

A System Without Rebates: The *Drug Channels* Negotiated Discounts Model

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Background

- In May, the U.S. Department of Health & Human Services (HHS) released [American Patients First](#). This report offers a detailed diagnosis of U.S. drug pricing along with the unintended consequences and warped incentives of our drug channel system.
 - The [gross-to-net bubble](#)—the difference between a manufacturer’s list price for a drug and the net price after rebates and other reductions—reached \$153 billion in 2017.
 - Patients with prescription drug deductibles and coinsurance face out-of-pocket costs linked to a drug’s undiscounted, pre-rebate list price, not to the net price.
- Key administration officials (Alex Azar, Seema Verma, Scott Gottlieb) have repeatedly criticized rebates and the drug channel’s reliance on list prices.
- Recent congressional testimony has outlined a long-range vision for a new system:
 - “[W]e may need to move toward a **system without rebates**, where PBMs and drug companies just negotiate fixed-price contracts. Such a system’s incentives, detached from artificial list prices, would likely serve patients far better.” –Alex Azar, 6/12/18
- The HHS [Request for Information](#) asked for feedback about “Reducing the impact of rebates,” stating in part:
 - “What should CMS consider doing to restrict or reduce the use of rebates? Should Medicare Part D prohibit the use of rebates in contracts between Part D plan sponsors and drug manufacturers, and require these contracts to be based only on a fixed price for a drug over the contract term?” – RFI, 5/16/18

Objectives

- In the following pages, I sketch out a possible new channel system that would:
 - Respond to the HHS vision for a “system without rebates”
 - Remove/decrease the reliance on list price as a component of intermediary compensation
 - Use negotiated discounts as an alternative to the current system of retrospective rebates
 - Require manufacturers to negotiate for desirable market access
- I have not attempted to determine *how* the current system could evolve or be changed into the new channel system. I highlight implementation issues on the last page.
- For background and analysis of the current drug channel system, see Drug Channel Institute’s [2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers](#).
- I welcome feedback on how to improve/refine this model.

Key Aspects of the *Drug Channels* Negotiated Discounts Model (1 of 2)

