RISK strategies CONSULTING

WHITE PAPER

The Highly Complex Pharmacy Supply Chain

Effects on Cost and Access to Critical Care

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The Highly Complex Pharmacy Supply Chain

Pharmacy Benefit Managers (PBMs) have served a key role in administering pharmacy benefits for decades, with their practices evolving over time to address changing market dynamics. Over the past few years, PBMs have faced scrutiny by key industry stakeholders due to their perceived lack of transparency, misaligned incentives, and failure to demonstrate value. Amid growing pressures from rising healthcare costs, PBMs and drug pricing have been thrust into the headlines, bringing these issues to the political forefront. While headlines are intended to raise awareness on these important issues, they have also shaped public perception in ways that may mistake and oversimplify the issues as well as divert focus from complexities and solutions.

Specialty pharmaceuticals, which are used to treat complex conditions such as autoimmune diseases and certain cancers, have driven a significant portion of the increase in pharmacy spending, including a recent approval of a gene therapy priced at over $4 million for an individual therapy.[1] As more specialty pharmaceuticals come to market and become a mainstay of treatment, pharmacy spend will continue to be driven exponentially higher. Advancements towards value-based pricing models, where the cost of a drug is linked to its clinical outcomes, are needed. This can help ensure the high prices of specialty pharmaceuticals are justified by their clinical benefits to patients.

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Given the rise in overall drug spend, and the related fact that it is the most utilized benefit by plan participants, it is important to examine PBMs closely, but with fair balance. A myopic focus on PBMs often overlooks the broader pharmaceutical supply chain, where multiple entities such as pharmaceutical manufacturers, wholesalers and distributors, the US government, group purchasing organizations (GPOs), health plans, pharmacies, healthcare providers and consultants play significant roles.

A clear understanding of all involved parties is crucial before attributing responsibility for the challenges contributing to affordable drug pricing. Accountability starts with understanding the multiple parties and layers of both the buy and sell sides of the pharmaceutical supply chain. Once the roles and relationships are clear, it is important to promote transparency among all players throughout the process.

This white paper will analyze the intricate and interdependent roles of key players within the pharmaceutical supply chain, each of whom, regardless of whether they are on the “buy” or “sell” side, has an opportunity to provide more transparency and the responsibility to contribute to medication affordability. A key underlying point to our analysis finds that other than the manufacturers who set price, and the government, all other members of the supply chain earn revenue from fees, spread pricing, or both. In order to attain full alignment and accountability, we need to recognize that the PBMs operate in such an environment and alone cannot bring true transparency and disclosure, as well as actual True Net Acquisition Cost.

Who are the players within the pharmaceutical supply chain, and what do they do?

Key players who are in scope:

1. Pharmaceutical Manufacturers (i.e., pharmaceutical companies or "pharma")
2. Wholesalers and Distributors
3. The US Government (federal and state)
4. GPOs (Provider and Formulary Rebates)
5. PBMs
6. Health Plans
7. Health Systems
8. Healthcare Providers (i.e., doctors)
9. Pharmacies
10. Consultants

1. **Pharmaceutical manufacturers** are at the top of the supply chain and establish baseline pricing. Pharmaceutical manufacturers are responsible for the research and development of medications that can impact the health, quality of life, and survival of patients. Investment and innovation by pharmaceutical manufacturers are critical to delivery of high quality care of patients; however, manufacturers bear a high level of financial risk as only about 12% of drugs that begin clinical trials will make it to Food and Drug Administration (FDA) approval.[2] Pharmaceutical manufacturers market their products within the supply chain to wholesalers and distributors, hospitals, healthcare providers, PBMs, pharmacies, consultants, and patients.

2. **Wholesalers and distributors** purchase goods from pharmaceutical manufacturers, negotiating pricing discounts, rebates, and other volume-based incentives with the pharmaceutical manufacturers for both distribution and data collection services. In turn, they sell and distribute the drugs to government, PBMs, pharmacies, hospitals, and healthcare providers at a profit. Wholesalers and distributors provide more than just shipping and logistics services; these entities sit in a unique section of the supply chain, as they work directly with the manufacturers and individual pharmacies that ultimately dispense the drugs. The services they provide to pharmacies include shipping, logistics, software, network access, and most importantly, product access.

