Understanding Drug Costs

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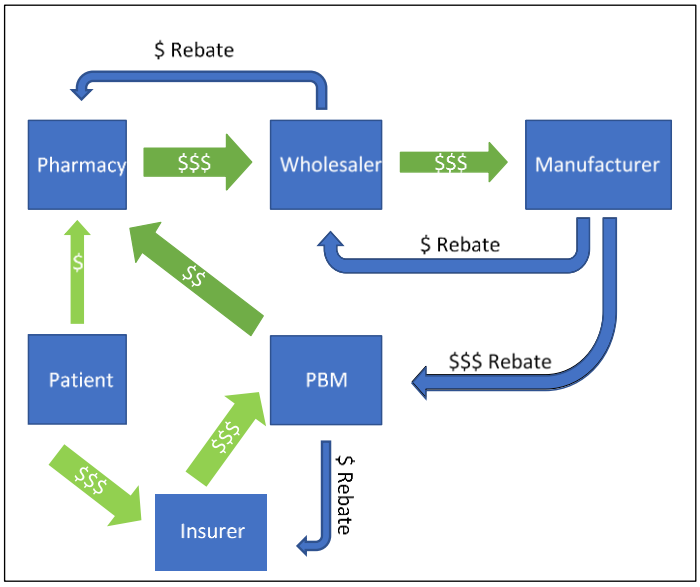
When considering "How" to control rising drug costs within the State, we must first come to understand the "What" drug pricing truly is and represents. It has become universally accepted that greater transparency behind the pharmaceutical industry is required, and many steps have been taken towards such a goal. However, the great "Truth" of drug pricing continues to elude us. The reason for this rests in understanding that the drug price is determined by "what the market will bear." Prices are based on a dynamic set of data much like traded commodities on Wall Street. They are further concealed by backend-rebates and proprietary contracts in a highly competitive market place. There is no specific pricing methodology or any magic invoice that will demonstrate "True cost". So how do we obtain the much-needed transparency? Forcing disclosure has yet to prove itself as we seem to find ourselves running into the pitfalls of jurisdiction issues and adequate enforcement. The suggestion then becomes to streamline rather than add to the processes of the system with the belief that the formation of a cooperative will foster greater transparency. So, whom to turn to?



<u>The Players</u>:

1. Manufacturers;
2. Wholesalers;
3. Pharmacies;
4. Insurers;
5. Pharmacy Benefits Managers;

The most probable cooperative opportunity rests with the pharmacy wholesaler. Most Manufacturers/Insurers/PBMs are simply large, out of state players and it would be difficult to conceive that any meaningful cooperation can be achieved. Some have even gone so far as to form cooperatives of their own, i.e. CVSCaremark or Walgreens/OptumRx. Furthermore, the PBMs have drawn extensive criticisms for their veiled business practices and thus would not stand as particularly promising candidates for a cooperative model. In fact, the proposal described below speculates a reduction to their level of involvement in the pharmaceutical delivery system. The community/retail pharmacy level is too far removed in terms of the actual costs or patient responsibilities; and thus, offers little value in delivering greater transparency. The pharmacy's costs are controlled by the wholesaler and limited in scope. The pharmacy's revenue is controlled largely by the Provider Service Arrangement Organization (PSAO) and the PBMs. This leaves then the Pharmacy Wholesaler as the logical point of cooperation. The Wholesalers are also most directly downstream from the Manufacturers and can provide the most savings! First, let's discuss the pharmaceutical product mark-ups that we know occur within the model noted in the flowchart above.

1. Manufacturer sells product to Wholesaler (WAC – Wholesale acquisition price or list price);
2. Wholesaler sells to Pharmacies (Invoice price);
3. Pharmacy sells to Patients via PBM (Retail Price);
4. PBM charges Insurer (Payer Drug Spend);
5. Insurer charges Patient (Premium).

Each transaction in the chain (WAC to Premium) incurs added costs. In forming the proposed cooperative in S140 we would effectively be bypassing as many inflationary transactions as possible and equating the Payer Drug Spend (Vermont Medicaid spend ~ $188M) to WAC. The question then becomes, "How much savings could be realized?"

To calculate the amount of potential savings with such streamlined acquisition we utilized costs reported to CMS by Vermont Medicaid. Working with one national wholesaler and comparing WAC costs to Vermont's drug spend it was found to show an estimated average savings on Generic drugs of 35%-40%. Generic drugs represent 80% of the prescription volume; however, they account for only 15% of the costs. Brand name drugs thus represent 20% of the volume and 85% of the Payer drug spend. In the same analysis, a 0-2% savings could be found. Keep in mind that these drugs are typically subject to deep manufacturer rebates and would continue to be so.

