



PHARMACISTS UNITED FOR
TRUTH AND TRANSPARENCY

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CONTRACT NEGOTIATING TOOL: Information on Contracts with Pharmacy Benefit Managers

This negotiating tool summarizes the various issues that arise when contracting with Pharmacy Benefit Managers for prescription benefits. The purpose of this negotiating tool is to provide information and is not legal advice.

This document was prepared with the assistance of Georgetown University's Harrison Institute for Public Law, which has more than 40 years of experience working for nonprofit clients on various local and national needs. The document represents the views of the contributors and does not represent the views of Georgetown University.

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EXECUTIVE SUMMARY

INTRODUCTION: Pharmacy Benefit Managers are third-party administrators who manage prescription drug plans for employers (hereinafter called “plan sponsors”). There are approximately 76 PBMs administering prescription drug plans for more than 215 million Americans. Two large companies (Express Scripts-Medco and CVS-Caremark) account for 70% of the market for prescription processing. The prescription drug industry is complex and highly technical – with PBMs connecting plan sponsors, pharmaceutical manufacturers, and pharmacists. While PBMs can provide industry knowledge to plan sponsors, how they operate is often unclear. For example, PBMs negotiate with pharmaceutical manufacturers to set prices for drugs; they also may negotiate rebates for using certain drugs – information that is not publicly available. Due to the lack of transparency, PBMs practices have been the subject of investigations and lawsuits.

Considering the leverage that PBMs have in the market, plan sponsors may not have the knowledge to effectively negotiate a contract that can provide a prescription drug plan at the best cost. In addition, many plan sponsors do not use the current contracting process (referred to as the “request-for-proposal”) to effectively outline contract terms or verify the projections that the PBM provides. This Contract Negotiating Tool is a resource for plan sponsors to understand the language and mechanics of a PBM contract. This tool is provided by Pharmacists United for Truth and Transparency (PUTT), a not-for-profit organization comprised of pharmacists and pharmacy owners who want to inform the public about the practices of PBMs.

The Tool lists topics in PBM contracts that can be vague and if left undefined, may raise costs for the plan sponsor. Each contains background information explaining why this topic can be problematic and includes tips to consider when drafting contract language.

TOPICS IN PBM CONTRACTS

Definitions: Many PBM-employer contracts contain language that is ambiguous, vague, or undefined. Undefined terms can lead to the plan operating differently than expected and could lead to increased costs. For instance, PBMs and plan sponsors may define brand and generic drugs differently, which could result in differing pricing terms for the same drug product. Additionally, if the pricing methodologies for drugs are not carefully defined, some pricing definitions may give the PBM too much authority to adjust pricing that is favorable to the PBM or structure plans in a way that the plan sponsor is not getting the lowest possible cost. These are just a few of many contract terms that may not be clearly outlined in PBM-plan sponsor contracts.

Drug Pricing: PBM contracts use a variety of pricing methods for drugs under a prescription plan. Many are not realistic indicators of actual market prices because they are either set by a manufacturer or the PBM, not the market. This makes it difficult for the plan sponsor to know the actual cost of drugs. As a result, many PBM contracts currently allow for “spread pricing,” which enables PBMs to charge plan sponsors more than they reimburse pharmacies, so the PBM can profit on the plan’s utilization – in addition to its fee for service. This makes it important for the PBM contract to clearly specify the pricing formula used for each drug category and allow the plan sponsor to verify how the PBM is pricing its drugs.

Rebates: PBMs negotiate with third parties, such as pharmaceutical manufacturers, to receive better deals or discounts for drugs. PBMs are incentivized to negotiate with these third parties due to the cost savings for plan sponsors, but also for the receipt of significant rebates. If the plan sponsor does not claim this revenue in the contract, the PBM can keep these rebates rather than forward them to the plan sponsor.

Plan Services: Plan services govern how a PBM will administer a prescription and how the PBM will assist plan members, promote better outcomes, and decrease overall costs. If these services are not addressed in the contract, it leaves the PBM with full authority to change or omit the services. For example, PBM contracts vary as to how fees are structured for the administration of plan services. Listing each service protects the plan sponsor from being charged for the same service under a different fee category while also confirming what services the PBM is expected to provide. While most of these services are beneficial to the plan sponsor, some services could potentially lead to increased costs and decreased member satisfaction.

ABOUT THIS NEGOTIATING TOOL

PBMs are third party administrators of prescription drug programs who contract with employers (referred to as “plan sponsors”) to provide prescription drug benefits to employees (referred to as “members”) of the plan sponsor. PBMs manage prescription drug benefits for approximately two-thirds of all Americans (Atlantic Information Services 2004, p. 329) and control the vast majority of prescription processing. There are an estimated 76 PBMs in the United States (FDA 2011, website). In this concentrated field, two of the largest PBMs, Express Scripts and Medco, merged in 2012. With this merger, Express Scripts-Medco now accounts for approximately 45% of the market. Together with CVS Caremark, these two companies account for approximately 73% of the prescription processing in the United States (Abelson 2012, p. B3).

PBMs provide an array of services to administer and manage prescription drug plans such as creating a formulary (a list of preferred drugs that will be covered under a plan) and negotiating drug prices with pharmaceutical manufacturers (Congressional Budget Office 2007, p. 10). PBMs also contract with pharmacies, where they reimburse pharmacies at an agreed price for the members’ prescriptions (FTC 2005, p.4). In addition to processing claims between pharmacies and plan members, PBMs review the medications members fill at all pharmacies under the plan (referred to as “drug utilization”). This data assists pharmacists to identify drug interactions and duplicate drugs, and can promote clinical interventions to improve the medication management of plan members (Cook, Kornfield, & Gold 2000, p. 13-14).

