Pharmacy Benefit Manager Drug Pricing in Massachusetts

Testimony to the House Committee on Post Audit and Regulatory Oversight

MASSACHUSETTS HEALTH POLICY COMMISSION

July 11, 2019

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth

Chapter 224 of the Acts of 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all people in the Commonwealth.

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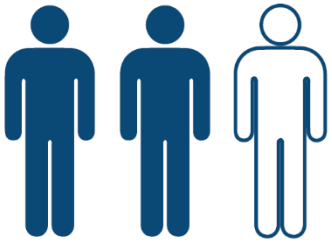
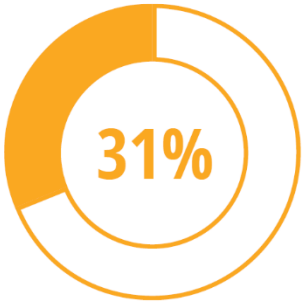
The growth in prescription drug spending continues to outpace the benchmark, contributing to significant affordability challenges for Massachusetts residents

- Total prescription drug spending at pharmacies grew **4.1% in Massachusetts in 2017**, net of manufacturer rebates and discounts.
- MassHealth prescription drug spending **nearly doubled in five years**, from $1.1 billion in 2012 to $1.9 billion in 2017, growing twice as fast as other spending.

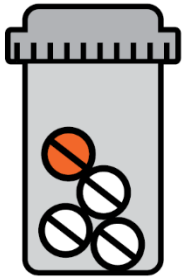
76%
view the cost of prescription drugs as **unreasonable**



2 in 3
view prescription drug costs as a **major problem**, second only to the cost of health insurance



reported it **somewhat** or **very difficult** to afford their prescription drugs



1 in 4
skip doses or cut pills in half due to **affordability challenges**

Sources: Source: Commonwealth of Massachusetts. The Governor's Budget Recommendation. Fiscal Year 2020 House 1. 2019 Jan 23. Available at: https://budget.digital.mass.gov/bb/h1/fy20h1/dnld_20/fy2020h1.pdf
WBUR Massachusetts Poll Survey of 660 Residents Age 18+ Field Dates: May 9-13, 2019; conducted by The MassINC Polling Group. https://d279m997dpfwgl.cloudfront.net/wp/2019/06/Topline-2019-05-WBUR-Statewide.pdf

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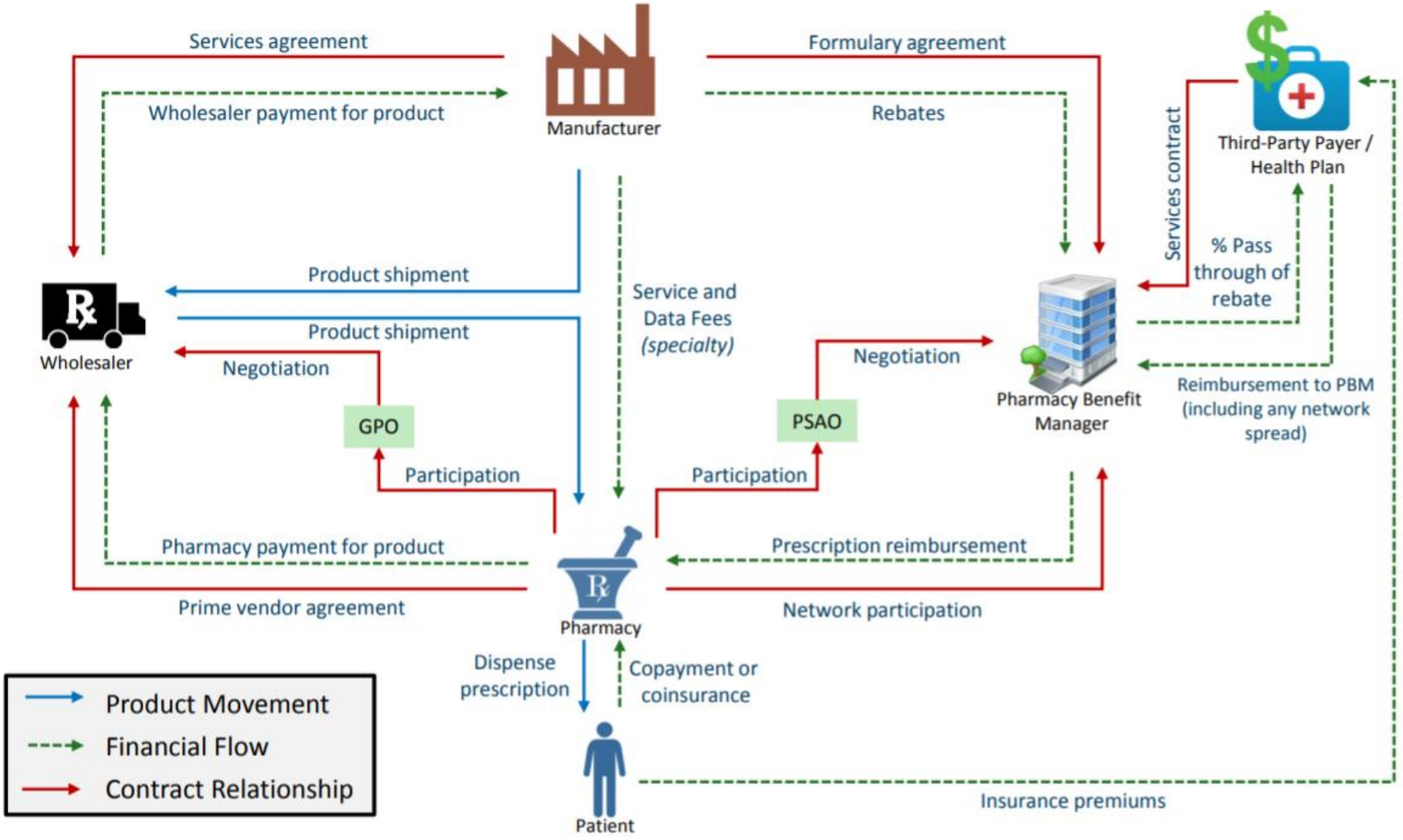
The complexity of the drug distribution and sales chain illustrates the need for transparency and action at many levels

Flow of drug products, services, and funds for drugs purchased in a retail setting



Notes and Source: Fein, Adam J., The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute, 2018. Chart illustrates flows for patient-administered, outpatient drugs. GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization

Pharmacy benefit managers (PBMs) play an important role in the management of drug benefits, but lack transparency into their pricing

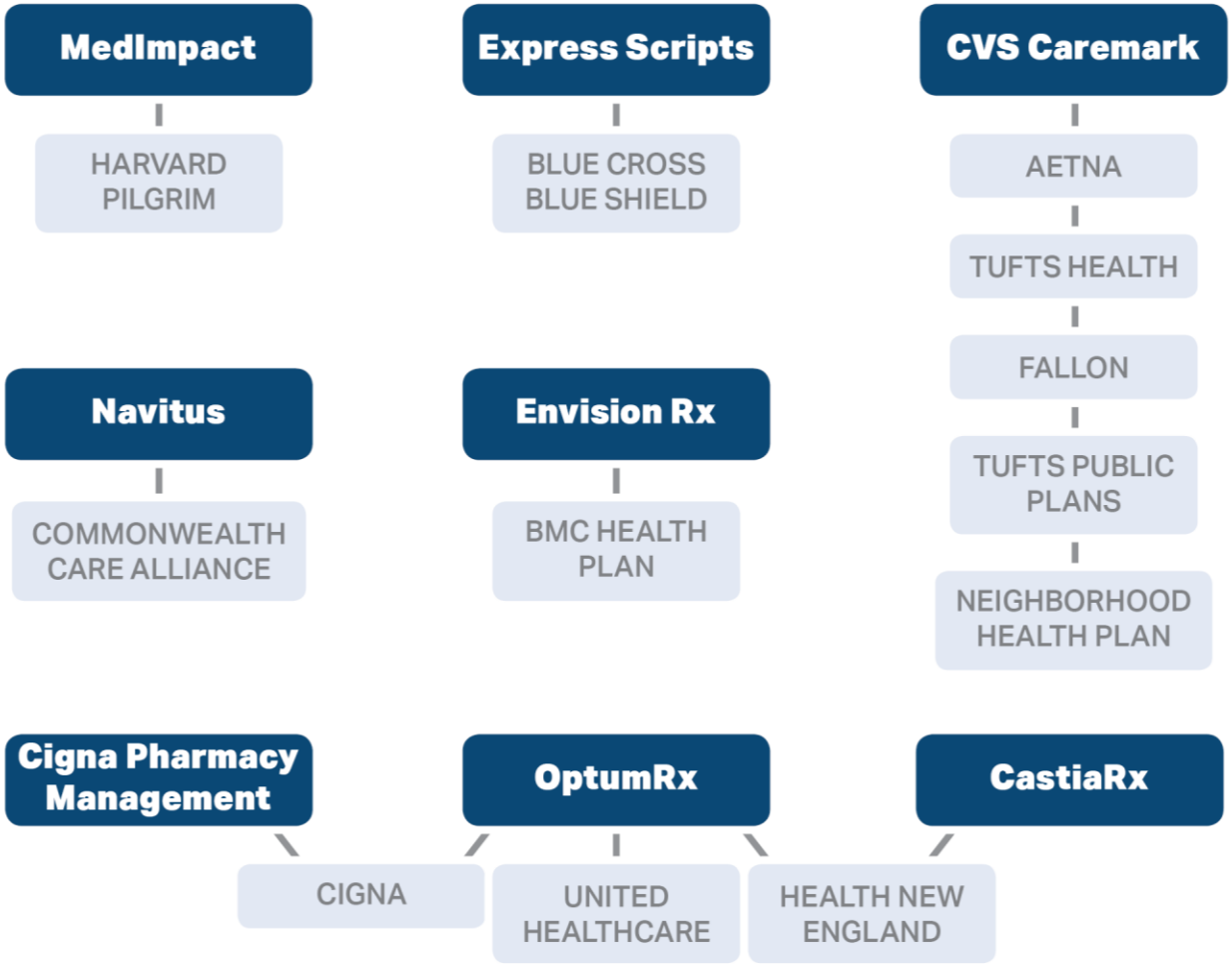
PBMs manage prescription drug benefits for many health plans and negotiate prices and rebates with manufacturers and payments to pharmacies

