TEXAS PUBLIC POLICY FOUNDATION
PolicyPerspective

Updated March 2020
Right on Healthcare

Touchpoints in the Pharmaceutical Supply Chain

by Stephen Pickett, Ph.D.
Healthcare Economist

Key Points

- Drug spending in the United States has been increasing in recent years and is expected to continue to grow due to rising drug prices and increased drug utilization.
- It is important for policymakers to understand the role of everyone involved in the supply chain in order to craft effective legislation to help control rising drug costs.

Executive Summary

In the United States, healthcare expenditures and prescription drug costs have been increasing in recent years and policymakers have been interested in slowing down these rising costs. To adequately address rising costs, there needs to be a solid understanding of where the money is going, who is involved, and what role everyone plays. Most people understand that manufacturers produce drugs and pharmacies sell drugs, but they probably are not aware of the existence of many of the other entities involved in the process. These entities play an important role, such as packaging the drugs, negotiating drug formularies, and facilitating payments. This paper identifies the prominent entities involved in the pharmaceutical supply chain and briefly explains their role.

Introduction

In 2019, prescription drug expenditures totaled approximately $360 billion and with rising drug prices and increasing drug utilization, expenditures are expected to continue to grow over the next decade (Sisko et al., 495; Statista). There are many entities involved in the process of producing and delivering drugs to consumers. Drug manufacturers discover new drug compounds, study their safety and efficacy, and manufacture them to be sold to consumers. Pharmacies are the most common point of contact for consumers needing to purchase prescription drugs. In addition to manufacturers and pharmacies, there are many other entities involved in the process, including wholesalers, third-party payers, pharmacy benefit managers (PBMs), pharmacy services administration organizations, and PBM auditors. Many of the entities are relatively unknown to consumers compared to manufacturers and pharmacies. As lawmakers and regulators at federal and state levels continue considering legislation to address increasing healthcare prices, particularly prescription drug costs, it is important for policymakers to understand who is involved in the process as they attempt to address rising pharmaceutical costs.

The purpose of this paper is to review the different touchpoints in the prescription drug supply chain, identifying the primary entities in the business. This is not intended to be a comprehensive list of every entity involved, nor will this process be true for every drug or every consumer. However, this paper illustrates how a typical prescription drug purchased from a pharmacy by an individual with health coverage will flow from the manufacturer to the end consumer and identifies the primary entities involved and how they earn revenue from the payments made by consumers.

This paper is divided into two sections. The first section introduces the entities that supply the physical drug to the consumer. The second section introduces the service providers that do not physically handle the drugs but are an important part of the financial transactions.

continued

Product Supply Chain

Drug Manufacturers

For a drug to reach the market in the United States, it needs to undergo a lengthy process of research and development, clinical trials, and eventually approval by the Food and Drug Administration (FDA). The details of this process are outside the scope of this policy perspective (see the FDA website for details on this process).

The manufacturer conducts extensive research and development to find a new drug to bring to the market. On average, it costs $2.6 billion and takes 10 years for a drug to complete the process of basic discovery through clinical trials and to be approved by the FDA (PhRMA, 22). Once a drug is approved by the FDA, it is ready to be sold to consumers. The manufacturer does not sell directly to consumers but will first sell its product to a wholesaler, which sells the drug to pharmacies, which eventually sell it to consumers.

Wholesalers

Once a drug is produced by the manufacturer it is sold in large quantities to wholesalers. The wholesaler typically receives discounts for buying in larger quantities, paying promptly, and purchasing drugs that have a relatively short expiration date (KFF 2015, 9). Wholesalers can broadly be categorized into two groups: full-line wholesalers and specialty distributors. Full-line wholesalers will sell a variety of drugs to a variety of purchasers, such as independent pharmacists, chain and grocery store pharmacies, mail-order pharmacies, and specialty pharmacies. Specialty distributors will typically only handle certain types of drugs that require extra care and/or sell to a specific group of purchasers (e.g., nursing homes) (Fein).

Working with wholesalers are several smaller entities, frequently subsidiaries of the larger wholesaler, that help safely distribute drugs to the pharmacies. *Pharmaceutical repackagers* repackage the drugs into smaller quantities to be distributed to pharmacies. *Labelers* work with distributors to ensure that the drugs are appropriately labeled, both to help consumers understand what they are taking and how to properly take the drugs. After the drug is packaged and labeled, it is then sold to the pharmacy which eventually sells the drug to the consumer.

Pharmacies

Pharmacies are frequently the final entity in the supply chain that sells prescription drugs to the end consumer. Pharmacies purchase prescription drugs from wholesale distributors, store the drugs, and sell them to patients. There are many different types of pharmacies. Most familiar to consumers are *retail pharmacies*, such as independent pharmacies, chain pharmacies (e.g., Walgreens, CVS), and grocery store pharmacies.

In addition to traditional retail pharmacies, several other forms of pharmacies sell prescriptions to patients. *Mail-order pharmacies* will distribute prescription drugs but do not have a physical location for consumers to visit. Instead, once they receive a prescription from a provider, they send patients their prescriptions through the mail.

Service Providers

In addition to the entities that produce and deliver prescription drugs to consumers, other entities involved in the process provide services but do not directly handle drugs. Here we describe the more prominent entities and the role they play in order for consumers to purchase their prescription drugs.

Third-Party Payers

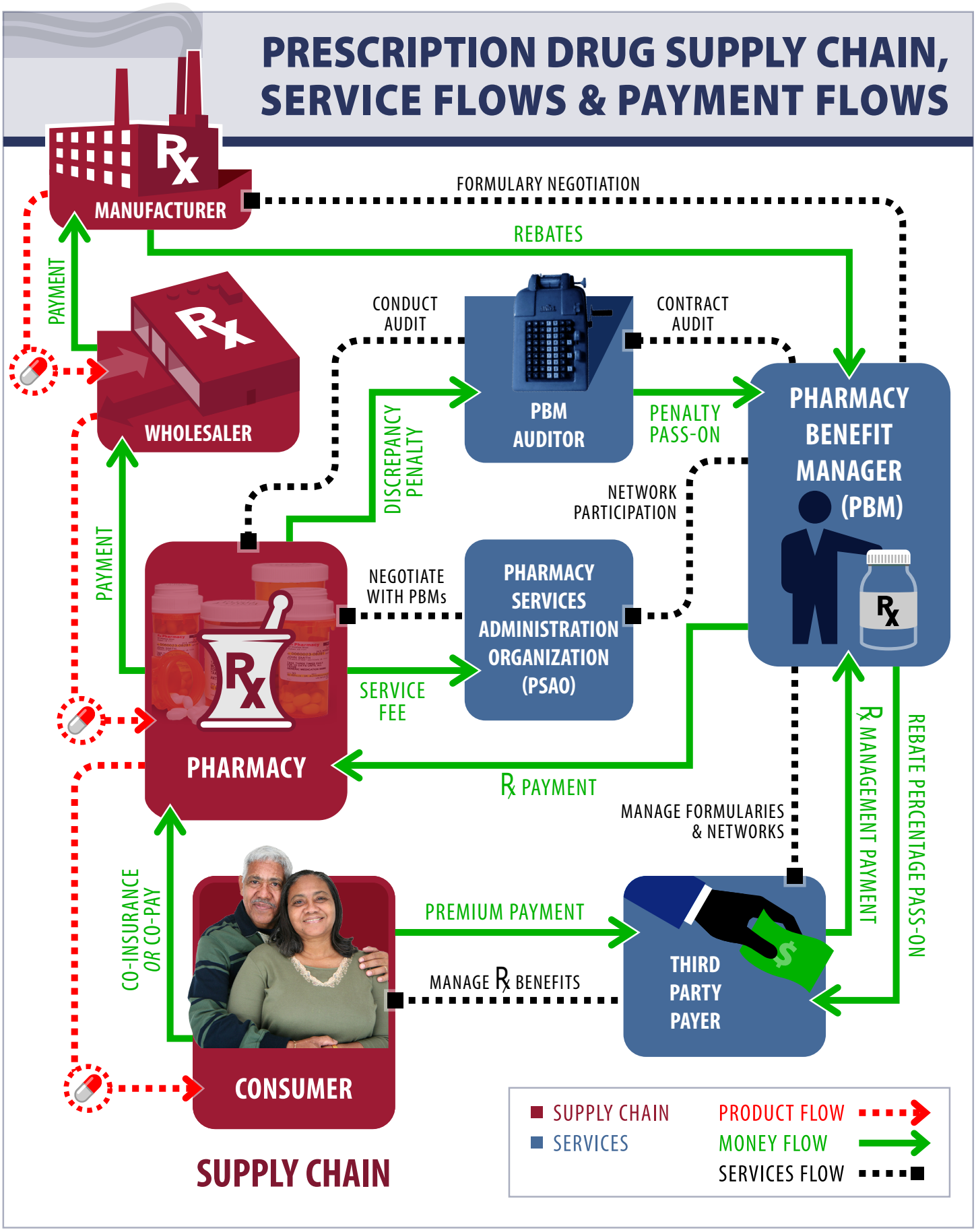
Third-party payers are the entities that offer pharmacy benefit plans to consumers in exchange for a premium. Third-party payers can be insurance companies, the federal government, state governments, or employers. Consumers with prescription drug coverage frequently have this combined with their health insurance; however, it can be a separate policy from their medical coverage (e.g., Medicare Part D beneficiaries). In the United States, roughly 98 percent of all retail pharmaceutical purchases are through third-party payers (KFF 2019).