PBMs generate revenue by three main methods (Garrett & Garis 2007, p. 37):

- **Pricing drugs**

Many PBMs further retain profits based on the drug prices they negotiate between a plan sponsor and a pharmacy. A common practice among PBMs, “price spreading,” allows PBMs to charge a plan sponsor for a drug, but pay a lower amount to the pharmacy that dispenses the drug and keep the difference (Garrett & Garis 2007, p. 36; Garis & Clark 2004, p. 20). PBMs also negotiate drug prices with pharmaceutical manufacturers independently of plan sponsors, which can influence what types of drugs are covered under a plan’s formulary (Kaiser Family Foundation, Health Strategies Consultancy 2005, p. 16, 24; FTC 2005, p. 44-45).

- **Negotiating rebates from drug manufacturers**

PBMs place brand drugs on a formulary because pharmaceutical manufacturers often provide rebates for using these drugs (FTC 2005, p. viii). Rebates are also the third main method for how PBMs generate revenue (Garrett & Garis 2007, p. 44). In a 2005 study, the Federal Trade Commission (FTC) estimated that the top 25 brand drugs accounted for 70 percent of the rebate payments that pharmaceutical manufacturers made to PBMs (FTC 2005, p. 48). Depending on the contract some PBMs retain a portion of a plan sponsor’s rebate dollars (Anderson, Samuels, & Sarraille 2012, webinar).

- **Charging a fee to manage drug plans (“plan services”)**

The types of plan services and related charges depend on the contract between a PBM and plan sponsor. Some PBMs charge a monthly fee per member while other PBMs charge a per transaction fee (Anderson, Samuels, & Sarraille 2012, webinar).

PBMs evolved as a means to lower overall drug prices and simplify the prescription services process by automating administrative services, obtaining discounts on drugs (ingredient cost), and managing drug utilization. However, PBMs have been under increasing scrutiny, including the subject of numerous claims and litigation, concerning whether their practices actually contribute to decreased costs. Exactly how PBMs generate revenue has been the subject of numerous claims and litigation involving the allegations of increased costs to the plan sponsor and the wrongful retention of profits (See U.S. v. Merck-Medco Managed Care, L.L.C., et al, 2004 WL 5018758 and In Re Express Scripts 2007). For example, in 2006, Medco settled a case with the Department of Justice over allegations of false claims (U.S. Dept. of Justice Press Release, Oct. 23, 2006). Included in the lawsuit were allegations that the company did not fulfill its contract obligations, for example, failing to track drug utilization and filling prescriptions with drugs to earn undisclosed rebates with drug manufacturers (See U.S. v. Merck-Medco Managed Care, L.L.C., et al, 2004 WL 5018758). Other lawsuits have alleged that PBMs engaged in practices so that physicians would prescribe brand drugs in order to receive higher rebates undisclosed to the plan sponsor (See In Re Express Scripts 2007; California Office of the Attorney General Press Release, April 26, 2004).

Even with the increased legal scrutiny, it is difficult to assess the actual prices in PBM contracts because this information is undisclosed (Freudenheim 2007). The overall lack of transparency in the PBM industry often makes it difficult for plan sponsors to assess the benefits of a prescription drug plan against the cost of the plan (Balto 2006, p. 3; Calabrese 2008, p. 12-13). Given the highly technical nature of prescription processing, many plan sponsors are unable to effectively identify language requiring a definition so that both parties understand contract terms (Anderson & Cosway 2010, p. 23). PBM contracts often have language that is ambiguous, vague, or undefined (Keel 2008, p. 16). Many plan sponsors may be unaware that important

terms are not adequately defined (Keel 2008, p. 17; Anderson & Cosway 2010, p. 23), potentially adding to the cost of a prescription drug plan (Keel 2008, p. 17; Anderson & Cosway 2010, p. 23). For example, in order to ascertain how a PBM receives rebates and to ensure rebates are passed through, plan sponsors can include contract terms addressing these issues. Alternatively, a plan sponsor can ensure that contracts include cost saving measures through adjusted administrative fees and copayments. These examples reiterate the importance of a carefully drafted contract to allow for agreements that meet the interests of both the PBM and plan sponsor.

These contracting concerns may be heightened by the current method of contracting with PBMs, the request-for-proposal (RFP) process, where plan sponsors or their consultants solicit PBMs to respond to the plan sponsor's request for a prescription plan (FTC 2005, p. 8). Many RFPs are structured with the plan sponsor or consulting firm sending a questionnaire to PBMs and asking the PBM to project costs for the plan sponsor (Pricewaterhouse Coopers 2001, p. 106). However, the PBMs' projections may not materialize in the final contract (Anderson, Samuels, & Sarraille 2012, webinar) as many plan sponsors do not use the RFP process to review actual contracts, outline contract terms, and verify that the actual prescription plan reflects the PBMs' projections (Anderson & Cosway 2010, p. 23; Stern 2005, Issue 4). Moreover, PBMs draft the contracts they negotiate with plan sponsors, often using templates that PBMs have developed (Keel 2008, p. 16; Stern 2005, Issue 4).

There are several aspects of a PBM contract that plan sponsors may want to change (J.P. Morgan 2012, p. 18), but they may not have the knowledge to ensure these changes take place. As such, Pharmacists United for Truth and Transparency (PUTT) is providing a Contract Negotiating Tool to provide information so that plan sponsors can understand common contract terms and their implications. PUTT is a nonprofit organization of pharmacists and pharmacy owners with industry-specific knowledge about PBMs. Like plan sponsors, pharmacies must contract with PBMs; however, pharmacists' knowledge of prescription processing and pricing has allowed pharmacists to become familiar with PBMs' practices. PUTT believes some of these practices may not only increase costs for plan sponsors, but also harm local pharmacies and their communities. For example, when PBMs require patients to leave local pharmacies to use PBM-owned mail order pharmacies, local pharmacies and the communities both lose. The pharmacy loses business and relationships with those they serve, and the community loses the ability to discuss prescriptions with a local pharmacist. PUTT hopes that by informing the public about the cost of prescription drugs associated with PBMs, PBM practices may change to the benefit of plan sponsors, members, local pharmacists, and their communities.

