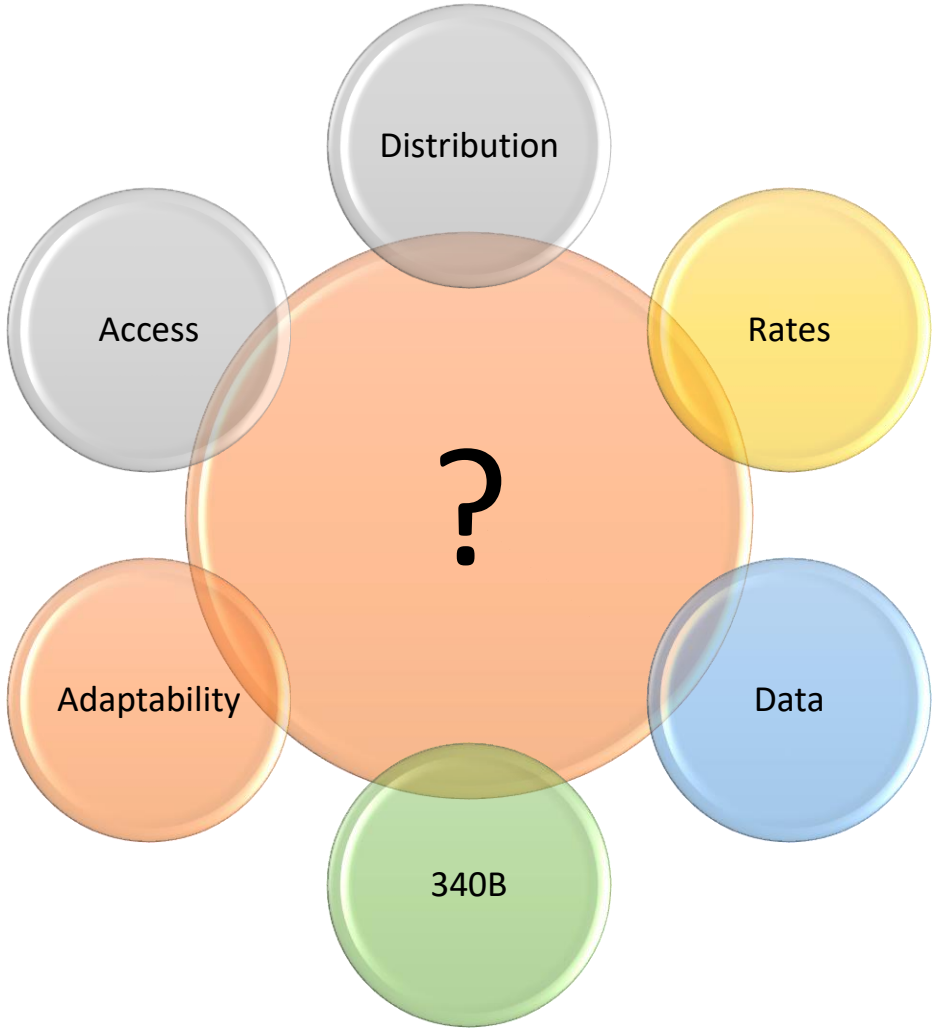
Who Controls Health Care? Who Should?



Testimony Vermont House Health Care Committee:

Jeffrey Hochberg

President Vermont Retail Druggists

04/26/23

The System is Broken

- There are challenges with Access to Care
- There are challenges with transparency in the system
- There are challenges with regulation of the system
- There are challenges with consumer protection/patient safety
- There are challenges with workforce sustainability

- Patient Costs are Rising; Access is Declining; and Demographic Needs are Increasing.

Summary:

- In order for the State to effectively control prescription drug prices, two things MUST happen:

  1.) reduce the Pharmacy Benefit Manager's control over the system thru regulation and **ENFORCEMENT;**
  2.) completely change the Pharmacy Model

The time has come to rewrite the fundamentals of an overly complex and expensive system. To do so, we must achieve a new sense of perspective so that we can better control and monitor our continual efforts. We must repurpose key players to properly pursue the "Triple Aim."

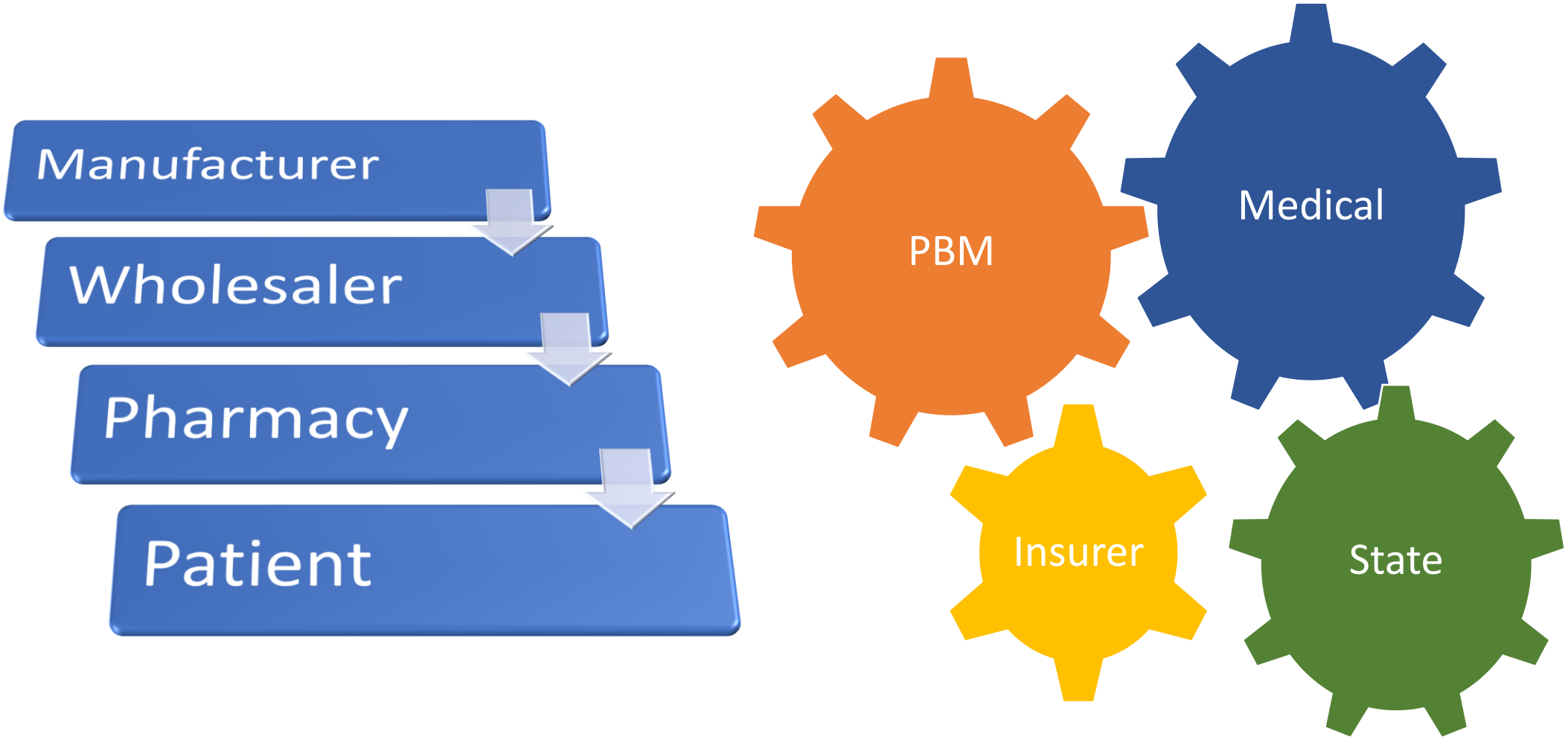
Current Pharmacy Pricing

- Overly complicated
- Lacking any sense of Transparency
- At least 5 inflation steps:

1. Manufacturer sells product to Wholesaler (WAC – Wholesale acquisition price or **List Price**);
2. Wholesaler sells to Pharmacies (**Invoice Price**);
3. Pharmacy dispenses drug to Patients and paid by PBM (**Retail Price**);
4. PBM charges Insurer (**Plan Drug Spend**);
5. Insurer charges Patient (**Premium**);

