Capital Rx

SOCIETY OF ACTUARIES

PBM Industry Update – What Actuaries need to know

May 16, 2023

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Today's Agenda

1. **PBM Overview**
2. **Common Contracting "Tricks" PBMs use to create optics**
3. **Summary of Rx Reporting Rules under CAA**

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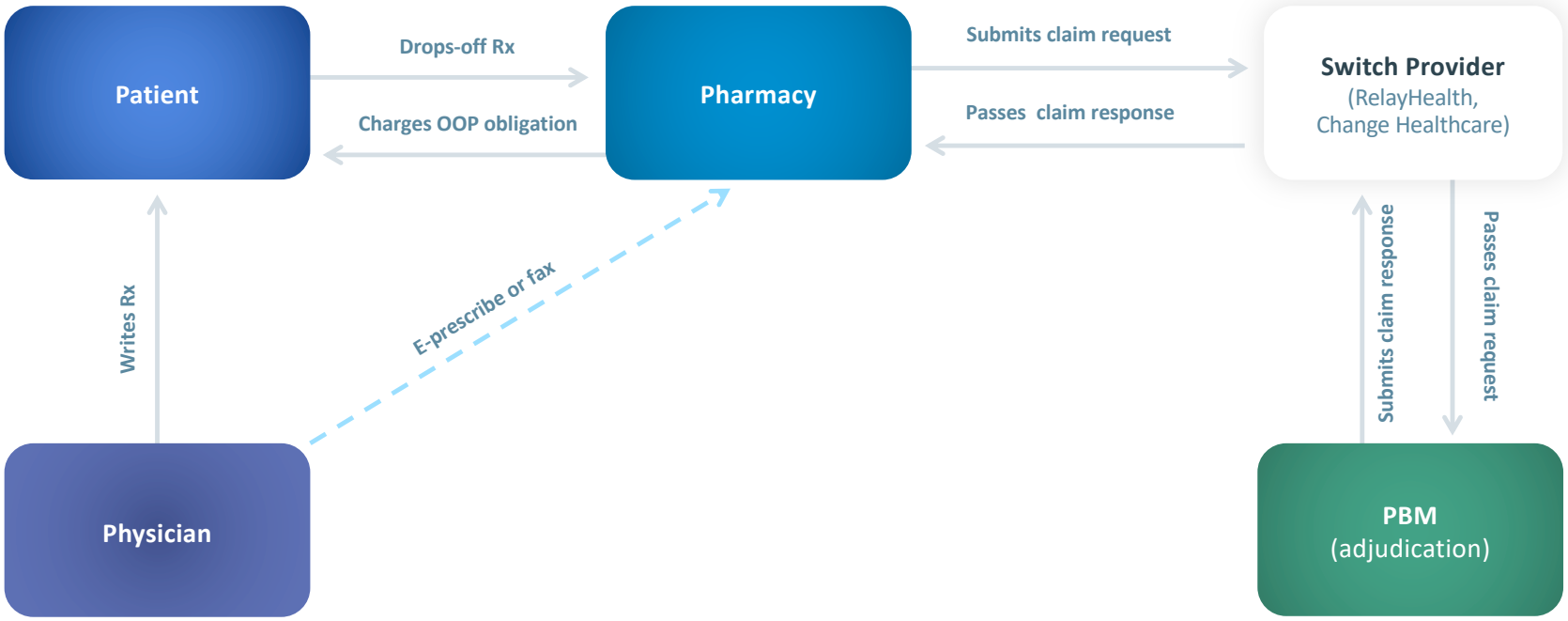
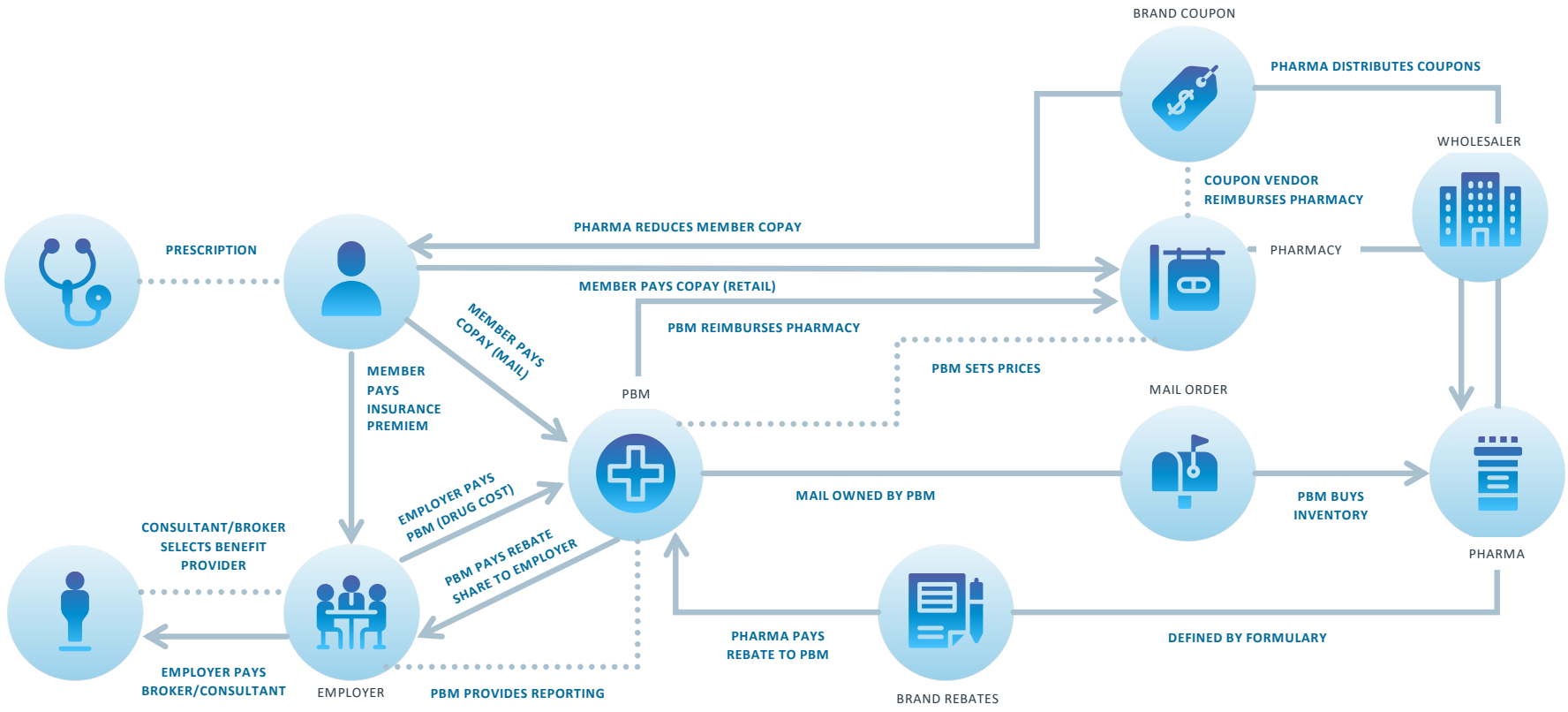
The PBM is the “middleman” in the pharmacy supply chain