PBMs face increasing scrutiny for using “spread pricing” for generic drugs

- With the practice of spread pricing, PBMs may charge payers substantially more (or less) for drugs than what they reimburse pharmacies
- Due to a lack of transparency, spread pricing has raised concerns about potential impact on value for public and private payers and contributions to high drug costs
- In the U.S., PBM practice covered 22% of PBM compensation in 2014, but rose to 54% in 2016
- The HPC sought to investigate the potential impact of this practice in the MassHealth Managed Care Organization (MCO) program and commercial markets in Massachusetts

Source: Fein A. 2017 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. Drug Channels Institute. Feb., 2017. Available at: http://drugchannelsinstitute.com/files/2017-PharmacyPBM-DCI-Overview.pdf

In Massachusetts, multiple PBMs contract with different health plans for a variety of functions



PBMS PERFORM A VARIETY OF FUNCTIONS FOR THE 12 PAYERS SURVEYED

12 pharmacy contracting

12 pharmacy claims processing

11 negotiate prices and discounts with drug manufacturers

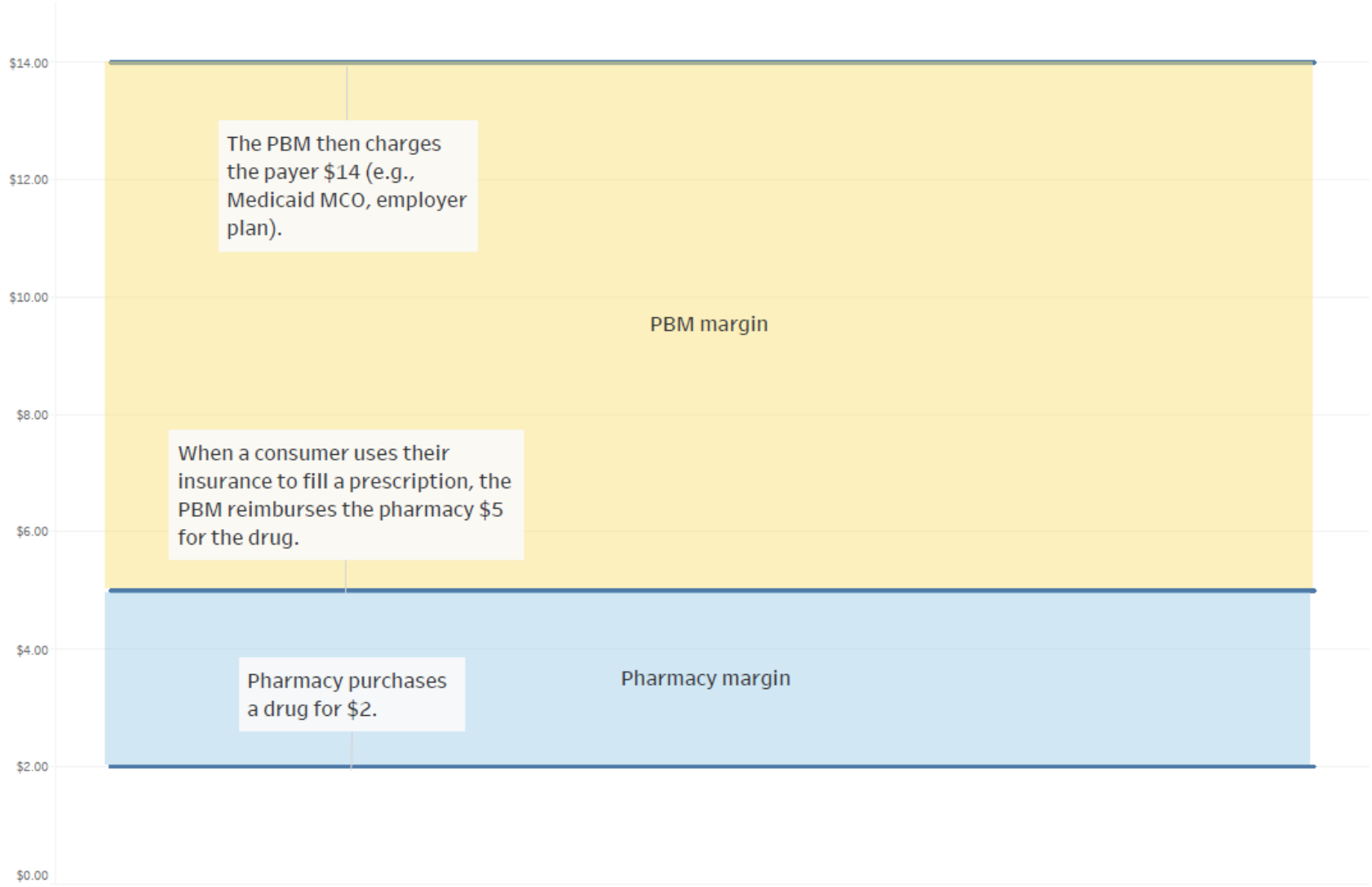
11 negotiate rebates with drug manufacturers

7 provide clinical management care programs to clients

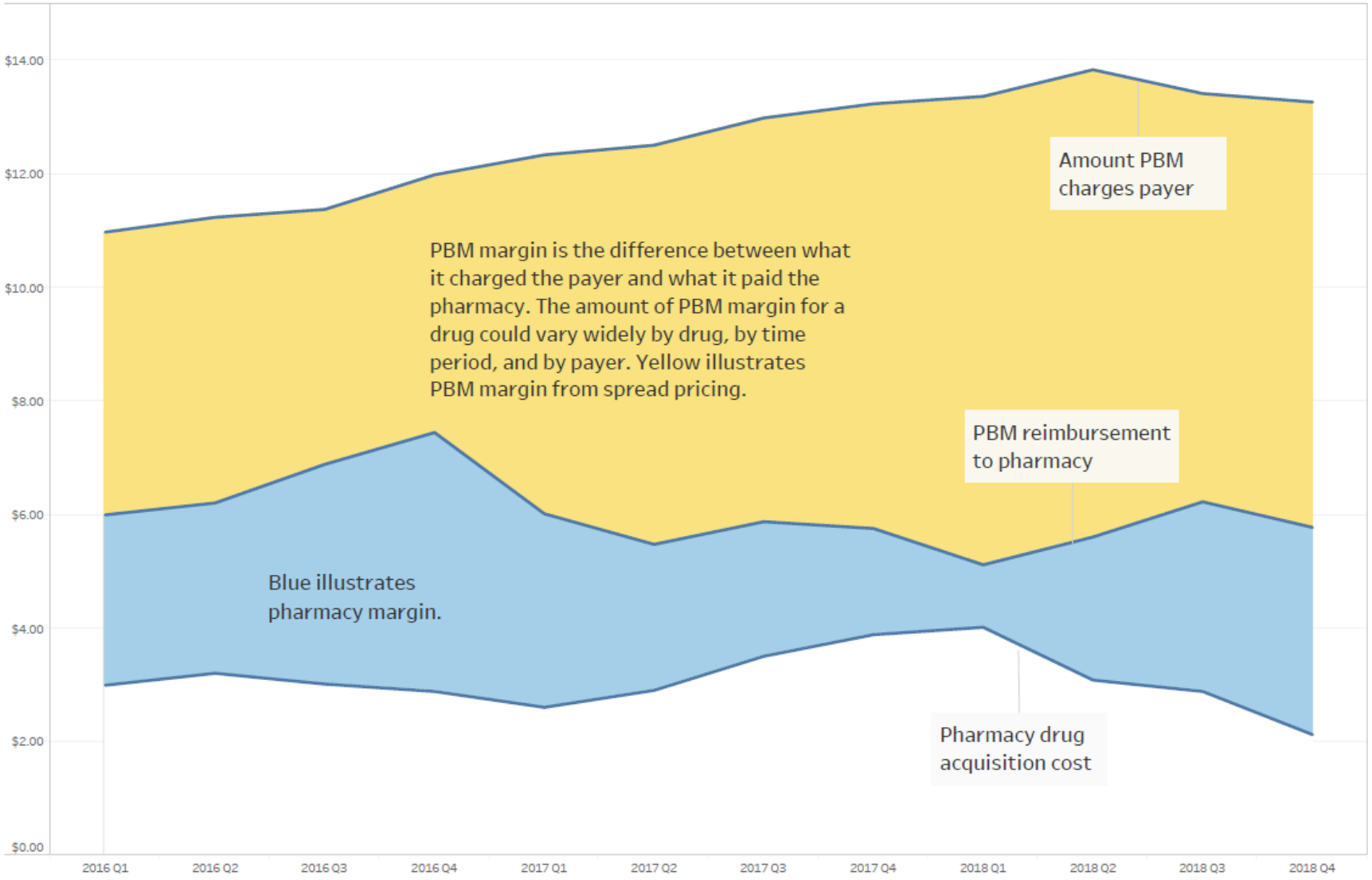
5 develop and maintain the drug formulary

Source: HPC analysis of pre-filed testimony pursuant to the 2018 Annual Cost Trends Hearing

