed that point to attendees at AMCP’s 2012 Educational Conference in Cincinnati on Oct. 4. “I think it behooves everyone to look at them. You could compare the reported AACs to what you’re using and try to figure out how you could negotiate fees with pharmacists or PBMs could negotiate terms with their customers, based on a standard that doesn’t have that built-in fluff. Everybody has to still make a business transaction that provides them an incentive to be there, but the incentives are going to come through in a different way.”

Download the files at http://tinyurl.com/9c8rrhy. Once CMS considers comments on the NARP and NADAC files, the data will be released in final form, with updates posted on at least a monthly basis. Comments should be submitted to RPS@cms.hhs.gov.

Contact Fein at (215) 523-5700, ext. 15, Lupinetti via Denise Apcar at dapcar@fdbhealth.com and Stento at JStento@avalerehealth.net.

Payers May Review AMP Data for Benchmarking Purposes


In addition to results from its Survey of Retail Prices, CMS on Oct. 5 posted new data pertaining to the calculation of federal upper limits (FULs) — or the maximum amount Medicaid will pay for generic drugs. As mandated by the health reform law, average manufacturer price (AMP) soon will be used to set the FUL, which will be no less than 175% of the weighted average of the most recently reported monthly AMP.

Originally defined as the average price paid to manufacturers by wholesalers for drugs distributed to the retail pharmacy class of trade, the Affordable Care Act expanded the definition of AMP to include direct sales by manufacturers to retail pharmacies. “Basically, it’s designed to get the wholesale price, manufacturer to wholesaler, so AMP should be in some relation to AAC [average acquisition cost],” explains Patrick Lupinetti, senior vice president at First Databank, Inc. “Manufacturers have no incentive to inflate the AMPs because the higher your AMP, the bigger your Medicaid rebate.”

In response to pharmacies’ concerns that the draft AMP-based FULs fluctuate on a month-to-month basis, which potentially creates problems when it comes to predicting state reimbursement rates, CMS published a draft file containing three-month rolling average FULs in addition to new draft FULs for June and July 2012.
“CMS has authority to implement [FULs] once they promulgate final regulations and get comfortable with the data, whereas the NADAC [National Average Drug Acquisition Cost] is really going to be a state-driven action where the state makes a decision to move away from compendia-based pricing, or average wholesale price, to a cost-plus reimbursement method,” explains Jenna Stento, a manager in the health reform practice at Washington, D.C., consulting group Avalere Health LLC. And unlike AAC, AMP only applies to generic pricing, so states may end up comparing both sets of data to determine the “lower of” the two for generic drug reimbursement, Stento predicts.

“The reimbursement piece on the FUL side is important, but I think what’s really interesting is we’re entering this era of transparency, where if you cross walk some of these files, you can take a closer look at margins across the supply chain,” she adds.

Comments on the AMP data can be submitted to FUL@cms.hhs.gov.
Contact Lupinetti via Denise Apcar at (650) 872-4514 and Stento at JStento@avalere-health.net.

NW Prescription Drug Consortium Sought Clarity When Pooling States’ Rx Purchases


Employers who don’t fully understand what they’re signing up for when they contract with a PBM may end up spending thousands and thousands of dollars more than they need due to a lack of pass-through pricing and aggressive financial terms. And that’s in addition to the money they’d need to spend down the road to audit pharmacy claims data — money that’s just not in the budget for many plan sponsors, warns Missy Dolan, administrator of the Oregon Prescription Drug Program.

Her advice? “Build a contract that’s so good and everything is defined and both sides agree to, and you don’t have to spend a lot of money on audits,” declares Dolan, who helped orchestrate a clearly defined, “customer-focused” contract for the Northwest Prescription Drug Consortium.

The consortium was established in 2006 by the Oregon Prescription Drug Program and the Washington Prescription Drug Program, both state purchasing programs that were created in 2005. “The point of the interstate consortium is to not only pool all of one state’s drug purchasing but two states’ drug purchasing in order that we can leverage the negotiating abilities through fewer and fewer contracts while providing exemplary service and, of course, the most transparency we can,” Dolan tells DBN.

The current contractor for the consortium is The ODS Companies, Inc., an Oregon-based insurance company that provides group and individual medical products, individual Medicare Advantage plans and stand-alone pharmacy plans. Since early 2007, ODS has handled all services for the consortium, including network development, claims processing, benefit administration, all drug management programs, mail order, and, more recently, group purchasing organization programs for facilities and eligible employer groups.

ODS subcontracts with vendors as needed (e.g., they use PBM partner MedImpact Healthcare Systems, Inc. for claims processing and pharmacy payment), but all
subcontractors must comply with the master consortium contract, which defines the terms, performance expectations and guarantees, explains Dolan.

As a result of that contract, individuals with inadequate prescription drug coverage or no coverage at all can join a discount program that offers savings averaging 55% on prescription drugs. This population has a generic utilization rate that exceeds 90%, but individuals also may obtain brand-name drugs at an average discount of 17.5% off the average wholesale price. The program is offered with no access fee and members enjoy the same discounts that the consortium’s employer groups are able to access. Mail order and specialty pharmacy services are available through the program.

Both public and private employer groups may also join the consortium and access the negotiating privileges of a larger pool and a transparent, customer-focused contract. As of Aug. 31, 2012, the consortium had 839,593 members in the pool.

Having learned from her own experience as a health insurance executive at PACC Health Plan, Inc. (which was later acquired by Health Net, Inc.) how daunting the request for proposals (RFP) process is, Dolan helped assemble a team of area experts with different backgrounds in health care, pharmacy purchasing and economics and developed a thorough list of requests when it came to transparency and pricing.

“Few people understand, as far as I’m concerned, the complexity of the whole pharmaceutical purchasing conundrum, and that’s what it is. That’s why group purchasers really need as much as help as they can get,” contends Dolan. “They didn’t get a degree in pharmacy purchasing and they’re up against pharmaceutical professionals.”

**Consortium Sought a Flexible Partner**

While several PBMs came to the table and asked a lot of questions, none of them ponied up an official bid during the most recent solicitation in 2010, says Dolan. After an initial four-year contract, ODS won a second solicitation for the consortium business through 2017.

“I think that the scope of what we’re doing is so much broader than what PBMs want to do at this point,” explains Dolan of why PBMs were hesitant to respond to the RFP. “They would rather stick to the employer groups, and we have a lot more than that. And the PBMs have said to us, ‘Well, we have a discount card and this is how it works,’ and we said, ‘Well, that’s not how ours works.’ We needed a partner who could really bring flexibility to our groups.”

What Dolan and her team ended up with was a full pass-through arrangement. And the consortium’s member groups consistently outperform market trend, boasts Dolan. Savings vary from group to group, depending on how tightly managed their program had been before joining the consortium, she explains. “However, one of the largest groups in Oregon enjoyed a negative trend at the end of their plan year when the market had risen by four points during the same timeframe.”

While the consortium has the right to audit any aspect of the program, Dolan says it has not requested a formal audit since 2007. “We are constantly looking at the numbers and testing them to make sure that the reimbursement levels are correct. And ODS is constantly checking them, too, because they’ve got some pretty severe penalties if they don’t meet the effective rates that have been guaranteed in the contract. So there’s a fair amount of self-monitoring,” adds Dolan. “They give us the reporting tools that we can actually use to tell that they’re delivering their effective rates and 100% pass-through.”

Contact Dolan at missy.dolan@state.or.us.
An Eight-Point Plan to Transparent Pharmaceutical Contracting


As featured in the Northwest Prescription Drug Consortium’s full pass-through arrangement with The ODS Companies, Inc., Oregon Prescription Drug Program Administrator Missy Dolan recommends that plan sponsors incorporate the following eight transparency “points” into their own PBM contracts:

(1) **Clearly defined services.** “Whether it’s claims adjudication or prior authorization, you should clearly define your expectations — what you want from that service — and include a financial guarantee for anything deliverable within those services,” Dolan tells DBN. For example, if the PBM is offering 10 services for a bundled fee of 49 cents per claim, Dolan recommends that those 10 services be explicitly defined so that one of them is not showing up somewhere else in the contract under a different name and the client is paying another arbitrary cost for what they assumed was covered in the bundled rate.

(2) **Clearly defined fees for any services outside of bundled fees.** In other words, set up the process for a service like custom report building and determine whether that will be charged to the client on an hourly basis or per project, whether an estimate can be given in response to a work order before the project is completed, etc.

(3) **No pharmacy spread.** Ensure that the group is paying the PBM what the pharmacy is getting paid rather than allowing the PBM to retain a portion of the pharmacy payment. The pharmacy does pay ODS an agreed-upon “access fee” of a few cents per transaction for system access.