Current Pharmacy Ecosystem



PBM Business Models

SPREAD PRICING

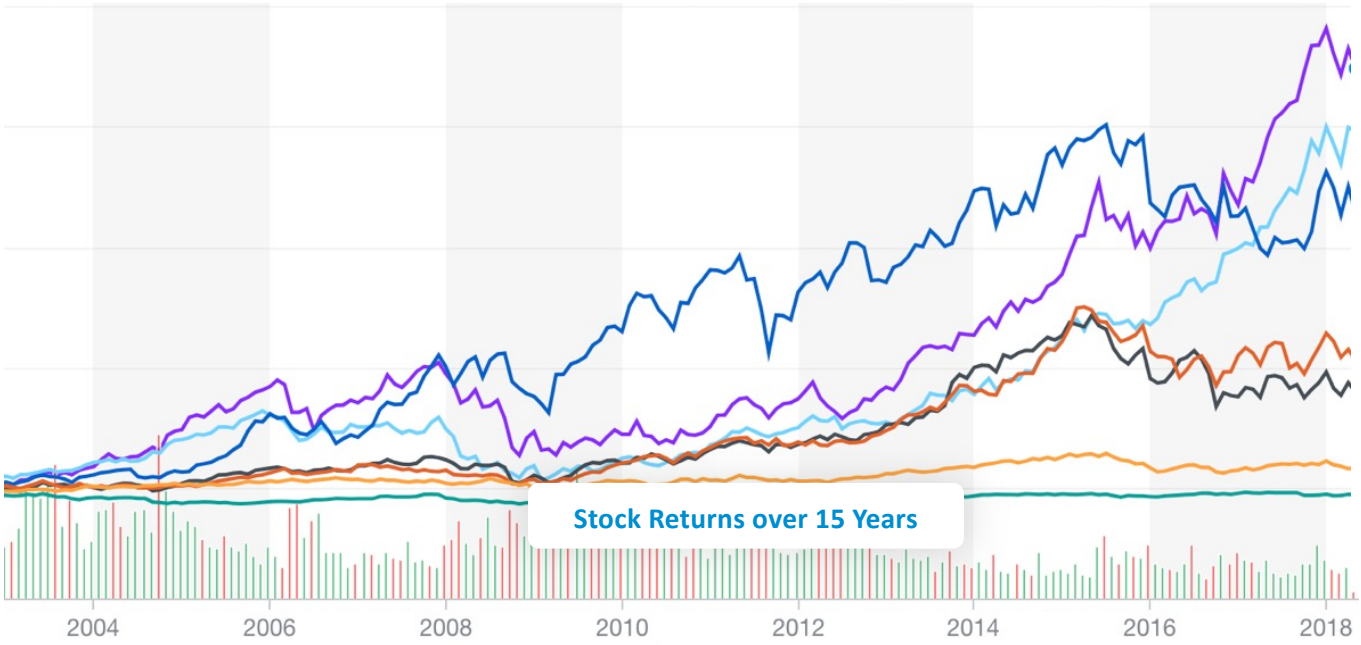
- The PBM pays the pharmacy a lower price for a particular drug compared to what they charge the Payer
- The difference between the two prices is called the "spread"
- PBMs do not charge an administrative fee under this model

PASS-THROUGH

- The PBM pays the pharmacy the same price for a particular drug compared to what they charge the Payer
- PBMs charge an administrative fee under this model

Most payers "think" they have a pass through model but there is often spread in these programs….. More on this later!

Business has been very good for the PBM industry



1,741% aetna CVS

1,478% EXPRESS Cigna

1,143% United OPTUM

PBMs

530% McKESSON

396% Amerisource

WHOLESALERS

80% NOVARTIS

-28% MERCK

MANUFACTURERS

SOURCE: YAHOO FINANCE

Today's Agenda

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2. Common Contracting Tricks PBMs use to create optics
3. Summary of Rx Reporting Rules under CAA

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Some PBMs rely on “optics” in their contracts to make their pricing seem better than it actually is.

Contract component differences for PBM’s	How can this be a problem?
Definitions of Brand and Generic for guarantee purposes	Can limit what is included as a generic for guarantee purposes. This often involves manipulation of the MAC list
MAC List	“Maximum Allowable Cost”. The price of a given generic drug varies daily as this list can be manipulated to increase PBM profits
Non-MAC generics	Can limit what is included as a generic for guarantee purposes. Non-MAC drugs can be generics reclassified as a brand
Definition of Specialty Drugs	Since Specialty drugs are discounted around 17% and generics are at 80+%, calling more generic drugs “specialty” lets the PBM make more money.
Treatment of Zero Balance Claims	Claims that are less than the co pay can be treated as claims paid at 100% discount
Definitions of “rebateable” claims	Can only apply to specific days supply fills or other exclusions

Which PBM offer is best (lowest net cost)?

