MILLIMAN WHITE PAPER

Reimagining pharmacy channel reimbursement within the supply chain

Guiding principles for equitable reimbursement models

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Much has been written about how the pharmacy supply chain is constrained by complex pharmacy reimbursement models, leading to challenges for all stakeholders. Prevailing reimbursement models have directly impacted pharmacy channel stakeholders, leading to reduced pharmacy provider profitability, lack of transparency, variable consumer costs, the rise of new channel partners, and consequential cross subsidization among product types.

It is commonly understood amongst pharmacy supply chain participants that over the past 20 years, payments to pharmacies for brand drugs (lower reimbursement) have often been subsidized with value paid for generic drugs (higher reimbursement). In preceding years as numerous products moved from brand to generic drug status, this system has been relatively stable and accepted by all stakeholders.

Executive summary

Recent events have started to bring more scrutiny to prescription drug pricing. Most recently, market events have disrupted the financial model that has been upheld since this discounted reimbursement model was deployed in the early 1980's. These events include:

- **Channel stakeholders who capitalize on the cross-subsidized system:** For example, generic drugs paid in excess of acquisition costs were prime for disruption as payers and patients were paying significantly higher cost on these products.
  - Two examples of stakeholders who are capitalizing on the cross-subsidized system are discount card vendors and independent mail order pharmacy providers exclusively targeting these types of generic drugs. (e.g., Mark Cuban Cost Plus and GoodRx).
- **Blockbuster drugs:** Cross-subsidized reimbursement models require a predictable balance between brand and generic utilization to maintain economic equilibrium within the pharmacy supply chain. The rapid growth of brand drug utilization, as seen with GLP-1 products, has resulted in increased costs to payers as well as unexpected erosion in pharmacy and wholesaler profitability.
- **Pressures on pharmacy profitability:** Changing brand and generic product mix has exposed weaknesses in historical pricing models resulting in lower profitability. This has caused chain drugstore and independent pharmacy closure rates to accelerate, while federal and state legislation to address inadequate reimbursement compared to drug acquisition costs has increased.

Stakeholders are beginning to consider a move toward other reimbursement models for prescription drugs. Drugs have historically been reimbursed as a basket of goods in aggregate with component-level guarantees. For example, A PBM may provide a pharmacy an AWP discount guarantee for 30-day supply generic claims and a separate AWP discount guarantee for 90-day supply brand claims. This market basket approach sets reimbursement for a defined basket of products, but does not contemplate profitability of individual products. This leads to inconsistencies between the costs incurred by the pharmacy and the reimbursements received for specific drugs, particularly for generics which experience a high degree of variability in purchasing. Newer cost-plus prescription drug reimbursement models attempt to closely align reimbursement with purchasing, which has the potential to create more stability and sustainability for the prescription drug financing system. For example, one of the nation's largest pharmacy chains introduced a cost-plus reimbursement structure. The chain claims this approach removes the cross-subsidization of brands with generics and will better align reimbursement with drug cost and pharmacy service value.[1]

As the pharmacy distribution market considers emerging reimbursement models, stakeholders are seeking solutions that support several key principles:

- **Cost-plus inspires stakeholders' confidence that reimbursement will be stable and cost-correlated**
- **Consistent financial performance over time**
- **Model conversion that is fiscally neutral for stakeholders**

To have the highest likelihood of success for rational and fair reimbursement, many believe that pharmacy supply chain stakeholders must consider the following:

- **A cost-plus reimbursement should originate with pharmacy providers.** Any cost-plus model brought forward by other stakeholders (e.g., pharmacy benefit managers (PBMs), payers, wholesalers) will have far more scrutiny and less adaptability. Only the pharmacy providers know their true acquisition costs and expenses incurred related to dispensing medications.
- **A successful pricing model will require broad adoption by pharmacy providers.** The model will be significantly unstable if multiple pharmacy providers bring forward disparate and competing cost-plus models. There must be a process and framework in place to create consistent comparison of pharmacy cost-plus models.

