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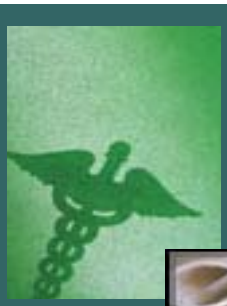

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Testimony of Susan A. Hayes

For

Committee on Oversight and Government Reform, Subcommittee on Federal Workforce

PHARMACY PS OUTCOMES SPECIALISTS

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41 East Main Street, Suite 200, Lake Zurich, IL 60047 • 847-540-9590 • www.pharmout.com

pharmacy outcomes specialists

Good morning, Representative Lynch and members of the Subcommittee on the Federal Workforce, I want to thank you for the opportunity to testify in front of you and answer your questions this morning. My name is Susan Hayes and I am a Principal with Pharmacy Outcomes Specialists. I have been in health care consulting since 1980 and have been involved in pharmacy benefits consulting since 1985. I was responsible for pharmacy benefits consulting for William M. Mercer from 1985 to 1991, consulting to large employers such as Mobil, Sara Lee Corporation and Marmon Group. I was Vice President of Marketing for Walgreens' Health Plus from 1991 to 1994, and for Systemed, now a division of Medco Health from 1994 to 1996. In 1996, with my partner, Kevin Johnson, I founded Pharmacy Outcomes Specialists. I am a graduate from Northeastern Illinois University with a Bachelor's in Criminal Justice and am a registered pharmacy technician in the State of Illinois. We have been in business for 13 years and have consulted to large employers such as Intel and Northwest Airlines, large unions such as Sheet Metal Workers International, the Communication Workers of America Local 1180 and AFSCME Local 37, Coalitions such as the Connecticut Coalition of Taft Hartley Health Plans, the Midwest Business Group on Health and government entities such as the Office of Personnel Management, TriCare Management Activity and the Defense Contractors Auditing Agency.

Pharmacy Outcomes Specialists has conducted over 600 audits, dozens of procurement projects, audited almost a billion prescription drug claims and reviewed hundreds of client contracts with pharmacy benefit managers. Specifically for Office of Personnel Management, POS conducted a review of the contracts for OPM of the Government Employees Hospital Association (GEHA)

and BCBSA in 2000, both of whom contracted with Medco Health for pharmacy benefit administration. POS also conducted a second project for OPM. POS was selected as an expert to testify on rebate administration when the United States of America sued Merck-Medco Managed Care. As part of that litigation I was asked to assist in educating the jury on the industry practices pertaining to contracting and the payment of rebates and incentives by drug manufacturers to PBMs, and payments of rebates by PBMs to their clients. I was also asked to review contractual arrangements that were subjects of that litigation.

In preparing my testimony today, I examined the problems encountered by federal and state governments when contracting for pharmacy benefits. I see three major issues: 1) PBM contracts, especially in their pricing provisions, are needlessly complex; 2) PBM contracts do not disclose hidden revenue sources, including drug rebates and pharmacy margins, and plan sponsors are often not aware of these monies, disadvantaging them in the negotiation process; and 3) and, even when the federal government does negotiate a fair contract with a PBM, PBMs paralyze the ability of the Federal Government to audit and make sure contracted provisions are truly met. All of these problems result in the government and private health plans paying more and more for prescription drugs while PBM profits soar.

Let's take these issues one at a time.

1. The pricing of prescription drugs is overly complex and hidden to purchasers, designed to confuse plan sponsors, and in turn disadvantages plan sponsors in the negotiation process. Prices of prescription brand drugs are based on discounts off Average Wholesale Price or AWP. The source of AWP pricing is primarily two pricing guides which are

published by two pharmaceutical cost data collection companies which each may charge as much as $25,000 a year to subscribe to obtain AWP prices. AWP prices may change on a daily basis and are complicated by the fact that a single drug may have over 50 prices due to different strengths, package sizes and manufacturers. As a result, plan sponsors, such as the OPM, have to pay exorbitant amounts, or hire auditors such as POS, to determine if they have been charged correctly and in accordance with the discount arrangements with their PBMs. Further, these prices are obtained from the actual manufacturer who sets the price of their drugs without the payor – plan sponsors – being aware of pricing changes or having the ability to negotiate these prices.

