The Pharmacist Activist

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Editorial

Our Profession's Own Pharmacy Care Administrator (PCA): Can a Dream Become Reality?

No other situations have had more of a destructive impact on community pharmacy practice and the provision of pharmacist services to patients than the unfair, oppressive, and non-negotiable terms of pharmacy benefit manager (PBM) prescription programs and their abysmal compensation for pharmacists. The most severe consequences are experienced by independent pharmacists, but many chain pharmacies are also negatively affected. For example, Rite Aid's financial problems are such that its best hope is that it will be acquired by Walgreens. Target, with its extensive and successful retail experience, could not find a way to be financially successful in operating its pharmacies, with the result that it sold them to CVS.

Concerns about PBMs and their programs have been the subject of numerous previous editorials in *The Pharmacist Activist* (for example, please see "Prescription Drug Prices – Billions for Pharmaceutical Companies, Insurance Companies, and PBMs, but Pennies for Pharmacies" in the March 2016 issue, "Outrages! – But Some With Opportunities!" in the May 2016 issue, and "Understanding and Reducing Drug Prices Must Start with Transparency" in the October 2016 issue). In March I had the opportunity to give a presentation in which I shared some of my "dreams" for the profession of pharmacy, one of which is the following:

> "The profession of pharmacy will establish our own prescription drug benefit administration program that provides incentives for achieving positive therapeutic outcomes for patients and equitable compensation for pharmacists, and does not include restricted networks or financial incentives that prevent or discourage continued use of the local pharmacy with which there is a long-term professional relationship and friendship with a personal pharmacist. The current system fragments pharmacist care and increases risk in the use of medications. We can provide a better, safer, and more efficient program.
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> But can our profession afford such a program? There is a declaration that we have heard often in the last year that can be adapted for our purpose. 'Mexico will pay for the wall.' Our version will be, 'Pharmaceutical companies will pay for this program,' and I would quickly add that it will be in their best interests to do so. After all, it is the drugs they have developed for which we as pharmacists will increase effectiveness and safety, increase societal recognition of the value of medications, and increase the companies' return on their investments."

This "dream" has been a strongly-held opinion of tens of thousands of pharmacists for many years, but the PBM programs have only gone from bad to worse. However, recent events and accusations of pharmaceutical companies, PBMs, and insurance companies against each other have resulted in a greater awareness of the secrecy, manipulation, and deception that characterizes many of the existing prescription benefit programs. Notwithstanding the size, wealth, and political influence of these companies, progressive change is necessary and the time is right for the dream of pharmacy's own pharmacy care administrator (PCA) to become a reality.

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Recent events and accusations

With the exception of the pharmaceutical companies that establish the prices for medications, almost everyone else is very concerned about the high cost of prescription drugs in the United States. In attempting to defend the prices for their medications, the pharmaceutical companies respond that nobody actually pays those prices because the PBMs and others demand such large rebates and discounts. The PBMs respond by saying the prices the companies charge are so high that they are forced to insist on much lower prices. When the pharmaceutical companies and PBMs are asked the specific amounts of discounts and rebates, both groups respond that the information is proprietary and can't be disclosed. The failure to substantiate accusations with specific information results in the further erosion of credibility of both the pharmaceutical companies and the PBMs. One estimate of the discounts, rebates, etc. is that, on average, they are 44% off the list prices of brand-name drugs. The PBMs claim to pass on most of these "savings" to their clients, but the specifics are a secret and even the clients are significantly restricted in what they can learn from their audits of the PBM they use ("Inside the 'Scorpion Room' Where Drug Price Secrets Are Guarded;" Bloomberg, May 4, 2017, Neil Weinberg and Robert Langreth).

The three largest PBMs, Express Scripts, CVS Health, and OptumRx (a unit of United Health) processed approximately 70% of the prescriptions in the United States in 2016. Anthem is one of the largest health insurance companies in the country and it has a 10-year contract with Express Scripts to administer its prescription plans through 2019. However, Anthem has sued Express Scripts for about $15 billion, accusing it of overcharging at a rate of about $3 billion a year during part of the contract period because it was not passing on what Anthem considered to be its share of the "savings" that the PBM had obtained from rebates and discounts from pharmaceutical companies. Express Scripts has recently noted that it does not expect Anthem to continue as a client when the current contract concludes at the end of 2019.

