Pharmacoeconomics and Pricing: Now and after healthcare reform.

Applied Pharmacoeconomics and Outcomes Research Forum

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Objectives

- Discuss potential impacts of healthcare reform on drug pricing at UCDMC and how this might effect:
  - Revenue and costs
  - Patients

- Describe how UCDMC uses pharmacoeconomic data and how drug pricing changes might affect this in the future.
UC Davis Medical Center

Statistics*
Licensed beds 613
ER visits 55,238
Clinic/office visits 918,036
Admissions 33,295

* For year ending June 30, 2009
UCDMC Pharmaceuticals Budget

Inpatient - $20M
Outpatient “retail” pharmacy - $12M
Clinic administered drugs – $30M
340B – $24M
non-340B - $6M
Potential impacts of PPACA on drug prices

- Expanded eligibility for Medicaid
- Increased Medicaid rebates
- Revised AMP calculations
- Expanded 340B eligibility
- Exclusion of orphan drugs
- Dispute resolution process
OBRA 1990 aka Dingell Bill

Created Medicaid drug rebate program

Manufacturers passed on costs to other sectors, resulting in Veterans Healthcare Act of 1992 creating the 340B program

Representative Dingell “I’m surprised they did that (raised prices).”

Lobbyist “I’m surprised he’s surprised.”
Other impacts of PPACA

- Medicare Part D expansion
- Closing the donut hole
- Biosimilars
- Inpatient 340B prices
Impacts on UCDMC

Medicaid expansion – decreased profitability of retail pharmacy

Increased Medicaid rebate – decreased 340B price/increased inpatient price
$3-5M savings

Inpatient 340B expansion - $5M savings

Medicare Part D expansion – increased profitability of retail pharmacy
Use of pharmacoeconomics at UCDMC

Cost minimization for inpatients
Relatively unsophisticated
Not entirely siloed
Look at reimbursement and impact on profitability, especially in clinic setting
Little changes with PPACA
Questions?