10 Needed PBM (Pharmacy Benefit Manager) Reforms — for patients NOW

Limit purpose and scope

1

PBMs started as third party administrators simply charging an administrative fee for processing claims. Its time they returned to only serving this core function

Require price transparency

2

Require PBMs to disclose both the price they are charging the plan, plan sponsor, or other insurer and the price paid to the pharmacy so all are aware of the differential.

Establish fair reimbursements

3

PBMs must establish a set system of ingredient reimbursement which covers the actual cost of the medication for pharmacies and ensure the availability at that price.

Set fair professional dispensing fees

4

PBMs must pay pharmacies a fair and reasonable professional dispensing fee which covers the applicable costs to dispense including overhead.

Equal treatment for ALL

5

Some PBMs own their own pharmacies or mail order pharmacies and require patients to use only those pharmacies. It appears that the PBMS may pay their pharmacies a higher reimbursement rate. This self-serving and profit driven practice should not be permitted.

Restrict use of rebates

6

Rebates have not been utilized to benefit patients and in fact evidence is showing that rebates are actually driving up the price of medications. Oversight and regulation is needed if they are not eliminated.

Better formulary management

7

PBMs establish restrictive self-serving formularies based on rebates offered and not necessarily based on medical evidence or patient cost.

Allow patients choice of pharmacy

8

Patients rely on the trust and relationship with their pharmacist who is embedded in and supports their community. This choice is important for optimum results!

Eliminate data sale or misuse

9

PBMs sell prescription data or use it themselves to target patients and urge them to switch pharmacies in possible violation of HIPAA.

Prohibit so-called "Gag Clauses"

10

PBMs have prohibited pharmacists from discussing many important aspects including how to lower costs. Pharmacists have been threatened and retaliated against for putting patients first..

For more information on PBMs and needed reforms, contact the **Pennsylvania Pharmacists Association.**
717.234.6151 or ppa@papharmacists.com

Pennsylvania Pharmacists Association

Understanding the Basics of Pharmacy
Key Pricing Terminology

AAC – Actual Acquisition Price The price paid by the pharmacy to acquire the drugs. Different uses and definitions have also sometimes made it a net amount of all rebates and discounts. But others typical limit it to the gross price paid to acquire.

AMP – Average Manufacturer's Price. Originally defined as the average price paid by a wholesaler to acquire drug for distribution to retail class of trade, it does not include the wholesaler profit to resell to pharmacy. This methodology was to be used in state Medicaid programs following the passage of the Deficit Reduction Act (DRA). However, there has been considerable discrepancy over the accuracy of this methodology, how it is reported, and what is included. Original ruling by CMS expanded average price to outside of the retail class of trade. It is unfair to include price to mail order and hospitals in the calculation as community acquisition costs exceed these due to class of trade differential. Sometimes RAMP has been used to specifically state it is limited to Retail AMP.

AWP – Average Wholesale Price. This is the published suggested wholesale price of a drug. While historically many pharmacy programs, both public and private, used it as a baseline; there has been a movement towards utilizing other methodology.

Who determines it? Each individual pharmaceutical manufacturer establishes the AWP for their specific drug products.

How does it change? Any time a manufacturer increases the price of a product, the AWP will also increase.

Where can you find a listing of AWPs? There are a couple of reliable national databank resources. Pharmacy Benefit Managers and others have contracts to regularly receive these price updates but may or may not update their systems as frequently as price increases occur.

Best Price – a term used in connection with Medicaid rebate calculations, it refers to the lowest price paid by any purchaser other than federal agencies and state pharmaceutical programs.

Co-Insurance – refers to a patient who has coverage under more than one insurance plan. The pharmacy bills the primary payer first and can use the secondary to cover some costs not covered by the primary plan.

Co-payment – refers to the amount that a patient, who has an insurance plan with prescription drug coverage, pays to the pharmacy for their prescription. This is the portion of the cost not covered by the particular plan. Co-payments vary depending on the design of the cost sharing aspect of the plan, the formulary, and whether a generic or brand product is dispensed. The co-payment is not retained by the pharmacy; it is applied against or deducted from the amount the plan reimburses to the pharmacy.

