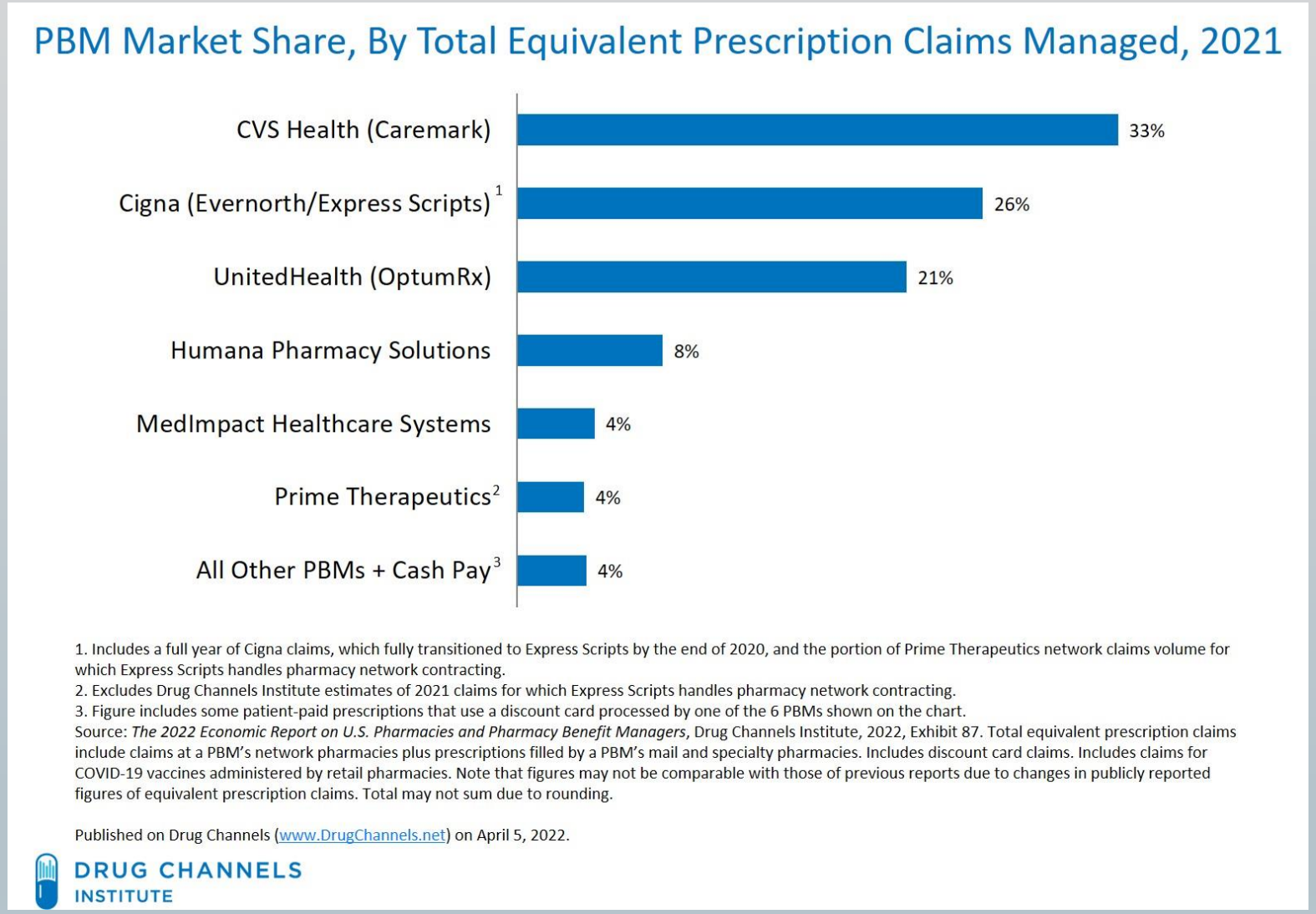
THE PBM PROBLEM

Jeff Hochberg President Vermont Retail Druggists



The Big 3

Three large, vertically integrated, and publicly traded corporations **CONTROL 80%** of the market:

CVS Health -
Insurer/PBM/Pharmacy

Cigna –
Insurer/PBM/Pharmacy

United Health -
Insurer/PBM/Pharmacy

Combined, they have an annualized revenue in excess of $600 Billion

Just how big is TOO BIG.