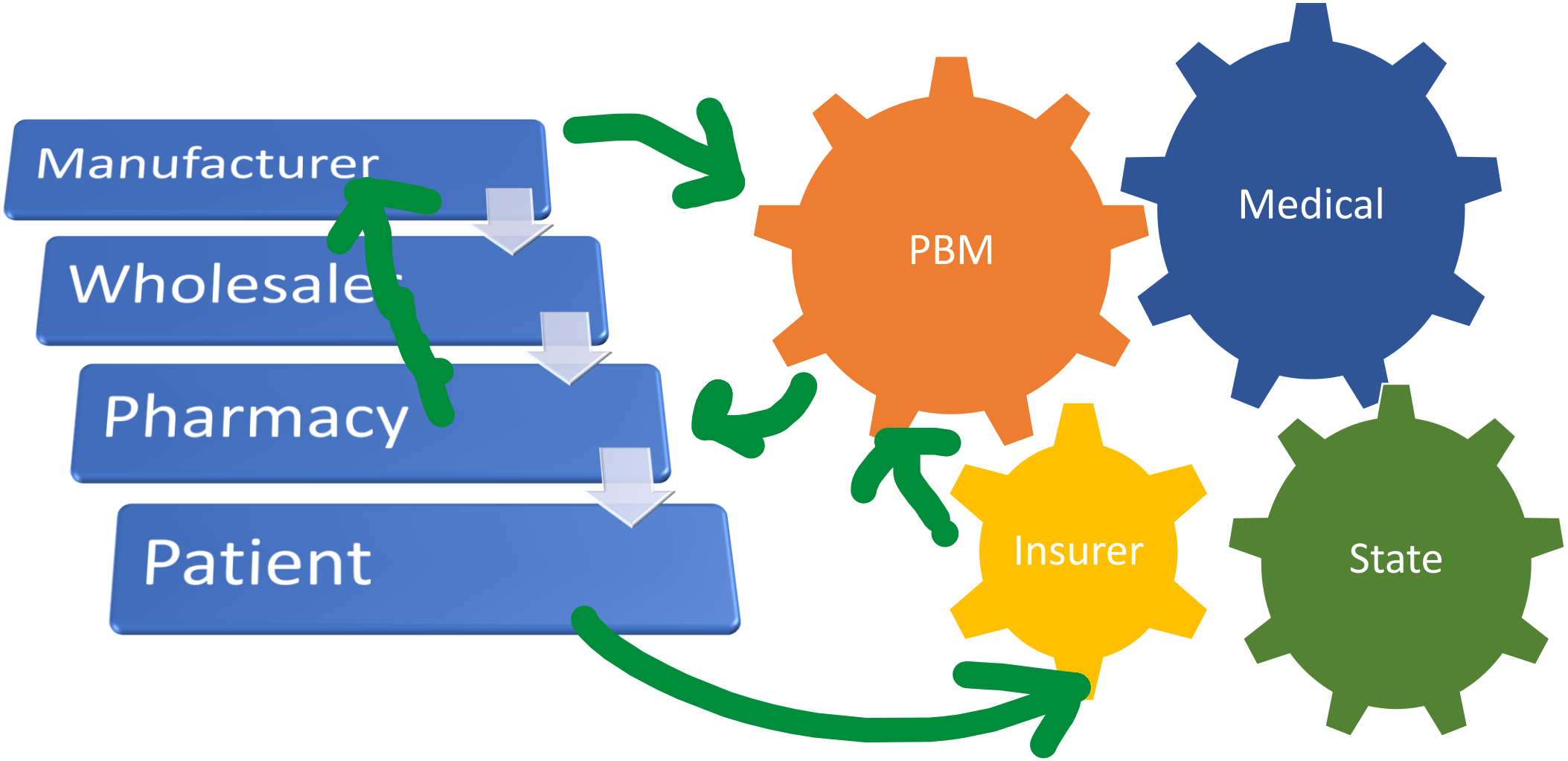
- Complete disassociation from true costs and drug product

Supply Channel along with Financial and Indirect Stakeholders

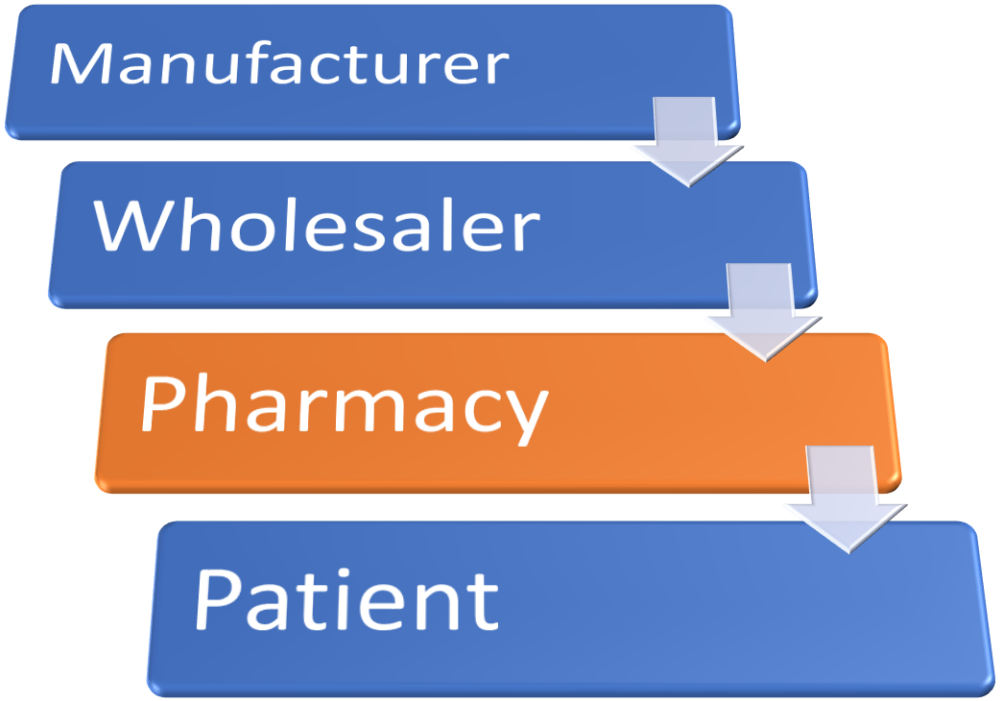


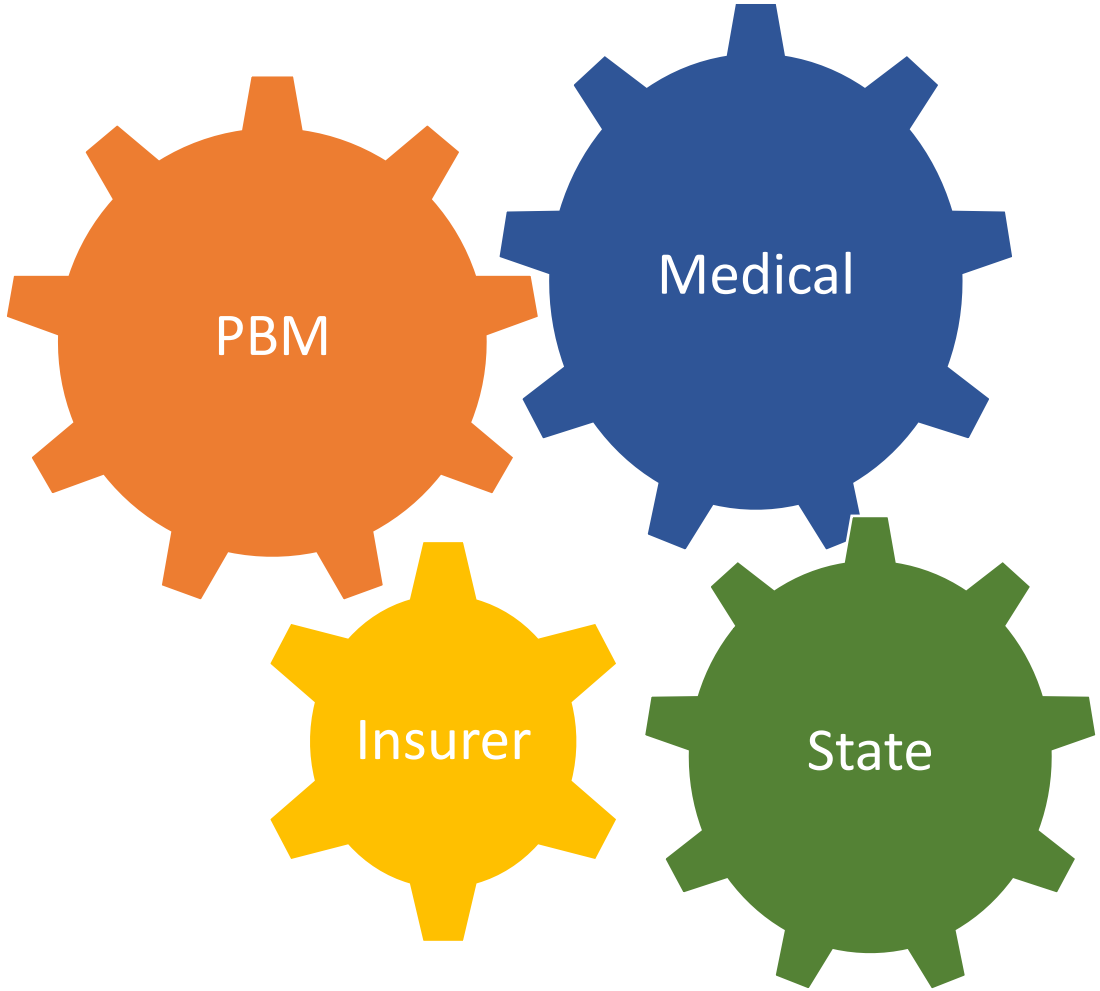
Supply Channel along with Financial and Indirect Stakeholders

