PBM Contracts: Innovative Strategies to Improve Your Plan’s Bottom Line

Thursday, February 12, 2015

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About the Speakers

BRIAN ANDERSON, M.B.A., is a consultant with the San Diego office of Milliman. He joined the firm in 2008, and has been a pharmacy benefits consultant since 2001. Brian has provided pharmacy benefit consulting services to a wide range of clients, including Medicare plans, Medicaid MCOs, VA, health plans, state systems, union funds, coalitions, high-risk pools, PBMs, GPOs and large employers. His consulting specialty is the prescription drug benefit market. His experience includes understanding prescription benefit operations, pharmacy benefit manager contracting, cost management, program development and yearly benefit planning. Contact Brian at brian.anderson@milliman.com.

JASON GOMBERG, FSA, MAAA, is an actuary with the Chicago office of Milliman. Jason’s areas of expertise are managed care, prescription drugs and provider payment systems. His current responsibilities include modeling and analysis of medical and prescription drug plans, both in the commercial and Medicare markets. In the commercial market, Jason has more than seven years of experience working for a major health insurance company. He had management roles in areas responsible for provider reimbursement levels, trend forecasting and predictive modeling used for both rating and disease management targeting purposes. In the prescription drug industry, Jason has several years of experience working for a pharmacy benefit manager. His responsibilities included consulting to health plan actuarial staffs on issues related to prescription drug coverage, including trend forecasting, benefit design and optimization, and marketplace trends. Jason has spoken on various health care subjects at several employer/broker conferences as well as actuarial industry meetings. Contact Jason at jason.gomberg@milliman.com.

TROY M. FILIPEK, FSA, MAAA, is a principal and consulting actuary in Milliman’s Milwaukee office and joined the firm in 2002. Troy’s areas of expertise are managed care, Medicare Advantage and prescription drugs. His current responsibilities include modeling and analysis of medical and prescription drug benefit plans, both in the commercial and Medicare markets. In the Medicare market, Troy works extensively with carriers, with particular emphasis on the Medicare prescription drug benefit. Troy assists Medicare Advantage plans, Part D Prescription Drug Plans and employers with strategic planning, Medicare bid preparation, retiree drug subsidy attestations and various other issues. He is a key contributor to Milliman’s Part D research efforts and has also worked with pharmaceutical companies and pharmacy trade groups/industry organizations on issues related to prescription drugs. In the commercial market, Troy has reviewed rating approaches and formulas, prepared rating manuals and models, analyzed historical experience, developed and opined on insurance company premium rates and provider reimbursement levels, and completed reserve analysis, as well as providing strategic consulting on a host of other items. Troy has written numerous articles for the Society of Actuaries, Milliman, and other publications. Contact Troy at troy.filipek@milliman.com.

Moderator: Jill Brown, executive editor of AIS

Three Ways to Submit Your Questions for the 30-Minute Q&A Session

Speakers’ presentation should run approximately 60 minutes, with 30 minutes of questions and answers. Questions may be submitted in three different ways:

Prior to the Webinar

(1) Email your question(s) to moderator Jill Brown at jbrown@aishealth.com or

During the Webinar

(2) To send a question from the Webinar page, go to the Chat Pod located in the lower left corner of your screen. Type your question into the dialog box at the bottom and then click on the blue send button or

(3) Dial *1 on your phone keypad and an operator will connect you to the moderator so that you can ask your question(s) “live” with the Webinar participants listening
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• **DRUG BENEFIT NEWS** is a hard-hitting newsletter for health plans, PBMs, pharma companies and employers. Published biweekly, it delivers both timely news stories and in-depth accounts of cost management strategies that are being employed by drug purchasers. Coverage includes up-to-the-minute news of industry consolidation, strategies for participation in exchanges, generic promotion tactics, formulary decisions, innovative benefit designs, drug pricing methodologies, PBM contracting, changes in Part D and other federal initiatives, and much more.

• **SPECIALTY PHARMACY NEWS** is a monthly newsletter packed with 12 pages of business news and management strategies for containing costs and improving outcomes related to high-cost specialty products. Designed for health plans, PBMs, providers and employers, the hard-hitting newsletter contains valuable insights into benefit design tactics, specialty markets for certain conditions, formulary decisions, merger and acquisition activity, payer-provider partnerships, patient adherence strategies, and new products.

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WEBINAR MATERIALS

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WEBINAR OUTLINE

Part 1: Brian Anderson, Jason Gomberg and Troy M. Filipek, Milliman

- Prescription Drug Trends
- The PBM Industry
  » Drug Delivery
  » Historical Approaches and Considerations
  » Current State of the Market
  » Predicting the Future
- Savings Opportunities
  » Request for Proposals
  » Important Contracting Provisions
  » Market Checks
  » Post-Contract Oversight Audit
- Case Studies

Part 2: Questions and Answers
PBM Contracts: Innovative Strategies to Improve Your Plan’s Bottom Line

Presented by:
Brian N. Anderson, MBA
Jason Gomberg, FSA, MAAA
Troy M. Filipek, FSA, MAAA

Sponsored by Atlantic Information Services, Inc.

