White Paper: The Average Self-Insured Organization Is Paying 67% More For Pharmacy Benefits Than Needed

INTRODUCTION

This White Paper highlights the key considerations your business should consider when evaluating pharmacy benefits management cost performance including but not limited to ingredient costs, rebates, and clinical services. This White Paper should not be relied upon as legal advice. You should contact us for advice on your specific circumstances.

Briefing Note
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ISSUE

Pharmacy Benefit Managers (PBM) have learned how to leverage the unsophistication of self-insured employers, and their advisors, to their financial advantage. Traditional, pass-through, and transparent PBM business models are for the most part the same. Very few reveal how much revenue is retained, by the PBM, for the services it performs. The part a PBM retains is referred to as earnings after cash disbursement (EACD)[i] or its management fee. EACD is a key driver of pharmacy costs. Given this reality, how much revenue the PBM generates from these services, on a per client basis, is information that is overlooked in far too many PBM contracts. PBM illiteracy, client and advisor casualness cultivate the deceptive practices PBMs employ which lead to the average self-insured organization paying 67% more for pharmacy benefits than needed.

CURRENT SITUATION

Asymmetric information, also known as "information failure," occurs when one party to an economic transaction possesses greater material knowledge than the other party. This typically manifests when the seller of a good or service possesses greater knowledge than the buyer[ii]. Although all PBM contracts with clients are viewable by both parties, PBMs operating under a traditional or pass-through model often employ contractual wording that allows for pricing and reimbursement mechanisms that render clarity of expenditure and actual cost drivers to be elusive and are designed to maximize the overall margin and "spread" for the PBM.

In response, the pharmacy benefit version of the "fee-only" fiduciary advisor has emerged in response to a desire among certain pharmacy stakeholders to bring radical

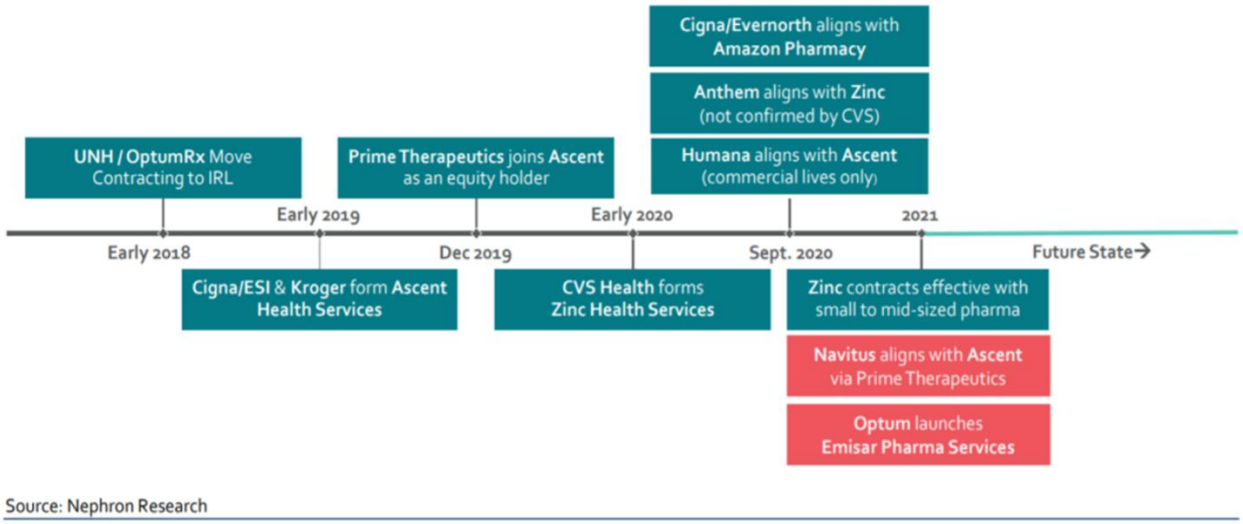
transparency to the drug pricing process. Put another way, the "fee-only" PBM charges a flat PEPM, PMPM, or per paid claim fee for its services and returns all negotiated discounts, rebates or other derived manufacturer revenue to the healthcare plan sponsor. Fiduciary language gives the healthcare plan sponsor legal grounds to pursue indemnification and liquidated damages should the PBM behave differently.