- In 2000 report, the World Health Organization found that "France provides the best overall health care."

- Published 21 June, in The World Health Report 2000 – Health systems: Improving performance

- "The combined revenue of the top three firms, who comprise just a small part of the U.S. health system, is larger than the entire amount France spends on all medical care for its entire population."

  - ~ Matt Stoller

  Research Director for the America Economic Liberties Project

FTC IS CONCERNED!

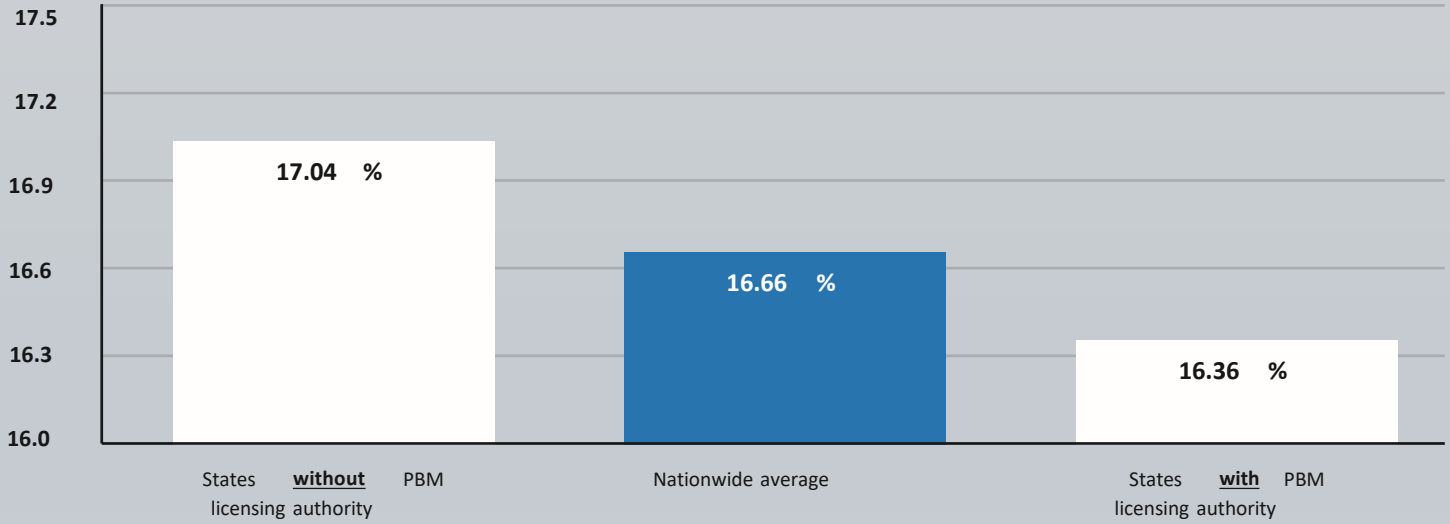
- Feb 25, 2022

FTC seeks public comments on pharmacy benefit managers' impact on patients, pharmacies

Will Regulation Raise Costs -Fact or Fiction?

- Between 2015 and 2019, health insurance premiums increased at a nationwide average of 16.66%. The premium increase in states with licensing authority over PBMs during that period was .3% below the national average, while states without licensing authority saw their premiums increase .4% above the national average!

Increase in health insurance premium costs by percentage (2015-2019)[1]



NCPA® NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

https://ncpa.org/sites/default/files/2021-06/ControllingPBMConflictsofInterestHealthcareCosts.pdf

1. Numbers based on data from the Kaiser Family Foundation (www.kff.org).

State of the State: Decreasing Access/Rising Costs

Between July 2019 and November 2021, Vermont saw the loss of 18 in-state pharmacies, 12 of which were independent.

