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Margin Shifting: Erosion of health system pharmacy margins by for-profits

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Learning Objectives

- Explain the drivers that are shifting pharmacy-related margins from health systems to for-profit companies.
- Describe strategies to prevent and mitigate margin-shifting actions.
- Discuss broader market trends and forces driving the shifts in sites of care and drug use for 340B hospitals and integrated delivery networks.

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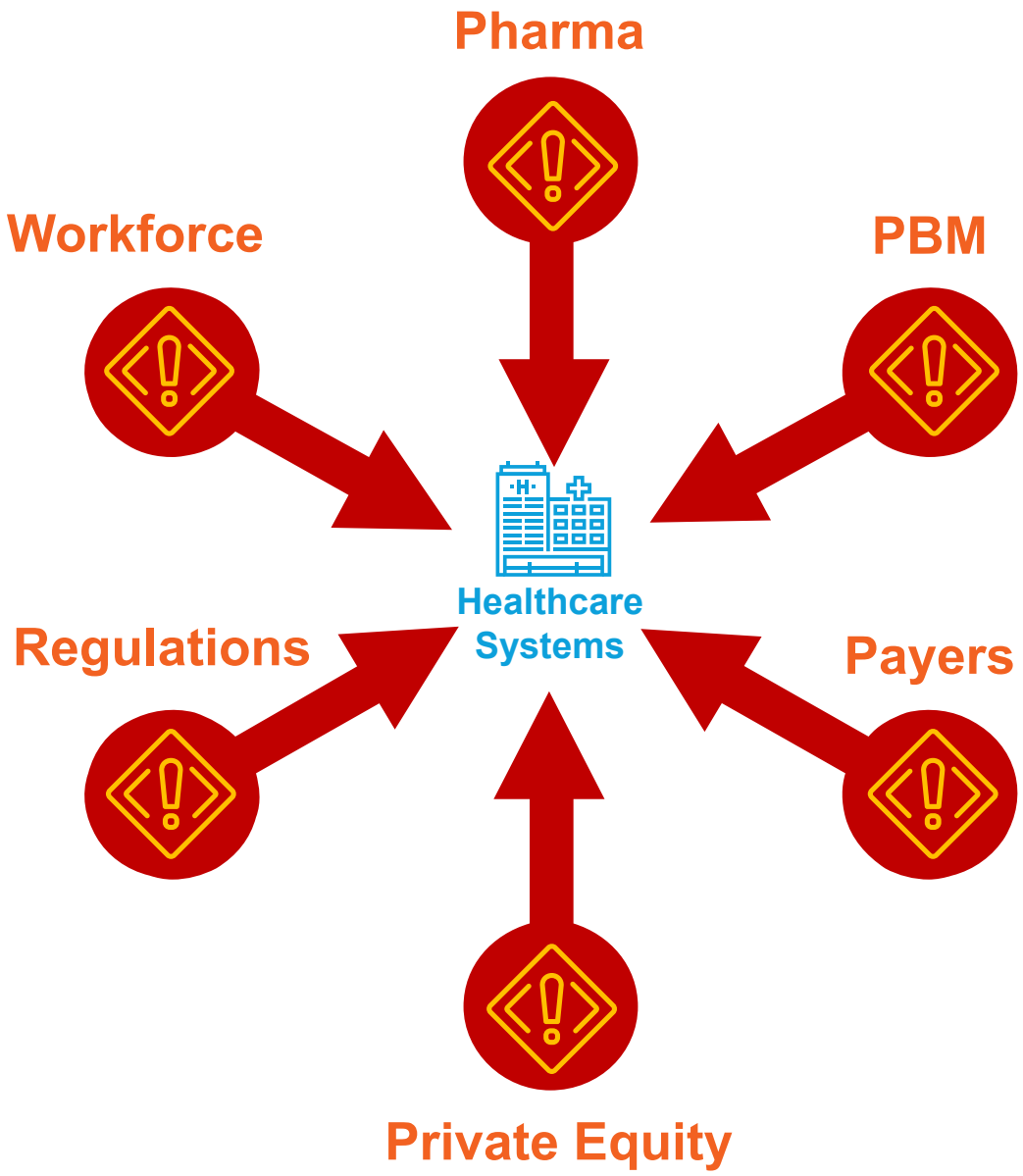
Threats to Healthcare Systems



Examples of Drivers That Are Shifting Margins to For-Profits

Pharma

- Restrictions/limitations to 340B contract pharmacies by eliminating bill-to/ship-to relationships
- Limited Distribution Drug (LDD) networks exclude 340B covered entity pharmacies