CONTEXT

1. The Lehigh County Controller's Office reviewed[iii] Lehigh County's prescription drug plan administered through Highmark which lost savings of almost $1.4 million, while battling a lack of transparency and openness about drug costs. Lehigh County elected to choose a fixed discount structure, meaning that it received a flat rate savings for each employee on its healthcare plan. Lehigh County is self-insured. It could have elected to take full rebate value which results from savings passed from the pharmaceutical company to the pharmacy benefit manager but chose not to do this. In 2019, Lehigh County found that the actual rebate value exceeded the fixed discount by $700,000. The Controller's Office also identified $654,749 in potential drug cost savings through a market check.
2. Ohio Attorney General Dave Yost says email shows OptumRx was overcharging the state – and knew it[iv]. Starting with its predecessor, a company called Catamaran that OptumRx acquired, the PBM administered prescription drugs for workers injured on the job. In all, OptumRx overcharged the bureau on more than 1.3 million claims for generic medications, the lawsuit says. The contract, in effect from mid-2009 until the fall of 2018, called for the PBM to charge the lowest of four potential prices for generic drugs, including a measure from the Centers for Medicare and Medicaid known as the Federal Upper Limit, or FUL for short. But in a series of May 2015 emails marked as "confidential," the Federal Upper Limit was never applied, despite the contract.
3. Rebates have increased in lock step with list price since at least 2013. For example, internal company documents collected for the U.S. Senate Committee's investigation[v] show that, in 2013, average rebates for long-acting insulin products hovered around 2% and 4% for preferred formulary placement. However, approximately six years later, rebates for the same product were as high as 79.75% [It's important to note that rebates vary by product, payer, and placement on a plan's formulary]. WAC data collected for the Committee's investigation also suggest list prices for long-acting and short-acting insulins have increased rapidly during this same period.
4. National PBMs have launched international group purchasing organizations (GPOs) to generate more profit and create opaqueness while touting transparency to clients. With a GPO, PBMs will avoid proposed U.S. regulations that would reform PBM pricing practices. Using a GPO, PBMs can develop new revenue sources from pharmaceutical manufacturers, such as contracting fees, compliance fees, prescription data services, and data portals, charged to their

clients. These new revenue sources are usually invisible to the plan sponsors, and not even on their radar. Most plan sponsors are focused on the pass through of rebates and other compensation directly tied to rebates, and likely not aware that PBMs have shifted the dollars elsewhere. A report by Nephron research says, "contracting entities are shifting discounts from the rebate profit pool 99% of which flows to clients to fee pools that may be retained by the PBM.[vi]"

Fig. 1: Offshore Tax and Pharma Contracting Entity Development Timeline



Source: Nephron Research

5. New York City Transit Authority hired ESI to administer and manage the prescription drug benefits NYCTA offered to its employees, retirees, and dependents. In the year prior to contracting with ESI, NYCTA paid $6 million for compounded prescription claims. To the shock and awe of the NYCTA, in the first year of its contract with ESI, NYCTA paid over $38 million for compounds. In fact, in June 2016, only two months after the contract term began, an individual's claim for an erectile dysfunction compound medication totaled $405,325.43 over three months. Critically, a significant portion of the compound claims contributing to the substantial increase in spending originated from just three providers and were largely fraudulent. Disturbingly, ESI conducted its own investigations into two of the providers and neglected to share the results with NYCTA.
6. Prescription drug overpayments (also known as "clawbacks") occur when commercially insured patients' co-payments exceed the total cost of the drug to their insurer or pharmacy benefit manager. A study[vii] by faculty at the USC School of Pharmacy and the USC Schaeffer Center for Health Policy & Economics explores the frequency and magnitude of co-payments exceeding prescription drug costs. It found that pharmacy customers would be better off paying cash 23 percent of the time and would save an average of $7.69 by using cash for those transactions, rather than insurance.

