Avoiding the Pitfalls of Pharmacy Pricing
Presenters

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Objectives

- Understand the complexities of pharmacy pricing
- Become aware of the rapidly changing cost trends
- Understand how to enhance current contracts to benefit PACE organizations
Drug Pricing Methodologies
Pharmacy Pricing Alphabet Soup

- **AWP** – Average Wholesale Price
- **WAC** – Wholesale Acquisition Price
- **MAC** – Maximum Allowable Cost
- **FUL** – Federal Upper Limit
- **NADAC** – National Average Drug Acquisition Cost
Average Wholesale Price (AWP)

- Widely accepted benchmark price for drug payers
  - Readily available for payers and pharmacies
  - Medi-Span® is commonly used publisher of AWP
  - Redbook® and Gold Standard® also publish
  - Pharmacy contracting typically a percentage discount of AWP

- Despite its name it is not very representative of purchase price of the medications
  - Often compared to “sticker price” on a car
  - Usually related to a mark-up on WAC
Where does AWP come from?

- Typically a number set by the manufacturer.

- Related to WAC – generally recognized multiplier for branded medications is AWP = WAC x 1.20
  - Improper inflation related to AWP lead to a 2009 lawsuit that rolled back this multiplier from 1.25

- This calculation generally does not hold true for multi-source generic medications.
Continued Use of AWP?

- Brand medications
  - Still primary source of contracting
  - Since multiplier is generally understood this is a reasonable benchmark to use
  - Consideration needs to be made on overall price and pharmacy incentives

- Generic medications
  - Although still used more payers are moving WAC or MAC contracting
  - Lack of consistency between AWP and WAC pricing leaves room for pricing manipulation.
List price from manufacturer to wholesaler or direct purchaser, not accounting for discounts
- Designed to more accurately depict the medication cost
- If AWP is the “sticker price” than WAC should be viewed as the “invoice price”
- Some medications do not have WAC pricing as they are sold directly to pharmacies
- Pharmacy contracting is typically a markup on WAC
Is WAC more accurate than AWP?

- Closer to Acquisition due to lack of artificial markup associated with AWP
  - 1.20 factor for brand name medications
  - Typically significantly more markup and variability with generic medications

- However several rebating and discounting opportunities are not factored into WAC
  - Wholesalers offer discounts off WAC to pharmacies
  - Manufacturers offer direct up front and rebating opportunities to pharmacies through wholesalers
  - Some pharmacies contract directly with manufacturers and maintain their own warehouses (primarily generics)
WAC instead of AWP?

- **Brand Medications**
  - Becoming a more widely used benchmark
  - Since WAC is typically used to calculate AWP you can back
    your way into the same contract (AWP – 13% = WAC + 4.4%)
  - Considerations need to be made to overall price and
    pharmacy incentives similar to AWP

- **Generic Medications**
  - Better contracting option than AWP as actual price is closer
    to acquisition price,
  - MAC would still be preferred as variability still exists from
    NDC to NDC of same product allowing price manipulation
Maximum Allowable Cost (MAC)

- Reimbursement limit for a multi-source product of the same strength and dosage form
  - All NDCs of the same drug are reimbursed equally
  - Usually NDCs are grouped by GPI (generic product indicator) or GSN (Generic Sequence Number)

- Limit is determined by individual payers or States (Medicaid MAC)
  - State MAC lists are typically based on acquisition cost, but should not exceed FUL (in aggregate)
  - Private MAC lists are created by PBMs/payers and are typically based on multiple pricing benchmarks including AWP, WAC, and NADAC
MAC Advantages

- Incentivizes pharmacies to order the lowest cost generics for their wholesaler

- Provides price stability to a plan/payer due to different pricing for different NDCs based on WAC and AWP

- Limits year over year inflation that can happen with AWP or WAC percentage contracts

- Prevents price manipulation that occur when pharmacies can order “High AWP” generics at similar acquisition prices
MAC Disadvantages

- No standard private sector definition
  - Created by the plan for the plan
  - No standard development basis (AWP, WAC, FUL)