3. **The Federal and State governments** are the largest buyers of pharmaceuticals. They also play a significant role of both regulating drug approvals through the FDA, as well as each of the other members of the supply chain.

   The government influences drug pricing both directly and indirectly. A government mandated lowering of reimbursement to pharmaceutical manufacturers, as we have seen recently as part of the Inflation Reduction Act (IRA), will result in increasing pressure (i.e., costs) on the private sector. For example, eighty percent of the drugs targeted by the IRA for 2026 saw price increases of 3% - 5% this past January.[3] The influences of government decisions can impact entities, such as hospitals, which may raise commercial rates when Medicare reimbursements are cut. The federal government also administers and oversees the 340B Drug Pricing Program enabling eligible healthcare providers to purchase outpatient drugs at significantly reduced prices, helping stretch resources to serve more low-income and underinsured patients. In recent years, this program has grown significantly, with various supply chain entities benefitting financially.[4] This growth has sparked controversy, raising questions about whether participants are using the program as intended.

4. **GPOs** exist in many ways and in many industries. Within the pharmaceutical supply chain GPOs can work with pharmaceutical manufacturers to provide administrative services such as credentialing and establishing provider networks. In return, Provider GPOs negotiate incremental drug discounts to pass on to network providers, while retaining administrative and data fees. Provider GPOs also provide lowered pricing, and in some instances, rebates to healthcare providers, hospitals, and pharmacies. Pricing levels are based on manufacturer programs for volume and/or data requirements negotiated by Provider GPOs. These Provider GPOs, like Premier, Asembia, Vizient and MHA provide tremendous buy side value and are considered Provider GPOs within this white paper. These Provider GPOs typically target specific classes of trade.

   Sell side Formulary GPOs also exist. Companies like Ascent Health, Zinc, and Emisar have recently launched Formulary GPOs designed to aggregate formulary rebates to help lower drug costs for members and plan sponsors. These Formulary GPOs are typically owned by the PBMs and are headquartered in countries other than the US in order to optimize tax benefits.

5. **PBMs** serve multiple purposes, and their roles extend beyond being intermediaries. Negotiating drug prices is one of their most recognized functions. PBMs are also involved in a complex array of responsibilities, including ensuring health and safety, negotiating and coordinating pharmacy networks, as well as ensuring successful implementation and administration of pharmacy benefit plans. PBMs operate on both the buy side (i.e., negotiating mail, specialty, and retail pricing) and on the sell side (i.e., working with plan sponsors and patients). Given their distinct position in the midst of both sides of the supply chain, PBMs are among the most highly rated entities in our overall economy.

   Two common criticisms of PBMs are their lack of transparency and disclosure tied to spread pricing and that it is not uncommon for them to be “vertically integrated” in order to optimize their profits. There is a need to review each of these criticisms.

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It is critical to acknowledge that other than the manufacturers and government, every entity participating in the pharmacy supply chain receives disclosed and undisclosed, direct and/or indirect fees and revenue streams. PBMs are not unique in this manner. Addressing the issue only as it pertains to them does not solve the foundational issue of ensuring alignment and accountability when it comes to patient and plan sponsor interests.

In regard to vertical integration, this occurs in differing ways, not only in the pharmacy supply chain and in healthcare, but throughout our economy and across multiple industries. Vertical integration in pharmacy should bring greater efficiencies, lower costs, improved clinical outcomes, member experience, and provider experience. In fact, it should help eliminate the undesired realties of fragmented care. Vertical integration will lead to improved profit margin for the enterprise in question. Profit is not "inherently bad or wrong;" in fact, it is needed to invest in innovation. The measures of the service provider's value proposition become the critical consideration.

A high-level outline of the PBM's duties and position demonstrates why they are so highly regulated on both state and federal levels.