Accomplishing this goal will require a thoughtful framework and consideration of stakeholder points of view. No doubt, there are nuances and considerations to work through and changing a well-accepted and historically proven pricing model will be difficult for all parties involved. The remainder of this whitepaper describes a framework for evaluating widespread adoption of a cost-plus pricing methodology for the pharmacy distribution model.

Background

HISTORICAL PERSPECTIVE – CHALLENGES WITH COMMON REIMBURSEMENT PRICE BENCHMARKS

Historical pharmacy reimbursement methods use average wholesale price (AWP) discounts and maximum allowable cost (MAC) pricing to determine point-of-sale cost and final claim settlement, in tandem with a market basket based reimbursement structure. As discussed, the market basket-based reimbursement structure often sets different AWP discount guarantees for various claim categories, such as 30-day supply generic claims or 90-day supply brand claims. This approach typically reconciles each claim within the defined market basket to the same AWP discount, regardless of the mix of drugs in that basket. There are limitations with these reimbursement models. For example, pharmacies often carry the financial risk of changing drug mix from discount models that are not consistent from drug to drug. Though AWP is commonly used for structuring pricing terms between trading partners, such as between PBMs and pharmacy, and between PBMs and payers, it is not closely correlated with pharmacy acquisition costs, particularly for generic drugs. This can result in material disconnects between pharmacy reimbursement and product purchase prices, which government programs (e.g., Medicare, Medicaid) have attempted to address through various means.[2] Furthermore, consumers often find unexplainable prescription price differences between pharmacy cash prices, insured benefit costs, and marketed discount card programs.

The persistence of AWP discount models stems from its deeply entrenched position within pharmacy benefit contracts. AWP discounts are consistently found in agreements between PBMs and payers, as well as in reimbursement contracts between PBMs/payers and pharmacy providers. The AWP model also allows for a relatively simple comparison of financial performance between different pricing arrangements. However, calculations of AWP discounts do not represent actual dollars spent by the payers nor payments received by pharmacy providers. Calculation of AWP discounts is influenced by costs and mix of products, mix of pharmacy providers with varying contractual arrangements, and benefit plan coverage decisions applicable to any specific AWP discount segment.

MAC pricing is a pricing methodology used by PBMs and payers, often in tandem with AWP, to set the maximum reimbursement limit at the product level for most generic drugs and some brand-name drugs with generic equivalents. MAC pricing is designed to manage overall reimbursement to AWP discount market basket guarantees and attempt to ensure reimbursement reflects variable acquisition costs and uncorrelated AWP costs for generics. The intention of MAC pricing management is to encourage the use of cost-effective generics while reimbursing

pharmacy providers at a price that is more closely aligned to acquisition cost of each drug. However, each PBM can set its own MAC list and associated unit price schedules by using proprietary algorithms and various market data sources. Lack of standardization and transparency in MAC pricing across PBMs leads to disputes from pharmacy providers regarding fair and equitable reimbursement. In addition, some generic drugs can be priced well above their market rates as PBMs often manage these prices to meet the contractual guarantees with payers and pharmacy providers. In response to these challenges, a substantial number of states have passed legislation[3] regarding the administration and transparency of MAC pricing.

As a result of prevailing reimbursement models, pharmacy channel stakeholders, including pharmacy providers, payers, and patients, often find the financial terms of agreements to be non-transparent and, difficult to tie to actual financial performance (e.g., pharmacy provider profitability, plan expenditure on specific drug products). This has led to the question of economic sustainability for pharmacy providers and the provision of traditional pharmacy services.

