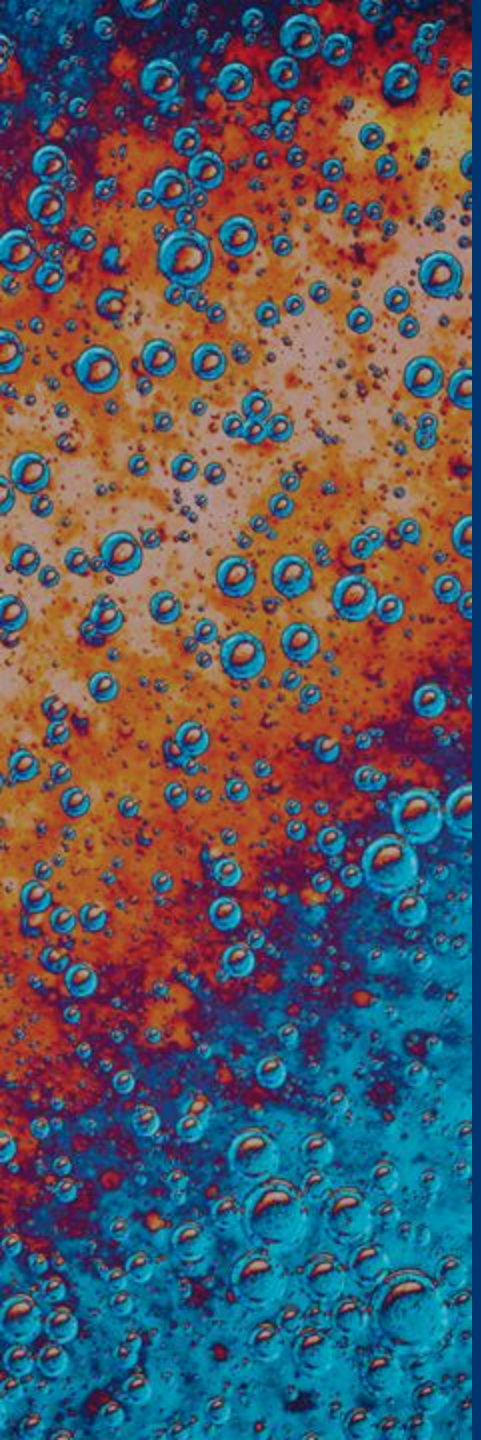

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# PBM Resources of Interest


PBM Playbook

November 8, 2023

The Honorable Chuck Schumer
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Republican Leader
United States Senate
Washington, D.C. 20510

PBM Reform Letter

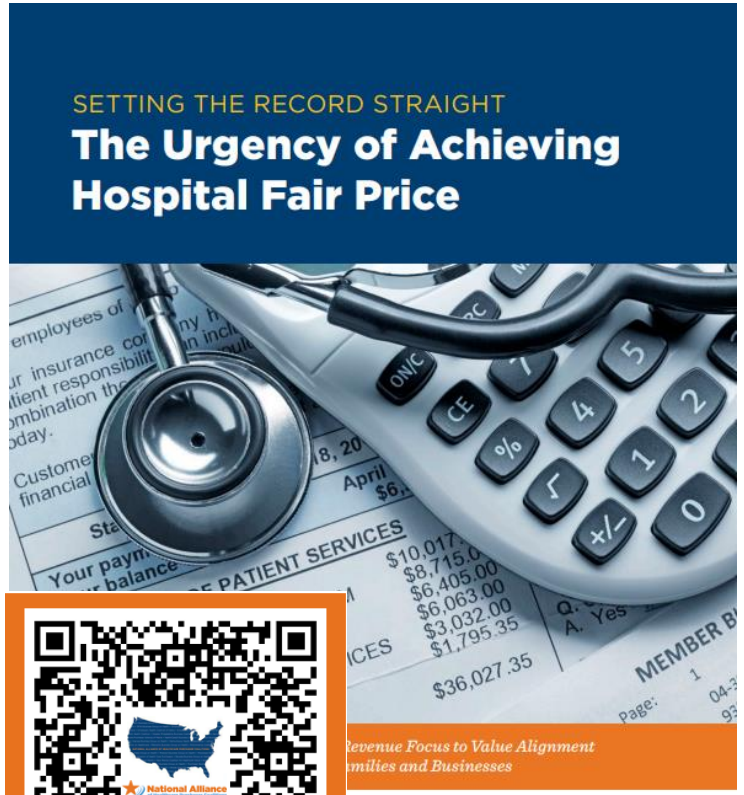
Dear Majority Leader Schumer and Republican Leader McConnell,

