HEALTHTRUST®

# Top 5 Things You Must Know To Negotiate A PBM Contract

*The Ultimate Guide to Securing Your Best Pharmacy Deal*

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# *Executive Summary*

As one of the largest prescription drug buyers in the US, we negotiate $14 Billion of pharmaceuticals annually for our members. About 30% of that is in our PBM program, which serves 300 different plan sponsors across the country. As a result, we have “seen it all” when it comes to types of PBM contracts.

Having the leverage to negotiate a PBM contract for our 3 million lives helps our team to uncover the myriad of tactics that are used in PBM agreement negotiations. Tactics that almost always protect the PBM’s profit margin, and unfortunately, do not serve the best interests of the plan sponsor.

Our objective is always the same: the best price plus most aggressive terms. So, we decided to create a free guide to help organizations cut through the murky language in their contracts.

This resource will help you shine a light on trying to secure in writing - the deal you thought you were *already* getting. So, what are the kinds of pricing tactics used? Let’s dive in!

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#1

# *Average Wholesale Price*

When you contract with a PBM, you generally are not paying a particular price for a drug, but rather receiving a discount off an index price.

Average Wholesale Price, or “AWP” is one of the most common and practical indices used for this purpose. But AWP is not the pharmacy or PBM’s actual acquisition cost; rather, it’s generally inflated by about 25% on average from what pharmacies really pay for drugs from the wholesalers.

AWP is published for each drug, all the way down to the National Data Code (NDC). The NDC-11 is an 11-digit number that covers all the details of a drug:

- Dose form (capsule, tablet, liquid)
- Strength (dosing)
- Manufacturer
- Package size (100-ct bottle, single syringe)

It’s published on a unit basis (per qty, meaning pill, capsule, vial, etc. ). Knowing the NDC-11 helps you identify everything about the exact product being looked at.

#1

# Average Wholesale Price

In the contract, a PBM will offer you discounts off the AWP, often broken down by type of drug. For example, Generic drugs filled at a retail pharmacy for a one-month supply might have one "AWP minus x%" guarantee, Brand drugs filled by the PBM's own mail order pharmacy might have "AWP minus y%" for those prescriptions, etc. How the AWP is specifically defined, though, is very important for PBM contracting purposes:

- If the AWP definition isn't sufficiently specific, this could allow the PBM to manipulate the calculation; selecting the highest AWP they can find.

  *For example, let's say the price you paid for a drug was $20.00; depending on the AWP definition, it might be measured as $30.00 under one contract (where the discount is 1 - $20.00/$30.00 or 33.3%); or in another contract it might be measured as $50.00 (where the discount is 1 - $20.00/$50.00 or 60.0%). That's a big difference in how well the PBM performed between the two: 33.3% vs. 60%, though they represent the exact same situation!*

- Remember that the guarantees the PBMs offer are based on buckets of drugs, not each individual fill. Therefore, if the PBM uses an AWP definition that allows them to claim more discount, they can use that money to offset other drugs too, potentially further raising their profit at your expense.

- PBMs may also buy larger quantities of the drugs and "repackage" them into different sizes with higher AWPs, as another way to create this advantage.

***What's in an NDC-11?***
***using XXXXX-YYYY-ZZ as an example***

| | |
|---|---|
| XXXXX (digits 1-5) | Manufacturer, repackager, or third-party labeler identifier |
| YYYY (digits 6-9) | Strength (50mg, 250mcg,…) dose form (capsule, tablet, liquid,…) and formulation (topical, oral, subcutaneous injection,…) |
| ZZ (digits 10&11) | Package size (100 count bottle, blister pack,…) and case size (2-pack of bottles shrink wrapped together) |

#1

# Average Wholesale Price

*So, what should you do with your PBM Contract:*

1. AWP should be based on a specific and credible index to begin with (typically this is Medispan), without allowing the PBM to sporadically change sources

2. AWP should be based on the "Actual NDC-11 dispensed"; using the full 11-digit NDC is important to make sure the PBM can't substitute a similar NDC (e.g., reflecting the same drug and dose but a different manufacturer)

3. AWP should be based on the actual date the prescription was dispensed - to make sure the PBM can't select another date where the AWP was higher, thereby raising the performance discount

4. Repackaging of product should not be allowed; it could allow determination of a higher AWP through use of a different package size

5. The AWP calculations should be in scope (eligible) for audits by the plan from time to time. Reviewing the calculations and source data for accuracy is always important

*This language should be negotiated and firm before you make your PBM decision. The financial impact of the language can cost you 1-3% of total ingredient costs.*

*Remember to always question everything!*

#2

# *Brand vs. Generic Drugs*

Drugs are typically grouped into buckets, with each having independent AWP discounts offered by the PBM.