and Revenue $$$

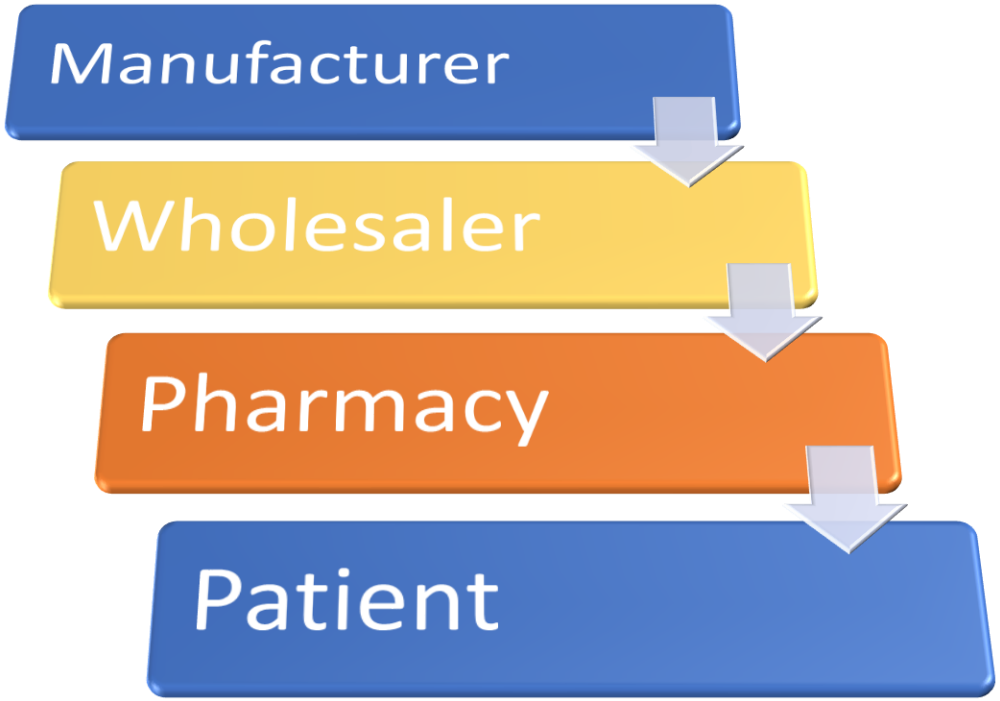


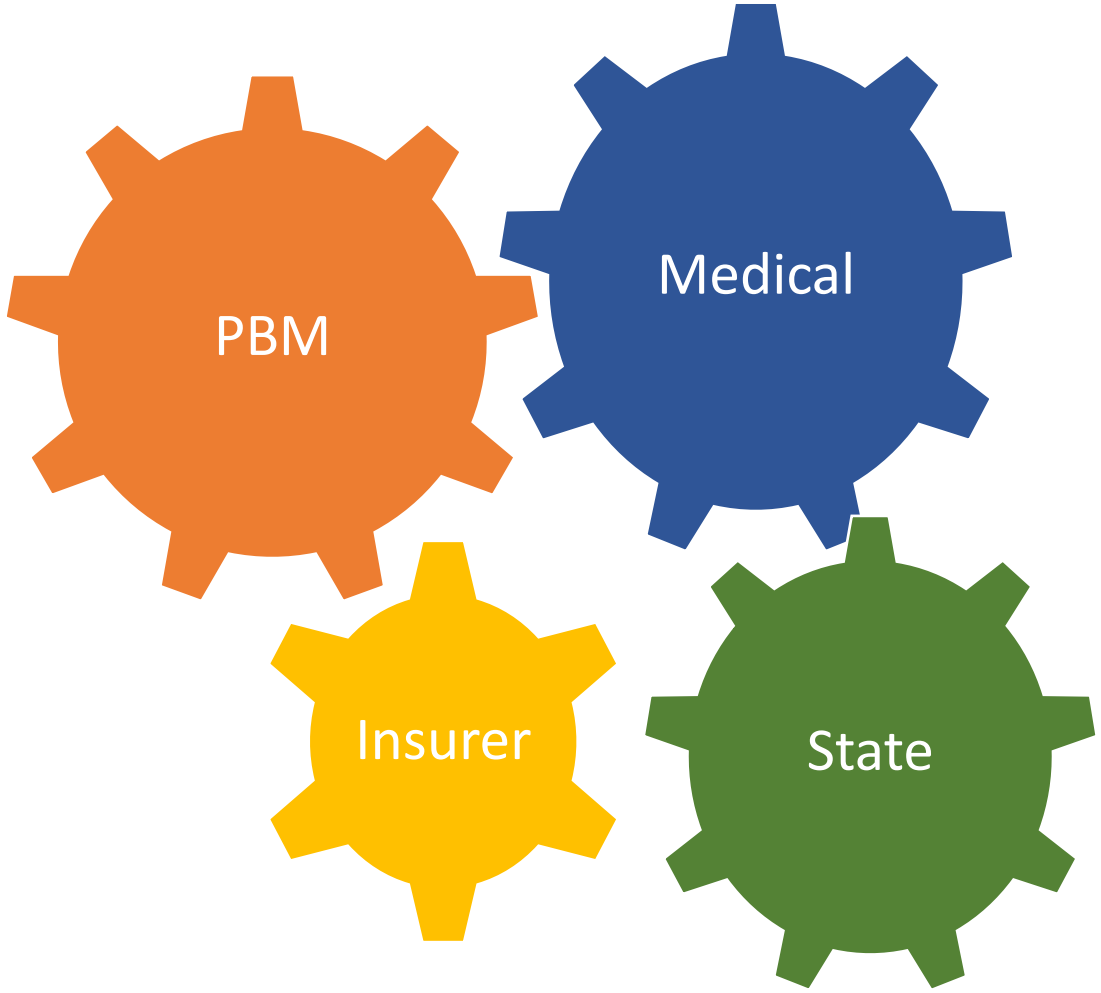
First Major Consolidation within Market players exemplified PBM owned/operated Pharmacies; or Pharmacy owned/operated PBMs