- *Administrative:* Benefit administration, setting coverage terms, ensuring compliance requirements are met, claims processing, and pharmacy network construct and reimbursement.
- *Financial:* Drug pricing negotiations, cost of goods, pharmacy network reimbursement, and responsibility for fraud, waste, and abuse monitoring.
- *Clinical:* Formulary development, creation/management of health and safety clinical alerts (as PBMs have a comprehensive view of all medications filled under a patient's pharmacy benefit), clinical management programs, and utilization management (clinical criteria managed for appropriateness of treatment).
- *Additional services:* Medical drug benefit management, digital health formularies, and specialty pharmacy services.

6. **Health plans** (and **Plan Sponsors** on the commercial side) negotiate with PBMs to provide medications for their covered population. These negotiations can be complex, sometimes involving the use of various group purchasing coalitions. The majority of people receiving pharmacy benefits do so through Commercial, Medicare, or Medicaid. Health plans are a central figure in both the buy and sell sides of the supply chain. Some own or are owned by PBMs. The performance of the PBMs is a critical success factor to the financial well-being of the health plans. Health plans also negotiate medical drug pricing and other financial terms (including rebates) from health systems for those drugs covered the medical piece of the health plan.

7. **Health systems** provide varying levels and types of care to patients. Health systems can be facility only based (in-patient and out-patient), as well as vertically integrated to include varying types of physicians. Health systems benefit from negotiated drug pricing discounts and rebates for drugs through their GPO agreements. Additionally, health systems that meet Section 340B Public Health Service Act definitions of an eligible 340B entity such as federally qualified health centers (FQHC) will have access to deeper discounts for certain brand drugs through the 340B program.

8. **Healthcare providers** are clinicians who provide care for the patient, prescribe medications, and charge for their services. These include, but are not limited to, physicians, physician assistants, nurse practitioners, optometrists, and dentists. Healthcare providers are core to our healthcare ecosystem, as they drive care decisions, coordinate care, and directly impact patient health. Healthcare providers also manage and bill health plans for services, including medical drugs, which require their supervision for administration. In these cases, they purchase the drug, administer it to the patient, and bill for both the drug and service, which is known as "buy and bill." This process is significant in the context of drug costs, as the "buy and bill" model allows healthcare providers to integrate drug costs into their billing, reflecting both the cost of the medication and the associated clinical services for administration.

9. **Pharmacies** deliver a critical service in interfacing with PBMs, wholesalers, healthcare providers, and patients. They deliver pharmaceutical products, provide clinical support, and are responsible for the safety of medications. Pharmacies differ, depending on if they are retail, mail-order or designated as a specialty pharmacy. Specialty pharmacies provide a distinct level of clinical and administrative support in comparison to a retail pharmacy.