(4) **Rebates and other remuneration are 100% auditable to the NDC level and must be passed through to the plan.** Dolan recommends that plan sponsors determine how the PBM is going to demonstrate in its rebate reporting how it’s delivering the guaranteed rate and 100% pass-through. And once again, “rebates” and “remuneration” must be clearly defined because both parties may have a different idea of what they call rebates, stresses Dolan. For the Consortium, the term “rebates” is all-inclusive; any remuneration coming to the administrator as a result of the groups’ utilization is distributed to the employer group.

(5) **No rebate-driven formulary or preferred drug list (PDL).** “You need to define what you want from a formulary. For example, the consortium’s is based on lowest net cost and, of course, efficacy and evidence-based research, etc. Rebates should not be at the top of the list,” asserts Dolan. “And because we have about 20 groups buried inside the consortium [and a state-mandated PDL in Washington], we want to make sure that that formulary is adaptable to what a specific group needs.”

(6) **Guaranteed effective rates for the term of the contract, for both administrative rates and for rate guarantees on brand, generic and specialty drugs.** This must include exactly how the effective rates will be calculated (e.g., discounted average wholesale price, with or without mail order, blended drug mix, net of dispensing fee, etc.). “Some contracts will offer a rate guarantee, assuming that a certain number of drugs are going generic in three years, while a five-year contract gives [the PBM] a chance to make a ton of money in the final two years because they’re going to pay a whole lot less” based on those predetermined rates,
explains Dolan. “What you have to say is, ‘Here’s the effective rate that we want, but any sav-
ings over that are coming to us, too.’ And that’s something that you can negotiate, because
they might say, ‘Well, we want to share some of the savings when all these brand drugs go to
generic.’ And so you might say, ‘OK, we get 80% of the savings and you get 20%.’ That has to be
clearly articulated or else they’re just going to take the savings.”

(7) Have a very inclusive list of definitions. “As I said before, don’t assume the same
understanding of any term. Even define the word ‘services’ and don’t be embarrassed to de-
fine it. If there is any term that could have two meanings, then define it in the contract be-
cause it may come back to haunt you,” advises Dolan.

(8) The contract should read very customer-focused. “PBM contracts tend to read like,
‘You’re joining our club and this is what you have to do to follow our rules.’ It’s just the op-
posite of how it should be; you’re the customer and it ought to read what that PBM is going
to do for you.” For instance, a PBM-focused contract may dictate that the client must choose
how they’re going to deliver payment (e.g., electronic fund transfer vs. biweekly check) when
it should be up to the client to define how they want to pay, argues Dolan.

Contact Dolan at missy.dolan@state.or.us.

As Pharmacy Networks Slim Down, Payers Have a Lot to Chew On, Suggest Experts


Call (800) 521-4323 for more information.

As the selling season continues to heat up, one of the hottest topics on the table this year
is the limited or narrow pharmacy network. Many drug benefit purchasers are including
narrow network options in their requests for proposals (RFPs), but there are numerous im-
plementation, plan-design and contractual considerations to be weighed before sealing the
deal, advised several industry experts at a recent AIS webinar.

While narrow networks existed prior to the 2011 dispute that resulted in Walgreen Co.
dropping out of the Express Scripts Holding Co. network, that rift has called considerable
attention to the concept and given plan sponsors and PBMs “a signal that it was OK for the
marketplace to take on retailers in a different way,” contended Brian Bullock, R.Ph., founder
and CEO of pharmacy benefit consultancy The Burchfield Group, at AIS’s June 19 webi-
inar, “Narrow Pharmacy Network Design and Implementation: Strategies for Health Plans
and Employers.” Moreover, that story demonstrated that (1) it was easier to move members
from one pharmacy to another than expected, and (2) “it’s likely that a smaller network can
achieve same-level access that a larger network can achieve,” Bullock said.

Historically, these networks have saved payers 50 cents to $1.50 per claim — or 1% to 2%
of drug spend — with some improvements on dispensing and administrative fees, observed
Corey Belken, Pharm.D., Burchfield’s market lead for the direct employer market, who also
spoke at the webinar. And the concept of “narrow” was anywhere below 50,000 contracted
network pharmacies, as opposed to the typical full network of about 61,000 stores. But PBMs
are starting to offer more aggressive approaches that build on the idea of dwindling phar-
macy loyalty, trimming networks down to 20,000 and even 4,400.
Express Scripts now is offering a tiered option it calls Express Advantage Network, a choice-based network that it says could trim drug costs by 5% or more. Tier 1 is the preferred network, consisting of roughly 20,000 pharmacies, and Tier 2 is a wider, nonpreferred network. The number of pharmacies in the latter depends on the client. The PBM is rolling this out to clients for 2013 with a few different approaches:

1. **Mandating that members are only able to fill prescriptions at the Tier 1 pharmacies;**
2. **Incorporating their consumerology and behavioral economics program** by allowing the patient to opt out and obtain their medication at a Tier 2 pharmacy; and
3. **Implementing a standard increase in the copayment to use the nonpreferred network.**

Other examples of narrow network designs highlighted by Belken include:

- **CVS Caremark Corp.‘s Maintenance Choice,** which gives members the option of filling a 90-day supply of a maintenance medication at a CVS store with the same reduced copay that they would have at mail. “From a plan sponsor perspective, obviously there are financial incentives in place as it relates to improved pricing. Typically, we’ll see 10 points of improved discount on the brand side, and a pickup on the generic side that is maybe not quite as significant,” observed Belken. Another benefit is this type of plan may come with fewer beneficiary issues than a plan sponsor might see with mandatory mail, he added. CVS Caremark also is looking at having a “wrap network,” so in certain locations where a member does not have a CVS store nearby, the PBM would offer a limited number of retail pharmacies where they could obtain a 90-day supply for the same preferred pharmacy copay, he said. CVS Caremark could not be reached for comment at press time.

- **The Walmart Rx Network offered by Humana Pharmacy Solutions,** the PBM subsidiary of Humana Inc., which features a highly limited network of 4,400 pharmacies, including Wal-Mart Stores, Inc. subsidiaries Sam’s Club, Walmart Express and Neighborhood Market, as well as Humana’s RightSourceRx mail order and specialty pharmacy operations. By selecting just the limited network, self-funded clients are guaranteed 10% savings off their drug costs, but if they adopt this alongside the new Rx4Value formulary, a limited four-tier option, they’re looking at 20% savings. During the webinar, Humana sales executive Nick Parrino revealed that the in-house PBM soon would roll out an even tighter formulary option called Rx4Skinny that removes multisource brands as well as brand drugs “that really have no clinical value.”

- **A direct-to-pharmacy contracting strategy,** in which the employer or plan sponsor directly contracts with the pharmacy or retail chain. “It essentially disintermediates the PBM to some degree, but the point to note there is you still have a PBM in the background,” said Belken. “I think you gain a higher level of transparency, so that’s definitely a positive. But on the flip side, there is a quite a bit of initial work that goes into that strategy,” such as laying out contracts with the various retail pharmacies and the PBM. Restat’s Align network is an example.

While many PBMs are now offering aggressive network options, some may prefer to keep their networks open and/or include 90-day options at retail, he added, pointing to SXC Health Solutions Corp. as an example.

When considering whether to incorporate a narrow network into your PBM contract, Belken said payers should:
◆ **Compare apples to apples when reviewing bids.** “Make sure that the PBMs are offering similar retail networks and try to level the playing field, if you have one vendor that’s excluding a major chain and one that’s including it.”

◆ **Protect yourself with an out-clause so that you don’t end up with a narrow network without consent.** “I think the language has to be written very clearly to state that for the removal of a major chain, there has to be either some financial repercussions and/or the ability to determine if there’s a major change like that, and it can’t be based just on geographical access.”

### Location Is Another Key Consideration

Having already partnered with Walmart to offer a preferred pharmacy network Prescription Drug Plan in the Medicare Part D program, Humana compared geographic access for its Medicare beneficiaries with its commercial population when considering the new narrow network. “What we found was pretty interesting: 90% of individuals in suburban ZIP codes are within five miles of a Walmart, and 70% of individuals in rural ZIP codes are within 10 miles of a Walmart,” revealed Parrino. Humana will run geographic access tests for each group to look at their membership footprint and determine if it makes sense for them to limit their network. “It’s not going to be for every single employer and every single group, but we’ve certainly had some strong interest in this,” he said of the new offering.

If a client is not ready to go full-throttle with a truly narrow network, Parrino said Humana recommends a dual pharmacy offering, where the employer adopts a limited network in conjunction with a broad one. Judging by how much they save over time by driving members to the Walmart-only pharmacies, they could slowly phase out the broad network, he suggested.

Express Scripts says the most ideal candidates for its new network are the clients who currently have 95% of households that are located within a five-mile drive of a Tier 1 pharmacy, but who still have a large percentage of their prescriptions filled at Tier 2 pharmacies.