Anthem is Express Scripts largest client and accounted for 16% of the prescriptions that the PBM processed in 2016. Although Express Scripts contends that the contract underperformed in its early years, it currently is very profitable for the PBM as noted in the following commentary in the *Wall Street Journal* (April 26, 2017; p. B16; Charley Grant):

> "Regardless of whether Anthem has a legitimate legal claim, there is no doubt that the contract was extraordinarily lucrative for Express Scripts as measured by unit profitability. That metric, reported as earnings before interest, taxes, depreciation, and amortization per prescription filled was $8.39 from the Anthem business in the first quarter. Express Scripts booked just $3.25 per script filled from other customers."

Perhaps such data has been available previously and I was just not aware of it. However, I am shocked by these numbers for processing prescription claims, particularly in the context of how Express Scripts and other PBMs have dictated such low compensation for the pharmacists who maintain the inventories of expensive medications, dispense the medications, and are expected to provide counseling and other services for patients.

The profession of pharmacy must no longer tolerate the disrespect and abuse to which we have been subjected. Most previous efforts to persuade, negotiate, and legislate positive changes have resulted in failures and frustration. If anything, we are caught in a downward spiral of exclusion from networks, unjustified fees, reduced compensation, and further loss of autonomy. We don't stand a chance in battles with giant pharmaceutical companies, insurance companies, and PBMs - UNLESS we have a better plan and own the program. The time to do this is NOW, while the pharmaceutical companies, PBMs, and insurance companies are fighting with and suing each other in efforts to determine which is most at fault for the exorbitant prices of medications.

Our own pharmacy care administrator (PCA)

The profession of pharmacy must continue its advocacy for legislative initiatives that will provide relief from the restrictions and conditions imposed by the PBMs. However, those who oppose our efforts are formidable and wealthy and, at best, successes will be compromises that will take many years to accomplish. We can't wait that long! Therefore, our best opportunity is to develop a system/program that will be quickly recognized to be superior to those that are currently available. To achieve this, I have the following observations and recommendations:

1. The mere mention of the designations "pharmacy benefit manager" and "PBM" has such negative and deceptive connotations that a different designation such as "pharmacy care administrator (PCA)" must be used. The use of the word "administrator" instead of "manager" must not be interpreted to mean that the proposed program will only be addressing the financial parameters of prescription claims. Rather, the program will include and provide incentives for high standards of pharmacy practice, positive therapeutic outcomes, and strategies to negotiate costs of medications in a manner that is cost-effective and consistent with quality standards.

2. A task force should be convened that would include individuals who have a commitment to the provision of the highest quality of pharmacist services and the advancement of the professional roles of pharmacists, and who have expertise with respect to pharmacist services and/or the legal, financial, organizational, management, and other areas that are critical for the success of the new program. I recommend that the leadership of the American

(Continued on Page 4)

New Therapeutic Agents Marketed in the United States in 2016

Generic name	Trade name	Manufacturer	Therapeutic classification	Route of administration	FDA classification[a]	New Drug Comparison Rating[b]
Alectinib	Alecensa	Genentech	Antineoplastic agent	Oral	1-P	4
Atezolizumab	Tecentriq	Genentech	Antineoplastic agent	Intravenous	P[c]	4
Brivaracetam	Briviact	UCB	Antiepileptic drug	Oral; intravenous	1-S	2
Cariprazine hydrochloride	Vraylar	Allergan	Antipsychotic agent	Oral	1-S	2
Defibrotide sodium	Defitelio	Jazz	Profibrinolytic agent	Intravenous	1-P	5
Elbasvir/grazoprevir	Zepatier	Merck	Antiviral agents	Oral	1,4-P	3
Eteplirsen	Exondys 51	Sarepta	Agent for muscular dystrophy	Intravenous	1-P	4
Insulin degludec	Tresiba	Novo Nordisk	Antidiabetic agent	Subcutaneous	1-S	3
Ixekizumab	Taltz	Lilly	Agent for psoriasis	Subcutaneous	S[c]	3
Lesinurad	Zurampic	Ironwood	Agent for gout	Oral	1-S	4
Lifitegrast	Xiidra	Shire	Agent for dry eye disease	Ophthalmic	1-P	4
Lixisenatide	Adlyxin	Sanofi	Antidiabetic agent	Subcutaneous	1-S	2
Nusinersen	Spinraza	Biogen	Agent for spinal muscular atrophy	Intrathecal	1-P	5
Obeticholic acid	Ocaliva	Intercept	Agent for primary biliary cholangitis	Oral	1-P	4
Obiltoxaximab	Anthim	Elusys	Agent for inhalational anthrax	Intravenous	S[c]	3
Olaratumab	Lartruvo	Lilly	Antineoplastic agent	Intravenous	P[c]	4
Patiromer sorbitex calcium	Veltassa	Relypsa	Agent for hyperkalemia	Oral	1-S	4
Pimavanserin tartrate	Nuplazid	Acadia	Antipsychotic agent	Oral	1-P	5
Reslizumab	Cinqair	Teva	Antiasthmatic agent	Intravenous	S[c]	2
Rucaparib camsylate	Rubraca	Clovis	Antineoplastic agent	Oral	1-P	4
Selexipag	Uptravi	Actelion	Agent for pulmonary arterial hypertension	Oral	1-S	4
Sugammadex sodium	Bridion	Merck	Muscle relaxant reversal agent	Intravenous	1-P	4
Velpatasvir/sofosbuvir	Epclusa	Gilead	Antiviral agent	Oral	1,4-P	4
Venetoclax	Venclexta	AbbVie	Antineoplastic agent	Oral	1-P	4