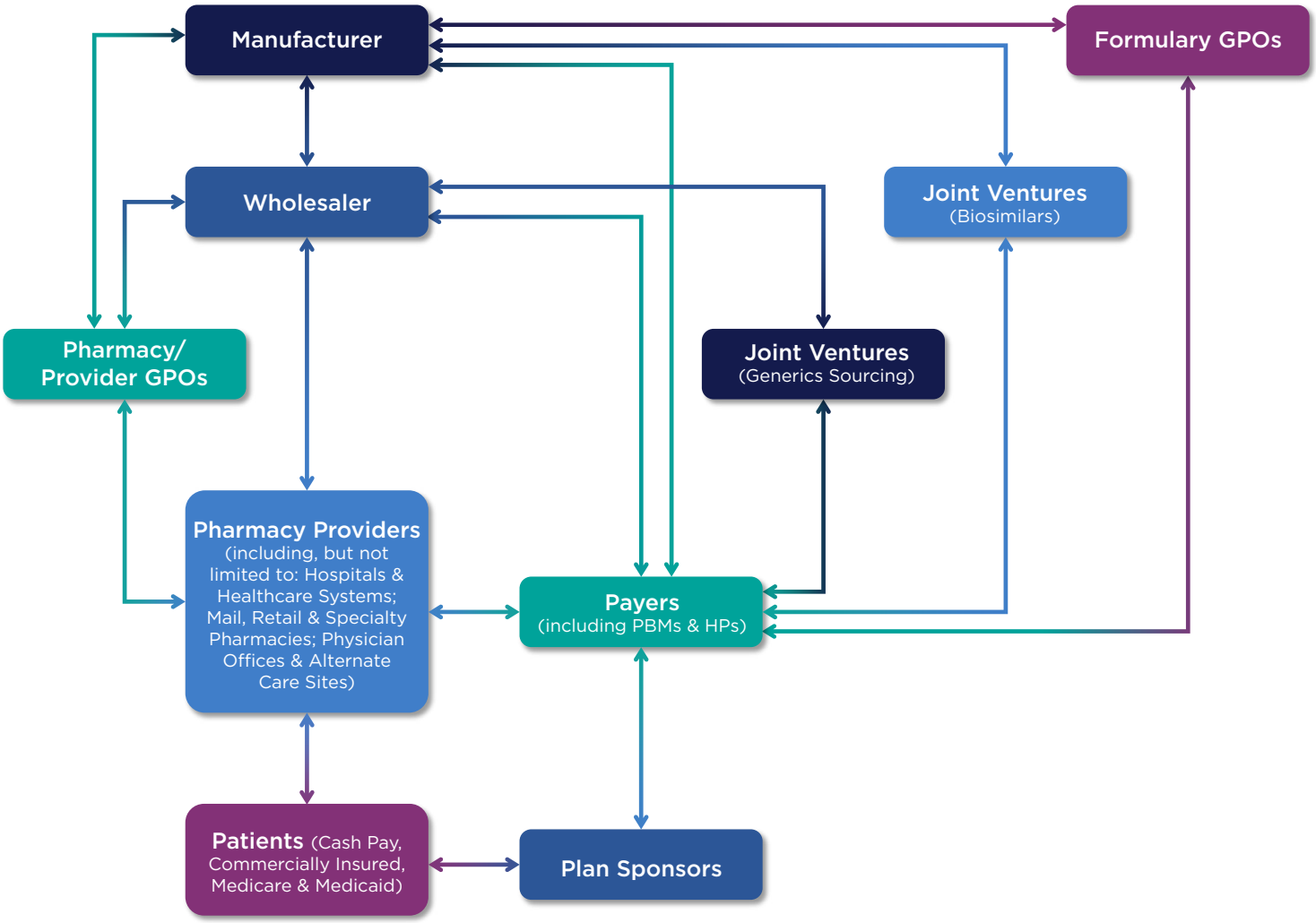
   Retail pharmacies are limited in their ability to support the dispensing of specialty drugs because they may lack the necessary accreditation, be unable to support the cold chain handling requirements, insufficient specialized clinical expertise, and/or technical capabilities including the ability to provide FDA required reporting. Each type of pharmacy (retail, mail-order and specialty) approaches purchasing and pricing differently.

   While not commonly discussed, pharmacies purchase drugs, leveraging GPOs and "Class of trade" discounts. Class of trade discounts are price reductions based on the classification of the purchaser. For example, a provider (physician class of trade) purchases certain medical drugs at a lower cost as compared to a pharmacy allowing for profitability through the prescribing and administration of the drug which is then sold to the patient (buy and bill).

10. **Consultants** serve as expert advisors who help negotiate PBM contract terms and pricing, ensure contract compliance, navigate benefit design, formulary application, and the selection of vendors that align with the needs and expectations of their clients. However, these interactions can be influenced by financial incentives or payments tied to service referrals which are often shaped by established relationships. Some consulting groups own coalitions involved in the supply chain, further complicating the ecosystem's dynamics, and in some cases, adding another layer of hidden fees and unknown administrative costs to the plan sponsor.

> It is important to note that Risk Strategies Consulting consults to pharmacy coalitions. We do not own or receive financial incentives from pharmacy coalitions or PBMs, which avoids perceived or actual conflicts of interest and reinforces the objectivity of our writings and services provided to our clients.

Illustration of Supply Chain Dynamics



How does a pharmaceutical manufacturer set pricing?