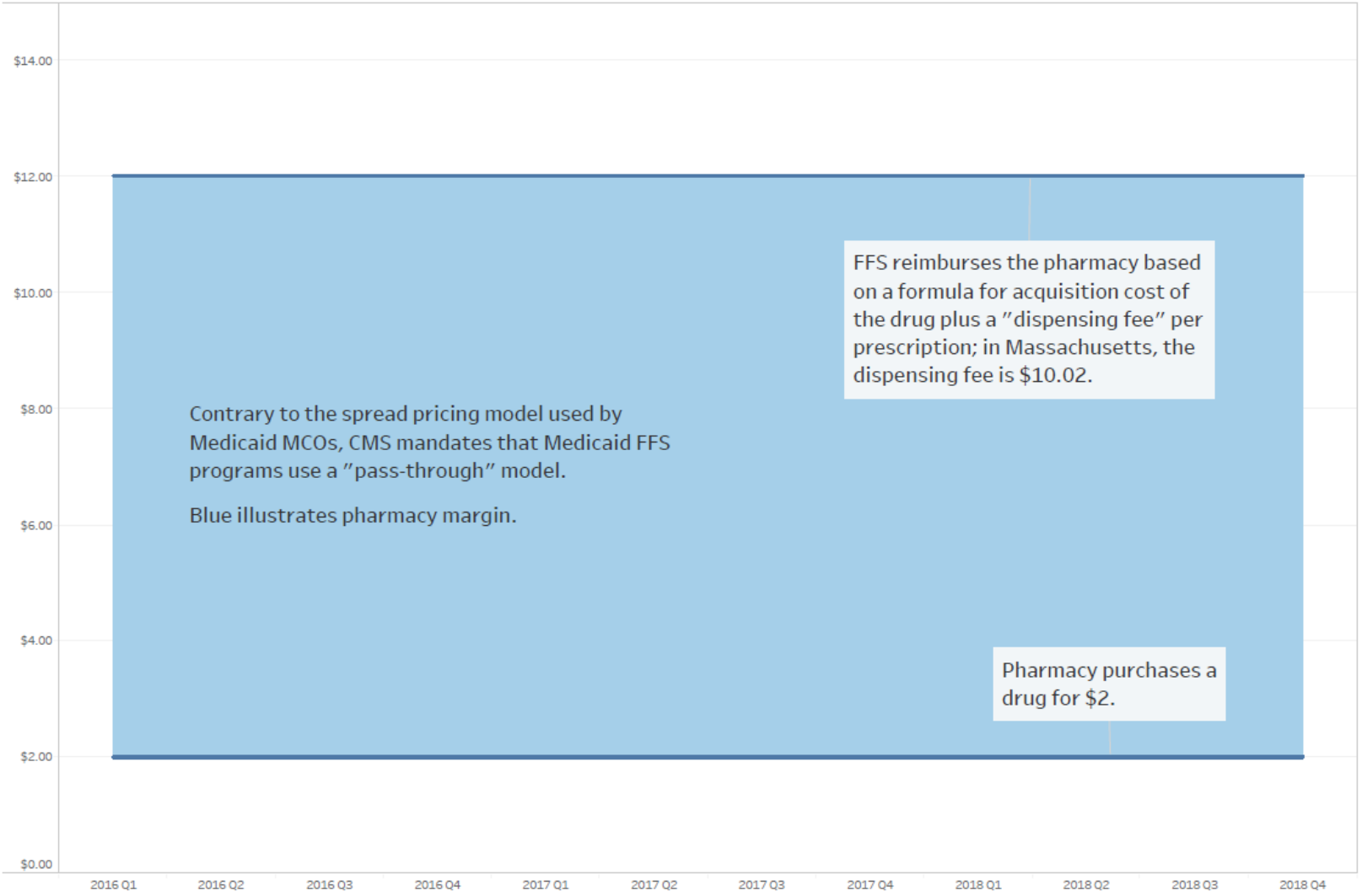
Illustration of spread pricing



PBM revenue is opaque to payers, employers, government, and the public



In contrast, the federal government mandates that Medicaid FFS use a “pass through” reimbursement model



There is an emerging concern that low pharmacy reimbursements in spread pricing can affect access to care

Low reimbursements can affect the **financial viability of pharmacies**, particularly independent pharmacies and pharmacies with a large share of Medicaid patients.

> *"Middlemen have to make some money, but we didn't expect it to be this extreme," said [Iowa pharmacist] Frahm, who said his pharmacy lost money in the [state's] jail account last year because CVS paid so little. "We figured everyone was playing fair."*
>
> *- Bloomberg*

> *"Everyone says that drug prices are going up, drug prices are going up, drug prices are going up. Historically my average revenue per fill has been going down down down," said a Boston-area pharmacist who wanted to remain anonymous because he fears retaliation from one of the pharmacy benefit managers he does business with.*
>
> *- Boston 25 News*

Sources: Langreth R, Ingold D, Gu J. "The Secret Drug Pricing System Middlemen Use to Rake in Millions" Bloomberg. Sept. 11, 2018.
Morelli J. "Prescription Drug Pricing Strategy: Where is the Money Going?" Boston 25 News. Jan. 14, 2019.
Commonwealth of Massachusetts. The Governor's Budget Recommendation. Fiscal Year 2020 House 1. 2019 Jan 23. Available at: https://budget.digital.mass.gov/bb/h1/fy20h1/dnld_20/fy2020h1.pdf

HPC Study Approach: Data Sources and Methodology

MassHealth prices

CMS State Drug Utilization Data (SDUD)

- Reports quarterly drug reimbursements and utilization among Medicaid FFS and MCOs in each state and nationally
- Most recent data available is Q4 2018

Commercial prices

MA APCD v6.0 Pharmacy claims

- Top 3 commercial payers: ~66% of commercially insured members in MA
- Most recent data available is 2016

Pharmacy acquisition costs

CMS National Average Drug Acquisition Cost (NADAC)

- Average prices paid by pharmacies to acquire drugs, based on a national, voluntary survey of 2,000 – 2,500 retail community pharmacies
- Mail orders and specialty pharmacies are excluded

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Notes: SDUD, APCD, and NADAC do not include rebates.

HPC Study Approach: Evaluating Impact of PBM Pricing Practices

MassHealth

- Compares MCO prices to FFS prices for drugs reimbursed by both programs
- Spread pricing vs. pass through policy: FFS prices represent a benchmark to evaluate PBM prices in the MCO program
- Currently no publicly available MCO data on PBM reimbursement rates to pharmacies
- Includes generic oral solids only

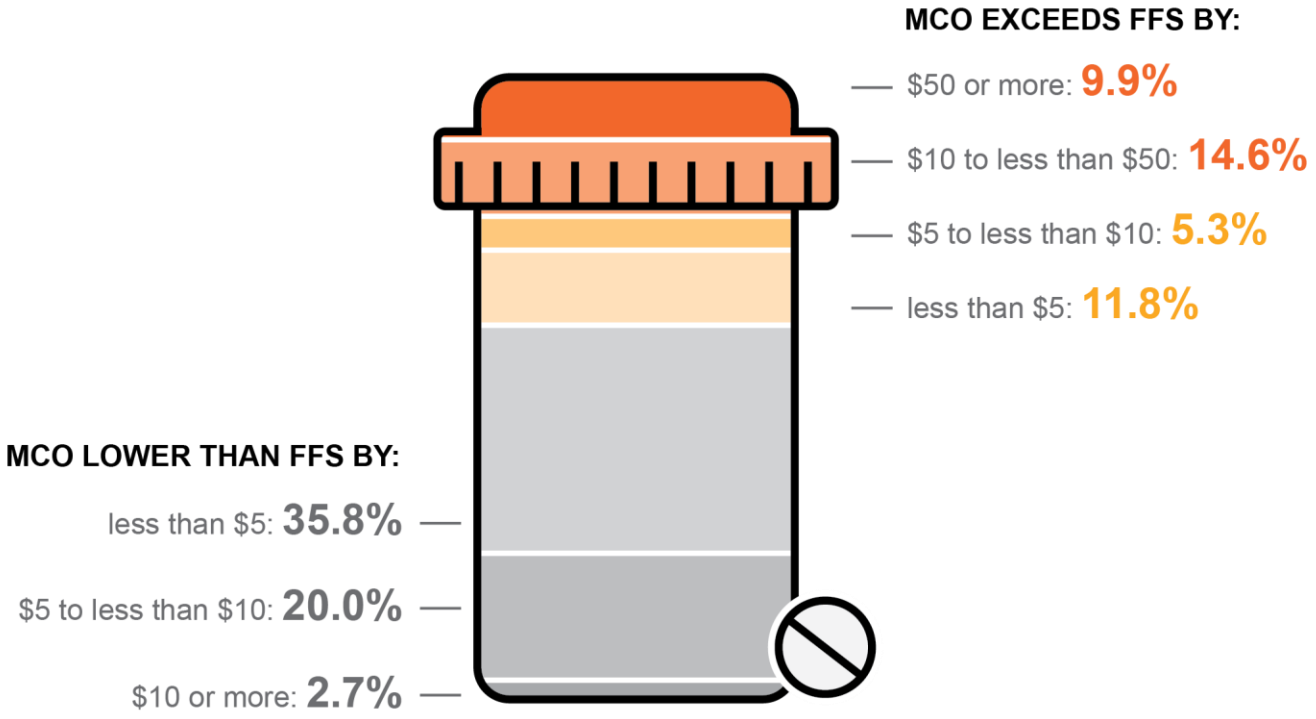
Commercial

- Compares average commercial payer price to pharmacy acquisition cost
- Difference includes dispensing fees to pharmacies and revenue kept by PBMs
- Currently no publicly available data on PBM reimbursement rates to pharmacies
- Includes generic oral solids only

Important Note on MassHealth Results:
Higher generic drug prices paid by MCOs come out of the fixed per-member (capitation) payment rate from MassHealth to cover a beneficiary's medical and pharmacy benefits. Therefore, while higher drug prices do not necessarily translate to direct state spending in the short term, these prices can lead to MCOs allocating fewer resources for other medical services and can raise spending in the long term through higher capitated rates.