With this tool, PUTT hopes to ensure that plan sponsors fully understand the various terms in a PBM contract so that the contract can fully represent their interests. The tool lists topics common in PBM contracts that are vague if the contract does not fully define them. Each contains background information explaining why this topic can be problematic, and includes tips to consider when drafting contract language. The tool also provides suggestions to safeguard a plan sponsor's interest when negotiating terms with a PBM. The topics are presented as a checklist to assist plan sponsors in identifying and addressing the most common issues related to PBM-plan sponsor contracts. This tool was drafted after conducting a literature review of issues with current PBM-plan sponsor contracts.

CONTRACT NEGOTIATING CHECKLIST

DEFINITIONS

- Claim
- Brand/Generic Drug
- Drug Pricing
- Full Disclosure
- Specialty Drug
- Transparency

DRUG PRICING

- Brand Drugs
- Generic Drugs
- Mail Order Drugs
- Specialty Drugs

REBATES

PLAN SERVICES

- Administration Fees
- Copay Structure
- Mail Order
- Specialty Pharmacies

VERIFICATION

- Audits
- Contract Term
- Disclosure
- Nonperformance
- Plan Updates
- Renegotiation Rights

CONTENTS

DEFINITIONS	6
BRAND/GENERIC DRUG DEFINITION.....	6
CLAIM.....	7
DRUG PRICING.....	7
FULL DISCLOSURE.....	8
REBATE.....	9
SPECIALTY DRUG.....	9
TRANSPARENCY.....	9
DRUG PRICING	10
BRAND DRUGS.....	10
GENERIC DRUGS.....	11
MAIL ORDER DRUGS.....	11
SPECIALTY DRUGS.....	12
REBATES	13
PLAN SERVICES	14
ADMINISTRATION FEES.....	14
COPAY STRUCTURE.....	14
MAIL ORDER.....	15
SPECIALITY PHARMACIES.....	15
VERIFICATION	16
AUDITS (REVIEW).....	16
CONTRACT TERM.....	17
DISCLOSURE.....	17
NONPERFORMANCE.....	18
PLAN UPDATES.....	18
RENEGOTIATION OF TERMS.....	18
REFERENCES	19

DEFINITIONS

The definitions section is a critical part of a PBM contract because it explains how PBMs will treat each term. Many terms may seem straightforward, but if left undefined, the PBM and plan sponsor may interpret these terms differently (URAC 2009, p. 3). Undefined terms can lead to the plan operating differently than expected and could lead to increased costs (Anderson & Conway 2010, p. 22). The following are common terms that may be found in PBM-plan sponsor contracts. If defined, they can ensure that both parties understand what the terms mean and avoid potential conflicts between the PBM and plan sponsor. Please note that some terms are further explained in other sections of this document.

BRAND/GENERIC DRUG DEFINITION

Formularies are lists of drugs that a PBM will pay for under a prescription plan (FTC 2005, p. 6). Drug pricing under formularies varies based on what kind of drug is being dispensed (Kaiser Family Foundation, Hoadley 2005, p. 4), but PBMs and plan sponsors may have different expectations of what type of drugs belong in a specific category. For example, without clearly defining what constitutes a generic drug, PBMs may classify generic drugs as brand drugs, resulting in increased charges to the plan sponsor and its members (Calabrese 2008, p. 12; Hayden 2011, p. 4).

If drug types are not defined, PBMs may preferentially list some brand products as generics when it benefits the PBM. For instance, many PBMs guarantee plan sponsors that they will dispense a certain percentage of prescriptions generically to save plan sponsors money (FTC 2005, p. 64). PBMs report how many generic prescriptions are filled to plan sponsors as the generic utilization rate. However, if brand and generic drugs are not carefully defined, PBMs may classify a certain drug as a brand for pricing, but classify the same drug as a generic when reporting the generic utilization rate (Cahn 2010, p. 2; FTC 2005, p. 65; Hayden 2011, p. 3). This can result in plan sponsors not only paying higher prices, but also allowing the PBM to represent cost savings that may not be accurate. Clearly defining what constitutes a brand versus generic drug can avoid inflated costs and ensure that PBMs are accurately reporting the use of generics under a prescription plan.

TIPS

- Require the PBM to classify brand and generic drugs based on a specified national reporting service, such as Medi-Span or First DataBank, with the inclusion of:
 - Specific coding requirements for brand classification.
 - Specific coding requirements for generic classification such as multisource coding of “Y” under Medi-Span.
- Propose:
 - Language that specifies that drugs identified as brand or generic drugs shall be considered brand or generic drugs, respectively, for all purposes.
 - Language that requires plan sponsor approval of any new drug classification methodologies.
- If the definition states that a brand drug is anything that is not a generic drug, carefully review the generic drug definition.
- Beware of definitions that define generic drugs as multisource products or require production by multiple manufacturers. Many generic products are only manufactured by one or two manufacturers, which would result in classifying these generics as brands.
 - If the PBM excludes single-source generics from its generic definition, propose:
 - Defining these products specifically and narrowly.
 - That the PBM provide a list of these products.
 - That the PBM provide updates on changes in this list.

CLAIM

Language that does not specify the definition of a “claim” may permit PBMs to collect funds unknown to the plan sponsor by interpreting the definition of a claim to favor the PBM (Calabrese 2008, p. 17). For example, a PBM may withhold passing through a rebate to the plan sponsor until the claim is collected, or may charge multiple administrative fees for the dispensing of one medication to a member due to the resubmission of the claim (Stern 2005, p. 2; Hayden, 2011 p. 4). Defining “claim” ensures that the PBM will reimburse the plan sponsor when money is due and will not overcharge on processing prescriptions.

TIPS:

- Propose language that specifies claims will not include duplicate, reversed, or rejected claims.
- Claims ought to cover all claims once “paid” and not claims that are only “collected”; PBMs may try to limit claims only to “collected.”

