

Hospital Employee Benefits: Negotiating with PBMs

*Why Pharmacy Leaders Must Participate in Hospital Employee Health
Plan Negotiation*

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Objectives

- Review basic PBM workflows and concepts
- Detail common pitfalls to avoid when negotiating with PBMs
- Share tips for how pharmacy leaders secure their seat at the table

Disclosures

- Ashley Mains Espinosa does not have any financial relationships to disclose

**Free speech doesn't pay the bills. This presentation and opinions expressed are solely my own and do not express the views or opinions of my employer (yet).*

Poll #1

How did we get here?



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Cincinnati.com
PART OF THE USA TODAY NETWORK

The Enquirer



Ohio Pharmacists
Association

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Ohio ends pharmacy middlemen contracts over 'spread pricing'



ANNUAL
CONFERENCE



ADVOCACY

The Columbus Dispatch

Ohio Auditor releases stunning Medicaid PBM audit report

Today, Ohio Auditor Dave Yost, in a presentation to the Joint Medicaid Oversight Committee, released the results of his audit of the Ohio Medicaid prescription drug program. To be blunt, the results are jaw-dropping.

To view the entire audit report, [CLICK HERE](#).

If you'll recall, in March, lawmakers and the Auditor released the results of the audit.

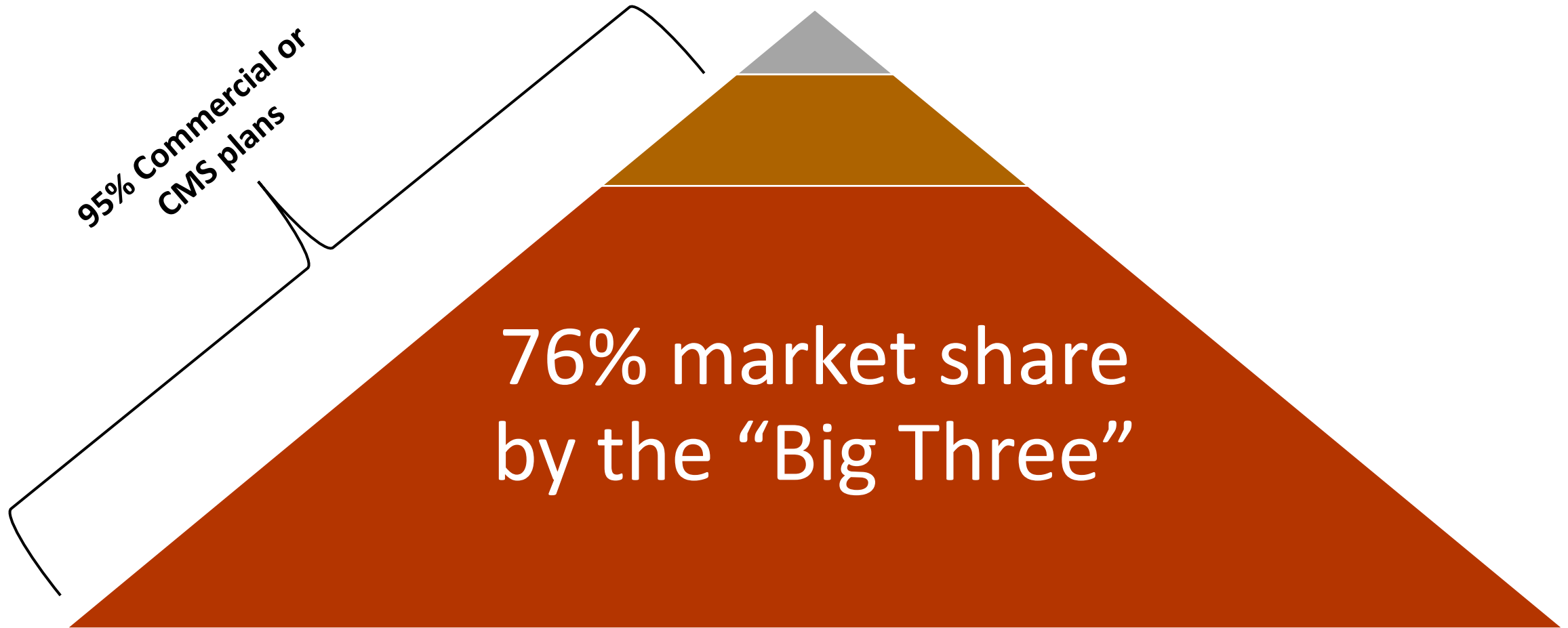
How did we get here?



