Answering Questions About Pharmacy Benefit Management Contracts

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Several community pharmacists have inquired about PBM agreements and what they should know. In response to these requests, the following article addresses those agreements and their collateral issues. It is written by a managed-care consultant and a retired community pharmacist. The questions and opinions are those of the authors and not of any other entity.

Pharmacists sign agreements with payers, i.e., pharmacy benefit managers (PBMs) and Health Plans, to provide prescription services to beneficiaries of health plans and purchasers' members. *[Note: For the sake of definition, payers are PBMs and health plans who pay bills, from the money provided by purchasers, (i.e., employers), both public and private. Beneficiaries are interchangeably referred to as members or patients.]* Purchasers contract with payers to negotiate payments for medications based on market rates for comparable products and services. These agreements contain rates for various networks (i.e. retail, mail, specialty, long-term care, etc.) The system is further compounded by the fact that many retail pharmacy chains also own PBMs.

Community Pharmacists Want to Know

Q What type of PBM agreements are there?

A From the purchaser's perspective there are generally three types of agreements with PBMs – *standard, pass through,* and *transparent. Standard* agreements provide a complete portfolio of PBM services including various pharmacy networks (independent, chain, deep discount, etc.), mail service, prospective and retrospective drug utilization review (DUR), specialty pharmacy, etc. Pricing for standard agreements includes AWP discounts for branded medications that guarantee average discounts due to different contracts with different pharmacy networks. Generic medications are paid at MAC with a guarantee based on average or "effective average" AWP discounts. Purchasers choose this option if they require maximum support for their pharmacy benefits.

Pass-through agreements, on the other hand, provide either a complete portfolio of services or a reduced portfolio that provides pricing guarantees, but may not include as much DUR and clinical support as the standard model. Pass-through models are presumably "transparent" because they contain no "pharmacy spread". *Pharmacy spread* refers to the element of agreements where the purchaser pays the PBM one fee and then the PBM pays the pharmacy another fee and keeps the difference. When an agreement does not contain spread it is known as "pass-through pricing." Purchasers choose this option if they require less support and have a legal or benefit-defined need for more transparency in vendor agreements.

There is a third model for agreements that is presumably *fully transparent. Fully transparent* indicates that all elements of the agreement are open for the purchaser to review. The purchaser pays only what the pharmacy submits for payment, all pricing is based on actual pharmacy contracts, and all elements of rebate contracts are open for audit. Purchasers choose this option if they have legal, CMS, Medicaid, ERISA, or other requirements for complete pricing and rebate transparency in vendor agreements.

In all of the above agreements, the PBM defers to the pharmacist for their professional judgment and compliance with all applicable state and federal laws.

Q Are all prescriptions paid at AWP minus 15.25%, plus a fee or something like that? Does the MAC mean anything to me?

A While a specific agreement between a PBM and a pharmacy includes payment terms for brand and generic drugs, the PBM frequently agrees on an "average" payment term for payers. For example, the PBM-pharmacy agreement may guarantee to pay the pharmacy AWP minus 15.25% for a brand prescription, and MAC for a generic. The difference between the actual and the average discounts may be large and accrues to the payer, not the purchaser or the pharmacy.

Alternatively, PBM-payer agreements are usually based on "lesser of" language such that each claim is paid at the lowest of the AWP discounted price, the MAC price or the U&C. In *pass through* and *transparent* agreements the payer pays an amount that is equal to the amount paid by the PBM to the pharmacy. However, MAC prices and drugs included on the MAC are variable. This means that it is necessary to know how a drug will be paid to ensure that appropriate generics are selected.

From the purchaser perspective, the AWP discount rates and MAC fee schedule are critical components of their drug payments. The purchasers' goal is to get the lowest AWP discount for brands, and pay MAC for all generics. Their assumption is that all generics are paid at MAC. When a multi-source generic is not paid at the

MAC price, member co pays may increase, members may complain that generics are available but they can only receive a brand, and the purchaser pays brand price for a multisource generic drug. If pharmacy receives a profit for these prescriptions, it is short-lived. The purchaser and patient will eventually find out. In terms of cost, the purchaser and the patient want the lowest cost for all drugs and will respect the professional that told them about the inequity, and provided a solution.

