



# 2019 Community Oncology Conference

*Ensuring quality, affordable & accessible cancer care*

## The Clash of DC Policy & Local Cancer Care Politics vs. Reality

**Ted Okon**  
**Executive Director**  
**Community Oncology Alliance**

# Healthcare Consolidation

*As Health Care Changes, Insurers, Hospitals and Drugstores Team Up*

By REED ABELSON

Centene to partner with Ascension  
Catholic hospitals  
Advantage plan

HEALTH CARE > Posted 4:00 AM | Updated at 8:05 AM

Across Maine, prices

*Fed Up With Drug Companies, Hospitals Decide to Start Their Own*

BUSINESS  
GM Cuts Different Type of Health-Care Deal  
Auto maker aligns with Henry Ford Health System in an attempt to cut coverage costs and improve quality of care

Bob Herman Feb 15

Hospitals  
drugs

Cigna CEO: More Choices To Come  
With Addition Of Express Scripts



Bruce J. Health  
I write about

Hearing Amazon's Footsteps

By NICK WINGFIELD and KATIE THOMAS OCT 27, 2017

Amazon hints  
plans with n  
not  
Phillip's Phoenix, A  
state pharmacy licen  
sell into other states

By KEVIN TRUONG

Post a comment / Feb 4, 2019 at

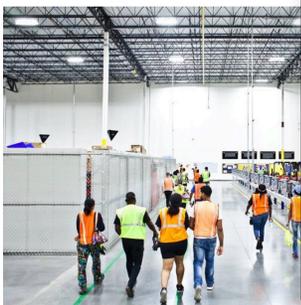
288 SHARES



The pharmacy is attractive to Am

*Amazon, Berkshire Hathaway and*

By NICK WINGFIELD, KATIE THOMAS and REED ABELSON JAN. 30, 2018



Employees at an Amazon warehouse in Florence, N.J. The company will join forces with Berkshire Hathaway and JPMorgan Chase to try to improve health care. Bryan Amelin for The New York Times

Business • Perspective  
CVS bought your local drugstore,  
health insurer. What's next, your

Clash of Giants: UnitedHealth  
Takes On Amazon, Berkshire  
Walmart

Companies moving to cut out middlemen  
and reduce drug prices for employees

Published: Aug 28, 2018 4:33 p.m. ET



Many Americans could benefit from deeper drug discounts

By YANCHUN LIU



Americans amid pressure on drugmakers to

Hat  
A laws  
Three's

BY LISA WOODS, JONATHAN R. SLOTKIN, MD, AND M. RUTH COLEMAN

## HOW EMPLOYERS ARE FIXING HEALTH CARE

Walmart has embraced a new approach to improve the quality of care and lower costs. The results have been dramatic.

# Why This is Important

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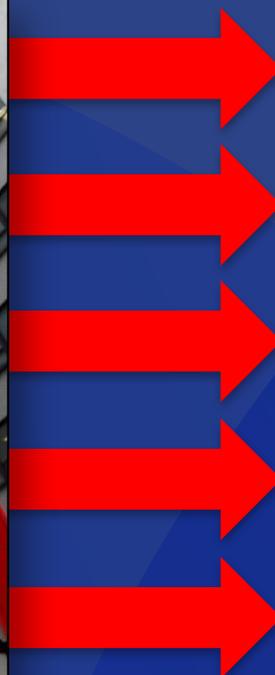
- Consolidation puts healthcare in the hands of big corporate for-profit and “nonprofit” entities
  - This takes medical decision making out of the hands of doctors and their patients
  - Costs have been shown to increase with consolidation, not decrease as promised
  - Healthcare becomes more “no nonsense” business rather than about people
- DC (Congress and the White House) trying to follow what is happening out there (away from the DC bubble)
  - This sets up a clash between DC politics and the reality of cancer care locally