- Lists are typically proprietary
  - Transparency concerns for pharmacies
  - Addressed by generic effective rates or GER (usually based on AWP)

- Update maintenance is not well defined
  - Has become less of a concern with more recent legislation addressing this issue.
Federal Upper Limit (FUL)

- List created and maintained by the federal government for use in State Medicaid programs
- Used to determine upper limit for reimbursement for generic and other multi-sourced drugs
- Although this list is created for use by State Medicaid Programs this list is available for public use
Federal Upper Limit (FUL)

To be included the medication must be:
- Multi-sourced with at least 3 “A-rated” therapeutically equivalent product as defined by the FDA’s Orange Book
- At least 3 suppliers of the medication be listed in the national compendia

Pricing Calculated:
- 175% of weighted average (based on utilization) of Average Manufacturer Price (AMP)
- If is determined that the calculated price is lower than the average retail pharmacies’ acquisition cost based on surveys (NADAC)
Created in August of 2011 to represent the true acquisition costs to retail pharmacies

Price list created by having a private firm survey a sampling of independent and chain pharmacies invoice prices

List is maintained, updated, and published on a weekly basis by CMS
Advantages of NADAC

- More representative of actual acquisition cost
- Used for brand and generic medications
- Updated regularly and established by CMS
- Can be used to prevent price games that are sometimes played with AWP and WAC
- Aligns pharmacy purchasing incentives with plan goals
Criticisms of NADAC

- Not all medications are on the NADAC list
- The sample size of the survey is small relative to the total number of pharmacies
- Since this is an average big chain pharmacies still have a volume advantage over small independent pharmacies
- If treated like a MAC list current dispensing fees would not support pharmacy labor costs
Applications to Specialty Pharmacy
Little Utilization – High Cost

- Specialty medications accounted for 28.1% of the total drug spend for Medicare recipients in 2016.
And It Is Growing

- The specialty trend is growing much quicker than the traditional drug trend

2016 Express Scripts Drug Trend Report
On Everyone’s Mind

- Managing specialty drug cost trend is very important in plan design in the industry

**FIGURE 5. Top Goal for Management of Specialty Drugs**

(n=298)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage specialty drug cost trend</td>
<td>51%</td>
</tr>
<tr>
<td>Reduce inappropriate utilization</td>
<td>13%</td>
</tr>
<tr>
<td>Improve adherence and persistency</td>
<td>11%</td>
</tr>
<tr>
<td>Reduce drug acquisition cost</td>
<td>10%</td>
</tr>
<tr>
<td>Manage site of care/place of service</td>
<td>7%</td>
</tr>
<tr>
<td>Reduce variability between pharmacy and medical benefit design</td>
<td>3%</td>
</tr>
<tr>
<td>Improve patient satisfaction</td>
<td>3%</td>
</tr>
<tr>
<td>Reduce variations in physician prescribing patterns</td>
<td>2%</td>
</tr>
</tbody>
</table>
How is Specialty Defined?

- High Cost
- Treat a Chronic, Complex Condition
- Requires Special Disease/Patient Monitoring
- Requires Special Handling/Storage
- Treat a Rare/Orphan Condition
- Requires special administration such as injection or infusion
Most specialty medications are brand and thus are contracted based on AWP.

Contract directly with specialty pharmacies:
- Specialty pharmacies can offer deeper discounts
- Can be challenging for PACE organizations due to Part D regulations
- This is the only way to manage limited distribution specialty meds
Managing Cost (Strategy 2)