Thursday, February 12, 2015
Agenda

- Prescription Drug Trends
- The PBM Industry
  - Drug Delivery
  - Historical Approaches and Considerations
  - Current State of the Market
  - Predicting the Future
- Savings Opportunities
  - Request for Proposals
  - Important Contracting Provisions
  - Market Checks
  - Post-Contract Oversight Audit
  - Case Studies
- Live Q&A
Some of the Questions to Be Answered During the Presentation

- How can plans assess the extent to which their current PBM contracts are competitive?
- What changes to the negotiation and contracting process must health plans make to develop a competitive and long-term PBM relationship?
- What steps should plans and their consultants take to keep contracts competitive and stay current on pricing and industry trends?
- How can plans guard against the addition of contracting language that may make deals less competitive?
- How do different pharmacy network options affect how competitive a contract is? How should plans assess the options?
- How should plans respond when their contracted PBM is acquired or merges?
Prescription Drug TRENDS
Annual Spending

Source: 2014 Milliman Medical Index
Breakdown of Spending

2014 MMI COMPONENTS OF SPENDING

- **$7,249** INPATIENT (31%)
- **$4,360** OUTPATIENT (19%)
- **$7,277** PROFESSIONAL SERVICES (15%)
- **$3,446** PHARMACY (4%)
- **$883** OTHER

Source: 2014 Milliman Medical Index
Trends

MMI Annual Rate of Increase in Costs by Component of Medical Care

Source: 2014 Milliman Medical Index
The PBM Industry:

DRUG DELIVERY AND PBM BASICS
Drug Delivery
Pharmacy Benefit Supply Chain

- Main stakeholders:
  - Manufacturers
  - Wholesalers
  - Pharmacies
  - Group Purchasing Organizations
  - Pharmacy Benefit Managers
  - Plan Sponsors
  - Consumers

Graphic Source: Pacific Business Group on Health
PBM Basics
Goals and Objectives

PBMs are intermediaries between pharmaceutical manufacturers, pharmacies, and various pharmaceutical purchasers (employers, health plans, etc.)

PBM goals and objectives include:

- Manage drug spend appropriately
  - Maximize manufacturer rebates
  - Optimize pharmacy discounts and dispensing fees
  - Decrease administrative costs
- Improve health outcomes
- Facilitate efficient administration of pharmacy benefits
- Growth and profitability
PBM Basics
Achieving Goals and Objectives

How do PBMs achieve these objectives?

- Economies of scale – bring volume to the table
- Plan design and formulary management
  - Align incentives with payer to manage costs
  - Monitor and respond to pipeline products and brands losing patent
- Alternative revenue sources
  - Mail order pharmacies
  - Leveraging “big data”
  - Assuming insurance risk
    - Part D Prescription Drug Plans (PDPs)
    - Part D Employer Group Waiver Plans (EGWPs)
    - Stop loss and reinsurance offerings
PBM Basics
Achieving Goals and Objectives

How do PBMs achieve these objectives?

- Outcomes improvement and other medication management programs
  - Influence physician prescribing and pharmacist dispensing behaviors
  - Identify potentially adverse drug interactions
  - Balance drug efficacy and cost
  - Identify low cost substitution opportunities
  - Manage patient adherence as a means to lower total healthcare costs
    - Pharmacy costs increase – good for PBM
    - Medical costs decrease by more – good for payer
The PBM Industry:

HISTORICAL APPROACHES AND CONSIDERATIONS
Historical Approaches and Considerations
Key Events for PBMs in the Last Decade

- Medicare Part D
  - Increased 65+ covered population that PBMs can manage by ~ 50%
  - 65+ pharmacy spend is 3-6x that of a < 65 population
  - More covered members => more contracting leverage

- Pass-through pricing in Medicare Part D

- Major brands lose patent and shift pharmacy spend to more profitable generics

- Specialty pipeline continues to grow

- Increased scrutiny with more government business

- More competition from smaller niche PBMs and large health plans

- M+A activity within and across sectors
The PBM Industry:

CURRENT STATE OF THE MARKET
Current State of the Market

PBM Considerations – Preferred Networks

Preferred Networks

- Better contracting terms in exchange for lower cost sharing
  - Pharmacies exchange better terms for additional market share
- Essential in Part D, spilling into commercial RFPs as requested option
  - Pharmacies pay rebates to Part D plans for preferred placement
- CVS Caremark structure allows for increased coordination of pharmacy and PBM business
- Tradeoffs with preferred vs. exclusive networks
- Access issues
  - More pharmacies nationally than several fast food chains combined
  - More pharmacies than medical options in PPO style plans
  - CMS investigating access closely in Part D given proliferation of preferred networks
Current State of the Market
PBM Considerations – Pass-Through Pricing

Pass-Through Pricing

- Definition
  - Medical
  - Pharmacy

- Required in Part D marketplace for pricing and reporting
- CMS able to enforce more broadly than commercial markets allow
- Spilling into commercial PBM RFPs as a requested option
- Several niche players trumpet transparency
- Has not caught on broadly outside of Part D
Current State of the Market
PBM Considerations – Formulary Management

Formulary Management

- Payers more willing to exclude certain medications to save money if limited or no clinical downside
  - Hep C is latest example
  - Brands being forced to compete in other brand only classes, including biologics
  - Market developing rapidly as more therapeutic classes added to exclusion list
- More opportunities recently with flood of new generic products and existing brands looking to preserve market share while they can
- Customization of formularies occurring at lower membership levels
- Tiering structures getting larger under Part D and spilling into commercial
  - Preferred/Non-preferred generic and specialty tiers
  - Willingness to move “house” brands to generic tiers and high cost generics to brand tiers
Current State of the Market
PBM Considerations – Formulary Management