# What You Need to Know

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- Healthcare changing like never before
  - Consolidation = profound impact on cancer care
  - Lines blurring between insurer and providers, especially pharmacy
- Lowering prescription drug prices (and costs) has become a political and media agenda – *like never before!*
  - Drug prices and companies in the crosshairs of Trump administration
  - Same holds true for Congress – both House (Democrat controlled) and Senate (Republican controlled)
- Need to score political victories can have a profound negative effect on cancer care
  - International Pricing Index (IPI) Model a perfect example
  - Giving insurers and PBMs more power to control medical decisions

# What is CVS???



**Medical Clinic**

**Benefit Plan Sponsor**

**PBM**

**Insurer**

**What Else?**



**Specialty  
Pharmacy**



**Drug Store**



**Mail Order  
Pharmacy**

# Drug Prices in the Crosshairs

## *Trump Proposes to Lower Drug Prices by Basing Them on Other Countries' Costs*

POLITICS

## It's not just Democrats: In dueling drug pricing hearings, at least some Republicans slam pharma, too

By LEV FACHER @levfacher and NICHOLAS FLORKO @NicholasFlorko / JANUARY 29, 2019



FIRST OPINION

## Alex Azar: Why drug prices keep going up — and why they need to come down

By ALEX M. AZAR II / JANUARY 29, 2019



President Trump and human serv...

## Drug Pricing in Am...

Date: Tuesday, January 29, 2019  
Time: 10:15 AM  
Location: 215 Dirksen Senate Office B...

The New York Times

## *Trump Officials Move to Lower Drug Prices by Passing On Rebates to Patients*



# Where's the Drug Price Issue Going?

- Trump wants a “win” on drug prices and doesn’t care about policy – *and I repeat this 3 times!!!*
  - So, HHS Sec. Azar needs a win on drug prices
- Medicare Part B is in the crosshairs like NEVER before – *and I repeat that 3 times!!!*
  - Giving MA plans ability to implement “fail first” (step therapy) and formularies
  - Back to “mandatory” demos — IPI is another Medicare Part B Experiment
  - Taking away protected classes
- Putting HUGE pressure on pharma companies
  - Both the administration and entire Congress
- Look for drug prices to be a HUGE election year issue

# Trump Blueprint on Drug Prices

- Covered virtually every area of drug pricing except for direct government negotiating
- Posed 132 questions asking input on many aspects of drug pricing
- Regardless of media portrayal, pretty comprehensive

22692 Federal Register / Vol. 83, No. 95 / Wednesday, May 16, 2018 / Notices

relationships between grantees and subrecipients. With this data, the contractor, to inform ASPE and ACP, will build a social/organizational network to depict how grantee and subrecipient organizations collaborate with one another through TVAP to better understand the existing network and identify potential opportunities for improving the efficiency of the network. ASPE anticipates completion of all data collection activities by October 2018.

**ESTIMATED ANNUALIZED BURDEN TABLE**

Type of respondent	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours
TVAP grantees	3	1	45/60	2.25
TVAP Subrecipients	253	1	45/60	189.75
<b>Total</b>	<b>256</b>	<b>1</b>	<b>45/60</b>	<b>192</b>

**Terry Clark,**  
Asst. Paperwork Reduction Act Reports Clearance Officer, Office of the Secretary.  
[FR Doc. 2018-10394 Filed 5-15-18; 8:43 am]  
BILLING CODE 4101-06-P

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Office of the Secretary  
RIN 0991-2A49  
**HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs**  
AGENCY: Department of Health and Human Services.  
ACTION: Policy Statement; Request for information.

**SUMMARY:** Through this request for information, HHS seeks comment from interested parties to help shape future policy development and agency action. **DATES:** Comments must be submitted on or before July 16, 2018. **ADDRESSES:** You may submit comments in one of three ways (please choose only one of the ways listed):  
1. *Electronically.* You may submit electronic comments to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.  
2. *By regular mail.* You may mail written comments to the following address ONLY: Department of Health and Human Services, 200 Independence Ave. SW, Room 600R, Washington, DC 20201.  
Please allow sufficient time for mailed comments to be received before the close of the comment period.  
3. *By express or overnight mail.* You may send written comments to the following address ONLY: Department of Health and Human Services, 200 Independence Ave. SW, Room 600E, Washington, DC 20201.  
**FOR FURTHER INFORMATION CONTACT:** John O'Brien, (202) 690-7886.