7. Documents[viii] provided to Axios reveal a new layer of secrecy within the maze of American drug pricing — one in which firms that manage drug coverage for hundreds of employers, representing millions of workers, obscure the details of their work and make it difficult to figure out whether they're actually providing a good deal. Each of the predominant health care consulting firms — Aon, Mercer and Willis Towers Watson — has its own prescription drug coalition made up of employers. The conventional wisdom is firms use the combined scale to negotiate lower drug prices with large pharmacy benefit managers, but there's no hard evidence the coalitions provide meaningful savings.

SOLUTION

In a financial context, a fiduciary is required to act in the best interest of the person or party whose assets they're managing. One of the biggest benefits to hiring a fiduciary to handle your pharmacy benefits is that a fiduciary must put their client's best interest ahead of their own profit. For example, insurance professionals who are not bound to a fiduciary standard have been known to recommend insurance products to their clients because they offer the highest commissions, and not because the products were actually in their clients' best interest. In addition to these examples, fiduciaries must:

- Make sure all pharmacy benefits advice is accurate and complete, to the best of their knowledge.
- Avoid and disclose all potential conflicts of interest.
- Clearly disclose all fees and commissions.
- Make pharmacy benefit recommendations that are consistent with the goals, objectives, and risk tolerance of their clients.

The fiduciary standard is much stricter than the "suitability standard" that applies to brokers, insurance agents, and other financial professionals. All the suitability standard requires is that as long as a coverage objective meets a client's needs and objectives, it's appropriate to recommend to clients (essentially the last bullet point in the fiduciary list only). Many pharmacy benefit managers and insurance professionals would rather be held to a suitability standard, as the fiduciary standard would cost them money, both in terms of commissions and the added cost of complying with the new standard of care.

Under TransparentRx's fiduciary model, contracts negotiated between us, clients, and third-party vendors are designed to be as understandable and transparent as possible which, ostensibly, is meant to encourage the best therapeutic outcomes and financial interests for our clients. There are fewer inherent conflicts of interest under a fee-only (PMPM) fiduciary model and no additional margin gained from favorable tier placement on high-cost/revenue drugs. Coverage and pricing considerations are

limited to the cost-benefit of the therapy itself, eliminating agency cost. Clients, on average, pay 51% less with TransparentRx compared to non-fiduciary PBMs.

STAKEHOLDERS' POSITIONS

There are a variety of roadblocks to radically transparent and fiduciary PBM services for employers. HR departments are bombarded daily with cold calls and bloated email in-boxes that can only be depressurized by clicking DELETE. Furthermore, HR must make time to consider fresh thinking, but it already has a full pate. In many cases, HR has been downsized to align with HR staffing ratio "efficiency" metrics to the point where there are not enough resources left in HR to even consider fresh thinking so as to increase HR's overall effectiveness. There can be a natural trepidation towards bringing a new way of thinking to the table of senior management.

For the consultants to HR, there are additionally different road obstructions to bringing another PBM model to customers. To begin with, there can be monetary ramifications. For counselors who are paid on a commission premise, the customer may request that they pay for specific administrations out of existing however always diminishing commission streams. This both decreases the advisor's revenue and adds to its administrative workload - an undesirable "one-two punch".

Fee-based consultants to have a dilemma. They need to meet their own personal goals of new business development and billable hours in order to receive a year-end bonus payment. The question then becomes, "If I introduce someone else's product/service to the client, how will this facilitate meeting my annual revenue target?" Most often the answer is it won't. For both types of advisors, their organizations can be at odds with the fiduciary model PBM.

