PHARMACISTS QUESTION PAYER AND PBM AGREEMENTS -- THEY WANT TO KNOW AND UNDERSTAND

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Several retail 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 retail 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 including retail, mail, specialty, long term care, etc. These agreements allow for competition between networks as for example between retail and mail service. The system is further conflicted with the fact that many retail pharmacy chains also own PBMs or have back office relationships where the PBMs adjudicate claims for pharmacy owned PBMs and pharmacy benefit administrators (PBAs).

Historically, the agreements minimized price competition in the retail networks, but promoted lower priced mail order service. Interestingly, retail pharmacy networks provided few competitive options in the market until chain pharmacies refused to sign agreements with exclusive mail service options. Retail pharmacy made a larger competitive attack on PBMs with discounted generics, so-called $4 generic options, and later with cost plus options. Interestingly, the focus continues to be placed on cost. Of greater concern is that the payers and their beneficiaries were, and are, left with less than optimal outcomes, as well as confused patients. Arguably, the next step is for retail pharmacy to declare to purchasers and their beneficiaries -- *the pharmacist who was sensitive to your costs is the same person who can solve your therapeutic problems.*

Questions from Retail Pharmacists

One of the authors has provided questions commonly voiced by retail pharmacists about the health plan and PBM Agreements. As a basis for answering questions it is necessary to define terms. The following is a short description of payer-PBM agreements that is fundamental to any discussion of pharmacy relationships to payers and PBMs.

> From the purchaser 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.

Question: Are all contracts the same? If I change something on the contract, will it be voided and I would be thrown out of the network. Shouldn't we all agree on one set of terms? If I sign a contract can I change it when I find out that my friend has different terms? If I have a complaint- what should I do? I blame the PBM for everything that is wrong in the system. Who else is wrong? Who do they blame for this mess?

The non-legal answer is that you need to read and understand all contracts. It is correct that many of the PBM-pharmacy contracts are very similar; however payment conditions, required data elements upon submission of a claim, and the responsibilities of the pharmacist are critical. For example, the basis for AWP (i.e., First Data Bank, Medi-Span, and Red Book), the frequency of AWP updates, and the assurance that the AWP will not be modified from the data source ensure that the pharmacy knows how it will be paid for brands. For generics the MAC payment lists need to be made available to the pharmacy so that appropriate choices can be made for which generic manufacturer to dispense. Further, there should be a definition as to how non-MAC'd generics, OTC, and specialty injectables will be compensated.

Complaints, changes, differences in the PBM agreements and competitive bidding are all legal issues. Purchasers have vendor agreements with payers like PBMs so they don't have to negotiate with 50+ thousand pharmacies in the USA. That doesn't mean that purchasers are not interested in pharmacy issues, but if these issues are not to be transmitted through the lens of the PBM, then the communication needs to be constructive. Communications about payment rates are not well received as the purchasers has contracted with the payer to find the best rates in the market place. Communications about service and solutions for therapeutic outcomes are constructive and useful to all stakeholders. Interestingly, payers defer all pharmacy dispensing issues, data lapses, and clinical decisions to network pharmacists.

Question: Are all scripts are paid at AWP minus 15.25% plus a fee or something like that? I make out on generics with that fee. The MAC doesn't mean anything; I get the better rate anyway right? Do they figure out the less than at the end of a month?

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. If the pharmacist reverses a claim, then the original and the reversed claim are not paid, unless the amounts paid do not agree. If the amounts do not agree, then the PBM may reverse the claim even when the amounts do not agree.

From the purchaser perspective, since all generics are not paid at MAC the purchaser is concerned that they are paying more than they should for some multisource products. When a multisource generics is not paid at the MAC price, members' copays may increase, member complain that generics are available on their benefits but they can only receive a brand, as well as the payer pays a price similar to a brand price for a multisource drug. If pharmacy receives a profit for these prescriptions, it is short-lived, because the purchaser and the patient will eventually find out and respect the professional that told them about the inequity.

Question: I have told my patients that mail order or "the catalog sales" option is not a good idea. I have stayed away from the 90-day option in my contracts. I thought I would lose too much money. Is it a good idea? Mail order is much more profitable for the payer

is that why they are pushing it? I hate mandatory mail order. What can I tell my patients to do to fight it?