**SUPPLEMENTARY INFORMATION:** The United States is the world's leader in biopharmaceutical innovation. American innovation has improved health and quality of life for millions of people, and was made possible by our intellectual property system, decades of government and privately-funded research, strong capital markets, and the world's largest scientific research base. By rewarding innovation through patent and data protection, American companies hold the intellectual property rights for most new, and potentially life changing, medicines. Our regulatory system is the most rigorous in the world, ensuring the safety and efficacy of drugs for American patients. Medicare, Medicaid, other Federal health programs, and private payers ensure Americans have access to medicines, from innovative new cures, to generic versions of medications that have markedly lowered costs for consumers. As part of President Trump's bold plan to put American patients first, the Department of Health and Human Services has developed a comprehensive blueprint that addresses many of the challenges and opportunities impacting American patients and consumers. The blueprint covers multiple areas including, but not limited to:  
• Improving competition and ending the gaming of the regulatory process.  
• Supporting better negotiation of drug discounts in government-funded insurance programs.  
• Creating incentives for pharmaceutical companies to lower list prices, and  
• Reducing out-of-pocket spending for patients at the pharmacy and other sites of care. HHS also recognizes that achieving the goal of putting American patients first will require interagency collaboration on pharmaceutical trade policies that promote innovation, and are transparent, nondiscriminatory, and

increase fair market access for American innovators. Furthermore, HHS seeks to identify when developed nations are paying less for drugs than the prices paid by Federal health programs, and correct these inequities through better negotiation. HHS has already acted to increase the affordability of medicines for millions of our citizens, but is also going much further in response to President Trump's call to action. Through the work of the Food and Drug Administration and the Centers for Medicare & Medicaid Services, HHS has tremendous ability to change how drugs are developed and paid for in the United States. The status quo is no longer acceptable. Millions of Americans face soaring drug prices and higher out-of-pocket costs, while manufacturers and middlemen such as pharmacy benefit managers (PBMs) and distributors benefit from rising list prices and their resulting higher rebates and administrative fees. An unprecedented re-examination of the whole system and opportunities for reform is long overdue. We believe a national focus on lowering list prices and out-of-pocket costs has the potential to create new and disruptive alternatives to the current system, while maintaining its many virtues. It is time to realign the system in a way that promotes the development of affordable innovations that improve health outcomes and lower both out-of-pocket cost and the total cost of care. Through this request for information, HHS seeks comment from interested parties to help shape future policy development and agency action.

**Table of Contents:**  
I. Previous Actions by the Trump Administration  
A. Increasing Competition  
B. Better Negotiation  
C. Creating Incentives to Lower List Prices  
D. Reducing Patient Out-of-Pocket Spending  
II. Responding to President Trump's Call to

# Blueprint Goals

- Increase drug competition 
  - Speed generic, biosimilar, and brand approvals
- Fix “global freeloading” 
- Change Medicare Part B 
  - Move Part B drugs to Part D
  - Revive the Competitive Acquisition Program (CAP)
- Fix 340B 
  - Move reimbursement closer to true drug acquisition cost
  - Tie 340B to charity care
- Reimburse MD practices and hospitals the same 
- Address PBM situation, especially rebates 
- Facilitate manufacturer value-based contracting 
- Drug price transparency 

# International Pricing Index Model

- Index Medicare Part B drug prices to market basket of other countries
- CAP for 50% of the country in a mandatory CMMI demo
  - “Private sector” entities to negotiate with drug manufacturers and distribute drugs
- Add on of a flat fee equal to historical ASP + 6%

**Notice:** This HHS-approved document has not been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.

[Billing Code: 4120-01-P]

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR CHAPTER IV**

**[CMS-5528-ANPRM]**

**RIN 0938-AT91**

**Medicare Program; International Pricing Index Model for Medicare Part B Drugs**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Advance notice of proposed rulemaking with comment.