- Negotiate a deeper discount with traditional pharmacy for specialty medications
  - Absolute dollar margin on specialty medications are much higher than traditional medications due to high cost of specialty
  - Specialty medications are typically easier to dispense as they come as unit of use
  - This would not be a good strategy for limited distribution as these are not available at traditional pharmacies
# Top 5 Specialty Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>AWP - 12%</th>
<th>AWP -16%</th>
<th>WAC</th>
<th>Diff from WAC (12%)</th>
<th>Diff from WAC (16%)</th>
<th>Savings to PACE plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revlimid® 25mg</td>
<td>$13,475.69</td>
<td>$12,863.16</td>
<td>$12,761.07</td>
<td>$714.62</td>
<td>$102.09</td>
<td>$612.53</td>
</tr>
<tr>
<td>Harvoni®</td>
<td>$33,264.00</td>
<td>$31,752.00</td>
<td>$31,500.00</td>
<td>$1,764.00</td>
<td>$252.00</td>
<td>$1,512.00</td>
</tr>
<tr>
<td>Enbrel® 50mg Sureclick</td>
<td>$4,690.75</td>
<td>$4,477.54</td>
<td>$4,442.00</td>
<td>$248.75</td>
<td>$35.54</td>
<td>$213.22</td>
</tr>
<tr>
<td>Humira® 40mg Pen</td>
<td>$4,689.94</td>
<td>$4,476.76</td>
<td>$4,441.23</td>
<td>$248.71</td>
<td>$35.53</td>
<td>$213.18</td>
</tr>
<tr>
<td>Copaxone® 40mg</td>
<td>$6,158.59</td>
<td>$5,878.66</td>
<td>$5,832.00</td>
<td>$326.59</td>
<td>$46.66</td>
<td>$279.94</td>
</tr>
</tbody>
</table>

*Price is based on a typical one month supply*
# Top 5 Traditional Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>AWP - 12%</th>
<th>WAC</th>
<th>Diff From WAC (12%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lantus® Solostar (1box)</td>
<td>$393.63</td>
<td>$372.76</td>
<td>$20.87</td>
</tr>
<tr>
<td>Spiriva® Handihaler</td>
<td>$388.82</td>
<td>$368.20</td>
<td>$20.62</td>
</tr>
<tr>
<td>Advair® Diskus 250/50</td>
<td>$390.44</td>
<td>$361.40</td>
<td>$29.04</td>
</tr>
<tr>
<td>Januvia® 100mg</td>
<td>$420.08</td>
<td>$397.80</td>
<td>$22.28</td>
</tr>
<tr>
<td>Xarelto® 10mg</td>
<td>$409.75</td>
<td>$388.02</td>
<td>$21.73</td>
</tr>
</tbody>
</table>

*Price based on typical 1 month supply unless otherwise specified*
Even with a 4% larger discount specialty medications still generate similar and reasonable dollar margins for pharmacies

<table>
<thead>
<tr>
<th>Diff from WAC (12%) Top 5 Specialty</th>
<th>Diff from WAC (16%) Top 5 Specialty</th>
<th>Diff Form WAC (12%) Top 5 Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>$714.62</td>
<td>$102.09</td>
<td>$20.87</td>
</tr>
<tr>
<td>$1,764.00</td>
<td>$252.00</td>
<td>$20.62</td>
</tr>
<tr>
<td>$248.75</td>
<td>$35.54</td>
<td>$29.04</td>
</tr>
<tr>
<td>$248.71</td>
<td>$35.53</td>
<td>$22.28</td>
</tr>
<tr>
<td>$326.59</td>
<td>$46.66</td>
<td>$21.73</td>
</tr>
</tbody>
</table>
Considerations for Strategy 2

- Who defines and maintains the specialty list?
  - PACE organization
  - Pharmacy
  - Pharmacy benefits manager

- How is the contract administered?
  - Most drugs for the purposes of contracting are identified by brand vs. generic codes or multi-source codes
  - Specialty list would typically have to be defined by generic product indicator (GPI), generic sequence number (GSN), or national drug code (NDC)
The Generic AWP Trap
AWP – “Ain’t What’s Paid”

- AWP discounts are raising over time

- Unlike branded drugs – there is NO relationship between the pharmacy’s cost for a multi sourced generic drug and AWP

- The AWP on the same generic drug varies by manufacturer

- A change from AWP–70% to AWP–75% is a 16.7% change in cost.
AWP rose by 10% and ironically – the discount rose by 10%.