Formulary - This is a list of prescription drug medications that a PBM or insurance program chooses to cover. In its purest form it is designed to be a list of one or two specific medications within a particular class for which the prescription drug plan will provide coverage at the lowest pricing. However, more and more, formularies have come to represent a list of medications for which the PBM has secured rebates from manufacturers and thus it is to the PBM's advantage to promote the use of these medications over others. This means that the lowest priced product may not necessarily be on a particular formulary. There are both open/voluntary formularies and closed/select/mandatory formularies.

FUL – Federal Upper Limit. A pricing concept similar to MAC, but reflects the maximum amount that Medicaid can reimburse for a drug product if there are three or more generic versions of the product rated therapeutically equivalent and at least three available suppliers. The limits were intended to ensure that the federal government was prudently buying drugs. This list is compiled and set by the Centers for Medicaid-Medicare Services, (CMS).

MAC – Maximum Allowable Cost. This is a term used in setting pricing for generic medications. It establishes the maximum price for which a pharmacy will be reimbursed for a selected product. It is based on a price per tablet or capsule. The MAC price does not take into account a specific generic company's products. It is to be based on the lowest market prices, regardless of manufacturer, for a particular product; but, oftentimes, there seems little to no rationale for the price. A MAC list may be created by a PBM, a state Medicaid program or a federally funded program.

NADAC – National Average Drug Acquisition Cost – this is a newer methodology utilized by many state Medicaid programs. It is based on a national average acquisition cost for retail purchasing of medications. Considered a more fair and equitable resource.

NDC Number – stands for National Drug Code. It is the national classification and numbering system for the unique identification of drug products. Portions of the number identify the pharmaceutical manufacturer, the drug product, and package size. The number is used for billing purposes.

PBM – Pharmacy Benefit Manager. PBMs are the administrators of the prescription drug benefit of an insurance plan. PBMs contract with employers, unions, or insurance companies (Blue Cross, Keystone, etc) to administer their prescription drug benefit program. PBMs contract with pharmacies, set compensation formulas for pharmacy payments, arrange and collect rebates from manufacturers, establish formularies (preferred drug lists), and determine patient co-payments. There are also PBAs – Pharmacy Benefit Administrators which do some of the same but usually charge an administrative fee only or are transparent in all their fees.

Rebates – An agreement between a PBM/insurance company and a manufacturer to show preference to one manufacturer's product over another's. The rebate amount is usually based on units dispensed (controlling the market, or increasing the market share of a manufacturer's line of products). The rebate dollars go to the PBM or insurance company. Rightfully, this money should go back to the contracted employers to reduce the cost of the benefit program. But this is rarely done.

WAC – Wholesale Acquisition Cost – The manufacturer's charge to the wholesaler to purchase the drug. The WAC is a published price and does not generally reflect any rebates of discounts.

This list of pharmacy terminology was compiled by the
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The U.S. Pharmacy Distribution and Reimbursement System for Patient-Administered, Outpatient Prescription Drugs