Q **Why do payers push mail order?**

A The retail argument against mail-order service is a reaction to a threat to business. The pharmacy that can dispense medications at lower marginal costs through purchasing and technology has the competitive advantage. Mail service, internet ordering of prescriptions, specialty drugs delivered by mail, and drugs obtained from international pharmacies are manifestations of competition. The problem then for community pharmacy is to provide its own options that are just as attractive.

Consider the issue of mail-order service, internet pharmacy, and specialty pharmacy with mail delivery from the member and the payer's perspective. They can get the same medication with usually the same packaging from any pharmacy. As a commodity, they are interested in the lowest price, especially when a thirty-day supply of a branded medication costs in excess of $100. Mail-order service becomes very attractive when a patient can save money. It is less attractive when the medication is considered necessary for the preservation of life. For example, when respiratory or pediatric medications are not received on time member complaints are common.

From the payer perspective, the difference between the AWP discounts for retail versus mail prescriptions needs to be large in order to favor mail-order. The original strategy was to offer mail discounts in excess of 5-6% for brands and fixed discounts of 50% or more for generics. The mail-order service benefits were also offered at zero dispensing fees and single copays to incentivize mail. However, agreements that offer deeper discounts in community pharmacy, e.g., within 5-6% of mail-order brand discounts and MAC rates with averages similar to fixed generic discounts at mail-order, the cost gap is not as attractive. Further, research and experience indicates that at least 2.5 to 2.7 copays are necessary for mail-order to ensure that the copay (i.e., the member's portion of the cost) is not shifted to the purchaser. As a result, there is less of a financial incentive to favor mail-order in these agreements.

Competitive options also exist at the community pharmacy level.

Emphasize to purchasers what you can do to improve coordination of care, decrease poly-pharmacy, improve compliance, and decrease medication errors in dosing and how drugs are taken. Keep a log of interventions and positive outcomes. You make opportunities based on outcomes, not on volume.

Chains and deep discounters that refused to sign agreements with mandatory mail-order, threatened potential access problems such that community pharmacies might not be within close geographic proximity for its members to obtain their prescriptions at local community pharmacies. Ninety-day point of sale (POS) options that provided discounts similar to mail-order makes retail filling of chronic prescriptions more attractive. Perhaps even more importantly, generic discounts offered at community pharmacies reverse the price differential in favor of retail.

Q **What can a community pharmacy owner do to win in this environment?**

A Keep your eyes on the patient and the purchaser. They have the need and they pay the bills. Focusing on short-term profits assumes that patients and purchasers will not ultimately understand other options. Instead:

- Provide cost savings on every prescription. Switch to generics of the prescribed drug if possible, or to a generic in the same therapeutic category so that the patient avoids brand copays and the purchaser pays a lower fee.
- Switch to a lower-cost brand in the same category if a generic is not available.
- Submit a U&C that is lower than the AWP discount. Establish a U&C that is based on cost plus as an understandable measure for the purchaser. Publicize your "transparent" savings to purchasers and members.
- Let patients know about lower cost options.
- Provide the discounted generic price in the U&C and publicize the savings to purchasers and members. Then publicize to the same purchasers and members sterilized examples of improved outcomes and risk avoidance, and what else can be accomplished with enhanced pharmacy programs.
- Contact purchasers directly to inform them of what you are doing to help control costs and what you can do to improve quality.
- Emphasize to purchasers what you can do to improve coordination of care, decrease poly-pharmacy, improve compliance, and decrease medication errors in dosing and how drugs are taken.
- Use examples of direct patient improvements in these areas.
- Keep a log of interventions and outcomes. You make opportunities based on positive outcomes, not on prescription volume.

Declare to payers, purchasers and their beneficiaries that the pharmacist who was sensitive to your costs is the same person who can solve your therapeutic problems Then solve those problems.