Requiring Cost-Based or Cost-Plus Reimbursement of Pharmacies Raises Costs and Undermines Value

Various states are considering legislation mandating a certain level of reimbursement for pharmacies by employers and other plan sponsors, whether by limiting the circumstances under which maximum allowable cost (MAC) programs can be used or requiring a specific methodology for reimbursing pharmacies (e.g., AWP, AAC, NADAC) plus a set dispensing fee. For example, one state enacted legislation requiring pharmacy benefit managers (PBMs) to reimburse pharmacies at least their invoiced acquisition cost – even if a lower priced option was available. These kinds of requirements do nothing to actually lower drug costs or improve value for patients; rather, they guarantee profits for pharmacies and increased revenue for wholesalers at everyone else's expense.

Cost-Based or Cost-Plus Reimbursement Undermines Affordability

"No matter how much a pharmacy spends to acquire a drug, they are guaranteed they will be repaid at least that amount, and likely more."[1] When employers and other plan sponsors are *required* to reimburse pharmacies at whatever cost the pharmacy purchases[2] a drug or using a specific cost-based methodology, an important cost and quality restraint is removed from the drug supply chain. These kinds of "guaranteed profit" requirements impose a "blank check" approach to reimbursement and undermine affordability for patients.[3]

Cost-Based and Cost-Plus Reimbursement Limits Competition and Transparency

Pharmacy reimbursement requirements promote use of off-invoice discounting, which decreases transparency of drug prices and further hamstrings pricing competition.

If the goal is to understand exactly how much drugs cost, it is necessary to consider all discounts and rebates associated with pharmacies' actual purchase price – whether they appear on an invoice or are recorded elsewhere. Survey-based reimbursement methodologies or reliance on pharmacy invoices cannot do that. Rather, they *can* lead to cost inflation (as high as 10%)[4], guaranteed profits for certain drug supply chain actors, and reduced transparency – all at the expense of patients, taxpayers, and plans.

Requiring Cost-Based or Cost-Plus Reimbursement Raises Costs

State officials set pharmacy reimbursement rates for Medicaid that often are higher than those for Medicare and the commercial market. If all state Medicaid programs were to use market-based pharmacy reimbursement, taxpayers would save an estimated $9 billion over 10 years.[5]

[1] David A. Hyman. The Adverse Consequences of Mandating Reimbursement of Pharmacies Based on Their Invoiced Drug Acquisition Costs. January 2016.
[2] Because of rebates and discounts, pharmacies' invoiced prices may not reflect actual drug acquisition costs – further inflating the potential for guaranteed profits.
[3] The inflationary consequences of similar cost-based reimbursement systems are well known. For many years, the federal government relied heavily on cost-based procurement for defense contracts, only to discover that this approach resulted in large cost over-runs, because defense contractors knew their costs would be reimbursed, however much they were.
[4] Washington Health Care Authority Fiscal Note for SSB 5857. *See* https://scholarship.law.gwu.edu/cgi/viewcontent.cgi?article=2483&context=faculty_publications.
[5] The Menges Group. Medicaid Pharmacy Savings Opportunities: National and State-specific Estimates. October 2016.

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Creating an Incentive for Pharmacies to Buy at the Lowest Price

Because pharmacies purchase different drugs at different times and in different volumes, the price of a particular drug can vary significantly among pharmacies—even within a specific drug class or type. If patients can fill their prescription at lower-cost pharmacy locations, they, and, if they are insured, their health plans, can spend less.

Employers and other plan sponsors, with their PBMs, contract with pharmacies for a set price for the same reason.[6] **These pharmacies, which typically form a plan's pharmacy network, are incented to *purchase* the drugs that they dispense efficiently and based on competitive market rates.**

How Market-based Pharmacy Reimbursement Models Work

MAC and other market-based pharmacy reimbursement models ensure patients, taxpayers, employers, and other plan sponsors – those ultimately paying for a drug – get the lowest possible price. These models are designed to give pharmacies an incentive to shop around among wholesalers to find a given drug at the lowest cost available.

Under market-based pharmacy reimbursement models, if pharmacies purchase a higher-priced product, they may not make as much profit or, in limited instances, may lose money on that specific drug. Alternatively, if they purchase drugs at a more favorable price available in the marketplace, pharmacies will make a higher profit. Market-based reimbursement models play an important role in keeping incentives aligned for payers and pharmacies.

Cost-Based or Cost-Plus Reimbursement Undermines Value-based Care

Reimbursement requirements discourage pharmacies from joining plans' preferred pharmacy networks, which undermines value for patients. In addition to lowering total drug spending and patients' out-of-pocket costs[7], preferred networks improve health outcomes, promote high-quality care, and advance the transformation to value-based care by:

- Incorporating risk sharing with preferred pharmacies to encourage higher use of cost-effective generics and other evidence-based health promotion strategies
- Including pharmacists in teams that integrate care for high-risk patients
- Incentivizing pharmacies to provide patient care services and supports as part of accountable care arrangements and other ways to further health outcomes

Bottom Line: Legislation requiring pharmacy reimbursement by employers and other plan sponsors is designed to benefit pharmacies, at the expense of patients, taxpayers, employers, and other plan sponsors.

[6] For example, when Medicare Part D plans switch to preferred pharmacy networks, beneficiaries, on average, pay lower premiums and lower out-of-pocket prices for drugs, with no concurrent reduction in access to drugs or pharmacies. *See* Oliver Wyman. Impact of the Elimination of Preferred Pharmacy Networks in the Medicare Part D Program. March 7, 2014.

[7] Amanda Starc and Ashley Swanson. "Promoting Preferred Pharmacy Networks." 1% Steps for Health Care Reform. 2021; and Milliman. The Value of Alternative Pharmacy Networks and Pass-through Pricing. 2010.