Health Care Reform – The PBM and Provider Perspective

Date: September 27, 2010

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How did we get in this mess?

"It's very realistic...it comes equipped with plenty of redtape."

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Providers – Who are the Stakeholders

- **Retail Pharmacy**
  - Drug Chains
    - Traditional
    - Supermarket
    - Big Box
  - Community Pharmacy
  - Associations
- **Mail Order Providers**
- **Specialty Pharmacy**
- **Long Term Care**
- **Ancillary Providers**

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PBMs – There are differences

- Fulfillment driven model
- Engine driven model
- Provider driven model
- Rebate driven model
- Net low cost driven model

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What's keeping providers up at night?

- Continued reimbursement pressures
- Potential changes in pricing benchmarks
- MAC pricing and the generic pipeline
- AMP and the effect on Medicaid reimbursement
- Restricted or highly directed network programs

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How have rates changed?

Year	Retail Brand	Retail Generic	Dispensing Fees
1990	10%	45%	$ 3.00
1995	12%	50%	$ 2.75
2000	13%	55%	$ 2.50
2005	15%	60%	$ 2.00
2010	17%	70%	$ 1.50

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How have rates changed?

Year	Mail Brand	Mail Generic	Dispensing Fees
1990	15%	45%	$ 1.50
1995	18%	48%	$ 0.50
2000	20%	50%	$ 0.00
2005	22%	60%	$ 0.00
2010	25%+	70%	$ 0.00

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What are some potential alternative pricing models?

- AWP – Adapted
- WAC
- AMP
- ASP
- Cost Plus
- Alternative Baselines – i.e. 340B
- Consignment Inventory

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AMP and the Effect on Reimbursement – Original Legislation

- Use AMPs to set Federal Upper Limits (FULs) on
- Medicaid reimbursement for generics
  - Set a FUL if 2 or more equivalent generics available
  - FUL = 250% of lowest AMP
- Post AMPs for brands and generics on public website
- AMP Was Defined As:

  Average price paid to manufacturers by wholesalers for drugs distributed to retail pharmacy class of trade

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Pharmacy Concerns:

- **AMP Rule Includes Sales To:**
  - Physicians, physician clinics
  - Medical facilities: Surgical centers, dialysis centers, mental health facilities, ambulatory care facilities
  - Hospital pharmacies, hospital clinics
  - Home infusion, home health
  - PBMs, mail order pharmacies, specialty pharmacies
- **Result: Much Lower Reimbursement**
  - Reimbursement 36% below pharmacy costs (GAO)
  - $21+ billion cuts over 10 years (CMS)

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What did Pharmacy do?

- **NACDS And NCPA Filed Lawsuit**
  - – Argued AMP rule violates statute's definition of AMP
- **Injunction Halts AMP Reimbursement Cuts**
  - – Also halts AMP website
  - – Almost 3 years and counting
- **Saves Pharmacies $5.5 Million Each Day**
  - – More than $5.3 billion saved so far

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What is proposed for Oct 1?

- Improved Method Of Calculating FULs
  - FUL = no less than 175% of weighted average AMP
  - Should be updated monthly
  - Smoothing process
- Fewer Caps On Medicaid Reimbursement
  - Set FUL only if 3 or more equivalent generics can be purchased by RCPs on a nationwide basis
- Limited AMP Website
  - Post weighted average AMPs for generics
- New Definition Excludes Improper Sales
  - AMPs Only Include Prices Mfrs Charge:
  - “Retail Community Pharmacies” (RCPs)
  - Licensed RCPs that sell to general public at retail prices
  - Wholesalers for drugs distributed to RCPs
- Specifically Excludes From AMP:
  - Customary prompt pay discounts
  - Bona fide service fees
  - Reimbursement for returns
  - Sales and rebates to PBMs, mail order pharmacies,
  - plans, hospitals, clinics, LTC pharmacies,

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What opportunities exist?

- Increase in the number of insured lives
- Aging population
- Closing of the doughnut hole
- Specialty growth
- Generic pipeline
- 340B partnerships
- MTM opportunities
- Adjunct/alternative sales

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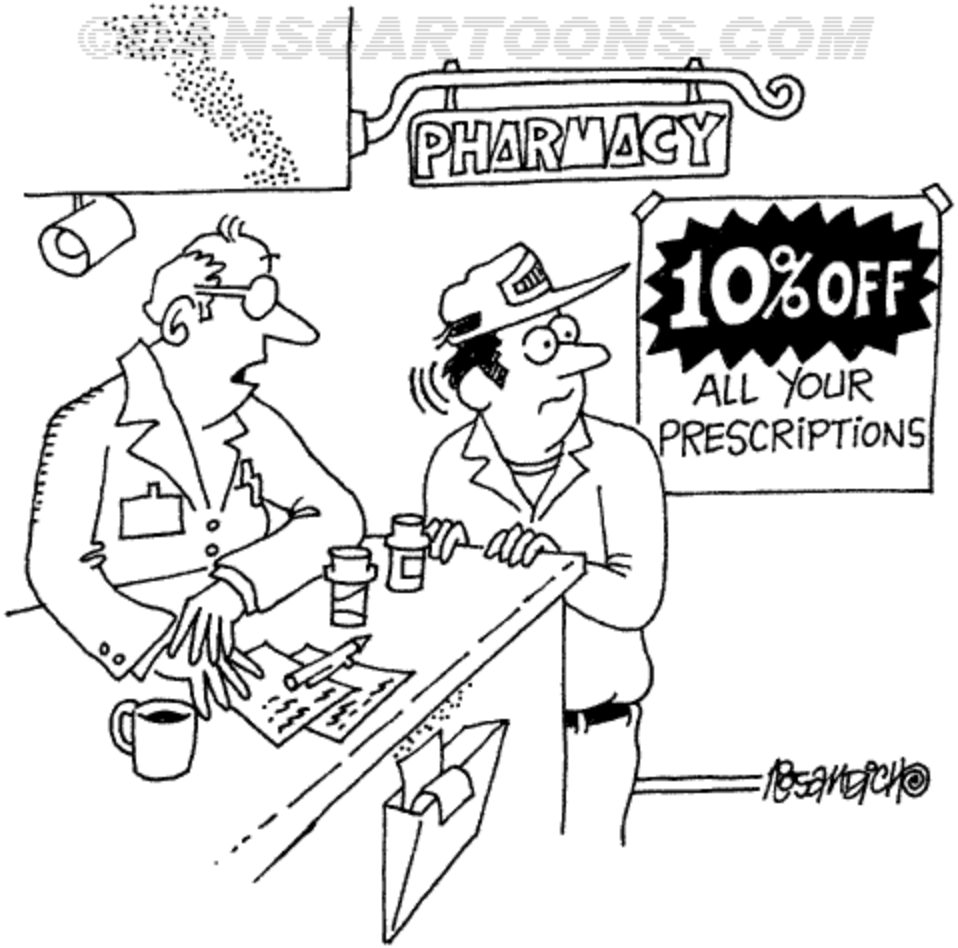
A different approach…



"We give 90 pills instead of 100."

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