
Pharmacy Benefit Managers and Managed Care: Where are we going & how do we get there together?
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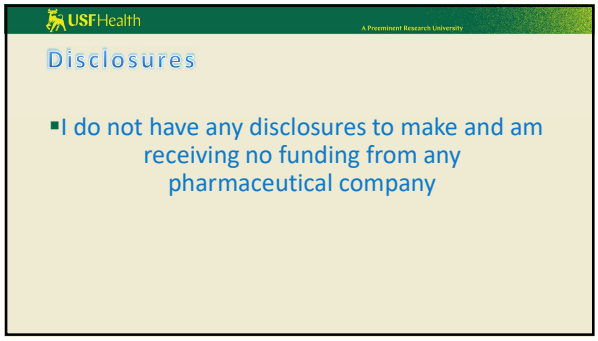
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Disclosures
I do not have any disclosures to make and am receiving no funding from any pharmaceutical company

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Questions

1. PBM's are only involved with commercial and Medicare prescriptions
2. Pharma companies pay rebates to PBM's and Health Plans to lower patient costs.
3. Drug Discount Cards improve Pharmacy Profits
4. Processors can set fees at any level they wish
5. Wholesalers help pharmacies increase profits
6. PBM's evolved from claims processors to formulary managers
7. Pharmacists learn how to manipulate the processes for payment

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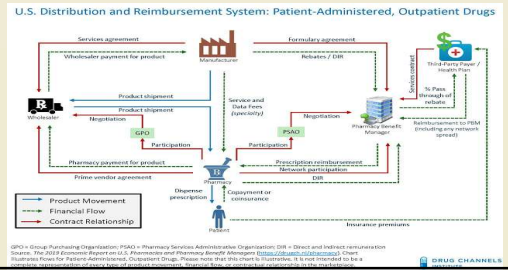
Pharmacy Reimbursement Maze



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Objectives

- Identify the evolving role of Pharmacy Benefit Managers
- Describe how clawbacks, audits and limited networks have affected pharmacies
- Define the process by which drug manufacturers calculate and deliver rebate payments to PBM's and how this affects pricing
- Review ways wholesalers operate as middlemen
- Describe what a PSAO or buying group do
- Review the availability of discount cards and how they impact payments to pharmacies and how PBM's use them
- Identify unscrupulous pharmacist behavior and their processes

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PBM's

- Pharmacy Benefits Manager
  - The third-party administrator (TPA) of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plan. They are involved in virtually all prescription transactions

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https://en.wikipedia.org/wiki/Pharmacy_benefit_management

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History of PBM's

- The first **PBM**, Pharmaceutical Card System Inc. (PCS, later AdvancePCS) originated in 1968 with the invention of the plastic benefit card. By the "1970s, they served as fiscal intermediaries by adjudicating prescription drug claims by paper and then, in the 1980s, electronically." Overtime they morphed to become the both the provider of services and the payer of these services, as well as the managers of pharmacy benefits with an eye on reducing healthcare costs.

http://www.medscape.com/viewarticle/432389

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How PBM's Affect Pharmacy

- They determine, set and enforce
  - Drug choices
  - Brand/Generic substitution
  - Therapeutic Substitution
  - Step Therapy
  - Prior Auth Requirements
  - Reimbursement rates
  - Fees
  - Days supply
  - Audit rules
  - Conversion to Mail Order
  - Exclusive Networks

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How PBM's Affect Patients

- They determine, set and enforce
  - Drug Choices
  - Therapeutic Choices
  - Copay prices
  - Days Supply
  - Pharmacy choices
  - Mail Order Requirements
  - Medication Justification

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Formulary Choices

- PBM's play a major role in selecting which classes and which medications in a class will be covered
- PBM's set tiered copays to affect prescribing habits
- Pharma companies are forced to give rebates to PBM's to either get on a formulary or receive favored position.
- These rebates are very rarely passed on to the patient, employer or health plan.
- Pharma often considers rebates in medication pricing
- PBM's control reimbursement amount to cause pharmacist to choose other branded product or generic

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How the PBM Process Works

Patient brings you a prescription ---Submit the claim

Goes to a switch then to processor

Processor looks at Pharmacy NABP, Drug NDC, Quantity, Directions, Days Supply, Formulary Status, Last fill date, Mail Order Requirements

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Processor sends back approval with estimated payment and copay
Processor shunts to discount plan(really not covered nothing applied to deductible)

↓

Wait for payment and DIR charges

↓

Processor sends back reject with message of needs for approval or outright rejects

↓

Fix noted problems and resubmit or Start P/A process

↓

Approval and Wait for payment and DIR charges

↓

check for P/A answers

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Direct and Indirect Remuneration

- A "catch-all" term designed to encompass a number of different types of fees and charges that PBM's and Plans take back from pharmacies
- These fees can include:
  - pay to play" fees for network participation
  - periodic reimbursement reconciliations or "clawbacks"
    - true-up" between a target reimbursement rate in a participating pharmacy agreement and the aggregated effective rate actually realized by a pharmacy
  - Penalties assessed to pharmacies for non-compliance with quality measures.