- Pharmacy manufacturer coupon programs
  - Seen as way to circumvent formulary
  - Not used in Medicare Part D

- Large formulary differences among PBMs and plans causing confusion among doctors
  - E-prescribing may not have plan design information by member
  - More physician time spent trying to attain access
Current State of the Market

PBM Considerations – Risk

Accepting insurance and other risk

- Started in mid-1990s with bad PBM risk deals and big losses
- Gun-shy since then but starting to re-emerge
- Risk mechanisms
  - Part D – Almost all midsize and large PBMs participate
  - Contractual trend guarantees or generic dispensing ratio (GDR) targets
  - Outcomes and adherence related measures
  - Reinsurance with smaller employers looking at self-funding
The PBM Industry:
PREDICTING THE FUTURE
Predicting the Future

PBM Considerations

- Expect more diversification and expansion beyond traditional middleman duties, including M+A activity
- Major concerns around government price controls that could reduce or eliminate their role
- Where is the next silver bullet with most traditional brands already losing patent and a big specialty pipeline? (Biosimilars?)
- Continued emphasis on pharmacy adherence as means to reduce medical costs and improve outcomes
- More exclusivity within pharmacy networks and formularies
Predicting the Future

PBM Considerations

- Greater customer demand for market checks and/or shorter contracts
- Continued growth in specialty pharmacy
- Managing the pharmacy spend in both the medical and pharmacy benefit
Savings Opportunities:
REQUEST FOR PROPOSALS
Request for Proposals
PBM Selection

Important questions to ask when evaluating a PBM:

- Does the PBM fulfill the organization’s needs in terms of costs, customer service, range of drugs available, and other factors?
- Is the organization getting the best possible financial arrangement?
- Is the contract written in a way that allows for transparency?
- Is the PBM willing to contract auditable and sustainable terms that the organization finds acceptable, such as transparency and fiduciary responsibility?
- Is the organization geared up to change PBMs (i.e., to go through with the implementation process and the oversight of PBM operations)?
Request for Proposals
2015 Considerations

Newer items to consider to maximize the savings:

- Should you consider an exclusionary formulary?
- What would you look for in a preferred pharmacy network?
- What will your specialty drug spend be in future years?
- Should you consider having certain drugs process through the medical or pharmacy benefit? (White bag vs. Brown bag)
- What are those rebates really worth?
Request for Proposals
Overview of the RFP Processes

- Prepare RFP
- Distribute
- Obtain questions
- Conduct a bidders conference call or in-person bidders meeting
- Respond to the questions
- Analyze financial bids
- Grade responses
- Summarize the responses
- Make recommendations for finalists
- Interview finalists
Request for Proposals
Draft Request for Proposal

Financial requirements
- Request traditional and pass-through pricing bids
- Request minimum discount
- Request minimum per claim guarantees for rebates from manufacturers

Qualitative requirements
- Administer current plan design and current formulary
- Maintain pharmacy access
- Performance guarantees
- Utilization management capabilities
- Various other contractual provisions
Request for Proposal

Next Steps

- Select finalists and request best and final offers
- Determine need for site-visit or on-site PBM presentation
- Review pros and cons of traditional vs. pass-through
- Review contract terms
- Begin implementation
Savings Opportunities:

IMPORTANT CONTRACTING PROVISIONS
Important Contracting Provisions

Effective Contracting

- Effective contracting is crucial to the success of the plan’s pharmacy benefit.
- Plans should consider doing the following every two years:
  - Renegotiate
  - Request aggressive renewal terms
  - Procurement
- Contract enforcement
  - Audits
  - Reconciliations
  - Invoice reviews
Important Contracting Provisions

Key PBM Contracting Issues

- Aggressive financial discounts
- “Lesser of” pricing for all network and mail-order pharmacies
- Defining the pricing guarantees
- Defining minimum rebate guarantees
- Defining key terms, such as transparency or pass-through
- Quarterly or year-end financial guarantee true-ups
- Agreeable termination clause
- Clear definition of a generic drug
- Measurable performance guarantees
- Auditing and market check provisions
- Customer service and member communications
- **100% of the rebates**
Important Contracting Provisions
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. Documents include:

- The original proposal
- List of administrative services
- Financial terms
- Performance guarantees with definitions
- Proposed maximum allowable cost (MAC) list
- Specialty drug price list
- HIPAA business associate agreement
- Plan design document
- Plan pharmacy program specifications
Savings Opportunities:

MARKET CHECKS
Market Checks

Benefits

- Market checks can be used as leverage in contract renewals to remind the PBM what level they should be performing at.
- If the current PBM refuses to meet the market check rates that are known to be consistent within the market, a plan may want to take its business to the market to procure a new PBM contract.
- In our experience, plans are often able to improve their pricing arrangements using a market check or RFP between 5%-30% of their currently contracted rates, with an average savings around 11%.
Market Checks