We are writing today to ask you to support the health care provided through private employers to 179 million Americans by enacting strong pharmacy benefit manager (PBM) reforms this year. It is imperative that affordable, private sector health benefits continue to be provided to America's workforce and that the health, well-being and productivity of American citizens is protected. Rising health prices are an unsustainable trend for everyone and employers are bracing for even greater costs in 2024.[1] For the reasons described below, the systemic market failure creating this problem cannot be fixed by the private sector alone and congressional action is necessary.

Needed reforms include commonsense changes to hold PBMs accountable to fair market practices when partnering with our nation's employers -- small, medium and large -- who are the largest customers of PBMs. PBM transparency, as with transparency across all healthcare stakeholders, remains one component of the goal to lower costs and ensure access to affordable, quality care. However, PBM transparency alone will not be enough to address the issues employers face in assuring that people covered by employer-sponsored plans are truly receiving the best care at the best price.

**We applaud the Senate's efforts to address the impact of anticompetitive PBM business practices on drug prices.** Legislation has been introduced; and committees have conducted numerous hearings and compiled extensive findings to document the impact of these anticompetitive practices, and policy solutions have been advanced.

[1] Umland, Beth, Sunit Patel, Tracy Watts, Health Benefit Cost Expected to Rise 5.4% in 2024. Mercer. September 7, 2023.




Setting the Record Straight:
The Urgency of Achieving Hospital Fair Price

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# Getting Real About PBMs

**Cheryl Larson**
President & CEO, Midwest Business Group on Health

**Alvaro Bedoya**
Commissioner, Federal Trade Commission

**John O'Brien, PharmD**
President & CEO, National Pharmaceutical Council

**Bob Zakrajsek**
Market Vice President, Navitus

**Cora Opsahl**
Health Fund Director, 32BJ Benefits Funds

**Jeff Townsend**
VP, Purchaser Services, Healthcare TN

**Joey Dizenhouse**
SVP, Head of Health Trust, Health Trust IHP

**Renzo Luzzati**
President, US-Rx Care

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- Serving National Footprint
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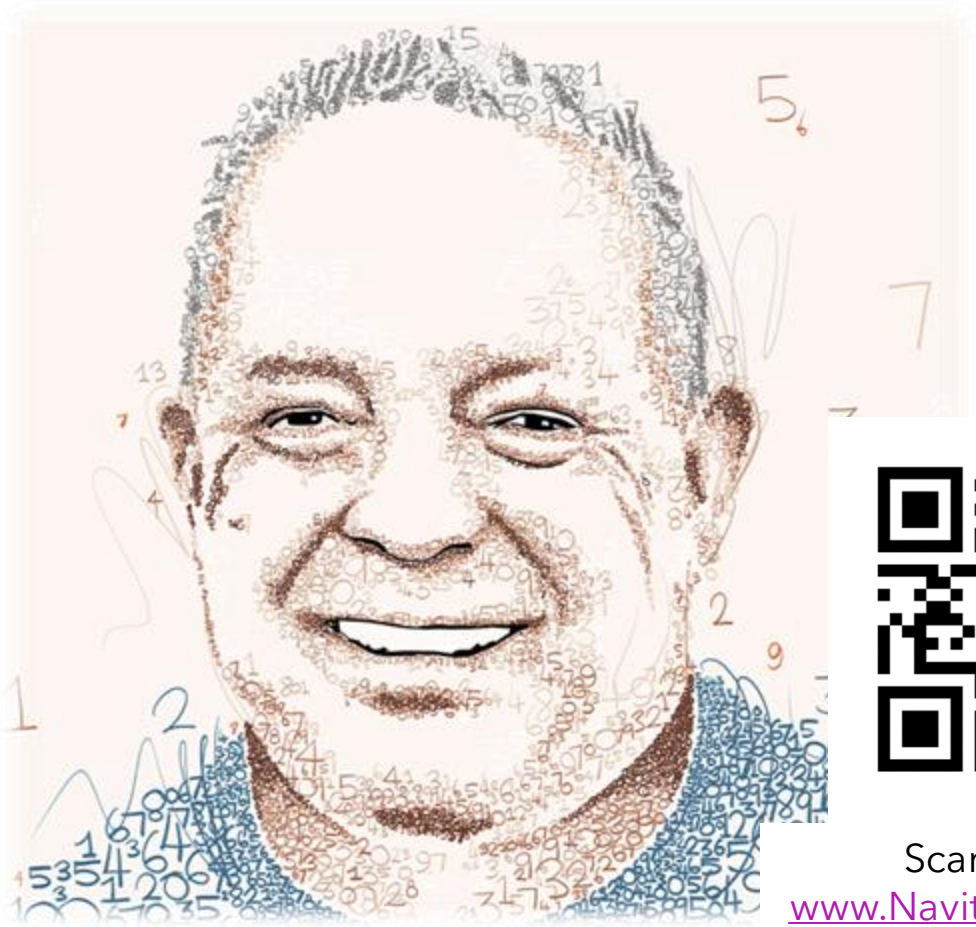
- ✓ We believe a lack of trust and true transparency have no place in an industry that impacts the wellbeing of millions of humans.



