What's in your contract?

A guide to successful PBM contracting

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CONTENTS

The Challenge:
Keeping Pharmacy Benefits Affordable

Employers face more and more challenges to keep the costs of their medical and pharmacy benefits affordable. New high-cost specialty drugs treat a variety of conditions like multiple sclerosis, arthritis, cancer, and rare diseases – all of which are driving up plan spend. One new orphan medication used to treat spinal muscular atrophy in children has a record price tag of $2.1 million for a one-time treatment.[1] The industry also faces pressures on drug pricing throughout the pharmacy supply chain. All told, this puts payers facing challenging decisions in less control over their pharmacy costs.

Levers to Reduce Costs

Employers often feel that they can reduce costs by increasing restrictions or member share of cost typically in the following ways:

- Increasing premiums
- Increasing co-payments or coinsurance
- Introducing or encouraging high deductible health plans
- Reducing access to certain medications via formulary restrictions
- Restricting access to certain pharmacies in a preferred or limited network

Instituting clinical programs like prior authorization, step therapy, or quantity limits. However, shifting cost to members results in complaints or “member noise,” and worse, a lack of medication adherence and compliance, which affects overall health. Another lever employers may use is to “carve out” pharmacy benefits from the medical benefit where they contract directly with a pharmacy benefit manager (PBM) in an effort to better manage their prescription plans. This can be done by using a stand-alone PBM provider or by self-insuring the pharmacy benefit with the medical provider’s PBM.

The most effective way employers can control drug costs is by enhancing the contract with their current PBM provider. What most employers often don’t realize is how continual monitoring and annual contract improvements will help plans and members pay less for their medications.

PBM contracting and negotiating can often be complex for employers. This white paper provides important insights and

Cost Shifting to Members

As plan spend continues to increase for employers and they are shifting cost to their members:

1. Premiums in Employer Sponsored programs have increased over 50% since 2009[2]

2. Individual Contribution to premiums has increased 74 percent & Employers by 48%[2]

3. Average deductibles have increased 162% in the past 10 years - vs. just 26 percent for earnings

4. More than 30% of patients are now in HDHP

perspectives on how PBMs work, and what employers need to know before, during and after contracting with a PBM to achieve the best possible pharmacy benefit cost savings.

A PBM Primer

PBMs are third-party administrators that design, implement, and manage prescription drug plans. PBMs process or "adjudicate" pharmacy claims at the pharmacy counter, also known as the "point of sale." They verify member eligibility and provide coverage, co-payment, and other drug information to the pharmacy so the pharmacy can process the prescription correctly.

After claims are processed, the PBM reimburses the pharmacy for the prescription, bills the plan sponsor for the claim, and calculates rebates as contracted with pharmaceutical manufacturers in order to reimburse the plan sponsor all or a portion of the rebate.

PBMs negotiate rebates with manufacturers for drugs on their formularies, or preferred drug lists, which indicate which drugs the plan covers. These contracts between the PBM and the manufacturer are not made available to the plan sponsor and can be difficult to audit.

PBMs also negotiate drug price discounts with network pharmacies. Plan sponsors will have the opportunity to select from a broad retail network that includes the largest number of pharmacy stores or a narrow retail network which often removes members access from one or more of the large retail network chains. The narrow retail network options often result in additional plan or member savings as the PBM can negotiate more favorable pricing through better volume commitments with those pharmacies in the network.

Some PBMs own specialty and mail-order pharmacies while other PBMs will subcontract this claim fulfillment. Plan sponsors can implement programs that require use of mail-order pharmacies for ongoing or maintenance medications that treat chronic conditions like diabetes or high blood pressure. Plans may also elect to limit specialty drug fulfillment to only the PBM's specialty pharmacies. While these programs may result in lower drug cost to the plan or to members, the mandated use of the PBM's owned pharmacies gives PBMs one more layer of control in addition to revenue from these claims particularly if an auto-refill protocol is in place.