Overview

- Review the current pricing arrangement
- Compare the current arrangement to recent offers seen or negotiated with other PBMs
- Analyze a full plan year of data and then project forward based on assumptions identified below
- Chose pricing offers based on competitive guarantees
- Reprice projected claims using the current contract and the comparator PBM pricing
- Calculate the repriced total cost as ingredient cost, plus dispensing fees, plus administrative fees, less rebates over the projection period
- Report the findings
Savings Opportunities:

MARKET CHECK CASE STUDY
## Case Study: Market Check

### Total Cost Over Contract Period (in Thousands)

<table>
<thead>
<tr>
<th></th>
<th>Current Pricing</th>
<th>PBMA - Original Offer</th>
<th>Recommended Target</th>
<th>PBMA - Final Offer</th>
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<tbody>
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<td><strong>Admin Fees</strong></td>
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<td><strong>$24,083</strong></td>
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<td><strong>Total Estimated Savings</strong></td>
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<td><strong>$3,236</strong></td>
<td><strong>$6,314</strong></td>
<td><strong>$4,731</strong></td>
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Savings Opportunities:

POST-CONTRACT OVERSIGHT
AUDIT
Post-Contract Oversight Audit
Verifying Contract Compliance

- Once the PBM’s operations are in place, an audit is necessary to:
  - Ensure the integrity of the contracted arrangement
  - Verify that the PBM is providing the sponsor and its members all contract benefits
  - Validate invoicing and rebate payments

- 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
"There's a good chance we're not getting a good deal because of the lack of transparency." — Patrick McFarland, OPM Inspector General (June 24, 2009)

PBM Transparency — key to lower Rx costs
Questions

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- www.milliman.com/Solutions/Services/Pharmacy-benefits-consulting/
- www.milliman.com/MyRxConsultant/
Glossary

**Average Wholesale Price (AWP):** A published national average of list prices charged by wholesalers to pharmacies. Average wholesale price (AWP) is not an actual price that purchasers or PBMs normally pay. It is used by most PBMs for setting prices reimbursed by outpatient pharmacies and prices charged to plan sponsors.

**Brand Name Drug:** A patented drug generally manufactured and sold by a drug labeler (single source brand name). There are instances in which more than one labeler may produce a brand name drug. These types of brand name drugs are referred to as multi-source brand name drugs.

**Dispense as Written (DAW):** Dispensed as written (DAW) is a code indicating which party is requesting the brand to be dispensed when a generic drug is available. The DAW codes are as defined by National Council for Prescription Drug Programs (NCPDP) as follows:

0 - No product selection indicated
1 – Substitution not allowed by prescriber
2 – Substitution allowed – patient requested product dispensed
3 – Substitution allowed – pharmacist selected product dispensed
4 – Substitution allowed – generic drug not in stock
5 – Substitution allowed – brand drug dispensed as generic
6 - Override
7 – Substitution not allowed – brand drug mandated by law
8 – Substitution allowed – generic drug not available in marketplace
9 – Substitution allowed by prescriber but plan request brand
Exclusion: Exclusion means that a drug, product, or service is not covered.

Fill Date: The date the prescription was filled; sometimes called “service date.

Generic Drug: Generic drug is a drug that is no longer protected by a patent. These drugs can be manufactured and distributed by different companies and must be approved by the U.S. Food and Drug Administration. Generic equivalent drugs are the same as brand name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Generic alternative drugs are not chemically identical to the brand in question, but are in the same therapeutic class and intended to treat the same conditions as the brand in question.

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

Medi-Span: Medi-Span is a division of Wolters Kluwer Health, Inc. that publishes a master drug database that provides a codified drug dictionary, drug vocabulary, and drug pricing for prescription drugs and medication-based over-the-counter products in the United States.

National Council for Prescription Drug Programs (NCPDP): A not-for-profit membership organization (www.ncpdp.org) that creates national standards for electronic healthcare transactions used in prescribing, dispensing, monitoring, managing, and paying for drugs and pharmacy services.
Glossary

**National Drug Code (NDC):** National drug code (NDC) is an 11-digit number, which serves as a universal product identifier for drugs. The U.S. Food and Drug Administration maintains and publishes NDC numbers and listing information.

**Over-the-Counter (OTC) drugs:** Over-the-counter (OTC) drugs are drugs that can be bought without a prescription. They are not covered under most prescription plans.

**Paid Claim:** For the purposes of this report, a paid claim refers to a claim that was not rejected by the PBM.

**Pharmacy Benefit Manager (PBM):** A pharmacy benefit manager (PBM) is an entity that administers the prescription drug portion of a health insurance plan offered by plan sponsors: self-insured employers, insurance companies, and health maintenance organizations (HMOs). PBMs provide pharmacy claims processing, mail order pharmacy services, and other services, such as rebate negotiations with drug manufacturers, development and management of pharmacy networks, formulary management, drug utilization review programs, generic drug substitution, and disease management programs.

**Pharmacy Network:** A pharmacy network consists of retail pharmacies, independent pharmacies, and mail order pharmacies under contract with a PBM contractor to provide services to a prescription drug plan, typically at a negotiated discounted fee.
Glossary

**Retail Pharmacy Network:** Retail pharmacy network is also known as “network.” This refers to a negotiated list of available pharmacies. The retail network can include both national chain pharmacies and independent pharmacies.