Introduction to Pharmacy Benefit Managers (PBMs)

- Introduced in 1960s
- Determines formulary and patient's copay
- Provide multiple services
 - Clinical functions
 - Formulary design/management
 - Systems targeting safety & outcomes.
- A number of mergers & acquisitions have resulted in the “BIG THREE”
 - CVS Caremark
 - Optum
 - Express Scripts

Pharmacy Benefit Management Primer



3.7+ Billion prescriptions

Pharmacy Benefit Manager Primer

- Software for clinical activities
 - Clinical checks for drug-drug interactions and duplicate therapies
 - Drug utilization reviews to notify pharmacist that the prescribed therapy may not be safe
 - Prior authorizations to help ensure the appropriate use of medications and to serve as a guide to use lower cost medications first, before going to more expensive branded medications
 - Medication adherence programs to increase compliance
 - Controlled substance monitoring for narcotics
 - Specialized clinical support from nurses, dietitians, and pharmacists
 - Close clinical monitoring for expensive and/or high-risk specialty therapies (i.e. “specialty pharmacy” — PBMs can own or contract with specialty pharmacies to provide this service)
- “Their sole job isn’t to control costs; the other arm of their business wants to make profits.”

How PBMs make money

- Payment rates
 - Per member per month (PMPM)
 - Per claim per month
- PMPM big picture
 - Total spend/participating employees
 - Industry average \$90-\$100
 - **Don't forget about drugs covered under the medical benefit