EXISTING COST-PLUS SOLUTIONS

Various cost-plus reimbursement models have emerged in recent years, which generally moderate drug price variability at the point of sale by calculating prescription costs to payers and consumers based on the prices paid by the pharmacy to acquire and dispense the product.[4,5,6]

State-Medicaid fee-for-service programs use a reimbursement benchmark and methodology based on "cost-plus" concepts for products available at retail pharmacy locations. Typically, reimbursement is determined as the lesser of several benchmarks representing pharmacy costs, such as the national average drug acquisition cost (NADAC), which is a drug-specific pricing benchmark published by the Centers for Medicare and Medicaid Services (CMS).[7] This benchmark is used to calculate pharmacy reimbursement, along with a set professional dispensing fee that attempts to align with the actual costs of providing pharmacy services.[8]

In 2023, one of the largest pharmacy chains in the United States, introduced a proprietary form of cost-plus reimbursement where retail payment for medications aligns with the chain’s product acquisition cost and a dispensing fee that reflects the value of pharmacy services[9]. The chain says the model aims to align reimbursement of pharmacy claims from payers to actual costs of drugs and pharmacy services provided by the chain.

Also in 2023, a major PBM introduced a pricing model they say aims to provide payers with a less complicated, cost-based pricing structure, by leveraging existing market price benchmarks such as predictive acquisition cost (PAC), wholesale acquisition cost (WAC), and NADAC. Additionally, this method will include a flat pharmacy fee and a percentage markup on drug spend.[10]

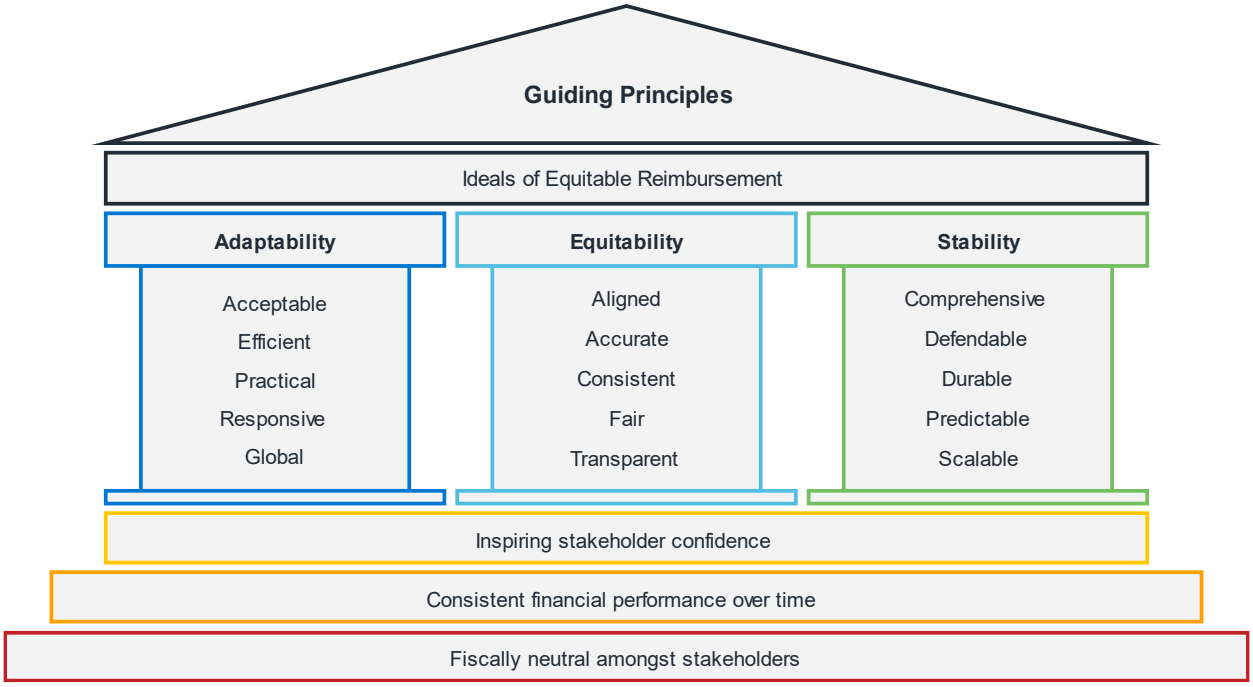
Other stakeholders also offer acquisition cost plus based pricing arrangements in the market. A PBM-owned specialty pharmacy has offered acquisition cost plus based pricing since opening over a decade ago.[11] A new entrant started by billionaire Mark Cuban launched a direct to consumer, acquisition cost plus based pharmacy in 2022.[12] While generally available, acquisition cost-based pricing has historically experienced much lower adoption than traditional AWP based models.