Prices for generic drugs are even more secretive. Each PBM sets a MAC list (Maximum Allowable Cost) which is closely guarded, which is not routinely given to clients and for which auditors must sign stringent non-disclosure agreements to obtain. MAC prices may vary by the day, the pharmacy or between clients of the same PBM. In fact, each PBM may have over 50 different MAC lists. Auditing these prices is complicated, even for the most experienced auditors and impossible for plan sponsors. Lastly, rebates are based on yet another anachronism, WAC (Wholesale Acquisition Cost) prices, which may loosely tie to AWP prices but have a life of their own, and may increase or decrease based on wholesaler backroom deals. Therefore, rebate amounts - more on this later – also cannot be easily verified by plan sponsors. Overall, the lack of transparency in how prescription drugs are priced and delivered makes these programs impossible to analyze by government agencies, which is no different than the private sector.

2. Contracts between PBMs and Plan Sponsors, even the largest plan sponsors such as OPM, do not adequately disclose where PBMs realize revenue and as a result disadvantage plan sponsors in the negotiation process. In a recent decision, the First Circuit Court of Appeals observed: "The health benefit provider often has no idea that a PBM may not be working in its interest. This lack of awareness is the result of the fact that there is little transparency in a PBM's dealing with manufacturers and pharmacies." [1] Essentially, these contracts do not adequately disclose the following:

i. There are additional monies or margin, perhaps as much as 5% of drug spend, that are retained by PBMs. This is done by charging a plan a higher amount for a prescription drug transaction than is reimbursed to a pharmacy for the same claim transaction, especially for generic drugs, since MAC lists are proprietary. This is known in the industry as "spread."

ii. Often as much as 50% of drug manufacturer rebate payments are never passed back to the plan sponsor but retained by the PBM. PBMs come up with different names for these rebates, such as cost effectiveness rebates, formulary rebates and market share rebates and then the PBM determines how to divide the "pie" of rebate and retain what they want and pass back to plan sponsors what the PBM thinks the client expects, without the client knowing that there is more.

iii. Patient drug histories and physician prescribing patterns are routinely sold to drug companies for profit by PBMs without physicians, patients or plan sponsor's knowledge or approval and without compensation by the plan sponsor or patient. Drug store chains who own PBMs also sell consumer

[1] *Change to Win, CVS/Caremark: An Alarming Prescription, www.changetowin.org*

spending information to insurance companies and others without compensation or the knowledge of patients, to the detriment of patients and these records of spending patterns are not considered "protected health information" under HIPAA.

The lack of transparency is PBM contracting is exacerbated by some PBM's resistance to disclosure of public contract information, even when this disclosure is required by state sunshine laws. For example, one PBM has brought at least eleven separate lawsuits seeking to block the release of its contracts covering public employees in Texas, even after the Texas Attorney General issued legal opinions is each instance stating that the PBM contract at issue should be released as a public document under well-established Texas law. A similar legal battle is underway in Michigan.

3. Contracts between PBMs and Plan Sponsors limit plan sponsors' ability to audit these contracts and disadvantage plan sponsors from verifying if contract terms are met. PBM contracts often contain certain "code words" that seem reasonable on the surface, but often stall audits for years or eliminate the audit altogether. Among the most insidious of these terms is "mutually acceptable auditor." For Caremark, Medco and Express Scripts, who together control a majority of the market, a "mutually acceptable auditor" may be one that is not experienced with rebate contracts, AWP sources or PBM policies and procedures, ones that are too expensive for most plans to afford, or ones that the PBMs coerces into fee arrangements to become "an acceptable" auditor. Most plan sponsors end up never finding an auditor that is acceptable to some PBMs. The Southeastern Pennsylvania Transportation Authority (SEPTA) sued its PBM in 2007 after it attempted, unsuccessfully, to conduct an audit of its plan.