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# Getting Real About PBMs

**Renzo Luzzati**
President,
US-Rx Care

#NatAllForum

2023 National Alliance Annual Forum

# Workshop #2
# Getting Real on PBMs

Joey Dizenhouse, FSA, MAAA
SVP, Head of HealthTrust IHP

Renzo Luzzatti
CEO, US-RxCare

# Agenda

We Welcome Your Input

## Modelling Pharmacy Offers – Simpler is not better!

- Many complexities and games exist within the contract
- To push back against the system, more detail, more often should be demanded
- ..But could it really be that bad? Yes. It can.

## Deeper Dive into Examples

- #1 – The Value of Pass-Through (focused on the "back-end")
- #2 – Contractual Definitions
- #3 – Formulary "Quality"
- #4 – Exclusions
- #5 – Value of the Vendor Themselves (from Culture, to Discipline, to KPIs)

## Open Dialogue

# Disclaimers

- Names have been removed to protect the innocent…..or the extremely guilty!
- We're not calling any babies ugly - promise
- We can scratch the surface with the time we have today, but not much deeper
- This presentation was requested by an Actuary and with input from an Actuary (sorry about that)
- Change is painful

# Where do PBMs try to make money? *...Everywhere?!*

| Retail Pharmacy | Mail Pharmacy | Specialty Pharmacy |
|---|---|---|
| Pricing spread between pharmacy and plan employer | Purchase Discounts | Purchase Discounts |
| Dispensing fee spread | Manufacturer Rebates for brands | Manufacturer Rebates |
| Administrative fees | Other Manufacturer Compensation | Other Manufacturer Compensation |
| Manufacturer Rebates | Timing/Cash Flow | Timing/Cash Flow |
| Other Manufacturer Compensation | Repackaging of product, spread pricing | Spread Pricing |
| Timing/Cash Flow | Clinical / Admin Services | Clinical / Admin Services |
| Clinical / Admin Services | | |

**A PBM Contract is made up of well over 100 key terms for which the slightest change of any can change the true deal value materially**

**Examples:**

- Brand / Generic Pricing Methodology
- Definition of Average Wholesale Price
- Which drugs are Rebateable and when
- Which money is paid to whom and under what circumstances