DRUG PRICING

PBMs use many different methodologies for drug pricing, most of which can be confusing to a plan sponsor (NASMD 2010, p. 2). Historically, the standard pricing methodology for PBM contracts has been Average Wholesale Price (AWP) (NASMD 2010, p. 5). PBMs calculated this methodology on pricing information that drug manufacturers reported (NASMD 2010, p. 5). PBMs utilized this manufacturer-derived data to contract with plan sponsors at a specified rate below this listed price for both brand and generic drugs (Garis & Clark 2004, p. 20). However, drug manufacturers tended to inflate the listed prices, making it difficult for plan sponsors to determine whether they were contracting at a good rate (*See New England Carpenters Health Benefits Fund, et al. v. First DataBank, Inc. & McKesson Co.*). Various reference databases supplied this information, resulting in numerous listed prices for any given drug, and potentially allowing PBMs to pick databases that favor them (Keel 2008, p. 5). In addition to these problems with AWP, the primary reporters of AWP ceased publication as of 2011, making any reported data out of date (NASMD 2010, p. 5).

Many PBM contracts utilize a generic pricing methodology called MAC (Maximum Allowable Cost) (Anderson, Samuels, & Sarraille 2012, webinar). This pricing methodology consists of a list of drugs that are capped at a certain price per unit of drug (NASMD 2010, p. 7). While price capping can seem appealing for plan sponsors, plan sponsors are often unaware of the potential problems this methodology can cause. For instance, PBMs select which drugs and at what prices to include on their MAC lists, and often limit the number of drugs included or change the lists at their discretion (Cahn 2008, p. 32). Additionally, PBMs may have multiple MAC lists, allowing PBMs to contract with pharmacies at a lower drug cost than with the plan sponsor, resulting in spread pricing (FTC 2005, p. 24; Keel 2008, p. 6). Furthermore, the actual price of some drugs may be below the capped price, causing the plan sponsor to pay a higher than market price (NASMD 2010, p. 9).

Another common pricing methodology is WAC (Wholesale Acquisition Cost) (Kaiser Family Foundation, Health Strategies Consultancy 2005, p. 17-18). This pricing methodology is often used for brand drugs, defined as the undiscounted list price that manufacturers charge to wholesalers exclusive of any discounts, rebates, or other reductions in payment (NASMD 2010, p. 8). While plan sponsors may perceive the list price to be a straightforward pricing methodology, WAC can still contain hidden costs (*See New England Carpenters Health Benefits Fund, et al. v. First DataBank, Inc. & McKesson Co.*). This pricing methodology is a manufacturer-reported value that is not easily verifiable, and not all drugs have WAC data available (NASMD 2010, p. 3, 8). Additionally, there are several different sources of WAC data, which can result in varying listed drug prices for the same drug. Coupled with the frequency that drug prices change, a PBM’s listed WAC price may not be reflective of actual drug prices (NASMD 2010, p. 3).

PBMs select and control the methodologies used to price drugs and typically do not give plan sponsors an opportunity to review or confirm that the drug prices reflect actual costs (Cahn 2008, p. 31). While some pricing methodologies may be less desirable than others, a contract will be strengthened if it clearly and adequately defines what pricing methodology the PBM will use to determine drug prices (Anderson, Samuels, & Sarraille 2012, webinar). Some pricing definitions may give the PBM too much authority to adjust pricing that is favorable to the PBM or structure plans in a way that the plan sponsor is not getting the lowest possible cost. Precise definitions of drug pricing formulas can assist to provide the plan sponsor with the lowest possible cost, and inhibit the PBM from making pricing changes unfavorable to the plan.

TIPS:

- Require the PBM to fully disclose any changes in pricing methodologies or the data utilized to determine pricing.
 - Specify “lesser of” pricing on all drug methodologies to ensure the lowest cost when the PBM’s price under its pricing methodology exceeds the actual price of the product.
- Require the PBM to clearly define all pricing methodologies.
 - If **Maximum Allowable Cost (MAC)** is used:
 - Request full disclosure and regular access to the PBM’s MAC list.
 - Request full disclosure of the discount level for generic drugs not included on the PBM’s MAC list.
 - Ensure that the plan sponsor’s MAC list does not differ from any MAC list agreed to with pharmacies where the plan will be utilized.
 - If the PBM does utilize multiple MAC lists, include language specifying that the plan sponsor’s MAC list must be the least costly.
 - Request the PBM to disclose the data it utilizes to formulate the MAC list and associated cost.
 - Request the PBM to disclose the frequency that pricing and drug changes are made to the MAC list.
 - Consider requesting approval of certain pricing changes.
 - Establish precise terms regarding the PBM’s policy for establishing MAC pricing on new generics from multiple manufacturers.
 - Consider establishing performance guarantees for the timing of MAC price establishment on new generics.
 - If **Wholesale Acquisition Cost (WAC)**:
 - Request the PBM to disclose the data it utilizes to formulate the pricing.
 - Request the PBM to disclose the frequency that pricing updates will occur.

FULL DISCLOSURE

Plan sponsors are often unaware of PBMs’ potential financial interests and are frequently uninformed of plan-derived revenue that could be passed on to the plan sponsor. For example, a PBM may receive rebates from manufacturers as a result of members filling prescriptions under the plan, but if full disclosure is not requested, may neglect to inform the plan sponsor or relay the funds (Brown 1997, p. 11). Additionally, plan sponsors are often uninformed of PBMs’ third party financial interests, such as PBM incentives to increase utilization of PBM-owned mail order or specialty pharmacies (Keel 2008, p. 8, 11). Specifically outlining what full disclosure means and what information the PBM is required to provide will ensure the plan sponsor is aware of any PBM practices that could result in lost savings (Anderson, Samuels, & Sarraille 2012, webinar).

TIPS:

- Request the PBM to disclose all manufacturer contracts yielding any payment to the PBM related to member utilization under the plan.
- Request the PBM to disclose all administrative fees and other incentives received in relation to the prescription plan, from sources including but not limited to: drug manufacturers, specialty pharmacies, and mail order pharmacies.
- Request the PBM to disclose any sources any revenue directly or indirectly related to the administration of the plan.
- Request the PBM to disclose any personal, business, or financial interests.

