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Benefits Alert

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Fiduciary governance: Evaluating, selecting, and contracting with pharmacy benefit managers

Learn methods and best practices for working with and monitoring pharmacy benefit managers.

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What's the impact?

- Although selecting and evaluating PBMs follows the same general process used in selecting medical plan TPAs, knowing the nuanced differences will help tailor your RFP process.
- Understanding the key factors to consider during the evaluation process will help decision-makers inform their choices and realize cost-savings.
- PBM agreements are undoubtedly one of the most complicated benefits-related services agreements and should be negotiated carefully.

Prior installments of this health and welfare plan fiduciary governance series have focused on best practices for selecting, evaluating, and monitoring medical plan third-party administrators (TPAs) and certain other service providers. We now switch gears to pharmacy benefit managers (PBMs). Like medical plan TPAs, PBMs serve as claims administrators (albeit for pharmaceutical

products) that determine eligibility for coverage and apply cost-sharing requirements (e.g., copayments, coinsurance, deductibles). Additionally, PBMs manage preferred pharmacy networks, including retail pharmacies, mail-order pharmacies, and specialty drug pharmacies.

That being said, the nature of the pharmaceutical industry and the role that PBMs play in it require health and welfare plan fiduciaries to evaluate PBMs in a somewhat different manner than they would evaluate medical plan TPAs. Of course, just like with medical plan TPAs, fiduciaries will evaluate service fees, claims administration capabilities, utilization management programs, and member services. However, PBM evaluation must also focus on complex financial issues, such as overall pricing structure (i.e., traditional versus pass-through/transparent), formulary management, rebate administration, and pricing guarantees. Failure to carefully consider these financial complexities could result in significant costs for plan sponsors.

This installment presents a high-level summary of the key considerations that plan fiduciaries should keep in mind when selecting, evaluating, and contracting with PBMs. It is far from comprehensive, and, as noted below, plan fiduciaries tasked with selecting and monitoring a PBM should retain qualified experts.

Getting ready for the RFP—Preliminary matters

Overall, selecting and evaluating PBMs follows the same general process used in selecting medical plan TPAs. The plan's fiduciaries will work with consultants to identify prospective PBMs and then issue requests for proposals (RFPs) to those PBMs. The RFP responses will be evaluated, and then a PBM will be selected. Despite these high-level similarities, health and welfare plan fiduciaries will need to navigate the complexities of the PBM environment. For instance, in preparation for the RFP, fiduciaries will need to consider the following:

EMBEDDED PBM OR CARVE-OUT PBM

An embedded (also known as carved-in) PBM is controlled by the medical plan TPA, such that the medical and PBM services are part of the same overall contractual arrangement. In many instances, the PBM is affiliated with the TPA.

By contrast, a carve-out PBM arrangement is under a separate contract, and often, the PBM is not affiliated with the medical plan TPA. Although not always the case, carve-out arrangements often produce savings by allowing multiple PBMs to bid for the contract. This can be true even if the medical plan TPA increases fees once the employer carves out pharmacy benefit services.

GROUP CONTRACTING

Some major consulting firms have partnered with PBMs to develop consortiums or alliances whereby several unrelated group health plans will contract with a PBM via the consortium or

alliance. The consulting firm negotiates a master agreement with the PBM, and the individual group health plans execute participation agreements. In theory, the greater purchasing power associated with group contracting produces greater savings for the group. However, individual group health plans often have no ability to negotiate pricing or programs and services. Further, they pay a substantial fee to the consulting firm that runs the coalition.

TRADITIONAL OR PASS-THROUGH/TRANSPARENT PRICING

Health and welfare plan fiduciaries will need to decide whether to seek a traditional pricing arrangement or a pass-through/transparent arrangement. Under a traditional arrangement, the PBM generates revenue from several sources, including spread pricing, mail-order pharmacy fees, rebate retention, etc. Often, when traditional pricing is in place, the PBM will charge no or lower administrative service fees to the group health plans. Note that spread pricing, which refers to the PBM practice of paying pharmacies less than it charges the group health plan (i.e., retaining the spread), now attracts scrutiny by state and federal regulators, so fiduciaries should use caution when evaluating spread pricing-based proposals.

By contrast, in pass-through/transparent pricing, PBMs do not utilize spread pricing and pass through 100% of rebates. The PBMs still generate revenue from in-house mail order or specialty pharmacy fees, but given the lack of other revenue sources, pass-through/transparent pricing arrangements typically include a higher administrative service fee.

Retaining consultants or counsel

The foregoing are complex considerations, and health and welfare plan fiduciaries will need to retain experts with specialized knowledge of the PBM industry, including pharmacy benefit consultants and ERISA legal counsel.

PHARMACY BENEFIT CONSULTANTS

Consultants play an important role in the PBM evaluation, but before retaining a consultant, fiduciaries must ensure that the consultant is not conflicted. It is common, though not universal, for consultants to receive commissions from PBMs, and health and welfare plan fiduciaries need to keep in mind that consultants are not subject to ERISA's fiduciary responsibility requirements. Health and welfare plan fiduciaries should request compensation disclosures from consultants (as required under the Consolidated Appropriations Act, 2021) and obtain written representations from consultants stating that no direct or indirect compensation will be received from the PBM in connection with the RFP. Fiduciaries must scrutinize these disclosures in determining whether an arrangement is reasonable.