DEFICIT REDUCTION ACT OF 2005

In Response to a group of reports in 2004 issued by the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG); CMS issued a change to its payment methodology to promote transparency and appropriateness for drug payments. The rule directed 2 relevant changes:

1. Address the collective finding that states were overpaying for drugs because they were using commercial drug pricing guides as the basis for setting state reimbursement levels. (**SPREAD PRICING)**
2. Evaluate whether other fees they pay pharmacies are adequate to compensate them for their costs in dispensing the prescription and redefine "dispensing fees" to cover a pharmacy's costs of dispensing the drug including overhead. **(DISPENSING FEES)**

LESLIE NORWALK, ESQ. - ACTING ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

"THIS NEW CALCULATION METHOD WILL ALLOW MEDICAID TO PAY MORE ACCURATELY FOR THE MEDICINES ENROLLEES NEED," NORWALK SAID. "FURTHERMORE, IT WILL YIELD A PAYMENT LEVEL THAT WILL BE SUFFICIENT TO ASSURE WIDESPREAD AVAILABILITY OF DRUGS FOR MEDICAID PATIENTS." THE TOTAL PHARMACY REVENUE FOR PRESCRIPTION DRUGS WILL DECLINE BY LESS THAN ONE PERCENT, ACCORDING TO INDUSTRY DATA, SHE ADDED.

CMS.gov Press Release Jul 06, 2007 "**NEW MEDICAID DRUG PAYMENT RULE"**
https://www.cms.gov/newsroom/press-releases/new-medicaid-drug-payment-rule

Inappropriate Dispensing Fees

NON-affiliated pharmacies are forced to accept contracts with PBMs that pay

little to nothing as a professional dispensing fee.

Pharmacists are vital members of the Health Care Team and provide crucial clinical services to Vermont communities.

They NEED appropriate professional fees.

Example: PAXLOVID (oral antiviral for CVD19)

*Paxlovid drug has no ingredient costs as part of the pandemic support

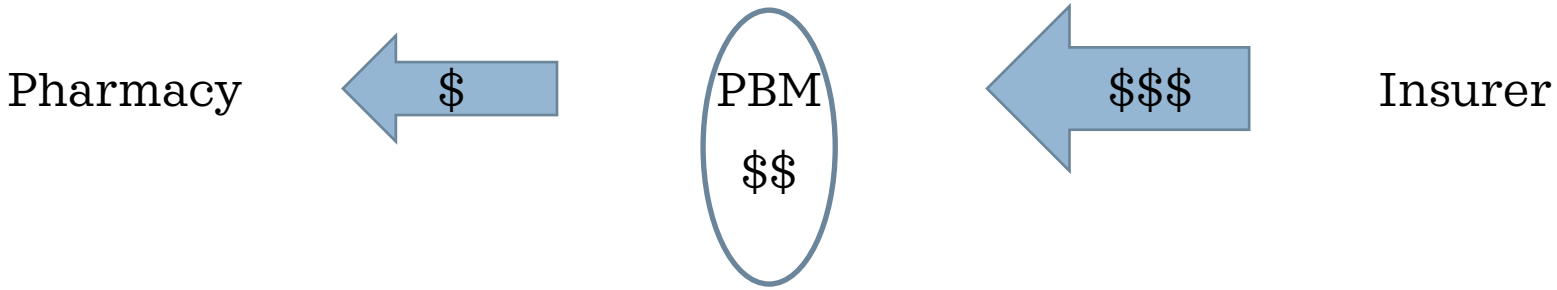
- Pharmacy submits claim to BCBSVT
  - Optum Rx pays Pharmacy **$0.08** as a professional fee
  - Pharmacy incurs **$0.07** claim submission fee with its switch provider

- A few weeks later, Optum makes weekly payment to pharmacy (835 File)
  - Optum claws back **$0.29** as a claim processing fee
  - State of Vermont collects **$0.10**/Rx assessment from Pharmacy.

Pharmacy's Gross Profit to help Vermonter with COVID: **(-$0.38)**/Rx ; before HR and other expenses.

