Spread vs. Pass-Through PBM Models and an Alternative to Traditional Evaluation

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TIMED OUTLINE

This course was developed to meet the education training requirements and provide students with 1 hour of continuing education.

Course Overview: Providing an overview of the Pharmacy Benefit Manager (PBM) practices and designs. Explain and explore the differences amongst PBMs with an emphasis in the spread model PBM and the pass through model PBM.

1. Introduction to Pharmacy Benefit Management (5 minutes)
    a. Roles
    b. Responsibilities
    c. Trends
    d. Status of legislation

2. PBM Models (5 minutes)
    a. True Pass-Through
    b. Traditional Spread
    c. Everything in between

3. Bundled or integrated offerings (10 minutes)
    a. Pharmacy and Medical administration are provided by the same entity.
        i. Cigna – ESI
        ii. Aetna – Caremark
        iii. Any provider of claims administration that requires use of a specific PBM
    b. I liken this to change in structure to the fashion industry. Styles come and go and come back again.
        i. PBM was started to separate the two sources of expense (medical and pharmacy) and was vehemently opposed with the same arguments used today.
        ii. It has long been established that unbundling is effective.
        iii. Medical carriers and PBMs are not acquiring each other because they like to adopt problems.
        iv. Profit is the driver and it is a big one.
    c. Danger
        i. Surplus in one line may be used to support the other.
            1. That obscures actual performance of both.
            2. Why would any carrier or TPA care about unbundling unless profit is involved?
            3. Use the oft requested "unbundling fee" as a measure of how much profit the PBM side is developing

4. Coalitions and NFP (5 minutes)
    a. Logically, you are simply adding a level of complexity and cost
    b. This is a typical flawed response to the PBM problem
        i. PBM was created to act as a go between with pharma that grew into a monster
        ii. A coalition simply creates a construct to negotiate with the last construct (PBM)

iii. That is insanity

c. You must make the PBM do your bidding
    i. Select a different PBM

5. Definitions (2 minutes)
    a. Why are they important

6. What is AWP (2 minutes)
    a. Where did it come from
    b. Relation to actual cost
        i. Discounts

7. What are Rebates (2 minutes)

8. Guarantees (2 minutes)
    a. Rebates and discounts
        i. What is guaranteed
        ii. Corruption of

9. Drug and Formulary Selection (2 minutes)
    a. How are drugs selected for formulary inclusion?
    b. Level of efficacy
        i. Select one drug that treats multiple disease states
        ii. Add additional drugs that treat very specific disease states most cost effectively
        iii. This includes cost of outcomes on medical side

10. How PBM compensation corrupts best practice (5 minutes)
    a. Spread pricing incents the PBM to make drug selection decisions that are not in the plans best interest.
    b. How?
        i. Retained pharma payments
            1. Rebates
            2. Market share incentives
            3. Narrow efficacy guidelines that restrict use of more effective drugs that have a narrower application
        ii. Goal of inflating rebate guarantees
        iii. Goal of inflating AWP discount guarantees
            1. High Cost Low Value drugs
                a. Examples of HCLV drugs
    c. Reference Adam Fein "Gross to Net" discussion
    d. Example of how annual inflation on spread also increases PBM profit
        i. % increase applies to the drug cost <u>AND</u> the associated spread

11. Other manipulations (5 minutes)
    a. Optics: manipulation of definitions. ie SSGs classified as brand, thereby increasing both AWP discounts on paper
    b. Optics: Using MAC performance as stated generic AWP discount, thereby increasing the performance appearance

c. Rebates: Using a formulary that incents drugs with higher rebates, thereby increasing both rebates and overall drug spend. They can then benefit from the optics of a high rebate or retain part of it.
d. Rebates: Using contract language to reclassify monies from Pharma, calling them admin fees or educational credits thereby decreasing the amount of money paid to client in rebates.
e. Clinical: Charging for Prior Authorization fees which do not effectively ever stop dispensing of medications
f. Guarantees: PBM typically do not achieve the contract stated discounts. In order to audit, the client is charged a fee as a deterrent. Collecting PBM underachievement can be difficult
g. Rebates: Rebate payment typically lags 2 – 3 months. If a client terminates these rebates are often retained by the PBM.
h. Rebates: Reclassification of what is considered 'specialty rebate' ie cherry picking the highest rebate medications as 'specialty' thereby increasing all buckets: retail/mail/specialty
i. DIR Clawbacks: Squashing independent pharmacies on reimbursement--ie reimbursing other pharmacies far below cost of the medication, ie CVS pays themselves a fair rate but achieves the discount guarantee via undercutting other pharmacies
j. Optics: Putting high cost drugs on formulary even as preferred because they have big rebates and high AWP discounts. This allows the PBM to pump up their average brand discount rate and their average rebate. The drug still nets out as more expensive than other alternatives.
k. Contracts: Zero Dollar Claims – a script that costs less than the member copay. By classifying them as a 100% discount they inflate their discount performance helping to meet guarantees.
l. Ever calculated your expected rebates based on guarantees?
    i. Never seem to match what the PBM calculates due to contractual details
    ii. Same for AWP discount guarantees

12. Evaluating the Pass Through Model (5 minutes)
    a. Increased reliance on reprice output
        i. Clearly defined reprice guidelines must be articulated
            1. What is the conversion rate for formulary disruption?
            2. What are the network access parameters?
                a. Is 90 day retail restricted at all?
                b. Is there any member incentive to use a particular network pharmacy?
    b. POS Rebates
        i. Are estimates only
        ii. Will require year end reconciliation
        iii. Will shift cost from member to the plan
        iv. There are other ways to more effectively reduce costs to the member.
    c. Only Effective Way
        i. Use a fixed date range of actual historical claims
        ii. 6 months minimum
        iii. Insure that AWP assigned is from MediSpan
        iv. Use MONY codes to define whether a script is brand or generic.

13. Conclusion (10 minutes)
    a. Questions
    b. Thank you