Proper lead time is also critical to implementing a narrow network, advised Belken. “Because Express Scripts had six months to prepare for the change to a smaller network, they were actually able to go out and re-contract with some of the independent pharmacies that maybe they had lost over time, and they took this opportunity to remind members who were taking maintenance medications that mail order was an option for them.” Belken recommended at least 60 to 120 days of lead time to effectively roll out the communication strategy prior to implementation.

“It’s important to review all aspects when you’re considering a narrow network to make sure that disruption and access — of course, going hand in hand — are lined up against financial considerations,” concluded Bullock. “If all three are in alignment to your satisfaction as a plan sponsor, then the narrower network may indeed be a valuable opportunity.”

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*For a recording and accompanying materials from the June 19 webinar, visit the MarketPlace at www.AISHealth.com, or call (800) 521-4323.*
PBM Audit Firms Seek to Reverse Errors, Recover Dollars Before They’re Spent


“You wouldn’t pay a huge credit card bill without knowing what’s on it, right? So what the heck is the deal with your prescription benefits manager?” asks a sympathetic-sounding male voice in an animated video sponsored by Truveris, Inc. The ad is for the health information technology (IT) company’s “real-time” invoice review product, which audits 100% of pharmacy benefit claims data to make sure the client’s PBM bill matches up with its actual contract terms.

Many health IT firms are in the business of performing PBM audits. Managed Medicaid and Medicare plans traditionally have been the most common users of these services, since they are on the hook for regular audits of “delegated entities.” But more and more private-sector payers are signing up for them in the hopes of catching costly errors, several industry experts tell DBN.

“When the PBM sends the employer a bill, the employer has a short turnaround time — usually two days — to pay it and many just pay without looking at them. What happens is many of the bills are wrong and could be off by 2%, thanks to systems problems, coding errors, changing price discounts, etc., and that can add up significantly over time,” asserts Michael Jacobs, R.Ph., vice president of national accounts at Truveris, a New York-based firm that serves health insurers, government entities, unions, FORTUNE 500 companies and other self-insured corporations. Jacobs formerly was national pharmacy practice leader at Buck Consultants.

The idea of real-time or concurrent invoice reviews is still relatively new to the pharmacy benefits industry, as technology has evolved to allow auditing firms to review 100% of claims for PBM billing errors and inconsistencies prior to payment — as opposed to the standard retrospective “pay and chase” recovery model, which tends to aggregate claims and/or review samples.

“There’s a higher degree of value in the marketplace for people to look at all transactions, whereas we used to just look at a sample and could say, ‘OK, I’m seeing a $5 copay where this should be a $10 copay,’” says Rob Shelley, president of PSRx Advisors LLC, a Minneapolis-based company that offers PBM pricing, audit and other pharmacy programs to public-sector clients.

“It’s not a surprise that as time goes on, pharmacy claims — like medical claims or hospital claims — would move into an area where people would look at them prepayment to say, ‘Is everything clean? Is it the way it’s supposed to be?’” adds Craig Stern, Pharm.D., president of Northridge, Calif.-based Pro Pharma Pharmaceutical Consultants, Inc., which serves self-insured employers, unions, health plans and other payers with a variety of pharmacy benefit solutions. “Because of the current technology, we have the capability for accounts payable to be able to audit invoices the same as they would a retrospective audit, so that they could in fact deal with all of the issues with benefits compliance, claim validity, pricing, etc.”
However, not every company has the right to conduct concurrent audits, and it depends on the client’s contract terms with the PBM, points out Kristin Begley, Pharm.D., vice president of strategic initiatives at Truveris. As a result, clients are encouraged to include invoice review rights in their requests for proposals. “Most PBMs agree the payer owns its data and has a fiduciary obligation to ensure price validation,” she explains. Whereas audit processes between managed care organizations and network pharmacies tend to be very contentious, Begley says that in her experience, most PBMs are accommodating when it comes to audits.

Prepayment audits, however, may not always be the most welcomed form of review. “We have encountered significant issues with many PBMs with the invoice auditing approach,” Shelley tells DBN. “It does not work universally because it can significantly disrupt the provider reimbursement structure if there is a withhold in claim funding. Many PBMs will either not agree to the auditor, or have other contractual stipulations prohibiting that method.”

**Eligibility, Benefit Design Contribute to Error**

Whether they’re conducting audits on a retrospective or concurrent basis, here are some of the pharmacy-benefit areas where firms identify problems:

◆ **Eligibility issues.** Is a plan paying out benefits to people who are no longer eligible? These errors usually occur within the enrollment file itself and are the result of the health plan inputting the wrong data such as an incorrect birth date or misspelled name, explains Stern. As a result, they fall on the health plan to fix, and can result in anywhere from 2% to 4% savings on an invoice. “Rarely are there eligibility problems found that are the result of the PBM or TPA or PBA [pharmacy benefits administrator]. They usually take the file as is and allow or don’t allow, but there’s still leakage there and it’s relatively small,” he adds.

◆ **Benefit compliance.** Are copay designs being followed? Are prior authorizations and step edits being appropriately processed? For example, “If a member moved into a retiree group, they might not have gotten flagged in the system and they are getting approved for higher-tier drugs that they shouldn’t be and cost way more than the generics they’re supposed to have first using the step-therapy model,” explains Shelley. “Or in the case of specialty pharmacy, sometimes people get an override that’s only supposed to last six months or a year, but it continues for some reason, such as an error where prior authorization rules do not expire appropriately and allow for unauthorized refills.”

Another thing that auditors look for is whether deductible accumulators are accurately processed. “If the company just implemented a high-deductible plan, and once people hit their deductible they have some kind of coinsurance, like 25% coinsurance for third-tier drugs while $5 copays are assigned to generics, that is actually difficult for a PBM to manage,” says Shelley. “That is where we’re seeing more attention to audits.”

“The more complex the benefit design, the more problems we see,” observes Stern. “And if benefits are not clearly defined, it’s more problematic and it usually ends up as disagreements between the plan and the PBM about what they wanted versus what was coded. There is usually a PBM worksheet where it’s determined how they’re going to adjudicate claims. Those sheets are not usually very detailed, so there may be a lot of gray area.” Stern says corrected benefit problems can lead to as much as 4% savings.

◆ **Invalid claims.** “These are often thrown out by PBMs and pharmacies as false positives, that they’re not really wrong, and it’s usually a case of getting more information from the pharmacy. In most cases, these are involved with fraud, waste and abuse, which is a
high-value target under Medicare Part D and becoming more high value in Medicaid,” contends Stern, who estimates that 2% to 6% of drug spend is tied up in invalid claims.

◆ Pricing. Is the PBM adjudicating claims at the correct price? Audit firms also look for whether the payer got the “lesser of” the average wholesale price (AWP) discount or the usual and customary price or MAC or other published pricing methodology.

“It’s very common to see where a different number was used than what’s in the reference database. The argument that is usually made is that it’s a timing issue: ‘You’re looking at pricing on a weekly basis but we change pricing daily,’” Stern explains. “But when you look at it, there is a subset of those claims for which timing is not the issue and people have just used the wrong AWP. With regards to pricing, depending on the degree of exactness to which claims are paid, the savings can be anywhere from 1% to 6% of drug spend.”

“With all of these variables, there is a lot of room for unintended error,” adds Begley. “When you have huge amounts of data, it’s just impossible for data to be perfect.”

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States Seek Control of Rebates, Increased PBM Transparency


Lawmakers in several states already are pushing bills aimed at controlling pharmacy spending in advance of 2011 legislative sessions, as pharmacy costs continue to rise and many still face huge budget problems. Hot-button issues in several states include calculating Medicaid pricing and rebates, mandating greater price disclosure from drug makers and implementing tighter restrictions on PBMs.

Getting a handle on Medicaid rebates will be the main focus for states next year, according to Sharon Treat, executive director of the National Legislative Association on Prescription Drug Prices (NLARx), a nonpartisan organization of state legislators. “The calculation for rebates has significantly changed and the federal government is getting a cut that they weren’t getting before,” Treat tells DBN. “And states lack the data to determine whether or not they’re getting appropriate rebates from the drug companies and whether the feds are taking the right amount.”

While the health reform law increases the amount drug companies must give states in rebates for Medicaid enrollees from 15.1% to 23.1% for brand-name drugs and from 11% to 13% for generics, it also mandates that 100% of those higher rebates go to the federal government. As a result, “we’re going to see some legislation that requires drug makers to report directly to the states on what their best price is and what all these other pricing mechanisms are that rebates are based on,” Treat maintains.

Some states are planning to introduce laws that would require drug companies to disclose both wholesale and retail prices, so that they can more accurately negotiate Medicaid federal and supplemental rebates, Treat says. They are also considering taking legal actions
to address the manipulation of average wholesale price information and enforce Medicaid “best price” provisions.