The third-party payer is involved in several financial transactions when consumers receive prescription drugs. First, the consumer pays insurance premiums to third-party payers for prescription drug coverage. On behalf of the beneficiary, the third party determines the benefit levels of the plan, works with a PBM to create formularies indicating which prescriptions are covered in the plan, and negotiates prices, rebates, and care programs with the manufacturer. When a beneficiary purchases a prescription from the pharmacy, the third-party payer reimburses the PBM, who in turn reimburses the pharmacy.

Pharmacy Benefit Managers

Pharmacy benefit managers work on behalf of third-party payers to negotiate drug formularies and rebates with manufacturers, to create pharmacy networks, and to dispense the covered drugs. Originally PBMs were created to adjudicate pharmacy claims for third-party payers (Werble 2017b). However, in recent years, they have become more prominent in the industry now that they negotiate drug formularies, rebates, and pharmacy networks and offer care management.

PRESCRIPTION DRUG SUPPLY CHAIN, SERVICE FLOWS & PAYMENT FLOWS



Their primary role is to negotiate drug formularies and rebates (Werble 2017b). Drug formularies place drugs in tiers, which determine different levels for member cost-sharing. A typical formulary will have generic drugs in Tier 1; Tier 2 are preferred brand-name drugs; Tier 3 are nonpreferred brand-name drugs; and Tier 4 are specialty drugs(Werble 2017a). PBMs use pharmacy and therapeutics (P&T) committees, consisting of physicians, pharmacists, nurses, and other healthcare professionals, to recommend which drugs are included in the formulary and where the drugs are placed (ASHP, 1; Rumore and Vogenberg).

Lower formulary placement corresponds to lower out-of-pocket costs for consumers, so manufacturers are interested in receiving lower placement to increase their likelihood of being purchased by the consumer. Manufacturers often pay rebates to the PBMs to get a preferential placement on the formulary for their products. PBMs typically keep a percentage of the rebates as payment for their services and pass along the remainder to the third-party payer, which may retain the rebate for their administrative services or pass it along to the consumer in the form of lower premiums.

In addition to rebates, PBMs earn revenue through practices called *clawbacks* and *spread pricing*. For many prescription drugs, a patient will pay a copayment, and the insurer will pay the remainder of the price. However, sometimes the copayment is more than the total cost of the prescription. In these situations, the PBM will keep the difference between the copayment and the drug cost, which is known as a clawback. A 2018 study found that 23 percent of pharmacy fills involved a patient overpaying for the prescription by at least $2.00 (Van Nuys et al.). Spread pricing occurs when a PBM charges the insurer a higher price than what is paid to the pharmacy (Kouvelis et al.). The PBM will keep the difference as revenue.

Pharmacy Services Administration Organizations

Pharmacy Services Administration Organizations (PSAOs) are organizations that contract with pharmacies (typically smaller independent pharmacies) to perform various administrative functions. The primary services PSAOs offer are typically contract negotiations with PBMs and third-party payers. Additionally, PSAOs offer a variety of other administrative services, such as claims adjudication, audit assistance, compliance support, or communications (GAO, 2).

Third-party payers contract with PBMs to create networks of retail pharmacies for their beneficiaries and negotiate prices with the pharmacies. Smaller, independent pharmacies that lack bargaining power against PBMs frequently contract with PSAOs. PSAOs negotiate on their behalf with PBMs and other third-party payers regarding networking, reimbursement rates, payment terms, and audit provisions, among other things (GAO, 2).

PBM Auditors

PBMs contract with PBM auditors to occasionally audit pharmacies to ensure accurate payments and accurate fulfillment of prescriptions to consumers. Audits are intended to ensure proper payments and prevent fraud, waste, and abuse. If the audit turns up inappropriate practices by the pharmacy, the PBM penalizes the pharmacy (Baird).While the intent of audits is to monitor payments and fulfillment of prescription drugs, concerns have been raised as to whether auditors are always acting in good faithto detect fraud, waste, and abuse (NCPA).

Conclusion

In this paper, we discussed many of the entities involved in the pharmaceutical supply chain and the associated entities that provide services throughout the process in which consumers buy prescription drugs. The average consumer likely does not know these different entities are involved in the process. As pharmaceutical expenditures are expected to increase in the coming years (Sisko et al., 495), consumers, employers, taxpayers and policymakers will want to know where their money is going. As policymakers look to curb rising drug costs, it is important to understand who is involved, what services they are providing, and how they are being compensated.

References

ASHP (American Society of Health-System Pharmacists) 2008. "ASHP Statement on the pharmacy and therapeutics committee and the formulary system." *American Journal of Health-System Pharmacists*. 65:2384-6.

Baird, Jeffrey S. 2018. "What to Know About Working with PBMs." *Pharmacy Times*, February 20.

CEA (The Council of Economic Advisors). 2018. *Reforming Biopharmaceutical Pricing at Home and Abroad.* CEA.

FDA (Food and Drug Administration). 2019. "Code of Federal Regulations Title 21." Accessed February 5, 2020.

Fein, Adam J. 2018. "2018 MDM Market Leaders: Top Pharmaceutical Distributors." Accessed February 5, 2020.

KFF (Kaiser Family Foundation). 2005. *Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain.* KFF.

KFF (Kaiser Family Foundation). 2019. "Retail Sales for Prescription Drugs Filled at Pharmacies by Payer: 2018." Accessed February 5, 2020.

Kouvelis, Panos, Yixuan Xiao, and Nan Yang. 2015. "PBM Competition in Pharmaceutical Supply Chain: Formulary Design and Drug Pricing." *Manufacturing & Service Operations Management*. 17(4):511-526.

GAO (U.S. Government Accountability Office). 2013. *The Number, Role, and Ownership of Pharmacy Services Administrative Organizations.* GAO.

NCPA (National Community Pharmacists Association). 2020. "PBM Reform." Accessed January 21.

PCMA (Pharmaceutical Care Management Association). 2020. "PBMs' Management of Specialty Drugs." Accessed January 21.

Pew. 2018. "A Look at Drug Spending in the U.S.: Estimates and projections from various stakeholders." February 27. Updated August 28.

PhRMA. 2015. *Biopharmaceutical R&D: The Process Behind New Medicines*. PhRMA.