**SUMMARY:** We are issuing this advance notice of proposed rulemaking (ANPRM) to solicit public comments on potential options we may consider for testing changes to payment for certain separately payable Part B drugs and biologicals (hereafter called “drugs”). Specifically, CMS intends to test whether phasing down the Medicare payment amount for selected Part B drugs to more closely align with international prices; allowing private-sector vendors to negotiate prices for drugs, take title to drugs, and compete for physician and hospital business; and changing the 4.3 percent (post-sequester) drug add-on payment in the model to reflect 6 percent of historical drug costs translated into a set payment amount, would lead to higher quality of care for beneficiaries and reduced

# International Pricing Index Model

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# International Pricing Index Model

- Index Medicare Part B drug prices to market basket of 14 OECD countries
  - Target is a 30% decrease in Part B drug prices
  - Create a blend of the index target price and ASP
    - Starts at 80% of ASP and 20% of the index price moving towards 100% index after 5 years

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# International Pricing Index Model

- Revive the previously-failed Competitive Acquisition Program (CAP)
  - Force physicians and hospitals to stop purchasing/billing drugs
  - Would have to deal with a CAP vendor(s)
  - CAP vendor would “negotiate” with drug manufacturers based on the ASP/index price
  - CAP vendor would bill Medicare for drug; providers would bill patients copay

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# International Pricing Index Model

- Pay providers a flat fee based on the historical add-on to ASP
  - Providers would not take title to the drug but would still be responsible for collecting the 20% patient copay

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# IPI: What's Wrong?

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- Indexing U.S. drug prices to foreign prices sounds great on paper but how do you really do it without other countries playing games?
  - And more cancer drugs available here than in any other country
- Biggest problem is CAP
  - It would fundamentally change how cancer patients get their drugs
  - It would change from just-in-time delivery of chemotherapy to ordering and waiting for chemotherapy from some middleman
- Changing cancer drug reimbursement would put even more pressure on community oncology practices, forcing more closures and consolidation into hospitals

# 340B and Payment Site Neutrality

Public Health & Policy > Medicare

## Site Neutral Payment, 340B Payment Cuts Raise Hospitals' Hackles

— Outpatient Prospective Payment System rule released Friday

by Shannon Firth, Washington Correspondent, MedPage Today  
November 02, 2018

WASHINGTON -- The Centers for Medicare & Medicaid Services (CMS) released two final rules that aim to narrow the difference between payments rates for hospital outpatient services and those provided in ambulatory surgical centers. The agency said the proposed changes would spur competition, lower costs for seniors, and "create a level playing field for providers."

In the final [Hospital Outpatient Prospective Payment and Ambulatory Surgical Center \(ASC\) Payment Systems rules](#) released Friday, CMS also increased 340B drug program cuts by expanding them to off-campus outpatient sites, triggering immediate threats of lawsuits.



This document is scheduled to be published in the Federal Register on 11/21/2018 and available online at <https://federalregister.gov/d/2018-24243>, and on [govinfo.gov](http://govinfo.gov)

Billing Code 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 416 and 419

[CMS-1695-FC]

RIN 0938-AT30

**Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final rule with comment period.

**SUMMARY:** This final rule with comment period revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2019 to implement changes arising from our continuing experience with these systems. In this final rule with comment period, we describe the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. In addition, this final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program. In addition, we are updating the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure under the Hospital Inpatient Quality Reporting (IQR) Program by removing the Communication about Pain questions; and retaining two measures that were proposed for removal, the Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure and Central

# The Middleman Dilemma

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- A “middleman” is just that – an entity that gets between doctor and patient
- Middlemen are insurance companies and pharmacy benefit managers (PBMs)
  - Insurers typically manage the “medical” benefit
    - Both commercial insurance and Medicare Advantage plans
  - PBMs manage the “pharmacy” benefit
  - Now, they are all merging!
- On one hand, the Trump administration wants to take away the PBM/insurer rebates that are fueling higher drug prices
- On the other hand, the Trump administration wants to give the PBMs/insurers more power over cancer care