According to Treat, Maine, Vermont and Texas have already passed this type of legislation. With these new laws, “states are in a good position to at least recoup what they’re owed under the new law, she explains. “While it doesn’t address the problem of the federal government taking some of the rebates we already receive, it does, at least, give us additional authority to make sure the federal government and drug companies are complying appropriately with the law and we’re not being gypped.” She adds that other states “would be very wise to get going quickly to pass legislation that gives them direct information from the pharmaceutical industry.”

In Montana, state officials are taking the rebate issue even further by introducing legislation that would allow any state resident to voluntarily sign up for a special Medicaid prescription drug program. According to NLARx, Gov. Brian Schweitzer (D) is drafting a federal request to CMS for an official Medicaid state plan amendment to allow the program. He says it wouldn’t cost the government any additional money, but instead would simply expand the number of people who can receive discounted drugs.

NLARx supports Schweitzer’s efforts. “We’ve seen drug prices to continue to go up — even some generic drugs have jacked up prices,” Treat says. “Anything that states do to go around the monopoly pricing that drug makers have is a good move, and I hope Montana is successful in this.”

Gift Ban Laws Need Restructuring

Another big trend this year that will carry over into 2011 are proposals to limit what some groups consider the drug industry’s “inappropriate marketing practices” to encourage the use of more expensive brand drugs over generics. But instead of introducing new laws, Treat explains, states will have to modify their existing laws to make them consistent with provisions in the health reform law and the Sunshine Act, which require that manufacturers of drugs, devices, biologics or medical supplies report information on their financial relationships with health plans, PBMs and other entities to the HHS Office of Inspector General.

“States that already have laws in place will be modifying them to be consistent and complement the federal law,” Treat explains. “In some cases that means actually beefing up the state laws, most of which do not give the more granular data that the federal government does. So they might be doing some things like linking their websites to the federal data, but they can also provide that for different prescribers that aren’t covered in the federal law.”

Some states have already taken these steps. Earlier this year, for example, state lawmakers in Minnesota began debate on three bills intended to reduce the influence of drug manufacturers on physicians’ prescribing practices. Supported by the Minnesota Prescription Coalition — which includes AARP Minnesota, some state insurers, labor unions and consumer groups — one bill, H.F. 1641, would strengthen a 1993 pharmaceutical gift-ban law by “clarifying the meaning of gifts [and] expanding the definition of prescriber and practitioner,” the group says in a statement. The state Senate passed the bill last March, but it was later tabled because it did not have the votes to be approved by a House committee. Florida and Texas are considering similar laws.

For many PBMs, an increased interest in transparency requirements will continue to be an issue. Despite a recent setback that states seeking more transparency experienced when a federal appeals court struck down provisions of a District of Columbia law that would have
required disclosure of conflicts of interest and pass-through of rebate savings, many states are still preparing to introduce similar legislation, according to Treat.

“There were some pretty good provisions that were put into the health reform law that have kept that issue alive — particularly in regard to states imposing those provisions on their own state purchasing decisions, which they have the full authority to do,” she says. “That kind of legislation would not be affected in any way because of the D.C. decision to perhaps move first in requiring audits and having more regulations around the negotiation of rebates and how all of that is done with respect to any state government program.”

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Alabama Makes Contentious Move to Replace AWP Pricing Benchmark With AAC


As the industry grapples with the question of what should replace the controversial average wholesale price (AWP) benchmark, Alabama’s state Medicaid agency is on schedule to implement a new pharmacy reimbursement system that it says “provides a transparent, timely and accurate pricing method” by paying providers based on the average acquisition cost (AAC) of drugs. While the state’s push for total transparency is causing a stir among all industry stakeholders, some experts say the likelihood that the system will spread to other states is slim since it could damage competition for pharmacies and PBMs.

The Alabama Medicaid agency filed a state plan amendment with CMS last month that would remove AWP from its current reimbursement methodology and add the invoice-based AAC to reimburse for brand and generic drug ingredient costs. The agency also requested approval to increase its dispensing fee from $5.40 per prescription to $10.64, based on a cost-of-dispensing survey it conducted.

To calculate the AAC for each drug, the agency will conduct semi-annual invoice surveys through accounting firm Myers & Stauffer. Each individual pharmacy will be randomly selected once during a two-year period and required to submit one month’s worth of invoices. Drug prices then will be updated on a weekly basis and eventually posted on the Alabama Medicaid agency’s website.

The state argues that these AAC data would be “resistant to individual efforts to manipulate it, since any single price report would have only a minimal effect when included in a large array.” It adds that the use of an average price, rather than actual cost, would encourage providers to seek better prices.

If CMS approves the amendment, Alabama would be the first state to use AAC and mandate that pharmacies disclose all of their actual pharmacy costs.

“As AWP has been found to be inflated in both state and national litigation, our agency must move away from fraudulent AWP pricing and toward reimbursement logic based on true estimated acquisition costs as mandated in federal guidelines,” Alabama Medicaid Commissioner Carol Steckel said in a statement. She was referring to a major settlement that stemmed from allegations that First DataBank, Inc. conspired with drug wholesaler

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McKesson Corp. to fraudulently inflate the widely used AWP benchmark from 2001 to 2005, which caused consumers and third-party payers to overpay for drugs (DBN 3/27/09, p. 1).

While some are calling the new model “progressive,” others are concerned that the state’s commitment to transparency is too ambitious. “This is clearly Alabama’s effort to be transparent,” Mark Singleton, Restat’s vice president of business and process improvement, tells DBN. “But the question is how far do you take that?”

Singleton says that by publishing AAC on a public website, “you are frying free enterprise.” He adds that “pharmacies don’t have a problem sharing what they paid with the state, they have a problem with the state sharing with other people.”

For example, “if you know that a Walgreens store is paying this amount, while the CVS store is paying another price and the independent is paying yet another price...that is too intrusive,” he explains. “You have to have some way to blind all those and mix them together.”

Singleton says some pharmacies are even considering suing the state for publishing the list “because the competition can know what they’re buying at.”

At a recent conference on transparent drug pricing benchmarks, Kelli Littlejohn, Pharm.D., director of pharmacy services for Alabama Medicaid, assured critics that the state’s pharmacy provider associations have been actively involved throughout the entire process of setting up the new system. “We’ve built enough coordination with pharmacy groups that we are confident this system will be successful,” Littlejohn said.

**Could Other States Adopt Ala. Model?**

If Alabama pulls it off, the question on everyone’s mind now is if the system will spread to other states. PBMs are especially concerned because it could expose the markups that some PBMs put on drugs. Because of this, some critics of the system say it can only be effective in Alabama because unlike most other states, most large private managed care companies do not have a big presence in Alabama. Furthermore, the state doesn’t use a PBM to help manage its pharmacy sector.

“I don’t think that what has happened in Alabama is difficult,” Littlejohn said, adding that she’s heard rumblings of other states holding discussions on the topic. “States and pharmacy groups just need to have an open communication about what needs to be done.”

Brian Anderson, a senior health consultant with Milliman Inc., contends that AAC is not viewed as a viable or desirable replacement for AWP by many. “It’s tough because every pharmacy is going to have a different AAC,” he tells DBN. “And getting a pharmacy to disclose their AAC is going to be difficult to pass through, especially for mail order pharmacy.” Moreover, because the pricing is updated less frequently, it may actually lead to higher costs since it does not address acquisition differently between chains and independents.

“There’s a lot of controversy over the whole concept,” Singleton says. “Because somehow these pharmacies have to find a way to make money, and they have to find a way to pay less, get rebates, do something to make a profit.” If states start using AAC pricing, “as an industry we would have to re-evaluate dispensing fees, because we buy down dispensing fees by cost of drug,” he adds.

In addition, “it would be a nightmare for us who adjudicate claims because the price that someone in Chicago and Alaska is paying is obviously a lot different,” Singleton argues. “Also, CVS is paying more than Grandma’s pharmacy down the road.”
Others remain concerned that AAC could be subject to the same potential abuses and issues experienced with AWP.

Speaking at the conference, Steckel said she is aware that people will still try to find ways to manipulate AAC, and “we’ll try to stay ahead of the curve.” However, she adds, “unless you have all the numbers on the table, you can’t talk about a fair reimbursement system.”

Pending state and federal approvals, the agency expects the changes to become effective in August, according to Steckel. Through the new reimbursement system, the state expects to see a $30 million reduction in pharmacy spending.

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**WAC and MAC Are the Favored Benchmarks to Replace AWP**


Average wholesale price (AWP) is viewed by many as unreliable and subject to manipulation, and some industry stakeholders are pushing to establish a new reimbursement benchmark to replace it. But with so many different three-letter acronyms to choose from, coming to a consensus on one might be impossible, given the number of organizations involved.

