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

August 20, 2014

Chair Singer and members of the Council, thank you for inviting me today. My name is Linda Nilsen, Executive Director of Benefits and Compensation at Princeton University and my role includes the design and administration of the university's prescription drug employee benefits 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 as well as related challenges.

Princeton University Drug Plan

The university prescription drug benefit plans cover more than 14,000 faculty, staff, students, retirees and their dependents. In 2013 these plans dispensed over150,000 prescriptions, including a mail order pharmacy where members get 90-day supplies at reduced cost for maintenance medications. Participants have fixed copays for generic, single-source brand and multi-source brand products.

Similar to other mid-sized employers, we administer our drug plan within the benefits department at Princeton University. To leverage our purchasing power, we are a member of a prescription purchasing coalition that collectively uses an external consulting firm to assist coalition members with utilization and cost data analysis, audits, pharmacy expertise, market checks, and advisement.

We review our Plan performance regularly for variations in spend, reconciling spend to utilization and to ensure we receive rebates in a timely manner. We also conduct annual performance reviews in two ways. First, we review Plan cost and utilization data directly with the PBM. Then, we review our Plan data again within the context of our purchasing coalition with the assistance of our consultant and all coalition members.

The coalition uses the expertise of an external consulting firm to conduct annual audits of adherence to contractual fees, discounts and performance guarantees. This process is complex and extensive due to the frequent changes of definitions of product class (generic, preferred and non-preferred) and the effective dates of a change in product classification.

Lastly, we solicit competitive bids every 3-5 years to ensure we are maximizing our group purchasing power.

Despite our thorough review of prescription plan costs and administration services, and the collective experience in our coalition as well as consultants who are experts in this field, it is extremely challenging for all the reasons described by the University of Michigan to fully evaluate the true cost of products and services we are purchasing.

Additional cost related challenges to employers and plan participants regarding PBM practices are:

1) excluding drugs from a formulary rather than moving a drug from preferred to non-preferred formulary status,
2) providing insufficient time and data to the employer to assess the impact of the formulary changes,
3) eliminating grandfathering of existing patients on chronic medications, and
4) changing existing contracted rebate guarantees as result of an employer's decision to refuse the exclusions.

Exclusion - When a drug is excluded the patient receives no benefit coverage (reimbursement) for that drug. The result of this exclusion is that a drug becomes unaffordable to many patients; these patients are then required to switch drugs regardless of how well the drug may be managing their medical condition. This change can introduce a question of patient safety, particularly for individuals on multiple drug products. As an example, if someone has diabetes, high cholesterol and high blood pressure and is using multiple drugs in different therapeutic classes to effectively manage their medical condition, it can be potentially life-threatening to change the balance of drugs that are working well together.

Timing - PBMs generally provide 120 days' notice to employers of a formulary change. The notice does not include data to inform an employer regarding the impact of the change financially or to their plan participants. The time needed to adequately assess the formulary change before making a decision to accept or reject such change prohibits employers from then providing adequate notice to plan participants regarding the change. For example, a patient using an excluded product to manage a health condition must appeal for continued coverage for their current product. This process requires the patient and patient's physician to submit an appeal. The appeal cannot be submitted until the new formulary is in place which requires a patient to a) stock-up on product prior to the change, b) go without product until an appeal is reviewed and approved, c) try a new product while appealing to have coverage for the current product or d) pay the higher price for the current product while appealing for future coverage. Adequate notice to book such appointments are necessary for patients who are well managed under a current regimen to maintain coverage for that drug.

Suggestions

Similar to the recent fee disclosure requirements introduced for investment options offered in a retirement plan, requiring **standardized reporting of all income** associated with an employers' plan participant utilization by major category (i.e. rebates, discounts, grants, marketing incentives and administrative fees) will enable employers to more effectively evaluate the performance and market competitiveness of a PBM. At this time, PBM contract negotiations which set pricing guarantees and volume steerage thresholds occur without the employer having a full understanding of all income the PBM experiences based on an employers' plan participant utilization.

Similar to ERISA notification requirements for material modifications to a plan, PBMs could have **notice period requirements** to its clients (and participants). This notice should include a **standard selection of information.** For example, notification of a product being removed from formulary is needed at least 180 days in advance of the change in order for employers to have sufficient time to 1) properly assess the impact of the change and 2) provide adequate notification to its plan participants of the change in benefit.

Grandfathering existing patients on an excluded product **for a specified period of time** will provide patients the time to meet with their physician to determine the safest course of action for their continued treatment with coverage including filing an appeal.