MassHealth Results: For drugs where MCOs paid a higher price than FFS, the difference was often substantial

In 2018 Q4, MCO/PBM prices were higher than acquisition costs for 95% of the unique drugs analyzed and exceeded FFS prices for 42% of unique drugs



Whether the MCO price is higher or lower than the FFS price, it is unclear how much of the payment the PBMs apportion to the pharmacy and how much is retained as revenue

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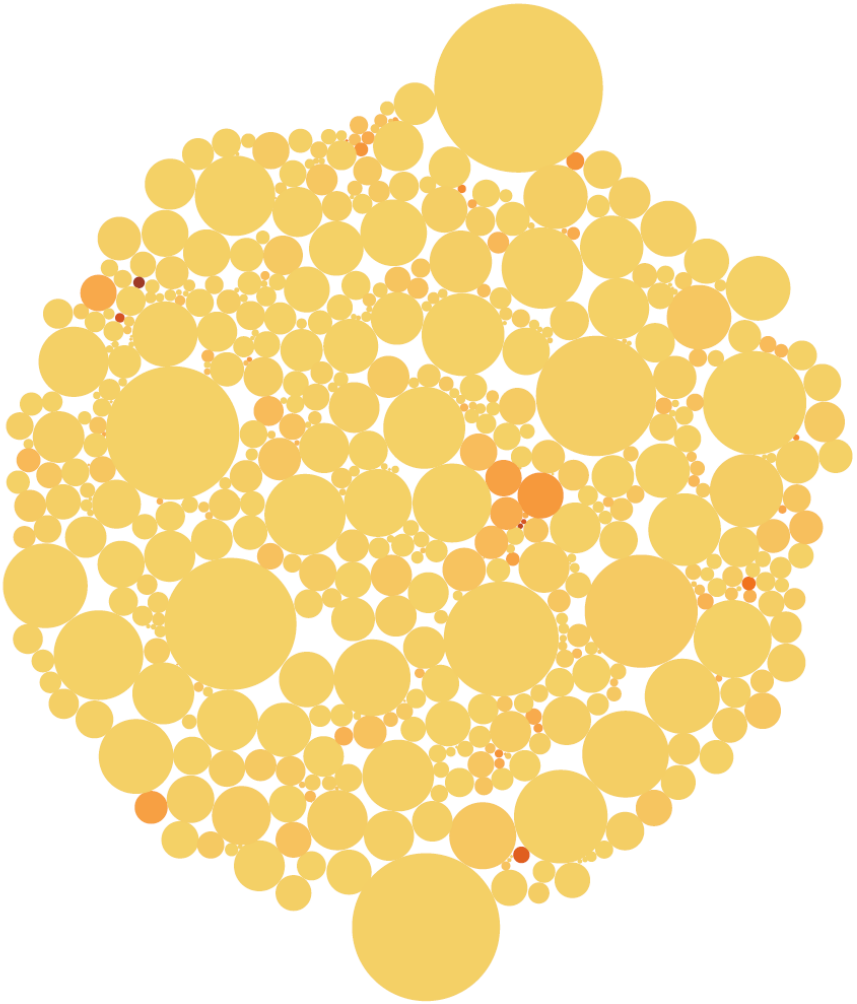
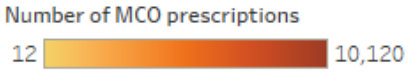
Average difference between MassHealth MCO/PBM and FFS prices per prescription, 2018 Q4

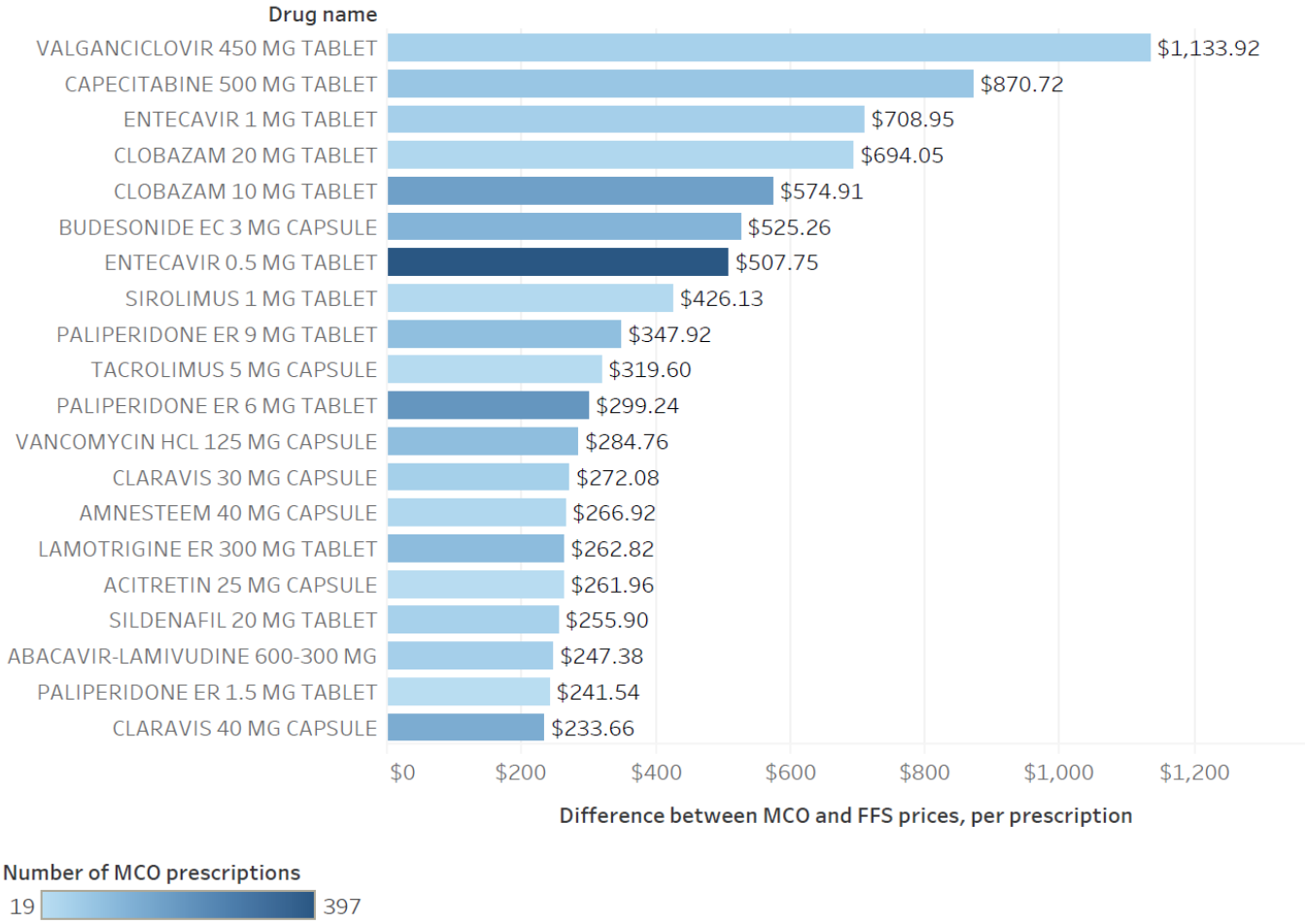




Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database.
Notes: Each bubble represents a generic oral solid for which the MassHealth MCO price exceeded the FFS price. Size represents average dollar difference per prescription for each drug. Units refer to a single unit of a dosage form, e.g. tablet, capsule. Each drug represents a single dosage form and dosage strength. Average unit price and average number of units per prescription reflects a weighted average across package sizes. Analysis includes only generic oral solids, identified through linking SDUD to NADAC. Only drugs reimbursed by both MCO and FFS were included. Drugs with 11 or fewer prescriptions dispensed were omitted. HPC methodology is adapted from 46Brooklyn.com.

MassHealth MCO/PBM price per generic drug prescription exceeded FFS prices by hundreds of dollars in many cases

Top 20 generic drugs in the MassHealth MCO program by average difference between MCO/PBM and FFS prices per prescription, 2018 Q4



Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database. Notes: Units refer to a single unit of a dosage form, e.g. tablet, capsule. Each drug represents a single dosage form and dosage strength. Average unit price and average number of units per prescription reflects a weighted average across package sizes. Analysis includes only generic oral solids, identified through linking SDUD to NADAC. Only drugs reimbursed by both MCO and FFS were included. Drugs with 11 or fewer prescriptions dispensed were omitted. HPC methodology is adapted from 46Brooklyn.com.