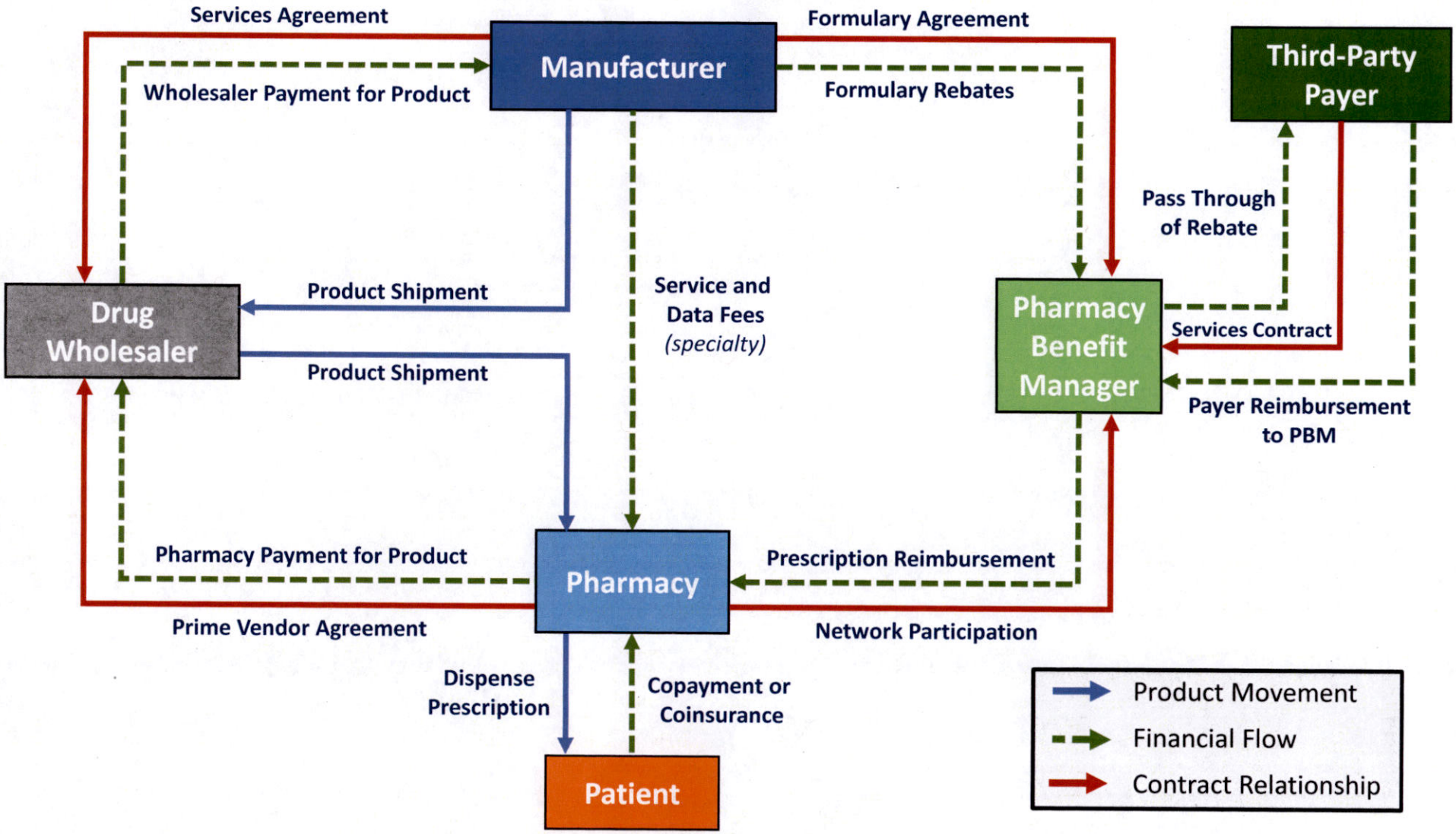


Chart illustrates flows for patient-administered, outpatient drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.

Source: Source: Fein, Adam. J., *The 2016 Economic Report on Retail, Mail and Specialty Pharmacies*, Drug Channels Institute, January 2016. (Available at http://drugchannelsinstitute.com/products/industry_report/pharmacy/)

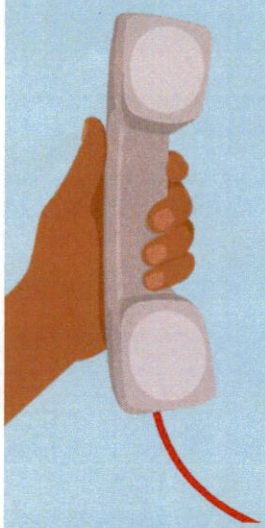
CVS pharmacy®

Hi, Christopher let's talk about your exit strategy.

Let's talk.

What is your store worth?
I can give you a good idea and answer all your questions.

Tell me more



Learn the answers to these questions:

Why is this a good time to sell?
How would you help me through the acquisition process?
What about my employees?
What about my patients?

To arrange a meeting call **1-614-503-1702**.

Shane Stockton
Regional Director of Acquisitions

Let's meet

Nationwide, independent community pharmacy represents an $80 billion health care marketplace and employs more than 250,000 people. More than 80 percent of independent pharmacies are located in communities of 50,000 population or less, providing essential health care services in underserved areas.