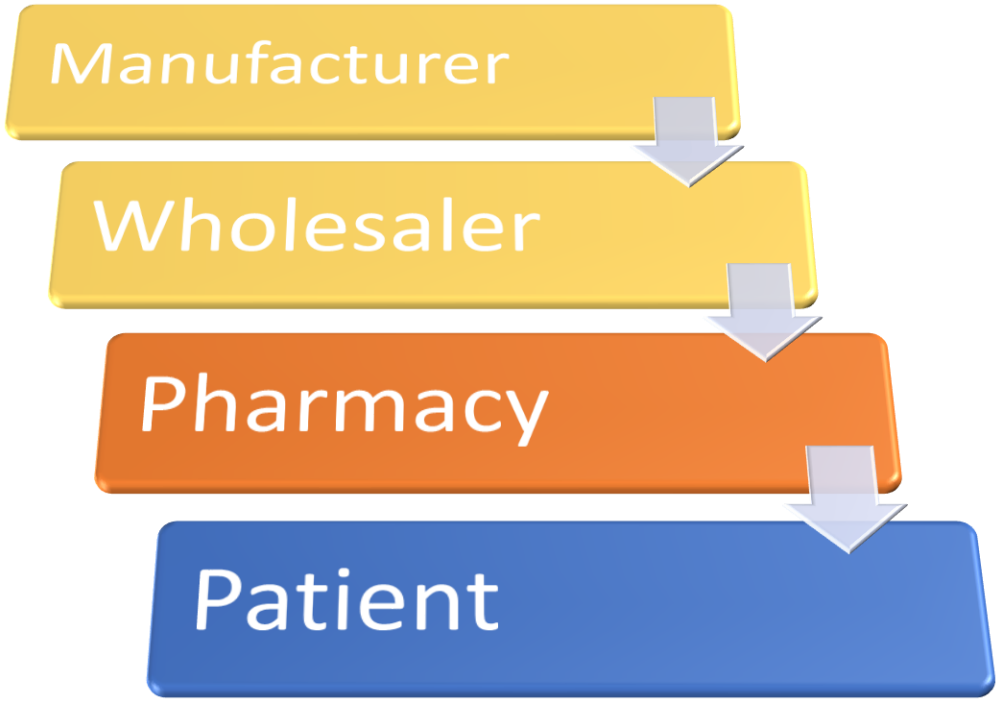


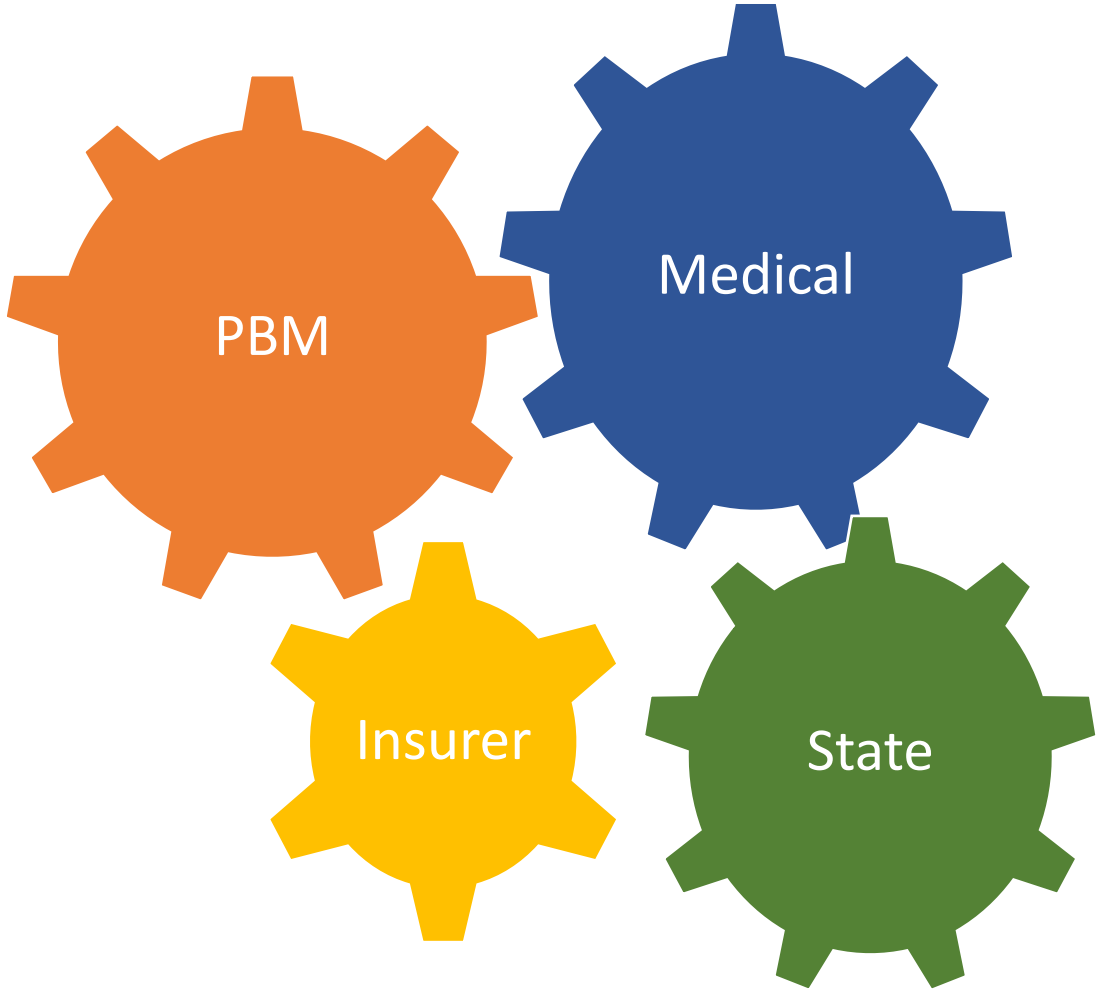
Principle customers for each major wholesaler is a national chain. National chain pharmacy and wholesaler merge.