ERISA LEGAL COUNSEL

Counsel with specialized knowledge of PBM contracting is essential to the process. ERISA counsel will also play an important role in the development of RFP materials, particularly in setting minimum contractual requirements for prospective PBMs and negotiating the terms and conditions of the full contract once the PBM is selected.

Bid evaluation

Once the prospective PBMs have submitted their bids, the plan's fiduciaries will work with the pharmacy benefits consultant to evaluate the bids. The key factors to consider are provided below.

PRICING

Each of the PBMs will quote basic fees for administration and various programs and services. Additionally, the PBMs will make certain guarantees related to the cost of the prescription drugs (i.e., ingredient costs), including discounts, dispensing fees, and rebates. All of these pricing components will need to be compared to determine which PBMs are providing better pricing than others.

CLAIMS ADMINISTRATION, UTILIZATION MANAGEMENT AND FIDUCIARY STATUS

Fiduciaries should evaluate the PBMs' claims administration practices to determine whether they are a good fit for the participant population. Additionally, fiduciaries should consider how the PBM identifies which drugs should be subject to utilization management and whether the utilization management program produces adequate savings for the plan. Whether a PBM is willing to acknowledge ERISA fiduciary status for claims administration and utilization management purposes is also an important consideration.

PIPELINE MANAGEMENT

The cost of pharmacy benefits is increasing dramatically, particularly as more and more specialty drugs are being released on the market. Fiduciaries should consider how the PBM evaluates new drugs and determines whether the drugs should be placed on the preferred drug list (or "formulary"). Also, whether the PBMs will commit to adding new generics and biosimilars to the formulary in a timely matter should be considered.

PROGRAMS AND SERVICES

In addition to utilization management, fiduciaries should evaluate ancillary programs and services that can reduce plan costs and ensure participant safety. For instance, PBMs typically offer special programs to manage opiate usage, improve adherence, and mitigate fraud and

abuse. All of the PBM's programs should be evaluated to determine the best fit for the participant population.

FORMULARY DISRUPTION

PBMs develop their own preferred drug list or formulary based on recommendations from their internal pharmacy and therapeutics committees. Given that the formularies will be somewhat different, fiduciaries will need to evaluate the extent to which plan participants will be disrupted by moving to a new formulary. For instance, a participant may be taking a drug that is a preferred brand under the current formulary but will be non-preferred in the new formulary. Although some disruption is unavoidable, fiduciaries should seek confirmation that a new PBM can transition or grandfather participants that would be disrupted under the new formulary.

TRANSPARENCY

Last but certainly not least is transparency. Over the past several years, there has been a significant push from state and federal regulators to improve transparency into PBM pricing practices and revenue. Fiduciaries should expect PBMs to provide all information necessary to ensure that the PBMs uphold their contractual requirements. This includes full access to claims data and the ability to audit drug manufacturer agreements.

PBM contracting

Once a PBM is selected, the plan's fiduciaries will need to negotiate the PBM agreement. PBM agreements are undoubtedly one of the most complicated benefits-related services agreements. First drafts are often riddled with omissions and ambiguities that, if left unedited, can enable unexpected revenue streams in favor of the PBM and can lead to costly disputes down the line. Rather than addressing specific contractual provisions, we offer three general goals that fiduciaries should seek to attain in the contract negotiation phase:

RFP CONSISTENCY

Health and welfare plan fiduciaries, along with their pharmacy benefit consultant and specialized ERISA counsel, should review the agreement to ensure that the terms and conditions align with the RFP requirements and the PBM's RFP responses. This includes commercial terms, the scope of program and services, basic service fees, pricing guarantees (i.e., ingredient cost, dispensing fee, rebates), and performance guarantees.

UNAMBIGUITY

Care must be taken to ensure that potentially ambiguous terms and conditions cannot be manipulated to generate revenue for the PBMs. For example, ingredient cost and rebate

guarantees are often subject to certain exclusions (i.e., certain claims are excluded from the guarantee calculation). Those exclusions must be clearly listed and defined so that a PBM cannot attempt to broadly apply the exclusion.

TRANSPARENCY

At the risk of being repetitive, PBM agreements must be reviewed to ensure that plan fiduciaries have the data and other information necessary to ensure the PBM's contractual compliance. This includes provisions requiring full access to claims data and robust audit rights.

Takeaways

Full-scale RFPs for PBMs are likely needed every three to five years, depending on the term of the PBM agreement. However, the pharmacy benefit arena is volatile, and pricing should be evaluated annually. Most PBM agreements permit annual market checks that allow for pricing adjustments if the agreement's pricing becomes non-competitive with the market. However, an annual market check is only one method of monitoring PBMs. Day-to-day monitoring and periodic audits are also important. In our next installment, we describe how fiduciaries can best monitor PBMs to ensure contractual compliance.

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