> The retail argument against mail 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 obtaining drugs from international pharmacies are manifestations of competition. The problem then for retail pharmacy is to provide its own options that are just as attractive.
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> Consider the issue of mail 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 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.
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> From the payer perspective the difference between the AWP discounts for retail versus mail prescriptions needs to be large in order to favor mail. 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 service benefits were also offered at zero dispensing fees and single copays to incentivize mail. However, agreements that offer deeper discounts at retail, e.g., within 5-6% of mail brand discounts and MAC rates with averages similar to fixed generic discounts at mail, the cost gap is not as attractive. Further, research and experience indicates that at least 2.5 to 2.7 copays are necessary at mail in order to ensure that the copay (i.e., the member's portion of the cost) is not shifted to the purchaser. As a result, in these agreements there is less of a financial incentive to favor mail.
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> Retail pharmacy has provided competitive options. Chains and deep discounters that refused to sign agreements with mandatory mail threatened potential access problems such that retail pharmacies might not be within close geographic proximity for members to obtain prescriptions at retail. Ninety-day point of sale (POS) options that provided discounts similar to mail makes retail filling of chronic prescriptions more attractive. Perhaps even more importantly, generic discounts offered at retail reverse the price differential in favor of retail.
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> Ultimately, whether 90-day prescriptions are filled at retail or mail, the member still receives a large amount of drug that is hopefully consumed as prescribed. If it is not, then the drugs are stockpiled, patients don't receive therapeutic benefits and the dispensing outlet is irrelevant. Mail service has promoted various compliance services, but compliance and persistence are still a major problem. Retail pharmacy has yet to provide a competitive option.

Question: Do I need to reconcile my claims – PBMs pay with a computer- how can I get hurt?

> Theoretically, all claims should be reconciled. At a minimum, select claims from each PBM or card program should be analyzed and reconciled for the fees applied, the AWP discount applied to brands, and if the MAC price paid for generics is consistent with the MAC price provided by the PBM. If a MAC list is not available from the PBM, then from a business perspective, reconciling generic claims is critical. Additionally, generics and multisource products that are not paid at MAC may provide additional revenue for the pharmacy, but they also lead to confusion among patients and payers who expect to pay a generic copay or coinsurance (i.e., a percentage of the drug cost) and price, but instead pay a brand copay and a brand cost.

Question: Regarding claims adjudication – It seems that all scripts are the same. Do I need to put in DAW 0 or 2 on every claim? Does it matter? Why do I have to submit an accurate MD ID? What difference does it make? Updating my AWP is not that important because the PBM will update it when I send it to the current price right?

> All claims are electronically adjudicated; as a result, they are all screened for validity, pricing, benefit compliance, etc. Any information that is provided needs to be valid or a claim is flagged for further review and may not be compensable. Further, all claims undergo DUR both at point-of-sale and retrospectively. In order to do DUR it is necessary to identify the prescriber, quantity, days supply, etc. When this data is not provided in the claim, then claims may be pended for review to determine if they are examples of abuse of the benefit.

Question: If a salesman tells me that I will be getting a rebate from the PBM on a rebate able drug, how do they send it to me? Who gets those rebates?

> Rebates are a revenue opportunity for payers. They do not generally filter down to pharmacies or physicians. Of concern is that rebates are frequently the reason that more expensive drugs are promoted, but generally members do not receive a rebate to lower the cost of each prescription. The member may pay copay at a lower tier, but they may also pay a higher portion of the prescription cost if they have deductibles, coinsurance, or "donut holes" as in MMA Part D. The opportunity exists for pharmacists to inform patients of their options.

Question: Based on what you know and understand, where do you see the future going? Will this current system go away?

Arguably, the major drivers of health care are globalism, consumerism, and information-ism. Globalism is driving competition for cost and service delivery at comparable quality to US providers. The internet has provided a huge information source for comparing cost and quality options as well as for educating all stakeholders in the benefits and liabilities of all healthcare options. For the last several years, the trend has been to shift more of the cost of all health care, including the cost of prescription medications, to the consumer. The goal is to make the consumer more of an informed purchaser for both cost and desired services. The idea is to include the member in the decision so that health care services are not based solely on provider incentives. When all of these trends are considered it becomes clear that health care is moving to more competition in price, service, access, quality, and equality -- hence competition for steerage to particular retail pharmacy outlets through coupons, PBM pharmacists promoting particular rebatable drugs, and promoting particular chain pharmacies for delivery of care. This will not change in the foreseeable future.

For pharmacy the trends mean that drugs and delivery outlets are commodities so price pressures will continue. Service delivery has always been a differentiating factor, but in the face of more information, service is a function of patient and purchaser education about the clinical therapeutic decisions and oversight that is being delivered. In the face of these pressures, the need for differentiation in service delivery is crucial. Face time with patients and purchasers is critical whether in person or electronically. Wide publication of national pharmacy successes is critical, but of greater importance is the emphasis on "what's in it for me" for every patient.

Question: Of all the issues facing pharmacy as a profession, which issue should we all band together and try to change if we can?

Fight pharmacist complacency! Pharmacists need to make purchasers and patients aware of the outcomes of the clinical therapeutic options that they deliver. Just doing the service is not enough. Providing information, education and viable options for the services that patients and purchasers care about is critical. Go directly to purchasers and provide evidence of clinical therapeutic outcomes that pharmacists provide better and more affordably than other health care practitioners. Make changes in patient care to mitigate risk, improve compliance, and achieve desired therapeutic outcomes, and promote these as real life examples of the benefit that pharmacists bring to the table. Cost and value are interrelated. Issues with pharmacy regulations, contracting with PBMs, and pricing are a function of payer and purchaser need. Everything else is window dressing.

Question: What can a pharmacist or owners do to live and win in this environment?

- 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.
- 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 copay 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 abut 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 outcomes, not on output.
- **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.***