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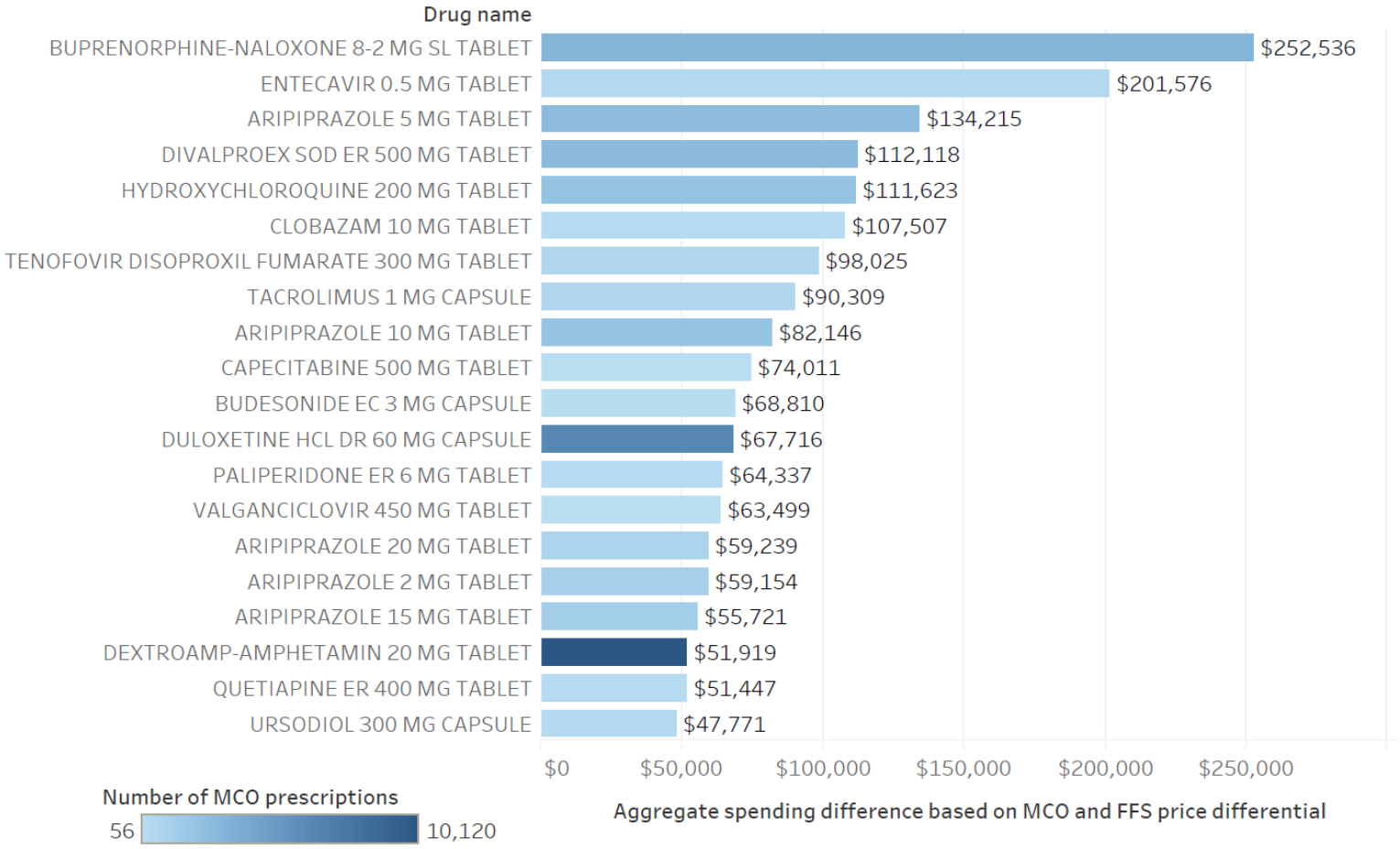
Higher MCO/PBM prices contribute to significantly higher aggregate spending for certain generic drugs compared to FFS

Top 20 generic drugs in the MassHealth MCO program by aggregate spending difference, 2018 Q4



Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database. Notes: Units refer to a single unit of a dosage form, e.g. tablet, capsule. Each drug represents a single dosage form and dosage strength. Average unit price and average number of units per prescription reflects a weighted average across package sizes. Analysis includes only generic oral solids, identified through linking SDUD to NADAC. Only drugs reimbursed by both MCO and FFS were included. Drugs with 11 or fewer prescriptions dispensed were omitted. HPC methodology is adapted from 46Brooklyn.com.

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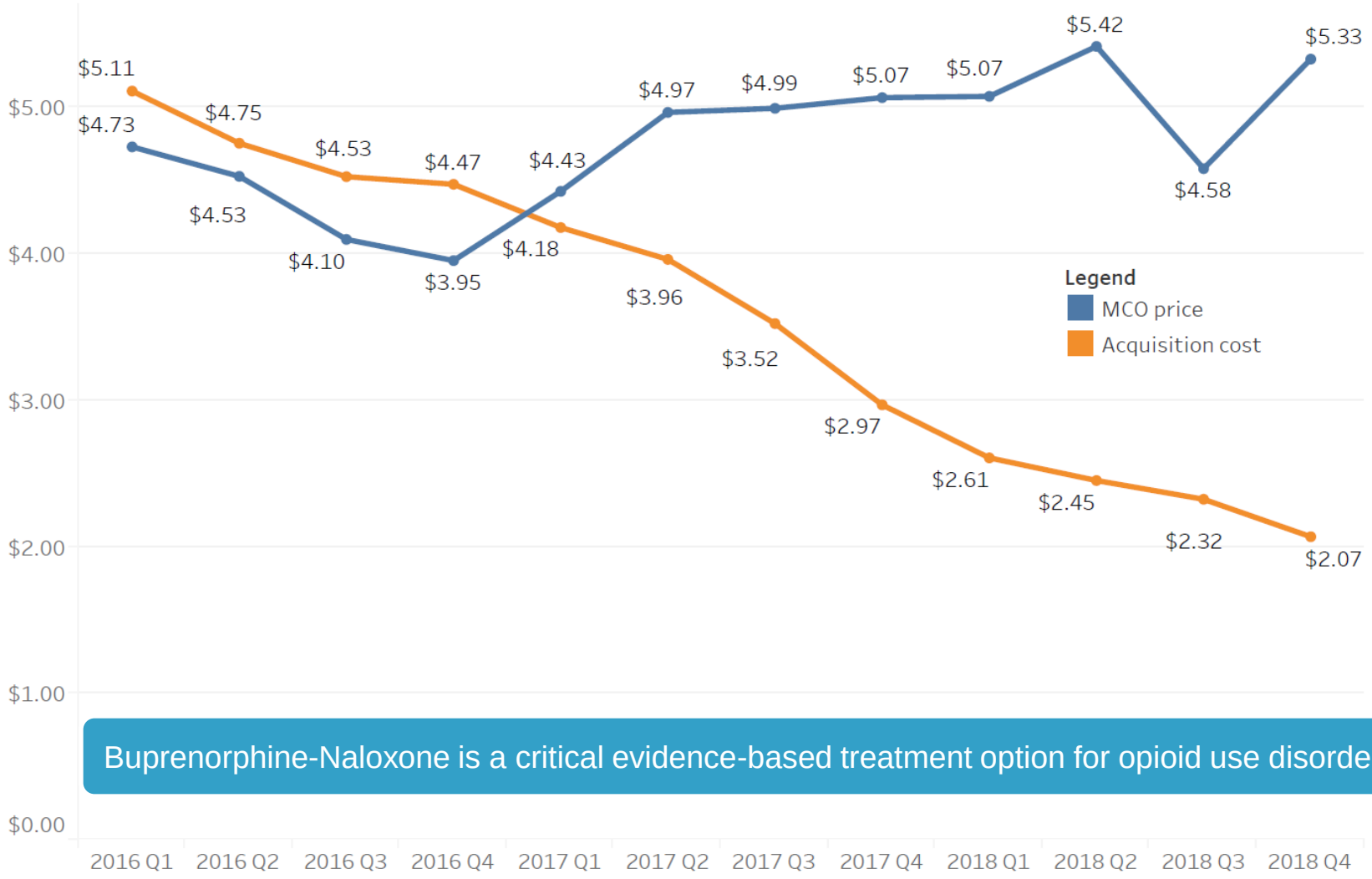
Despite a 60% decrease in the acquisition cost for Buprenorphine-Naloxone (generic Suboxone), MCO/PBM prices increased 13% between 2016 and 2018

Average pharmacy acquisition cost and MCO price for Buprenorphine-Naloxone 8-2mg SL, per tablet