How to determine which drugs go into which bucket?  Something as simple as generic versus brand should be easy, right? Unfortunately, no.

Before diving too deep, let's review a little relevant background: drug patenting in the United States:

- A manufacturer of a new drug will generally receive patent exclusivity for ~20 years. During that time, that company is the only one who may sell that drug. This is called a Branded drug product, and while under patent protection these drugs are relatively quite expensive (given the market monopoly given to the manufacturer during this period)
- Once the patent expires, there can be a second notable period where a generic alternative of the drug hits the market, but via a single manufacturer. This is called a "single source generic" and lasts for another 6 months after patent expiration, typically. During these 6 months, the drug is priced more like a brand, even if it is technically a generic (since there is still no competition)
- Finally, after that 6 months expires, many more manufacturers will often come forward with their generic versions of the drug, creating strong market pressures to drive price lower

How a PBM contract defines and classifies drugs as Brands or generics has substantive impact on overall value. And moreover, there are many variations of how this tactic is used in practice.

#2

# *Brand vs. Generic Drugs*

Here's how the math works - when the PBM takes a subset of drugs and contractually calls them brands instead of generics, they can actually raise their offered AWP discount to you for ***both*** generics and brands without giving any more money away. In other words, they make their offer look better, measured by AWP discounts, yet it really isn't any better at all.

To illustrate, let's assume a plan has a simple claims history that looks as follows:

| Drug "Bucket" | AWP | AWP Discount Offered | Total cost AWP*(1-Discount) |
|---|---|---|---|
| Brands | $1,000 | 20% | $800 |
| Single Source Generics | $300 | 80% | $60 |
| All Other Generics | $500 | 80% | $100 |
| ***Total*** | ***$1,800*** | | ***$960*** |

In the deal above, all generics are receiving the deeper (80%) AWP discount – including Single Source Generics.

But what if the PBM decided to treat single source generics as brands? Then the PBM could retain the difference as additional profit, or raise their AWP discounts to get back to the same economics.

Let's assume they choose the latter strategy and see what happens to the deal terms (table on next page).

#2

# *Brand vs. Generic Drugs*

*Former Example*

| Drug "Bucket" | AWP | AWP Discount Offered | Total cost AWP*(1-Discount) | | AWP Discount Offered | Total cost AWP*(1-Discount) |
|---|---|---|---|---|---|---|
| Brands | $1,000 | *30%* | $700 | | 20% | $800 |
| Single Source Generics | $300 | *30%* | $210 | ⟷ | 80% | $60 |
| All Other Generics | $500 | *90%* | $50 | | 80% | $100 |
| ***Total*** | ***$1,800*** | | ***$960*** | | | ***$960*** |

In our example, the PBM was able to raise their generics discount from 80% to 90% and their brands discount from 20% to 30%, without changing the net economics at all.

We used single source generics as our focus in the above example, but there are many subgroups of drugs which can get re-characterized to cause this same sort of problem, each requiring diligent negotiation to prevent.

In essence, it is very important that the overall definitions are clear about which drugs receive which discounts. These definitions should be objective and unambiguous. Moreover, they shouldn't be able to be changed throughout the plan year based on PBM discretion.

#2

# *Brand vs. Generic Drugs*

*So, what should you do with your PBM Contract:*

1. Single Source generics should be classified as generics in the contract as a first step, but there is more.
   *You will also want to make sure single source generics themselves are defined properly (so to include even those situations where the drug has truly only one generic manufacturer).*

2. The generic definition should also include generics in short supply (in other words preventing the PBM from moving drugs to a lower discount level because of supply levels).

3. The generic definition should also include any drugs that may be under patent litigation (happens every day in PharmaLand).

4. The Generic definition should also include what are called “House Generics” or “DAW-5” claims. These are claims that a pharmacy dispenses as a generic even though the drug is a brand. This normally happens because the pricing is very low, meaning a bigger AWP discount is warranted.

5. Any drug that is moved to be treated as a brand should at least receive the minimum rebates as well. We’ll talk more about rebates soon, but for now the point is that each drug should be bucketed the same way for discounts and rebates.

*This language should be negotiated and firm before you make your PBM decision. The financial impact of the language can cost you 3-6% or more of total non-specialty drug spend.*

*Remember to always question everything!*

#3

# *Specialty Drugs*

Specialty drugs are the most ambiguous segment in pharma today. They're also most likely the largest single area of spend for your plan.

And even if they aren't today, they will be soon, given that almost the entire pharmaceutical development pipeline focuses on these types of drugs.