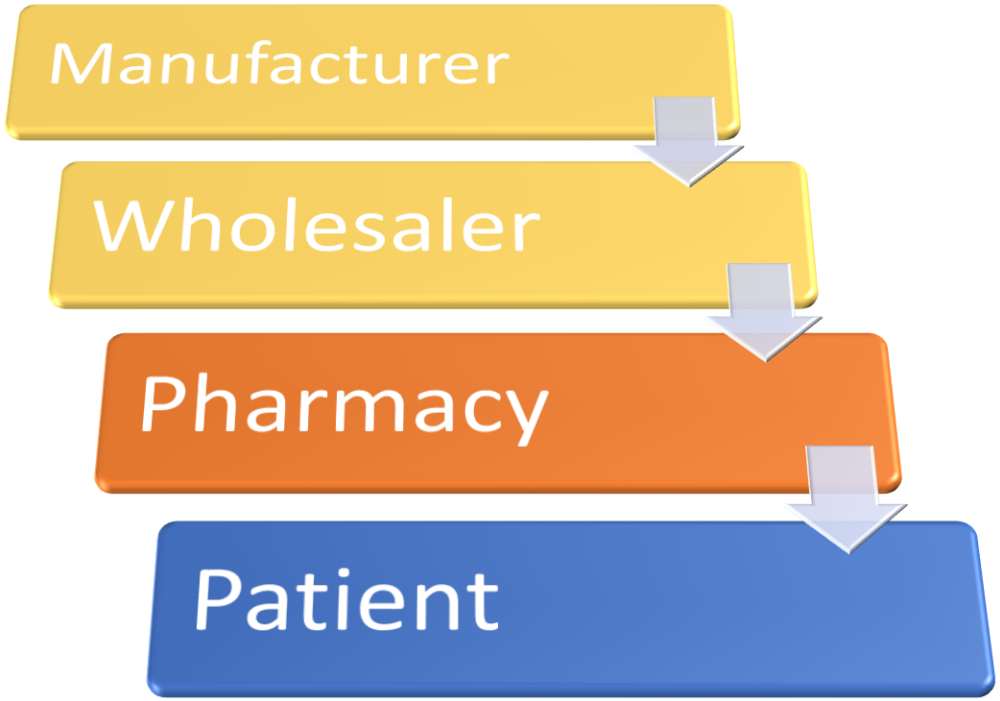


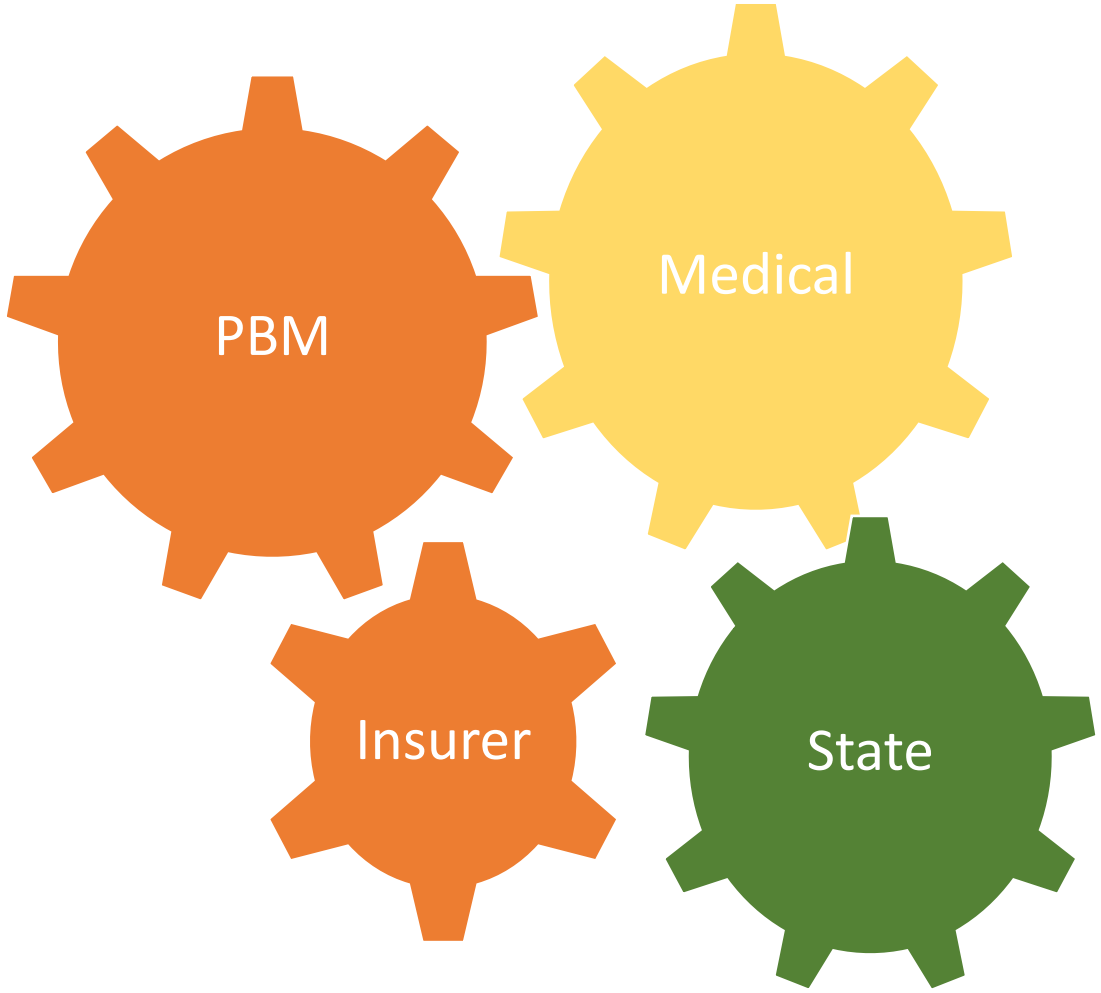
Manufacturer dependent upon PBM for formulary placement



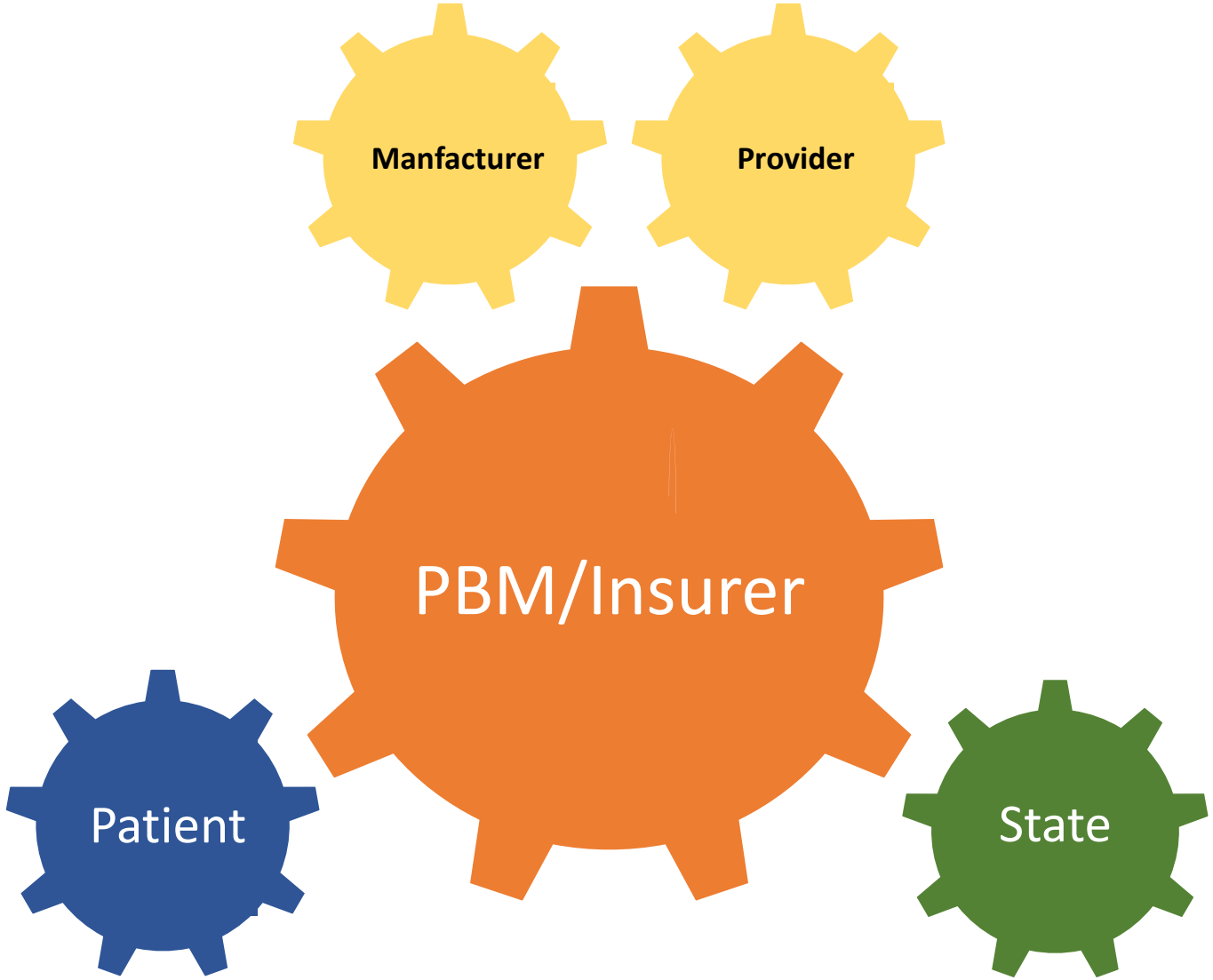


Big 3 PBMs are ALL Subsidiaries of Major Insurers directly influencing Medical Rates. Recent push incorporating Primary Care