**Specialty Drug:** Specialty drugs are pharmaceutical products that are typically expensive and require special handling and monitoring. They can be administered through injection, infusion, inhalation, or other non-oral methods. Many are biologically developed (biologics) and can be used to treat chronic, life threatening, and rare conditions such as various types of cancer, growth hormone deficiencies, multiple sclerosis, hemophilia, and rheumatoid arthritis. There is not an industry standard definition of a specialty drug; each PBM tends to have its own definition and list of drugs that it treats as specialty drugs.

**Specialty Pharmacy:** Specialty pharmacy is 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. Many PBMS own their own specialty pharmacies.

**Usual and Customary (U&C) Charge:** U&C charge is the amount a retail pharmacy will charge a patient who is not covered by a benefit plan or who chooses to self-pay for the prescription. This is also referred to as the "cash" price.
PBM Assessment Tool Implies Vendor, Provider Disconnect


Employers of participating coalitions around the country this month are getting a first look at a comprehensive tool from the National Business Coalition on Health (NBCH) comparing PBM services and may be surprised by a few of the results. While all the PBMs that participated in the evaluation scored well on various types of utilization management, they fell short when it came to engaging with members and/or physicians on some clinical aspects, according to two executives who helped develop the tool.

NBCH launched the PBM quality assessment tool earlier this year with the cooperation of six PBM vendors that allowed themselves to be rated on various aspects of their service (DBN 5/9/14, p. 3). The six vendors that completed the survey are Cigna Pharmacy Management (the in-house PBM unit of Cigna Corp.), Envision Pharmaceutical Services (EnvisionRxOptions), Express Scripts Holding Co., PerformRx, LLC (the PBM subsidiary of AmeriHealth Caritas) and UnitedHealth Group’s OptumRx and UnitedHealthcare units. OptumRx answered as a stand-alone, “carve-out” PBM, while UnitedHealthcare responded as a carve-in PBM.

The participating PBMs answered a 35-page questionnaire. Their responses were reviewed by a small team of trained consultants who assigned scores ranging from 0% to 100% to the various components covered by the survey. The tool does not include any pricing data. The results will be shared with members of 27 coalitions.

Some initial results shared by NBCH with DBN show that all plans were lacking in the following areas:

- The amount of information provided to assist practitioners in appropriate prescribing, and how and when alerts are used;
- Monitoring members on drugs for chronic conditions like asthma, chronic obstructive pulmonary disease, diabetes, coronary artery disease, depression and substance use and providing alerts for lapses in adherence;
- Adherence rates for key medications for diabetes and hypertension;
- Appropriate medication treatment of members with diabetes and hypertension and members with asthma; and
- Managing drug-drug conflicts and opioid misuse.

“I think we were surprised a little bit that they did not do a better job of monitoring adherence and notifying physicians and interested parties when patients were not refilling and so on and so forth,” observes John Miller, executive director of the Mid-Atlantic Business Group on Health, who developed the tool based on NBCH’s comprehensive eValue8 survey. “I was also a little bit surprised about the lack of management of overuse of opioids, which has become an important topic and has been getting a lot of attention these days.”

“It seemed like some of the PBMs, even though some of them do academic detailing, a lot of them don’t seem to interact with the physicians on the more clinical types of things,” adds Foong-Khwan Siew, Ph.D., director of eValue8 at NBCH.
Siew says she observed “an interesting disconnect” between what carve-out PBMs, in particular, typically say they have access to vs. what they reported in the survey. For example, some of the PBMs “don’t seem to know the ethnic-racial makeup of the people that have drugs being dispensed,” she says. “And we all know in the prescribing information there’s always special information about different types of populations. When I spoke to some of the PBMs about this, they said that between relying on the plans to have that information and the doctors to do the right thing, they really feel they don’t need to do that, which I think is absolutely crazy.”

Miller adds that the tool can be used to assist in the request for proposals (RFP) process, but that he primarily views it as a management tool that employers can use as the basis for conversations with PBMs on what areas need improvement.

“The PBM industry is becoming increasingly complex and without the experience, knowledge and proper support resources, the task of selecting a vendor and negotiating a contract that meets the objectives of your organization can be overwhelming,” remarks James Downing, Jr., director of global benefits at McCormick & Co., Inc., one of the employers that will access the tool. “The NBCH assessment is a resource that provides an apples-to-apples analysis in key areas of consideration.”

Downing adds that McCormick plans to use the tool as “a resource guide that assists in assessing the areas that are most important to our overall PBM strategy and a conversation guide when interacting with our executive decision makers.”

For more information, contact NBCH spokesperson Cary Conway at cary@conwaycommunication.com. ♦

**Early Adopters of True Choice Network Cash in by Cutting Out the Middleman**


A new limited pharmacy network that was launched by two major Las Vegas employers last year is now gaining traction in Nevada and beyond, as other plans hear of the network’s seamless implementation and documented savings. But the twist is that since the network is owned and managed by the plan sponsors, PBMs must compete for their business based on the quality of the other services they provide.

Kevin Hooks, R.Ph., a 30-year industry veteran and former PBM executive-turned-consultant, explains to *DBN* that True Choice Nevada (or True Choice America, depending on where the plan sponsor is located) was borne out of frustration at a 2012 coalition meeting, at which some of the large Las Vegas-based employer groups that he represents were voicing some very familiar complaints about their PBMs.