PBMs negotiate contracts to administer the pharmacy benefit for plan sponsors, either directly with the plan or through a group purchasing arrangement or coalition. Smaller employers with fewer members find themselves in a weaker negotiating position and it may become difficult to secure strong financial terms and performance guarantees. Coalition contracts often show great initial savings, however the value may diminish over time and plans often find they have less control over plan decisions and limited to no access to claim or contract details. Coalitions often come with significant membership fees and create new revenue to both the PBM and the administrator of the coalition.

Perhaps the greatest negotiating disadvantage is PBM contract complexities. There are a number of proprietary drug pricing and fee calculation tools and techniques that PBMs use in order to manage contract guarantees. And in contracting, words matter! The use of ambiguous words, non-specific definitions and guarantee caveats and exclusions once again leave the PBM in control. The opaque intricacies of how pharmacy benefits contracts are structured can impact the value to the plan sponsor and ultimately members.

Whether it's working with pharmaceutical manufacturers or retail networks, PBMs will improve their negotiation power by using their total lives under management to help in keeping pharmacy costs down . While some of this value is passed along to plans and covered members, it is important to note that rebates with drug makers and price discounts with pharmacies also provide PBMs opportunities to generate revenue. In some cases, PBMs do not disclose the specific details of these negotiated discounts, reimbursements and percentage spreads they receive (and in most cases, are not required to disclose). The plan sponsor should seek out the greatest degree of transparency possible to more clearly understand pharmacy plan costs and the potential for savings.

A Look at the Industry: Market Consolidation with Health Plans

Payers may be disadvantaged by the consolidation of the PBM and pharmacy supply chain market. The "Big 3" PBMs dominate market share, who together processed 76 percent of prescription claims in 2018, according to Drug Channels Institute[3]. The top six PBMs handle more than 95% of total U.S. equivalent prescription claims.

The market also has added complexity as insurance carriers now own or are owned by PBMs. These and other PBMs own distribution channels such as retail, mail-order, and specialty pharmacies. With the marketplace evolving, vertically integrated organizations now have the ability to exert greater control over patient access, site of care management, dispensing pharmacies, and drug pricing. While some of this may benefit plan sponsors and members, it also has the possibility to create less choice for members and less transparency into the organizations revenue stream.

PBM Contract Terms (and What You Need to Know)

Terms and Definitions
To help better understand PBM contracts, below are some key terms and definitions that the pharmacy benefit management industry uses. We also outline where opaqueness can impact each of the components described below, along with some questions payers may want to ask.

Rebates – Payments PBMs receive from manufacturers to lower the price of drugs, often to secure a preferred position on a plan's formulary for access to members. PBMs make rebate guarantee agreements with manufacturers to lower the list price. It is important for payers to have a clear understanding of how their PBM is using these agreements to secure the best possible drug pricing for members in their pharmacy benefit.

Potential for opaqueness: Rebate contracts are closely guarded by non-disclosure agreements.

Questions to ask: Are there lower cost, equally effective drugs in the therapeutic categories that have a lower net price than the drug with the rebate? What percentage of the rebate does the PBM keep? If there is over-performance on rebate guarantees, does the PBM keep the difference? Is there additional revenue to the PBM, outside the definition of a rebate, that is attributable to utilization of rebatable drugs?

Formulary – Lists of covered drugs members can purchase through their plan. Formularies, also known as "preferred drug lists," are typically divided into tiers with certain tiers having higher out-of-pocket costs for plan members. Manufacturers' rebate payments and guarantees can determine which drugs are on a formulary tier with assigned out-of-pocket cost. Members need the most cost-effective access to medications. Sometimes, rebate arrangements for high-list-price drugs can actually cause the member to pay a very high cost out of pocket.