# Examples

# Example #1 – The Value of Pass-Through (Back-End)

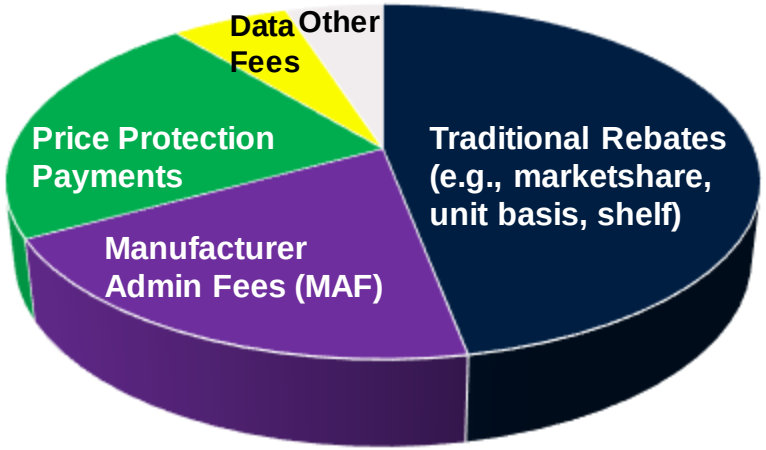
## Background

- "Back-End" refers to compensation that is provided by manufacturers to aggregators and then ultimately given to the plan sponsor in some way
  - Most PBM deals have some form of minimum guarantee (per claim, PMPM) plus some form of settlement based on actuals (the "pass-through")
- Back-end monies have exploded over the last 20-25 years
  - In 2002: ~5% of total spend
  - In 2023: 35%-40% or more of total spend (today's much higher total spend)
- When you measure the value of minimum rebates in your analysis, it's primarily a cash flow thing
- We are not saying you must add specific value for pass-through; but consider the magnitude of the difference between deals you're evaluating
- Remember – this is NOT just about the money you might or might not get in rebates; it directly affects the alignment of incentives between you and your PBM

# Example #1 – The Value of Pass-Through (Back-End)

## The "Numbers" (via rebate example)

- What do the dollars actually look like from manufacturers to aggregators? Varies by PBM, molecule, etc, but…..




*If you don't reflect this in your analysis, you may inadvertently give more credit to the deal with more inherent misalignment*

- Now consider three deals which are identical in every way with the exception of pass-through treatment:

| | Yield | Deal #1 (No pass-through) | Deal #2 (Rebate only) | Deal #3 (Full pass-through) |
|---|---|---|---|---|
| Net Spend (before rebates) | | $10,000,000 | $10,000,000 | $10,000,000 |
| Minimum Rebates | $2,500,000 | $2,500,000 | $2,500,000 | $2,500,000 |
| Actual Rebates | $2,750,000 | | $250,000 | $250,000 |
| MAF, PPP, Etc. | $1,000,000 | | | $1,000,000 |
| **True Net Spend** | | **$7,500,000** | **$7,250,000** | **$6,250,000** |
| | | | **-3.3%** | **-16.7%** |

# Example #1 – The Value of Pass-Through (Back-End)

## Questions to Ask Yourself

- Are you getting pass-through?
  - Even if you don't receive full pass-through, what are the elements and magnitude of compensation that exists?
- What is the definition of pass-through?
- Where does the money go (i.e., how many hands does it touch before it reaches you)
- Does your PBM make more money when the plan spends more under the pharmacy benefit?
  - Does your PBM profit from medications dispensed?

# Example #1 – The Value of Pass-Through (Back-End)

## Actual Contract Language Examples

- PBM may pass through certain manufacturer payments to its clients or may retain those payments for itself…
- PBM contracts for its own account to obtain formulary rebates attributable to the utilization of certain brand drugs and supplies ..
- PBM and PBM's wholly-owned subsidiaries and affiliates act on their own behalf, and not for the benefit of or as agents for Sponsor, Members, or the Plan.
- PBM also may receive other compensation from manufacturers for the performance of various programs or services, including, for example, formulary compliance initiatives, clinical services, therapy management services, education services, inflation protection programs, medical benefit management services, cost containment programs…. This compensation is not part of the formulary rebates or associated administrative fees, and PBM may realize positive margin..

# Example #2 – Contract Definitions

## Background

- Have you ever noticed it's difficult to get a signed agreement early enough to confirm your PBM decision?
  - Valuations are often done based on what the PBM says (e.g., in response to RFI/RFP)
- The PBM contract - aka "modern day hieroglyph"
  - One word (even one letter) can results in +/- 30% actuarial value
  - At least 30-40 key definitions that drive big bucks in PBM contracts
- Examples
  - "Single source generics are In fact but one element of a broader category of definition games attached to "Generic Drug categorization"
  - Some examples:
    - Generic Drug categorization (which of itself has several features, including Single Source Generics, Patent Litigation, ShortSupply, DAW5, etc.)
    - Average Wholesale Price (AWP)
    - Maximum Allowable Cost (MAC) List
    - Limited Distribution Drug (LDD)
    - Zero Balance Logic
  - For Today, we'll focus on the Single Source Generic ("SSG") definition in more detail