“It was the same old story: They’re not transparent, pharmacy costs aren’t going down, their trend is higher than what everybody else is reporting,” says Hooks, who is founder of The Virtuous Group, LLC, a referral-only consulting group that works with large self-funded employers and Taft-Hartley and public entity organizations. “So I looked at them and said, ‘All you guys ever do is complain. You pay a consultant a bunch of money to go out to RFP,
you get a contract that you think’s good and three years later you complain again….You’ve been with so many different PBMs, it’s like Elizabeth Taylor and her husbands.”"

Hooks, who founded Catalyst Health Solutions, Inc. (Catalyst Rx) in 1994 and served as that PBM’s president until a few years before it merged with SXC Health Solutions Corp. in 2012 to become Catamaran Corp., suggested that these plan sponsors essentially cut out the middleman, remove pricing from their vendor RFPs and contract directly with the pharmacies.

“This coalition had already done a pretty unbelievable job of contracting with hospitals in Nevada, so I said, ‘Why not do the same thing with pharmacies?’” continues Hooks. “I still had my retail pharmacy contacts from back in the 1990s/early 2000s, and basically built a pharmacy network that enables the employers to physically touch, feel and hold every contract. Then, once they had the rates directly with the pharmacies, they could pick a PBM based on the quality of service” in areas such as customer contacts and clinical management.

Culinary Union Local 226 and MGM Resorts International were the first two plan sponsors to adopt the network when True Choice was launched in May 2013. Now, dozens of payer groups with more than 600,000 members are poised to save a combined $15 million in the first year alone, and more payers in Nevada and other states are interested in joining as well. While these groups are mostly self-funded and public entities, Hooks says even a 50,000-life HMO is in the process of adopting the program. That plan is “small enough to where they can totally build their own internal pharmacy PBM like [UnitedHealth Group] or [Cigna Corp.], but they’re large enough to where they could still see savings in the millions of dollars,” he says.

The True Choice network typically excludes one large chain for a total of about 42,000 pharmacies, although there is an “open network” option that groups can select “based upon the least amount of disruption with the most savings,” says Hooks. “As you can imagine, the limited network option was selected 100% of the time to date” with virtually no member disruption so far.

A representative for Culinary Union explains that in addition to its own efforts to communicate the network change to its membership, Walgreen Co., the major participating drugstore chain, took several steps to kick off the new network and achieve minimal member disruption. “We do not like our participants to be inconvenienced…and [Walgreens] actually agreed to bring on temporary help for 60 days as scripts were transferred over and individuals were learning the new process, so it would be as seamless and painless as possible,” says the representative, who asked not to be identified for this article.

The discounts achieved through True Choice are greater than what Culinary Union was getting from its PBM, Catamaran, and the union has already “saved millions,” attests the representative. After conducting an RFP that vetted vendors on aspects other than pharmacy network management, the union opted to stay with Catamaran based on “price and customer service,” and wrote the use of True Choice into the PBM contract.

“Once the payer owns the network rates, it now makes ‘high touch,’ smaller and mid-sized PBMs that typically could not compete on price more palatable,” adds Hooks. As a result, employer groups can direct their full attention to “more efficient cost savings programs” such as formulary design, disease management, medication therapy management and other plan design elements, he suggests.
There are also no maximum allowable cost limits on generic drugs, which means employers are not tied up waiting for the PBM to update their MAC lists when a drug goes from a single source to multisource generic and the price drops, explains Hooks. Moreover, the network rates are based on a discount off the average wholesale price or wholesale acquisition cost-plus.

**True Choice Is Market-Ready**

“The notion of a client-owned network is not a new one,” points out Robert Ferraro, R.Ph., director of the national pharmacy practice at Buck Consultants. Caterpillar Inc., for instance, inked direct pacts with Wal-Mart Stores, Inc. and Walgreen Co. in 2008 and 2009, respectively. The difference, however, is that True Choice is essentially designed for “mass consumption,” observes Ferraro, who does not have any clients that currently use the program. “We typically see clients develop/manage a network strictly for themselves, whereas Kevin has a product that can be delivered to the market. The product is very innovative and certainly disruptive to the larger PBM’s business model,” he tells *DBN*.

Nevertheless, the model raises several questions for payers that are considering adoption, advises Ferraro. A few questions that plans may want to ask are:

- **Will the PBM try to recoup its losses of pharmacy network spread by offering less aggressive rates on specialty and mail?** Hooks says upon conducting the first RFPs in early 2013 without the opportunity for PBMs to make money on the pharmacy spread — or the difference between the drug’s acquisition cost and the reimbursement to the pharmacy — he was surprised to find that the PBMs did not significantly raise their administrative fees, nor offer considerably different mail or specialty discounts. Optimal candidates for this type of model would have low to no mail order utilization and an open specialty pharmacy network, suggests Ferraro.

- **Who owns/guarantees the retail network performance?** “In all our RFPs, whether the contract is traditional or transparent we always negotiate minimum guarantees on rates and dispensing fees that the PBM must reconcile to,” says Ferraro. In the case of the True Choice program, the guarantee is held directly with the network pharmacies via the contracting efforts with True Choice, adds Hooks.

- **Who will handle credentialing and auditing of the network?** “PBMs ensure licensing is current and use onsite or desktop audits on signature logs or outlier claims to keep the network in check,” Ferraro explains.