Rumore, Martha M., and F. Randy Vogenberg. 2017. "PBM P&T Practices: The HEAT Initiative is Gaining Momentum." *Pharmacy and Therapeutics*. 42(5):332-335.

Sisko, Andrea M., Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Sheila D. Smith, Andrew J. Madison, Kathryn E. Rennie, and James C. Hardesty. 2019. "National Health Expenditure Projections, 2018-27: Economic and Demographic Trends Drive Spending and Enrollment Growth." *Health Affairs*. 38(3): 491-501.

Statista. 2019. "Prescription drug expenditure in the United States from 1960 to 2019." Accessed February 7, 2020.

Van Nuys, Karen, Geoffrey Joyce, Rocio Ribero, and Dana Goldman. 2018. *Overpaying for Prescription Drugs: The Copay Clawback Phenomenon*. USC Shaeffer Center.

Werble, Cole. 2017a. "Health Policy Briefs: Formularies." *Health Affairs*, September 14.

Werble, Cole. 2017b. "Health Policy Brief: Pharmacy Benefit Managers." *Health Affairs*, September 14.

ABOUT THE AUTHOR

Stephen Pickett, Ph.D., is a healthcare economist for the Right on Healthcare Initiative at the Texas Public Policy Foundation. Prior to joining the Foundation, Pickett worked in the health insurance industry where he researched the relationship between different insurance products and healthcare utilization and outcomes, as well as alternative provider reimbursement strategies. His research during graduate school focused on the impacts of the Affordable Care Act's marketplaces on Texans and how providers change their behavior when alternative payment models are introduced.

Pickett received his Ph.D. and M.A. in economics from Rice University and his B.B.A. in business fellows and mathematics from Baylor University.

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How Formulary Construction Leads To Higher Prices and Decreased Access

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Coalition of State Rheumatology Organizations – President
Alliance for Safe Biologic Medicines – Chair
Clinical Assist. Prof of Medicine – Tulane Univ School of Medicine
The Rheumatology Group – New Orleans, LA

CSRO
Coalition of State Rheumatology Organizations

A Few Definitions

- **Formulary** – the list of medications that insurance will pay for
  - **Preferred Drug List** – drugs that must be "failed first" before other drugs will be paid for – STEP THERAPY/FAIL-FIRST
- **Specialty Drugs**– "expensive" medications
- **Copay**- fixed amount for a drug or service
- **Co-insurance** - % of price for drug or services (specialty drugs)

FORMULARY - THE KEY

- **List of drugs** that **insurance will pay for**
- If expensive drug is not on the formulary

NO ONE WILL TAKE IT

Who Constructs the Formulary?

- **Pharmacy Benefit Managers** (PBMs)
  - Hired by Health Plans/Employers
    - Manage prescription drug benefit programs
  - Act as intermediaries
    - Health Plans/Employers, Manufacturers, Pharmacies

Mergers

Vertical Business Relationships Among Insurers, PBMs, and Specialty Pharmacies, 2019

Source: Drug Channels Institute research. AllianceRx Walgreens Prime is jointly owned by Prime Therapeutics and Walgreens Boots Alliance.

This chart appears as Exhibit 77 in *The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute*. Available at http://drugch.nl/pharmacy

DRUG CHANNELS INSTITUTE

PBMs Ultimately Determine

What - Constructing the Formulary

When - Step therapy, NonMed Switch (UM tools)

Where - Pharmacy network, mail order

How Much – Copay, Co-insurance

Breaking Down the Drug/Money/Services Flow

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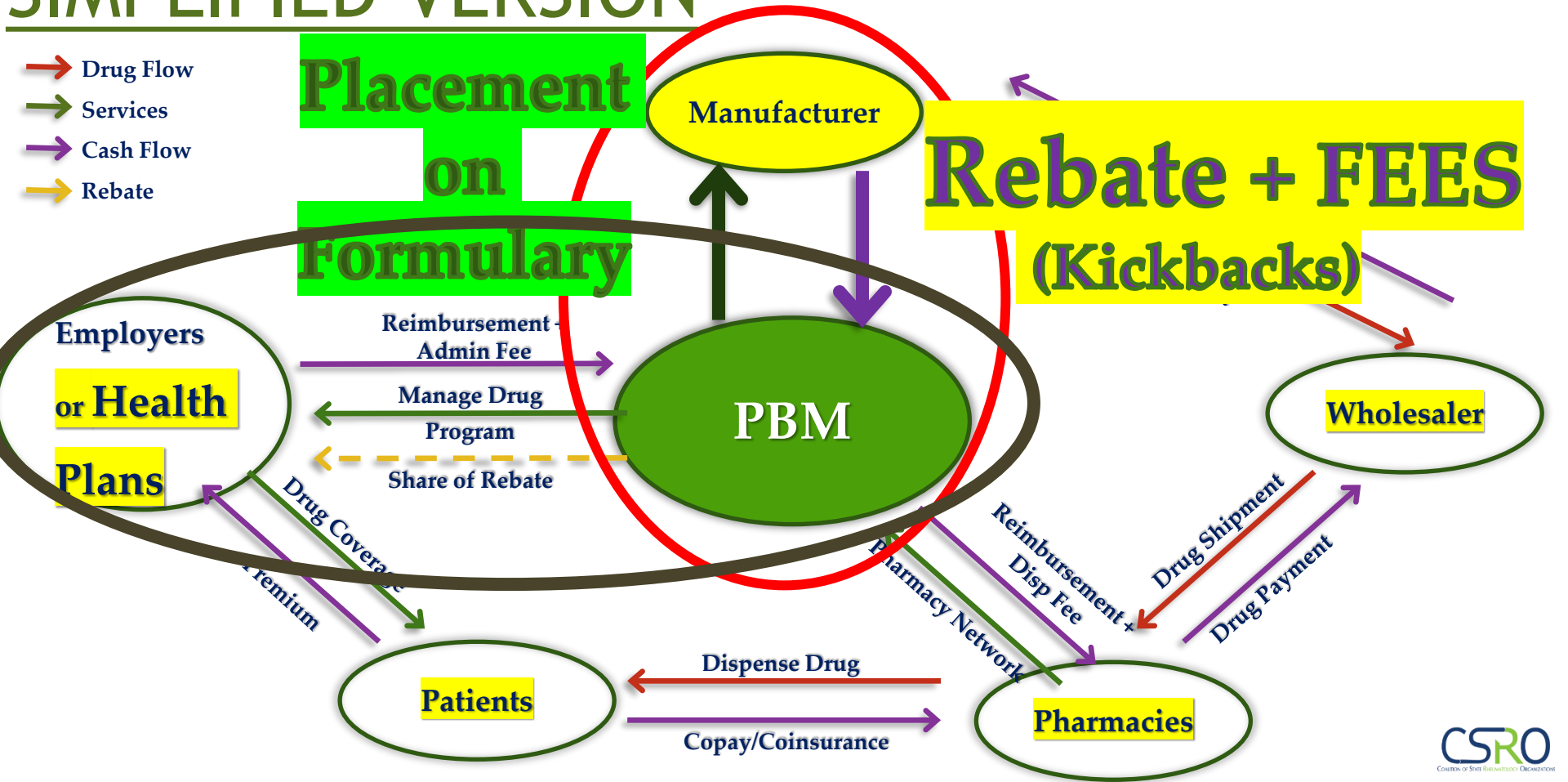
SIMPLIFIED VERSION



It's All About the Formulary & Preferred Placement

Manufacturers Fight For Preferred Placement

- **Benefits Of Preferred Placement**
  - **Step Therapy** – Patients must take *THEIR* drug first
  - **Non Medical Switching** – Patients are switched to *THEIR* drug
  - **Excludes Competitors** to *THEIR* drug

What Determines Preferred Placement?

- **Efficacy?**
- **Safety?**
- **Lowest list price?**

Guess again…..