SEPTA claimed in its lawsuit that Caremark, "has wrongfully blocked SEPTA's efforts to conduct an audit of Caremark's performance as SEPTA's PBM." Specifically the PBM engaged in tactics to delay and block the audit, first agreeing to provide certain claims data to SEPTA that was necessary to the audit, and then failing to produce that data and refusing to sign a tolling agreement to preserve SEPTA's claims while the audit was pending. In its lawsuit, SEPTA expressed the frustration of plan sponsors and auditors alike: "Having exhausted all efforts to conduct a thorough audit and to resolve amicably any and all problems with Caremark's practices, SEPTA was forced to bring this action to protect its public assets and interest of its members and beneficiaries in controlling the cost of prescription drugs." [2]

Another practice of PBMs to limit the auditing of contracts is to require the auditor to submit the audit report to the PBM first for approval before the audit report is delivered to the plan sponsor, after which the PBM holds its approval. This tactic often stalls an audit in progress for one to two years while the PBM continues to perpetrate errors.

Some impartial auditors are eventually approved. However, for some PBMs, "approved auditors" fall into one of three categories: one, the PBM has paid the auditor to place business with the PBM, two, the auditors testify for the PBM or three, the auditor and PBM have some "side deal arrangement." In the situation where the audit firm is paid to place business with the PBM, the audit firm is paid a per claim fee for the life of the three year contract to monitor the contract. No wonder these audits often find that the PBM is performing perfectly. Other auditors testify on behalf of a PBM in court cases in order to gain favor with

[2] *Change to Win, CVS/Caremark: An Alarming Prescription, www.changetowin.org*

the PBM. These auditors are then the only ones "tagged" as acceptable, but auditors that testify on behalf of the client are considered objectionable. Still other auditors have other mutual back-pay schemes with the PBM industry like a large consulting firm's arrangement with a PBM to pass this consulting firm additional consulting services to "review" the PBM Coalition formed by the auto industry, the consulting firm and the PBM; or other arrangements where the consulting firm is compensated by the PBM for placement of clients.

Why are some auditors so easily "approved"? Because objective third party audits expose costly errors by PBMs. Audits completed by the United States Office of Personnel Management in 2006 identified over $13 million in administrative fees collected from the Federal Employees Health Benefits Program (FEHBP) Retail Pharmacy Drug Program between 2000 and 2005 by its PBM AdvancePCS – which should have been considered drug rebates and returned to FEHBP as the contract specified. These audits also found that AdvancePCS was not in compliance with all provisions of the contract and federal procurement regulations.

In my experience in over 600 audits, not one audit has yield a perfect report card. Some errors have been found in all 600 audits. Some were minor misunderstanding about plan design terms or eligibility "snafu's." Honest mistakes given that there are 12,000 drug code identifiers, 55,000 pharmacies, millions of patients, physicians and other providers and a host of system logic and rules applied to 3 second claims transactions. However, many findings related to ignoring PBM contractual obligation to plan sponsors to reduce costs and improve patient health.

Representative Lynch, I was surprised to see in your invitation letter to me that Federal Costs for pharmacy benefits are 30% of total health care spending. Normally, I would see pharmacy costs as 20% of total health care and I would conclude that your program is "no deal." All of the problems with the PBM industry that I discussed above are causing the government to spend more that it should on prescription drug benefits for the FEHBP. So that FEHBP can be a model for public and private plans, I am hopeful that the government will reform it contracting processes in the upcoming re-bidding of several of FEHBP plans, including PBM services that are subcontracted through Blue Cross and Blue Shield, and that regulations can be passed that require, particularly for Federal Employees, the following measures:

- Fully transparent contracting for PBM services, so that the government and the public can ensure that tax dollars are being wisely spent,
- Pricing terms are clear in PBM contracts and that pricing is "passed through" from the pharmacy to the plan sponsor with no margin,
- AWP brand pricing information becomes readily available to plan sponsors and PBM forced to publish MAC pricing for generics,
- Rebate payment sources and types of rebates received by the PBMs are fully disclosed and 100% of the rebates are passed on to the plan,
- Data selling of any kind, associated with health care product spending or pharmacy data should require the explicit approval of plan sponsors, physicians and patients,

- The plan sponsor's selection of a qualified auditor should not be routinely thwarted by PBMs and all plan sponsors should have the ability to fully audit all aspects of the PBM contract
- Auditors that accept payments of any kind from PBMs or drug companies should be required to fully disclose the information to prospective plan sponsors.

I once again thank you for the opportunity and will now entertain any questions that you have of me.