Most stakeholders agree that the basic requirements for any benchmark should include that it be reliable, transparent, easy to use, frequently updated and recognized by all pharmacy networks, according to Chuck Reed, vice president of business management at AmerisourceBergen Corp.

While no formal industry consensus has been reached, the majority of stakeholders are gravitating toward using wholesale acquisition cost (WAC) for reimbursement of brand drugs and maximum allowable cost (MAC) for multiple-source products.

According to the *Journal of Managed Care Pharmacy (JMCP)*, WAC is a pharmaceutical manufacturer’s reported list price for a prescription drug for sale to wholesalers. It also is the benchmark price used for brands in deals between wholesalers and pharmacies.

“WAC works well for brands,” Reed explains, because it’s not calculated by compendia, so it “is seemingly less susceptible” than AWP to manipulation.

While no standardized definition for MAC exists, it is usually a reimbursement limit per individual multiple-source drug entity, strength and dosage form, and is established by PBMs, health plans and states, *JMCP* says.

The one thing industry players can’t seem to agree on is what benchmark should be used for single-source generics. “I think the market is pushing towards PBMs setting their own price on generic drugs,” contends Brian Anderson, a consultant for Milliman, Inc. “This is something they are actually already doing.”

According to Anderson, 80% to 90% of all generics already have a MAC price. “And since 70% of drugs dispensed are generics, we’ve essentially already moved away from AWP for
the majority of items,” he tells DBN. It’s possible, he adds, that the industry could set a universal MAC list that everyone has to compete off, and then use different pricing mechanisms for brand drugs.

“AWP is pretty murky already,” Anderson explains. “Plan sponsors really don’t understand it. But what they can do is say AWP minus 18% is better than AWP less 15% — so you can see that on a piece of paper and make an educated guess on what kind of an impact that could make on your trend.”

Other benchmarks that were considered include:

◆ **Average manufacturer price (AMP),** which is defined as the price available to retail that reflects discounts and other price concessions. AMP was redefined in the recent health reform law and is expected to be used by the government next year.

◆ **Average sales price (ASP),** which is based on manufacturer-reported actual selling price data and includes a majority of rebates, volume discounts and other price concessions offered. ASP is currently used for Medicare Part B drugs administered by physicians.

◆ **Federal upper limit,** which is a unit price calculated and published by CMS for each drug entity, strength and dosage form.

Best price, which is the lowest price available from the manufacturers during the rebate period to any entity in any pricing structure, and includes rebates, discounts and other price concessions. This benchmark could be applied only to brand drugs.

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**Government, Plans Focus on PBM Transparency to Control Costs**


Congress and major players within the health care industry already are putting more weight on the importance of transparency in PBM contracts. But even though payers have been warned about hidden fees that are jacking up the costs of drug benefits, many health plans and large employers still fail to include provisions in their PBM contracts that ensure they receive every dollar due to them, warned experts at a recent AIS webinar.

“The overall climate in Washington is that something needs to be done about transparency,” Susan Hayes, principal of Pharmacy Outcome Specialists, said during the April 1 webinar on how to guarantee PBM transparency. “And large employers and health plans will be looking to the government for a blueprint on how to do it.”

Hayes pointed to legislation aiming to strengthen government oversight of PBMs participating in the Federal Employees Health Benefits Program (FEHBP) that advanced in the House of Representatives earlier this month. If passed, the FEHBP Prescription Drug Integrity, Transparency, and Cost Savings Act, H.R. 4489, would prohibit unauthorized prescription switching by PBMs, require a 99% return on all drug rebates to FEHBP and grant the Office of Personnel Management strong audit rights.
Hayes said the bill has “a very good likelihood of passing.” But even if it doesn’t pass, the goal of complete “pass-through” pricing will remain, she maintained.

Kevin Nagle, president and CEO of Envision Pharmaceutical Services, Inc., said that the use of pass-through pricing versus “lock-in” pricing has already spread throughout the private and public sectors. “CMS concluded that pass-through pricing models prevented additional profits from being generated by the PBM at the expense of beneficiaries and the taxpayer,” Nagle, who also spoke at the webinar, explained. “As a result, over the last few years more and more state agencies have been demanding transparency as well.”

**Plans Should Seek Pass-Through Pricing**

The health reform law recently signed by President Barack Obama mandates pass-through pricing for PBMs participating in state exchanges starting in 2014.

However, since it is not a requirement yet, Nagle said payers must take advantage of their leverage during the request-for-proposal process to extract full disclosure and strong contract terms with “real” pass-through pricing and enforceable financial and performance guarantees.

Full disclosure, according to Nagle, means forcing your PBM to reveal all financial benefits it receives or charges for, including retail pharmacy transactions, specialty rebates and administrative fees received from pharmaceutical manufacturers. All of these “must be documented in the contract between plan sponsor and PBM with full audit rights,” Nagle said.

He added that the main problem with the traditional, nontransparent PBM model is that plans don’t know what they’re getting because there’s little consistency in pricing methodologies. “Average wholesale pricing [AWP] comparisons are common occurrences and often misleading,” he explained. “And custom national drug codes — pre-packaging and private label — cause great pricing confusion.” He contended that gross inequities exist in generic prices among AWP, acquisition cost and Maximum Allowable Cost (MAC) pricing.

One way that Envision negotiates rebates, for example, is by returning them to plan sponsors at the point of sale. For example, in its negotiations with drug manufacturers, the PBM asks, “if we had to give 100% of the rebate that you forward to us to the payer at the point of sale, will you give us the maximum discount that you offer your particular contract-ed PBMs?” Nagle explained. “And many of them said yes. So we have that in our pharma-ceutical contracts with our manufacturers.”

Whatever the system, plans must take a close look at their contracts with PBMs, Nagle asserted. “It’s all in the contract,” he added. That’s “because any financial guarantees that a PBM puts in the contract can be debunked or excluded if other parts of that contract allow them some type of caveat or exclusion so that those guarantees are no longer valid.”

When negotiating a contract, Nagle recommends plans follow these guidelines:

- **Select two finalists and negotiate all guarantees, terms and conditions before making the award;**
- **Ensure full audit rights are reserved for the plan sponsor or designee;**
- **Require that the PBM use the lowest published AWP, but never authorize highest AWP on brand or generic product pricing, average AWP or high-cost pre-packaged drugs;**
- **Guarantee that the methodology for generic pricing is disclosed (i.e., AWP or MAC model); and**
Never select a winner of an award until the contract has been reviewed by experts.

“The simple, most important point is negotiating a contract that holds the PBM accountable for its guarantees well in advance of declaring the award,” Nagle advises.

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Landmark Drug AWP Settlement Is Finalized; Pricing Rollback May Save Rx Payers $1.5B


A federal judge on March 17 granted final approval to a long-awaited legal settlement that would roll back average wholesale prices (AWPs) on roughly 1,440 pharmaceuticals—a move that some industry consultants estimate will result in a 0.7% to 1.6% reduction in Rx payers’ annual drug spending and provide $1.5 billion in overall savings. But an employee benefits consultant tells DBN that PBMs and pharmacies aim to nullify any savings that Rx payers are entitled to under the AWP reduction by renegotiating contracts with “cost neutrality” provisions.

For their part, PBMs contend that the pharmaceutical marketplace has long since adjusted for the allegedly excessive AWPs, which took place in the early and mid-2000s, and that the settlement represents an “unprecedented” move by the courts in industry pricing matters. Moreover, an attorney representing the PBM industry says the ruling will likely be appealed.

The closely watched ruling by U.S. District Judge Patti Saris in Massachusetts clears the way for publisher First DataBank, Inc. (FDB) to reduce by roughly 4% the AWPs on 1,442 National Drug Codes (NDCs), representing more than 400 individual brand drugs. The ruling is set to become effective roughly 180 days following the “final judgment,” which had not been submitted to the court as of DBN press time.

The agreement stems from allegations that FDB conspired with drug wholesaler McKesson Corp. to fraudulently inflate the widely used AWP benchmark from 2001 to 2005, which caused consumers and third-party payers (TPPs) to overpay for drugs. Under the alleged scheme, FDB and McKesson increased the “spread” between the lower prices that pharmacies pay to acquire drugs using wholesale acquisition cost (WAC) and the higher prices they later charge health plans for the same drugs under AWP. Increasing the WAC/AWP spread from 20% to 25% starting in 2001 allowed retail clients to reap larger profits at the expense of consumers and TPPs.