“Bidding War”

Among Drug Makers

For Preferred Place on Formulary

Based on

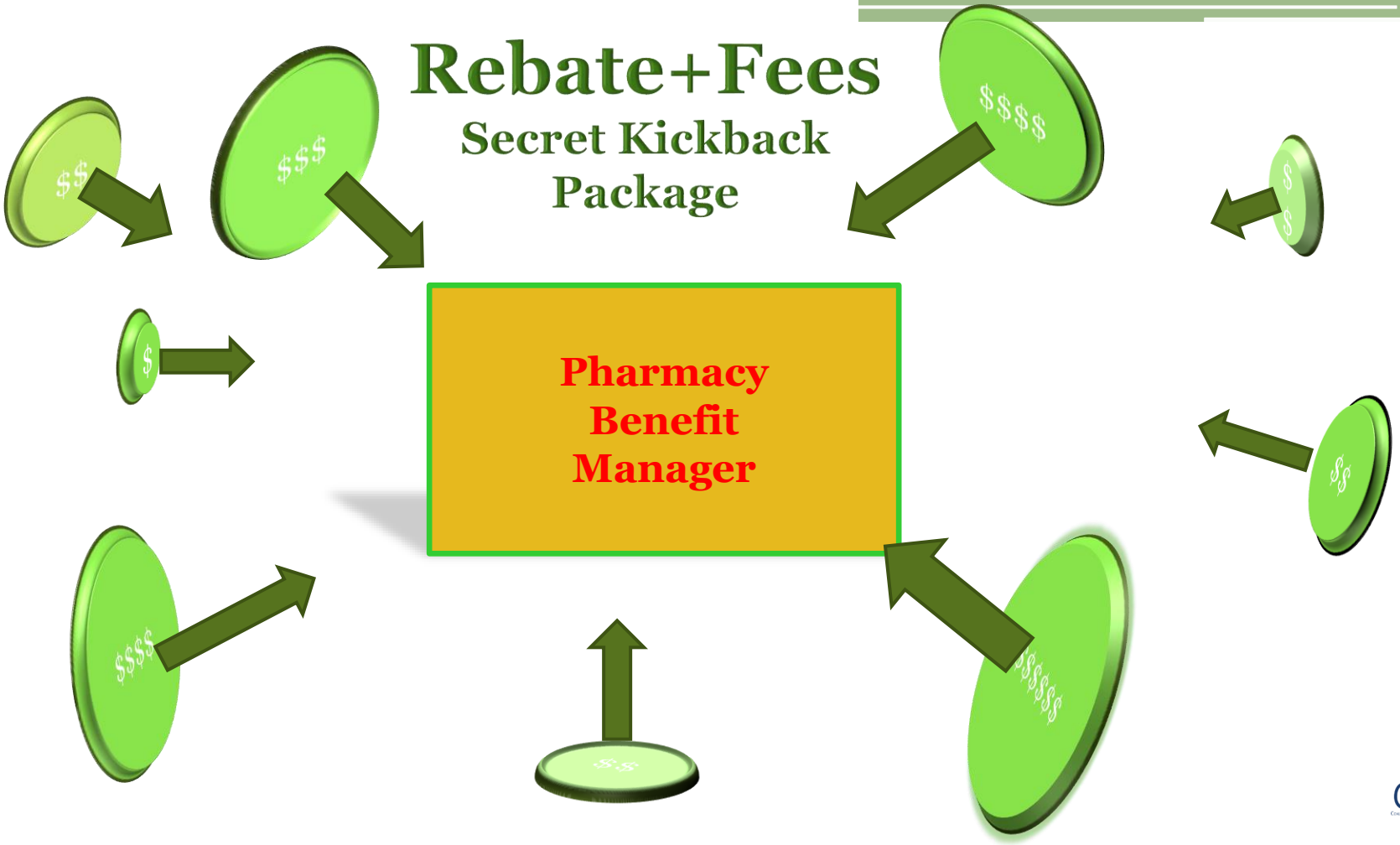
HIGHEST Price Concession

SOURCES: ERISA Advisory Council. PBM Compensation and Fee Disclosure https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014ACreport1.pdf. Published November 2014. Eickelberg HC. The prescription drug supply chain black box: How it works and why you should care. American Health Policy Institute. http://www.americanhealthpolicy.org/Content/documents/resources/December%202015_AHPI%20Study_Understanding_the_Pharma_Black_Box.pdf. Published 2015. Accessed January 10, 2017; Compliant, Boss v. CVS Health Corp., No. 2:17-cv-01823 (D.N.J. March 17, 2017), https://www.bloomberglaw.com/public/desktop/document/BOSS_et_al_v_CVS_Health_Corporation_et_al_Docket_No_217cv01823_DN?1496256418.

CSRO

Rebate+Fees

Secret Kickback Package



The Equation

Formulary Rebate =

List Price x % Rebate x # Scripts filled

1. List price of the drug
2. % rebate promised
3. # Scripts filled (*Market share*)

An Increase In Any One Of These Variables

Better Chance At Preferred Placement

Which Drug Has The Best Bid?

	Drug A	Drug B	Drug C
List Price	$2,000/mo	$4,000/mo	$5,000/mo
Rebate %	60%	40%	40%
Formulary Rebate Total	$1,200	$1,600	$2,000

What Does Competition Do ?

What Does Competition Do to Prices???

COMPETITION DRIVES PRICES DOWN

BUILDING A HOUSE

WINNER= Lowest Bidder

COMPETITION DRIVES PRICES UP

SELLING A HOUSE

WINNER= Highest Bidder

Our Formulary Construction Model

- PBMs receive rebates/fees based on a % of the list price of the medicine.
- These price concessions can be over 50% of the list price.
- **<u>This creates a perverse incentive for HIGHER PRICED MEDICINES, not lower, because the HIGHER PRICED MEDICINE can provide the larger rebate /fee package.</u>**

The Higher the LIST PRICE…
The Higher the Fees…

- Administration fees
- Inflation fees -price goes up triggers another payment
- Procurement fees
- Care management/services fees
- Other fee for service arrangements “Bona fide service fees”

Collectively known as “Other Pharma Revenue”

- ***MOST IMPORTANT - Patient Cost**

Patient Co-insurance % Is Based On List Price

FROM EXPRESS SCRIPTS CONTRACT (Axios.com)

