Would you ever pay $20 for a Starbucks Coffee?

Troy Trygstad, PharmD  MBA PhD
Disclaimer(s)

- I practice community pharmacy on nights and weekends
  - I’m pro pharmacist and primary care
- I lead a nationwide clinically integrated network of 3,300 pharmacies
  - 4th largest “chain” by single signature in the United States
- I’m also a pharmaceutical health policy/health services researcher by training
  - View the world through the lens of economics
• Where does the money go?
• Drugs are expensive (sometimes).
• Pharmacy is not expensive.
• The disconnect.
• The $20 Starbucks Coffee
• “Rents”.
• Benchmark pricing.
• Value Based Contracting.
• Pharmacy Quality Networks.
• Results.
Where does the money go?  
(Hint: it’s worse with non-Rx categories)
Where does the money go?

(Hint: Pareto would blush)


Drugs are expensive. (Some of them, but not many)

Express Scripts, Components of Change in Net Drug Spending, Traditional vs. Specialty, 2019

- Change in unit cost: Traditional drugs -6.4%, Specialty drugs 4.4%, Overall 0.9%
- Change in utilization: Traditional drugs 1.4%, Specialty drugs 7.2%, Overall 1.4%
- Overall change in drug spending: Traditional drugs -5.0%, Specialty drugs 11.6%, Overall 2.3%

Source: Drug Channels Institute analysis of Express Scripts drug trend report. Figures are for Express Scripts' commercial clients and include the effect of rebates.

Published on Drug Channels (www.DrugChannels.net) on February 25, 2020.

Drug Channels Institute
Pharmacies are **NOT** expensive.

- **$31,200,000,000** (Community Pharmacy Gross Margin) - 0.86%
- **$156,200,000,000** (Community Pharmacy Gross) - 4.3%
- **$242,900,000,000** (Retail Gross) - 6.7%
- **$100,000,000?** (MTM Spend?) - 0.003%
- **$347,000,000,000** (Post-Rebated Gross) - 9.6%
- **$3,600,000,000,000** (National Health Care Spend)

The disconnect(s).
(Small number of fills, big % of cost)

Spend

- "Specialty Medications"
- "Regular Medications"

Rx Fills

- "Specialty Medications"
- "Regular Medications"
PBM Business Models
(business model migration over time)

Administration Phase (70s, early 80s) – profits by administrative efficiencies

Generic Conversion Phase (late 80s, 90s) – profits by brand to generic conversions

Rebates Phase (early, 00s, 10s) – profits by drug rebates, some b2g

Spread Phase (late 00s, 10s) – profits by drug rebates, spread pricing

Vertical Integration Phase (late 00s, 20s) – profits by channeling, profit-shifting
Ever pay $20 for a Starbucks Coffee?

(If you bought it from a PBM you might)
Ever pay $20 for a Starbucks Coffee?

(Coffee is very cheap to procure and produce)
Ever pay $20 for a Starbucks Coffee?

(If you bought it from a PBM you might)

Latte price breakdown
Matt Milletto of the American Barista & Coffee School breaks down the $3 cost of a 12-ounce latte:

$2.23
300% mark-up

32¢
Two shots of espresso

20¢
Steamed milk

15¢
Cup, lid, sleeve, stirrer

5-10¢
Rent, labor, utilities

A. Raymond/The Seattle Times

+ $2-$17+

To Administer
Rents.

(Economist’s view)

Flow of $100 Across Various Channels -- Overall

- $24 to Administer
- $19 to Administer
- $3 to Administer
- $15 to Dispense and Optimize Use

10% of Fills are 80% of the Cost

(This imbalance has changed the PBM industry)
From Transparency to Opacity
("Rents" require market confuscation)

Administration Phase (70s, early 80s)

Generic Conversion Phase (late 80s, 90s)

Rebates Phase (early, 00s, 10s)

Spread Phase (late 00s, 10s)

Vertical Integration Phase (late 00s, 20s)
The rise of discount cards.

(How is it that insured individuals elect NOT to use their insurance?)

Pharmacy Paid For Drug
- Sponsor Paid Pharmacy For Drug
  - PBM Rebate + Admin Fee + “Spread”
    - Pharmacy Reimbursed For Drug
      - Pharmacy “Cash” Price
        - Forced Patient Out of Pocket

...and many others...
including now **In-House** PBM/Insurer Cards!
NADAC-Plus: An emerging paradigm in pharmacy pricing?

Kevin Pierce, ASA, MAAA
Andrea Sheldor, FSA, MAAA

Due to drug price transparency concerns, cost-plus contracting is receiving greater attention. This paper discusses national average drug acquisition costs (NADAC) as a basis for cost-plus pricing.

With increased consumer and regulatory scrutiny on drug prices, stakeholders in the pharmacy supply chain are exploring drug pricing alternatives. The cost-plus pricing method establishes drug prices based on acquisition costs plus an explicit spread or fee. NADAC-Plus pricing is a form of cost-plus pricing that relies on NADAC as a reference. This paper introduces NADAC and describes the opportunities and limitations of using NADAC as a basis for pharmacy pricing.