	Current Deal	Proposed Deal
Brand Discount	18.5%	19.5%
Generic Discount	81.0%	85.0%
Specialty Discount	19.0%	22.0%
Brand Rebate	$ 175	$ 250
Specialty Rebate	$ 2,400	$ 3,500

The PBM market is being manipulated due to a lack of objective oversight and understanding of the complexity

Common Contract Concerns	Example
Varying Definitions of Brand and Generic	Can limit what is included as a generic for guarantee purposes (MAC, Single Source Generics, DAW-5)
Varying Definitions of Specialty Drugs	How are they defined? Long lists vs short lists. How do rebates apply?
Rebates vs. Lowest net Cost	High cost drugs are included on the formulary because of a large rebate…. But not large enough to get to lowest net cost. Also, with all the reclassifying, consultants often over estimate rebate revenue

There are other “Optics” but these 3 are the biggest “levers” a PBM can use to improve the appearance of the bid.

Most consultants DO NOT adjust for these differences

Varying Definitions of Brand And Generic

BAD

"Generic Drug" means a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active Ingredient(s) and on the MAC list.
See MAC List. (P 27)

P27. "MAC List" means a list of prescription drug products identified as readily available as Generic Drugs, generally equivalent to a Brand Drug (in which case the Brand Drug may also be on the MAC List) and which are deemed to require pricing management due to the number of manufacturers, utilization and pricing volatility. Whether a Prescription Drug Claim processes at the Generic ingredient cost rates set forth on **Exhibit A-1** is subject to the Covered Drug's inclusion on the MAC List and the application of "dispensed as written"" protocols and Sponsor defined plan design and coverage policies.

GOOD

Exhibit A-1
Pharmacy Reimbursement Rates

Participating Pharmacy Reimbursement Rates

Minimum 50,000 Participating Pharmacy Network

PBM 1 National Preferred Formulary
Sponsor-Owned Pharmacy
(excludes Specialty Products)

Brand Ingredient Cost
Single Source Generic Drugs are priced as brands
Year 1: Lower of AWP –17.25% or U&C
Year 2: Lower of AWP –17.50% or U&C
Year 3: Lower of AWP –17.75% or U&C
Pass-Through

Generic Ingredient Cost[1]
Year 1: Lower of AWP –17.25%, MRA, or U&C
Year 2: Lower of AWP –17.50%, MRA, or U&C
Year 3: Lower of AWP –17.75%, MRA, or U&C
Pass-Through

"Generic" shall mean and refer to Prescription Drug(s) designated as "Y" in Medi-Span's Generic Product Indicator.

The Generic Reclassification Game

How can discount rates be inflated if only 2% of generics are re-classified as brand drugs?

Category	Sub-Category	AWP	AWP Discount	Percent of all Drugs	Clean Language	Non-Mac Counted as Brand	Amount Discount is "Overstated" by the PBM
Brand		$ 600	19.0%	11.0%	19.0%	22.2%	3.2%
Generic	Non-Mac	$ 400	40.0%	2.0%	84.0%		
Generic	MAC	$ 400	85.0%	86.0%		85.0%	1.0%
Specialty		$ 8,000	20.0%	1.0%	20.0%	20.0%	
Total		$ 498		100.0%			

BAD

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The Specialty Drug Game

Large specialty drug lists allow various generic drugs to be reclassified as specialty drugs

		AWP	AWP Discount	Distribution with 500 Drugs on Specialty List
Brand		$ 600	19.0%	11.0%
Generic	Non-Mac, Single Source Generics, DAW -5	$ 400	40.0%	2.0%
Generic	MAC	$ 400	85.0%	86.0%
Specialty		$ 8,000	20.0%	1.0%
Total		$ 498	65.1%	100.0%
Weighted Average Ingredient Cost (Pre Rebate)				$ 173.86

		AWP	AWP Discount	Distribution with 2,000 Drugs on Specialty List
Brand		$ 600	19.0%	11.0%
Generic	Non-Mac, Single Source Generics, DAW -5	$ 375	40.0%	2.0%
Generic	MAC	$ 375	85.0%	84.0%
Specialty		$ 3,650	20.0%	3.0%
Total		$ 498	61.3%	100.0%
Weighted Average Ingredient Cost (Pre Rebate)				$ 192.81

