



Eliminate All PBM Contract Loopholes

by | Linda Cahn

Maximizing prescription coverage savings depends on writing and obtaining a PBM contract that is free of loopholes and adding savings programs.

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ur PBM always seems to be playing ‘dirty tricks’ on us,” a coalition representative recently bemoaned. “No matter what we do, we don’t obtain the savings for our member plans that we expect.”

Not surprisingly, a review of the pharmacy benefit management (PBM) contract showed that the so-called dirty tricks all flowed from numerous contract “loopholes.” While the coalition labored to ensure its members reduced and controlled their costs, plan costs continued to increase.

Basic Contract Concepts

For a contract to protect a plan—and decrease and thereafter control costs—the plan sponsor needs to cling fast to several core contracting concepts:

- Every contract ambiguity must be eliminated, lest the PBM be free to interpret the contract differently from the way the plan sponsor might expect. A plan sponsor will have a problem if it reviews any contract provision and can’t determine *precisely* what it means.
- Every contract contradiction must be eliminated, lest provisions the plan sponsor is

- relying on have no value. In a dispute, the plan sponsor will point to certain language, and its PBM will point to different language. And the plan sponsor likely will be left holding an empty wallet.
- It's the plan—not its PBM—that will be disadvantaged by any weak or ambiguous or contradictory contract term. Remember how the process works: The PBM invoices the plan sponsor, the plan sponsor pays the PBM, and if and when the plan sponsor conducts an audit and there's a dispute, it's the plan sponsor that needs to be reimbursed because the PBM failed to satisfy clear contract terms.
 - Like an orchestra that's only as strong as its weakest player, a contract is only as strong as its weakest provision—particularly its weakest financial provision. If every contract loophole except one is eliminated, the PBM will be free to use that loophole to “take back” the savings generated from all the plan sponsor's other efforts, and perhaps charge even more.
 - Similarly, a plan sponsor must make sure it has a “control” over

every cost, or its PBM will be able to overcharge the plan for that cost. For example, a price guarantee must cover all drugs in the category being guaranteed or, if certain drugs are excluded, those must have some other form of “price control” over them to control their costs.

In short, a plan sponsor must view its PBM contract as if it is a balloon filled with money that the PBM is obtaining from multiple contract deficiencies: If the plan sponsor squeezes the balloon to eliminate some—or even most—contract deficiencies, the PBM will take just as much of the plan's money—or perhaps even more. The PBM will just shift where it gets its money from the deficiencies that have been eliminated to the deficiencies that remain. Accordingly, a plan sponsor that wants to decrease and thereafter control its costs must pop the balloon entirely and eliminate *all* contract deficiencies.

Here's a description of a few of the contract problems that must be addressed.

PBMs' Definitions

For a contract to be without ambiguities, every significant contract term must be clearly defined in the contract's

definition section. And each definition must eliminate all “wiggle room” that might allow a PBM to interpret the term however it chooses.

Unfortunately, defective contract definitions are the rule, not the exception, in PBM contracts. PBMs' boilerplate contract definitions for core terms like *brand drug*, *generic drug*, *specialty drug* and *rebates* almost always work in the PBMs' favor.

For example, for years a large PBM has contractually defined *brand drug* to include any drug “subject to patent litigation.” But every drug is subject to patent litigation! Therefore, the PBM is free to define any drug as a brand drug.

Relying on that short phrase, the PBM has repeatedly claimed in audits of its guarantees that it can categorize many commonly used generic drugs as brand drugs. For example, it has treated gabapentin (Neurontin) as a “brand drug,” even though gabapentin became available as a generic in 2004, and discounts of average wholesale price (AWP)—80% have long been available for gabapentin.

The PBM's categorizations enable the PBM to shift an enormous number of commonly used generic drugs into the PBM's calculation of its satisfaction of its “brand drug” contract guarantees of about AWP—18%. Doing so enables the PBM to easily satisfy its brand drug guarantees, while simultaneously charging more for all drugs that are actually brand drugs.

Moreover, when the PBM shifts less-well-discounted generics (of say, AWP—45%) into the brand category, it doubles its benefits: It *adds* the weak discounts (e.g., 45%) into brand drug guarantees of, say, AWP—18%, mak-

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ing it easier to hit its brand guarantees, and it *removes* the weak discounts (e.g., 45%) from its generic guarantees of, say, AWP – 70%, making it easier to satisfy those guarantees as well.