Several factors are considered when pharmaceutical manufacturers set their pricing, with profitability being a central consideration. Drug prices are influenced by numerous economic and business factors as viewed and experienced by the manufacturers. The immediacy at which US citizens typically receive access to pharmaceutical products as compared to the populations in other countries is one such consideration. The lengthy, difficult, and costly process tied to gaining FDA approval is another key consideration. For every drug that receives approval, there are copious others that fail at various stages of development and clinical trials, leaving costs to be recouped by those few drugs that make it to market. Pharmaceutical manufacturers have investors, and therefore must recoup research and development costs and make a profit.

Pharmaceutical manufacturers set the Wholesale Average Cost (WAC), also referred to as list price, which can change daily, based on their economic remuneration needs to get their drug to the marketplace, and ultimately, the patient. These prices are set and categorized according to class of trade. Examples of classes of trade include, but are not limited to, retail, mail-order, specialty pharmacies, hospitals, long term care (LTC) facilities, Veterans Affairs (VA) institutions, physician offices, home infusion services, government programs (including Medicare and Medicaid best pricing), and alternate care facilities.

Some drug costs are a direct result of FDA mandates with which pharmaceutical manufacturers need to comply, such as handling, quality control/pedigree, data collection, and reporting. Pharmaceutical manufacturers frequently outsource these administrative services to third parties, and their remuneration may come in various forms including bona fide services fees, as defined by the Centers for Medicare and Medicaid Services.

All of the above factors contribute to the final pricing of drugs. A WAC value is ascribed by the manufacturer to the drug as an estimate of the baseline price retail pharmacies pay for a drug from their wholesaler prior to contractual discounts. The Average Wholesale Price (AWP) is the index utilized by PBMs for the cost of brand, generic, and specialty drugs. AWP is generally derived by applying a simple mark-up of 20% to the WAC. As with WAC, AWP prices vary by drug on any given day based upon the price at which the drug was purchased.

The dynamics of generic drug pricing are far more volatile and sophisticated due to the larger number of manufacturers delivering alternatives with the resulting heightened level of competition. To account for these dynamics, Maximum Allowable Cost (MAC) pricing was established decades ago by PBMs to standardize marketplace reimbursement for generic drugs. This has helped grow competition and has lowered prices by enabling pharmacies to purchase product(s) from a larger number of sources, as compared to the sourcing availability of brand drugs.

How does the government impact pricing?

Government regulations play a key role in drug pricing dynamics and affect various segments of the healthcare market. Regulations result in direct and indirect consequences within the market. For example, when Medicare network reimbursement rates are reduced, healthcare providers and facilities often respond by increasing their fees in the commercial sector. This adjustment is a strategy to compensate for revenue deficits created with lower Medicare reimbursement. Government has just now begun the process of negotiating pharmacy reimbursement levels on a limited basis. The initial known results are mixed. The effects will change and grow on an as yet unknown basis as these negotiations are extended and expanded. The Inflation Reduction Act (IRA), which was passed in 2022, has far-reaching implications throughout the pharmacy ecosystem.[5] There and known and unknown outcomes and we expect both initial changes as well as a move towards future state possibilities, particularly as the law is enacted and evolves over a period of time. Key initial considerations include the following:

- **Coverage Gap Discount Program vs. Manufacturer Discount Program**

  The IRA introduces a fundamental shift in how pharmaceutical manufacturers contribute to Medicare Part D expenses, particularly through the transition from the Coverage Gap Discount Program to the Manufacturer Discount Program. In the Coverage Gap Discount Program drug manufacturers were responsible for 70% of drug costs. Now, under the IRA, manufacturers are responsible for 10% of drug costs during the initial coverage phase and 20% during catastrophic coverage. This redistribution of financial responsibility is designed to alleviate costs for Medicare and therefore creates an environment whereby pharmaceutical manufacturers are likely to increases prices to the commercial market in order to maintain profitability. This could result in higher drug prices for commercial plans or lead to strategic changes in how drugs are priced and marketed across different payor segments.