Potential for opaqueness: Formulary options are often tied to rebate cont*racts that may actually drive up costs when lower cost options are available. Also, "restrictions" may not be as restrictive as you might think. If a prior authorization (PA) is required, and if approved a large percentage of the time, it may cost the plan more: When approved, plans will pay for the drug and all of the fees plus the PA processing fee. If a prior authorization usually gets approved, the plan sponsor should request an evaluation of the drug's formulary status.*

Questions to ask: Are there drugs on the formulary that will cause my members to pay the list price at any point in time? What is the percentage of restricted drugs that are ultimately approved via the PA process? How many members (number and percentage) will be disrupted (negatively impacted) by your formulary compared to what they have today?

Specialty Drugs – Specialty drugs are typically the highest priced, so payers need to work closely with PBMs to manage this category closely as members often have a significant out-of-pocket cost. Payers also need to ensure their PBMs are helping to mitigate the budget impact of newly FDA approved specialty drugs. PBMs should be educating payers on new high-cost medications for which payers will need to prepare strategies to manage, including budget impact. Hepatitis C medications in 2014 caught many payers (and PBMs) by surprise. Since then, the industry has become more proactive in preparing plans for budget impact. Plans should be receiving regular updates from their PBMs on upcoming high-cost drugs in the pipeline.

Questions to ask: How will you help me prepare for the impact of upcoming, high-cost medications? Will they automatically be covered? What is the amount of spend I may see based on my population? What are industry standards of care we must follow, and are there ways to manage the impact? Are my members required to use your specialty pharmacy? Do you administer an auto-refill program for specialty drugs? Do you have policies for limited first fills for therapies with high abandonment rate due to adverse effects?

Prior Authorization (PA) – There are some prescribed medications that are generally higher priced in a formulary that may require a PA, verifying the drug is appropriate for the member. Payers can request a list of drugs most often requiring a PA and why they require PA.

Potential for opaqueness: Verify that drugs that require a PA are not processing with high approval rates. If they are, plans are unnecessarily paying for PA processing fees for drugs that tend to get approved anyway.

Questions to ask: How much is each PA fee (clinical and operational PAs)? Do excluded drugs, such as lifestyle drugs, have the option to be approved via PA? What percentage of PA drugs are approved?

Auto-Refill – Auto-refill is an option whereby pharmacies automatically send maintenance medications to members with chronic conditions on a regular basis (monthly for 30-day supplies and quarterly for 90-day supplies) to ensure that medications don't run out, which can negatively affect adherence and compliance. Payers need to make sure auto-refills are not automatically being charged against their pharmacy benefit plans if members are not continuing to take the medication, as this leads to unnecessary spending. If payers wish to make auto-refill available to their members, they should know what the PBM/pharmacy protocol is for auto-refill.
Potential for opaqueness: This area can be a huge cost driver to the PBM – unnecessarily leading to stockpiling of medications. PBM pharmacies (mail order and specialty) and network pharmacies that administer an auto-refill program will automatically dispense refills based on specific refill protocols for how much medication the member may still have on hand from the previous dispense. PBM contracts will often set that range to be between 60-percent to 84-percent of the previously dispensed days' supply. Early refill programs can result in members receiving up to one extra 90-day supply at the end of the year, costing the plan and the member more than necessary.

Questions to ask: Do you have an auto-refill program? What is the protocol for sending refills automatically to members? What policies do you have in place to ensure refills are not sent when a member asks to discontinue receiving auto-refilled prescriptions?

Employer Group Waiver Program (EGWP) – An additional component of an employer-sponsored pharmacy benefit plan that can be offered to retired employees. An EGWP is a Medicare Advantage Plan contracted through CMS that can provide lower cost drug benefits to retirees than other Medicare or supplemental benefit plans. EGWP benefits are partially funded with federal government money and partially co-funded by the employer. Employers who offer an EGWP in their pharmacy benefit provide employees the opportunity for uninterrupted cost-effective drug coverage from work to retirement. Employers need to monitor, with their PBM, changes in federal funding of Medicare Advantage as well as increases in retirees to manage potential risks of spikes in overall pharmacy plan costs.