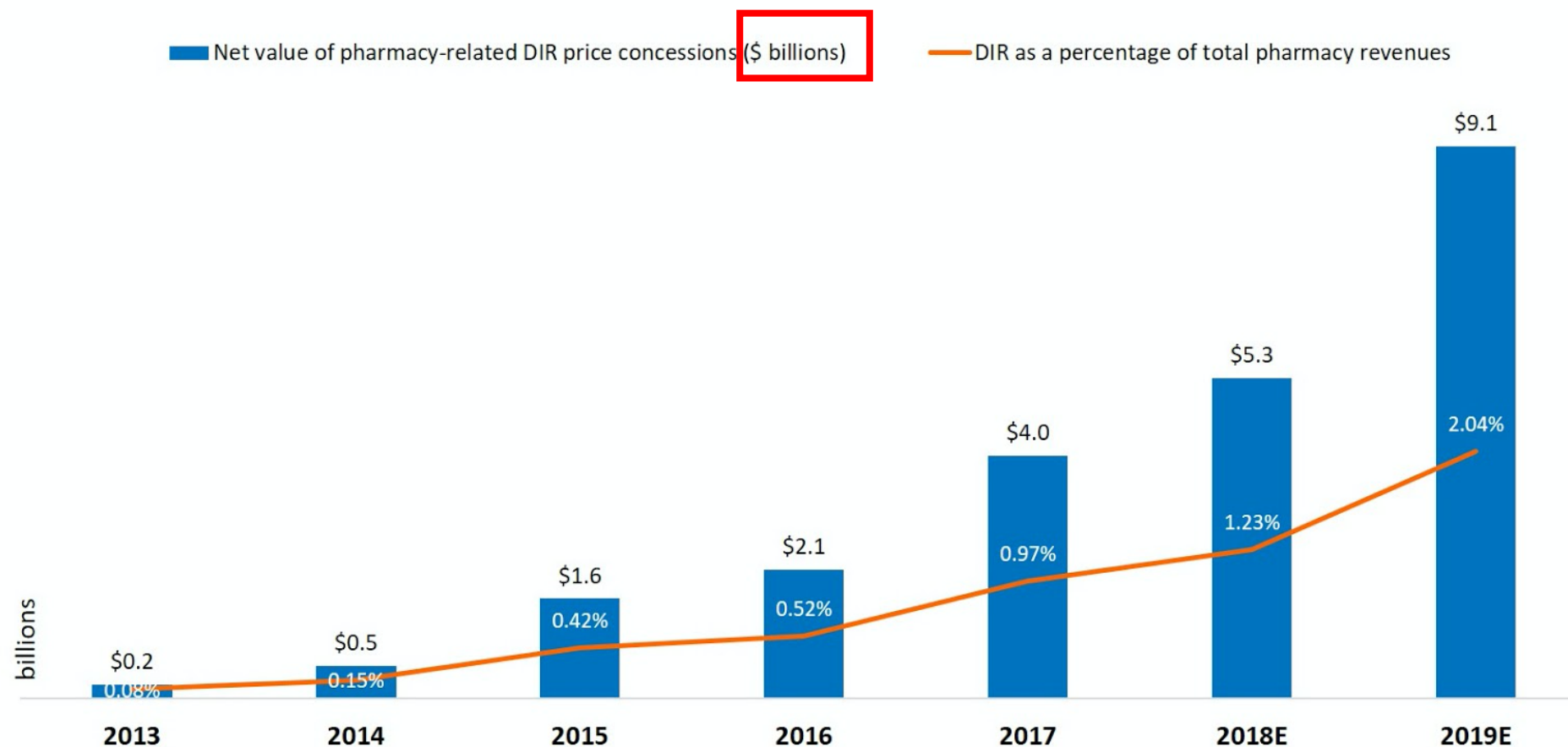
How PBMs Make Money

1. Claims processing and data fees;
2. “Spread margins” on top of retailers’ own margins and lately, direct and indirect reimbursement (DIR) fees, that are collected from retail pharmacies in return for being included in their networks;
3. Rebates given by Pharma on small molecule brand drugs in return for preferred status on formularies;
4. Profit margins on 90-day generic Rx filled by captive mail order operations.
5. Rebates give by Pharma on speciality (biotech) drugs in return for preferred status on formularies;

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Net Value of Pharmacy DIR Fees in Medicare Part D, 2013 to 2019



DIR = Direct and Indirect Remuneration

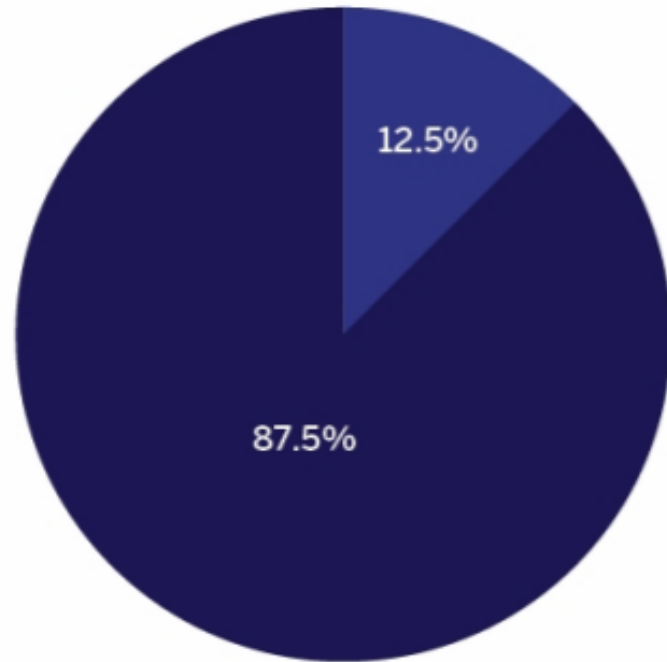
Source: Drug Channels Institute analysis of data reported by the Centers for Medicare & Medicaid Services and U.S. Government Accountability Office (2013 to 2017); Drug Channels Institute estimates based on Inmar Intelligence data on DIR as percentage of pharmacy revenues (2018 to 2019). Figures in billions.

