

MEMORANDUM

To: Self-Funded Groups Eligible to Carve-Out Pharmacy Benefit Management

From: Borislow Insurance

Date: March 19, 2024

Re: PBM Consulting & Compensation

Purpose: This memorandum explains the manner in which Borislow Insurance is and is not compensated for its placement of pharmacy benefit manager (PBM) arrangements with the self-funded employer sponsored group health plans to which it provides brokerage and consulting services. While our principal purpose is to inform and educate employer/plan sponsors, this memorandum also serves as part of our efforts to comply with the broker and consultant disclosure requirements enacted as a part of the Consolidated Appropriations Act (CAA). These are the rules that require brokers and consultants to disclose to plan fiduciaries, in writing, of all direct and indirect compensation they receive for providing services to plans.

No Compensation: Borislow Insurance does not earn any direct or indirect compensation from Pharmacy Benefit Managers (PBMs).

No conflicts of interest: On February 5, 2024, a class action lawsuit was filed against Johnson & Johnson, alleging that the company breached its fiduciary duty under ERISA by mismanaging the plan's prescription drug benefits. The case is *Lewandowski v. Johnson & Johnson, et al.*, and the complaint alleges that the fiduciaries of a group health plan paid excessive fees and other markups to the plan's PBMs for specialty generic drugs. While it is too soon to generalize, this complaint could well be a harbinger of a wave of litigation alleging breach of fiduciary duty in selecting and monitoring welfare plan vendors. Of note, alleged breaches in fiduciary duty may include failure to adequately consider non-traditional PBMs, failure to adequately negotiate favorable contract pricing, and failure to carve out specialty pharmacy from their PBM contracts.

Diligence: At Borislow, plan sponsors and plan members always come first. We prioritize value and partner only with those PBMs who align their incentives with our clients' and plan members' best interests. Our goal is to ensure that our clients can feel confident that we support their performance of their fiduciary duties under ERISA. We thoughtfully advise our clients to ensure that their chosen PBM aligns with their organizational and member interests. We proactively request member disruption reports and consider potential changes. For example, when deciding whether to cover Weight Loss drugs, we collaborate with our PBM partners to track the number of prior authorizations that are rejected/denied due to plan exclusions. This helps to delineate what is denied due to lack of clinical appropriateness versus what is denied due to plan exclusions. Most importantly, we do not rely on the PBMs' representations and promises. We do the research and draw our own conclusions, which are always in the best interest of our clients.

Intentional on pricing: Traditional PBM contracts and pricing are opaque. Therefore, wherever possible, we do not even entertain contract offers that are amenable to price manipulation. Where that is not possible, we strongly advocate for removing unfavorable contract language – terms like offsetting, MAC list manipulation and other sources of direct and indirect revenue PBMs and their consultants receive at the expense of plan sponsors and plan members. (We are not lawyers, of course; we therefore encourage clients to have their PBM contracts reviewed by counsel familiar with PBM contracts and arrangements.)

Not inclined to chase rebates: We prioritize achieving the best patient clinical outcomes at the lowest possible net cost to the plan and plan member.

Looking beyond the spreadsheet: We prioritize member experience, contract flexibility and transparency, and data visibility over projected financials based off archaic pricing models that are built to benefit the PBM at the expense of the plan sponsor and plan member. For example, it makes no sense for a client/consultant to demand an airtight PBM contract with aggressive guarantees if a PBM can simply violate those contract provisions and incur only limited liability or no liability at all.

Termination flexibility: The industry is rapidly evolving. Consequently, it's important to maintain flexibility. We always aim to have a termination without cause clause written into client PBM agreements. When successful, we fiercely advocate for the removal of any claw back language triggered by client termination without cause. The devil is in the details.

Looking beyond the guarantees: While financial guarantees are a safeguard for PBMs, we don't solely grade our PBMs on how well they performed to their guarantees. Instead, we evaluate PBM performance based on member experience and net per member per month (PMPM) spend.

Disregard unrealistic hypotheticals: PBMs will project millions in savings through enhanced offerings like Patient Assistance Programs (PAP). These models tend to assume 100% utilization or adoption, which is unobtainable. We view projected savings through a pragmatic, thoughtful, and human lens.

The Spectrum of Transparency: We prioritize PBMs that strive to be 100% transparent with no spread in their pricing. Data visibility and independent audit rights for plan sponsors are crucial to measuring success (or failure).

Holistic view: We consider the impact of PBM decisions on clinical outcomes. We assist our plan sponsors in navigating complex issues like the national ADHD drug shortage. In some cases, members are driving hundreds of miles to get prescriptions, doctors are writing prescriptions to a dizzying number of different pharmacies, patients are even switching medications because they can't get their script filled. At best, these situations are worrisome – at worst, they threaten patient health.

Engage Clients: Many brokers/consultants insulate their PBMs from their clients. We don't. We engage our PBMs to meet with our clients. We empower our clients to be a part of the decision-making process and relationship building at every step.

Engage our partners: We work with our clients' chosen Third-Party Administrators (TPAs) and Stop Loss Carriers to streamline efficiencies in patient care, capture savings opportunities, and identify opportunities to enrich the member experience.

Creating Solutions. *Delivering Outcomes.*

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