So, what is a specialty drug? Definitions can vary widely, adding to the complexity. To give some examples, specialty drugs can be defined (a) simply by their cost, (b) by their distribution/handling (require special logistics or controls, such as temperature, or (c) by the type of molecule they are - such as complex biologics.

Remember that every drug has its own NDC-11, including specialty drugs. This means that ultimately, it should be possible to characterize them in a list, knowing drug by drug which are specialty for purposes of the contract.

Just like non-specialty drugs, specialty drugs will receive both discount guarantees (e.g., off of AWP) and rebates. We will talk more about rebates later, but one of the biggest differences between specialty and non-specialty drugs is that specialty drugs receive much larger rebate guarantees from the PBM to you. For example, a PBM contract might promise the plan sponsor:

- $200 in rebates for each brand non-specialty drug filled by your employees
- $2,000 in rebates for each brand specialty drug filled by your employees

Therefore, the simple categorization of a drug as specialty or not can mean big bucks on your contract value. And while there is no standard definition here, the more ambiguous your definition is, the more risk you're taking on.

#3

# *Specialty Drugs*

Specialty drugs are further grouped into sub buckets as well. One of the most important such sub-groups is known as “Limited distribution drugs”, or “LDDs”.

An LDD refers to a drug that is highly targeted or rare and used for very complex patients with complex illness. It should mean where the manufacturer only contracts with one, two, or perhaps a few pharmacies to dispense their product across the country. In these cases, the PBM may not be able to dispense out of their own pharmacy, and pricing won’t be as good.

While there are others, consider several other important specialty drug sub-groups:

- New to market drugs – which may look to treat drugs differently for the first period of time after they hit the market
- Biologics – which refers to the materials used to produce the drug and/or the process used for regulatory approval
- Biosimilars – which refers to a type of generic drug as applied to a biologic molecule
- Individual Drug Classes – which can mean certain classes of drugs are treated as specialty or not, based on the condition treated, type of drug, etc.

#3

# *Specialty Drugs*

*So, what should you do with your PBM Contract:*

1. Regardless of the specialty definition, a fixed list of NDCs that fully represent specialty drugs offers you the most protection. This list should include the financial terms associated with each drug (if different) and/or be explicit about any drugs which receive different terms.

2. This specialty drug list should not be updateable merely at PBM discretion (risks moving of drugs to non-specialty without your approval or benefit).

3. Limited distribution drugs ideally should be treated the same as any other specialty drug (for discounts, for rebates); note that having that protection negates the need to try and objectively define LDDs - which we could write an article on all by itself!

   *If you're unable to get PBM to agree to treat LDDs the same as other specialty drugs, then make sure their definition is as explicit as possible, and calls out the particulars in an objective way (e.g., based on the number of pharmacies used)*

4. Make sure any movement of drugs on or off the specialty drug list requires approval by the plan, and with notice (otherwise the strong contract you negotiated may become stale quickly).

*This language should be negotiated and firm before you make your PBM decision. The financial impact of the language can truly cost you 20-30% or more or your Specialty drug spend.*

*Remember to always question everything!*

#4

# *Rebate Language*

How rebates are determined and reconciled are both critical to the value of your deal.

Most PBM deals offer minimum rebates that vary in amount by type of claim (retail, mail, specialty) with the largest amounts paid on specialty drugs. And beyond the variability of which bucket to classify a drug, there is also an important question of "which drugs are eligible for the minimum rebate or not."

→ Illustrative Example:
$200 Per brand retail
$750 Per brand mail order
$2,000 Per brand specialty

For example:

- PBM may offer you a minimum of $200 per brand drug filled at retail
- But the actual underlying money the PBM receives from the pharmaceutical manufacturers might vary from $0 to $1,000+ on the drugs filled
- So the PBM is giving you an amount - either an exact amount or a minimum guaranteed amount for rebates, and then absorbing the risk of actual utilization to some extent

Most PBM contracts employ many tactics here. Some will move drugs liberally from specialty classification to something else (where the money owed is much lower). Others will exclude many types of drugs from the rebate payments.

*Or even worse, some contracts won't specify exactly what is excluded but rather give the PBM the ability to determine this on the fly (which will never be good for you!).*

What you want to make sure of is that each drug is unambiguously defined into a rebate bucket. Any rebate exclusions should be both logical and not interfere with your plan performance.

#4

# *Rebate Language*

Then there is the question of what happens with any extra money the PBM earns over the amounts paid to you.

It's important to note the difference between "rebate" (with a small "r") versus "Rebate" (with a big "R"). This refers to the fact that many larger plan sponsors (because of their size), ask for all the rebate money - meaning the PBM has to pass on any rebates earned above the guarantees. But rebates are but just one piece of the larger compensation pie that manufacturers pay PBMs (and a shrinking one at that!).

