Fiduciary Check In

How to Receive Optimal PBM Value and Service

September 15, 2022

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

Speakers



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Role of Fiduciary

- Health plan sponsors have a fiduciary obligation to disperse plan assets in a prudent manner for the exclusive benefit of plan participants and beneficiaries.
- The standard to carry out such obligation for a health plan is simply a good faith compliance effort.

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ERISA Fiduciary Obligation to Identify and Eliminate Pharmacy Benefit Consultant Compensation Streams from Traditional PBMs

September 15, 2022

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One of the Primary Targets of Section 202 of the CAA

- Significant undisclosed payments to pharmacy benefit consultants by traditional PBMs are resulting in excessive drug spend.
- Most pharmacy benefit consultants (e.g. 95%) are receiving significant “referral fees” from the traditional PBMs that they recommend to plan sponsors.
- In return for these significant (undisclosed) revenues, these financially conflicted consultants “look the other way” on dozens of traditional PBM profit-centers.

An important lesson from the 401(k) fee cases

- UNDER ERISA, FIDUCIARIES CANNOT RELY BLINDLY ON THE ADVICE OF THEIR CONSULTANTS. Fiduciaries must obtain fiduciary training from ERISA counsel and educate themselves on prescription drug pricing, PBM contracts and PBM operational practices.
- The following slides may open up some eyes in this regard.

Pharmacy Benefit Consultant "Referral Fees" from Traditional PBMs

- Many pharmacy benefit consultants are receiving $1-$5 per paid pharmacy claim annually from traditional big PBMs (in addition to any direct consulting fee they receive from the plan sponsor annually).

Plan Size	PBM "Referral Fees" (Annual)
5,000 employees	$200,000-$300,000
20,000 employees	$1M-$1.5M

- One large consulting firm's PBM coalition reportedly generates more than $500M in annual revenue for the consulting firm. The lion's share of that revenue comes from the traditional PBMs, not coalition membership fees.

Big Problem #1 – The RFP Process is "Rigged" in Favor of the Traditional PBMs

- Pharmacy benefit consultants make sure that a traditional PBM will "win" virtually every RFP process.
- Only the traditional PBMs pay "referral fees" (i.e. kickbacks) to the consultants, so the traditional PBMs almost always win.
- In some cases, the traditional PBMs pay extra "bonuses" to the consultant when the incumbent PBM is selected for another three year contract.
- Most mid-sized PBMs do not pay referral fees to consultants – so, the mid-sized PBMs are almost always eliminated from the RFP process in the early stages.

Big Problem #1 – The RFP Process is "Rigged" in Favor of the Traditional PBMs (cont'd)

- For example, the conflicted consultants will not give mid-sized (pass-through) PBMs any credit in their scoring system for:

  - Maintaining a value-based formulary (rather than a rebate-driven formulary) which prefers lower cost brand drugs over higher cost brand drugs, when clinical efficacy is equal.

  - Having lower "approval rates" on high cost prior authorization drugs, because most mid-sized PBMs consistently apply appropriate clinical preconditions. Mid-sized PBMs are not compensated based on a plan sponsor's drug spend.

  - Providing flexibility to customize the formulary without financial penalty (e.g. to cover insulin glargine at a 65% discount to Lantus rather than Semglee at a 5% discount to Lantus).

  - Providing full audit rights which the traditional PBMs DO NOT PROVIDE.

  - Excluding 100-200 "stupid" drugs, which are dramatically over-priced and have much less expensive alternatives, usually available over-the-counter without a prescription.

  - Providing full access to pharmacy claims files upon request (ALL FIELDS, INCLUDING PRICES PAID).

  - Obtaining significant financial subsidies from drug makers on high cost specialty drugs, which reduce sponsor drug spend.

Big Problem #2 – Conflicted Consultants Do Not Challenge Traditional PBM "Profit Centers"

- Failure to define "brand drug" or "generic drug" in the PBM contract, so the PBM can move drugs into the wrong (brand or generic) calculations to generate additional pricing spread and/or reduce their minimum rebate obligations.

- Charging higher prices on "limited distribution" Specialty Drugs, when there is no such category. All specialty drugs have limited distribution – they are only available from specialty pharmacies.

- Requiring members to use the PBM's mail order pharmacy for maintenance medications.

  [PBM then charges higher prices at mail order (than at retail) using generic drugs with hyper-inflated AWP list prices.]

- Requiring that Specialty Drug pricing will be in accordance with the PBM's "standard days' supply practices."

  [PBM then dispenses 90-day supplies of expensive specialty drugs (rather than 30-day supplies), to accelerate sales and reduce their minimum rebate obligations by 67% in the process.]

Big Problem #2 – Conflicted Consultants Do Not Challenge Traditional PBM "Profit Centers" (cont'd)

- Providing a brand level discount on Specialty Drugs (e.g. AWP-20%), but including many generics on the Specialty Drug List which inflates the PBM's spread on brand Specialty Drugs.

- Providing that all "Rebates" will be passed through to the plan sponsor, but defining "Rebates" to exclude millions of dollars in rebates which have been recharacterized as "service fees" (not "Rebates").

- Providing an "Inflation Protection Program" with minimal or no value to plan sponsors, but pocketing all price protection rebates in the fine print.