This is the Current State of Health Care

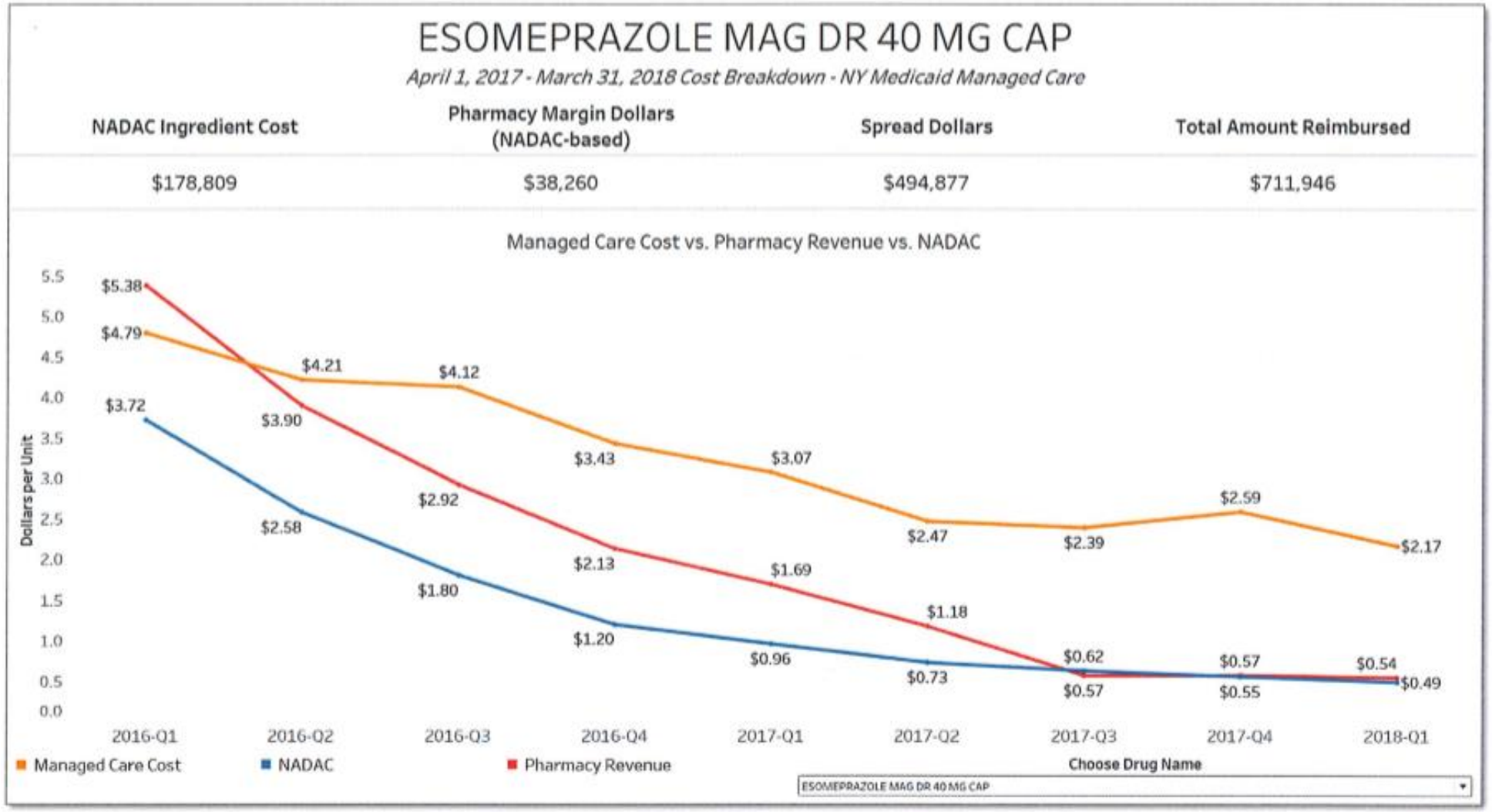


The Spread

ESOMEPRAZOLE MAG DR 40 MG CAP

April 1, 2017 - March 31, 2018 Cost Breakdown - NY Medicaid Managed Care

NADAC Ingredient Cost	Pharmacy Margin Dollars (NADAC-based)	Spread Dollars	Total Amount Reimbursed
$178,809	$38,260	$494,877	$711,946



3ΔXIS Advisors

The Spread

NADAC is the National Average Drug Acquisition Cost at the Pharmacy Level (Invoice Price)

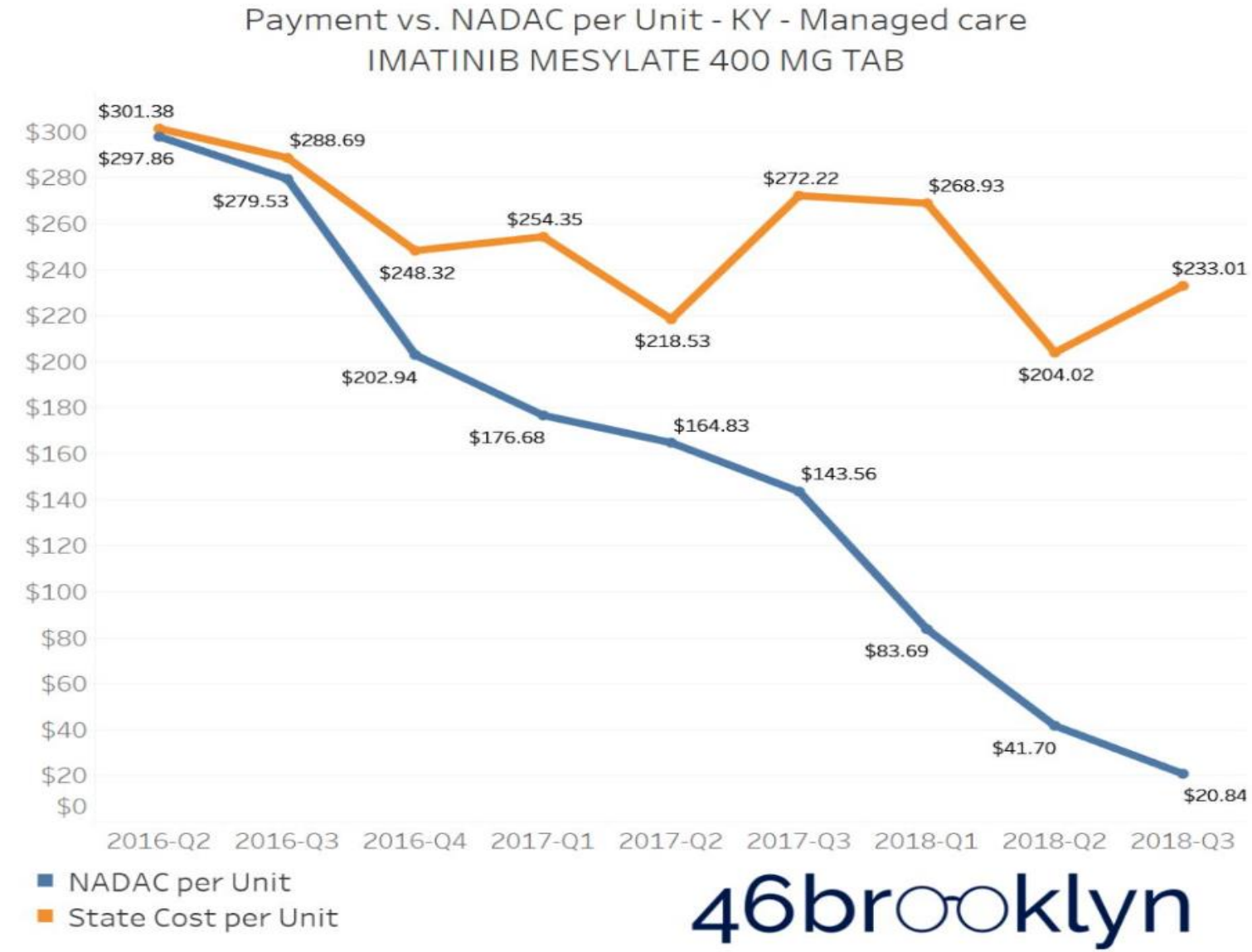


Figure 1
Source: CMS.Data.gov; 46brooklyn Research

PHARMACISTS UNITED FOR TRUTH AND TRANSPARENCY

In its October 2019 newsletter PUTT released the following which further articulates the “Spread” and how it affects consumers

[Pharmacists United for Truth and Transparency - Pharmacists United for Truth and Transparency (truthrx.org)]

Two Patients Walk into a Pharmacy:

Two patients walk into a pharmacy on the same day with identical prescriptions for generic drug Y. Both patients have the same group policy.

Patient A – Has not yet met their deductible for prescriptions and must pay out of pocket.

Patient B – Has met their deductible and has zero copay for maintenance medications and $5.00/month for non-maintenance medications.

Prescription 1

Drug Y is a common generic maintenance med and taken once a day.

The pharmacy processes the prescriptions for a 30-day supply of each and the Pharmacy Benefit Manager sets the prices to charge along with the associated “reimbursement basis” used to calculate said amount (note: per PBM to Pharmacy contract, PBM may utilized various basis to calculate payment.”

	PATIENT A	PATIENT B
PBM PAYS PHARMACY	$0.00	$1.36
PATIENT PAYS PHARMACY	$4.08	$0.00
“Reimbursement Basis”	“Contract Price”	“MAC Price”

Both patients request a 90-day supply of the drug Y, so long as pharmacy is capable of filling as such:

	PATIENT A	PATIENT B
PBM PAYS PHARMACY	$0.00	$10.00
PATIENT PAYS PHARMACY	$10.00	$0.00
“REIMBURSEMENT BASIS”	“MAC Price”	“MAC Price”

Prescription 2:

Patient B has a second prescription is for a non-maintenance medication that is taken 1 a week. The prescription is written for Drug Z #12.

The pharmacy processes the prescription twice. The first for an 84-day supply. The second for a 90- day supply. EVERYTHING ELSE STAYS THE SAME.