Published on Drug Channels (www.DrugChannels.net) on February 13, 2020.



DRUG CHANNELS
INSTITUTE

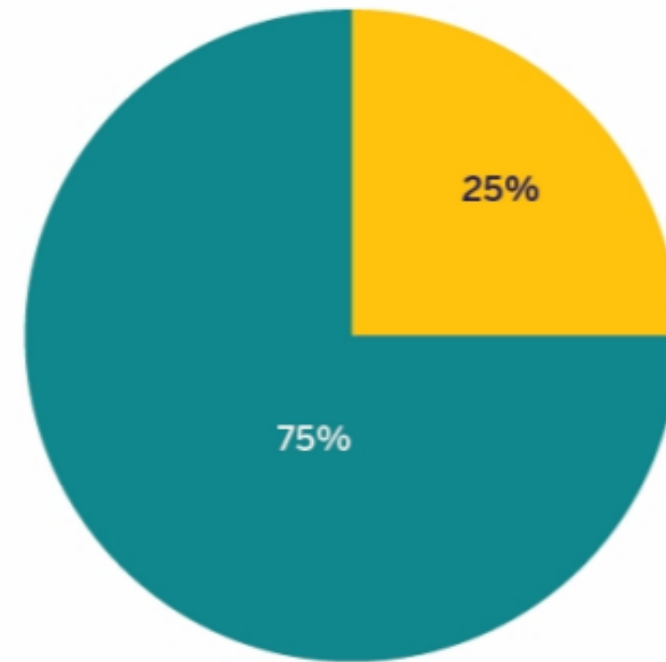
The Form of DIR Fees



Poll #2

- Execute DIR Fees via 835 file (both lump sum and claim level)
- Execute DIR Fees via invoice

The Ability to Receive Claim Level Detail



- Plans only provide claim level detail upon request
- Plans provide claim level detail in the 835 remittance file

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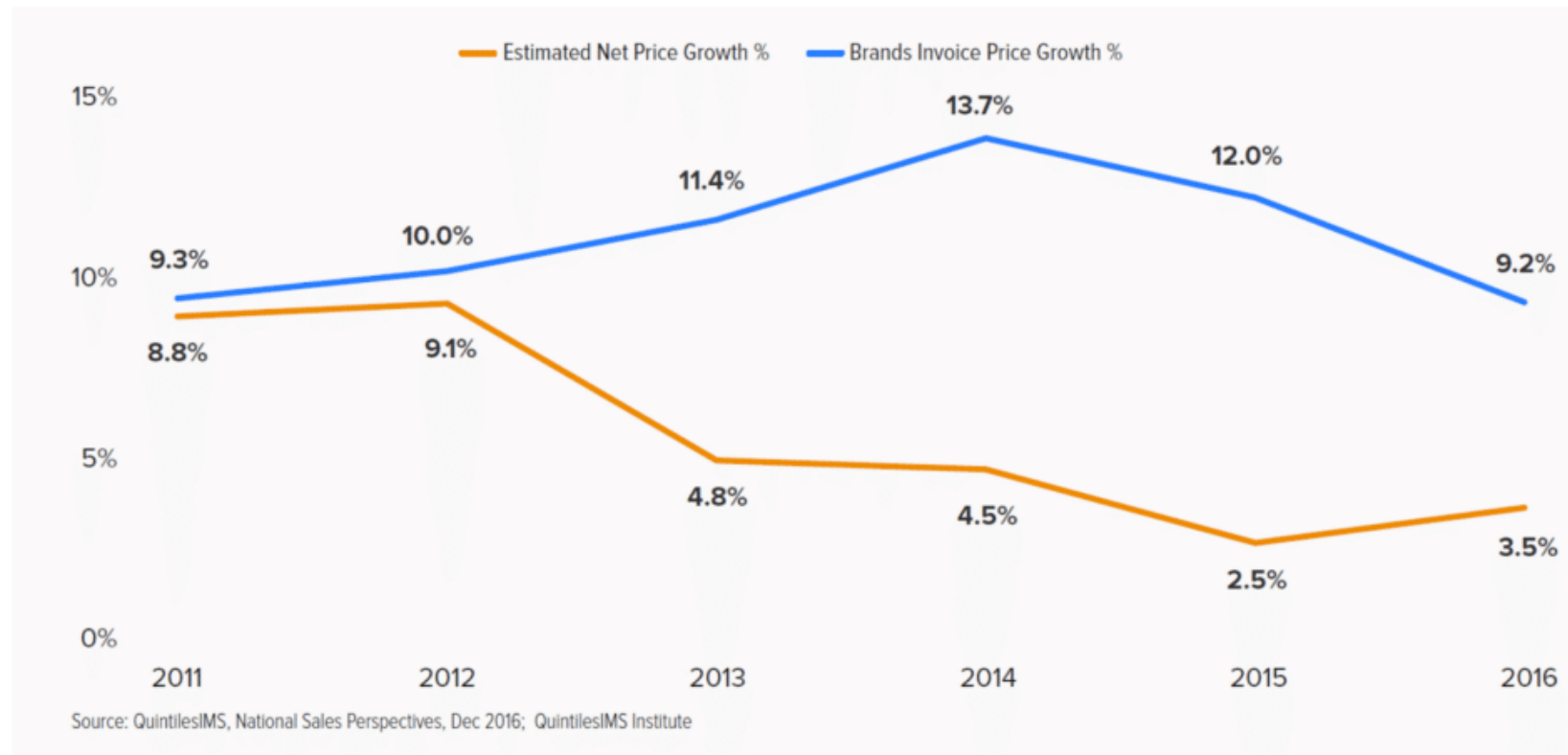
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PBM-owned pharmacies