REBATE

PBMs negotiate prescription formularies with pharmaceutical manufacturers and consequently place certain medications that would normally be more expensive, such as brand medications, as preferred drugs because they receive rebates from manufacturers that offset the costs (Rentmeester & Garis 2008, p. 947-48). In addition to requesting the PBM to pass through rebates to the plan sponsor, explicitly defining the term “rebate” can help plan sponsors understand what rebates it is entitled to receive. Without a clear definition of rebate, the PBM may receive revenue from a manufacturer related to the plan sponsor’s utilization of the prescription plan, but categorize it as something else and retain it (Keel 2008, p. 5).

TIPS:

- Define “rebate” as any manufacturer-derived revenue related to plan utilization, including but not limited to formulary revenue, market share utilization, administration fees, and data fees.

SPECIALTY DRUG

Under current PBM-plan sponsor contracts, the pricing models for specialty drugs are generally much less defined than standard brand or generic drugs (Keel 2008, p. 5). Many PBMs retain the authority to adjust the classification of specialty drugs classification without involving the plan sponsor (Cahn 2009, p. 4). Without clearly defining what constitutes a specialty drug, PBMs may classify non-specialty drugs as specialty drugs, resulting in increased charges. PBMs often require plan sponsors to use specialty pharmacies to dispense specialty drugs. Many PBMs own the specialty pharmacies they require plan sponsors to utilize, allowing them to gain a greater share of profits (NACDS 2011, p. 2). If the PBM does not own the specialty pharmacy, the PBM often receives and retains rebates from dispensing these products, incentivizing the PBM to utilize specialty pharmacies (Cahn 2009, p. 4). Defining specialty drugs can help avoid any unnecessary use of specialty pharmacies and ensures that plan sponsors receive rebates for specialty drugs when warranted.

TIPS:

- Either the plan sponsor or PBM can define specialty drugs by providing an all-inclusive list of drugs considered specialty products. Propose that the PBM may not classify drugs as specialty drugs unless the plan sponsor approves of the inclusion.
- Include a right for the plan sponsor and PBM to jointly update the list at least quarterly to ensure that new drugs are covered.

TRANSPARENCY

In order for plan sponsors to understand how their prescription plans are operating, plan sponsors need information about some of the PBMs’ practices. However, there is often an overall lack of transparency about PBM business practices (Garrett & Garis 2007, p. 61-64). As a result, plan sponsors may be unable to verify if and how contractual obligations of the PBM, such as providing guarantees and administering plan services, are being met (Hayden 2011, p. 7; NACDS 2011, p. 3). Requesting transparency on how the PBM is fulfilling a contract allows plan sponsors to adequately assess the performance of the PBM and to ensure that the PBM is meeting its obligations. However, stating that the PBM must provide transparency may not guarantee that transparency will actually occur. Plan sponsors can provide specific measures on how plan sponsors can assess a PBM’s performance under a contract (Anderson, Samuels, & Sarraille 2012, webinar) (*see Verification section*).

TIPS:

- Request the PBM to provide both full disclosure and verification of fulfilling all PBM obligations, including but not limited to drug formularies, pricing methodologies, and MAC and specialty drug lists.
- Request the PBM to provide access to any and all agreements relating to the administration of the plan, including but not limited to pharmacy networks, manufacturer rebates, and any and all claim data.

DRUG PRICING

PBM contracts currently use a variety of different pricing methodologies to determine how much to charge the plan sponsor for drugs (NASMD 2010, p. 7-10). Many pricing methodologies are not indicators of actual market prices, making it difficult for the plan sponsor to know the actual costs of drugs (NASMD 2010, p. 7-10). Some PBM contracts also do not specify the pricing methodology for certain drug products at all. (Keel 2008, p. 5). If the contract does explain the pricing methodology, it may not identify which database the PBM is using to calculate drug costs. This vagueness may give the PBM the ability to switch methodologies if they favor the PBM's interests, or even allow the PBM to calculate drug costs for some products without utilizing a database (Keel 2008, p. 5). For instance, the PBM may purchase drugs in bulk, repackage them into smaller quantities, and then assign a new inflated drug cost to the repackaged product (URAC 2009, p. 29).

In addition to the importance of the PBM contract clearly specifying the pricing formula used for each drug category, plan sponsors can strengthen the contract by including a right to verify how the PBM is pricing its drugs. Many PBM contracts currently allow for "spread pricing," which enables PBMs to charge plan sponsors more than they reimburse pharmacies, therefore permitting the PBM to profit on the plan's utilization (Garis & Clark 2004, p. 18). Some PBMs consider this standard practice as a way for the PBM to attain profits, while other PBMs utilize higher fees to attain profits and do not participate in "spread pricing" (Anderson & Cosway, 2010, p. 23; URAC 2009, p. 22-23). This unclear area of pricing is another reason why plan sponsors can incorporate "transparency" in the contract either with post-contract tools or requests for disclosures so that plan sponsors can understand and assess the value of the services it is receiving.

TIPS:

To address concerns with drug pricing the contract:

- Specify the pricing formula used for all categories of covered drugs;
- Specify the database used to determine the pricing formula(s);
- Prohibit the PBM from charging prices in excess of the database's listed price, including but not limited to assigning new prices to repackaged drugs;
- Request disclosure of any differing pricing formulas or lists used with pharmacies; and
- Require transparency of whether the PBM practices "spread pricing" or "passes through" the same price from the pharmacy to the plan sponsor.

BRAND DRUGS

PBMs use a variety of different pricing methodologies for brand drugs and there is no standard pricing formula (CBO 2007, p. 6-10). Considering the many different pricing methodologies, the plan sponsor can request that the PBM clearly outlines the pricing for brand drugs in the contract.

TIPS:

- Ensure that "brand drug" is carefully defined (*see Definitions section*).
- Require the PBM to define the methodology used (*see Drug Pricing in Definitions section*).
- Propose that the PBM pass through the prices on brand drugs from the pharmacy to the plan sponsor (in other words, that the price to the plan sponsor is the same as the price to the PBM).
 - If the PBM refuses, request disclosure of any differences in price between the plan sponsor's charge and the pharmacy's reimbursement to deter the PBM from creating unreasonable "spreads" (*see Verification section*).
 - If the PBM refuses, negotiate for lower administrative fees, as the PBM will be attaining profits from "spread pricing."