# Example #2 – Contract Definitions

## The Numbers

Suppose we have the following Baseline data:

| Claims Experience | AWP | Ingredient Cost | Discount |
|---|---|---|---|
| **Brand** | $4,100,000 | $3,500,000 | 14.6% |
| **Multi-Source Generic** | $4,500,000 | $1,200,000 | 73.3% |
| **Single Source Generic** | $1,400,000 | $1,000,000 | 28.6% |
| **Total (Overall)** | **$10,000,000** | **$5,700,000** | **43.0%** |

# Example #2 – Contract Definitions

## The Numbers (continued)

Grouping the same claims data in different ways, we'll observe the discount rates change – PBMs will do this to help their deal to "spreadsheet" better

### Example A - SSGs are included with Generics:

| | AWP | Ing. Cost | Discount |
|---|---|---|---|
| **Brands** | **$4,100,000** | **$3,500,000** | **14.6%** |
| Multi-Source Generics | $4,500,000 | $1,200,000 | |
| Single-Source Generics | $1,400,000 | $1,000,000 | |
| **Bucket w/ "Generics"** | **$5,900,000** | **$2,200,000** | **62.7%** |
| **Total Overall** | **$10,000,000** | **$5,700,000** | **43.0%** |

### Example B - SSGs are included with Brands:

| | AWP | Ing. Cost | Discount |
|---|---|---|---|
| Brands | $4,100,000 | $3,500,000 | |
| Single-Source Generics | $1,400,000 | $1,000,000 | |
| **Bucket w/ "Brands"** | **$5,500,000** | **$4,500,000** | **15.7%** |
| **Multi-Source Generics** | **$4,500,000** | **$1,200,000** | **73.3%** |
| **Total Overall** | **$10,000,000** | **$5,700,000** | **43.0%** |

***If PBM treats SSGs as Brands, average discount gets better:***

- *Generic average is almost 17% better*
- *Brand average is almost 8% better*

***… And data didn't change***

# Example #2 – Contract Definitions

## Questions to Ask Yourself

- Do you have an executable contract in hand before making your decision?
- Are the embedded definitions codified?
- Are Brands and Generics clearly defined for measurement of pricing and rebate guarantees?
- How are rebates defined? Narrowly or broadly (e.g., 100% of all manufacturer payments)
- Where is ambiguity in the language? Any room for interpretation (which invariably will work against you!)
- Any non-capitalized terms that are representing material value?

# Example #2 – Contract Definitions

## Actual Contract Language Examples

- "Generic Drug" means a pharmaceutical, including a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name…on the basis of a proprietary algorithm. The reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes.

- "Brand Drug" shall mean a pharmaceutical product, including a Covered Drug that is a prescription drug, including over-the-counter drugs dispensed pursuant to a prescription, medicine, agent, substance, device, supply or other therapeutic product that is not a Generic Drug.

# Example #3 – Formulary Quality

## Background

- When PBM proposal analysis are done, they typically try to represent the information apples to apples using logical assumptions to narrow the scope (e.g., assume the same type of formulary)
  - Makes sense to do this
  - But in doing the comparison, do you try to evaluate the formularies for their underlying exclusions and clinical rigor? Most do not
  - The valuation is typically just comparing the discounts and rebates against your historical plan utilization with or without trend (and while you can't do everything, this is a big one to ignore)
- What about simply reflecting which drugs the PBM is covering and reflecting key difference
  - For example, a drug that new PBM is covering and prior one did not – you won't have historical utilization but you should expect some moving forward
- Problem is → Covering a "BS Drug" will add meaningfully to your cost, yet the typical pricing methodology will show such a deal as having superior value!

# Example #3 – Formulary Quality

## The Numbers

**Duexis is a combination drug of Famotidine (Pepcid) and Ibuprofen (Advil) that is priced around $2,500 for 30 days' supply and rebates about $2,000**

- Let's consider a fairly common example from previous years, that is not as relevant today → Duexis…..
- When PBM covers Duexis on formulary, they earn $2,000 per fill in rebate money while promising you a minimum of $200-$300; therefore covering this drug yields a lot of rebate money to share (or keep!)
- But Duexis is just Pepcid and Advil (both drugs available OTC and dirt cheap).
  *even if the PBM passed the whole $2,000 through, you would have paid net $500 for Pepcid and Advil (versus OTC cost < $20)*