- Retail, mail order, specialty
- “Gross-to-net rebate bubble”

Protected Brand Invoice and Net Price Growth



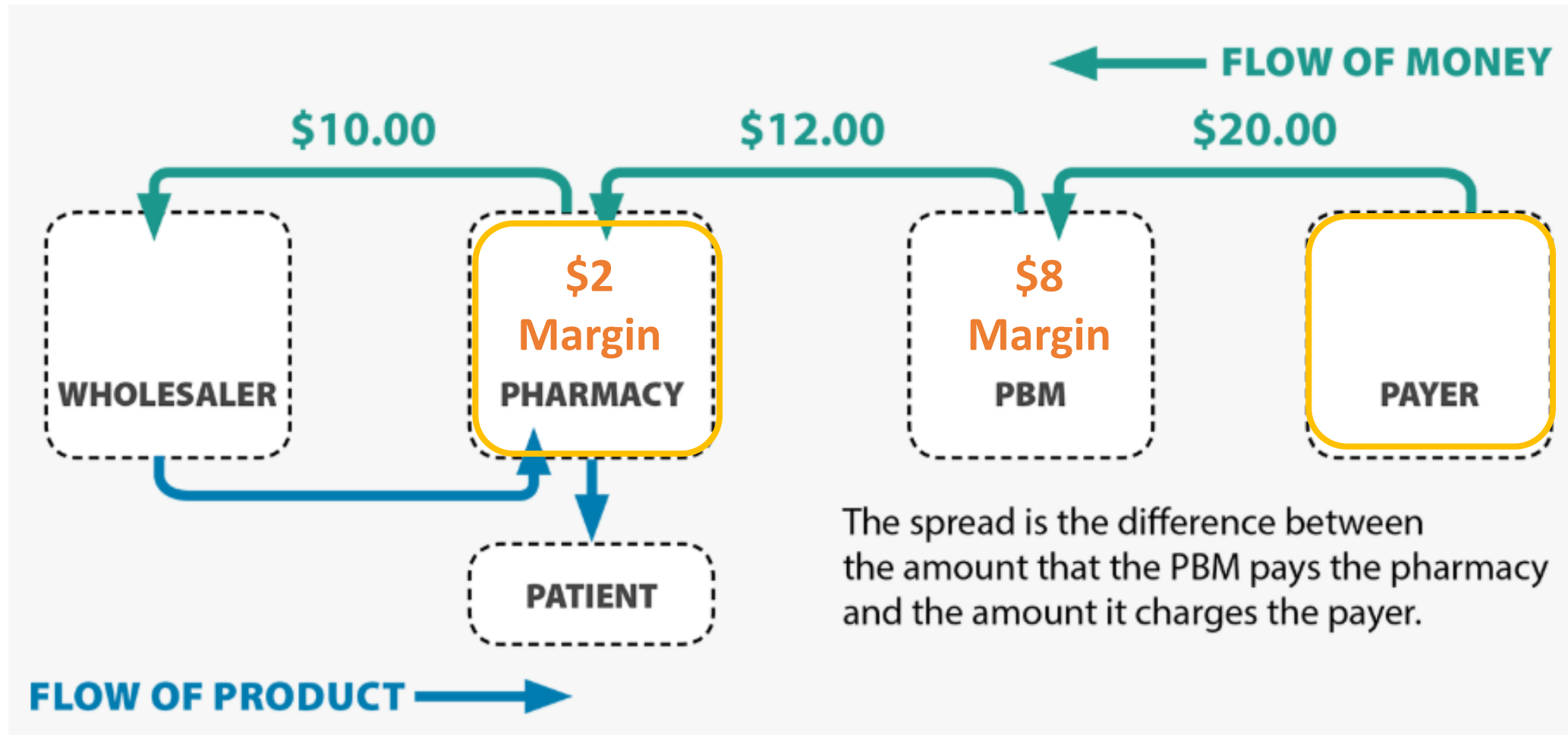
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The death of independent pharmacies