Publisher Medi-Span, a division of Wolters Kluwer Health, Inc., also negligently published the same false drug prices, according to Saris, who approved a separate Medi-Span settlement on March 17. Under both settlements, FDB and Medi-Span have agreed to reduce AWP reimbursement rates to 120% of WAC on the NDCs in question. Independent of the settlements, FDB and Medi-Span said they would apply the same markup to all other NDCs in excess of 120% of WAC, and would stop publishing the AWP benchmark two years after the settlement is finalized. Separately, McKesson agreed in November 2008 to pay $350 million to settle the charges. That settlement agreement is still pending. All of the defendants denied any wrongdoing.
In her ruling, Saris cites an expert testifying for the plaintiffs who estimates that the rollback could provide as much as $1.03 billion in prospective savings to TPPs and customers. But the plaintiffs’ expert also acknowledges that the exact amount will be difficult to predict because many parties are likely to renegotiate their contracts, according to Saris.

For example, she writes, Blue Cross and Blue Shield of Michigan contends that the rollback of the AWP markup is likely to generate no benefits for the TPP class because PBMs will simply renegotiate the reimbursement contracts with TPPs.

“Still even assuming the renegotiations will dissipate the value of the settlement, the rollback will have the added advantage of righting a wrong and providing greater transparency in drug pricing, a notoriously opaque business,” Saris states. She also maintains that the rollback will benefit consumers who make copayments for listed drugs based on AWP, “because the percentage payment will reduce the amount of the copay.”

Prescription Access Litigation (PAL), an advocacy group that includes as members plaintiffs in the settlement, says the rollback of prices on the 400 drugs could yield more than $1.5 billion in future savings on drug costs. “Perhaps of even greater importance, this lawsuit… has exposed the weaknesses of the pharmaceutical pricing system that have allowed drug makers and wholesalers to manipulate or ‘game’ the benchmark prices that government programs and insurers use for reimbursement,” PAL said in a March 18 prepared statement.

**PCMA: Problem Has ‘Already Been Fixed’**

But the Pharmaceutical Care Management Association (PCMA), a large PBM trade group, vigorously disputes the expected savings estimates and other claims. There aren’t any egregious discrepancies in contract pricing between 2002-2003 and now, says Stephanie Kanwit, special counsel to PCMA. “Largely speaking, the market for pharmaceuticals has already adjusted to that little rise — remember it’s on 1,400 NDCs — and it’s a 4% differential. We’re saying it’s already been fixed. No problem. Don’t fix it, because it ain’t broke.”

Furthermore, Kanwit contends the judge’s order is “unprecedented” in its burden on non-parties to the lawsuit. “I cannot find a case where a federal judge has interfered to this extent in industry pricing, and ordered a prospective price adjustment because of something that allegedly occurred six or seven years ago,” she tells DBN, noting that PCMA or other industry groups will likely appeal the ruling and ask for a stay while the appeals court reviews the case. No appeal had been filed as of DBN press time.

Another group opposed to the settlement is the National Association of Chain Drug Stores (NACDS). “The AWP reductions will cut Medicaid reimbursement by about $68 million each year,” according to a March 17 prepared statement by NACDS. “In addition, pharmacies that are unable to renegotiate their private sector reimbursement contracts will face a net 4 percent reduction in AWP-based reimbursement.”

Kanwit says, “First, we bought allegedly inaccurate data, and now we’re being asked to shoulder the burden in fixing the problem.” As an alternative, PCMA has advocated using the $350 million McKesson settlement fund, as well as smaller amounts from FDB and Medi-Span, to settle the charges (DBN 1/2/09, p. 1).
Consultant Says PBMs Seek to Nullify Deal

But Emil B. Kraft, principal and chief actuary at pharmacy benefits consulting firm DeepView Solutions, Inc., says the settlement should result in annual Rx savings of between 0.7% and 1.6% for health plans, employers and other Rx payers. A health plan or employer group paying $100 million per year in pharmacy costs, for example, could realize a savings of between $700,000 and $1.6 million, Kraft says.

“For some self-funded payers that have a $300,000 spend, it’s a lot closer to the insignificant side of the spectrum,” he tells DBN. “You’re not going to hire someone to do a $20,000 repricing and trench-warfare negotiation project to save $3,000 to $4,000. But there are a lot of employer groups that have seven-, eight-, or nine-figure pharmacy spends. Those folks have a lot more at stake in this.”

However, in anticipation of the AWP settlement, many PBMs have written “cost neutrality” provisions (i.e., those that would maintain the same pricing levels pre- and post-settlement) into their contracts, which could be used to nullify any expected savings, Kraft says. He suggests that plan sponsors secure a copy of the pharmacy contract and go over it with a consultant as soon as they are notified by their PBM or insurance carrier that the PBM or carrier intends to change contractual provisions in response to the settlement. Kraft offers other advice to Rx payers, including:

◆ Inform your carrier/PBM that because it is the party requesting a change to an in-force contract, you assume it will reimburse you for any expert consulting you retain to perform a due-diligence review of the proposed changes. “They may not agree, but this strikes the right tone and is a reasonable request,” Kraft says.

◆ Assess the AWP settlement language, as it can vary widely and may be ambiguous. “In these cases, you are justified in defending an interpretation consistent with being due your settlement savings,” he says.

◆ Assess the contract language for a 90-day out clause. “Even if you do not want to leave, the option can be used as negotiation leverage,” according to Kraft.

◆ If you are forced to accept “cost neutrality,” consider having your carrier/PBM’s view of cost neutrality audited before accepting it. “This is important to be sure your carrier/PBM does not use the settlement as an opportunity to put you in an even worse financial position,” Kraft asserts.

Kraft says he has heard many arguments from PBMs attempting to justify the need for cost neutrality. He contends those are really “arguments for why they and pharmacies are trying to nullify the intent of the settlement.”

For example, “Some PBMs assert that Rx payers are getting a better deal now than they were five years ago. We would expect employers to respond, ‘Great, now on top of that, we are going to add the settlement savings I’m due.’” He also slams the argument that the market has already adjusted to the pricing differential. That line of reasoning is what one would use to talk someone out of filing a lawsuit, or for convincing a judge not to let the suit go forward, Kraft says.

“We’re past that. The judge has approved the settlement,” he says. “The expressed purpose of the settlement is to provide relief to plan sponsors and employees. Now we’re talking about how to execute this.”

To view Saris’ March 17 order, access http://pacer.mad.uscourts.gov/opinion.html and click on “All Recent Opinions.” ✧
PBMs, Health Plans Would Have to Revisit Thousands of Pacts After AWP Settlement


Health plans, PBMs and other stakeholders may have to renegotiate tens of thousands of contracts if a federal judge approves First DataBank Inc.’s (FDB) proposed agreement to reduce average wholesale prices (AWP) on thousands of pharmaceuticals. The settlement, which could receive final approval from a federal judge in January, stems from allegations that FDB conspired with drug wholesaler McKesson Corp. to fraudulently inflate the widely used AWP benchmark in 2002 and 2003 — a move that caused consumers and third-party payers (TPPs) to overpay for pharmaceuticals.

But some stakeholders are hoping to avoid the onerous task of revisiting contracts by convincing U.S. District Judge Patti Saris in Massachusetts to end the long-running AWP legal battle with another recently proposed financial settlement. McKesson agreed in late November to pay $350 million to settle the charges. Both FDB and McKesson deny any wrongdoing.

At a Dec. 17 fairness hearing on FDB’s proposed settlement, Saris declined to approve the deal immediately, and instead ordered experts representing various stakeholders to determine exactly which drugs were subjected to the alleged pricing scheme. FDB in October 2006 agreed to roll back the AWP benchmark by roughly 4% on the drugs in question. The list of drugs subjected to the rollback, however, has dropped from more than 8,000 National Drug Codes (NDCs) in FDB’s 2006 agreement to 1,356 NDCs under the deal now. FDB also has said it would phase out its publication of AWP two years after the settlement.

The court has scheduled a Jan. 27 rehearing on the matter. But some stakeholders are hoping the AWP rollback issue will become a moot point.

The Pharmaceutical Care Management Association (PCMA), which represents PBMs, strongly opposes the AWP rollback. Rolling back AWP on certain drugs would “impose substantial administrative burdens on non-party intermediaries like PBMs while doing nothing to help consumers,” PCMA argued in a letter last month to Saris.

Instead, PCMA urges Saris to use McKesson’s $350 million settlement to address any alleged wrongdoing. “McKesson has put all of this money in the pot, a huge amount, let that be the settlement money,” says Stephanie Kanwit, special counsel to PCMA. “That’s how class actions work. You get money, you get coupons, you get dollars off,” she tells DBN.

FDB’s proposal to lower AWPs, by contrast, would unnecessarily change a key contracting benchmark in the pharmaceutical market, Kanwit asserts. “We said to the court that’s just not necessary. The marketplace has already taken care of that.”