Potential for opaqueness: You may not know what changes in EGWP federal funding are occurring and how they may impact your plan.

Questions to ask: Ask your PBM how they will keep you updated on all changes in EGWP, particularly in funding.

Pharmacy Networks – PBMs contract with pharmacies to be included in their networks so members have easy access to pharmacies to fill their prescriptions. There are several network options – some that lead to lower costs, and some that actually have the potential to drive up costs.

- Limited pharmacy networks typically excludes one of the two large national retail pharmacy chains in exchange for better pricing discounts from the competitor.

- A preferred network is similar, but the disadvantaged chain pharmacy has a higher copay differential that incentivizes the member to use the competitor's pharmacy.
- Performance networks offer certain performance guarantees that drive plan savings.

Potential for opaqueness: If a performance network over-performs, the PBM may share in the over-performance if it is disclosed to the payer. The spread pricing may increase to the additional benefit to the PBM if networks disadvantage certain pharmacies.

Questions to ask: If you have a limited or preferred network, ask the PBM what the differential is in discounts between what they pay the pharmacy and what they charge the plan. This is often done in the requests for proposals. If they have a performance network, ask how the money associated with the over-performance is dispersed. If the PBM is proposing a change in network configuration, ask for an estimate of savings and what the member disruption or negative impact will be to the member.

A Payer Checklist for PBM Contracting

There is no such thing as "standard" language in a PBM contract, and contracts vary from PBM to PBM. Payers are ultimately responsible for negotiating the most favorable contract terms, and clear definitions in contracts help protect the plan and its members. Here is a checklist of contract considerations that should be addressed:

1. **Definitions-** Need to be clear, particularly for how drugs are categorized and especially generics; Anything ambiguous could result in claims that can shift more costs to employers.

2. **Guarantee Exclusions –** Most common claims should not be excluded when financial guarantee language is agreed to between an employer and a PBM (permissible exclusions could be 340B claims and paper claims); Employers should minimize exclusionary language for areas such as rebate and discount guarantees to preserve their maximum value in the contract.

3. **Specialty Guarantees –** Typically the single biggest cost driver of pharmacy benefit plans, employers should ensure separate specialty drug financial guarantees are well defined and written into their contracts, specifically:
   - Specialty drug retail rebate guarantee
   - Specialty drug retail discount guarantee
   - Specialty drug mail order/specialty pharmacy discount guarantee; and
   - Specialty drug mail order/specialty pharmacy rebate guarantee

4. **Performance Guarantees –** Employers establish predetermined levels of service with the PBM and, if not met, the PBM remunerates dollars back to the employer; Employers should negotiate performance guarantees on agreed amounts or financial targets (at-risk dollars to the PBM) for what PBMs will compensate back if not met, typically a dollar amount per employee plan member and a different dollar amount per non-employee plan member for each performance guarantee not met. Employers should also make sure performance guarantees are written into contracts annually and that employers can change the allocated the dollars at risk for each guarantee annually.

5. **Offsetting Language –** Should not be included if at all possible or minimized as offsetting can undervalue financial guarantees; Every category of financial guarantee – such as rebates, discounts, generic dispensing rates, specialty drug price caps or clinical outcomes – should be listed separately by dispensing channel and not combined in any way in contract guarantees

6. **Market Checks –** Employer contracts with PBMs typically include language that allows the employer the opportunity to benchmark the financial pricing of their contracts against industry and competitor rates over the contract's tenure (sometimes annually, but at a minimum in year 2); Employers should seek to receive (and have included in contract terms) improvements in pricing equal to or better than pricing determined by the market check benchmarking.

7. **Contract term and termination –** Employers should aim to negotiate for short contract terms and/or contract language that provides the maximum number of options and scenarios where they can terminate their contract if they need to. PBM contracts should be negotiated to allow termination without fee and without penalty. If termination fees or penalties will apply, they should be clearly outlined in the PBM contract.