- Let's look at how this affects the PBM ability to offer you value in the deal

| | Before Duexis | After Duexis |
|---|---|---|
| Count of Generic Fills (%) | 13,500 (90%) | 13,450 (90%) |
| Count of Brand Fills (%) | 1,500 (10%) | 1,550 (10%) |
| Ingredient Costs | $1,000,000 | $1,000,000 |
| Rebate Guarantee Per Brand | *$250.00* | *$250.00* |
| Rebate Yield to PBM | $400,000 | $500,000 |
| Hypothetical "all in" min guarantee | $266.67 | $322.58 |
| Retention possible over minimum | **$16.67** | **$72.58 (more than 4x)** |

**Assumptions**

- Focused on the retail spend analysis
- Only change from before to after → Add Duexis
- Assume with Duexis, 50 Rxs added (handful of patients) replacing negligible costs otherwise
- Ignore patient out of pocket for these purposes
- Total rebate yield before of 40% of ingredient costs
- Minimum rebate guarantee $250 per brand fill
- Duexis has $2,500 ingredient costs with 80% ($2,000) rebate yield

# Example #3 – Formulary Quality

## Questions to Ask Yourself

- Have you looked at differences in formulary between deals, and at least mapped the economics for a subset of the biggest BS products?
  - Even while remaining with your PBM, what about annual formulary changes?
- What about brands covered over generics, does your PBM make arguments to cover? Are you looking at the numbers?
- What about Specialty drugs? Are there individual drugs that shouldn't be covered given their net cost profile? Who do you rely on to tell you what they are?
- Does your PBM allow changes in their formulary to best suit your needs?

# Example #3 – Formulary Quality

## Actual Contract Language Examples

- Guaranteed Rebate amounts, if any, set forth herein, are conditioned on adherence to various Formulary management controls, benefit design requirements, claims volume, and other factors stated in the applicable pharmaceutical manufacturer agreements…

- Rebates and the guaranteed rebate amount are contingent upon Client's adoption, without deviation, of PBMs formulary and formulary exclusions, as well as any changes PBM makes to its formulary and formulary exclusions, and the implementation of any step therapy required by PBM, as well as any changes PBM makes to its utilization management programs…

# Example #4 – Exclusions from Value Offered

## Background

- We often talk about headline rates (AWP Discounts, Minimum Rebates) but no two deals are the same
- Many times there are full or partial exclusions;
  - Full exclusion means the claim simply does not get the value
  - Partial exclusion could mean it's ambiguous (which is dangerous and even more complex)
- The analysis has to try and simplify that into modeling, recognizing that the current deal and proposed new deals will always have different rules
  - Can even include the renewal offer ("we're going to raise your minimum rebate by 50%, aren't you excited?!")
  - Three different coalitions offering the same PBM will have three sets of rules here
- Examples of exclusions (which could apply to discounts, or rebates or both)
  - Limited Distribution Drugs
  - New To Market Drugs (vague on its own, make sure to refer to the definition)
  - 340B (while some of these claims should be excluded, there are others which should not; how you characterize such claims matters!)
  - Drugs in short supply
  - Certain pharmacy types or locations (LTC pharmacy, certain States)
  - Non-formulary drugs (another potentially ambiguous term)

# Example #4 – Exclusions from Value Offered

## The Numbers

- Again, let's look at two deals which are otherwise identical in every way – except one deal excludes Limited Distribution Drugs from discount guarantee and the other does not (further assume the definition of LDD is the exact same between them)
- Many deals are structured as an "overall discount rate" for specialty, such that the rate earned is that overall rate, except any exclusions

- Again, let's look at how this subtle difference affects the resulting value

| | Deal 1 - LDD included | Deal 2 - LDD Excluded |
|---|---|---|
| AWP (non-LDD) | $1,875,000 | $1,875,000 |
| AWP (LDD) Total Ingredient Costs | $625,000 | $625,000 |
| **Total AWP** | **$2,500,000** | **$2,500,000** |
| Ingredient Cost (non-LDD) | $1,500,000 | $1,500,000 |
| Ingredient Cost (LDD) | $500,000 | $537,500 |
| **Total Discounted Ingredient Cost** | **$2,000,000** | **$2,037,500** |
| Additional Cost from Exclusion | | $37,500 (1.9%) |

**Assumptions**

- Focused on Specialty spend only for the example
- Specialty AWP Discount = AWP minus 20%
- Total Specialty Claims = 240
- Subset of Brands which are LDD = 40 (16.7% of total)
- AWP for subset of Brands which are LDD = 25% of total AWP
- Ignore patient out of pocket for these purposes
- Actual discount earned on LDDs averages AWP minus 14%

# Example #4 – Exclusions from Value Offered

## Questions to Ask Yourself

- Where there are more exclusions, how might that affect the PBM's propensity to fill particular drugs?
- Are you looking at the exclusions between deals (with proper documentation) and lining them up
  - Is there an executable contract articulating these exclusions which can be measured and managed?
- Do you know how many claims are being affected and reconciling / auditing accordingly?