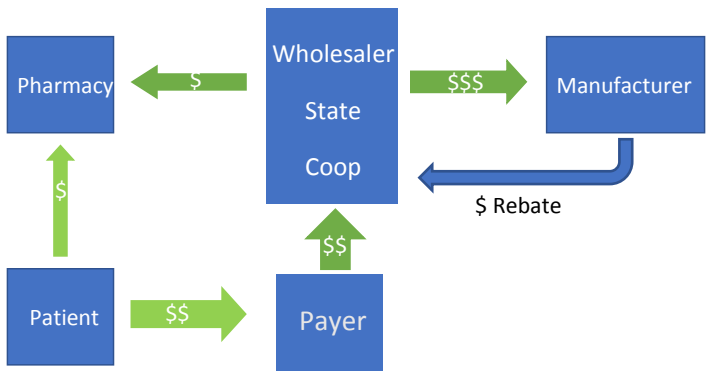
The savings calculations:

1. Generic/Brand = 80/20 volume and 15/85 of spend $$$
    a. Generic spend = 15% of $188M = $28.2M in generic drug spend
    b. 35% savings on ($28.2M) = **$9.9M savings on Generics**

2. Brand spend = 85% of %188M = $159.8M in brand drug spend
    a. 1% savings on $159.8M = **$1.6M savings on traditional brand spend**
    (*still eligible for manufacturer rebate)

Total estimated savings = $9.9M + $1.6M = $11.5M in drug spend savings

The Method



The pharmacy and DVHA would utilize the same systems to dispense and process prescriptions, only the $ amounts would change. Instead of reimbursing the pharmacy the retail cost of the drug product, DVHA would only pay the pharmacy a dispensing fee. The wholesaler will shift the cost of the product directly to DVHA at the transparent "dead net price". In most situations the product invoicing would occur at the point of reorder or replenishment to the pharmacy. This "replenishment model" is much like that being employed by FQHCs and 340B pharmacies today and can adequately provide the necessary inventory and reconciliation mechanics. Such a model will reduce the monthly capital expenses for both DVHA and the community pharmacies. Furthermore, it will aid the community pharmacy's budgeting ability by providing more stable figures for a sizable portion of their business (on average DVHA represents 25% of a pharmacy's business). Eliminating the transaction level financial challenges from the pharmacy's duty, pharmacists can increase their efforts toward further cost savings measures and quality improvements. Future developments could help actualize the pharmacist's role as key players in achieving the Triple Aim!

The overarching goal of this collaboration would be the creation of a Vermont State Pharmacy Wholesale Distribution system much like we see with Alcohol. An accountable and TRANSPARENT State entity would thus be created to ensure that Vermonters receive access to the pharmaceuticals they need, at the lowest possible costs. Expansion of this system to other payers such as BCBSVT will unify the insurance market within the State paving the way for other simplification strategies that will ultimately stabilize premiums of every Vermonter. Wholesale distribution requires substantial infrastructure to work efficiently. It also means the creation of a vast number of different JOB opportunities for Vermonters. The result will be a streamlined system that will provide some of the greatest cost savings ever seen in the country. It will reduce costs to their minimums and will also give the State the means to best "monitor" the fluctuating drug prices. Every cost increase will be identified at the earliest possibility.

Now that Transparency can be realized what can the State do to gain leverage against the pharmaceutical manufacturers and "contain" drug prices? The answer to this rests in the thing that manufacturers covet most after sales… the **DATA**!

The Power of DATA and its reward $$$

Gaining ultimate control of the distribution will help initially reduce costs and maintain if not increase consumer access to pharmaceuticals. Sustainability is the next step. To achieve that LEVERAGE must be attained on the manufacturers to continue to put competitive pressures on prices. There are 2 things that manufacturers need:

1. Product selection (controlled thru distribution/formulary pushes by the Payers)
2. Utilization Data.

The later presents an opportunity for the State to overwhelming gain control of the manufacturers in pharmaceutical industry for Vermonters and secondly, provide a revenue stream to further offset costs. Data mining is a multi-BILLION $$$ industry and it is already occurring. Enter the Switch!

The Switch is a standardized claims processing platform that operates between every pharmacy software system and pharmacy benefits manager. It utilizes the NCPDP format to communicate, meaning one format that is already UNIVERSALLY employed. The Switch captures ALL pharmacy information from Patient Demographics to 3rd party payment. EVERYTHING is captured which is why it holds so much value. Each utilization of the "Switch" incurs a fee, a cost that every pharmacy and "PBM" (mostly passed back onto

pharmacies) must pay per submission. Fees range from $0.03 to $0.15 per submission. What most people don't realize is that this information is "sold" to data mining companies at similar rates. There are 4 primary switch companies with Relay Health being the largest and most active politically.

Application

Switch Data could be used to enhance functionality, in Real-Time, of the Vermont Prescription Monitoring System (VPMS) for controlled substances reducing dependency for data to be Uploaded to system by pharmacies. It will improve the Department of Health's oversight of prescribing habits and enhance functionality to include epidemiologic oversight. Imagine the State's response capabilities to an influenza outbreak in Rutland County when we couple enhanced oversight with efficient distribution. Control of switch data can also create a revenue stream for the State. What if data miners were to pay State for data. That data can be used as bargaining chip with manufacturers for enhanced rebates and lower WAC thru the State Wholesaler. The data can be passed thru to EMR records for enhanced patient records leading to enhanced care. Lastly, and most importantly; control of the data will protect Vermonters Privacy from special interest groups.