

Written Testimony for the ERISA Advisory Council Hearing on PBM Compensation and Fee Disclosure

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Chair Singer and members of the Council, thank you for inviting me today. My name is Keith Bruhnsen, Assistant Director of Benefits Administration at the University of Michigan, and my primary role is Manager of the university's prescription drug plan. I appreciate the opportunity to make this presentation to the ERISA Council as a benefit plan sponsor, and to discuss our experience with Pharmacy Benefit Managers' (PBMs) disclosure of compensation and fees. I will restrict my comments to our experience during the past 10 years as a purchaser and administrator operating a "carve-out" outpatient prescription drug plan. I hope to illustrate how we have addressed some of the challenges regarding PBM disclosure of compensation and fees.

1. U-M Drug Plan History

The University of Michigan is a top ranked, public research university with a large academic medical center. As an employer plan sponsor, our goal is to deliver a quality prescription drug benefit that is affordable to our members, supports employee retention and recruitment goals, and assists with having a healthy workforce while being responsible stewards of public resources.

In 2003, the university removed (carved out) its prescription drug coverage from its multiple medical plans and consolidated it into a single prescription drug plan with expanded and harmonized coverage for all participants, regardless of the medical plan they choose. The university drug plan is self-insured and self-administered, and uses world-class internal resources for management, employing strong cost-containment strategies, and contracting with best-in-class vendors.

The management of prescription drugs is one of the most complex areas of health care, and as such, most benefit administrators delegate pharmacy management to medical plans. The arrangements for the administration, dispensing and payment for prescription drugs is convoluted and requires sophisticated data and savvy business practices given the multiple vendors and financial changes in the market today. The university has taken on the challenge to address prescription drug management and is a sophisticated purchaser of PBM services. We have contracted with several PBMs over the past 10 years, and have conducted three extensive Request for Proposals (RFPs) with a demanding set of service requirements to meet our plan design and our desire to closely manage cost. The university is a non-ERISA plan as a governmental institution.

2. Plan Operation Model

The university benefit drug plan covers more than 100,000 faculty, staff, retirees and their dependents with an annual drug spend in 2013 of \$95 million dollars. The plan oversees the annual dispensing of nearly one million prescriptions, including a voluntary mail order pharmacy where members get 90-day supplies at reduced copays for maintenance medications. Members have flat copays below national averages using a typical three-tier copayment design.

Having a fiduciary responsibility to ensure public funds are appropriately used for the institution and its beneficiaries requires us to find the lowest-cost delivery channels, use best practices in plan management, and hold our PBM accountable for its pricing and service delivery. Over 90 percent of plan claims are dispensed in retail pharmacies, so obtaining best pricing through a PBM is critical to keeping cost and member copays low. We have annually experienced lower than national annual price trend rates producing millions in savings for the institution and our members.

We administer our drug plan within the U-M Benefits Administration Office, with two pharmacists on the staff, internal and external data support, use of external pharmacy consultants and auditors, and professional staff to address enrollment and escalated claim problems. We require that PBMs provide us the ability to in-source any function we feel better equipped to manage. Internally we manage the formulary, plan design, clinical programs, member communications, and hold contracts for mail and specialty pharmacy. The PBM is contracted for claims processing, data access, retail networks, e-prescribing, prior authorizations, appeals, and rebate administration. Details of the university's 2013 metrics on drug plan cost and utilization are provided in the attached chart from the University of Michigan 2013 Prescription Drug Annual Report. I would be glad to respond to any questions regarding the report.

We manage our plan based on three key operating principles.

1. First is to manage toward the lowest net cost using evidence-based decision making to achieve optimal and safe utilization based on sound clinical evidence. By using proper clinical science, we have a high level of physician support and a low number of appeals. Since not all drugs offer good value, our analysis looks at net cost to identify "best value" medications based on clinical value and cost-effectiveness, often eliminating newer high-cost and low-value branded medications that offer no clear advantage over older brands and generic medications. This approach may differ from some PBM national open formularies where rebate revenue determines a drug's formulary placement and results in higher plan costs.
2. We focus on "appropriate use" of medications – meaning the right drug, in the right amount, at the right time for that member. That helps to eliminate waste, overuse, misuse, and abuse, and address off-label prescribing. This also requires PBM programming and coding of a plan design using multiple utilization programs such as: limitations on quantities and supplies based on U.S. Food and Drug Administration (FDA) approved indications; safe use of pill splitting for cholesterol medications; dose optimization to consolidate drug therapy; prior authorizations using customized criteria;

step therapies to ensure an attempt at specific first-line agents or generics; and switch programs that transition members to generics, with physician approval. Most of our programs are documented on our web site and are sometimes accompanied with published research (<http://benefits.umich.edu/plans/drugs/index.html>). Our experience demonstrates that controlling plan design and formulary and implementing various clinical management programs can, by extension, address cost control.