# Eliminate PBM Rebates

- Proposed rule would effectively eliminate PBM rebates from Medicare/Medicaid
- Manufacturers could provide discounts directly to patients
- Eliminates manufacturers' claim that rebates drive up list prices of drugs



DEPARTMENT OF HEALTH & HUMAN SERVICES

## Fact Sheet: Trump Administration Proposes to Lower Drug Costs by Targeting Backdoor Rebates and Encouraging Direct Discounts to Patients

The Department of Health and Human Services Secretary Alex Azar and Inspector General Daniel Levinson have proposed a regulation that would create incentives to lower list prices and reduce out-of-pocket spending on prescription drugs. This proposal has the potential to be the most sweeping change to how Americans' drugs are priced at the pharmacy counter, ever, by delivering discounts directly to patients at the pharmacy counter and bringing much-needed transparency to a broken system.

The proposed regulation would address a perverse incentive identified by the Department by expressly excluding from safe harbor protection under the Anti-Kickback Statute (AKS) rebates on prescription drugs paid by manufacturers to pharmacy benefit managers (PBMs), Part D plans, and Medicaid managed care organizations. The proposal would create a new safe harbor protecting discounts offered to patients at the pharmacy counter. Finally, the proposal would create new safe harbor protection for fixed fee services arrangements between manufacturers and PBMs.

The President's drug pricing blueprint identified how the current rebate-based system rewards higher list prices, enriches middlemen, and drives up patients' costs. Now HHS is taking action to encourage the drug industry to shift away from the opaque rebate system, and toward a system that offers true discounts to the patient at the point of sale.

Point of sale discounts will lower out-of-pocket costs for patients using drugs with high prices and high rebates, particularly during the deductible or coinsurance phases of their benefits. This proposal aims to change the incentives in our system that reward list price increases.

### WHAT'S WRONG WITH TODAY'S SYSTEM

The current rebate-driven system is part of an unacceptable status quo characterized by high prices and backdoor deals. It creates three main problems for patients:

**1. Rebates reward ever-increasing list prices.** Everyone in today's system, including PBMs and Part D plans, typically negotiate rebates as a percentage of list price. When list prices rise, everyone benefits but taxpayers and the patients paying for the drug.

PBMs play an important role in negotiating with drug companies. But if the negotiation favors higher rebates instead of lower cost drugs, it can lead to higher list prices. Indeed, nearly every drug company taking a January 2019 price increase announced that all or nearly all of the increase was being paid to PBMs or insurers as rebates.

A system that favors higher list prices hurts patients, who often pay a percentage or all of the list price. It also drives up total spending for plans and payers.

# Step Therapy & Protected Classes

- MA plans given the authority to apply step therapy to Part B drugs
  - One goal is to reduce drug costs through “fail first” utilization of least expensive drug
  - Second objective is to give MA plans power to negotiate down drug prices
- “Fail first” drug is not necessarily the least expensive drug but the most profitable drug for the PBM/insurer
- Eliminating protected classes

## Medicare Advantage Prior Authorization and Step Therapy for Part B Drugs

Aug 07, 2018 | Leadership, Medicare Part C, Medicare Parts A & B, Prescription drugs

Share    

Today, the Centers for Medicare & Medicaid Services (CMS) introduced much-needed competition and negotiation into the market for physician-administered and other Part B medications that will result in better deals and lower drug costs for patients. As part of the agency's ongoing activities to deliver on President Trump's promises outlined in his American Patients First [Blueprint](#), CMS will provide Medicare Advantage plans the option of applying step therapy for physician-administered and other Part B drugs in a way that lowers costs and improves the quality of care for Medicare beneficiaries. Medicare Advantage (MA) plans will have the choice of implementing step therapy to manage Part B drugs, beginning January 1, 2019 as part of broader care coordination activities that include patient rewards and incentives. Currently, there are more than 20 million beneficiaries enrolled in MA plans.