For sake of clarity, **Rebates do not include**, for example,

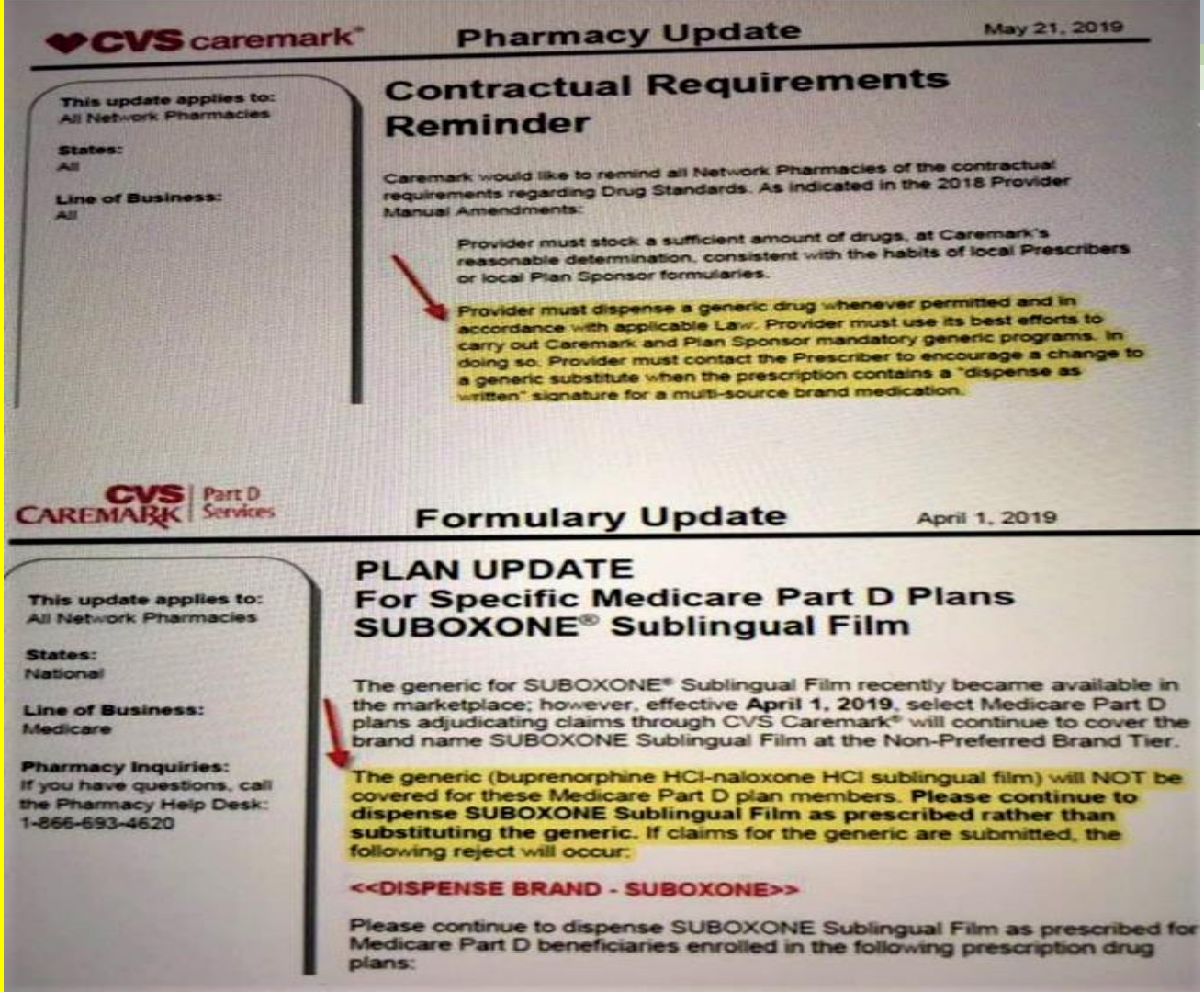
- **Manufacturer Administrative Fees;**
- **Inflation payments**;
- **Product discounts or fees related to the procurement** of prescription drug inventories by ESI Specialty Pharmacy or the Mail Service Pharmacy;
- **Fees** received by ESI from pharmaceutical manufacturers for **care management/ services** provided with the dispensing of products;
- **Other fee-for-service arrangements** whereby pharmaceutical manufacturers generally report the fees paid to ESI or its wholly-owned subsidies for services rendered as **"bona fide service fees"** (collectively, "**Other Pharma Revenue**")
- Such laws and regulations, as well as ESI's contracts with pharmaceutical manufacturers, generally **prohibit ESI from sharing** any such "bona fide service fees" earned by ESI, whether wholly or in part, **with any ESI client.** https://www.axios.com/drug-pricing-contract-express-scripts-d536e8a9-a8a3-4bc9-8028-05453e617326.html

Express Scripts' Lawsuit Reveals Striking Information About PBM Rebates*

Invoice Date	Type of Contract	Formulary Rebate	Admin Fee	Price Protection Rebate	Total
Jan-16	Commercial	$1,612.50	$24,963.90	$5,689.26	$32,265.66
Jan-16	Medicare	$450	$2,652.13	$5,184.14	$8,286.57
2/1/16: kaleo increases Evzio list price from $937.50 to $4,687.50					
Apr-16	Commercial	$7,125.00	$129,517.29	$4,951,923.90	$5,088,566.19
May-16	Commercial	$9,937.50	$137,162.51	$2,266,092.01	$2,413,192.02
Dec-16	Commercial	$4,312.50	$56,395.65	$977,873.22	$1,038,581.37
Dec-16	Medicare	$3,375	$12,468.56	$219,218.80	$235,062.36
	Total	**$26,812.50**	**$363,160.04**	**$8,425,981.33**	**$8,815,954.17**

*http://www.pharmacybenefitconsultants.com/rx-alerts/time-to-determine-if-your-pbm-is-hiding-rebates

Brand Chosen Over Generic



CVS caremark

Pharmacy Update

May 21, 2019

This update applies to:
All Network Pharmacies

States:
All

Line of Business:
All

Contractual Requirements Reminder

Caremark would like to remind all Network Pharmacies of the contractual requirements regarding Drug Standards. As indicated in the 2018 Provider Manual Amendments:

Provider must stock a sufficient amount of drugs, at Caremark's reasonable determination, consistent with the habits of local Prescribers or local Plan Sponsor formularies.

Provider must dispense a generic drug whenever permitted and in accordance with applicable Law. Provider must use its best efforts to carry out Caremark and Plan Sponsor mandatory generic programs. In doing so, Provider must contact the Prescriber to encourage a change to a generic substitute when the prescription contains a "dispense as written" signature for a multi-source brand medication.

CVS CAREMARK | Part D Services

Formulary Update

April 1, 2019

This update applies to:
All Network Pharmacies

States:
National

Line of Business:
Medicare

Pharmacy Inquiries:
If you have questions, call the Pharmacy Help Desk: 1-866-693-4620

PLAN UPDATE
For Specific Medicare Part D Plans
SUBOXONE® Sublingual Film

The generic for SUBOXONE® Sublingual Film recently became available in the marketplace; however, effective **April 1, 2019**, select Medicare Part D plans adjudicating claims through CVS Caremark® will continue to cover the brand name SUBOXONE Sublingual Film at the Non-Preferred Brand Tier.

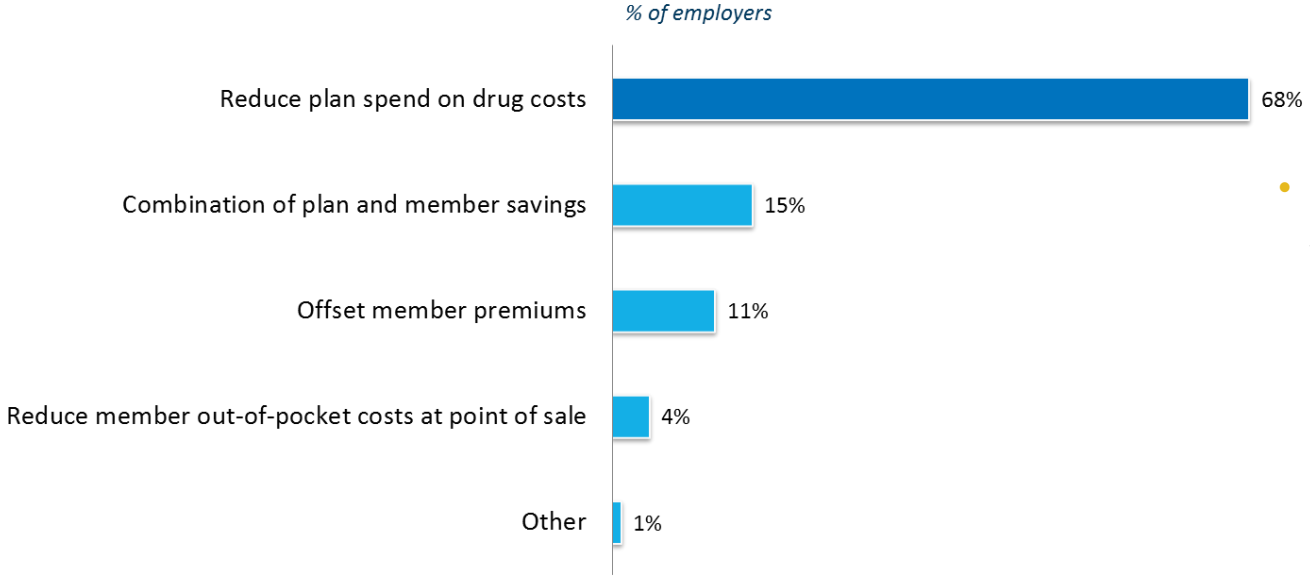
The generic (buprenorphine HCl-naloxone HCl sublingual film) will NOT be covered for these Medicare Part D plan members. **Please continue to dispense SUBOXONE Sublingual Film as prescribed rather than substituting the generic.** If claims for the generic are submitted, the following reject will occur:

<<DISPENSE BRAND - SUBOXONE>>

Please continue to dispense SUBOXONE Sublingual Film as prescribed for Medicare Part D beneficiaries enrolled in the following prescription drug plans:

What Plans Do With Rebates

Employers' Use of Formulary Rebates, 2017



- ***"These funds are used primarily to offset total plan costs for the employer, not to offset the costs incurred by the patients whose prescription activity generate those rebates"***

Source: Drug Channels Institute analysis of *Trends in Benefit Design Report*, PBMI, 2017. Total does not sum to 100% due to rounding.