How Rebates Can Misalign PBM Incentives – One Drug Example

	Discounted Ingredient Cost	Rebate Generated	Client Rebate Amount	PBM Rebate Amount	Actual Drug Cost	Net Employer Cost
PBM 1: **Brand Drug ABC**	$300	$150	$120	$30	$150	**$180**
PBM 2: **Brand Drug XYZ**	$180	$20	$20	$0	$160	**$160**

In designing a formulary, PBM 1's financial incentives differ greatly from that of PBM 2

Other Tricks of the Trade:

- What constitutes a rebate? Money back from the manufacturer comes in at least 3 forms (a percentage of WAC, an administrative fee, price protection)
- What is a "rebateable script".
  - Do non-generic, generics apply? These drugs might apply to the brand discount guarantee, but are they considered brands for rebate purposes as well?
  - What about branded drugs that are part of the high deductible?
  - Are specialty drugs eligible for rebates? If so, which ones?

How Do You Protect Yourself Against These Bad Contracting Practices?

- Review the contract first, not last
- Make adjustments to the bids based on the contract language
- Secure full audit rights

Adjustment #1 – Brand-Generic Definition

When Non-MAC generics are counted as Brands, lower the Brand Discount by 3.2% and lower the Generic Discount by .8%

Category	Sub-Category	AWP		AWP Discount	Percent of all Drugs	Clean Language	Non-Mac Counted as Brand	Amount Discount is "Overstated" by the PBM
Brand		$	600	19.0%	11.0%	19.0%	22.2%	3.2%
Generic	Non-Mac	$	400	40.0%	2.0%	84.0%		
Generic	MAC	$	400	85.0%	86.0%		84.8%	0.8%
Specialty		$	8,000	20.0%	1.0%	20.0%	20.0%	
Total		$	498		100.0%			

BAD

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Adjustment #2 – Specialty Drug Definition

When a large list of specialty drugs is provided (over 500 drugs), raise the expected overall drug cost by 1- 192.81/ 173.86 = 10.9%

		AWP	AWP Discount	Distribution with 500 Drugs on Specialty List
Brand		$ 600	19.0%	11.0%
Generic	Non-Mac, Single Source Generics, DAW -5	$ 400	40.0%	2.0%
Generic	MAC	$ 400	85.0%	86.0%
Specialty		$ 8,000	20.0%	1.0%
Total		$ 498	65.1%	100.0%
Weighted Average Ingredient Cost (Pre Rebate)				$ 173.86

		AWP	AWP Discount	Distribution with 2,000 Drugs on Specialty List
Brand		$ 600	19.0%	11.0%
Generic	Non-Mac, Single Source Generics, DAW -5	$ 375	40.0%	2.0%
Generic	MAC	$ 375	85.0%	84.0%
Specialty		$ 3,650	20.0%	3.0%
Total		$ 498	61.3%	100.0%
Weighted Average Ingredient Cost (Pre Rebate)				$ 192.81

Adjustment #3 – Formulary Rebate Exclusions

Don't take the big per script rebate offered by the PBM at face value. Only about 50-70% of brand drugs are "rebateable" based on the language. Or you can ask the PBM per all script rebates, no exclusions ($78 per script)

Select Formulary (200 Exclusions)		AWP (+10%	AWP Discount	Distribution with 500 Drugs on Specialty List	Select Formulary Rebate (200 Exclusions)
Brand		$ 660	19.0%	13.5%	$250
Generic	Non-Mac, Single Source Generics, DAW -5	$ 400	40.0%	4.0%	
Generic	MAC	$ 400	85.0%	81.0%	
Specialty		$ 8,800	20.0%	1.5%	$3,000
Exclusions	Overrides			0.1%	$3,214
	LDD			0.1%	$3,462
	Biosimilars			0.1%	$3,750
	Transplant			0.1%	$4,091
	Oncology			0.1%	$4,500
	HIV			0.1%	$5,000
Total		$ 561	57.9%	100.0%	
Weighted Average Ingredient Cost (Pre Rebate)				$ 235.97	
Weighted Average Ingredient Cost (Post Rebate)					$ 157.22

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So…Which PBM Offer is Best?