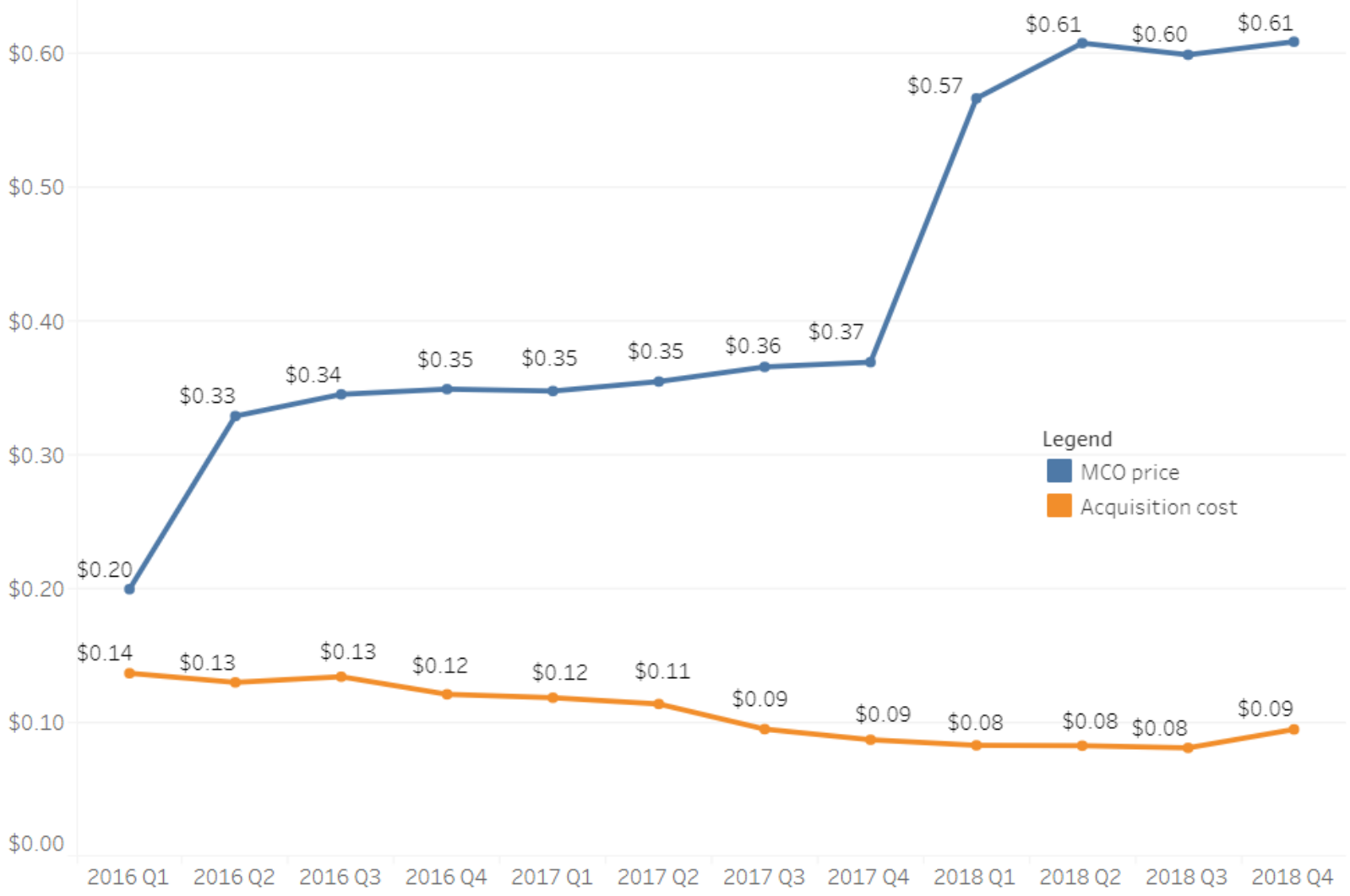


Buprenorphine-Naloxone is a critical evidence-based treatment option for opioid use disorder

Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database.
Notes: National Drug Code 00054018913.

Example of acquisition cost unaligned with MCO/PBM price: PrePLUS

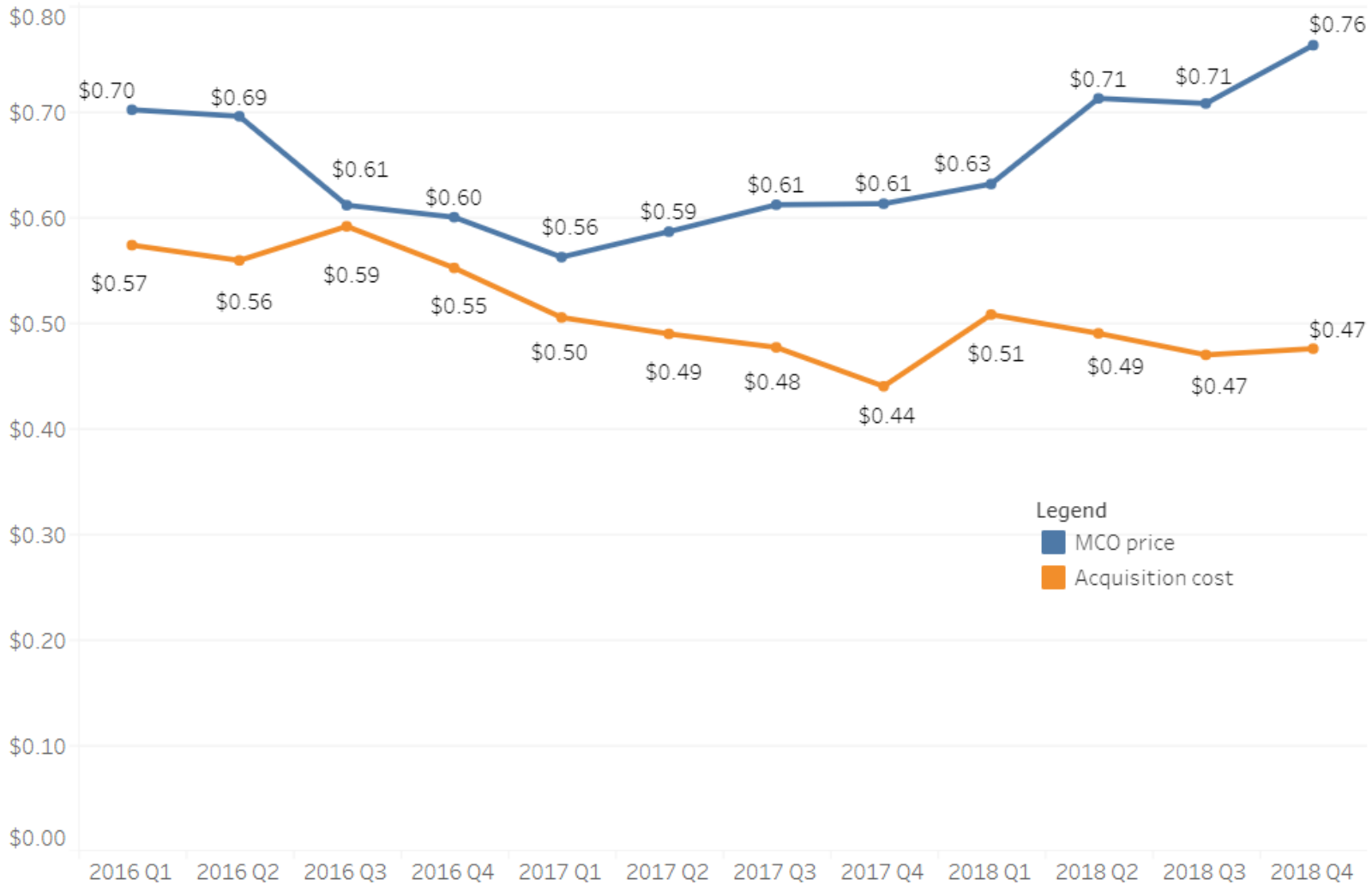
Average pharmacy acquisition cost and MCO price for PrePLUS 27 mg Fe; 1 mg FA, per tablet



Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database.
Notes: National Drug Code 69543025810.

Example of acquisition cost unaligned with MCO/PBM price: Dextroamp-amphetamine

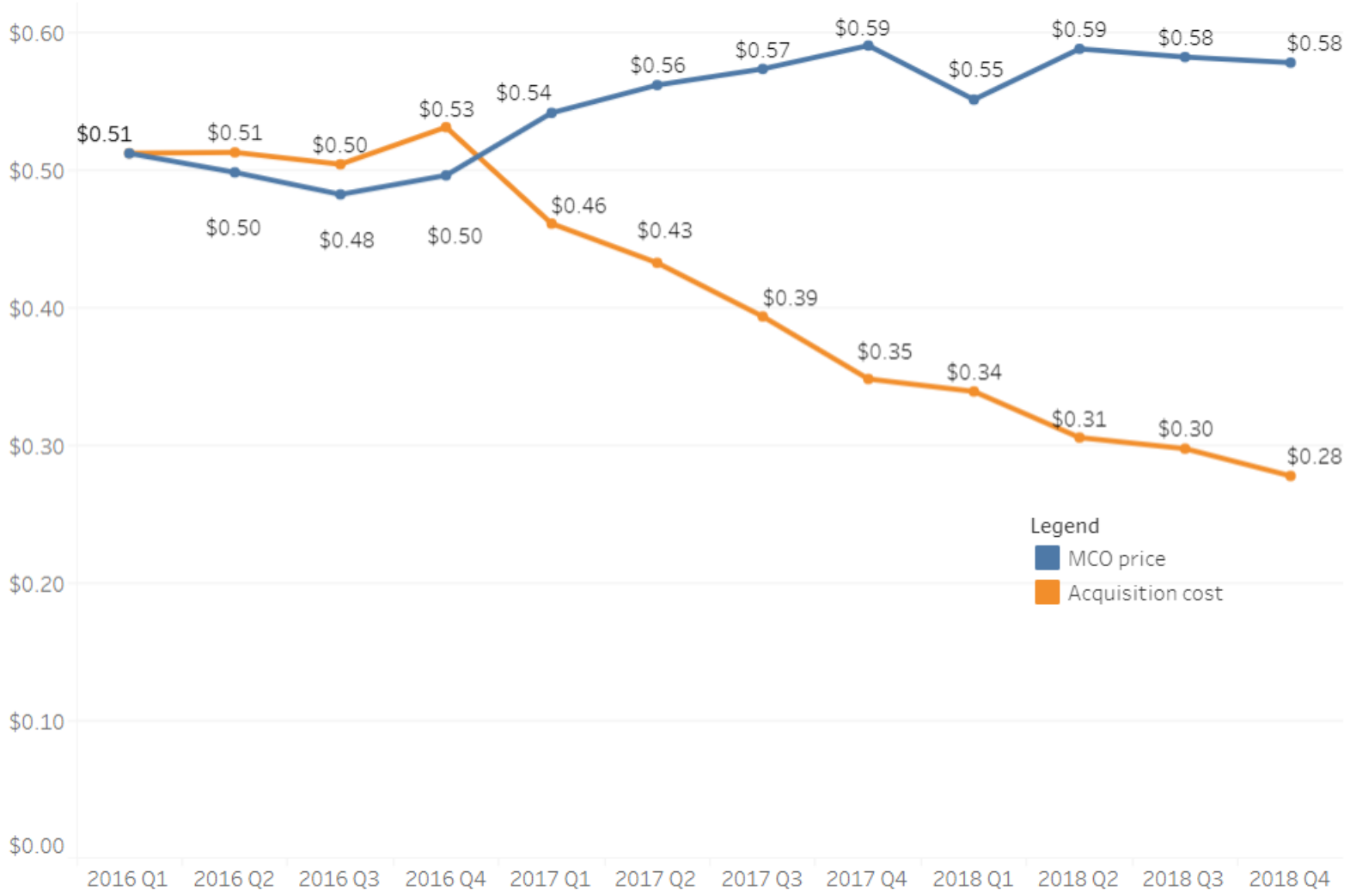
Average pharmacy acquisition cost and MCO price for Dextroamp-amphetamine 10 mg, per tablet



Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database.
Notes: National Drug Code 00555097202.