- Delaying the coverage of new generics, so that higher cost brands can be sold for additional months (or years).

- Blocking coverage of certain generics, so higher cost brands can be sold indefinitely.

Big Problem #2 – Conflicted Consultants Do Not Challenge Traditional PBM "Profit Centers" (cont'd)

- Ignoring the availability of "biosimilar" drugs, which are less expensive versions of certain high cost biologic (i.e. not chemical) drugs. Biosimilars are FDA approved and have been widely accepted in Europe for many years (PBMs do not exist in Europe).

- Charging $10/pill for generic Cialis, when the PBM's acquisition cost is less than $.50/pill. A 2,000%-4,000% mark-up on a popular, high volume generic.

Big Problem #3 – Conflicted Consultants Protect Traditional PBMs

- Traditional PBMs routinely make promises in their RFP bids which are mysteriously not included in the final PBM contract.

  [Consultants will not take responsibility for these expensive contracting errors because "they are not lawyers."]

- Consultants did not say anything in 2018-2020 when traditional PBMs moved their rebate agreements to group purchasing organizations ("GPOs"), so (i) the rebate agreements would no longer be available for audit review, AND (ii) the GPOs could siphon-off some of the rebates for their PBM owners.

- Consultants have not disclosed the fallacy of high AWP discounts for generic drugs. An AWP-85% discount for generic drugs is meaningless because the AWP list prices for many generics are hyper-inflated, and the AWP discount percentages are therefore meaningless. **Plan sponsors need to control the price, not the discount percentage.**

  [Would you be happy with an 80% discount on a new BMW if the sticker price was $2M and the net price was therefore $400,000?]

Big Problem #3 – Conflicted Consultants Protect Traditional PBMs (cont'd)

- Consultants do not recommend annual audits of the traditional PBMs, and many suggest that such audits are a waste of time.
- Consultants do not require generic MAC prices to be market competitive – traditional PBMs take large percentage spreads on common, high volume generics.
- Consultants do not inform plan sponsors of important developments in the drug industry which are opportunities to reduce drug spend, because those opportunities will reduce traditional PBM profits (e.g. handling of Lantus generic, all biosimilars).
- Consultants do not challenge traditional PBM programs which many times increase drug spend (e.g. Generic-to-Brand Interchange Programs).
- Consultants offer bare bones service agreements, which contain a limited list (or no list) of PBM monitoring obligations.
- All of the foregoing "failures" are in addition to the subjects listed in prior slides, and these slides do not contain an exhaustive list of problems.

Conflicted Consultants Do Not Challenge Traditional PBM Audit Limits

- Plan sponsor can only use an auditor that is approved by the PBM.

  [Pharmacy benefit auditors will not dig deep in an audit because traditional PBMs will "blackball" them from future audits if they expose too many PBM overcharges.]

- Auditors can no longer review the actual rebate agreements between the PBM and drug manufacturers, because the agreements have been sent to an affiliate of the PBM overseas (e.g. Ireland, Switzerland).

- Audits can only go back one year (was 3 years, then 2 years, now 1 year).

- No auditing of other PBM revenue streams from drug manufacturers (most of which are rebates which have been recharacterized as "service fees" or inventory purchase discounts).

  [The dollar value of these "service fees" are sometimes 20x to 100x the fair market value of the services actually being provided by the PBM to the drug maker.]

Do Not Accept "Bogus" Consultant Disclaimer Letters (with caveats) Under Section 202 of CAA

- "Consultant is not taking any compensation from the PBM which directly relates to the plan."
- "Consultant is not taking any compensation from the PBM which is related to the consultant's services to the plan."
- "We do not receive any compensation directly from your PBM for the work we do for you, or any other client."

* * * *

The foregoing caveats cause the disclaimers to be legally ineffective (i.e. worthless) to the plan sponsor (fiduciaries).

Recommended Next Steps Regarding CAA Compliance

- Retain experienced ERISA counsel which specializes in PBM contracting, drug pricing and rebates, RFP oversight and PBM audits. Has counsel logged at least 1,000 hours of PBM work for each of the last 5 years? There are very few of these lawyers who represent plan sponsors (fiduciaries), rather than PBMs.

- Seek and obtain clean (no caveats) disclaimer letters from your pharmacy benefit consultant. The national and regional pharmacy benefit consulting firms will not provide a clean disclaimer letter.

- If a consultant refuses to comply with Section 202 of the CAA, you must report them to the Department of Labor promptly, as required by the CAA.

- Get a "second opinion" from qualified ERISA counsel on (i) the sufficiency of the consultant's service agreement, and (ii) whether your PBM contract is fair and reasonable for both the plan sponsor and PBM.

- Retain an independent data analytics firm to receive a duplicate set of your pharmacy claims monthly, so such data is readily available for an independent analysis when needed.

Questions?



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Upcoming Webinars and Meetings

Annual Forum

November 7-9, 2022 (in-person only)

Recent webinar and town hall recordings now available under "Resources"

- 5 Tenets to Managing Health in an Uncertain "VUCA" Environment
- Better Health NOW: Relooking at Primary Care Strategy
- The New Hybrid Workplace Built on Resilience
- A Fresh Look at Reference-based Pricing



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