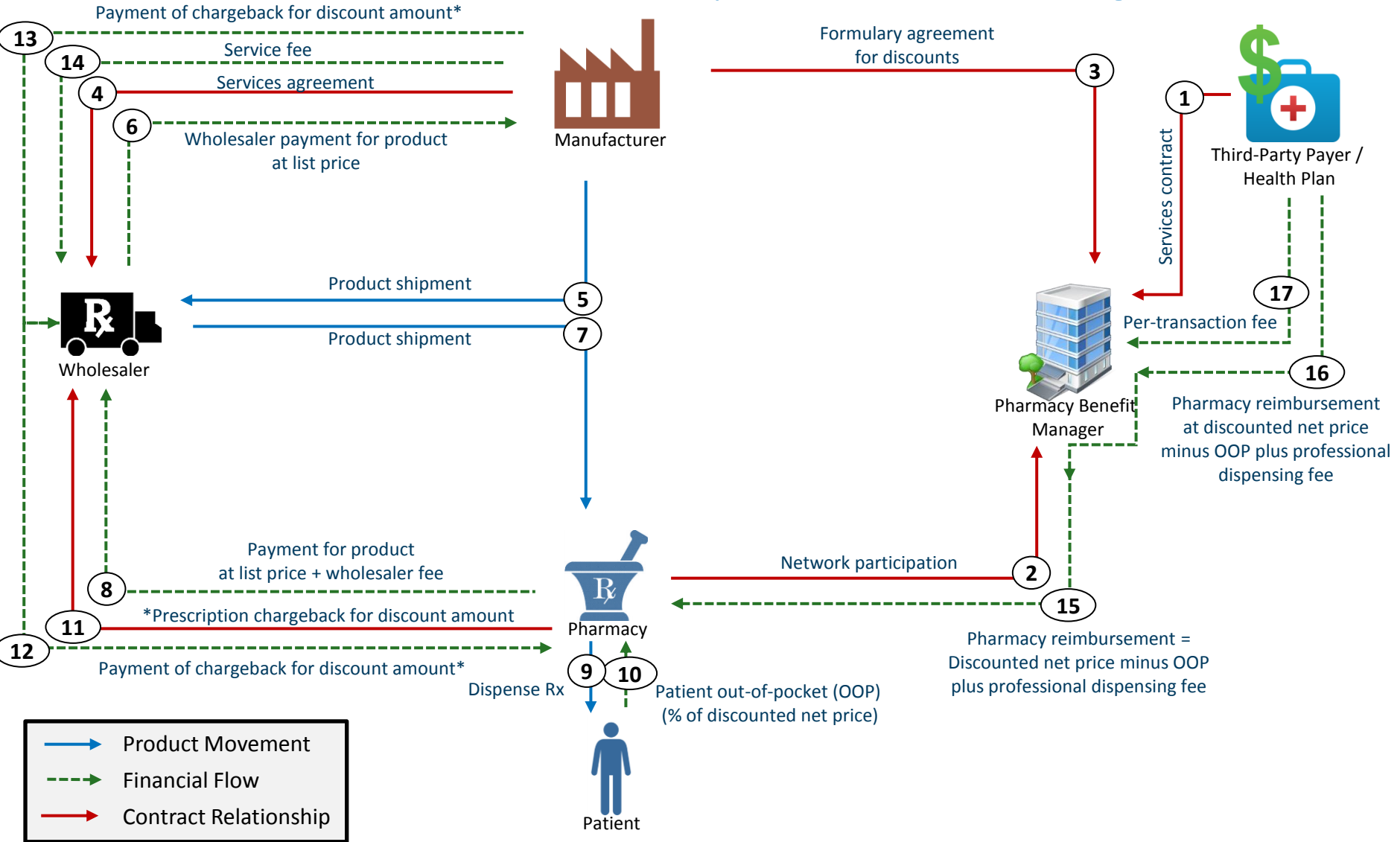
- PBMs would function as a combination of GPOs and benefit plan administrators.
 - PBMs would negotiate upfront discounts with manufacturers on behalf of plan sponsors. Plan sponsors continue to use formularies to favor certain products.
 - PBMs would handle the flow of funds from the payer to pharmacies, but earn only fixed per-transaction fees.
 - PBMs would not be compensated with manufacturer-paid administrative or service fees.
 - Neither PBMs nor plan sponsors would participate in a flow of rebate funds from a brand-name manufacturer.
- A patient's out-of-pocket payment would be either a flat copayment or a coinsurance based on the net discounted price (after rebates).
 - Patient out-of-pocket costs would decrease compared with the current system.
 - Manufacturers would still be able to provide copay offset support to patients.
- The existing physical distribution system would remain in place. However, the compensation of distribution intermediaries—wholesalers and pharmacies—would not be based on a drug's list price.
 - Wholesalers would be compensated by manufacturers and pharmacies based on per-unit or per-service fees that are unrelated to a drug's list price.*
 - Pharmacies would earn fixed per-prescription professional dispensing fees (as they do for fee-for-service Medicaid prescription dispensing).

Key Aspects of the *Drug Channels* Negotiated Discounts Model (1 of 2)

- The system would require the development of a new type of per-prescription, plan-specific chargeback.
 - Traditional chargebacks permit discounted acquisition costs for a pharmacy's or provider's entire purchases. Here, the chargeback would be a per-prescription discount that is specific to a patient's benefit plan design.
 - Manufacturers and payers would gain more transparency and data about the sale and distribution of prescription products.
- The warped incentives of the gross-to-net bubble would vanish or be minimized.
 - PBMs and plans would prefer a product, portfolio of products, or therapeutic category with the lowest discounted net price.
 - The net discounted price would still be based upon formulary placement, the number of competitors, placement vs. competitors, and other factors.
 - When evaluating two drugs with comparable net prices, PBMs and plan sponsors would have no incentive to favor the high-list/high-rebate product over the product with a lower list price and smaller discount from list.
 - A brand-name manufacturer would no longer have an incentive to increase list price for better formulary placement. Any increase in list price would be based on business and economic conditions.*

* If manufacturers are required to provide advance notification of price increases, then the distribution channel could profit from price increases. See [Thanks, California! SB17 Will Trigger Massive Speculative Buying, Windfall Pharmacy Profits, and Supply Chain Disruption](#), *Drug Channels*, October 2017.