These models seek to resolve the inherent issues present in current pricing frameworks described elsewhere in this whitepaper. However, each model has its own shortcomings when evaluated from the perspective of key stakeholders.

Guiding principles for market-wide adoption

As the pharmacy distribution market considers emerging reimbursement models, stakeholders are seeking solutions that support several guiding principles, which are illustrated in Figure 1.

FIGURE 1: GUIDING PRINCIPLES FOR REIMBURSEMENT MODELS



Successful use of this framework, when considering new reimbursement models, relies on stakeholder adoption of the base-layer principles and pillars including:

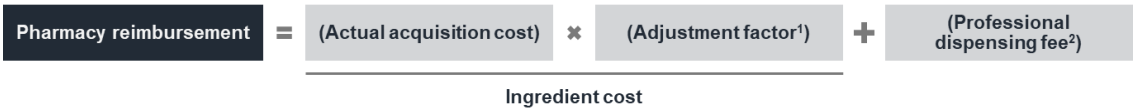
- **Methodology that inspires stakeholder confidence:** The pricing methodology must ensure equitable reimbursement aligned with supply-chain contracts. It should produce fair, accurate, and transparent reimbursements that stakeholders can trust.
- **Consistent financial performance over time:** The pricing model must offer stable and predictable financial performance over time for both payers and pharmacy providers. It should consistently apply to all drugs and be easily scalable, with clear justification for the pricing logic.
- **Model conversion that is fiscally neutral for stakeholders:** For the model to be widely accepted by payers, it must remain fiscally neutral to existing supply-chain contracts. It should be adaptable across multiple stakeholders and acceptable to various parties. The model must be flexible, practical, and sustainable for the long term.

METHODOLOGY INSPIRES STAKEHOLDERS' CONFIDENCE

The existing pharmacy reimbursement landscape is complex and unclear, involving intricate definitions, use of third-party benchmarks, and multi-step calculations but is familiar to all parties in this format today. Few current benchmarks, such as AWP, WAC, MAC, predictive acquisition cost (PAC), or NADAC, fully meet the guiding principles within the pillars of adaptability, equitability, and stability.

Straightforward pharmacy reimbursement methodology

The framework should create consistency in the reimbursement methodology to pharmacy providers. A straightforward methodology may not require complex definitions, carve-out products, or inclusions and exclusions from effective rate calculations. An example is illustrated below:



1. **Adjustment factor** is a negotiable, but highly prescriptive, percentage adjustment to the actual acquisition cost to adapt the calculated ingredient cost to pharmacy-specific purchasing economics. This approach conceals actual pharmacy costs, thereby protecting supplier confidentiality agreements. This rules-based markup may include inventory management costs, variable dispensing costs, variable margins, and purchasing adjustments. This may also include additional service model costs associated with unique pharmacy types such as long-term care (LTC) pharmacy providers or certain rural pharmacy providers essential for access to pharmacy services.
2. **Professional dispensing fee** is a negotiable flat fee applicable to the dispensing of pharmaceuticals to consumers and should be sufficient to cover pharmacy-specific revenue requirements in excess of the cost of goods sold (COGS), as defined by and represented in the actual acquisition cost file. Professional dispensing fees may vary by brand and generic drug type, dispensing days supply, payer line of business, network type (e.g., broad or narrow), and pharmacy type.

CONSISTENT FINANCIAL PERFORMANCE OVER TIME

Current reimbursement models manage the inflating AWP benchmark by increasing discount rates (reducing reimbursement) year-over-year, creating a perception of value. Stakeholders may also be concerned that removing this dynamic will reduce or eliminate pharmacy providers' continual pursuit of maximizing purchasing efficiencies. Therefore, the framework should:

- Create market incentives for continued purchasing efficiency due to cost-plus removing these incentives.
  - Pharmacy providers must have continual pursuit of optimizing generic dispensing which is ensuring that the lowest cost equivalent drug is always dispensed.
- Provide evidence that purchasing efficiencies are continually passed on to payers.
- Produce consistent financial performance over time so payers can accurately model their future year costs.