Other definition loopholes that are common in PBM contracts allow a PBM to:

- Classify drugs as *brand* and *generic* based on the PBM's discretion. (Why bother having a definition, if the PBM gets to determine the definition after the contract is executed?)
- Classify drugs based on the PBM's own, undisclosed algorithm (ditto)
- Classify drugs as *brand* and *generic* based on First DataBank or Food and Drug Administration (FDA) classifications (a meaningless definition, since First DataBank and FDA don't provide *brand* and *generic* classifications)
- Identify *specialty drugs* as any drug that fits into one of many loose and vague descriptions (at least one of which typically describes many drugs that aren't specialty drugs). As a result, clients have no way to reliably identify specialty vs. nonspecialty drugs.

Plan sponsors that review at their PBM contract definitions are very likely to discover at least one of those problems.

Eliminating all such loopholes will require a plan sponsor to change its PBM's boilerplate definitions. To address a contract's brand drug/generic drug definitional problems, the plan might want to contractually require its PBM to use Medi-Span's actual indicators to define brand and generic drugs. To eliminate a specialty drug definitional problem, the plan sponsor might create a contract exhibit list identifying every specialty drug as of the inception of the contract, contractually require the PBM to amend the list every quarter based on the plan sponsor's written approval of new-to-market specialty drugs, and cross-reference the list (and all amendments) in the *specialty drug* definition.

In short, *every* core term in the PBM contract should be defined, and *every* definition needs to be airtight.

The Pass-Through Pricing Myth

Most PBMs claim to provide "pass-through pricing," not "spread pricing." But few actually do.

Pass-through pricing requires the PBM to pass through, for *every* drug dispensed, the PBM's actual drug costs. Thus,

a pass-through pricing contract makes clear that the only profits a PBM can make are those contained in the plan sponsor's administrative fee.

In contrast, *spread pricing* allows a PBM to make an unknown and unknowable profit spread based on the difference between the amounts the PBM pays for drugs (which the PBM is never willing to disclose to the plan sponsor) and the amounts that it invoices.

Although most PBMs claim that most of their contracts are pass-through pricing contracts, typically such contracts provide retail pass-through pricing without identifying which of the PBM's many contracted pharmacy rates the PBM will pass through. That allows the PBM to pass through its weakest rates to its pass-through clients. Moreover, typically PBMs' so-called pass-through pricing contracts allow spread pricing for mail and/or specialty drugs. Notably, most PBMs now own their own mail and specialty pharmacies, meaning the PBMs are able to keep all profit spreads for themselves.

Useless Guarantees

Virtually all PBM contracts contain numerous price guarantees. Plan sponsors—and consulting firms—evaluate the savings they expect to achieve based on those guarantees. And then, after implementation, clients wait until a year has passed to use audits to see if their PBMs satisfied the guarantees. Unfortunately, it's only then that clients learn (assuming their auditors are competent) that their guarantees are riddled with loopholes.

To begin with, many guarantees are based on ambiguous *brand* and *generic* drug definitions. For example, the contracts contain ingredient cost—and dispensing fee—guarantees for retail "brand," retail "generic," mail "brand" and mail "generic" drugs. The contracts also contain "per brand script" rebate guarantees. However, as previously described, if the contract's definitions of *brand* and *generic* allow the PBM to transform "brand" drugs into "generic" drugs, and "generic" drugs into "brand" drugs, the PBM can easily satisfy its guarantees and still overcharge the plan sponsor simply by wrongly categorizing drugs.

Also, almost no contracts require PBMs to classify each drug the same way for all purposes. Thus, a PBM can simultaneously classify a specific drug as (1) a *generic* for adjudication purposes (meaning the plan will pay more money given a participant's lower generic copayments); (2) a *brand*

takeaways >>

- Any ambiguities or loopholes in a contract may end up costing a plan sponsor more than it should be paying.
- Every significant contract term needs to be clearly defined and not open to interpretation.
- Many contracts that include price guarantees allow a PBM to classify the same drugs differently for various purposes.
- A transparent contract should allow a plan sponsor to choose its own auditor and not prevent the auditor from reviewing what should be reviewed.
- The plan can save more money by implementing savings programs such as mandatory generic, prior authorization, step therapy and quantity limit programs and a highly tiered formulary.

for guarantee purposes (making it easier for the PBM to satisfy its guarantees); (3) a *generic* for rebate purposes (enabling the PBM to decrease the amount that it pays under per brand script rebate guarantees); and (4) a *generic* for calculating its “generic fill” rates (thereby potentially misrepresenting how often participants actually use generic drugs).