In fact, rolling back AWP would not result in any significant savings to consumers or TPPs, Kanwit argues. “It will be a ripple in the marketplace,” she says, noting that PBMs and TPPs had already adjusted for the higher AWP. “But we have to renegotiate to make sure it’s cost neutral. That takes time and energy on the part of PBMs...It imposes some costs on retailers, on PBMs and on TPPs.” If there was conspiracy on the part of McKesson and others, “why do this to the industry, especially now that you’ve got the $350 million McKesson pot?” she adds.
Suit Centers on AWP Spread

The litigation centers on claims that FDB and McKesson increased the “spread” between the lower prices that pharmacies pay to acquire drugs using wholesale acquisition costs (WAC) and the higher prices they later charge health plans for the same drugs under AWP. Increasing the WAC/AWP spread from 20% to 25% starting in 2001 allowed retail clients to reap larger profits at the expense of consumers and TPPs, such as insurance companies, according to plaintiffs’ law firm Hagens Berman Sobol Shapiro LLP.

Steve Berman, a partner at Hagens Berman Sobol Shapiro, said in a late November website blog posting that the settlement agreement with McKesson is “paving the way for industry change,” and represents a “big win for consumers and third parties.”

Plan sponsors, meanwhile, should be prepared to review their PBM contracts as the AWP agreement situation remains fluid, says Joshua Golden, a senior pharmacy consultant at Hewitt Associates.

The vast majority of PBM contracts contain clauses giving PBMs the right to adjust pricing on a “fair and equitable basis,” he says in an article in the fourth quarter 2008 Benefits Quarterly, which is published by the International Society of Certified Employee Benefit Specialists. At the very least, contracts give PBMs the right to reopen the pact for renegotiation, Golden adds.

“Make sure any new contract includes the right to evaluate and approve any kind of pricing changes the PBM or health plan wants to make in the event of any major changes to AWP,” he writes. “Above all else, be careful not to grant them [i.e., PBMs] the unilateral right to make sweeping changes at their own discretion.”

Kanwit, however, says PBMs simply would want to adjust pricing to preserve cost neutrality. “We want our client X to have exactly the same deal that it had post the rollback and pre the rollback,” she says.

Some stakeholders are taking a wait-and-see approach to how it all turns out. “Whatever the outcome of the pending litigation, it would be our hope that the final decision of the court will lead to a more transparent system, a clearer understanding of drug payment methods, and, more importantly, an appreciation of the real impacts of the proposed pricing arrangements,” says the Academy of Managed Care Pharmacy.

Contact Kanwit through Charles Coté at ccote@pcmanet.org. For more information from the plaintiffs, visit www.hbsslaw.com/McKesson_classaction.htm. ∗
Negotiating Pharmacy Benefit Contracts: Strategies for Health Plans and Employers

Wednesday, October 24, 2012

Supplemental Materials

Effective Contracting With Pharmacy Benefit Managers: Protecting a Plan Sponsor’s Sources

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Effective Contracting with Pharmacy Benefit Managers: Protecting a plan sponsor’s resources
by Brian N. Anderson and Robert Cosway

Prescription-drug expenditures are one of the fastest-rising components in U.S. health care, increasing by double-digit percentages in nine of the 12 years from 1996–2007 (Figure 1). In 2006, according to the Kaiser Family Foundation, Americans spent $216.7 billion for prescription drugs, more than five times the amount spent in 1990.1 By 2018, prescription spending is projected to reach $453.7 billion.2 These facts challenge healthcare plan sponsors to keep costs under control while still providing effective coverage.

PBM selection
Selecting a PBM is a complicated decision. There is no one-size-fits-all solution. Some PBMs are large companies serving many clients, and some are small, serving fewer. It may seem natural that a plan sponsor with a large member base would look first to big PBM companies, but size is not the most important factor in making a choice.

Some questions to ask when evaluating your current PBM or considering a new one:
• Does the PBM fulfill your organization’s needs in terms of costs, customer service, range of drugs available, and other factors? Identify the most important criteria for your organization. If price is number one, let that be a guiding point; if customer service is most important, then you will need to concentrate on this element. Thorough evaluations are complex and require an effective request for proposal (RFP) process, thorough data analysis, and onsite evaluations.
• Are you getting the best possible financial arrangement?
• Is the PBM willing to contract auditable and sustainable terms you find acceptable, such as transparency and fiduciary responsibility?

2 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis, and Bureau of the Census.
• Is your organization geared up to change PBM's (i.e., to go through with the implementation process)?

## Contracting

Effective contracting is crucial to the success of your plan’s pharmacy benefit. New drugs are constantly coming onto the market, and prices are always fluctuating. To keep up with the ever-changing pharmaceutical industry, it is a good idea to renegotiate, procure, or request aggressive new renewal terms for the PBM contract at least every two years. You may want to secure more favorable terms from your current PBM or, if that doesn’t seem promising, choose a new PBM.

Key contracting issues include having defined arrangements for items such as:

- “Lesser of” pricing for all network and mail-order pharmacies to ensure you are receiving the lowest cost available for a drug
- Pricing guarantees for brand-name and generic drugs
- Minimum rebate guarantees
- Formulary program discounts
- Quarterly or year-end financial guarantees
- True-up or reconciliation
- Agreeable termination clause
- Clear definition of generic drugs
- Measurable performance guarantees
- Auditing provisions

Negotiating the contract is the key to locking in the arrangement you were promised during the selection or renewal process. Moreover, do not assume the contract will include all discounts, rebates, and financial guarantees agreed to during the selection or renewal process. Remember to verify that the contract language properly captures what was agreed upon.

Contract enforcement of the performance guarantees and financial terms can be conducted through claims auditing, on-site reviews, reconciliations, and invoice reviews. Please refer to the chart “Understanding Key Contract Terms” to assist with navigating PBM contract terminology.

## Pricing Methodologies

Most PBMs employ a traditional pricing approach known as spread pricing, meaning that the PBM negotiates aggressive contracted rates for drugs at lower prices and invoices their clients (plan sponsors) at higher contracted rates, profiting from the spread between the two sets of rates. Others, however, use pass-through pricing, which means they charge clients a flat fee per claim or per member and pass the exact purchase price or reimbursement rate through to the client. Under either method, the PBM contract should clearly define the agreed-upon charge basis for drugs dispensed at mail-order, retail, and specialty pharmacies.

Sometimes a combination of the pricing methodologies is best. For example, a PBM may employ traditional spread pricing, but with a pass-through true-up yearly or quarterly, allowing clients to see what they are paying for, verify the contract terms, and make sure that any discounts are being passed through to the client.

Whichever business model the PBM employs, having clearly recognizable transparent terms is the key to your organization’s oversight function and must be spelled out in the contract. It is important not to confuse the term “transparency” with “pass-through.” These terms are not interchangeable, and if used in the contract should be defined.

## Defining the Plan’s Cost for a Particular Drug

The PBM contract should define how much the plan pays the PBM for each prescription filled for the plan’s members. Because there are thousands of individual prescription drugs, it is not practical for the contract to list a price for each individual drug. Instead, most contracts define the plan’s cost for a drug as a discount from a published ingredient cost. The ingredient cost is usually defined as a percentage of the average wholesale price (AWP) of the drug. AWP can be classified as a sticker price for prescription drugs. Payments made by plan sponsors to the PBM are typically based on AWP minus some

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**What is a PBM?**

A Pharmacy Benefit Manager (PBM) is an organization that provides administrative services to managed-care organizations, self-insured companies, and government programs in processing and analyzing prescription claims. PBM services can include:

- Contracting with a network of pharmacies and negotiating drug prices and rebate arrangements
- Developing and managing formularies, preferred drug lists, and prior authorization programs
- Processing claims for prescription drugs
- Maintaining patient-compliance programs
- Performing drug-utilization review
- Operating disease management programs

Many PBMs also operate mail-order pharmacies or arrange to make prescriptions available through mail-order pharmacies.
discount percentage, or an overall net effective AWP discount. The percentages off AWP can vary greatly from drug to drug. For example, the PBM contract could define retail brand-name drug discounts to be “AWP minus 17.5 percent,” or “guaranteed overall annual brand-name discount is equal to AWP minus 17.5 percent.” These examples represent different ways of pricing drugs at pharmacies. The first example is a straightforward discount for every brand-name drug and the second is an average of the discounts off brand-name drugs.

AWP is a price derived from data reported by pharmaceutical manufacturers for brand-name and generic drugs. At this time, the neither the prescription-drug industry nor governmental agencies require AWP to reflect actual sale prices. As a result, AWP should not be considered an accurate reflection of actual market prices for drugs. Several companies publish the AWP of prescription drugs in printed and electronic databases. Drug manufacturers either provide information used to create AWPs, or report AWPs to the companies that publish AWPs. Since multiple companies publish AWP lists and multiple pharmaceutical manufacturers produce the same drug, there can be multiple AWPs for a drug. A PBM contract should identify which publisher of AWP is to be used.