Published on Drug Channels (www.DrugChannels.net) on January 18, 2018.

DRUG CHANNELS INSTITUTE

CSRO

Thank You!

"Let's never forget that the public's desire for transparency has to be balanced by our need for concealment."

340B Program – 1992 Legislation

Sec. 340B PUBLIC HEALTH SERVICE ACT

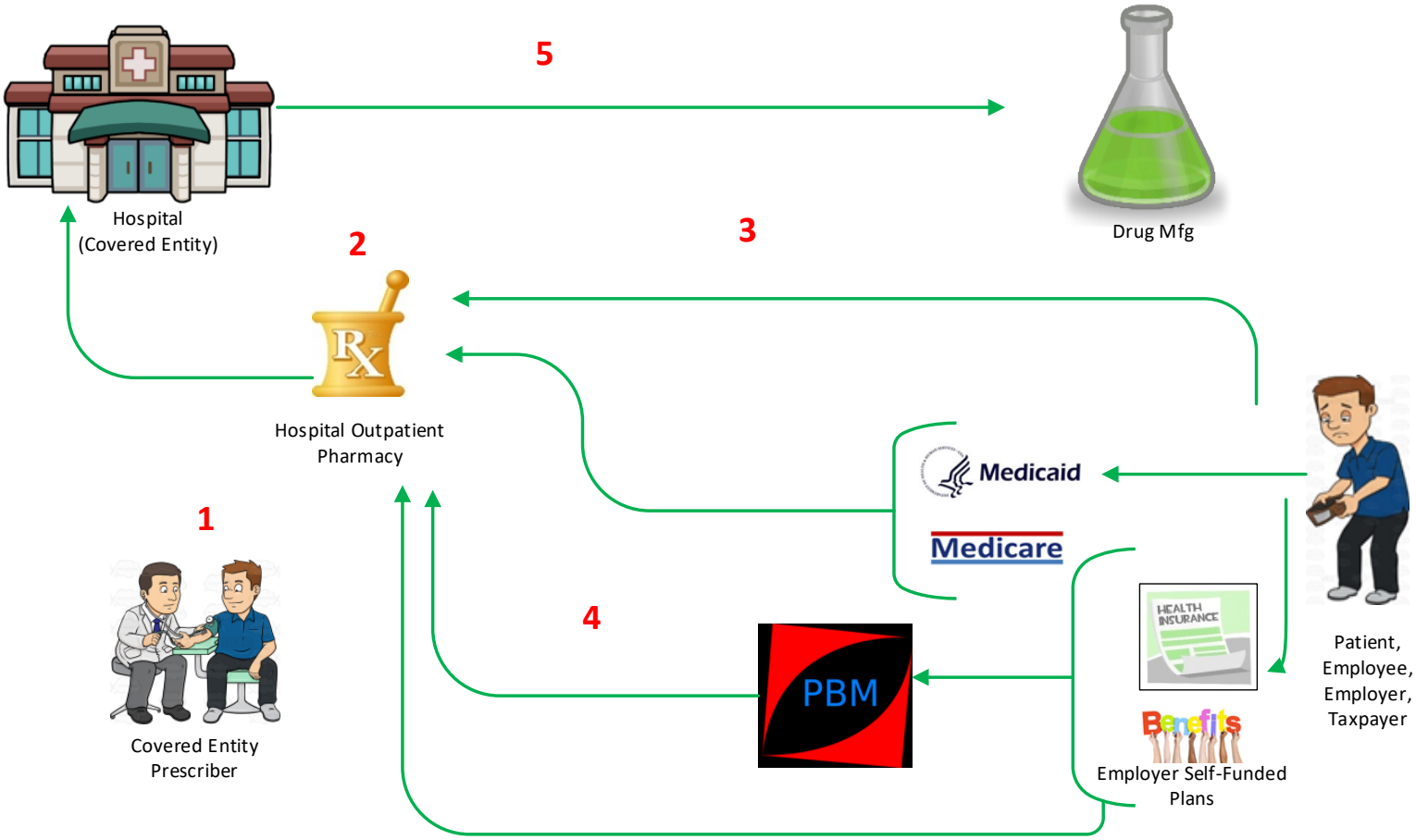
INTENT: …to enable (covered) entities to stretch scares Federal resources as far as possible, reaching more eligible patients and providing comprehensive services…"

Prepared for:

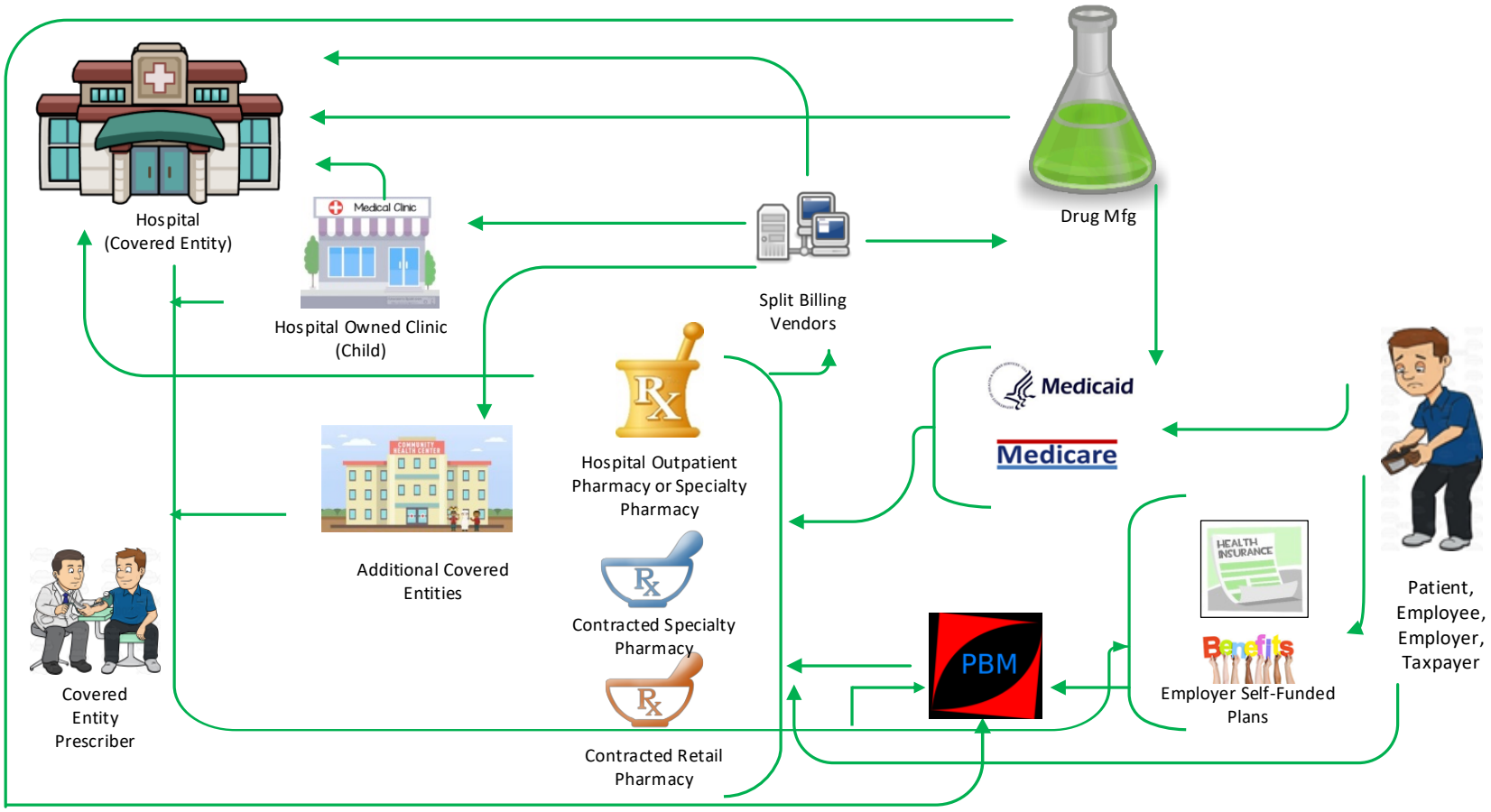
Texas Public Policy Foundation

Prepared by Marilyn J Bartlett, CPA, CMA, CFM, CGMA
October 13, 2020

340B Program – Intended Cash Flow



340B Program – Follow the Money



340B Program – Driving up Healthcare Costs

- Middlemen sharing in 340B Savings with no decrease in their prices
  - Contracted Pharmacies
  - Insurance Companies, Employer Self-Funded Plans, PBMs
  - Split Billing Vendors
- Drug Prices
  - Penny Pricing
  - 8% of the RX Market
  - Prescribing higher cost brand-name drugs for 340B discount
  - Passing on the discount to low-income, uninsured?

Where are the 340B Savings?

"We don't know"

340B Program – The Questions?

The Law:

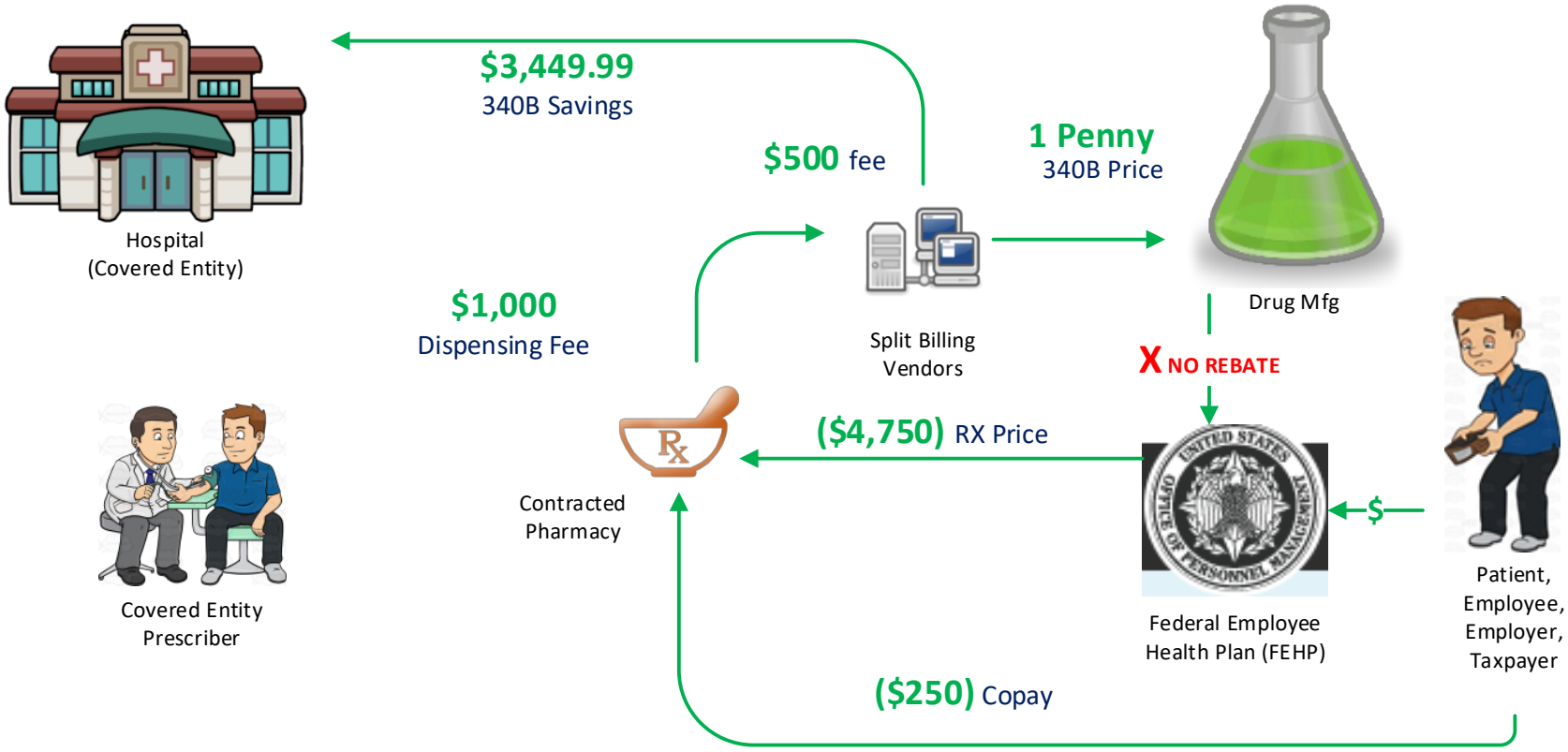
- Does the current 340B Program meet the original intent of the law? Are the low income, vulnerable receiving the program benefits?
- Are current practices of sharing 340B Savings, expansive retail pharmacy networks, and expansion to insured patients included in the law?

Is the Law relevant after 25 years?

- Are the low income, vulnerable receiving low-cost medications through other channels?
  - Medicaid: (1992) 29 million people at a cost of $120 billion; (2016) 72 million people at cost of $575 billion
- Do 340B Savings to NFP and DSH Hospitals, Insurance Companies, Pharmacies, PBMs, Split Billing Vendors, and others serve the low income, vulnerable patient needs?
- Define the issue – is there a better, direct way to address the issue?

FEHP – Bringing it home

Humira Prescription




PATIENTS
RISING NOW
The Default Setting of the U.S. Healthcare System Should Be:
Getting the Right Treatment to the Right Patient at the Right Time

Access, Affordability, & Value in American Drug Pricing

The Road to Transparency

PATIENTS RISING NOW

What Patients Want

- Complete transparency in drug pricing from beginning to end of supply chain
- Putting treatments back in the hands of doctors and not insurers and pharmacy benefit managers
- Streamlined access to prescribed treatments
- High-value treatments without the use of discriminatory Quality Adjusted Life Years (QALY)
- An innovative pipeline financed by public/private partnerships & venture capital

What Patients Don't Want

- To continue allowing the secretive drug supply chain players to feed their bottom line on the backs of hard-working American patients,
- To continue accepting PBMs/Insurers as the final say in patient treatment,
- To continue experiencing access barriers that delay treatments and hinder outcomes for patients,
- To pursue activation of a discriminatory QALY-based system like UK/Canada creating more hurdles for our most vulnerable patients, and
- To be okay with fewer innovations being developed because no one had the stomach to fix the entire drug supply chain.