#12 TABS OF DRUG Z	BILLED FOR 84 DAY SUPPLY	BILLED FOR 90 DAY SUPPLY
PBM PAYS PHARMACY	$1.69	$142.07
PATIENT PAYS PHARMACY	$15.00	$10.00
“REIMBURSEMENT BASIS”	“MAC Price”	“MAC Price”

Where do the majority of 90-day Rx’s come from? Ever see the advertisements for “try our mail-order and save”?

By imposing the higher “contract price” during the deductible upon the patient is the PBM in violation of some consumer protection law(s)?

Established 2015

18 V.S.A. § 9473 Pharmacy benefit managers; required practices with respect to pharmacies

(b) A pharmacy benefit manager or other entity paying pharmacy claims shall not:
(2) impose a higher co-payment for a prescription drug than the maximum allowable cost for the drug;

By imposing the higher “contract price” during the deductible upon the patient; is the PBM in violation of the above statute or other consumer protection law(s)?

Kaiser Family Foundation's take on Rebates

KFF – "Rebates do not directly lower the out-of-pocket costs that patients pay for a drug."

Prescription Drug Rebates, Explained | KFF
– animated video **Published: Jul 26, 2019**

The Value of Rebates

- The Association Between Drug Rebates and List Prices

By Neeraj Sood, PhD, Rocio Ribero, PhD, Martha Ryan and Karen Van Nuys, PhD February 11, 2020

The Association Between Drug Rebates and List Prices – USC Schaeffer

Drug rebates and list prices are positively correlated: On average, a $1 increase in rebates is associated with a $1.17 increase in list price.

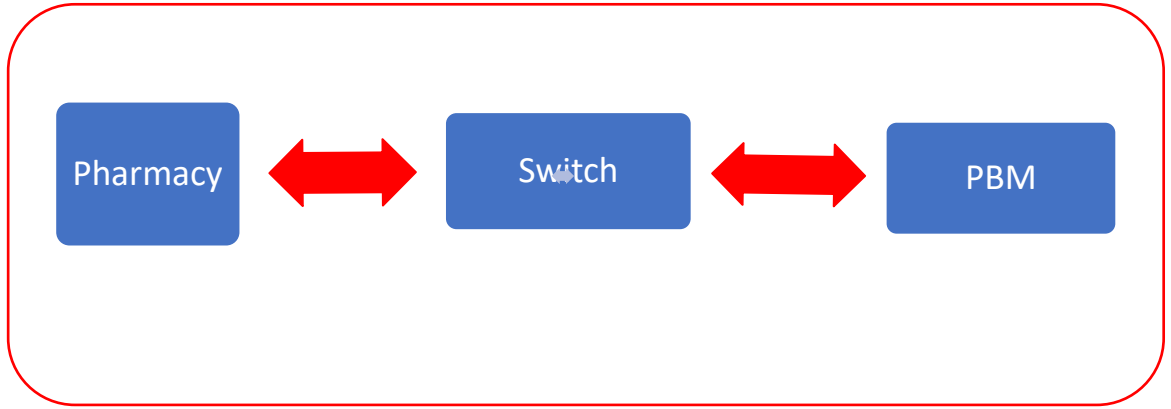
Brand Preferred vs Generic

• Suboxone	$259.62	vs	Bup/Nal	$60.16
• Lialda	$1082.50	vs	Mesalamine	$152.85
• ProAir/Proventil/Ventolin	NA/NA/$54.95	vs	Albuterol	$12.63
• Latuda	$1367.20	vs	Lurasidone	$6.24
• Symbicort	$329.21	vs	Bude/Formort	$199.37
• Viibryd	$318.90	vs	Vilazodone	$23.86

Data = Power

- Manufacturers want two things:
  - Market presence – “Formulary Status”;
  - Utilization data – NCPDP data.

Switch Companies and Data Miners



The Switch facilitates the claim adjudication process between the Pharmacy and the PBM. Each transaction carries a cost ranging from $0.03 to $0.15 per transmission. Switch processors sell Patient Data to Manfacturers/Insurers/Governments.

NOTE: The Switch packages ALL pharmacy data into **1 Format**!

340B: Focus on Brand Names

- Large discounts exist on Brand Name Drugs which represent 80% of total Drug Spend.
  - Discount roughly 90% of Wholesale Price
- 340B expansion has inflationary effect upon Manufacturer list price.
- Comparison of Supplemental Rebates to True 340B Pricing extremely difficult.
- 340B revenue accounting needs improvement.

Comparison NADAC to 340B (as of 04/25/23)

Drug	NADAC	Current 340B
Humira (pen) *Specialty	$3370.96704	$0.01
Ozempic	$301.07319	$126.23
Advair HFA 230 (ea)	$512.26	$0.12
Suboxone Film	$8.61860	$4.1857
Eliquis	$8.97238	$0.5127
Dexilant	$9.85849	$0.0098
Proventil HFA (ea)	$76.22	$0.0700
Victoza (pen)	$340.5492	$0.03000

Vermont WILL HAVE an Access Issue

- In 2010 there were 37 Independent Pharmacies Operating in Vermont
- Today there are 16

- 1500 pharmacies closed btw 2020 and 2021 (2/3 were Independents)
- Chains are consolidating and pushing Mail-Order Central Filling

- As we approach implementation of DIR reform Jan 1, 2024 we can expect more closures.

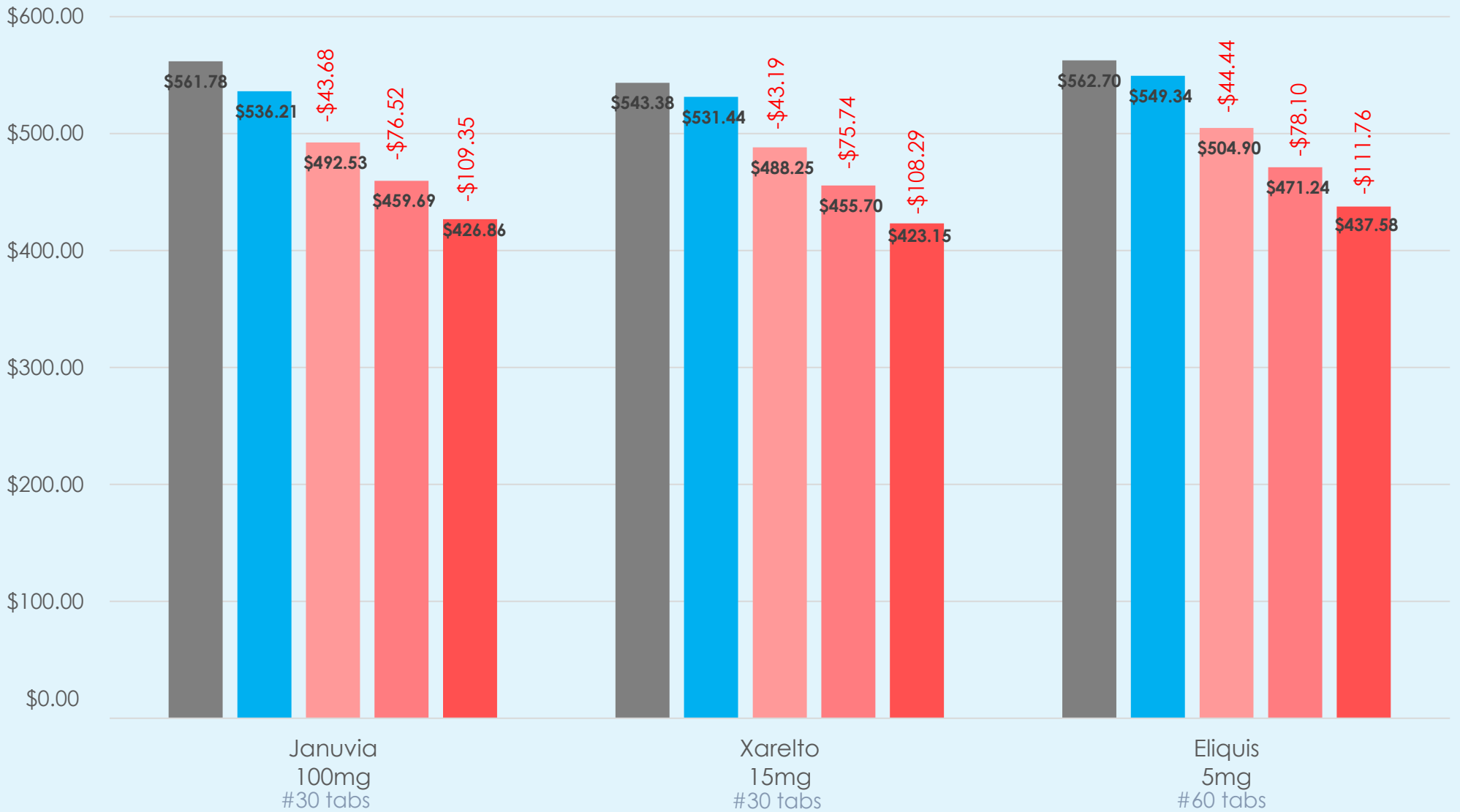
Q1 + Q2 of 2024 = DIRmageddon

Setting the Stage

- Independent pharmacies are integral to Part D plan network accessibility.
  - Avg. independent derives 36% of script volume from Part D
  - LTC pharmacies derive 60 – 70% of script volume from Part D
- Of the 1500 pharmacies that closed between 2020 and 2021, more than 2/3 were independents
- Pharmacy closures are leading to pharmacy deserts
- What is the cause?
  - Vertical integration
  - PBM steering to affiliate pharmacies
  - Below-cost reimbursement from PBMs
  - Restricted/preferred networks block independents
  - The list goes on...