Most contracts also fail to define which drugs will be included in, or excluded from, guarantees, leaving a PBM free to exclude many drugs from guarantees and charge whatever the PBM wants for those drugs, or include many low-cost drugs in guarantees even though the PBM had nothing to do with the drugs’ low costs. Or contracts specifically exclude many drugs that shouldn’t be excluded (like specialty drugs dispensed from retail pharmacies), leaving clients without any contractual “pricing control” over those drugs. Or contracts specifically include many low-cost drugs that shouldn’t be included that weaken the utility of the guarantees (like 1¢ drugs, Veterans Affairs drugs or *340b* drugs—those dispensed through the federal 340b program that requires drug manufacturers to provide outpatient drugs

to certain entities at significantly reduced prices).

The Rebate Labeling Game

Most PBMs also play what our firm calls “The Rebate Labeling Game.” Here’s how it works:

PBMs write contracts with their clients where they agree to pass through all rebates from drug manufacturers. However, PBMs also write contracts with drug manufacturers that require the manufacturers to pay not only “rebates,” but also money with many other labels, such as *administrative fees, purchase money discounts, health management fees or data sales fees*. Plus, PBMs write contracts with other third parties, such as wholesalers and distributors, to receive many other kinds of financial benefits.

As long as any third-party financial benefits that the PBMs receive are not labeled with the same label as contained in the PBMs’ contracts with clients, the PBMs get to keep the money.

Stated otherwise, unless a plan sponsor’s contract makes clear, in unambiguous airtight language, that the PBM must pass through the plan’s pro-rata share of all financial benefits the PBM receives from every third

party—and the contract identifies a feasible way to measure and audit the PBM’s pass-through of that pro-rata share—the PBM will deprive the plan of immense savings it otherwise could obtain.

Anything-But-Transparent Contracts

A “transparent” contract requires that the PBM lets the plan sponsor see—and audit—all documents and data related to all core contract matters, including, at the very least: (1) the PBM’s actual reimbursement costs for retail drugs; (2) the PBM’s actual acquisition costs for mail and specialty drugs; (3) all third-party financial benefits the PBM receives, not just “rebates” from drug manufacturers; (4) the PBM’s contracts with retail pharmacies; and (5) its contracts with all other third parties that result in any financial benefits.

A transparent contract must also enable a plan to select its own auditor, allow the auditor to review and report to the plan sponsor on all the above-described documents and data, and not in any way circumscribe any work the auditor needs to perform. Unfortunately, virtually all PBM/client contracts prevent those activities from occurring.

A plan sponsor that reviews its con-

tract is almost certain to discover language that restricts the auditors the plan sponsor can retain, allows the PBM to “mutually approve” the auditor (a provision that enables PBMs to veto the most competent and independent auditors), and requires the auditor to sign a confidentiality agreement (that will preclude the auditor from seeing what he needs to see and reporting to the plan sponsor on what it needs to know).

PBMs also know that auditors rarely tell their clients about the confidentiality agreements the auditors sign, even though auditors know the agreements may undermine their audits’ effectiveness. Why do auditors keep silent? Because they know that if they complain about PBMs’ confidentiality agreements, PBMs will be unlikely to “approve” the auditors the next time the auditors try to conduct an audit.

In sum, unless a plan sponsor rewrites its PBM’s boilerplate contract, generates language that requires real transparency by detailing the documents and data the PBM must produce, and attaches as an exhibit its version of an appropriate auditor confidentiality agreement (eliminating all PBM requirements that will gut the possibility of a meaningful audit), the contract will not be a “transparent” contract, no matter what a PBM may claim.

Renegotiation, Carve-Out and Termination Rights

Today’s prescription drug marketplace is rapidly changing. PBMs are merging, and new PBMs willing to provide better terms are entering the marketplace. Brand drugs are losing their patents, and more low-cost generic drugs are becoming available. Numerous new specialty drugs are entering the market, and existing specialty drugs for the first time are becoming available at lower costs.

Accordingly, any contract that locks a plan sponsor into its specified terms—and precludes the sponsor from terminating the contract unless there is a “material breach” or “cause”—is a bad idea. Every PBM contract should allow plan sponsors to terminate “with or without cause, on 90 days’ notice.”