What is NADAC?
NADAC estimates the national average drug invoice price paid by independent and retail chain pharmacies. NADAC excludes specialty and mail order pharmacies and does not reflect

Recommended Read

Benchmark pricing. Average Wholesale Price ("Aint’ What’s Paid")

**FIGURE 1:** COMMON NADAC QUESTIONS & ANSWERS

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is NADAC?</td>
<td>National average drug acquisition cost for retail pharmacies.</td>
</tr>
<tr>
<td>Who contributes to NADAC?</td>
<td>Independent and retail chain pharmacies voluntarily contribute.</td>
</tr>
<tr>
<td>What is included / excluded?</td>
<td>Drug invoice prices are included. Rebates, price concessions, and off-invoice discounts are excluded. Specialty and mail order pharmacies are excluded.</td>
</tr>
<tr>
<td>How often is it published?</td>
<td>Random surveys are conducted monthly. NADAC datasets are updated weekly.</td>
</tr>
<tr>
<td>How is NADAC determined?</td>
<td>Average of voluntarily reported data by pharmacies. 450–600 pharmacies typically contribute per month.</td>
</tr>
</tbody>
</table>


**FIGURE 2:** NADAC EQUIVALENT DISCOUNTS OFF AWP (USING OCTOBER 2018 NADAC AND OCTOBER 2018 AWP)

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>MEDICARE</th>
<th>COMMERCIAL</th>
<th>MEDICAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>92.6%</td>
<td>90.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Brand</td>
<td>20.1%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Specialty</td>
<td>24.8%</td>
<td>24.2%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

Utilization by drug type and business line. Please refer to the Methodology section for more information on our approach for developing the values in Figure 2.

AWP (or other benchmark) Model vs. NADAC Model

Typical Pharmacy PBM Contract: “AWP – 82% + $1.00 Dispensing Fee”

NADAC PBM Contract: “NADAC + $8.50 Dispensing Fee”

The Difference?: A better benchmark of what the pharmacy paid for the drug and nearly all of payment is for the service.

Otherwise – you have no idea whatsoever what you are actually paying for the Coffee!

Imagine if Visa or Mastercard charged you a $17 transaction fee on a cup of coffee
You can check what you pay against NADAC

(How much are you paying for the transaction?)

https://healthdata.gov/harvest_source/datamedicaidgov
Value based contracting.

(Why did this trend miss Pharmacy Sector?)

Good Haircut

....Same Reimbursement

(not related at all to medical outcomes...)
From a Retail Spread Business to...

...A Services-Based Business

Spend

```
“Specialty Medications”
```

```
“Regular Medications”
```

Rx Fills

```
“Specialty Medications”
```

```
“Regular Medications”
```

Touches

```
“Regular Medications” – Mail Order
```

```
“Regular Medications” - Community Based
```

More than 1 Billion Face-to-Face Opportunities Wasted Annually
How did pharmacy get here?

(Lack of Alignment...)

“I save money building bridges!”

“I get paid to build tunnels!”
Why can’t pharmacy play?

*(Left out of Outcomes-based VBP conversation...)*

Pharmacy Benefit

- Medications
  - Services

Supply of Services

Medical Benefit *(Plan)*

- Lower BP
- Lower A1c
- Lower Hosp.
- Lower Total $$

Demand for Outcomes
What does a Services-Based VBP program targeting clinical outcomes look like for pharmacies?

- **Example Diabetes Program (Targeted Pts.)**
  - Intervention
    - *Patient goals*
    - *Medication Reconciliation*
    - *Problems – medical problems, drug therapy problems, and health concerns*
  - *Plan of Care*
  - *Report Lab results: A1c, fasting blood glucose, and blood pressure*
  - Data/Reporting
    - *Electronic Care Plan*

- **Payment**
  - $60 & 80 PMPM
  - 25% Withheld
  - 80% Threshold
  - Engaged (Care Plan)
  - A1c Reported
  - 25% Threshold
  - A1c <9.0
  - 50% Threshold
  - A1c <9.0
What does a Services-Based VBP program targeting clinical outcomes look like for pharmacies?

• Example Asthma Program
  • Intervention
    • *Whatever works*
  • Data/Reporting
    • *None from Pharmacy*
    • *Claims analysis of ED visits*

• Payment
  • $10 PMPM
  • Shared Savings Upside
    • *65% of Savings to Pharmacy Network*
Results.

- **HEDIS**: Healthcare Effectiveness Data and Information Set
Accountable Pharmacy Networks are not a Unicorn and Many Plans are Moving Toward Value-Based Pharmacy Contracting

Results.

Accountable Pharmacy Networks are not a Unicorn and Many Plans are Moving Toward Value-Based Pharmacy Contracting

IF COMMUNITY PHARMACIES COULD SUBMIT AGREED UPON EVIDENCE OF BIOMETRIC TEST RESULTS OR PHYSICAL ASSESSMENT FINDINGS FOR A QUALITY MEASURE IN ACCORDANCE WITH DATA SOURCE MANDATES (E.G., POINT OF CARE TESTING FOR HEMOGLOBIN A1C AND SUBMIT TESTING RESULTS; BLOOD PRESSURE MEASUREMENT FOR BLOOD PRESSURE CONTROL), HOW LIKELY ARE YOU TO CONTRACT WITH COMMUNITY PHARMACIES TO PERFORM THE SERVICE?

2019

- Unsure: 33%
- Very unlikely: 50%
- Unlikely: 17%

2020

- Unsure: 8%
- Very unlikely: 8%
- Unlikely: 15%
- Likely: 46%
- Very likely: 23%

NOTE: 2019 N = 12; 2020 N = 13
Questions?