PATIENTS RISING NOW

The Patients

Patient #1
Individual Market

- Individual Marketplace Plan for *One Person*
- Annual Earnings: $75,000-$100,000 (self-employed)
- Only two plans cover her MS medication; no generic
- Annual Premium: $8700/Annual Deductible: $8150
- Ineligible for subsidies/Plan uses copay accumulator
- Sanofi-Genzyme provides free medication through copay override; she negotiates cash price with doctors. Insurance card is not used.
- Has useless $16,850 annual catastrophic coverage
- Logged 13 hours on the phone trying to get free medicine last month – still no medicine from the Specialty Pharmacy

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Patient #2
Employer Sponsored

- Employer sponsored plan for individual and son
- Annual Salary: $47,000
- Transitioned to a HDHP in 2020
- Counted on copay assistance to help cover this new expense as it was used in 2019
- Premium: $3588/Deductible: $4500
- Copay accumulator implemented by his plan
- Virginia accumulator ban & $50 max copay do not help
- Currently choosing to pay $800+ every 90-days for insulin and forgoing his psoriatic arthritis medication. Psoriatic arthritis is returning.

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The Plans

Case Study #1: Texas MS Patient (Individual Marketplace Plan)

Only Option Covering MS Medication

- Monthly/Annual Premium: $720/$8640
- Max OOP/Deductible: $8150/*Includes Pharmacy After Deductible Met*
- Only one HSA plan available; but did not cover her doctors or medication
- Plan implemented a copay accumulator, which kept her from ever meeting deductible

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Case Study #2: Jack and his son – Virginia (Employer Sponsored Plan Tier Options)

	$900 Deductible	**$2850 Deductible**	**$4500 Deductible**
Bi-Weekly Contribution	$337.05	$186.72	$135.78
Max OOP (In-Network)	$4800	$6550	$6550
FSA Eligible (front load)	Yes	Yes (after deductible)	Yes (after deductible)
HSA Eligible	No	Yes	Yes
HSA Company Contribute	N/A	No	$150/300

Note: Max OOP will have absolutely no bearing on specialty medication and will not help those patients

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Case Study #2: Jack and his son (Cost Analysis)

	$900 Deductible	$2850 Deductible	$4500 Deductible
Annual Premium:	$8763.30	$4854.72	$3530.28
Dental/Vision:	$627.64	$627.64	$627.64
Front-Loading FSA:	$105.77/$2750	$105.77/$2750	$105.77/$2750
HSA Company Contribute:	N/A	$300 from company	$300 from company
HSA Fully Funded:	N/A	$265.38/$6900	$265.38/$6900
Maximizing Benefits:	$466.96, bi-weekly	$582.01, bi-weekly	$531.07, bi-weekly
Pre-Tax Savings:	$2750	$9650	$9650
Annual Expenses:	$12140.96	$15132.26	$13807.82

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Case Study #2: Jack and his son
The Pharmacy Cash Cow

	$900 Deductible	$2850 Deductible	$4500 Deductible
Generic:	30% ($10 min/$20 max)	30% (After deductible)	30% (After deductible)
Formulary:	30% ($62.50 min./$125 max.)		
Non-Formulary:	45% ($100 min./$200 max)		
Specialty:	30% -- NEW for 2021 Specialty Copay Card Program?		

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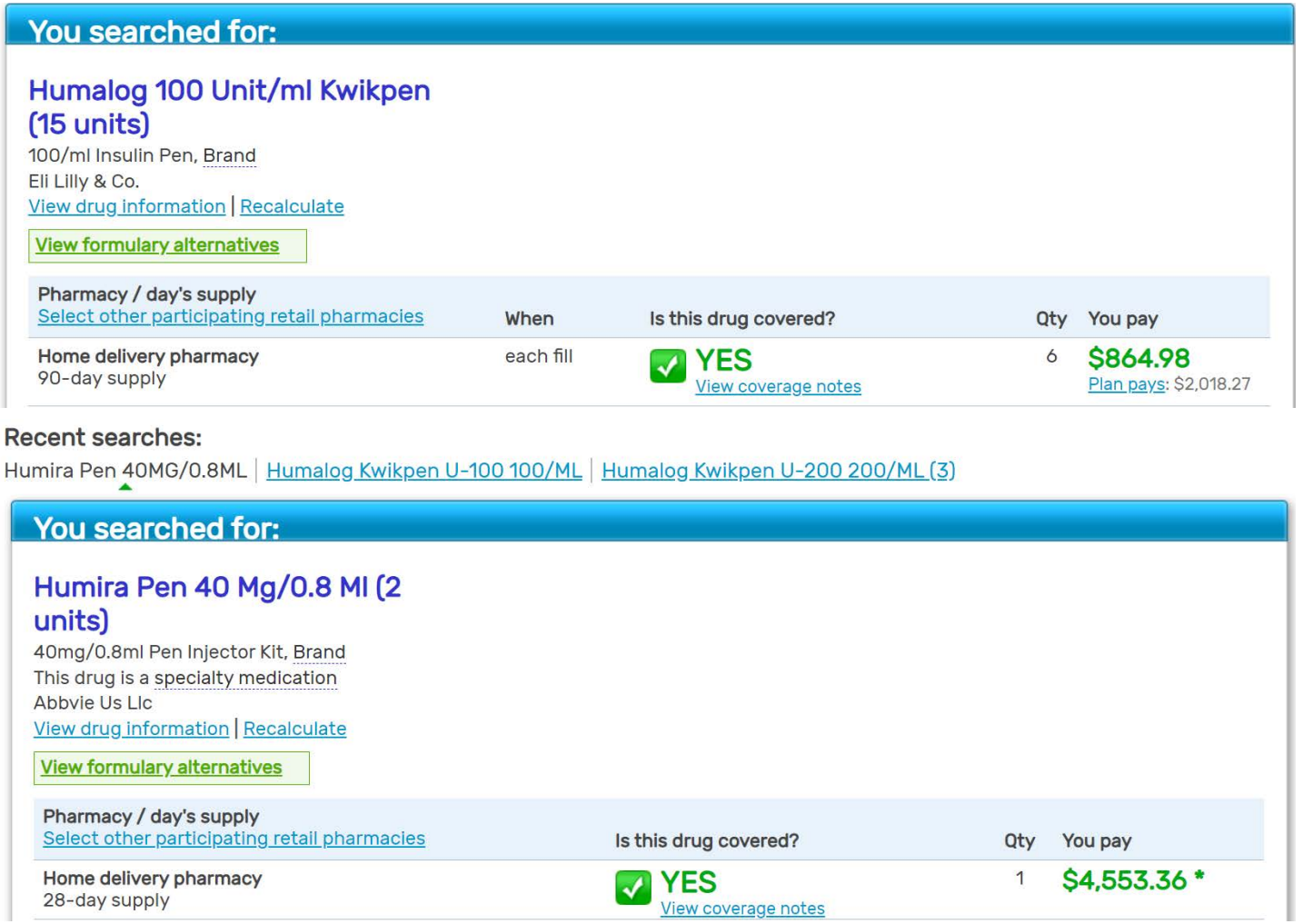
Jack's Pharmacy Login



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Policy Solutions

Solution #1: Never Overpay at the Pharmacy Counter

Patients should only pay what a pharmacist is being reimbursed for all public plans

Employers and consumers should be educated to seek the same within their plans

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Solution #2: Share the Savings

Transparency at the pharmacy counter would curb the cost shifting of pharmaceuticals to patients

Transparency in drug pricing would eliminate the need for accumulators and coupons

Pharmaceutical assistance should be reserved for the neediest among us, not for Jack to get Humalog and Humira

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Solution #3: True Max Out-of-Pocket

Max out of pocket (OOP) based on income level for all Americans on a Medicare/Medicaid plan

Max OOP should include pharmaceuticals not just healthcare

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Solution #4: Encourage Individual Small Business/ Solopreneur Marketplaces

Creates robust plan options for small business and individuals lacking options

Offers opportunity for consumer education around how best to use their healthcare dollars

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Solution #5: Create GHL – Guaranteed HSA Loans

Allows working people with chronic, pre-existing conditions to frontload an HSA to cover health expenses

Empowers patients to take charge of their health care

Having this option would help people like Jack and @TexasPatient

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THANK YOU

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