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**Rx Coalition Deal With Envision Promises Aggressive Discounts**


After a nine-month search for a PBM that would concede to some aggressive contract terms, the newly formed National Prescription Coverage Coalition on Sept. 18 said it contracted with Envision Pharmaceutical Services. The new pact features pricing and
guarantees for every drug currently being dispensed, as well as pricing safeguards for new drugs entering the marketplace, including specialty agents.

“Every PBM client’s costs are ultimately controlled by one matter — and one matter only — its PBM contract. But unfortunately, in today’s marketplace, virtually all PBM/client contracts are so stuffed with loopholes that the contracts are nothing but smoke and mirrors, leaving clients without any real cost controls,” laments Linda Cahn, executive director of the new coalition and president of Pharmacy Benefit Consultants, a consulting and auditing firm based in Morristown, N.J.

Enter the National Prescription Coverage Coalition, which Cahn says “upends that reality” by offering price controls that she has long sought for her plan sponsor clients and eliminates the need for entities to conduct their own requests for proposals (RFPs). Twenty-five PBMs were invited to participate in the coalition’s RFP.

**Deal Includes Specialty Guarantees**

One key aspect of the Envision agreement is that it mandates a minimum guaranteed discount on every specialty drug currently in the marketplace — more than 850 specialty drugs. In contrast, most PBM contracts guarantee discounts on only about 100 or 200 specialty drugs, while a few offer discounts on 400 to 500 specialty drugs, according to Cahn. “But that still leaves PBMs free to charge inflated prices on hundreds of specialty drugs,” she contends in an interview with DBN.

In addition to guaranteed discounts on a comprehensive list of existing specialty drugs, the contract features an automatic discount on new-to-market specialty drugs, which Cahn says almost no PBM client contracts provide. The coalition’s experts also have the right to negotiate regularly to improve the automatic discounts, and if Envision is unable or unwilling to provide as good or better discounts as are available in the marketplace, the coalition can carve out the new drug from the agreement and obtain it through another vendor, although the incumbent PBM would continue to adjudicate the claims.

Similarly, the coalition will continuously monitor Envision’s retail and mail prices for newly available generic drugs to make sure that the PBM is reducing its invoiced costs for those drugs as their prices fall.

Other features of the contract include:

**Two different generic drug ingredient cost guarantees.** One is on generic drugs that have just entered the market and are typically not competitively priced, while the other is “far more aggressive” and applies to all other generic drugs.

**Maximum price guarantees for certain commonly used generic drugs.**

**100% pass-through of financial benefits,** including but not limited to rebates, that the PBM receives from all third parties, not just drug manufacturers.

In addition, coalition members will receive a “set-up audit” that is automatically conducted after implementation to verify that the PBM accurately loads the member’s benefit plan design into its computer system. The coalition will also perform various other audits for all members, including a pass-through pricing audit based on the PBM’s actual remittance statements to pharmacies and an audit to verify pricing guarantee satisfaction.

Moreover, the agreement features extensive reporting from Envision — including detailed prior authorization reports — and the use of step therapy, quantity limit and other
utilization management programs that will result in savings, says Cahn. At the same time, the coalition retains the right to carve out any of these programs and rely on a third-party vendor.

The coalition is open to corporate, union and municipal health plan sponsors for a monthly per plan beneficiary fee. That fee is based on two core components: the number of plan beneficiaries, and the number of different benefit plan designs, explains Cahn. Each new member group commits itself to one year and can renew on an annual basis.

The contract with Envision is open-ended, meaning the coalition can contract with additional PBMs, and coalition members can move their business between PBMs. “We have created a contract that provides every coalition member with maximum flexibility,” adds Cahn.

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Consultants Give Glimpse of 2015 RFP Season, Say Service Is Key


As health plans, employers and other drug plan sponsors conduct requests for proposals (RFPs) and consider making a PBM switch for 2015, several pharmacy benefit consultants suggest service will be a top differentiator for vendor selections.

“I think [PBM industry] consolidation has impacted the quality of service on clients,” asserts Helen Sherman, Pharm.D., vice president at Solid Benefit Guidance. Some of these “service pains” created by recent mergers and acquisitions pertain to resolution on coding and other operational issues, she tells DBN. Meanwhile, Sherman says her firm’s Medicare Part D plan sponsor clients are interested in PBMs’ ability to support favorable star ratings and medication therapy management programs.

Sherman adds that she’s seeing less RFP activity by both health plan and employer clients this year and more aggressive bids by the PBMs to negotiate renewals before their clients have a chance to send out an RFP. “Most employers would like to go to the market, but it’s a very intense process,” she tells DBN. “So I would say I’m seeing PBMs successfully work through their renewals and at times renegotiating terms and conditions and services in the contract.” And that may be in part due to clients’ exhaustion from multiple implementations of Affordable Care Act requirements, she suggests.

“Our large employer clients have been particularly interested in exploring the marketplace this year,” reports Josh Golden, a consultant at Pharmaceutical Strategies Group LLC. “This is driven by two primary factors: First, inconsistent service levels across the major PBMs have left a number of clients frustrated with their incumbent. Second, our clients are learning that the competitive bid process almost always drives a better financial outcome compared to a non-competitive renewal. They’re willing to invest time and resources to pursue that additional value.”