	Current Deal	Proposed Deal
Brand Discount	18.5%	19.5%
Generic Discount	81.0%	85.0%
Specialty Discount	19.0%	22.0%
Brand Rebate	$ 175	$ 250
Specialty Rebate	$ 2,400	$ 3,500

So…Which PBM Offer is Best?

	Current Deal	Proposed Deal	Adjusted Deal
Brand Discount	18.5%	19.5%	13.5%
Generic Discount	81.0%	85.0%	82.4%
Specialty Discount	19.0%	22.0%	16.0%
Brand Rebate	$ 175	$ 250	$ 165
Specialty Rebate	$ 2,400	$ 3,500	$ 2,307
Average Cost	$ 76.20	$ 36.20	$ 83.00
Relative Value	100%	48%	109%

Contract Provisions			
Single Source Generic as Brand	N	Y	(0.030)
Single Source Generic as Generic	Y	N	(0.026)
Non-MAC as Brand	N	Y	(0.020)
DAW - 5 as Brand	N	Y	(0.010)
Specialty Drug List 500	Y	N	1.000
Specialty Drug list 1,000	N	N	1.008
Specialty Drug list 2,000	N	Y	1.023
Open Formulary	Y	Y	1.000
Select Formulary 100	N	Y	1.031
Select Formulary 200	N	N	1.061
Specialty Rebate Excludes Overrides	N	Y	0.920
Specialty Rebate Excludes LDD	N	y	0.920
Specialty Rebate Excludes HIV	N	Y	0.920
Specialty Rebate Excludes Transplants	N	y	0.920
Specialty Rebate Excludes Oncology	N	Y	0.920

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Basic Requirement and Government Report

- Requires submission by Plan Sponsors of information on prescription drug (Rx) and health care spending to federal agencies
- Information will be used by agencies to produce a public report on:
  - Rx reimbursements
  - Rx pricing trends
  - Role of Rx costs in contributing to premium increases or decreases

Purposes

Regulators say information will:

HELP TO

- Identify major drivers of increases in prescription drug and health care spending
- Understand how prescription drug rebates impact premiums and out-of-pocket costs
- Promote transparency in prescription drug pricing

ENABLE POLICY MAKERS TO MAKE INFORMED DECISIONS TO SUPPORT GOALS OF

- Identifying excessive Rx pricing driven by industry concentration and monopolistic behaviors
- Promoting use of lower-cost generics
- Addressing impact of manufacturer rebates, fees, and other remuneration on Rx prices, plan/issuer costs, and consumer costs

Statute

- The RxDC requirement comes from:
  - Section 204 of Title II, Division BB of the Consolidated Appropriations Act of 2021 (CAA), which is codified at:
    - Internal Revenue Code (IRC) § 9825, 26 USC § 9825
    - ERISA § 725, 29 U.S.C. § 1185n
    - Public Health Service Act (PHSA) § 2799A-10, 42 USC § 300gg-120

Regulations & Resources

- Interim Final Rule issued Nov. 23, 2021, adding:
  - 26 C.F.R. § 54.9825-1T, et seq.
  - 29 C.F.R. § 2590.725-1, et seq.
  - 45 C.F.R. § 149.710, et seq.
  - CMS site has links for regulations, instructions, FAQS, and other info: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection
  - REGTAP site—can sign up for updates: https://regtap.cms.gov/
  - Questions for CMS: Call 1-855-267-1515 or email cms_feps@cms.hhs.gov with 'RxDC' in body of email

DEADLINES & HOW TO SUBMIT

NOTE: *Account creation can take up to two weeks*

Deadlines

- December 27, 2022 for 2020 and 2021 data, (extended to 1/31/23)
- June 1, 2023 for 2022 data
- June 1 of all subsequent years for prior year's data
- Original first deadline was December 27, 2021, but agencies extended it

How to Submit

- Health Insurance Oversight System (HIOS) RxDC Module
- Must set up an account through CMS Enterprise Portal if you don't have one. See HIOS Portal RxDC Quick Reference Guide on CMS site.