Reliable financial projections

- A robust pricing paradigm ensures that all stakeholders can use standardized price files and benchmarks to project financial performance accurately over time. This involves calculating costs for payers, revenue and profit margins for pharmacy providers, and total prices paid by consumers. For any reimbursement methodology to be accepted, it must ensure that significant market events or changes in drug utilization do not affect the relative economic performance among stakeholders.
- Payers and PBMs require clear, consistent pricing structures to assess costs and forecast dispensed pharmacy cost effectively. PBMs also seek operational stability as the market transitions from other models. Regular updates to drug price lists, including changes in pricing and drug availability, are crucial.
  Additionally, a transparent pricing methodology and compliance processes are essential for accurate claims processing and long-term success.

MODEL CONVERSION IS FISCALLY NEUTRAL FOR PARTIES

The overall financial performance of a cost-plus arrangement must match that of existing models. Payers expect that pharmacy benefit costs will not increase unexpectedly due to a change in methodology. Similarly, pharmacy providers cannot offer additional price concessions due to a methodology change. If revenue neutrality is not achieved, the market will resist a new methodology. A transition period may be required during which traditional pricing models and cost plus models are both available to allow for moderation adoption over time, with payers and providers gaining experience and comfort with newer models.

Integration with payer pricing arrangements

Most PBM contracts with payers are three-year contracts with guaranteed minimum discount rates relative to AWP for various drug or service type classifications, such as brand or generic, specialty pharmacy, or days supply. Payers expect year over year improved AWP discount rate guarantees to maintain economic equivalence due to AWP inflation. As a result, PBMs continually negotiate higher AWP discount rates with pharmacy providers year over year as well, resulting in equivalent or lower reimbursement on the same basket of goods. As the market shifts to acquisition cost-based pricing, PBMs, payers, and consultants must develop reliable indices for projecting acquisition cost inflation or deflation to fairly compare these arrangements with established AWP-based methods.

Pharmacy providers typically have year over year drug-purchasing efficiencies they provide back to PBMs and payers through these ever-escalating contracted discounts off of AWP. This is the manner they pass along drug-purchasing cost efficiencies to payers year over year, but pharmacy providers also have escalating expenses associated with dispensing drugs. In a traditional model, payers no longer have an easily measurable metric to ensure their costs are remaining flat or improving and have no exposure to escalating expenses related to a pharmacy's dispensing functions. In a new model, pharmacy providers will need to instill confidence that all drug-purchasing efficiencies are passed-through at 100% rate by receiving exclusively the drug acquisition cost for reimbursement. In addition, the pharmacies will now derive the vast majority, if not all, of their margins and pay for their expenses with a dispense fee, which will be expected to increase each year with inflation.

These dynamics will initially be foreign and difficult for payers and consultants to evaluate; therefore, a framework to evaluate these items must be accounted for to ensure adoptability by PBMs and payers.

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NEW MARKET PRICE BENCHMARK

Prerequisites for a new market price benchmark

An improved price benchmark that addresses limitations in existing approaches, is a prerequisite to market-wide adoption of an uncomplicated cost-plus methodology. Below are the key requirements for an adaptable, equitable, and stable price benchmark.

1. **Standardized transparency:** Pharmacy contributors adhere to a clearly formulated "price" definition when determining their price benchmark to ensure market payers can trust that the reimbursement basis is not susceptible to manipulation. The method lays out a clear set of rules to calculate drug ingredient costs. For example, "price" should mean the pharmacy's purchase price for all products, effective as of a consistent point in time, net of all chargebacks, purchase allowances, free goods, and distribution or other fees, payments, or rebates paid by a pharmaceutical manufacturer or supplier that can be passed through to the pharmacy's bottom line. This may also include some ancillary costs that pharmacies commonly include in their internal accounting of drug costs to ensure most pharmacies can comply. The set of rules also incorporates approaches to continually improve purchasing to drive additional value to payers and patients. Adherence to this definition is particularly important if multiple pharmacies are to contribute to a new weighted market price benchmark.