Some "trusted" advisors have developed proprietary services, such as a coalition, that competes with the carved-out fiduciary PBM. Or, introducing a fiduciary PBM can actually decimate an entire pharmacy consulting practice as it services would no longer be required. An example here would be a consulting firm's Pharmacy Consulting Practice that the client would no longer need if the fiduciary PBM were in place. Moreover, if the fiduciary PBM service does not work as purported, the entire client relationship can be put at risk. Finally, HR advisors are expected to be objective on the client's behalf which is difficult to achieve when a one-of-a-kind idea is on the table for consideration.

METHODOLOGY

From 2014 through 2024, over three million pharmacy claims were repriced using a fiduciary pricing model as the baseline. Medi-Span was used as the unit drug pricing source. The PBM service agreements from which these claims derived were scored, with

a weighted rubric, on criteria including but not limited to benefit design, network pricing, clinical performance, and rebates.

RECOMMENDATIONS

- Require consulting firms to have skilled staff with extensive PBM knowledge. The Certified Pharmacy Benefits Specialist (CPBS®) is the only education program which verifies competency in advanced pharmacy benefits management practices.
- If executing a fiduciary PBM service agreement is not an option, draft an entirely different contract that eliminates all loopholes. Require consulting firm to draft, negotiate, and finalize the PBM contract during the competitive bidding process.
- Draft an RFP questionnaire seeking only verifiable information. Upload it and your contract simultaneously to an automated, end-to-end RFP management solution.
- Select semi-finalists, in a competitive PBM bidding process, based on radically transparent and binding contract terms. Avoid at all costs proposals with the constituent elements not spelled out. PBMs that don't provide radical transparency should be eliminated from consideration.

CONCLUSION

Most self-insured employers, and their advisors, don't know what they don't know. Pharmacy Benefit Managers provide transparency and disclosure to a level demanded by the competitive market and generally rely on the demands of prospective clients for disclosure in negotiating their contracts. The best proponent of transparency is informed and sophisticated purchasers of PBM services. The purchaser needs to understand not only what they want to achieve in their relationship with their PBM but also the competitive market and their ability to drive disclosure of details on services important to them. Assessing transparency is done more effectively by a trained eye with personal knowledge of the purchaser's benefit and disclosure goals. Consequently, the average self-insured organization is paying 67% more for pharmacy benefits than needed.

[i]Tyrone Squires, 11/9/2021, Employers Guide Blog for Overseeing PBMs, 6/1 /2022, <https://transparentrx.com>
[ii]Andrew Bloomenthal, 5/19/2021, Investopedia, 6/5/2022, <https://www.investopedia.com>
[iii]Lehigh County Controller's Office, 1/29/2021, PR Newswire, 2/3/2021, <https://www.prnewswire.com/>
[iv]Darrel Rowland, 12/27/2020, The Columbus Dispatch, 12/29/2020, <https://dispatch.com>
[v]Congress of the United States, 5/16/2022, FTC-2022-0015-0001 Solicitation for Public Comments on the Business Practices of Pharmacy Benefit Managers and their Impact on Independent Pharmacies and Consumers
[vi]Rebecca Pifer, 7/1/2020, CVS reportedly creating group purchasing organization for PBM business, 6/7/2022, <https://www.healthcaredive.com/news/cvs-reportedly-creating-group-purchasing-organization-for-pbm-business/580889/>
[vii]Karen Van Nuys, PhD, Geoffrey Joyce, PhD, Rocio Ribero, PhD and Dana Goldman, PhD, 3/12/2018, Overpaying for Prescription Drugs: The Copay Clawback Phenomenon, 3/18/2018, <https://healthpolicy.usc.edu/research/overpaying-for-prescription-drugs/>
[viii]Bob Herman, 12/6/2021, Documents reveal the secrecy of America's drug pricing matrix, 12/21/2021, <https://www.axios.com/2021/12/06/aon-express-scripts-contract-employers-drug-price-data>