8. **Reconciliation –** Employers should establish contract terms with the PBM for a set schedule of financial guarantee payments (e.g. minimum rebate as well as full rebate pass-through, discount and drug dispensing fee guarantees), and reporting of these payments; To minimize delays in these payments, employers should negotiate the soonest possible reporting notifications and payment within 30-180 days after the close of a quarter or contract year.

9. **Payment Terms –** Terms of payment and schedules of how often payments are made by the employer to the PBM for fees and claims submitted are typically incorporated into the contract. Employers should seek to negotiate reasonable time periods with their PBM for making these payments in their plans.

10. **Allowances and Credits –** Just like in a mutual fund plan, there are fees and costs for PBM management and oversight services of an employer's pharmacy benefit plan. However, PBMs will frequently provide financial allowances and credits for most of these fees, including general plan administrative credits, plan audit credits, member and plan sponsor communications credits and other credit areas. Employers should make sure a maximum number of credits are included and spelled out in the contract and utilized before the end of the contract.

11. **Data Rights –** Employers should codify within their contracts maximum access rights to any and all of their contract-related data and documentation for their own use, a third party's use, or the PBM's use to help manage plan performance, contract compliance, ongoing plan improvements and services; Plan data and documentation can be used to develop new analytics and reporting types, research and statistical analysis, and for identification of trends and insights.

12. **Changes –** Ongoing employer and member updates of proposed changes to categories like drug price lists, formulary tier switches of medications, and co-pay and overall plan benefits

13. **Transparency –** While securing full disclosure of contract payment and pricing methods remains challenging, PBMs may be more amenable to sharing more of this information with employers given new local laws and national legislative initiatives mandating various aspects of drug pricing and cost transparency, including MAC drug lists.

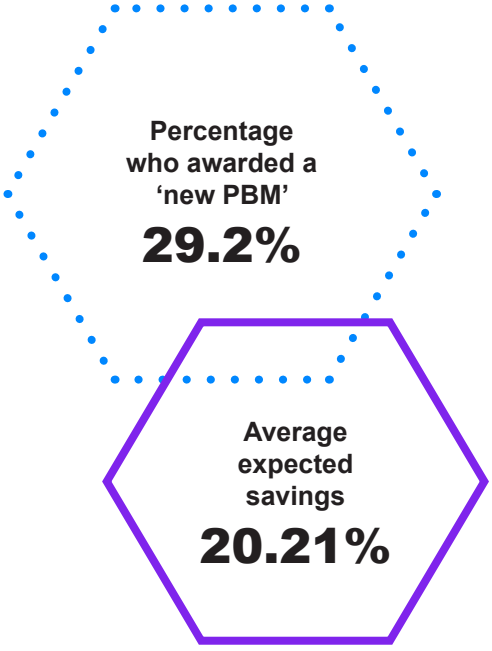
14. **Terminology & definitions –** The contract should include mutually agreeable language with clear definitions for each item that can impact the way drugs are priced, rebated, and guaranteed.

Opportunities to Improve PBM Contracts

With a clearer understanding of what PBMs do, how the money flows through the supply chain, and how PBMs contract, payers are more equipped to assess their options in PBM contracting. Payers' ultimate goal is to negotiate a contract that effectively cuts costs without cutting benefits.

Payers can ask for pricing improvements throughout the contract term. Options include:

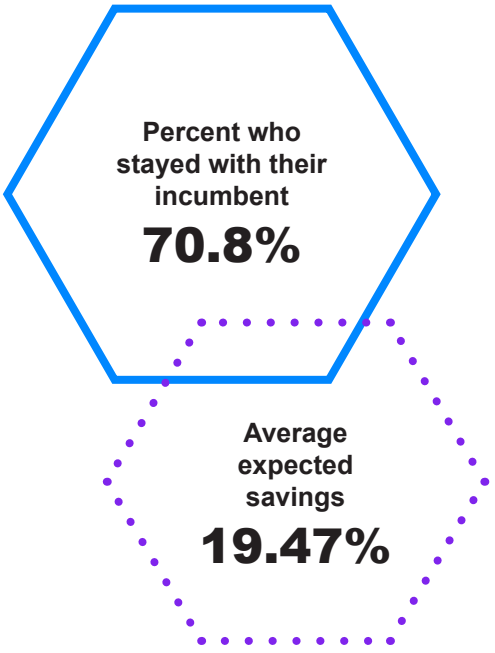
1. Market check: typically done in year two of the contract or every year if desired
2. At contract renewal, payers can go out to bid to drive competitive pricing in a reverse auction process
3. And payers can assess their contract performance at any point during the year via ongoing oversight



Overall average savings 20.01%

Employers often find that current contract terms and conditions – and pricing –can be improved. If market checks don't have the savings payers need, they may wish to go out to bid to see if other options would result in additional savings. Oftentimes, payers go out to bid and find the incumbent PBM offers deeper savings when put through a competitive bid process. It is important to note that PBMs compete with each other to earn their business. The process may result in deeper plan savings without having to change PBMs.

For instance, Truveris clients with more than 2,000 lives that went out to bid with a 1/1/2020 start date via a PBM reverse auction platform are projected to save an average of 20 percent of total plan costs over a three-year contract. Not all plans moved to a new PBM to benefit from the savings – 71 percent of plans stayed with the incumbent PBM and still had a projected savings of 19.5 percent of total plan costs.



Employers with an average life count of 1,075 moved to a new PBM 51 percent of the time with an expected savings of 28 percent over a three-year contract. The remaining plans stayed with their incumbent PBM and had an expected savings of nearly 18 percent.

There is a Better Way to Buy and Manage Pharmacy Benefits

Human resources benefits managers are charged with managing a variety of benefits, from life and disability insurance to medical insurance and pharmacy benefits. Selecting a PBM typically includes a complex process that requires an understanding of how PBM contracts work and ends in spreadsheet comparisons that focus on unit price rather than total plan costs. The complex pharmacy benefit contract negotiating process can be simplified for payers. With PBM-focused technology and expertise, third-party advisors can help with the process.

At any point in the contract term, an employer should also have ongoing access to their data so they can analyze PBM contract compliance and plan performance. With access to PBM-focused technology and expertise, payers can identify any discrepancies in the areas of claims adjudication accuracy, contract compliance, and performance guarantee verification. If the employer is not satisfied that their PBM has addressed and fixed the discrepancies, they can work with a third-party advisor in PBM contract oversight for correction.

Third-party advisors can help payers with PBM negotiations so they can be confident in the contracting process and assist in managing ongoing and emerging issues impacting pharmacy benefits throughout the contract term.

While there is a convergence of various market and regulatory forces at federal and state levels advocating for greater transparency, we are not there yet. And yet, greater transparency is possible.

Need help getting started?

Truveris is the leading pharmacy benefits procurement, oversight, and insight solution provider. We help employers measure and manage the PBM procurement and oversight process with our proprietary purpose-built platform. Contact us **www.truveris.com** to learn more.

Works Cited

1 Feuerstein, A., 2020. Novartis Gene Therapy For Fatal Disease Delivers Strong Sales. [online] STAT. Available at: <https://www.statnews.com/2020/01/29/novartis-gene-therapy-for-fatal-childhood-disease-delivers-strong-sales-during-fourth-quarter/> [Accessed 19 July 2020].

2 KFF. 2019. 2019 Employer Health Benefits Survey - Summary Of Findings. [online] Available at: <https://www.kff.org/report-section/ehbs-2019-summary-of-findings/> [Accessed 19 July 2020].

3 Adam J. Fein, P., 2019. CVS, Express Scripts, And The Evolution Of The PBM Business Model. [online] Drugchannels.net. Available at: <https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html> [Accessed 19 July 2020].