Example of acquisition cost unaligned with MCO/PBM price: Junel Fe

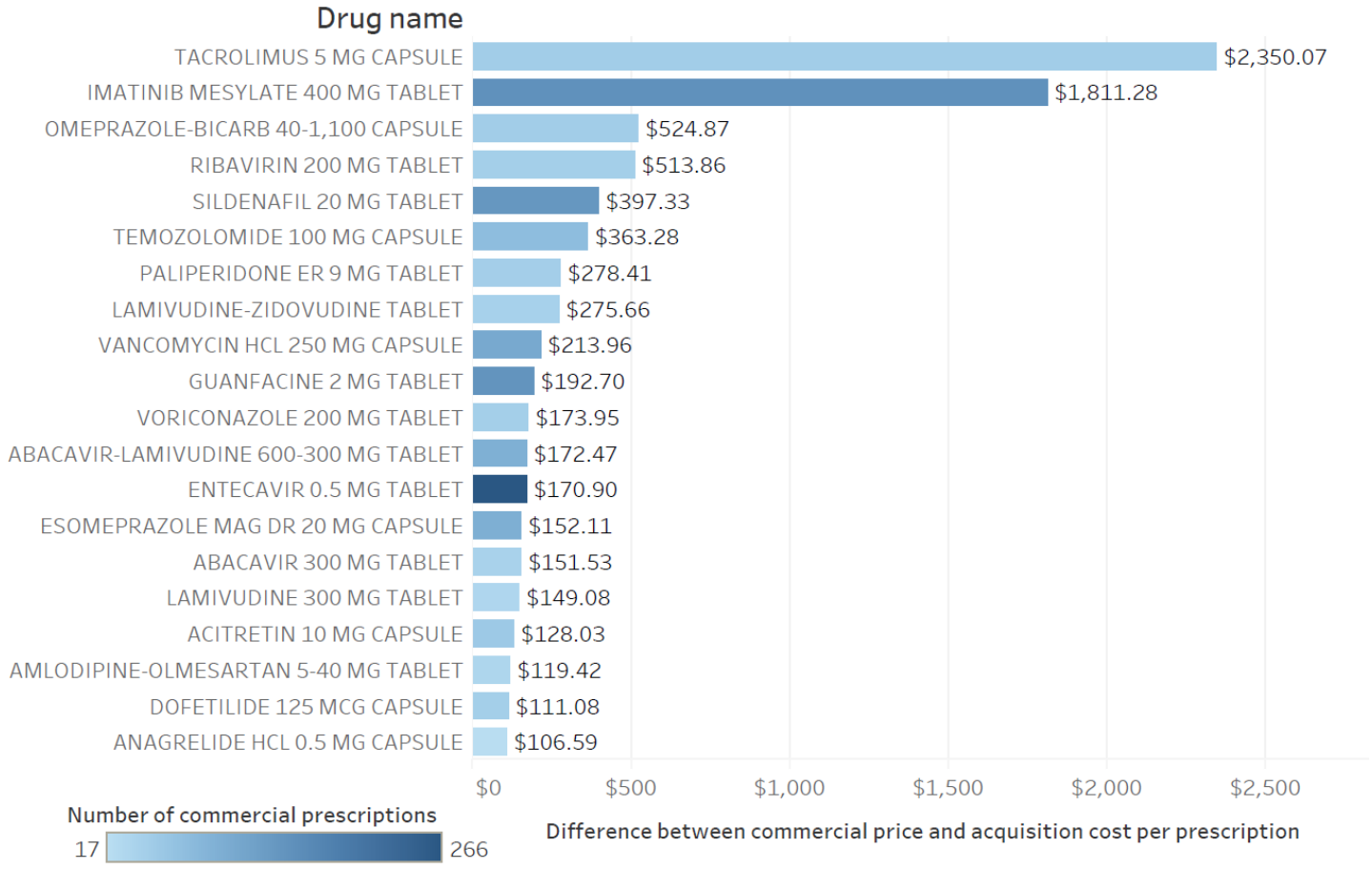
Average pharmacy acquisition cost and MCO price for Junel Fe 1 mg-20 mcg, per tablet



Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database.
Notes: National Drug Code 00555902658.

PBM price differences per prescription in the commercial market exceeded acquisition costs by hundreds of dollars for many generic drugs

Top 20 generic drugs by average difference between Massachusetts commercial price and acquisition cost per prescription, 2016 Q4



Sources: Centers for Medicare and Medicaid Services, National Average Drug Acquisition Cost (NADAC) database. Center for Health Information and Analysis, Massachusetts All-Payer Claims Database (APCD).

Notes: For drugs with various strengths, only the strength with the highest volume of prescriptions is shown. Analysis includes only generic oral solids. Each drug represents a single dosage form and dosage strength. Average unit price and average number of units per prescription reflects a weighted average across package sizes. Drugs with 11 or fewer prescriptions dispensed were omitted. For each drug, claims in the top and bottom 1 percentile of price were excluded to minimize the influence of outliers. HPC methodology is adapted from 46Brooklyn.com.

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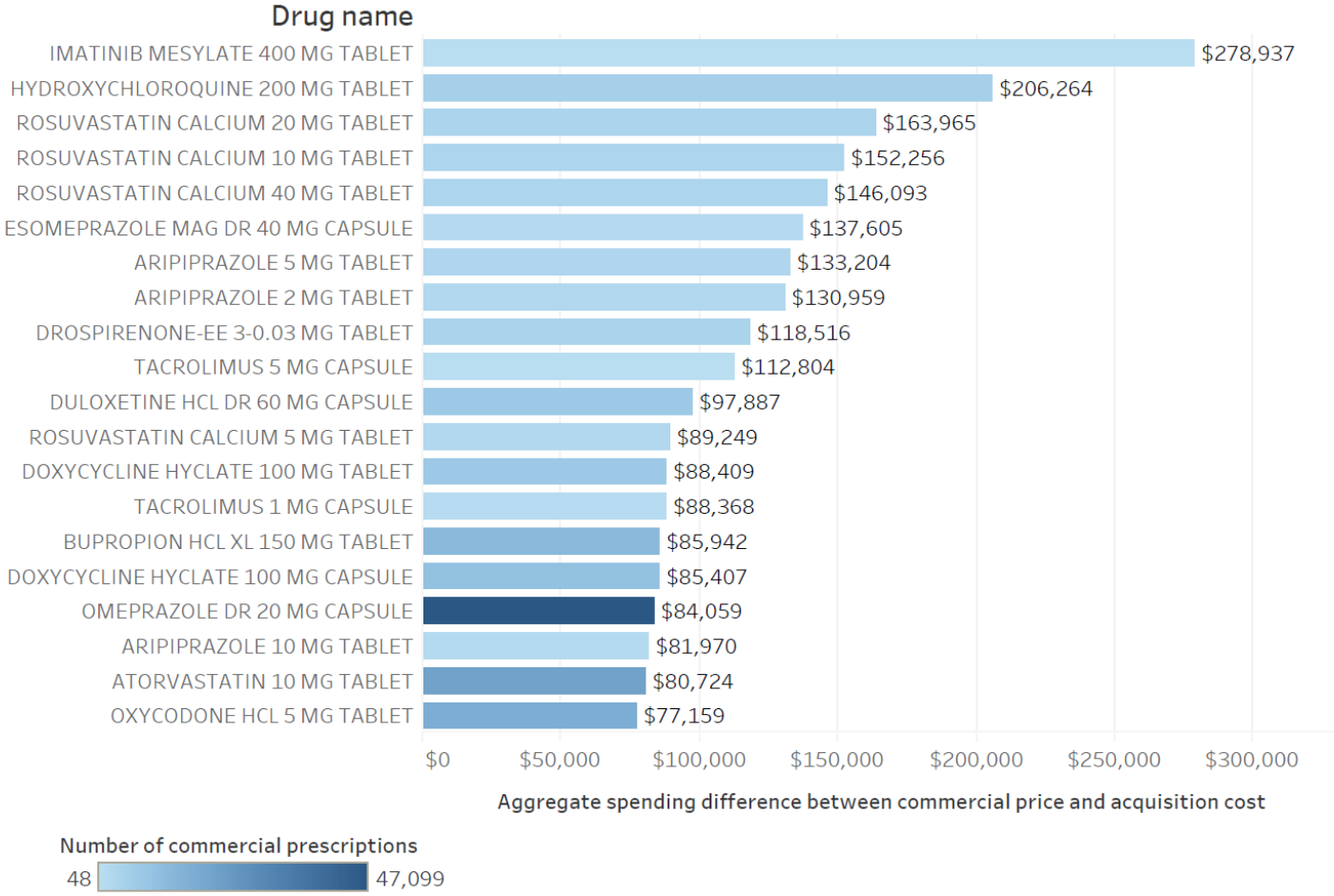
Higher commercial PBM prices for generic drugs contributed to significantly higher aggregate spending compared to acquisition costs

Top 20 generic drugs by aggregate spending difference between Massachusetts commercial price and acquisition cost, 2016 Q4



Sources: Centers for Medicare and Medicaid Services, National Average Drug Acquisition Cost (NADAC) database. Center for Health Information and Analysis, Massachusetts All-Payer Claims Database (APCD).