# Example #4 – Exclusions from Value Offered

## Actual Contract Language Examples

- The Specialty Drug Rebate calculations exclude the Excluded Claims, Exclusive Limited Distribution products, Limited Distribution Drugs not dispensed by the preferred specialty pharmacy, New to Market Specialty Drugs, New to Market Biosimilar Drugs and New to Market Limited Distribution Drugs

- All brand drug Claims will be included in Rebate reconciliations, except for the following Claims:
  - Over the Counter (OTC) products
  - 340B Claims
  - Coordination of benefit or secondary payor Claims
  - Paper or Member submitted Claims
  - Non-formulary products
  - Products subject to manufacturer disputes

# Example #5 – Value of the Vendor Themselves

## Background

- Background
- The PBMs behavior should be expected to be based on their underlying incentives (why expect anything different?)
  - Are they acting in your best interests? Or is this a zero sum game because their loss is your win and vice versa
- This can be extra tricky as there are plenty of qualitative elements here that are hard to calculate. But there are definitely quantitative elements as well
  - For example: Let's look at the administration of clinical edits (Prior Authorization)
- If the PBM keeps money from the manufacturer based on which drug is dispensed, then how might we expect claims utilization to vary based the drugs' financial incentives?

# Example #5 – Value of the Vendor Themselves

## The Numbers

- Let's look at the Prior Auth approval rates (directionally correct examples) for "Tumor Necrosis Factor Alpha" drugs (which are expensive agents to treat a myriad of autoimmune conditions → Humira, Enbrel, Simponi Aria, Cimzia
- Consider three types of deal
  - → A) PBM administers the PA and you use their standard requirements / language
  - → B) PBM administers the PA but you have customized it (e.g., focus on documentation rather than attestation)
  - → C) You still use the customized edit in B), but you also move the PA administration to a third party who is not dependent upon approvals
- Impact:

| TNFα Comparison | Deal A) PBM Standard Edits | Deal B) Custom Edits Admin'd By PBM | Deal C) Custom and 3rd Party Admin |
|---|---|---|---|
| Total number of submitted claims | 100 | 100 | 100 |
| PA Denial Rate | 20% | 40% | 55% |
| **Approved cases** | **80** | **60** | **45** |
| Drug ingredient cost | $480,000 | $360,000 | $270,000 |
| PA administration fees | $3,000 | $5,000 | $15,000 |
| **Total Cost** | **$483,000** | **$365,000** | **$285,000** |
| Savings relative to Deal A) | | $118,000 (24.5%) | $198,000 (41.0%) |

**Assumptions**

- Only change is related to the edits (type and administration)
- Focused on costs of TNFα only
- Ignore patient out of pocket costs and rebates for these purposes

# Example #5 – Value of the Vendor Themselves

## Questions to Ask Yourself

- Where does the money go?
- Who is incentivized to properly look out for you as the plan sponsor? Really think about it
- What technical metrics can you demand to see (in this example, how about PA approval rates?!) to demonstrate the magnitude of value and proof of concept
- Do you trust your PBM to make the best clinical decisions for plan enrollees even when those decisions negatively impact the PBM's bottom line?
- Do you believe your PBM is always striving for the lowest net cost for each and every medication dispensed to plan participants whether from a clinical or sourcing perspective?
- Is the PBM subsidizing their clinical fees because of funds earned in other places?

# Example #5 – Value of the Vendor Themselves

## Actual Contract Language Examples

- Sponsor has engaged PBM to provide on an exclusive basis, either directly or through its subsidiaries, pharmacy benefit management services, including, among other things, pharmacy network contracting; pharmacy claims processing; mail and specialty drug pharmacy; cost containment, clinical, safety, adherence, and other like programs; and formulary administration ("PBM Services") pursuant to the terms described in this Agreement.