If a plan sponsor wants to decrease and control its costs over time, its contract must also contain detailed “rights to

renegotiate.” Renegotiation rights at least should include every guarantee and the plan sponsor’s administrative fees, and should be quarterly or annual, depending on what they are addressing.

To ensure that a PBM will renegotiate in good faith—and be willing to provide a plan sponsor with consistently competitive terms—a contract must also contain carefully drafted “carve-out” rights. For example, by contractually

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providing a plan with the right to carve out any (or all) specialty drugs, a plan sponsor will have the leverage to revise and continuously obtain competitive specialty drug pricing. Plus, if the contract contains “90-day with or without cause” termination rights and a PBM raises difficulties during negotiations on too many matters, the plan sponsor will have the flexibility to terminate the contract essentially whenever it wants and take its business elsewhere.

Savings Programs With Holes

A plan can achieve significant savings if it drafts and insists on obtaining an airtight PBM contract. Having done so,

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the plan can achieve even greater savings by implementing savings programs, like a mandatory generic program, prior authorization program, step therapy program, quantity limit program and a highly tiered formulary.

However, the converse is also true. Without an airtight contract, the plan sponsor may end up spending far too much money. And without savings programs, it will forfeit the ability to seriously decrease its costs. Here's why:

An airtight contract ensures that the unit price a plan pays for a product will be low. Savings programs ensure that participants have incentives (1) to use certain products rather than others (for example, low-cost generics rather than high-cost brands) and (2) to purchase appropriate amounts of drugs (for example, by limiting the quantity of an initially dispensed oncology drug, because most patients rarely stay on the same oncology drug for very long).

When a new coalition client recently asked our firm to analyze its loophole-ridden contract, and we simultaneously learned it had not implemented truly effective savings programs, our firm was able to witness the impact of both problems. Reviewing the group's costs for the antidepressant Prozac and chemically equivalent generic fluoxetine illustrates what we learned.

An analysis of only a few months of claims data showed that the client's existing PBM was grossly overcharging the client for generic drugs— invoicing an average cost of \$16 per retail fluoxetine script when a reasonable cost would be \$4-\$10 per script, and \$48 per mail fluoxetine script when a reasonable cost would be \$10-\$25 per script.

Moreover, because brand Prozac is so much more expensive than generic fluoxetine and the client did not have a mandatory generic program in place, although members had used only ten Prozac scripts and 328 fluoxetine scripts during the short

period, the total cost for the ten brand scripts was more than the total costs of the 328 generic scripts—\$7,233 vs. \$7,129.

Thus, if the client was serious about controlling its costs, it could easily reduce its costs by more than 50% on this single drug simply by (1) changing its contract and forcing its PBM to provide appropriate pricing and (2) implementing a mandatory generic program that would require members to use fluoxetine or pay the difference between Prozac's and fluoxetine's costs. Together, those two steps would ensure that the client's only cost would be the newly reduced cost it had achieved for fluoxetine, leaving the few members who had previously insisted on purchasing Prozac to either switch to fluoxetine or pay the difference in the two drugs' costs. After all, why should ten people be allowed to buy a brand drug and cost a plan more than \$7,000 when several hundred members are buying a chemically equivalent generic drug for less than that amount?

Conclusion

To increase prescription coverage savings, plan sponsors must obtain PBM contracts that are entirely free of loopholes. To do so, a plan sponsor can conduct a request for proposal (RFP), draft and negotiate an entirely different form of PBM contract, and use the RFP's leverage to get at least one PBM contestant to accept its contract terms before it selects a PBM as its finalist. Thereafter, the plan should keep abreast of new developments and renegotiate pricing terms and guarantees regularly. The plan should also monitor PBM's satisfaction of all contract terms through audits. And it should implement savings programs to ensure it is creating incentives for participants to select low-cost drugs and purchase only the quantity of drugs they are likely to use.

A plan that is too small to undertake those tasks, or is large and hasn't the time, may want to consider joining a coalition. However, before doing so, the plan sponsor should review the coalition's contract with its newly trained eyes and make sure the contract has eliminated at least the deficiencies stated in this article. Otherwise, the plan sponsor will be adding to its costs with the coalition's additional fees but will find that it is no better off.

In sum, at a time when plans are desperate to decrease costs, no plan should be paying for drugs pursuant to a loophole-ridden PBM contract and ignoring the savings that can be achieved via carefully crafted and effective savings programs. ■