- Ensure post-contracting tools that can verify charges for all drug claims, including but not limited to the production of drug receipts and auditing rights.
- If **Wholesale Acquisition Cost (WAC)** is used, ensure the methodology is properly defined (*see Drug Pricing in Definitions section*).
- Do not accept pricing under **Average Wholesale Price (AWP)** because it is no longer a methodology currently used (*see Drug Pricing in Definitions section*).
- Specify “lesser of” pricing to ensure that the lowest cost when the PBM’s price under its pricing methodology exceeds the actual price of the product.

GENERIC DRUGS

Although generic drugs are generally less expensive than brands, plan sponsors can still save significant money on generic drugs if pricing is carefully outlined in the contract. The vast majority of drugs dispensed on any plan will be generic, and pricing among different PBMs and prescription plans can vary greatly (ASPE 2010, p. 1). Effectively outlining generic pricing will help to decrease overall plan costs.

TIPS:

- Ensure that “generic drug” is carefully defined (*see Definitions section*).
- Require the PBM to define the methodology used (*see Drug Pricing in Definitions section*).
- Propose that the PBM pass through the prices on generic drugs from the pharmacy to the plan sponsor (in other words, that the price to the plan sponsor is the same as the price to the PBM).
 - If the PBM refuses, request disclosure in any differences in price between the plan sponsor’s charge and the pharmacy’s reimbursement to deter the PBM from creating unreasonable “spreads.”
 - If the PBM refuses, negotiate for lower administrative fees, as the PBM will be attaining profits from “spread pricing.”
- Ensure post-contracting tools that can verify charges for all drug claims, including but not limited to the production of drug receipts and auditing rights.
- If **Maximum Allowable Cost (MAC)** is used, ensure that the methodology is properly defined (*see Drug Pricing in Definitions section*).
- For **Zero Balance Due** transactions, where the pharmacy’s listed drug price is below the PBM’s calculated price:
- Request the PBM to exclude these transactions from discount guarantees; permitting the PBM to include these claims in calculating guarantees allows the PBM to take credit for negotiating lower costs when the lower cost is simply due to the pharmacy’s prices.
- Specify “lesser of” pricing to ensure that the lowest cost when the PBM’s price under its pricing methodology exceeds the actual price of the product.

MAIL ORDER DRUGS

Many PBM contracts promote utilizing mail order pharmacies to fill members’ prescriptions (FTC 2005, p. 17). While the pricing for mail order drugs can often appear competitive, PBMs often own or are affiliated with these pharmacies. PBMs with a financial interest in a mail order pharmacy may inflate drug prices by repackaging drugs (URAC 2007, p. 34). Drug repackaging refers to when an entity purchases drugs in bulk and then repackages the drugs into smaller containers for distribution. While retail pharmacies also dispense medications from larger pack sizes, the price for the product is based on the original, larger pack size (Causey 2009, p. 4). However, if the PBM repackages drugs, it may assign a new inflated price to the repackaged container of drugs, and then bill the plan sponsor using the smaller repackaged size with the higher price per unit (NACDS 2011, p. 3). This can lead to increased costs for plan sponsors and increased profits for the PBM that owns the mail order pharmacy. While one study found that PBM-owned mail order pharmacies rarely repackaged drugs for the top ten

drugs (FTC 2005, p. 97), it is important that the plan sponsor knows whether or not repackaging occurs under its contract. Additionally, it is not uncommon for generic drugs to be less expensive at retail pharmacies, thus plan sponsors may benefit from ensuring that pricing for mail order drugs still provides the lowest cost (URAC 2007, p. 34).

TIPS:

- Propose that the PBM pass through the prices on mail order drugs from the pharmacy to the plan sponsor (in other words, that the price to the plan sponsor is the same as the price to the PBM).
 - If the PBM refuses, request disclosure in any differences in price between the plan sponsor's charge and the mail order pharmacy's reimbursement to deter the PBM from creating unreasonable "spreads."
 - If the PBM refuses, negotiate for lower administrative fees, as the PBM will be attaining profits from "spread pricing."
- Require the PBM to disclose whether the PBM repackages drugs into smaller packages.
 - If the PBM repackages drugs, require the PBM to specify the pricing methodology used for these products.
 - Specify that the plan sponsor's unit cost must be "lesser of" the originator's unit cost to ensure that repackaged drugs are not sold at a higher price per unit than what the PBM purchased the drugs.
- For generic drugs, request **Maximum Allowable Cost (MAC)** be used:
 - Ensure MAC is properly defined (*see Drug Pricing in Definitions section*).
- Ensure post-contracting tools that can verify charges for all drug claims, including but not limited to the production of drug receipts and auditing rights.
- Specify "lesser of" pricing to ensure that the lowest cost when the PBM's price under its pricing methodology exceeds the actual price of the product.

SPECIALTY DRUGS

Specialty drugs are generally the most expensive drugs utilized by plans, yet are also the drugs that often lack clear pricing methodologies (Keel 2008, p. 5-6). Since many plans require specialty drugs to be dispensed by specialty pharmacies, the majority of which are owned by PBMs with limited competition, it is important for the plan sponsor to carefully review the pricing methodologies for these products (NACDS 2011, p. 2).

TIPS:

- Request the PBM to pass through the prices on specialty drugs from the pharmacy to the plan sponsor (in other words, that the price to the plan sponsor is the same as the price to the PBM).
 - If the PBM refuses, request disclosure in any differences in price between the plan sponsor's charge and the pharmacy's reimbursement to deter the PBM from creating unreasonable "spreads."
 - If the PBM refuses, also negotiate for lower administrative fees, as the PBM will be attaining profits from "spread pricing."
- Ensure post-contracting tools that can verify charges for all drug claims, including but not limited to the production of drug receipts and auditing rights.
- Propose that the PBM provide an inclusive list of all specialty drug products covered under the prescription plan according to this pricing methodology.
- Specify "lesser of" pricing to ensure that the lowest cost when the PBM's price under its pricing methodology exceeds the actual price of the product.