The Drug Channels Negotiated Discounts Model: Patient-Administered, Outpatient Brand-Name Drugs



Source. Drug Channels Institute research. Chart illustrates hypothetical flows for a patient-Administered, outpatient brand-name drug.

* The chargeback is a per-prescription discount that is specific to a patient's benefit plan design.

Channel Flows in the *Drug Channels* Negotiated Discounts Model (1 of 2)

1. The plan sponsor hires a PBM for administrative services associated with prescription drug benefit plans, including: plan design and administration; formulary development and management; member services; utilization management; reporting; and other claims-related services. The PBM earns service fees from the plan sponsor.
2. The PBM assembles a network of pharmacies that are electronically linked to the PBM.
3. PBMs negotiate for pricing concessions from brand-name manufacturers. These concessions are structured as *discounts* that are applied at the point of prescription dispensing.
4. The manufacturer and wholesaler negotiate compensation for distribution services that is based upon fixed fees per unit or fixed fees per service.
5. The manufacturer ships a large volume of products at the list price to a drug wholesaler. The wholesaler places these products into its inventory.
6. The wholesaler pays the manufacturer for the products. (The wholesaler could receive standard payment terms, e.g., cash discount for payment within a specified number of days.)
7. The pharmacy orders product from the wholesaler and places the product into its inventory.
8. The pharmacy pays the wholesaler for the product at the list price plus a fee for the wholesaler's services. (The pharmacy could still receive payment terms from the wholesaler.)
9. A patient with insurance fills a prescription at a network pharmacy.
10. Using the patient's insurance plan, the pharmacy determines the discounted net price of the prescription. The patient pays a copayment or a coinsurance based on the discounted net price.

Channel Flows in the *Drug Channels* Negotiated Discounts Model (1 of 2)

11. The pharmacy submits a plan-specific, per-prescription chargeback request for the discount amount to its wholesaler.*
12. The wholesaler credits the pharmacy for the discount amount. The pharmacy's net acquisition cost is now equal to the net discounted price, i.e., the list price minus the plan-specific prescription chargeback, plus the wholesaler fee.*
13. The wholesaler submits the plan-specific, per-prescription chargeback request to the manufacturer and is paid by the manufacturer.*
14. The manufacturer pays the wholesaler the fee negotiated in flow 4.
15. The pharmacy submits an invoice to the PBM for the remaining prescription balance minus: (1) the patient's out-of-pocket obligation, and (2) the discount amount is applied. The PBM pays the pharmacy the discounted net price minus the patient's out-of-pocket obligation plus the professional dispensing fee. The dispensing fee is determined per the [Medicaid Program; Covered Outpatient Drugs; Final Rule](#), Section 447.502.
16. The PBM submits an invoice to the plan sponsor for the amount paid to the pharmacy (list price minus discount amount, minus patient out-of-pocket). The plan sponsor reimburses the PBM for the amount paid to the pharmacy.
17. The plan sponsor pays a per-transaction flat fee to the PBM.

* For flows 11 to 13, an alternative approach would permit the manufacturer to provide the discount directly to the pharmacy.

Implementation Issues and Challenges

- The discounted net price would be visible via the per-prescription chargeback system and the amounts shown to the patient at the point of dispensing. This level of transparency could reduce total discounts that manufacturers are willing to offer. There will need to be a technological solution to protect proprietary discounting information.
- Upfront discounts could conflict with outcomes- and value-based contracting, because outcomes may occur long after discounts are negotiated. In theory, the net discounted price could be adjusted with a product guarantee or warranty refund.
- The technology standards and transactional infrastructure to implement the new per-prescription chargeback system need to be developed.
- New types of data would be transmitted among drug channel participants. To compute/audit the per-prescription discount, for example, pharmaceutical manufacturers would need plan numbers and benefit designs as part of the chargeback data set.
- The negotiated discounts system may not be able to coexist with the current rebate system. It will be difficult for companies to operate simultaneously with both the current and future system.
- This system applies to products covered under a patient's pharmacy benefit. It may not apply to provider-administered products covered by a patient's medical benefit.