Effective Contracting with Pharmacy Benefit Managers:

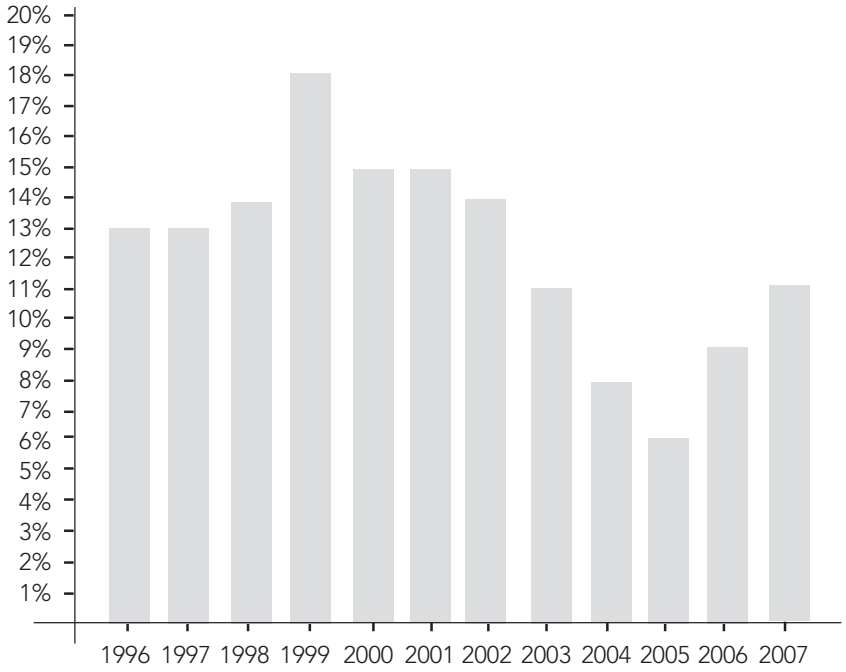
Protecting a plan sponsor's resources

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.

FIGURE 1

AVERAGE ANNUAL PERCENTAGE CHANGE IN U.S. PRESCRIPTION-DRUG EXPENDITURES, 1996-2007



Source of data for 1996–2006: Kaiser Family Foundation, "Prescription Drug Trends," Fact Sheet #3057-07 (September 2008), p. 1. Available at http://www.kff.org/rxdrugs/upload/3057_07.pdf. Source of data for 2007: Milliman Press Release, May 14, 2008, available at *http://www.milliman.com/news-events/press/pdfs/milliman-says-2008-medical-PR05-14-08.pdf.*

Pharmacy Benefit Managers (PBMs) play a central role in managing prescription-drug benefits. Plan sponsors rely on PBMs to provide their members with access to affordable medications through an efficiently run delivery system. But are they getting the best possible services at a reasonable cost?

Effective PBM contracting can save money while helping maintain the health of plan members. It is important for plan sponsors to evaluate the services they are getting from their PBM, review costs and quality, and consider changing vendors if their current PBM doesn't measure up to expectations.

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?

[1] Kaiser Family Foundation, "Prescription Drug Trends," Fact Sheet #3057-07 (September 2008), p. 1. Available at *http://www.kff.org/rxdrugs/upload/3057_07.pdf*

[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 PBMs (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 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 guarantee 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 to not 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.

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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 to80 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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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:

Pharmacy Benefit Management Institute, Prescription Drug Benefit Cost and Plan Design Report 2008-09 Edition. Available at *http://www.pbmi.com/product.asp?id=54*

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.

[3] Adapted from U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), available at http://www.hrsa.gov/opa/glossary.htm.

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.