*Think about "Rebates" as the whole pie and "rebates" as the slice.*

Today, "rebates" may only be 70-80% of the total compensation paid; so, what else is there?

- Manufacturer Admin fees or "MAF" which can be up to 5% of the drug cost
- Price Protection Payments, which are usually indexed to drug cost inflation and where the Manufacturer has to credit the PBM for the full change in price
- Data fees paid for sharing information with the manufacturers
- New types of compensation are invented/labeled all the time

This means that even when the PBM promises you all the rebate money, you're not getting what you think. Large plan sponsors may be able to negotiate 100% pass through of rebates, but it's much more difficult to get 100% of truly all compensation passed through.

#4

# Rebate language

*So, what should you do with your PBM Contract:*

1. Demand 100% pass through – and not just of rebates but other forms of compensation as well.
   *You will likely have a hard time getting 100%, but be sure to demand the requirement for disclosure of all money received by the PBM (allowing you to quantify the impact at a minimum).*

2. Be explicit in defining which drugs are not paid the minimum rebate;  the smaller this list is, the better (though sometimes exclusions are logical; such as for generic drugs, where rebates are rarely paid). And be clear that unless noted as an exclusion, all other prescriptions receive the rebate amount.

3. Try to explicitly document that key sub-types are included for application of the rebates; some of the most important areas where rebates should be paid but are often contractually excluded:
   - Brand drugs that are non-formulary
   - Limited Distribution Drugs
   - New To Market Drugs
   - Biologics and Biosimilars
   - Drugs where the manufacturer doesn't pay anything to the PBM for whatever reason
   - Drugs where Pharma denied paying the PBM monies owed (which can happen for several reasons)

4. Demand that minimum rebates are paid quickly and associated documentation be included for plan validation.

*This language should be negotiated and firm before you make your PBM decision. The financial impact of the language can cost you up to 50% - yes half - of total Rebates (with capital "R").*

*Remember to always question everything!*

#5

# Treatment of Generics

We know that drugs grouped into buckets for pricing purposes, but did you know there can even be multiple different prices for the same drug.

Earlier we reviewed the discounted AWP as one price for a drug, but there are others as well:

1. *Usual & Customary price ("U&C") also known as the cash price. This is the price charged by the pharmacy for cash paying customers without insurance and is often used for when the pharmacy is trying to generate customer foot traffic via volume of a particular drug.*
2. *The Maximum allowed cost price ("MAC"). This is a subset of products where the PBM may also have the ability to set the price for many individual drugs.*

Typically, the contract offers an overall Generic Effective Rate (also known as "GER") which applies to the combination of the "MAC'd" and non-MAC'd generic drugs. In other words, the generic drug discount offered for the bucket is calculated across all generics; those on the MAC list and those not on the MAC list.

As you probably guessed, the MAC list is another item the PBM can have excessive control over and use it for their own benefit as a pricing tactic. Specifically, the more that the PBM can a) control which drugs are on the MAC list and b) control what the MAC prices are, the more they can limit their risk and bolster their profits.

Sadly, most PBM contracts are relatively silent on MAC lists. And the less that is codified in the contract, the more flexibility the PBM has to exploit the results.

Now, you might be thinking "it's no big deal, generics are a small portion of our spend". But watch out, because the PBM can use the latitude they have with the MAC list to secure additional profits on your plan - ***even on Brand drugs***!

#5

# Treatment of Generics

*So, what should you do with your PBM Contract?*

1. Make sure the Total generic discount (GER) guarantee encompasses all kinds of generics (where MAC or non-MAC).

2. Ensure that the MAC list is contractually well defined. The more rigor in the definition the better, which should include at a minimum:
   - How the MAC list is determined (PBMs have many different ones to choose from)
   - How MAC prices are determined (again, many choices)
   - Why or how often a MAC price can change
   - What notification requirements exist prior to any changes (e.g., does PBM have to notify you when MAC prices change by a certain level)

3. Overall audit rights should include the MAC list, which should be available any time upon request.

*This language should be negotiated and firm before you make your PBM decision. The financial impact of the language can cost you 2-5% of total non-specialty drug spend.*

Remember to always question everything!

# Conclusion

We hope that this guide helps you secure the best possible benefits program for you and your plan participants.

Our program has been designed to eliminate risk from the contract, and offer you a ready-to-go, iron-clad set of protections contract with full audit and transparency rights. We provide the most aggressive terms available on the market.

We cover over 3M lives across the country, for plan sponsors ranging from 2,000 covered lives to over 400,000 – incorporating each of the items we've discussed in this guide in our contracts, plus others.

Please contact us at HumanCapitalSolutions@HealthTrustPG.com to learn how we ensure these factors can serve you in your next contract.

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