Pennsylvania

Number of independent community pharmacies:	960
Total sales:	$3,474,205,440
Pharmacy sales:	$3,210,165,827
Front-end sales:	$264,039,613
Number of full-time employees:	9,024
Total prescriptions filled:	57,356,160
Part D prescriptions fillied:	20,648,218
Medicaid prescriptions filled:	9,176,986
Additional economic activity* generated by independent community pharmacy in state of Pennsylvania:	
Sales:	$3,126,784,896
Employment:	3,610

Financial data represented here is for the 2016 tax year.
For more information, please contact the NCPA Advocacy Center at karry.laviolette@ncpanet.org.

**Additional economic activity refers to the increase in economic activity – usually at the local level – that results as pharmacy employees spend and invest their earnings. The effect of that spending is compounded as workers spend their money at local businesses. Those businesses in turn have additional income to invest locally. As each round of spending weaves through the economy, community pharmacy's impact is multiplied.*

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Pennsylvania's Pharmacists: Improving People's Health

By 2020 there will be an estimated shortage of 20,400 primary care physicians in the U.S. Even if nurse practitioners and physician assistants are fully utilized, patient needs will not fully be met.[1]

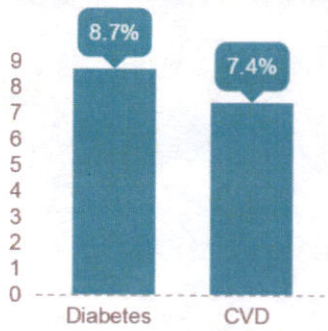
Pennsylvania has a shortage of 88 physicians.[1] The 12,830 highly trained Pennsylvania pharmacists are ready to bridge the gap by providing chronic disease management and wellness and prevention services.[2]

Meeting Patients' Needs in Pennsylvania

12.6 Million people[3]

64% of the physicians needed to deliver care[1]

12,830 Pharmacists ready to help[2]



Prevalence of chronic disease in Pennsylvania[4,5]

Diabetes

Diabetes is a complex condition that is often managed by multiple medications. Pharmacists can optimize care and help patients understand their medications and their condition in order to improve outcomes and avoid complications.[6-9]

Cardiovascular Disease (CVD)

For patients with uncontrolled high blood pressure, waiting even two months to optimize medications increases the risk of complications, including hospitalizations. Pharmacists are highly accessible members of the care team who significantly improve blood pressure control and can provide timely follow-up and monitoring to improve outcomes.[10]

50% of Pennsylvania residents were vaccinated for the flu[11]

Immunization rates across the U.S. have continued to increase since pharmacists began vaccinating.[11]

Smoking causes nearly 1 of every 5 deaths in the U.S. each year.[12] Pharmacists are qualified and capable of providing smoking cessation counseling.

20% of people in Pennsylvania smoke cigarettes[12]

50% of people with chronic diseases do not take their medicines correctly.[13]

Medications are critical for the treatment of chronic conditions. Pharmacists can help patients use them safely and effectively to avoid medication related problems.[14]

Pennsylvania spends $14,021,900,000 annually on prescription medications.[5]

Investing in pharmacists' services optimizes the use of those prescription medications. Decades of research have proven the value of including pharmacists on healthcare teams. Improved health outcomes, lower costs, and increased access to care could be a reality for Pennsylvania residents if pharmacists were fully empowered to serve as patient care providers.

On average **$1,000** per patient per year is saved with pharmacist interventions for patients with chronic conditions.[6-8, 16]

Pharmacists' counseling and adherence programs can save the healthcare system **$164** per patient in the 6 months following the start of a new prescription medication.[17]

72% of Pennsylvania hospitals were penalized for high readmission rates.[5]

Pennsylvania spends 28.7% of its General Fund Expenditures on Medicaid.[5]

Patients are **3X** more likely to stay out of the hospital when pharmacists provide clinical services after discharge.[18]

Pharmacists in Ohio delivered a 4.4:1 ROI when providing medication therapy management services to Medicaid patients. Pennsylvania pharmacists could do this too![19]

$4.40 saved per $1 spent on pharmacists' services

This information was developed through a collaboration between APhA and NASPA with generous support from the Community Pharmacy Foundation.

NASPA APhA Community Pharmacy Foundation

References available at www.pharmacistsprovidecare.com