If your plan has a locked in discount – you are eating the 10% AWP increase.

MeridianRx retail claims data

<table>
<thead>
<tr>
<th>Year</th>
<th>Average AWP Per Script</th>
<th>Average Discount</th>
<th>Average Paid Ingredient Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$78.55</td>
<td>80.26%</td>
<td>$15.51</td>
</tr>
<tr>
<td>2016</td>
<td>$80.25</td>
<td>80.92%</td>
<td>$15.31</td>
</tr>
<tr>
<td>2017</td>
<td>$86.46</td>
<td>82.24%</td>
<td>$15.36</td>
</tr>
</tbody>
</table>
Since AWPs are set by manufacturers each NDC may have a different AWP
  ◦ There are multiple manufacturers for most generic medications and AWPs can vary widely
  ◦ These different NDCs commonly cost the pharmacies very similar prices

Misaligns incentives of providers and payers
  ◦ Pharmacies can profit more using the higher AWP versions of generics
  ◦ Some manufacturers will set AWPs high to incentivize the purchase of their product
<table>
<thead>
<tr>
<th>DRUG</th>
<th>LOW AWP</th>
<th>HIGH AWP</th>
<th>AVERAGE AWP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omeprazole Cap 20mg</td>
<td>0.74500</td>
<td>4.44867</td>
<td>3.69309</td>
</tr>
<tr>
<td>VITAMIN D CAP 50000UNT</td>
<td>1.45640</td>
<td>1.97190</td>
<td>1.85833</td>
</tr>
<tr>
<td>FUROSEMIDE TAB 20MG</td>
<td>0.12278</td>
<td>0.17160</td>
<td>0.14004</td>
</tr>
<tr>
<td>FUROSEMIDE TAB 40MG</td>
<td>0.14030</td>
<td>0.20300</td>
<td>0.15979</td>
</tr>
<tr>
<td>AMLODIPINE TAB 10MG</td>
<td>2.37322</td>
<td>2.67333</td>
<td>2.37968</td>
</tr>
<tr>
<td>SIMVASTATIN TAB 20MG</td>
<td>3.69456</td>
<td>4.92098</td>
<td>4.91690</td>
</tr>
<tr>
<td>AMLODIPINE TAB 5MG</td>
<td>1.72222</td>
<td>1.90234</td>
<td>1.73392</td>
</tr>
<tr>
<td>CLOPIDOGREL TAB 75MG</td>
<td>4.36180</td>
<td>6.96114</td>
<td>6.92495</td>
</tr>
<tr>
<td>METOPROL TAR TAB 25MG</td>
<td>0.10780</td>
<td>0.27000</td>
<td>0.24654</td>
</tr>
<tr>
<td>GABAPENTIN CAP 300MG</td>
<td>1.32960</td>
<td>1.34180</td>
<td>1.33203</td>
</tr>
</tbody>
</table>

Pharmastar PACE Claims Data
## 2017 Top 10 PACE Generics

<table>
<thead>
<tr>
<th>DRUG</th>
<th>LOW AWP</th>
<th>HIGH AWP</th>
<th>AVERAGE AWP</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMEPRAZOLE DR 20 MG CAPSULE</td>
<td>1.114</td>
<td>4.44864</td>
<td>4.16413</td>
</tr>
<tr>
<td>VIT D2 1.25 MG (50,000 UNIT)</td>
<td>0.7194</td>
<td>2.03</td>
<td>1.84948</td>
</tr>
<tr>
<td>FUROSEMIDE 20 MG TABLET</td>
<td>0.1167</td>
<td>0.429</td>
<td>0.18825</td>
</tr>
<tr>
<td>AMLODIPINE BESYLATE 10 MG TAB</td>
<td>0.1153</td>
<td>2.67333</td>
<td>2.37952</td>
</tr>
<tr>
<td>FUROSEMIDE 40 MG TABLET</td>
<td>0.1333</td>
<td>0.5868</td>
<td>0.2179</td>
</tr>
<tr>
<td>AMLODIPINE BESYLATE 5 MG TAB</td>
<td>1.6429</td>
<td>1.94778</td>
<td>1.7372</td>
</tr>
<tr>
<td>ATORVASTATIN 40 MG TABLET</td>
<td>0.8573</td>
<td>10.69833</td>
<td>5.7776</td>
</tr>
<tr>
<td>GABAPENTIN 300 MG CAPSULE</td>
<td>0.18</td>
<td>1.3418</td>
<td>1.32004</td>
</tr>
<tr>
<td>PANTOPRAZOLE SOD DR 40 MG TAB</td>
<td>0.434</td>
<td>5.26714</td>
<td>4.67895</td>
</tr>
<tr>
<td>CLOPIDOGREL 75 MG TABLET</td>
<td>0.4123</td>
<td>6.96114</td>
<td>6.94138</td>
</tr>
</tbody>
</table>