REBATES

PBMs generate significant revenue from third party rebates (Garrett & Garis 2007, p. 26). PBMs negotiate with third parties, such as pharmaceutical manufacturers, to receive better deals or discounts for plan formularies (GWU 1999, p. 7). PBMs are incentivized to negotiate with these third parties due to the cost savings for plan sponsors, but also for the receipt of significant rebates. However, if the PBM does not pass these rebates on to the plan sponsor, the plan sponsor could be paying more for the prescription formulary, or may not be receiving revenue that its members' utilization entitles it to receive (In re Express Scripts 2007, p. 1144-47). If the plan sponsor does not specify this revenue in the contract, the PBM can pocket these rebates rather than forward them to the plan sponsor (In re Express Scripts 2007, p. 1144-47).

TIPS:

- Ensure that all sources of rebate revenue are included.
 - The PBM agrees to pass through to the plan sponsor any and all of the following:
 - Formulary rebates
 - Market-share rebates
 - Other rebate revenue
 - Administrative fees or credits
 - Data aggregation payments or data sale revenue
 - Pharmaceutical manufacturer revenue associated with compliance and adherence programs.
 - The previous list applies to any and all collected and uncollected credits.
 - Propose that the PBM disclose any other revenue received directly or indirectly from pharmaceutical manufacturers that cannot be attributed to specific client utilization.
 - Request that this disclosure will occur at least annually.
- Negotiate for passing through as close to 100% of revenue as possible.
- Negotiate for rebates to be passed through at the point of sale rather than waiting for the PBM to first collect the claim from the third party.
- For data sales revenue, include a provision disallowing the PBM from sharing data sales if the PBM will not agree to pass through 100% of revenue.

PLAN SERVICES

Plan services outline how a PBM will administer a prescription and what services the PBM will provide to assist customers, promote better outcomes, and decrease overall costs (Cook, Kornfield, & Gold 2000, p. 13-14). While many of these services are beneficial to the plan sponsor, some services could potentially lead to increased costs and decreased member satisfaction. Many of these services are not addressed in the contract, leaving the PBM with full authority to change or omit the services they provide.

ADMINISTRATION FEES

PBM contracts vary as to how fees are structured for the administration of plan services. Some contracts stipulate a flat fee for all plan services, while others charge for different services individually (Anderson, Samuels, & Sarraille 2012, webinar). Regardless of the fee structure, listing each service protects the plan sponsor from being charged for the same service under a different fee category while also confirming what services the PBM is expected to provide (URAC 2007, p. 29). Therefore, plan sponsors can benefit from articulating and defining what services it expects from the PBM. This will help ensure the expectations of both parties and provide the plan sponsor the scope of services it is paying for under the contract.

TIPS:

- Determine every program that will be a part of the plan and specify that the administration fee will be included in that program. Some programs include:
 - Adherence Management
 - Clinical Consulting
 - Coordination of Benefits
 - Customer Service
 - Drug Utilization Services
 - E-Prescribing
 - Formulary Management
 - Generic Utilization
 - Mandatory Generic Program
 - Mandatory Mail Order
 - Mandatory Specialty Pharmacy
 - Medication Therapy Management
 - Prior Authorization
 - Step Therapy

COPAY STRUCTURE

PBMs structure drug formularies by placing medications into different tiers (Kaiser Family Foundation, Hoadley 2005, p. 3-4). The tier of a medication determines the copay cost to plan members. For generic medications, the listed generic copay cost may exceed the actual cost of the medication (Stern 2005, p. 2).

TIPS:

- Specify that listed copays for tiered medications may not exceed the cost charged by the pharmacy.
- For all claims below the listed copay, the patient's copay ought to equal that cost.

MAIL ORDER

Mail order pharmacies are a controversial aspect of PBM contracts (see generally FTC 2005). These pharmacies are often owned or affiliated with the PBM, which allows the PBM to have greater control over pricing and rebates. These pharmacies can provide cheaper prices as compared to retail pharmacies, but some prices may be more expensive and the calculation of rebates unclear. Therefore, a plan sponsor can benefit from carefully reviewing mail order programs to ensure that they provide the plan sponsor with the lowest cost, while also maintaining quality services to its employees.

TIPS:

- Require mail order pricing to be specifically defined (*see Drug Pricing section*).
 - Ensure post-contracting tools that can verify charges for all drug claims, including but not limited to the production of drug receipts and auditing rights.
- Request comparisons between mail order pricing and retail pricing to determine differences in cost.
- Request flexibility in retail versus mail order services based on what pharmacy will provide the lowest cost.
 - If the plan sponsor prefers mail order, consider requesting initial prescription fills to take place at retail pharmacies at 30-day supplies to limit waste during medication regimen changes.
- Specify that all mail order rebates be passed through (*see Rebates section*).

SPECIALTY PHARMACIES

Specialty pharmacies are generally required for the dispensing of specialty drugs, which are the most expensive drugs under prescription plans. In 2012, the FTC estimated that the largest PBM alone, Express Scripts-Medco, controlled approximately 30% of the specialty drug market (FTC Statement, p.8 2012), making it prudent for plan sponsors to be cautious as PBMs may have a financial interest.

TIPS:

- Require specialty drug products to be specifically defined (*see Definitions section*).
- Require specialty drug pricing be defined for all covered products (*see Drug Pricing section*).
- Negotiate for greater discounts on specialty products, or lower administrative fees, as the PBM may have more leverage due to owning the pharmacy.