Pharmacies Losing Money on Medicare Part D Prescriptions, which Impacts Patient Access.

Medicare Part D Spending vs pharmacy reimbursement: one produces fair compensation in a NADAC + Dispensing fee model, the other results in a quicker trip to the coverage gap and losses due to PBM payments below acquisition cost. Based on NADAC and AWP for a 30-day supply.



What Medicare Part D Pays*

NADAC + $11 Dispensing fee** — Not utilized in Medicare Part D

AWP-25% + $0 Dispensing Fee

AWP-30% + $0 Dispensing Fee

AWP-35% + $0 Dispensing Fee

Today's reality for independent pharmacies; PBM reimbursements below cost***

Why do PBMs do this?
To pocket the difference and steer patients to pharmacies they own or are affiliated with.

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

* Medicare Part D Average Spend calculated using a data forecasted by CMS Medicare Part D dashboards 2017-2021.; **Dispensing Fee calculated using data acquired from Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State chart provided by medicaid.gov; ***Not including additional DIR Fees; NADAC data utilized dated 3/8/23. AWP data accessed 3/8/23.;

DIR Armageddon

- Medicare Part D DIR fees are now approx. 5-6 percent of GROSS Rx revenue from all payers
  - Represents 3rd highest expense after COGS (78%) and payroll (13.1%)
- MedPac March 2023 Report to Congress
  - DIR fees were $12.6 billion for 2021 (a $3.1 billion (+33%) increase from $9.5 billion in 2020)
- One of our members, an independent pharmacy owner, in 2022 paid $430,157.70 in DIR fees, versus $215,125.49 in 2020, an increase of approximately $215,000 in 2 years.
- His year-to-date 2023 DIR fees (with 7 days left in the quarter, at the time of this writing) are $88,798, versus $66,271 for DIR fees in the first quarter of 2022.

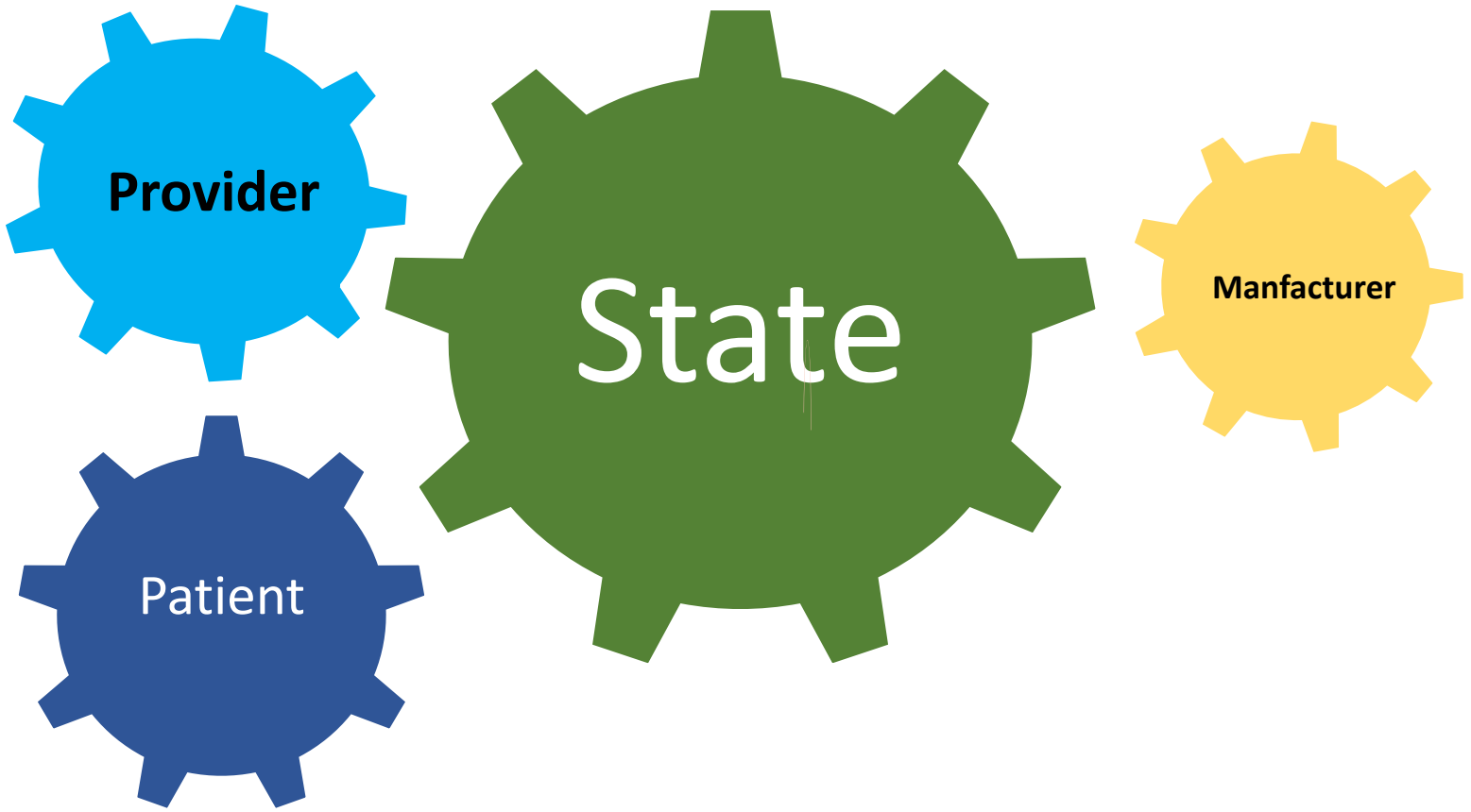
The DIR Hangover is Real

- Medicare Part D CY24 contract offerings (approx. examples)
  - Brands: AWP-26% + $0 dispensing fee (30ds) and AWP-31% + $0 dispensing fee (90ds)
- Most independent pharmacies buy at approx. WAC- 4% = AWP-20%
- Rates such as this coupled with YOY double-digit increases in DIR fees make the first 3-6 months of 2024 unbearable for independent pharmacies
- Lines of credit/building reserves
- Cash flow is dire situation/concern

Further Data Research

- https://www.46brooklyn.com
  46brooklyn Research is an Ohio non-profit corporation whose purpose is to improve the accessibility and usability of U.S. drug pricing data. 46brooklyn takes the myriad drug pricing data sources scattered across the web and stitches them together into data visualizations that can be used by the public to better understand how the drug supply chain functions. 46brooklyn also writes and publishes original research that uses the data within its public data visualizations to shine light on the hidden and complex underbelly of the drug supply chain.
- https://www.3axisadvisors.com/
  3 Axis Advisors is an elite, highly-specialized consultancy that partners with private and government sector organizations to solve complex, systemic problems and propel industry reform through data-driven advocacy. With a primary focus on identifying and analyzing U.S. drug supply chain inefficiencies and cost drivers, we offer unparalleled expertise in project design, data aggregation and analysis, government affairs and media relations.

Lessons from the Pandemic for Pharmaceutical Distribution:



STEP 1. State Direct Involvement with Logistical Warehousing and Wholesale Distribution of Pharmaceutical Drugs

- Actual Acquisition Cost Learned
- Lower Costs
- Increase Access
- Increase Epidemiological Data and Response
- Create Contingency Storage for Emergency Response