SPREAD PRICING

- "Spread Pricing" is the difference between what the PBM reimburses the Pharmacy vs what it collects from the Insurer.

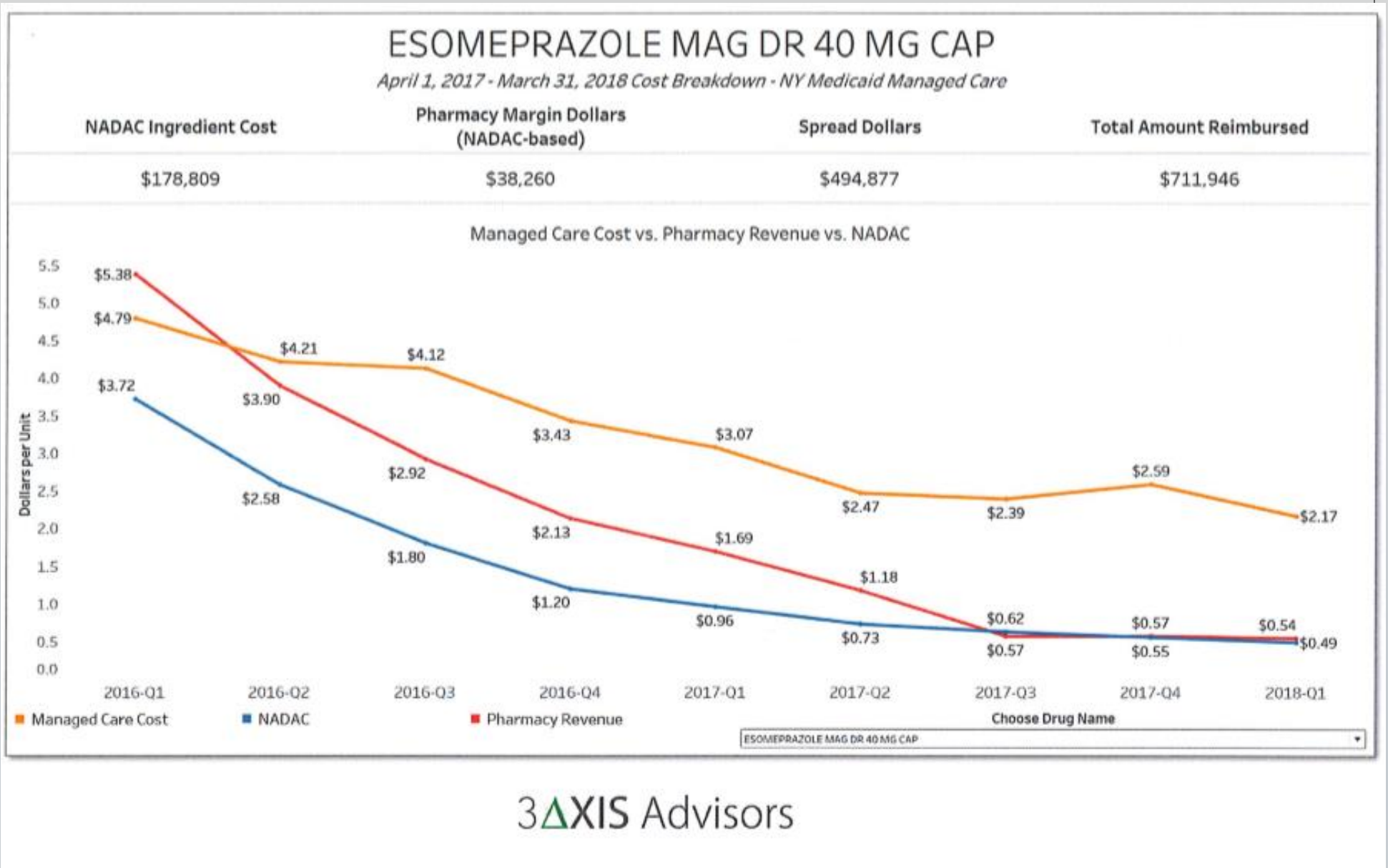


The Spread

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)