VERIFICATION

PBMs consider many critical components of a PBM contract, such as claims data or rebate information, proprietary and do not share this information with the plan sponsor (In re Express Scripts 2007, p. 1145). If the PBM contract does provide a right to audit, many require that the PBM select or approve any auditor, further limiting the plan sponsor's ability to ensure an independent and objective review (Keel 2008, p. 2; NACDS 2011, p. 3). Since claim errors can exist even under the most transparent contracts, plan sponsors can safeguard their contracts by requesting audits to verify claims (Hayden 2011, p. 1). Incorporating forms of verification in the contract will ensure that the PBM is processing claims and operating according to its contract.

AUDITS (REVIEW)

Even if all of the other elements of contracting are addressed, plan sponsors may not receive the performance they expect if they do not propose a process to verify that a PBM is meeting its contractual obligations (Hayden 2011, p. 1; Anderson & Cosway 2010, p. 25-26). Auditing evaluates the value of PBM services and can assist plan sponsors to compare PBMs in future RFPs. PBM contracts may limit the ability for plan sponsors to audit their practices, either by limiting the auditor or the frequency of audits (Keel 2008, p. 2; NACDS 2011, p. 3). Furthermore, many PBMs consider certain information and data to be proprietary and will not allow the plan sponsor to access information to verify contractual obligations (Keel 2008, p. 3-4). Note, however, that the plan sponsor owns much of this information that is considered proprietary, such as claims data, because the information is about its plan and plan members.

Auditing rights are necessary to assure that PBMs are meeting their performance guarantees, and to protect against simple errors in pricing, formulary implementation, and benefit design that could lead to substantial increased costs (Hayden 2011, p. 1). By addressing auditing rights with the PBM carefully, plan sponsors can ensure they are receiving appropriate audit rights and can evaluate the performance of their PBM contract (Keel 2008, p. 3-4).

TIPS:

- Incorporate full audit rights to all:
 - Administrative fees
 - Claims data
 - Clinical coverage criteria
 - Customer service calls
 - Eligibility Records
 - Formulary decision-making records
 - MAC lists
 - Mail service purchasing invoices
 - Manufacturer rebate and administrative fee contracts
 - Other delegated tasks
 - Retail pharmacy purchasing invoices
 - Specialty pharmacy purchasing invoices.
- Retain the right to select the auditor.
 - It is important that the plan sponsor retain the right to select the auditor; however, the PBM may require mutual assent or approval.
 - Retain right to review the audit report before PBM comments and reviews.
- Specify the timing and frequency that audits may occur, including how much notice an auditor will provide the PBM prior to an audit.

CONTRACT TERM

Many plan sponsors do not want to change their PBM agreements frequently, as this poses an inconvenience to its members and causes additional work for plan negotiators (JP Morgan 2012, p. 6). However, many PBM contracts are structured so that the contract terms do not provide plan sponsors with a timely opportunity to review terms and adjust needed concerns.

TIPS:

- Negotiate for a contract term no longer than two years.
- If a longer contract term is preferred, request renegotiation rights (*See Verification section*).

DISCLOSURE

Disclosure is necessary for plan sponsors to know if a PBM has financial interests or conflicts with third-parties affecting their prescription plan (Anderson, Samuels, & Sarraille 2012, webinar). PBMs contract with and often even own some of the third parties that determine the price of the drugs under prescription plans. Because of this vested relationship, plan sponsors may benefit from requesting the PBM to provide full disclosure of any potentially competing financial interests (Keel 2008, p. 5). Additionally, without full disclosure of interests to the plan sponsor, a PBM can retain the receipt of rebates, pricing discounts, and other forms of revenue without knowledge of the plan sponsor (In re Express Scripts 2007, p. 1144-47).

TIPS:

- Define what “full disclosure” means to the plan sponsor (*see Definitions section*).
- Request the PBM to provide full disclosure of:
 - Administrative fees
 - Claims data
 - Clinical coverage criteria
 - Customer service calls
 - Eligibility Records
 - Formulary decision-making records
 - MAC lists
 - Mail service purchasing invoices
 - Manufacturer rebate and administrative fee contracts
 - Other delegated tasks
 - Retail pharmacy purchasing invoices
 - Specialty pharmacy purchasing invoices.
- Request the PBM to fully disclose any ownership or financial interest with a manufacturer, pharmacy, or other party related to the plan sponsor’s claims that provides revenue to the PBM.

NONPERFORMANCE

Articulating the specific consequences of nonperformance in a PBM-plan sponsor can help plan sponsors ensure that the PBM meets all of its obligations.

TIPS:

- Specify that failure of the PBM to meet any of its obligations as outlined by the contract will equate to nonperformance.
- Negotiate for as close to 100% refund on all PBM claims and services non-performed.
- Propose the PBM provide a refund for nonperformance within ninety days of notice of nonperformance.

PLAN UPDATES

Given the fluid nature of the prescription business, plan sponsors can benefit from a right to incorporate plan updates under its PBM contract (Anderson & Conway 2010, p. 23). The introduction of new drugs, new manufacturers of generics, and even new third party-PBM contracts can affect the pricing of a prescription plan. Specifying the frequency and requirements of plan updates will help ensure that the plan sponsor is receiving the most current discounts and rebates

TIPS:

Request the PBM to update the following at least every quarter:

- Drug classification
 - New generic drugs
 - New multisource drugs
 - New novel drugs
 - MAC list
 - Specialty drug list
- Require the PBM to fully disclose any and all changes related to the agreement.

RENEGOTIATION OF TERMS

In addition to the importance of an agreeable contract term, a plan sponsor can benefit from retaining the right to renegotiate its contract. Many plan sponsors do not change prescription plan services frequently due to the administrative cost and potential inconvenience to plan members (JP Morgan 2012, p. 6). A plan sponsor's desire to remain in the contract provides leverage to the PBM to continue its services under the status quo. Retaining a right to renegotiate contract terms can ensure that the plan sponsor has the right to renegotiate terms if it's not satisfied and can help to prolong the relationship with the PBM.

TIPS:

- Propose a right to renegotiate any and all terms of the contract at least yearly, including but not limited to:
 - Administrative fees
 - Performance guarantees
 - Plan services
 - Pricing methodologies
 - Rebate allocation.

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