One example of AWP not being an accurate reflection of actual market prices for drugs is generic drugs. While a discount of 15 to 23 percent off AWP may reflect a reasonable market price for brand-name drugs, discounts ranging from 40 to 80 percent off AWP are needed to produce the typical market price for generic drugs that have been on market for at least six months. The discounts used to price generic drugs are a direct reflection of how your contract is written, including the way the contract defines a brand-name and a generic drug, and the pricing discounts.

While some PBM contracts define the cost of generics as a discount off AWP, using a much higher discount than for brand-name drugs, many include a completely different structure, maximum allowable costs (MAC). Each PBM has its own MAC list(s), which may give the PBM sole discretion to define and change the maximum price it will pay for generic drug products. Since 60 to 80 percent of prescriptions may be for generics, the management and oversight of the MAC list plays a significant role in the overall management of the plan’s prescription-drug costs.

Effective auditing and oversight will aid enforcing the MAC list(s) and mitigate significant pricing changes, which may be more costly to the plan. The use of MAC lists applies to both traditional and pass-through pricing methodologies. In some cases, a PBM may have multiple MAC lists operating behind the scenes. It is important for a PBM to disclose or attach these MAC list(s) affecting your plan in the PBM contract. A PBM will update its MAC list(s) from time to time with additions, removals, and pricing changes. These changes can be significant and the updates may occur as often as weekly or may only occur quarterly. Because of the constant changes in MAC lists, it may be necessary to request to receive updated MAC lists when changes occur or to receive historical listings of pricing changes at year-end for use in an audit.

Average Wholesale Price (AWP) litigation

Lawsuits have been filed by some plan sponsors alleging that AWPs were unlawfully inflated, increasing the prices of certain drugs. The lawsuit resulted in a court ruling that required First DataBank and Medi-Span to modify their published AWPs starting Sept. 26, 2009. This court ruling affects each plan sponsor, PBM and pharmacy, because each organization will need to address the resulting changes in AWP. The changes in AWP implemented after Sept. 26th, 2009 will have a significant impact on the calculation of the contractual ingredient cost for most brand drugs.

The court ruling requires that for all prescription drugs with a current AWP mark-up over the wholesale acquisition cost (WAC) in excess of 20 percent, First DataBank and Medi-Span must reduce their published AWPs on Sept. 26th, 2009 such that the AWP mark-up over the WAC is no greater than 20 percent.

PBMs are using two primary approaches to modify their contracts with plan sponsors and pharmacies. The intent of both is to unwind the change in AWP, so that the ingredient costs paid by plan sponsors...
and paid to pharmacies are unchanged under the new AWPs. The first approach appears to be the most common approach adopted by PBMs.

1. Adjust post-September 26th, 2009 published AWPs so they are based on the same mark-up rates as were used prior to September 26th, 2009, with no change to the contracted AWP discounts.
   This process involves adjusting the published AWP price of each prescription drug to remove the impact of the settlement. For example, if the WAC markup for a particular drug is reduced by the settlement from 125 to 120 percent, the PBM would adjust the AWP back to the pre-settlement amount based on 125 percent. This process could be completed concurrently for each claim processed, or by assessing a batch of claims before a pharmacy is reimbursed. Alternatively, some vendors plan to publish AWPs that include this adjustment to undo the court-ordered decrease.

2. Use Published Post-Settlement AWPs, and modify the contractual AWP discounts.
   This approach would adjust the contractual discounts so that the resulting ingredient costs are the same as if the current discounts were applied to the pre-settlement AWP levels. This is done by reducing the AWP discounts for brand and generic drugs so that when First DataBank’s and Medi-Span’s post settlement published adjustments are released, the AWP discounts for brand and generic drugs are reduced proportionately. The revised AWP discounts will have to be negotiated by the PBM with both sponsors and pharmacies.

Under either approach, plan sponsors are not benefiting from the court-ordered reduction in AWP. In theory both approaches are designed to be cost neutral for plans sponsors, but sponsors should be cautious in agreeing to open-ended AWP litigation-related pricing provisions, especially if they require changes to their current PBM contract. Many PBMs are asking plan sponsors to sign addendums to their contracts to address the AWP litigation issues. These addendums may negatively influence pricing terms in the contract or provide the PBM the sole discretion to define claims-pricing methodology. Since AWP is the basis for most drug pricing and is a constantly moving target, it is recommended to closely monitor and audit your plan’s drug pricing to ensure the plan is not being overcharged.

Exhibits to the PBM contract
A PBM contract requires the attachment of numerous important documents. If these items are not included, a plan sponsor’s ability to perform effective audits and collect any recoveries due may be limited. These documents include:
- List of administrative services
- Financial terms
- Performance guarantees
- Proposed maximum allowable cost (MAC) list
- Specialty-pharmacy drug price list
- The original proposal
- HIPAA business-associate agreement
- Plan design document
- Plan pharmacy-program specifications
- Performance guarantee definitions

Post-contract oversight audit
Once the PBM’s operations are in place, an audit is necessary to ensure the integrity of the contracted arrangement and verify that the PBM administrator is providing the sponsor and its members all contracted benefits.

The audit should involve a thorough assessment of administrative functions, including:
- The accuracy and timeliness of cost controls, systems, and procedures
- The accuracy of management information
- The accuracy and timeliness of claim payments and rebates
- The effectiveness of internal controls

A PBM audit’s main value is to identify and resolve errors in the plan setup and claim-adjudication process to mitigate prospective plan-administration issues. While an audit may also identify retrospective problems, it can be difficult to recover retrospective payments. The recovery effort is dependent on the clarity of the contract terms and the supporting detail of the auditor’s assertions.

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Many PBMs are asking plan sponsors to sign addendums to their contracts to address the AWP litigation issues.
An independent third party that has experience in pharmacy-claim payments under various plan designs, utilization patterns, administration processes, online pharmacy claim-processing systems, clinical programs, operational protocols, rebate methodologies, and customer-service practices and procedures often conducts this audit. These audits are necessary for plans to perform their fiduciary responsibilities and to enforce contractual terms.

Summary
As the pharmaceutical industry continues to change and prescription-drug costs continue upward, plan sponsors should review the services they are receiving from PBMs and decide whether they are working with the right vendor and whether their PBM contract gives them the best coverage for the best price.

For further information:

McKesson Proposed Settlement Web site. Available at http://www.mckessonawpsettlement.com/

### Understanding Key Contract Terms

The following is a partial glossary of terms that may appear in a PBM contract.³

**Actual acquisition cost (AAC):**
The net cost of a drug paid by a pharmacy, including discounts, rebates, chargebacks, and other adjustments, but not including dispensing fees.

**Average manufacturer price (AMP):**
The average wholesale price for drugs distributed to retail pharmacies, a benchmark created by Congress in 1990 for calculating Medicaid rebates.⁴

**Average sales price (ASP):**
The weighted average of all non-federal sales to wholesalers, net of chargebacks, discounts, rebates, and other benefits tied to the purchase of the drug product, whether paid to the wholesaler or the retailer.

**Average wholesale price (AWP):**
A published national average of list prices charged by wholesalers to pharmacies. AWP is sometimes referred to as a "sticker price" because it is not the actual price that large purchasers or PBMs normally pay.

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**Best price (BP):**
The lowest price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or the government. BP includes cash discounts, free goods that are contingent upon purchase, volume discounts, and rebates. It excludes prices to some federal agencies, such as the Indian Health Service and the Department of Veterans Affairs, as well as state pharmaceutical assistance programs, depot prices, and nominal pricing.

**Formulary:**
A preferred list of drug products that typically limits the number of drugs within a therapeutic class available to plan members. Some health plans develop closed formularies (only listed drug products are covered or reimbursed) whereas others develop open formularies or impose restrictions such as higher patient cost sharing for non-formulary drugs.

**Mail order:**
A participating pharmacy that provides home delivery services through common carriers, as well as other services described in the PBM contract.

**Maximum allowable cost (MAC):** The maximum cost allowed for a generic drug product as set by the PBM.

Also known as “network,” this refers to a negotiated contract list of available pharmacies. The retail network can include both national chain pharmacies and independent pharmacies.

**Specialty pharmacy:**
A contracted pharmacy providing prescription items that require special handling or administration. A PBM usually contracts the discounts, administrative fees, and dispensing fees at a rate different from other discounted arrangements.

Wholesale acquisition cost (WAC): The price paid by a drug wholesaler to the wholesaler’s supplier, typically the manufacturer.

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4 This and subsequent “average” prices are generally determined by HRSA, but it is a good idea for a plan sponsor to discuss exactly what the term means with reference to prices paid to the PBM.