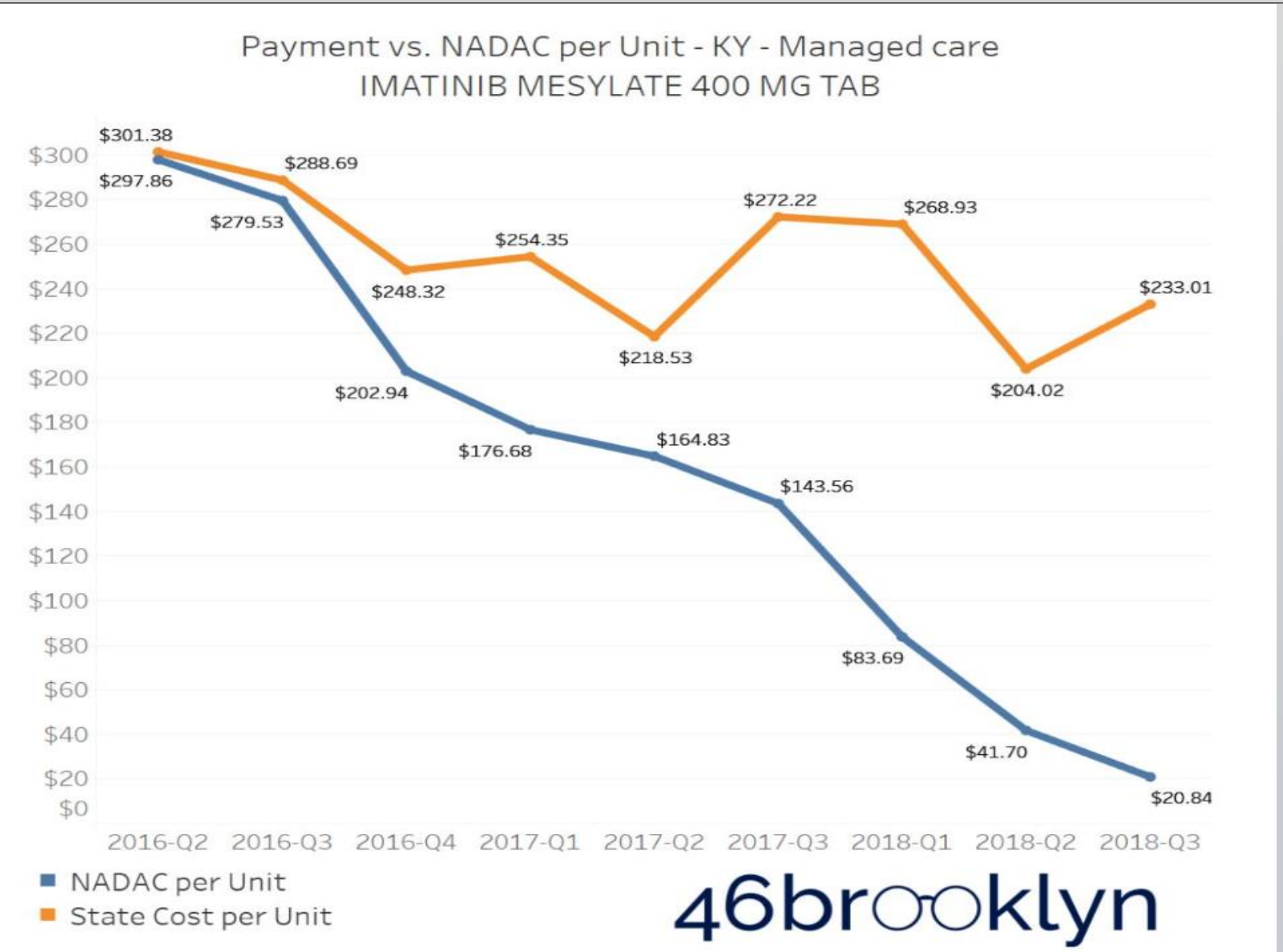
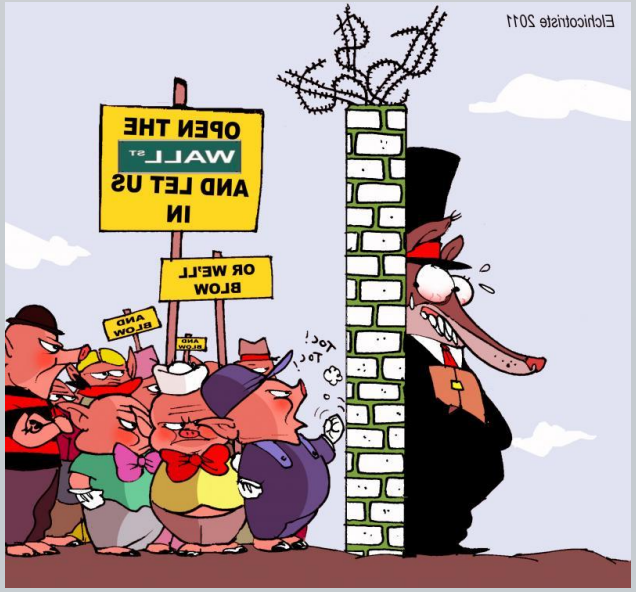