- All Decisions respecting the provision of Home Delivery and Specialty Pharmacy Covered Prescription Services by Administrator's Home Delivery Pharmacy and Specialty Pharmacies will be made solely by Administrator's Home Delivery Pharmacy and Specialty Pharmacies and their duly authorized personnel, and not by Client.

- Exclusivity. During the Term, PBM will be Sponsor's exclusive provider of PBM Services for Sponsor's Plans offering a prescription benefit. The financial terms set forth are conditioned on that exclusivity.

# Closing Comments

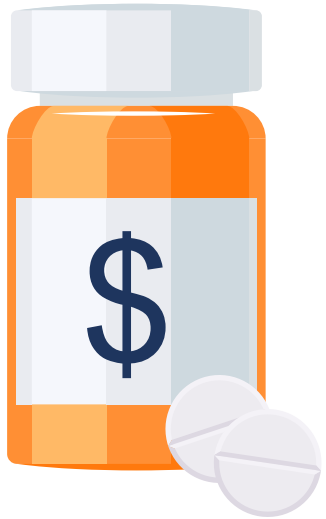
- Change is never comfortable – but something has to give
- The details matter and while this gets really technical, the opportunity is meaningful
- Not all PBM deals are created equal

**Thank you!**

# Examples

# Pharmacy Trend - Inflation in costs year over year

*Trend Considerations = Unit Cost + Utilization + Mix/Intensity + Volatility*



**Cost**

**Price of the same agent over time**

**Utilization**

**Propensity to use/fill particular agents over time**

**Mix or Intensity**

**Substitution of a one agent for another over time**

??

**Volatility**

**Cost range for new agents over time**

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**Joey Dizenhouse**
SVP, Head of Health Trust, Health Trust IHP

**Renzo Luzzati**
President, US-Rx Care

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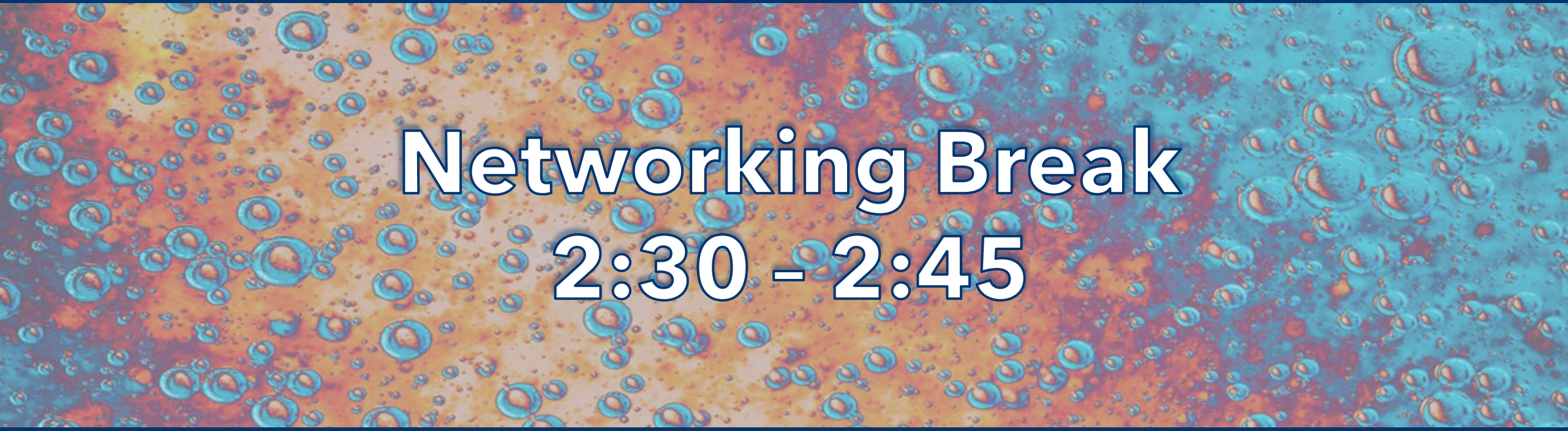
National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

# ANNUAL FORUM
# TEMPERATURE RISING

IGNITING CHANGE FOR A NEW ERA

**NOVEMBER 13–15, 2023**

Crystal Gateway Marriott | 1700 Richmond Highway, Arlington, VA

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