- **Reinsurance and Reimbursement**

  The IRA also brings substantial changes to the structure of government reinsurance for catastrophic coverage, reducing it from 80% to 20% of drug costs. The change transfers a larger portion of the financial responsibility to Medicare Part D plan, which must now cover 60% of catastrophic coverage costs. The drastic reduction in government reinsurance shifts the financial burden to private payors. The IRA also introduces a premium stabilization mechanism to limit the average premium increase for people enrolled in Part D. whose legality has been contested. This provision may introduce unintended consequences for taxpayers

The immediate consequence is likely to be an increase in new premiums and change in formularies for Medicare Part D. For the commercial market, the effects could be profound. We expect long-term impact with new drug launch pricing set substantially higher to compensate for impact of future price negotiations and the IRA Rebate Inflation penalties associated with drug price increases that outpace inflation. As Medicare Part D plans become more financially strained, payors may reduce the number of available Prescription Drug Plans (PDPs) or increase costs associated with these plans. In the commercial sector, there are fewer avenues to distribute such risk, which may result in drug prices increasing to plan members and consumers. Additionally, this could lead to decreased competition among PDPs, resulting in fewer choices for the consumer.

> The FDA's Accelerated Approval Program allows for expedited or earlier approval for drugs that address serious, life-threatening conditions.

Another key aspect of where government affects both price and cost are around contingent approval officially known as FDA Accelerated Approval.

The FDA's Accelerated Approval Program allows for expedited or earlier approval for drugs that address serious, life-threatening conditions. While this pathway enables faster access to potentially life-saving therapies, it also introduces significant challenges and complexities within the pharmaceutical supply chain.

Over the past five years, more than 15 oncology products that received accelerated FDA approvals were withdrawn from the market, either because they failed to deliver the promised clinical benefits or due to significant safety issues[6]. These oncology treatments, costing up to $250,000 per year, posed a substantial financial burden on plan sponsors, who ultimately paid for therapies that did not result in clinically meaningful improvements for the patient. Such withdrawals highlight the risks inherent in the accelerated approval process, where therapies are approved based on preliminary evidence. For the supply chain, these withdrawals create significant disruptions and financial impact. Specifically, plan sponsors and PBMs must reassess coverage decisions, and patients who have begun treatment with these drugs may need to transition to alternative therapies. With the Office of the Inspector General's (OIG) final rule providing safe harbor under the Stark Law and Anti-Kickback Statute, there is opportunity for pharmaceutical manufacturers to effectively leverage value-based agreements for therapies that have received accelerated approval.[7] These agreements can help ensure that payments are tied to actual patient outcomes, thereby mitigating financial risk, and enhancing the value provided to plan sponsors and patients.

Looking to Solve the Problems at Hand

This white paper has outlined the complexities of the buy-sell supply chain as well as the distinct position that the PBM sits within it. We have also touched on some of the legitimate concerns that PBMs create, and their limited ability to address foundational issues for which they are held disproportionately responsible.

PBMs have begun to deliver new pricing and financial models that increase disclosure and transparency. These models are a reasonable starting point but require further clarity and simplification.

It is in the best interest of the PBMs and their customers to offer financial models on a True Net Acquisition Cost basis. Disclosure of all direct and non-direct revenue streams will remove the existing distrust of the PBMs while also enabling them to demonstrate accurate and sophisticated value propositions tied to operational excellence, optimal clinical and financial outcomes, enhanced member and provider experience, as well as health equity. The models and approach we are putting forward would highly disrupt the marketplace. The results would include realization by buyers that the behaviors and practices of other members of the pharmacy supply chain would need to be addressed. There would need to consider how health plans and health systems would disclose or disgorge themselves of the revenue streams they are receiving, Consultants would need to build new valuation models that quantify and qualify non-financial issues and considerations while also moving their financial modelling to the needed per member per month cost basis. This leads to a series of questions around who has a state in maintaining the status quo and therefore, the overall readiness for change in the marketplace.