www.ncpa.co/pdf/faq-direct-indirect-remuneration-fees.pdf

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Direct and Indirect Remuneration

- The National Community Pharmacists Association survey provided examples of these problems, but none of the pharmacists would talk on the record for fear of being kicked out of the PBM networks.
  - A major PBM required the pharmacy to collect a $35 copay for a generic allergy spray, then took $30 back from the pharmacy
  - A PBM charged a $15 copay for insomnia drug Zolpidem, then took back $13.05.
  - Patients were charged $30 above the cash price for a generic cholesterol medication
  - Pharmacists are specifically barred from discussing the cash price under terms set by contracts between them and the PBMs (this has changed but beware….)
  - If we do sell it as cash it can affect our star ratings as the PBM does not see that the patient is on a measurable medication
  - Cash payments don't always count toward annual drug deductibles, consumers who expect a lot of drug costs might want to think twice about paying cash.

http://khn.org/news/author/julie-appleby/6-24

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Direct and Indirect Remuneration

- DIR fee" may be used by a Plan/PBM to bolster their assertion that these fees cannot be determined at the point of sale—which would explain why these fees are collected from pharmacies after claim adjudication
- When the PBM when takes back a portion of that patient payment from the pharmacy that money does not go to the consumer or their insurer, but is generally kept by the PBM
- The fees themselves are legitimate, but there does not seem to be adequate disclosure to the pharmacies or the contracting entities by the Plan/PBM as to exactly how these fees are calculated either at contract initiation or at the time these fees are actually taken.

http://khn.org/news/author/julie-appleby/6-24
www.ncpa.co/pdf/faq-direct-indirect-remuneration-fees.pdf

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Other PBM Costs

- Audits with unrealistic demands
  - Charge for errors including loss of drug revenue and fines
  - Hold payment on non-contested claims
- Long reimbursement times for payments
- Lumping of payments to make verification payment of individual scripts difficult
- Very difficult to challenge claims, may be moved out of network.

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Formulary Choices

- Formulary life cycle- new product new class
  - New product comes on market and usually 6 month window of PBM coverage
  - New product is rejected or not covered by PBM
  - PBM begins to negotiate rebate with pharma
  - Rebate is determined and new product goes on formulary, usually 3rd tier or PA provided
  - Increased rebates can move to lower tier
  - PBM's look for better rebates from class competitors

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Formulary Choices

- Formulary life cycle-existing class
  - New product is rejected or not covered by PBM
  - PBM begins to negotiate rebate with pharma
  - PBM uses pharma companies to bid rebates up
  - Once rebate is approved the other product is no longer covered or covered at higher copay
  - Other companies can come back to bid rebate higher

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How Rebates Affect Pricing

- Pharmaceutical pricing is complicated, but goes something like this: Drug companies set the sticker price for their drug. They then negotiate prices on these drugs with insurance companies and PBM's, that put them in the hands of patients.
- The higher-rebated drugs might move their way up a "drug formulary" list, meaning they are more likely to show up on a preferred benefit plan, and patients are more likely to buy them.
- Sticker prices appear to remain high and continue to rise. Rebates decrease the transparency of true drug prices and as as an industry rebates have doubled over the past 10 years. Analysts estimate that over $90 billion in sales is rebated back each year.

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How the deal goes down

- Managed Markets representatives reach out to the PBM to get on formulary
  - Multiple trips and calls to speak to clinical and financial departments
  - Negotiations on fees, rebates and copay tiers
  - Agreement on high deductible plans and effects on above
  - Review of all drugs in company's basket and rebates

At the same time

PBM representatives reach out to Managed Markets of a pharma company

- Contact other branded companies in the same drug class
- Try to play one company against the other to maximize rebate and fees
- Threaten to drop other products in the company's basket to increase rebates
- Try to get discounts for purchasing products for PBM owned mail order

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Hidden PBM Profits and Controls

- High Deductible Plans- Until a patient meets their deductible the PBM has no costs
  - Pharma still has to pay a rebate
  - Pharma still has to pay the fees
  - Prescriptions flipped to discount card rather than being rejected, patient pays for higher priced medication, PBM has no expense
- PBM sets reimbursement rates for pharmacies
  - Contracts call for WAC minus reimbursement for pharmacies
    - PBM can have exceptions
    - PBM negotiates all different rates of reimbursement with
      - Chains
      - Groceries
      - PSAO
      - Independents
      - Mail Order
    - Often times the pharmacy owner has no idea what their rate is from any specific PBM
  - PBM controls reimbursement time period for payment
- There is no correlation between what PBM reimburses and what pharmacy pays for product.

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Wholesaler Effects

- Wholesalers have an effect on Pharma pricing and Pharmacy Profitability

- Pharma
  - Fees to stock on shelves in warehouse
  - Fees to keep certain stocking level
  - Fees to deliver product to pharmacy
  - Discounts for certain volume goals

- Pharmacy
  - Multiple contract levels
  - Drug exceptions
  - Brand % of orders penalty
  - Short dating for payment.