Terminology

- RxDC—Rx=prescription drug, DC=data collection
- Regulations refer to “section 204 data submission””
- Instructions use word “member” for “person who has health coverage,” including participants, beneficiaries, enrollees, and dependents
- This presentation will generally use “member”
- “Reference year” is calendar year for which data is provided

Who Must Submit

Health Insurance **Issuers** offering

- Group coverage
- Individual market coverage including
  - Student plans
  - Exchange plans
  - Non-Exchange plans
  - Coverage issued through an association

Group Health Plans, including

- Fully insured plans
- Self-insured plans
- Non-federal governmental
- Church plans under IRC
- Federal Employees Health Benefits (FEHB) Plans

Grandfathered & Non-Grandfathered Plans (if otherwise covered)

Items to Consider with CCA Reporting

- Plan should ask to receive a copy of the reports, even if your PBM is filing the reports for you
  - Plan should not be charged more to receive a copy of the reports
- Once received, review the reports
- These reports are designed to provide greater transparency into plans' prescription drug spend
  - Does the total spend and total rebates make sense?
- PLANS not the PBM are responsible for the accuracy of the information

Aggregated versus Plan Specific Information

- Your PBM can provide YOUR data or aggregated data or similarly situated plans
  - Such as, all self-insured clients in New York
- Require your PBM to provide plan specific data, otherwise:
  - You will not be able to determine if spread pricing is occurring on your claims or other client claims
  - You will not be able to determine if rebate spread is occurring on your claims

Rebate Information

- In the interim rules, rebate amounts must include ALL rebates paid to the REBATE AGGREGATOR on behalf of the plan's claims
  - That means if there is a rebate aggregator, there should be a delta between "Rebates Retained by Plan/Issuer/Carrier" and "Total Rebates/Fees/Other Remuneration" as the aggregator should have retained some amount as its fees
  - Manufacturer Assistance Programs and Coupon Assistance programs do not have to be in the "rebates" column but must be deducted from total spend by the plan
    - This is "tricky" if the claims are "outside" of the plan, need more clarification on this point from CMS

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Will this effort create more transparency?

Yes, but it might be a while

- The ultimate goal is to provide bi-annual reporting to Congress and plans could review what the industry trends are compared to its own experience
- But CMS has 18 months to produce the combined reporting information

The reports do not differentiate what the plan may or may not have agreed to contractually

- One plan may have “agreed” to have the cost of rebate administration deducted from rebate payments, another may be “surprised” to learn than the PBM or aggregator has deducted part of the rebate

Top 50 Report

- These reports are designed to help plans determine increases in spending by drug
  - Does the plan want to continue to pay for high-cost generics or generics with spending increases?
  - Same question for brands, but will this be allowed (can the plan change the PBM's dictated formulary) and how will this affect rebate guarantees?
  - Will this create customized formularies by each PBM client?

Plan Spending

- These reports will focus on the amount spent versus premiums and will be interesting conversations for fully or partially insured plans?
  - Where spending is less than premiums, will this require a re-evaluation of premiums?
  - Also, for carved in plans, where the ASO fee is offset by rebates, this could also create some interesting conversations.

Take away

- Even if your PBM submits the report, the plan is responsible for the accuracy
- This requirement is for the PLAN's benefit, to ensure your PBM is providing you more transparent information
- Each plan should review the information:
  - Is it accurate to a reasonable level?
  - Are there drugs with high costs that the plan might want to consider not covering?
  - Is the plan receiving all contracted rebate payments?
  - Is the PBM being straightforward in providing information?

D1	D2	D3	D4	D5	D6	D7	D8
Premium and Life Years (Membership, Medical Plus Rx)	**Spending by Category** (Medical and Rx)	**Top 50 filled brand drugs** (Rx)	**Top 40 most costly drugs** (Rx)	**Top 50 drugs by spending increase** (Rx)	**Rx Totals** (Rx)	**Rx Rebates by Therapeutic Class** (Rx)	**Rx Rebates for top 25 Drugs**

Report List

Sample Submission

- Municipality with 1,000 employees, 2,500 members
- Total Rx Spending of $6 million with $1 million in rebates

- Comments / Insights on D6 and D8