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ALERT

PBM Contracting: What Plans Should Know About the Emerging Models for Pharmacy Program Service Delivery

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Follow the Leader? That is the Question

Anyone administering a pharmacy benefit program today knows that moving to a new model of service delivery seems all the rage. Deconstructing and reconstructing a system that is not providing the level of drug discounts, rebates, and operational efficiency for which health plans and plan sponsors (plans) believe they have contracted is a constant source of frustration – not unlike that of an aching tooth whose pain is managed but never eradicated. So, the question that reverberates is whether your plan should remain as is, embrace incremental change, or completely jettison the status quo.

There are many new models of pharmacy program service delivery under consideration and their number and design are limited only by creativity. We discuss three such models below, which we have titled *Product/Service Disaggregation*, *Program Segmentation*, and *Industry Disruption*. As you begin to contemplate whether there are new models – or aspects of new models – that your plan should consider, please be mindful of the following. First, there is no clear line of demarcation among the models we describe (or likely any future models). Each model includes aspects of the others, and our naming convention is solely to allow you to form some mental distinctions among them. Second, many of these models are emerging – newly created and becoming more widely known – but untested. We are unaware of empirical data that would affirm that the models (as we describe them) are achieving/have achieved their intended outcomes. For example, it remains to be seen whether decoupling the contracting for drug discounts/rebates from other pharmacy program

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services actually attains a greater level of discounts/rebates, or whether contracting with multiple pharmacy benefit managers (PBM) for each program segment provides greater ease/less disruption if replacing an individual PBM is required.

These (and many other) open questions have not diminished plans' desire to continue their quest to change the pharmacy program status quo. With our experience working with clients implementing each of the models described below, Wiley is uniquely positioned to serve as a guide in exploring the legal dimensions of these efforts.

Emerging Models for Pharmacy Program Service Delivery

Product/Service Disaggregation. To overcome the fear of being left behind as other plans unearth what might be a magic bullet for transformative change, plans have begun to test the waters. For some plans, entering these uncharted waters has been cautious, iterative, and methodical, and generally focuses on a single concern, such as increasing drug discounts and rebate payments. We have provided legal counsel to plans as they begin this iterative journey by first contractually reserving the right to seek sources of discounted drugs from other entities, and then actually contracting with such entities to provide a limited array of discounted drugs (e.g., limited categories of generic drugs). We refer to this approach (which is the least disruptive to the status quo) as Product/Service Disaggregation.

Program Segmentation. For other plans, their desire to foster change might be focused on creating a more competitive environment for PBM contracting. This goal is realized by plans either through (i) segmenting their pharmacy program by channel (i.e., retail, mail, and/or specialty programs) and then entering into contracts for each channel, or (ii) (similar to Product/Service Disaggregation) isolating a single program service (e.g., claims payment) and then contracting with a single PBM/service provider for the isolated/segmented service (s), while maintaining all other program services with another PBM/service provider. We refer to this approach as Program Segmentation.

Industry Disruption. There are some plans that are ready to "rip the band aid off" and jump into the deep end. This approach seeks to reconstruct a pharmacy program from the foundation to the roof by treating each component of the program as unique. As such, determining the appropriate model of service delivery requires examining each component of the pharmacy program and then determining which model works best for *that* component.

Under this approach, a plan might combine elements of Product/Service Disaggregation and Program Segmentation by, for example, determining whether the claims payment function should be procured and contracted independently, whether it should be bundled with other administrative services (e.g., clinical management), or whether this function should be assigned to one of the providers for the supply side services – retail, mail, or specialty. For supply side services, a plan might consider for example: (i) whether it should contract with a single, traditional PBM for all such services; (ii) whether it should contract with separate PBMs for each of the supply side services; or (iii) whether one or more PBM(s) should be contracted for the traditional pharmacy program services, with a separate service provider contracted to procure discounted

drugs and rebates. We refer to this approach (which is the most disruptive to the status quo) as Industry Disruption.

The Wiley team has represented plans in their contracting efforts with PBM/pharmacy service providers in each model – *Product/Service Disaggregation*, *Program Segmentation*, and *Industry Disruption*. Through these myriad representations, some clear overall advantages and disadvantages have emerged, as well as considerations for contracting for a multi-vendor pharmacy program.

Considerations For Decision Making

Time and Resources. For each of the models, a primary consideration regarding the future construct of your pharmacy program must be whether you have sufficient time, and financial and operational resources to implement structural program changes – whether such changes are profound or modest.

Determining whether there is adequate time requires contemplating the desired effective date of the redesigned program (including any regulatory approvals that might be needed) and then working backwards. The procurement process will be critical, as fully describing your vision for your new program in the RFP/solicitation (including required cooperation, collaboration, and critical interdependencies) will be essential to ensuring that you receive reliable pricing from all offerors and that they fully understand the directional contours of your new program. Additionally, because some PBMs/service providers might require longer implementation periods than others, establishing the sequencing of program implementation must be factored into the timeline.

With respect to resources, reinventing a pharmacy program requires that key players be "all in" from day one and be committed for the duration of the effort (which can extend 18 to 24 months from procurement to final contracting, depending on the scope of the changes). Plans should be honest in their assessment of whether there are sufficient personnel to: (i) continue to oversee the existing program while also developing multiple new (or retooled) contracts; (ii) undertaking multiple contract negotiations; (iii) socializing the redesigned program internally, with accounts, and (as necessary) with regulators; and (iv) operationalizing the new to the market program.

Contracting Requirements and Guardrails. Fundamental to the success of a redesigned multi-vendor pharmacy program will be developing guardrails for the contracting process. Contracting among different PBMs/service providers (which might vary by sophistication and resources) will not work successfully if each PBM/service provider believes every contract term is open to change and contract negotiations can last for months. Thus, at the outset (i.e., with the RFP or other solicitation) the terms of engagement must be clearly delineated and then uniformly enforced. Foregoing this important step will engender unnecessary confusion and potentially undermine pre-set deadlines.

Equally important to the contracting process is the contract itself. The success of a redesigned pharmacy program requires a realistic focus on the contractual vehicle that will link multiple PBMs/service providers. For example, in developing the contract for the various products/services/programs, plans should consider which terms must be uniform among all PBMs/service providers (e.g., certain definitions [applicable law, brand/

generic drugs, etc.], plan audit rights, regulatory flow-downs and other regulator-imposed obligations, requirements for vendor-to-vendor cooperation and collaboration, etc.), and those contract terms that are unique to each PBM/service provider. Obviously, creating well-constructed contracts will be critical to the success of any new model and including legal counsel early (at the RFP/solicitation phase) and at every stage of the process will help ensure an efficient transition.

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Considering a new approach to pharmacy program service delivery can be exhilarating, particularly when the impetus for such change is to provide members and accounts a pharmacy program that better achieves your desired goals (whether they be revenue diversification, lowering drug costs, greater administrative efficiency, and/or a broader group of PBMs/service providers from which to contract). Each of the models we describe – *Product/Service Disaggregation*, *Program Segmentation*, and *Industry Disruption* – to some degree attain one or more of these goals. However, change is not always the right approach. Even as it seems many plans are embracing the wave of change, you should not be reluctant to acknowledge that *for YOUR plan,* maintaining a traditional, competitive procurement might yield the best result given all considerations. Whatever future course you choose, the health care team at Wiley has broad-based experience to assist you in realizing your goals. As those who routinely operate in the world of PBM contracting know, experience matters.

Contact Us

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