- Declining reimbursement
- DIR fees
- Vertical Integration
- No chance of survival

Spread pricing



What does transparency really mean?

- Understanding how partners make their money
- No bait and switch
 - Full rebate pass-through
- Not requiring “contracting out of” all the bad deals
- Access to data
- No patient pilfering or requirements to use their pharmacy



Problem List

1. Spread pricing
2. Rebate games
3. Profit margins from PBM-owned pharmacies
4. Reduced reimbursement to competitors
5. DIR fees
6. Gross-to-net rebate bubble
7. Repackaging



Health benefit design and selection

- **Timing:** Every ~3 years
- **Key Leaders:** HR, Finance, and CEO
- **Key stakeholders:**
 - Internal
 - Health benefit design is typically led by the HR executives
 - Chief Financial Officer or designee care about costs which typically increase year over year
 - Chief Executive Officers may be fully engaged or completely disconnected, however, a key influencer and the ultimate decision maker
 - External
 - Brokers/Consultants – outsourcing the RFP process and selection of benefit providers to organizations with more expertise
 - Health plan account manager – direct liaison; will go over your annual/quarterly numbers

Working with benefits consultants: Friend or Foe?

- Incentives
- Consulting fees to companies
 - “Preferred partners”
 - “Finder’s fee”
- Guiding types of questions on RFP
- Certified brokers with best practices
 - Eliminate hidden agreements that raise the cost of employee benefits



Health benefit design and selection

Process:

- RFP
 - Health plan/TPA and PBM together or separated requests
 - Over 100 question survey
- Data
 - May not allow for “non-traditional” payment models
 - Intended for AWP-minus, not cost-plus or PMPM
- Recommendation
 - In line with goals of project and values at the table
 - If consultants, consider kickbacks
 - Often land on one of the “Big Three”

Securing your seat at the table

- When is your current contract up? When does your organization planning its next RFP?
- Build relationships with HR and CFO ahead of RFP
 - *You* are the voice of wisdom when it comes to all-things pharmaceutically oriented
 - Understand and leverage partnership of payment model for entity-owned pharmacies
- Aligned incentives
- Make HR look good
- Invite PBMs you trust to participate along with the rest

Leadership skills to navigate with senior decision makers

- Relationship building = TRUST
 - Competence = your knowledge of the process
 - Character = your commitment in shared goals; how you've treated HR about pharmacy reimbursement
- Seeing things from their level
- Identify what you know and don't know