Notes: Analysis includes only generic oral solids. Each drug represents a single dosage form and dosage strength. Average unit price and average number of units per prescription reflects a weighted average across package sizes. Drugs with 11 or fewer prescriptions dispensed were omitted. For each drug, claims in the top and bottom 1 percentile of price were excluded to minimize the influence of outliers. HPC methodology is adapted from 46Brooklyn.com.

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States and the federal government are pursuing action to increase transparency and oversight of PBMs. Example approaches include:

Ohio

In August 2018, the Ohio state auditor found that PBM profit accounted for 31.4% ($208.4 million) of the $662.7 million paid by Ohio Medicaid MCOs on generic drugs, during the one-year period from April 1, 2017 through March 31, 2018.

As of January 1, 2019, the Ohio Department of Medicaid terminated its spread pricing contracts and implemented a pass-through model.

Louisiana

In June 2019, Louisiana's Governor signed 3 pieces of legislation to: **1)** license and regulate PBMs, **2)** restrict spread pricing, **3)** prohibit PBMs from reimbursing a local pharmacy less than a chain pharmacy, **4)** enable the LA Dept. of Health to assume direct responsibility for Medicaid pharmacy services under MCOs, and **5)** empower pharmacists to decline to dispense a covered prescription if the reimbursement amount is less than the acquisition cost

New York

In April 2019, New York's Governor signed New York's budget that: **1)** Prohibits pharmacy benefit managers (PBMs) in the Medicaid program from retaining any portion of spread pricing, and **2)** requires the registration of PBMs.

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Source: Newly Enacted Law. National Academy for State Health Policy, Center for State Rx Drug Pricing, https://nashp.org/new-laws/
State Legislative Action to Lower Pharmaceutical Costs, National Academy for State Health Policy, https://nashp.org/rx-legislative-tracker-2019/

So far in 2019, state legislatures have passed 22 bills addressing issues related to PBMs. Example approaches include:

Maine

In June 2019, Maine's Governor signed legislation which establishes that: **1)** PBMs have a fiduciary duty to their client carriers, **2)** prohibits carriers and PBMs from penalizing pharmacists for disclosing costs to consumers, **3)** requires PBMs savings be used to lower premium costs or remitted directly to the covered person, and **4)** stipulates that PBM compensation constitutes an administrative cost.

West Virginia

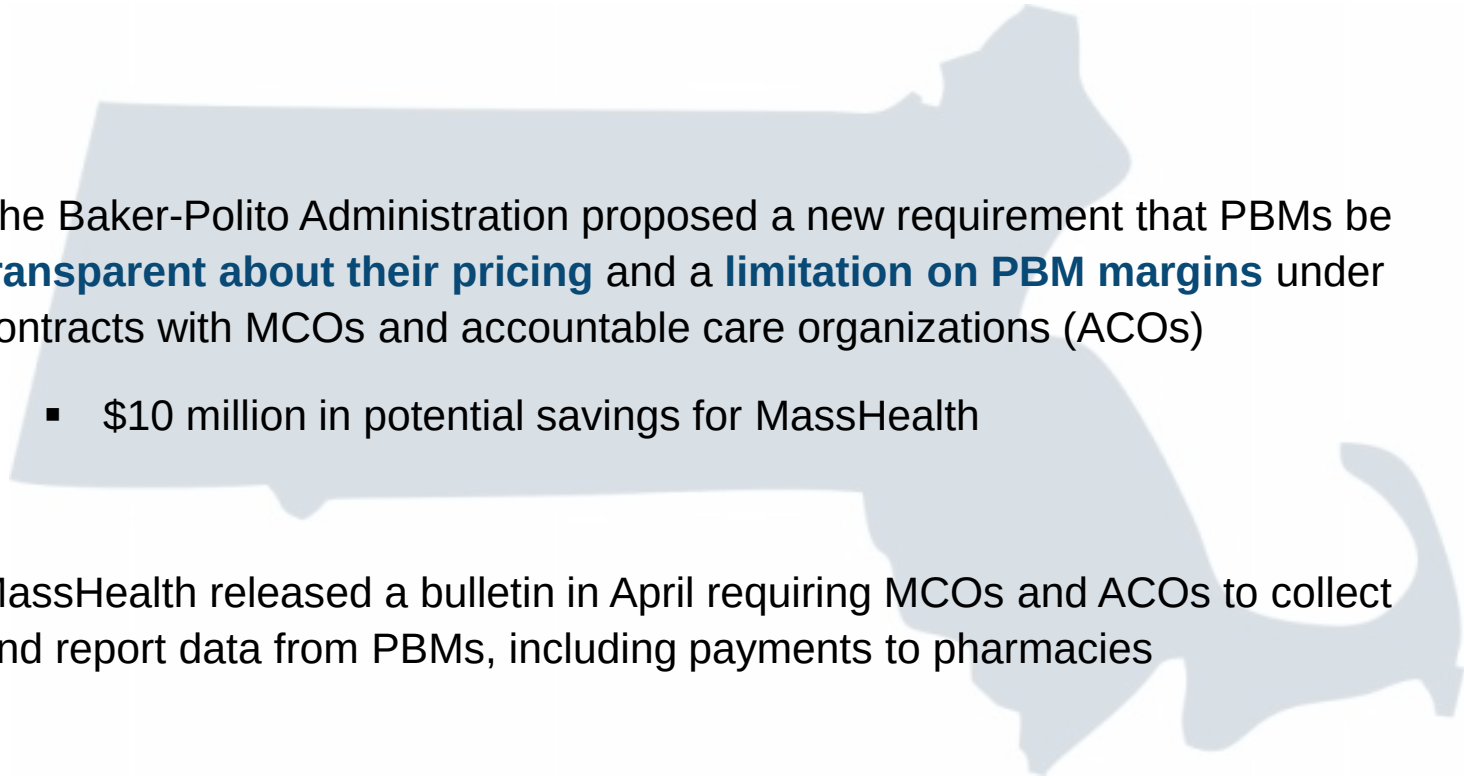
In 2017, West Virginia fully carved out pharmacy benefits from the Medicaid MCOs and shifted them to a FFS reimbursement structure. A recent state report found $54.4 million savings in the first year after implementation.

United States

In May 2019, the Centers for Medicare & Medicaid Services (CMS) released guidance for Medicaid and CHIP managed care plans regarding the calculation of a plan's Medical Loss Ratio (MLR), to ensure that health plans can monitor spread pricing in Medicaid appropriately.

Sources: Newly Enacted Law. National Academy for State Health Policy, Center for State Rx Drug Pricing, https://nashp.org/new-laws/
State Legislative Action to Lower Pharmaceutical Costs, National Academy for State Health Policy, https://nashp.org/rx-legislative-tracker-2019/
Ohio Auditor of State. Ohio's Medicaid Managed Care Pharmacy Services. 2018 Aug 16. Available at: https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf
West Virginia Bureau for Medical Services. https://dhhr.wv.gov/bms/News/Pages/West-Virginia-Medicaid-Pharmacy-Savings-Report-is-Now-Available!-.aspx
The Columbus Dispatch. https://www.dispatch.com/news/20180504/ohio-shies-away-from-drug-plan-that-saved-west-virginia-38-million
CMS press release May 15, 2019. Available at: https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not

Activity in Massachusetts



- The Baker-Polito Administration proposed a new requirement that PBMs be **transparent about their pricing** and a **limitation on PBM margins** under contracts with MCOs and accountable care organizations (ACOs)
  - $10 million in potential savings for MassHealth
- MassHealth released a bulletin in April requiring MCOs and ACOs to collect and report data from PBMs, including payments to pharmacies

Conclusions and Policy Considerations

- For generic drugs reimbursed by both MCO and FFS programs, the MCO/PBM price was **higher** than FFS in 42% of unique drugs, and the difference was often substantial
  - In 2018 Q4, MCOs paid an average $159 per prescription for generic Suboxone, 111% higher than the average FFS price of $75; this difference and high utilization of the drug led to its #1 rank for highest MCO-FFS spending difference
- High drug spending leaves **fewer resources** for MCOs to allocate to other services and can raise long-term spending through higher capitated rates
- PBMs assert that spread pricing models provide more predictability for payers than pass-through models, in which drug prices for plans fluctuate directly with changes in drug costs
- Greater transparency in spread pricing is needed so payers, employers, and government can make **informed choices** about allocation of state spending or commercial premium dollars, including appropriate compensation for both pharmacies and PBMs

The HPC has consistently recommended a comprehensive approach to pharmaceutical reforms that addresses the entire drug distribution chain

The HPC has included policy recommendations to reduce pharmaceutical spending for the past four years. Recommended actions:

- Authorize EOHHS to establish a process for **rigorous review of high-cost drugs**
- Increase the ability of MassHealth to **negotiate directly with drug manufacturers** for additional supplemental rebates and outcomes-based contracts
- Increase public transparency and oversight for pharmaceutical manufacturers, medical device companies, and pharmacy benefit managers (PBM), including through **mandated participation in the annual cost trends hearing and reports on health care cost drivers**
- Increase state oversight of PBM pricing and take steps to **limit the practice of "spread pricing"**
- Require payers and PBMs to **disclose any manufacturer rebates** it receives and take action to pass those savings on to employers and patients
- Pharmacies should be encouraged to proactively **disclose prescription drug cost information to patients**
- Address prices for drugs covered under the **medical benefit** of a health insurance plan
- Payers and providers should pursue a range of strategies to maximize value in drug spending, including **value-based contracting strategies**, treatment protocols and guidelines, prescriber education and variation in prescribing patterns, and monitoring prescribing patterns

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