According to the 2014 Pharmacy Benefit Manager Customer Satisfaction Report, which is based on a survey of 394 plan sponsors and conducted by the Pharmacy Benefit Management Institute (PBMI), plan sponsors are generally satisfied with their PBM, giving
them an overall rating of 7.5 on a scale of 1 to 10 (DBN 5/9/14, p. 4). PBM.s were rated on various components of their business, including service. Commitment to good customer service, one new service dimension added for the 2014 survey, received an average 7.6 rating.

“The major thing for my client base is service,” remarked Arthur Shinn, Pharm.D., of Lake Worth, Fla.-based Managed Pharmacy Consultants, LLC, when asked during a recent ISI Group LLC webinar how he helps clients differentiate between the major PBM.s during RFP season. “They don’t want phone calls from their members; that’s to them the worst thing that can happen. So they’re concerned about customer service, or member service.” Catamaran Corp., for example, is very “customer service-oriented” and put together a customer service team for a particular client with a large “foreign-speaking” membership base, he said.

Consultants Question Carve-In Deals

While stand-alone PBM.s may give employers the hard sell on their ability to manage trend and deliver the best price, carved-in entities like Cigna Corp’s PBM unit, Cigna Pharmacy Management, and UnitedHealth Group’s OptumRx are pitching their integrated solutions to potential clients. These captive PBM.s argue that keeping medical and pharmacy benefits under one roof can lead to better patient outcomes and reduce overall spending. But Golden says he doesn’t think the value of this integration has been effectively demonstrated.

“As much as I would love to see the integrated delivery model of the captives bring real value to the industry, at this point it feels more like marketing spin than true innovation,” sighs Golden. “I hear the sizzle, but I don’t see the steak.”

According to the PBMI survey, 41% of employers surveyed said they procure pharmacy and medical benefits from the same vendor, while 54% use a stand-alone PBM and 6% were unsure.

“For those medical vendors that outsource pharmacy to a separate PBM, there is an uphill battle to prove to the marketplace why their integrated bid is worth the extra layer of administration and profit margin,” adds Golden. “Clients are asking: ‘What do I lose by dealing directly with the PBM?’ I don’t think the medical vendors have answered this challenge yet.”

But Sherman has been on the other side of that conversation as former director of clinical services at RegenceRx — which serves Blue Cross and Blue Shield plans in the Pacific Northwest as RegenceRx and recently branched out to serve other health plans and employer groups as OmedaRx — and can empathize with the carved-in entities’ challenge in describing what they do.

“I think a PBM to a potential buyer can tell their story because it’s a chunk of the story; it’s less complex than trying to understand and articulate the integration piece,” she suggests. “It’s easier for purchasers to grasp those concepts and offerings than the complexity of medical and pharmacy together and how it all works.”

By “watching over the whole picture,” Sherman argues that carve-in arrangements can benefit both patients and payers. “When it comes to medications and especially specialty medications, the infused drugs are generally under the medical benefit and the self-injected drugs are under the pharmacy benefit, and there can be variations in coverage criteria just because two different organizations are developing those that may not harmonize,” she explains. “So I think from a coverage standpoint, there are significant advantages to having
that all together. For patients, it’s optimal because they’re not being bounced back and forth trying to figure out where this drug is covered. So carving in [solves] a lot of logistical issues.”

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**Plan Sponsors Continue to Weigh Narrow Networks vs. Disruption**


As PBMs like MedImpact Healthcare Systems, Inc. continue tweaking their retail networks to achieve aggressive discounts for clients, employers may need more convincing of the value proposition around narrow networks, suggest two pharmacy benefit consultants.

More than 75% of The Burchfield Group’s health plan clients employ some type of preferred or narrow pharmacy network. “However, there has not been a significant appetite for narrow networks in the employer segment,” observes Founder and CEO Brian Bullock, R.Ph. “Simply stated, the savings made available to the sponsor through narrow or preferred networks is not worth the member disruption.”

He adds, “Large groups continue to negotiate improved discounts [from PBMs] that surpass the savings from narrow networks. If and when pricing competition cools, narrow or preferred network options may re-emerge as a savings strategy for employers.”

While Pharmaceutical Strategies Group LLC has observed increased interest in narrow and tiered network arrangements from its employer group clients, Senior Pharmacy Consultant Josh Golden concurs that “actual uptake on these strategies has been slower for employers than it has for health plans. We expect to see these strategies continue to expand in the employer group segment this year.”

A recent Pharmacy Benefit Management Institute survey of employers found that the use of narrow or limited pharmacy networks remained consistent between 2012 and 2013. While 18% of respondents in 2013 offered a preferred pharmacy network, 11% offered a limited network — defined as eliminating at least one major pharmacy chain from the network — representing no major change from the previous year’s 19% and 11%, respectively (*DBN* 12/20/13, p. 3).

Golden adds that he’s noticed an increase in direct-to-employer marketing efforts by specific pharmacy retailers, which PBMs generally support “up to a point,” he tells *DBN*. “They prefer to maintain some control over the retail channel, so they are reluctant to support an arrangement that involves a direct contract between the client and the retailer, instead encouraging clients to opt into one of the PBM’s existing preferred network solutions. In some cases, they will customize these to meet client needs. A rollout of this type of strategy is relatively manageable, and can occur off-cycle, creating a unique mid-year savings opportunity for clients.”

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