Terms you should know

- PMPM: per member per month
- Medication Dispense Report (or equivalent)
 - Dashboard Report
- AWP: Average Wholesale Price
- WAC price: Wholesale Acquisition Cost
- MAC price: Maximum Allowable Cost
- 340B and associated principles
- NADAC: National Average Drug Acquisition Cost; a “cost plus” pricing benchmark; used primarily for FFS medicaid; ingredient cost used)



Numbers you should know

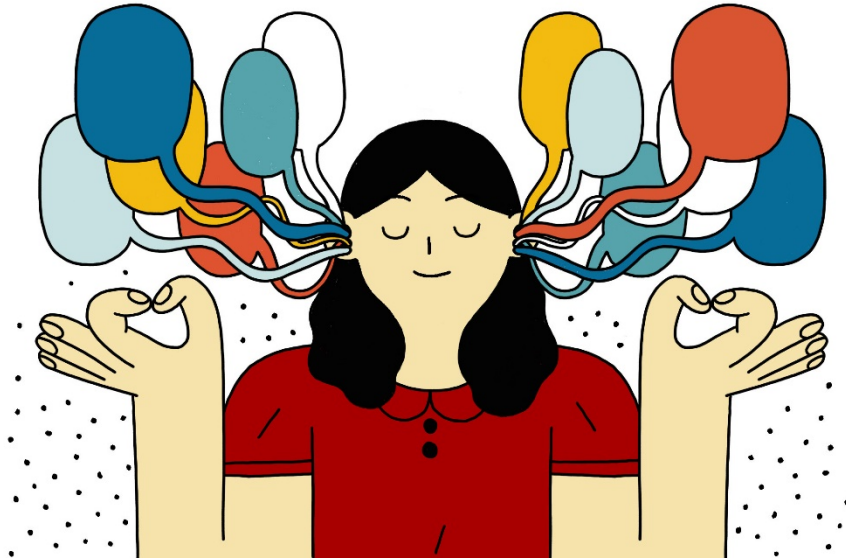
- For how long does the plan/PBM contract run?
- What is your PMPM?
 - Industry average is around \$90-100 PMPM
 - Doing it well with 340B is \$40-\$50 PMPM
 - Where its been; where its going
- Rate of health plan cost increases
- Reductions in stop loss premium; metrics of success are not appropriately aligned
- Reimbursement rate for internal pharmacies
- What are your rebates? How are they passed through?
- Your fill data (You own your data!)

ASHP Policy

- Price transparency, fair reimbursement for medication dispensing services & direct patient care services provided by pharmacists
- Pharmacist leaders need to be involved in the process
- Members seeking education

Lessons learned the hard way

DO THIS



NOT THAT



[Image credits](#)

<https://hdqwalls.com/gunslinger-wallpaper>

<https://www.nytimes.com/guides/smarterliving/be-a-better-listener>

Values-driven work

- Tie to organization's values
- Identify top values driving the project
 - Cost savings
 - Pain point reduction
 - Minimize disruption
 - Access to data
 - Better control: preferred/exclusive filling for patients

Further Study

- Benefit design
- Clinical programs
- Implementation
- Disruption

Run, don't walk

Financially, if it doesn't lower your overall PMPM, it doesn't make sense

How can I drive change?

- Get to the table
- Specifically request a transparent PBM in the RFP process
- Get to know the consultant/broker in charge of the process
- Weigh in on the RFP questionnaire
- Choose how much you want to rock the boat

Key Takeaways

- Get lost learning more about this
 - <https://nu-retail.com/> - The writings of Lawrence Abrams
- Avoid the game of Whack-a-Mole
- Understand how everyone makes their money
- Get invited to the decision table
- Align goals and incentives

[illegible]

You are a Hero

Thanks to my heroes on this topic

- Lawrence Abrams
- Samm Anderegg
- Antonio Ciaccia
- Scott Knoer
- Reid Smith
- Nick Wimpy

Thanks for your attention

Thanks for any questions

- ashley.mains@gmail.com