Payers

- Specialty pharmacy limited networks exclude 340B covered entity pharmacies
- Biosimilar designations based on rebate payments to payer vs best pricing for hospital/health system.
- White Bagging / require outpatient administered medications be obtained by payer/PBM designated pharmacy vs. health system
- Unfavorable contract terms reduce reimbursement and set unreasonable credentialling requirements

PBM

- 340B price discrimination when 340B prescription eligibility is known or suspected

Payers/PBM

- Direct and indirect remuneration (DIR) fees claw back payments from hospital/health system

Private Equity (Multiple Sites of Care)

- For-profit firms that provide “solutions” and contract terms to health systems which are financially lopsided and hard to extricate out of for future autonomy (e.g., specialty pharmacy, 340B data/transaction administrators, rebate aggregators).

Questions?

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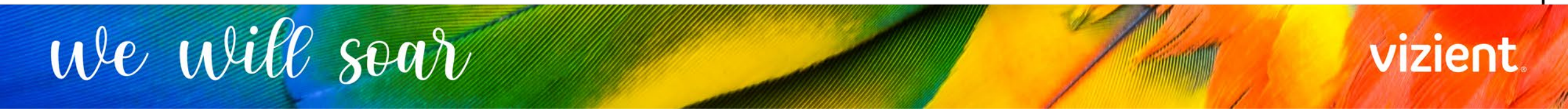

Appendix

Examples of Drivers That Are Shifting Margins to For-Profits (1/3)

#	For-profit	Site of Care	Action	Impact
1	Pharma	Retail/Specialty Pharmacy	**Prevent 340B contract pharmacies** by eliminating bill-to/ship-to relationships	Decreased access to 340B discounted drugs by covered entities; manufacturers continue to sell drug but at non-340B discounted prices; increased burden on pharmacy for infrastructure costs
2	Pharma	Retail/Specialty Pharmacy	**Limited Distribution Drug (LDD) networks** that exclude 340B covered entity pharmacies	Decreased access to 340B discounted drugs by covered entities; manufacturers continue to sell drug but at non-340B discounted prices
3	Payers	Retail/Specialty Pharmacy	**Specialty pharmacy limited networks** that exclude 340B covered entity pharmacies	Drives prescriptions to vertically integrated, payer-owned pharmacy to keep margin inhouse or to special arrangement pharmacies that would enable manufacturer rebates to payers versus 340B discounts to covered entities

Examples of Drivers That Are Shifting Margins to For-Profits (2/3)

#	For-profit	Site of Care	Action	Impact
4	PBM	Retail/Specialty Pharmacy	Reduced reimbursement to pharmacies when 340B prescription eligibility is known or suspected (e.g., **340B price discrimination**)	Pharmacy receives reduced payment by the PBM for prescriptions that are eligible (or even just suspected to be by covered entity relationship) for 340B. PBM pays less, Pharmacy margin is reduced.
5	Payers/PBM	Retail/Specialty Pharmacy	**Direct and indirect remuneration (DIR) fees** intended to tie to quality measures (e.g., adherence).	Payers and PBMs claw back payments made to pharmacies for dispensed prescriptions. Lack transparency and minimal, if any, ability to reduce.
6	Payers	Outpatient Infusion Center (HOPD and Free-Standing)	**Biosimilar designations** for outpatient administrations **based on rebate** amount to payer, not best pricing for hospital/health system.	Hospital/health system may be required to purchase a higher-priced biosimilar to prevent claims denials. Also requires cost for additional overhead to manage multiple biosimilars for same reference drug and billing denials.

Examples of Drivers That Are Shifting Margins to For-Profits (3/3)

#	For-profit	Site of Care	Action	Impact
7	Payers	Outpatient Infusion Center (HOPD and Free-Standing)	Require outpatient administered medications be obtained by payer/PBM designated pharmacy vs. health system (e.g., **White Bagging** vs. Buy-and-Bill).	Health system pays for all of the infrastructure to safely infuse/administer medication, external pharmacy (likely payer-owned) receives revenue, payer potentially receives manufacturer rebate, manufacturer avoids 340B discount.
8	Payers	Outpatient Infusion Center (HOPD and Free-Standing)	**New contract terms** by large national payer networks that set unreasonable credentialling requirements and **significantly reduce reimbursement**.	Health systems required to comply with new contract terms and price concessions or lose large portion of business.
9	Private Equity	Multiple	**For-profit firms that provide "solutions"** to health systems through contracting terms that are financially lopsided and hard to extricate out of for future autonomy (e.g., specialty pharmacy, 340B data/transaction administrators, rebate aggregators).	Health system may receive the benefit of fast-tracking a service or program but loses significant portion of financial opportunity, especially as program matures.