Pharmastar PACE Claims Data
Look at What’s Paid

- Looking at the discount is misleading

- Small changes in discounts result in big changes in cost
  - Going from paying .25 on the dollar to .24 is a 4% reduction in cost
MAC vs. Discount off AWP

- Stated discount favors the pharmacy
  - The discount can be gamed
  - Doesn’t align price incentives
  - Discounts are rising

- MAC lists can be scary to pharmacies
  - Pharmacies have less control
  - MAC lists maintained by PBM and confidential
  - Some PBMs not responsive to market changes
What Can Be Done?

- If you don’t use a PBM there are still things that can be done
  - Don’t lock in rates over years
  - Use a MAC list established by the your state’s Medicaid program if available
  - Set a MAC for your most widely used generics based on NADAC prices
  - Consider paying a higher dispensing fee to move to a cost–based model for ingredient cost
Wrap Up And
Future Directions
How to Contract

- AWP and WAC are reasonable benchmarks for brand name medications
  - If using AWP a discount off AWP should be used, for PACE organizations a reasonable discount would be in the low teens (−12% to −13%)
  - If using WAC typically would be a few percentage point over WAC, for PACE organization a reasonable mark-up would be (+3% or 4%)
  - The rate that is reasonable is subject to change
How to Contract

- Considerations of absolute price should be made for high cost specialty medications
  - Most specialty meds are discounts off AWP as they are brand
  - Even a few percentage points difference can save the plan a considerable amount and still pay pharmacies a fair amount.
  - AWP – 15% or 16% would be a reasonable amount for a PACE organization to pay at a traditional pharmacy
MAC lists are preferred for generic medications

- Prevents some of the price manipulation that can occur with AWP and WAC
- PBM typically would maintain these lists
- If no PBM involved you could specify a specific state MAC list to be used by the pharmacy
- If MAC is not an option than WAC would typically be more reasonable than AWP, discounting a few points (−3 or −4%) off WAC for generics
Is NADAC the Answer?

- Should represent something closer to a true acquisition cost
  - Critics argue that only a small sample of pharmacies respond to the survey
  - Since it is an average, higher volume pharmacies still have an advantage

- Would reduce percentage effect that leads to huge absolute dollar mark-ups on specialty medications
Is NADAC the Answer?

- Could be viewed as publically available MAC list created by CMS
  - Would likely require significantly higher dispensing fees (cost+ model)
  - Can be used for both brands and generic medications
  - This is being considered to be used by Medicaid for pricing
Key Takeaway

- Review Pharmacy Contracting
  - Avoiding locking in long-term contract rates
  - When using percentage-based contracting take absolute dollar amounts in consideration
  - Avoid AWP contracting for generic medications
  - Remain aware of where the industry is moving
Questions?
References


Elsevier/Gold Standard. *Drug Price Types and Options for a Future Standard*,

Centers for Medicare and Medicaid Services. *Affordable Care Act Federal Upper Limit Methodology and Data Elements Guide*, 24 Feb 2016,
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Centers for Medicare and Medicaid Services. *Methodology for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs*, Nov 2013,


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