Figure 1
Source: CMS.Data.gov; 46brooklyn Research

Spread Pricing is a Weapon of PROFIT

"Spread Pricing" is a tool by which the PBM middlemen can obscure the "True" costs of medications and profiteer from the separation of contracts.

The Insurer – PBM Contract vs. PBM Contract – Pharmacy



BUT "SPREAD PRICING" MODELS ARE CHEAPER FOR BENEFICIARIES…

Fact or Fiction?

Two Patients Walk into a Local Pharmacy

Both get the same medication and have the same insurance

Patient A is in Deductible

PBM Reimbursement = $0.00

Patient Out-of-Pocket = **$4.08**

Price Basis = “Contract Price”

Patient B is in Benefit Stage

PBM Reimbursement = **$1.36**

Patient Out-of-Pocket = $0.00

Price Basis = “MAC pricing”

MAC stands for Maximum Allowable Cost

Mail Order is a Savings, Right???

Patient A is in <u>Deductible</u>

PBM Reimbursement = $0.00

Patient Out-of-Pocket = **$4.08**

Price Basis = “Contract Price”

<u>3 months @ Mail</u>

PBM Reimbursement = $0.00

Patient Out-of-Pocket = **$10.00**

Price Basis = “MAC pricing”

Patient B is in <u>Benefit Stage</u>

PBM Reimbursement = **$1.36**

Patient Out-of-Pocket = $0.00

Price Basis = “MAC pricing”

<u>3 months @ Mail</u>

PBM Reimbursement = **$10.00**

Patient Out-of-Pocket = $0.00

Price Basis = “MAC pricing”

IF $1.36 WAS THE "MAXIMUM ALLOWED COST", WHY DID THE PATIENT PAY 3 TIMES THAT AMOUNT IN DEDUCTIBLE?

$10.00 COPAY FOR 3 MONTHS WOULD SEEM LIKE A DEAL FROM THE PATIENT PERSPECTIVE BASED ON $4.08/1 MONTH, BUT...

Which is right?

Mail Order "MAC" Games

Same medication, Same Insurance, Same Quantity

QTY #12 Billed as 84 Day supply

PBM Reimbursement = **$1.69**

Patient Out-of-Pocket = **$15.00**

Price Basis = "MAC pricing"

QTY #12 Billed as 90 Day supply

PBM Reimbursement = **$142.07**

Patient Out-of-Pocket = **$10.00**

Price Basis = "MAC pricing"

Where do the majority of 90 Day Rx's come from? PBMs establish different Networks for 1- 84 Day supply (Retail) vs 90 Day supply (Mail). Often, Independents are prohibited from participating in the latter.

“Pro” or “Anti” – Consumer?

- ***Enacted 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;

What about 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.

H 353 IS NEEDED TO CREATE THE APPROPRIATE SAFE-GUARDS TO ENSURE VERMONTERS ARE NOT BEING TAKEN ADVANTAGE OF.

Anything short of complete transparency can no longer be afforded.