3. Our success requires we identify and contract with the right PBM for competitive pricing, plan flexibility, and control. We need to implement designs, programs, and drug formulary changes as often as necessary. I raise this important issue because there are competing interests between PBM profitability and plan sponsor cost. PBMs benefit from economies of scale and prefer plans with common formulary and limited variations from standard coding practices.

The PBM industry has been widely criticized and subject to litigation by plan sponsors regarding their pricing methods with pharmacies and rebate practices with pharmaceutical manufacturers. PBM services today have evolved beyond being purely drug claims processors. It has been our negotiating position that inherent conflicts of interest exist where PBMs have entered into the drug delivery distribution channel as owners of mail order and high-cost specialty drug pharmacies. In these instances, they not only purchase and dispense products but also set the prices for the plan sponsor and are able to promote dispensing more prescriptions.

3. PBM Services and Pricing

PBMs provide specific services essential for today's drug plan management given the complexity of drug plan designs, channels for drug dispensing, and the ever growing scope of formulary coverage and drug cost. PBMs have expertise and sophisticated technology for certain functions that they are well suited to administer. These include real-time, point-of-sale eligibility verification and claim processing, customer contacts, rebate administration, pharmacy networks, and payments to pharmacies. PBMs house large databases for tracking eligibility, member use, and claims payments, and they can provide analysis of trends. PBMs verify member eligibility and either approve or deny claims based on safety edits, plan design, formulary rules, and other plan utilization programs aimed at appropriate use.

A subset of formulary drugs have prior authorization (PA) criteria and PBMs work with physicians and pharmacies to get those approved, changed, or, if denied, handled as a medical necessity appeal. We tightly monitor PBM claims, PA approvals, and administrative charges based on years of experience finding routine errors in invoicing and at pharmacies because of PBM coding. PBMs by nature are volume-driven businesses and the more prescriptions they process, the greater the associated revenue. Holding PBMs accountable for accurate claims processing based on plan designs, charging members the correct cost share, and making correct and timely payments to pharmacies is essential to good management. Surprisingly, it's contractually the plan's obligation, not the PBM, to report errors, overpayments, and inaccurate pricing.

Daily interaction occurs between PBMs, physicians, members, and pharmacies to resolve claim problems and payments on behalf of the plan sponsor and its members. Most PBMs provide staffing of 24-hour service centers to handle high volumes of member, physician, and pharmacy contacts. Beyond claim and customer services PBMs have various contractual reporting requirements, including drug utilization reviews (DURs) to assess patterns of use and prescribing. We have direct access to our claims data and conduct our own extensive data analytics to ensure claim processing, coding, and pricing are within contractual requirements.

4. Request for Proposals (RFP) and Negotiating PBM Agreements

A best practice is to conduct PBM market pricing exercises or an RFP for PBM services every few years. It is a major undertaking to change PBMs as it results in some level of operational disruption to plan members, pharmacies, and prescribers. The RFP outlines plan requirements, specifications on pricing, fees and services, and then codifies those arrangements into a master service agreement between the PBM and plan sponsor. We use a national pharmacy consultant to advise on current market pricing, PBM models, assist with development of the RFP specifications and criteria, and assist with the quantitative and qualitative analysis of each PBM's bid proposal. A support team of procurement, legal, pharmacist and benefits operations staff are instrumental to evaluate, interview bidders and negotiate contract terms. Note that we also require our consultants to disclose any conflicts or collusive arrangements with PBMs.

The RFP process can take a year or more because the analysis is highly complex and requires converting various pricing proposals from PBMs into a single format. PBMs use different standards and definitions for brand and generic drugs as well as different Maximum Allowable Cost (MAC) list pricing, and they set pricing differentially based upon delivery channels (retail, mail) and by supply levels (30 day vs 90 day). Other costs evaluated and included are administrative processing fees on a per transaction or Per Member Per Month (PMPM) basis, projected rebate revenue, and fees for clinical programs like prior authorizations, step therapy, appeal services, coding, e-prescribing fees, member mailings, paper claims, ID cards, data extracts and electronic connectivity, system training, etc. Developing a metric to provide apples-to-apples comparisons is complex but important in order to determine best PBM cost, services, and savings. For drug discounts we use a 'total effective discount rate' and 'total savings' comparing bidders to our existing baseline expenditures to determine the relative difference between comparators. A national standard on pricing models for RFP needs to be established.

As an experienced purchaser, we have learned to carefully watch for clear definitions and pricing terms, including the terms covering rebates regarding what claims qualify, and when and how they are paid. Contract terms have a direct impact on the cost a plan will incur.