[a]FDA classification of new drugs: 1 = new molecular entity; 4 = combination product; S = standard review; P = priority review
[b]New Drug Comparison Rating: 5 = important advance; 4 = significant advantage(s); 3 = no or minor advantage(s)/disadvantage(s); 2 = significant disadvantage(s); 1 = important disadvantage(s)
[c]A biological approved through an FDA procedure that does not assign a numerical classification

Pharmacists Association (APhA) and the National Community Pharmacists Association (NCPA) identify individuals who have the needed expertise and convene this task force as quickly as possible.

3. Unless there are legal or other considerations that would preclude doing so, I recommend that APhA and NCPA develop, with appropriate collaboration and contracts with others as needed, and *own* the proposed program. An alternative possibility would be to have the pharmacists who participate in the program have ownership involvement in a manner similar to the structure of current pharmaceutical wholesaler/independent pharmacist collaborative organizations.

   I anticipate that the proposed program would be a very attractive opportunity for potential investors. However, it is essential that the ownership and other influences within the program reside and remain in the profession of pharmacy. There have been some previous initiatives that were developed with good intentions for patients and pharmacists that, when they reached a certain level of size and success, were acquired by a large PBM or otherwise moved in a direction with very different priorities. Safeguards must be put in place for the continued assurance of positive therapeutic outcomes for patients and advocacy for the advancement of the professional roles of pharmacists.

4. A network of pharmacies can be quickly established. Specifically, independent community pharmacies provide the opportunity for establishing the largest network of participating pharmacies with the broadest geographical distribution. Provision would also be made for the participation of selected chain pharmacies that are willing to meet the standards of the proposed program and provide the expected counseling, monitoring, and other professional services.

   Many independent pharmacies, as well as some chain pharmacies, are currently struggling to financially survive. The proposed program would provide an opportunity to not only survive, but thrive, both professionally and financially, and also encourage entrepreneurism that would result in the establishment of new independent pharmacies.

   We must recognize, however, that there are community pharmacists who have not remained current with respect to the advances and other changes in drug therapy, and who are not in a position to now acquire that expertise, or hire another pharmacist who has the expertise to implement programs such as medication therapy management that would be included in the proposed program. For these situations, the professional organizations that own and administer the program, in collaboration with colleges of pharmacy, could establish a network of pharmacists and student pharmacists with expertise in providing such services who could be retained on a part-time or consultant basis by the pharmacies having these needs.

5. The proposed program will provide equitable compensation for pharmacists and be administered in a transparent manner. The latter feature alone will be very attractive to potential clients for whom the secrecy regarding the financial provisions of current programs has been cause for frustration and litigation.

A bold goal

The proposed program will require significantly greater resources to provide equitable compensation for participating pharmacists than is provided by the current programs administered by PBMs. However, in considering the billions of dollars that are presently extracted from prescription plans by PBMs for their "services" and profits, I am confident that the proposed program will not only have better and safer outcomes for patients, as well as equitable compensation for pharmacists, but also will be provided more efficiently.

Recognizing my personal lack of expertise and experience with respect to the development and operations of a pharmacy benefit program, I spoke with a pharmacist friend who has administered such programs. I asked him if my dream of our profession developing a program that would be competitive in recruiting Anthem as a client when its contract with Express Scripts concludes in 2019 was realistic. He promptly responded that he considered this realistic and I am emboldened to identify this as a goal. There will need to be earlier localized and incremental steps, the first of which is to establish the task force of experts!

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