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Wholesaler Effects

- Wholesalers have an effect on Pharma pricing and Pharmacy Profitability
- Pharma
  - Fees run 10% of WAC on average
  - If you don't agree to fees, they won't carry your product
  - Extra Dating to Pay their bill
  - New product introductions require special deals and dating to get them to stock,
  - Extra fees to place in all DC's
- Pharmacy
  - Discounts have decreased in past 18 months
  - Rationing of products
  - Desire to limit your choices

Seek out direct purchases from Manufacturers to lower your costs

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Manufacturer Copay Cards and Programs

- These copay or cash buy down cards reduce the cost to the patient. They work for both cash and commercial claims, but reimbursement is not the same. Cannot be used with Medicare, Medicaid or US Government programs.

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Manufacturer E-Vouchers and Direct Programs

- E-vouchers are Manufacturers copay programs that the switch automatically applies and are seamless,
- Direct programs usually have a limited network and pharmacies have 1 processing ID for all patients, Sales Reps provide selected pharmacy information to prescribers
- Cannot be used with Medicare, Medicaid or US Government programs.

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Discount Drug Cards

- These are unlike manufacturers copay or cash buy down cards as nothing is paid to the pharmacy. The pharmacy agrees to discount the cash price, but they often don't know it.

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Discount Drug Cards

- These discount cards have bin, pcn, group and id number just like insurance cards
- Bins can be
  - Commercial only
  - Medicare only
  - Discount only
  - All three
- This can cause confusion and cost both pharma and pharmacy money
- PBM's provide discount cards and convert to DDC to give the impression of insurance savings for patient

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Discount Drug Cards

- Discount cards that have bins also used buy insurance can increase pharma costs and decrease reimbursement and loss of customers to the pharmacy .
  - These appear to manufacturer copay buy down cards to be primary insurance, so patient receives the commercial buy down and pharma pays more
  - Since there is no reimbursement to pharmacy the amount that a copay card would pay is reduced.
  - Fees for processing are often higher than commercial plans
  - PBM's that issue these cards get patient information with each use and recruit these cash customers to their mail order services I

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Discount Drug Cards

- New Ideas are taking more money out of the pharmacy's profits
  - PBM's and others are now taking claw-backs on discount cards
  - If the pharmacy usual and customary is lower than the Discount Cards calculated price, the processor returns the higher price for the patient to pay and then "claws-back" the difference from the payment to the pharmacy.
  - Companies like Blink health and the Express Scripts/Good RX alliance negotiate discounts with some brand manufacturers and for uninsured customers and pharmacies make less money.
  - Some discount cards companies have built a multi-level like system to reward lay people to hand out discount cards.
  - Processors of Discount cards pay to have the data added to the EMR prescribing so when new rx comes in, it appears that office is providing new insurance info.

https://www.nytimes.com/2017/05/08/health/express-scripts-drug-prescriptions-prices.html?_r=0

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Policing our Profession

- Pharmacists are cutting corners and doing less than legal things that are causing problems for the whole profession and technology is getting them caught
  - Fraudulent insurance claims – loss of Medicare and Government participation, jail time, loss of pharmacy ownership
  - Fraudulent Free Trials or Cash Portion of copay cards - Processing free trial or cash cards and not dispensing product. Pharma pays the pharmacy, but they don't order product.
    - Software matches coupon use to product ordered
    - Pharmacists have been arrested for theft and filling a prescription with out a legitimate prescription(even though it was not dispensed.
  - Pop-up pharmacies- Owners get a license and open pharmacy and run multiple pharma cards and then disappear and hope to collect payment. Often these are not owned by pharmacists, but employee pharmacist loses license and may receive jail time

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Policing our Profession

- Pharmacists are cutting corners and doing less than legal things that are causing problems for the whole profession and technology is getting them caught
  - Pharmacists are closing out commercial claims and then opening the claim back up to split bill and manipulating the insurance copay to cause pharma to pay more.
  - Pharmacist who own multiple pharmacies are submitting same claim at multiple locations and attempting to trick both PBM and Pharma.
  - Many pharma companies, including ours, research this data and also pay investigative companies to look at the data
  - We aggressively pursue pharmacies for fraud.
  - We have removed 46 pharmacies for fraud from our programs since last November and we have alerted legal authorities on 7, and prosecuted 2.

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Summary

- Profitability in the retail pharmacy is decreasing
- More entities are taking money from the pharmacy
- PBM's are finding ways to reduce pharmacy payment while increasing fees
- Drug prices are increasing due to DIR, Rebates and Fees and these must be calculated
- PBM agreements with pharmacies are not standardized and can vary greatly
- Pharma paid rebates and wholesaler fees are constantly increasing causing higher retail prices
- Pharmacists and owners need to resist the desire to cut corners legally

Questions ????

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