5. Pharmacy Pricing

PBMs offer various pharmacy networks for plan sponsors, and keep pharmacy contracts confidential. Those contracts may include transaction fees with the pharmacies for processing

claims. We believe PBMs obtain their targeted revenue goals between pharmacy pricing, various plan administrative fees, and rebates under our contract.

PBMs provide valuable service to benefit plan sponsors, and PBMs also are extremely profitable companies that have evolved with complicated pricing arrangements over time. PBMs use their volume to leverage and extract best pricing from pharmacies and rebates from manufactures. We understand that PBMs negotiate reimbursement rates at various times throughout the term of our agreements and that we receive and agree to a blended rate of pharmacy discounts and dispensing fees. To what degree pharmacy discounts and rebates are fully passed on to the plan sponsor or are augmented with other revenue to the PBM is difficult to verify. Asking a PBM to disclose all sources of revenue is complex as they may define revenue as a discount, rebate, data fee, a credit, or some other administrative or education fee.

PBMs offer a single set of discounts and dispensing fees, known as ‘traditional pricing,’ using average wholesale price (AWP) discounts. Or, upon request, they may offer pass-through pricing where plan invoices reflect actual pharmacy payments. We have learned to negotiate deeper annual drug discounts and dispensing fees adjusted for each year of the agreement with specific guarantees and penalties with the expectation that the PBM is continually improving their contracts with pharmacies and should share the improvement with their plan sponsors.

For generic drugs, we are dependent upon the PBM to monitor and adjust the MAC list to reflect market changes in pricing, which occur weekly with new and existing drugs. We want a MAC list that is aggressive but fair. Otherwise, pharmacies will not participate. We have frequently found it difficult to understand why a brand drug coming off patent has not received a MAC price or has a long delay in receiving one. We hear from pharmacies complaining about the MAC price list being too aggressive, and we respond by reviewing pricing with the PBM to ensure pharmacies are fairly compensated across their total volume of claims with our plan.

We evaluate a given PBM’s MAC list for its performance or ‘total effective all-in generic discount rate’ and then negotiate a guaranteed minimum effective discount rate and methodology for evaluating the performance for each year of the agreement. At year end, if the PBM fails to maintain the minimum rate they are at risk for any overpayments to the plan. It’s a complex analysis, but one that’s needed due to the lack of access to retail pharmacy pricing agreements. Nothing precludes a PBM from renegotiating steeper discounts with pharmacies at any point, and they are not required to pass those savings along to plan sponsors. Or, if the PBM and pharmacies have agreements for other payments or revenue, we would be unaware of those agreements.

To avoid the conflict of the PBM profiting from owning pharmacies, the university requires the PBMs to administer our claims processing for mail and specialty pharmacy under the pricing terms we have contracted. We believe a PBM cannot fairly set drug pricing while owning the pharmacy and purchasing from a wholesaler or manufacturer for specialty, brand, and generic drugs with contracts we cannot audit, especially the MAC list which is adjusted monthly.

PBMs are responsible to ensure accurate claim adjudication with set algorithms prior to payment. Beyond that, our experience shows PBM monitoring is limited to periodic desktop audits and selective in-person pharmacy audits. When errors are found, recoveries or overpayments are made back to the plan. We have engaged external auditors for plan implementation audits and ongoing monthly claim audits of our PBM. The audits revealed coding errors that we would not normally detect, resulting in financial recoveries and continued improvement in accuracy of claim processing.

Direct contracting with mail pharmacy and specialty pharmacy provides an opportunity for the university to use a best practice of 'acquisition cost plus' where the pharmacy provides its actual acquisition cost for drugs and we negotiate a separate and fair dispensing fee to cover the pharmacy overhead plus margin. This type of arrangement is generally not available through PBMs. A separate contact for mail and specialty avoids the typical PBM opaque business practice of 'spread pricing.'

Our retail networks use pass-through pricing as the best practice to ensure we are obtaining the lowest and most current cost. However, it's openly disclosed that PBMs have varied contracts and pricing with pharmacies. PBMs agree to pass-through pricing even though it presents some risk to PBMs as they are limited to their higher administrative fees. This compares to traditional pricing providing the PBM an opportunity to adjust discounts with pharmacies while they lock-in payer agreements for a set term. We have limited means to monitor and validate that actual pass-through pricing is being provided. Hence, we depend upon negotiating minimum guaranteed pricing and rebate levels. Contracts often provide PBMs the right to pursue other sources of revenue and compensation with pharmaceutical manufacturers, typically with a percentage cap on the aggregate cost of rebates. We would desire to have full access and disclosure to PBM revenue sources to have a fair opportunity to negotiate our share, but can only negotiate what we know about.