Acquisition cost and acquisition cost pricing are two very different things. Acquisition cost is what the purchasing entity pays for the drug; acquisition cost pricing is how the PBM prices the claim at the point of sale. Acquisition cost pricing is gaining momentum in the marketplace.

Acquisition cost leads to far greater transparency. It can also provide insights into purchasing incentives on the buy side that can drive pharmacies to prefer and dispense certain products (i.e., DAW-5, stocking programs, biosimilar interchange strategies.)

Under acquisition cost, the model and controls can facilitate transparency with auditing needs to ensure the fiduciary responsibilities can be met by employers for compliance with the Consolidated Appropriations Act (CAA). The alignment with acquisition cost pricing removes the impact of spread/arbitrage and volume-based incentives that are associated with opaqueness and distrust.

Shifting to acquisition cost and acquisition cost pricing models where the focus is on cost or PMPMs is a significant shift in paradigm as it relates to PBM pricing, can help foster alignment, and can be an asset to further comply with fiduciary responsibilities.

How does contingent approval (FDA accelerated approval) drug pricing impact the supply chain?

Risk Strategies Consulting has negotiated a series of contracts with major PBMs that enable transparency, disclosure, and audit defined by True Net Acquisition Cost. Our experience tells us that there are varying definitions of “transparency,” “pass-through,” “acquisition cost,” and “net acquisition cost.” A well-negotiated contract should include the following key provisions:

- Net Acquisition Cost should include all direct and non-direct manufacturer-based revenues received by the PBM. These include all rebates, post-purchase discounts, member education-based remuneration, invoice credits, purchase contract-based reconciliation amounts received form the manufacturer, wholesaler, distributor, or any other seller of the drug.

Pursuant to CMS definitions, acquisition costs exclude bona fide service fees. Any other non-legally and/or regulatory-required bona fide service fees negotiated with manufacturers and other entities should either be included in the calculation of Net Acquisition Cost or clearly delineated, valued, and disclosed to the plan sponsor, as well as being subject to full audit.

- Net Acquisition Cost excludes any portion paid by the drug manufacturer using copay assistance dollars, patient assistance funds, and drug manufacturer coupons. These types of subsidies should be delineated, valued, and disclosed to the plan sponsor, as well as being subject to full audit.
- For PBM-owned, mail-order and specialty pharmacies, calculating Net Acquisition Cost takes on a somewhat specific methodology. One must decide which supply chain-based contracting entity upon which Net Acquisition Cost is being calculated. Choices include the GPO in which the PBM participates, the PBM itself, or a subsidiary of the PBM that is contracted with the PBM for distribution to customers. Negotiation of Net Acquisition Cost for PBM-owned pharmacies also requires clear definitions and pricing of dispensing fees for specialty, brand, and retail medications. The dispensing fees for specialty drugs should vary/be tiered based upon a series of considerations, including inventory carry costs, complexity, and required timeliness for delivery of the medication to the patient, as well as other factors.
- PBM-owned pharmacies direct purchase product. As a result, acquisition cost is defined as the actual net purchase price at the NDC-11 level of the drugs dispensed from these pharmacies, and the monthly average unit purchase price across the PBM's Specialty Pharmacy book of business. These costs are determined based on actual purchase invoices, and/or remittance statements received from a PBM-owned pharmacy's wholesaler, manufacturer, distributor, and/or any other seller of the drug. In order to optimize transparency and cost effectiveness, the contracted rate should be at the same level as the PBM-owned pharmacy has negotiated through any GPO in which it participates. If no GPO is in place, the cost paid by the plan sponsor should match the rate that the PBM-owned pharmacy itself has negotiated. Care needs to be taken to avoid instances where the PBM-owned pharmacy has created a subsidiary or other entity for contracting purposes.
- Retail pharmacy acquisition cost is the pass through of an entity's **contracted rate** (discount and dispensing fee) **at the NDC-11 level** with each participating pharmacy at the NABP/NPI level based on its network participation agreement. The amount paid to the pharmacy is the amount that is billed to the client. The Net Acquisition Cost is based upon the price provided by the contracting entity from the retail pharmacy side. In order to optimize transparency and cost effectiveness, the contracted rate should be at the same level as the retail pharmacy has negotiated through any GPO in which it participates. If no GPO is in place, the cost paid by the plan sponsor should match the rate that the retail pharmacy itself has negotiated. Care needs to be taken to avoid instances where the retail pharmacy has created a subsidiary or other entity for contracting purposes. Is the contracting entity a GPO owned partially or in full by the retail pharmacy, the retail pharmacy itself, or a subsidiary/other entity created by the retail pharmacy for contracting purposes?

