

Making Dollars and Sense of Recent Drug Pricing Developments



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Recent legal action is shining a harsh light on questionable price reporting practices of First Databank (FDB), one of the most commonly used sources of drug pricing information by pharmacy benefit managers.

PBMs frequently use FDB's published list of average wholesale prices — or AWP — as a benchmark upon which to negotiate drug discounts with retail pharmacies. For example, if FDB assigned Drug A an AWP of \$100, PBMs typically will negotiate a percentage discount based on that AWP amount, pass the savings along to their customers and, when using a “spread” arrangement, keep some of the discounted monies for themselves. This often complex process highlights the central role drug pricing companies like FDB play in the costs employers and employee ultimately pay for prescription drugs.

FDB's methods to garner its pricing information have not always been clear. What is known, however, is that FDB typically uses “catalogue” prices published by drug manufacturers as they sell drugs to wholesalers, who then sell them to dispensing pharmacies. These prices are known as the

wholesale acquisition cost (WAC). The WAC amount is simply multiplied by a factor to arrive at the AWP. This “factor” has become the primary cause for concern.

Historically, the factor had been around 20%. However, beginning in 2002, FDB began reporting the AWP as a 25% markup from WAC. FDB hasn't articulated why — despite that wholesale prices reported by manufacturers typically had *not* increased — the 5% increase was implemented.

Nevertheless, this incremental increase in the spread between WAC and AWP may have caused a spike in pharmacy expenditures by both plan sponsors and consumers. Some purchasers may have experienced little or no impact because they renegotiated more aggressive AWP discounts from their PBMs during a time that coincided with the escalation in spread between WAC and AWP. However, not all plan

sponsors achieved these more aggressive contracting rates and were thus economically disadvantaged by the artificial shift in baseline costs.

Based on an analysis by Pharmaceutical Strategies Group, the change could have resulted in program costs shifts of 1% to 4%, depending primarily on the types of medications



used, the channel of delivery (i.e., retail versus mail) and whether the sponsor renegotiated for more favorable rates.

Following a 2005 lawsuit regarding this practice — and a tentative settlement reached last fall — it appears that FDB will roll back the artificial spread increase between AWP and WAC for any drug that had a markup in excess of 20%. This is slated to take effect by second quarter 2007. In addition, and more importantly, FDB is planning on completely discontinuing its AWP pricing benchmark within two years of final legal proceedings.

Propelling change

The need for a new pharmacy pricing benchmark has been evident for many years. The recent legal action against FDB may very well be the long-needed impetus to drive appropriate industry changes. The next pharmacy pricing benchmark needs to be one that provides better accuracy, verifiability, availability, timeliness and transparency. Though there are several competitors for the next generation of pharmacy pricing benchmarks, there does not appear to be a clear drug-pricing alternative that will solve all of the problems related to pharmacy reimbursement.

Employers and other purchasers of pharmacy benefits should continue to lobby those in industry and government

to attain a solution that meets the standards just outlined.

A change in the pricing benchmark for prescription products is a welcome necessity. However, it must be remembered that drug pricing by entities like FDB is only one part of a larger drug spend equation. Keeping costs down requires taking into account *all* drug spend-related factors. Overall drug costs are driven by cost and utilization factors, plus member cost share. Payers need to be informed and educated about each of these important drivers of overall pharmacy trend. The flurry of discussion around AWP relates to a payer's price inflation, which is extremely relevant, but only one part of the equation.

With this in mind, here are concrete things for benefit managers to do now:

1. Determine whether your current PBM agreement includes a provision that allows renegotiation of contract pricing based on industry-wide changes to reimbursement and/or pricing mechanisms.
2. Estimate the impact of any proposed modification to WAC/AWP spread adjustments to your current program based on your current contractual provisions.
3. Implement potential alternative pricing mechanisms as part of future procurement activities (e.g., cost plus, modified WAC, etc.).
4. Implement appropriate language

into current and future contracts to protect against artificial price inflation and manipulation.

5. Don't forget that the most important driver of pharmacy program costs is utilization. Implementing effective programs to influence the use of generics and OTC products can generate 10% to 15% savings over current program costs.

This is an important time in the evolution of pharmacy pricing benchmarks. Though most of the industry currently is relying on the AWP metric as a benchmark for reimbursement programs, there is wide agreement that a change is now required. Employers should lobby aggressively to ensure that the next phase of pharmacy pricing meets the standards important to purchasers.

Moreover, employers must not lose sight of the fact that pricing — regardless of the benchmark — is only part of the equation. Long-term relief from escalating program pricing will only be achieved through the optimal balance of price, member cost share and utilization management. —**E.B.N.**

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