3. **Complete:** Full pharmacy product portfolios must be included in the creation of unit cost benchmarks for all products within the pharmacy market to avoid the need for complex methodologies and additional benchmarks to address reimbursement gaps.
4. **Correlated:** Price benchmarks based on actual net product acquisition cost should ideally reflect pharmacy-level acquisition costs at the lowest enumerated price points, and be highly correlated with true pharmacy cost if they reflect a weighting of multiple pharmacy cost files. This requires that benchmarks be frequently refreshed with up-to-date pricing information. Recency of pharmaceutical acquisition costs is paramount to correlate benchmark prices to the market.
5. **Confidential:** Maintaining product-level economic confidentiality is essential to protect free-market competition among stakeholders. Use of an independent third party to validate cost files between channel partners will enhance fidelity of the files and increase acceptability by trading partners.

ADDITIONAL CONSIDERATIONS

Regulatory scrutiny

A well-established benchmark can minimize pharmacy and payer risks, and reduce operational costs associated with regulatory compliance stemming from previous reimbursement models. Due to the variability in reimbursements from AWP and MAC, many states have enacted laws[13] to regulate pharmacy reimbursement, including mandates to cover actual drug acquisition costs and procedures for challenging MAC reimbursement. Several states require commercial and non-regulated payers to reimburse pharmacy providers at least at the NADAC price or no less than affiliated providers. For example, West Virginia mandates minimum reimbursement for all payers, including commercial payers, at an amount less than NADAC plus a professional fee of $10.49.[14] A cost-plus reimbursement model can help meet these regulations, and possibly limit the need for future regulations, thereby lowering administrative costs related to managing disputes and regulatory oversight.

Pharmacy-specific proprietary acquisition cost file

Several pharmacy groups have created acquisition cost arrangements with PBMs and payers based on the respective pharmacy's proprietary acquisition cost files. Direct to employer (DTE) arrangements between pharmacies and employers gained traction in the early 2000s as an example of how employers could gain transparency, and pharmacies could leverage actual drug purchasing costs to receive cost-correlated reimbursement.[15]

This reimbursement model, while offering some benefits, has not gained widespread adoption. Traditional reimbursement models benefit from economies of scale in leveraging a large national PBM's full size to negotiate network contracts. Additionally, the lack of industry standardization of acquisition cost calculation and implementation can make operationalizing direct contracts based on acquisition cost administratively burdensome.

Conclusion

The pharmacy reimbursement landscape is at a pivotal juncture, with traditional models being challenged to achieve fair and equitable compensation for pharmacy providers while also presenting price transparency gaps for PBMs, payers, and consumers. The emergence of cost-plus reimbursement models presents a promising alternative, which proponents say attempts to align reimbursement more closely with actual acquisition costs across all stakeholders. However, the transition to these models is fraught with challenges, including the need for industry consensus on benchmarks, transparency in pricing methodology, confidentiality of pricing, and confidence in economic neutrality.

Payers and PBMs require clear, consistent pricing structures to assess costs and forecast dispensed pharmacy cost effectively. PBMs also seek operational stability as the market transitions from other models. Regular updates to drug price lists, including changes in pricing and drug availability, are crucial. Additionally, a transparent pricing methodology and compliance processes are essential for accurate claims processing and long-term success.

For cost-plus models to gain widespread acceptance, they must be straightforward, equitable, and stable, providing clear benefits to all stakeholders involved. By addressing these challenges and adhering to the guiding principles, the pharmacy industry can move towards a more durable and transparent reimbursement system that enhances value for payers, pharmacy providers, and consumers alike. The authors are releasing this white paper as a pre-requisite to a broader study in progress to be published soon.

CAVEATS AND LIMITATIONS

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