Understanding the entities with whom the underlying supply chain contracts lay, as well as the contracting terms and conditions themselves, are the foundation of needed alignment, accountability, disclosure, and transparency. This also includes thorough and complete audit rights that enable a full and accurate depiction of all applicable financial and non-financial terms and conditions. The subject matter expertise to fulfill these obligations lies with the consultant community. In turn, the consultants need to be held accountable for the depth, accuracy, and objectivity of their work product. Plan sponsors are facing significant challenges and liabilities around their fiduciary responsibilities. Scrutiny in this area will increase as likely will the number and types of lawsuits brought against plan sponsors for supposed failure to meet their fiduciary responsibilities. Plan sponsors need to protect themselves and their plan participants by requiring full disclosure and transparency as well as needed levels of expertise form their consultants. As with all other vendor partners, contracts between plan sponsors and their consultants should provide needed protections and transfer of liabilities.

The evaluation of PBMs often relies on traditional metrics such as rebates and guarantees, with insufficient emphasis on factors such as contracting transparency, True Net Acquisition Cost, clinical value, and health equity.

This includes a top-down grasp of the business model, sources of revenue (both direct and indirect), conflicts of interest, network dynamics, and supply chain interception points. Such an understanding is necessary to ensure transparency for appropriate auditing and contracting. It is vital to consider how the PBM purchases, and how their model is configured, for clinical, experience, and finance components. Expertise across contracting, analytics, and audit are paramount to assessing these details and translating them into impactful changes.

> “There are numerous entities and factors affecting drug pricing and utilization, with every player in the pharmacy supply chain adding to the issues at hand.

Conclusion

There are legitimate questions about PBMs, but there are also legitimate questions as to why the focus and concern have been solely on PBMs. Facts have been overrun by fear and confusion. Some entities have a stake in maintaining this dynamic. The fact that pharmacy benefit has its own language and jargon adds to the confusion, leading to emotion superseding critical thinking. We agree that aspects of PBMs require transformation to enhance transparency and better align with the interests of plan sponsors and members, but focusing solely on PBMs presents a limited perspective.

There are numerous entities and factors affecting drug pricing and utilization, with every player in the pharmacy supply chain—from manufacturers developing therapies to those ensuring that medications reach the right patients —adding to the issues at hand.

A disproportionate amount of government hearings, regulatory actions, and content published or shared on social media has focused only on the actions of the PBMs. Throughout this white paper, several key players were highlighted, each uniquely positioned within the supply chain who limit transparency and disclosure around various fees and revenue streams they collect. Realization of needed solutions require alignment and accountability from each and all members of the buy and sell sides of the supply chain.

As with all payor types, PBMs must deliver value based on cost of goods, operational excellence, optimal clinical and financial outcomes, enhanced member and provider experience, as well as health equity. The adoption of True Net Acquisition Cost will enable the market to move forward into more sophisticated and needed value propositions.

Due to both the present and future levels of drug spend, as well as the ways emerging drug therapies will change how care is delivered, it is critical that PBMs evolve and innovate to a "pharmacy first" rather than "pharmacy only" business model. The PBMs will need to invest in broader and deeper data sets including medical claims, laboratory results, unstructured data tied to members and providers, as well as non-traditional data sets that provide needed insights around consumerism. These evolved PBMs will need to develop and utilize predictive and prescriptive models that identify individuals with rising clinical risks, as well as physicians and other clinicians who can provide needed care based on emerging measures and metrics tied to quality. The market will require the development initiatives and tools that solve for existing shortfalls of member experience around both clinical and administrative matters.

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