PHARMACY BENEFIT CONTRACTING TOOLKIT ©

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HEALTHCARE PURCHASER ALLIANCE OF MAINE

ABOUT THIS TOOLKIT

Pharmacy spend makes up almost a quarter of total health spend, and that amount has been steadily increasing over the last several years. There's not a lot that purchasers can do about manufacturer price increases and the introduction of expensive specialty drugs. But a significant portion of pharmacy dollars goes to middlemen, like pharmacy benefit managers, or PBMs. And there are many provisions that purchasers can include in their contracts with PBMs that can reduce the dollars flowing to middlemen and significantly lower plan pharmacy costs.

This toolkit is not meant to be an exhaustive list of contract terms or replace your current PBM RFP, but it includes terms that can help purchasers eliminate waste and games in their PBM contracts, and substantially lower their pharmacy spend. These include:

- Making sure manufacturer rebates are broadly defined and that 100 percent are passed through to the purchaser
- No spread pricing, so that the PBM charges the purchaser the exact same amount they pay the pharmacy
- Limiting PBM revenue to a flat admin fee
- Total formulary flexibility to ensure the plan incentivizes drugs with the lowest net cost and excludes low-value drugs
- Pricing metrics that aren't susceptible to gaming
- Access to data to conduct market checks
- Capacity to carve out mail order and specialty drug management
- Programs to more actively manage a plan's pharmacy costs

DISCLAIMER

- EXECUTIVE SUMMARY OF ESSENTIAL TERMS -

SPREAD PRICING

- Do you utilize a pass-thru design for all drugs (retail, mail, and specialty), where the PBM bills the plan exactly what the pharmacy provider is paid for each claim, and the PBM does not derive any profit or other remuneration from any source for any covered item dispensed from a retail pharmacy? If not, please explain.
- How do plan sponsors confirm via audit that rates are pass-through? That is, do plan sponsors have access to pharmacy contracted rates for specific drugs? And do plan sponsors have unrestricted auditing rights to verify no-spread pricing, including no limits on who they choose as their third-party auditor?

REBATES

- Will you pass through 100% of all manufacturer payments, rebates, and price reductions to the plan sponsor, with rebates defined as including all direct and indirect compensation, concessions and remuneration that the PBM receives from a pharmaceutical manufacturer (brand or generic) or any other third party.
  - Will you provide the plan sponsor with regular reporting that includes drug-level rebate amounts?
  - Does your organization use a rebate aggregator? If so, what percent of gross rebates/ revenues are paid to the aggregator?

FORMULARY

- Does the plan sponsor have flexibility to customize its formulary without limitation, including decisions around what drugs to include or exclude, as well as how to tier drugs.
  - Do you offer a formulary that is based on lowest net cost or provide lowest net cost information (including rebates) to the plan sponsor?

PRICING DEFINITIONS & GUARANTEES

- Will you and your vendors use Medi-Span definitions in pricing guarantees and contract language:
  - Generic drug. The term generic drug shall mean the following: the multisource code field in Medi-Span MONY information fields contains a “Y” (generic).
  - Brand drug. The term brand drug shall mean the following: The multisource code field in Medi-Span MONY information fields contains an “M” (co-branded product), “O” (originator brand), or an “N” (single source brand).
- Do you offer PMPM or other price/savings guarantees? If so, please describe, including any required programs that plan sponsor must implement to take advantage of the guarantee.
- Will you adjudicate all claims according to the “lowest of” logic such that members always pay the lower of the applicable copayment or the contracted price/allowed amount (i.e., no clawbacks)?

CARVEOUTS

- Does the plan sponsor have the authority to carve out:
  - Specialty pharmacy (including specific specialty drugs)
  - Mail order
  - Prior authorizations and step therapy
  - Clinical management
  - Formulary management
- Describe any impact on admin fees when a service (e.g., specialty, mail order) is carved out.

VALUE-BASED PROGRAMS

- Describe any value-based savings programs you offer (ex: coupon maximization, patient assistance, international sourcing, specialty and clinical management, network optimization, channel management, etc.) How utilized are these programs and what average savings do they generate?
- Do you offer the ability for the plan sponsor to 'turn off' specific value-based programs?

CONTRACT TERM & FEES

- Will you offer a one-year contract, with one-year renewals available?
- Are plan sponsor administrative fees your only source of revenue? If not, please detail all additional revenue sources, and services not included in the base admin fee.
- Will the PBM disclose all direct and indirect fees, commissions, and other revenues that it receives or pays that are related to this contract?
- Will the plan sponsor or its designated third party auditor -- utilizing any audit partner they choose, regardless of the payment methodology -- have unrestricted operational and financial audit rights upon 30 days notice?

DATA ACCESS & UTILIZATION

- Does the plan sponsor have the right to obtain net cost information (factoring in rebates and all other passed-through monies) for each drug dispensed through the plan?
- No restrictions, limitations, or unreasonable fees may be imposed by the PBM or its agents on how the plan sponsor can use or share its claims data or materials derived from claims data, For example, full access cannot be limited through NDAs or DUAs that prohibit utilization of any data or through designation of such data as proprietary by the PBM or any of its partners.

SPECIALTY

- If your specialty program generates revenue, describe how that does not disincentivize robust clinical management of specialty patients that could result in fewer or lower cost specialty drugs?