6. Rebates

PBMs have access and use our claim data with pharmacies, wholesalers, e-prescribing hubs, data sources, for clinical purposes, and with pharmaceutical rebates. The most common shared PBM revenues are manufacturer rebates for having branded drugs as a preferred status or meeting other criteria on the plan's drug formulary.

Rebates can be paid by the PBM under a number of different arrangements with the PBM: sharing a percentage of the total rebates, a pass through arrangement and/or guaranteed minimum arrangement. Rebates complicate plan management and we would prefer instead that manufacturers provide lower drug costs to compete within a drug class. But rebates are a reality and plan sponsors must therefore negotiate a rebate payment arrangement. As generics have now become the vast majority of prescriptions -- 85% for the university's plan -- there are fewer rebate arrangements to negotiate.

We have audited a large PBM on rebates. We selected a national auditing firm and found it took two years to negotiate the agreement to audit. The PBM wanted assurance of a firewall between the auditing division and the company's pharmacy consulting practice. The

results of the audit showed less than 1 percent claim variance, both under and over payments, but more importantly that the PBM was unable to satisfy the auditor in fully explaining its invoicing, collection, and distribution of payment processes.

7. Other PBM revenue sources

PBMs have many sources of revenue with clinical management programs, safety programs, reporting programs, data services, appeals, medication reviews, and custom generic programs. Most of these programs and services are typically straight-forward per member or per claim administrative cost and are not problematic other than to validate their cost-benefit.

There are some examples of typical revenue sources with PBMs. When a brand drug goes generic, often the first generic manufacturer may have been granted an exclusivity period to market the generic for 6 months. The manufacturers may approach the PBM to sell to their payers an exclusive extension of their brand drug, blocking competing generics on the formulary, and asking the brand drug be dispensed at the generic copay to member. This is done in exchange for a substantial rebate shared between the payer and PBM, which may provide a net lower cost than the use of the generic. A careful analysis needs to be conducted to ensure promised savings are real. These programs undermine the purpose of a formulary, are confusing, and send conflicting messages to members and prescribers, and they may result in problems with later moving members to the generic drug. We typically decline these offers.

8. Conclusion

Requiring transparency and disclosure on compensation and fees from PBMs is necessary in order to validate that a plan sponsor's interest is being well served. We have a right to know how the PBM is making money on our drug claims to negotiate sharing in the revenues. Holding PBMs accountable for adjudicating drug claims on the plan design they are paid to administer is standard practice and it would be an improvement to have disclosure on all forms of compensation and fees PBM's receive related to a plan's activities.

From the University of Michigan 2013 Prescription Drug Annual Report

2013 Cost and Utilization Metrics

	All Claims		Non-Specialty		Specialty	
	Cost and Utilization	Change from 2012	Cost and Utilization	Change from 2012	Cost and Utilization	Change from 2012
Claim Volume	979,135	2.33%	967,958	2.20%	11,177	14.90%
Utilizing Members	76,633	2.62%	74,716	0.11%	1,917	14.10%
Total Drug Cost	\$95,169,988	1.71%	\$71,649,818	-3.6%	\$23,520,170	22.01%
Plan Cost	\$85,261,922	2.98%	\$61,974,228	-2.8%	\$23,287,694	22.23%
Member Cost	\$9,908,066	-8%	\$9,675,590	-8.4%	\$232,476	9.72%
Percent Member Total Cost Share	10.41%	-1.5%	13.50%	.52%	1.00%	-0.11%
Plan Cost PMPM	\$72.52	0.30%	\$52.71	-5.30%	\$19.81	19.05%
Member Cost PMPM	\$8.43	-10.98%	\$8.23	-10.83%	\$0.20	5.26%
Avg Number of Claims Per Utilizing Member Per Year	12.8	No Change	12.7	No Change	5.8	No Change
Avg Day Supply per Claim	43	No Change	44	2.33%	31	4.03%

PMPM=Per (Eligible) Member per Month

2013 Tier Utilization Metrics

Drug Tier	Paid Claims	% Total Claims			% Plan Cost		
		2013	2012	Change	2013	2012	Change
Tier 0	48,957	N/A	Not Measured	5%	N/A	Not Measured	N/A
Tier 1	802,891	82%	80%	2%	26%	27%	-1%
Tier 2	68,539	7%	14%	-7%	46%	58%	-12%
Tier 3	58,748	6%	6%	0%	19%	15%	4%

Note: Tier 0 represents claims where the out of pocket cost to the member is \$0. Prior to 2013, this only applied to insulin and syringes for diabetes. In 2014, \$0 copay was also applied to preventive care drugs under the Affordable Care Act including contraceptive products for females