### What is Step Therapy?

Step therapy is a type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions. For example, using step therapy plans could ensure that a senior who is newly diagnosed with a condition begin treatment with a cost-effective biosimilar before progressing to a more costly drug therapy should the initial treatment is ineffective. By implementing step therapy along with care coordination and drug adherence programs in MA, it will lower costs and improve the quality of care for Medicare beneficiaries.

# PBM Horror Stories

Delay, Waste, and Cancer Treatment Obstacles:

## The Real Horror of Pharmacy Benefit Managers

There is growing awareness in the United States in favor of the pharmacist as an unavoidable part of our lives for over 260 million Americans included on plan formularies to receive drugs through their PBM.

However, while the role of policymakers and the takes place of the impact of PBM is growing, the role of the pharmacist is being eroded.

This paper is the first in a series of papers on cancer patients' privacy.

### AN AVOIDABLE DEATH

Derek, a young husband, was diagnosed with brain metastases from melanoma. A ray of light appeared in the form of a specialist at the pharmacy. Proven to have the ability to extend life, the drug offered. Located in his doctor's office was this potentially life-prolonging on the pharmacy shelf—but not mandated that Derek purchase his own mail-order specialty pharmacy faxed to the PBM all the necessary prior authorization, and for the his wife waited to hear that the approval. Upon receiving the prescription to the PBM's specialty wait again.

One week later, the drug still had not been notified that they had

April 2017

## Unaccountable Benefits: The Real Horror of How PBMs Impact Patients

There is no shortage of horror stories about Pharmacy Benefit Managers (PBMs) and their offshoots and service lines. PBM impacts patients receiving their medications.

Originally created to lower per-member-per-month costs, PBM corporations have become arbiters of the care that cancer patients receive. A combination of PBM unaccountable managers that are focused on

This paper is the second in a series of papers on cancer patients' privacy.

### PBM KNOWS BETTER THAN YOU

A community oncology and hematologist in Pennsylvania was being forced to use a specialty pharmacy for their patients' prescriptions, despite the practice in-office dispensary. They had actually PBM two years earlier for the right to however, approval was still "pending."

Frank was one of the clinic's patients. His oncologist prescribed an appropriate specialty pharmacy. Upon submitting it to the PBM specialty pharmacy, the PBM called the clinic and approval was denied for the submit if the oncologist were to change to several other cancers, they would tell the clinic responded by noting that this change, that they refused to comply with reporting it to the State of Pennsylvania minutes of that call, Frank's medication without any changes.

Edward was another of the clinic's patients. He had been prescribed a specific dosage, to be taken twice a week, for five weeks. However, when the PBM specialty pharmacy had cut

May 2017

## Bureaucracy, Denial, and Another Pharmacy Horror Story

The dire consequences of a health care system dominated by Pharmacy Benefit Managers (PBMs) who must interact with

Initially established as a way to reduce costs, PBMs have slowly eroded the benefits of pharmacy benefit plans, and drugs a patient will receive. PBMs have become so bold or notifying them of their actions.

This paper is the third in a series of papers on cancer patients' privacy.

### PBM-PHARMACY ERROR KILLS PATIENT

Carla, a colorectal cancer patient, had been on oral medication that has been on the market for years. Carla's PBM mandated that she use a large, well-known specialty pharmacy that had the medication and patient contact or instructions.

Carla's oncologist prescribed this medication in rounds with the following schedule: one week on, one week off. The PBM unfortunately, neglected to include the instructions on the label. After up in a hospital's intensive care unit, Carla's experience was the straw that broke the camel's back, and the practice's pharmacy with a pharmacist-manager. Many of their patients are still in danger from PBM-mandated, mail

September 2017

## Danger, Delay, Denial: Another Pharmacy Horror Story

The cautionary tale of the United States learned. The United States presence of these ever-growing while leaving behind pain, suffering, and death.

This is the fourth paper in a series of papers on cancer patients' privacy.

Today, while PBMs are contracted to provide services, they are not involved in Medicare Part D. It has also dictated that insurance companies in Medicare Advantage.

These proposals have been put forth to the network of shadowy rebates to demonstrate, this has all been done.

The following PBM horror stories have been changed to protect privacy.

### BUREAUCRATIC MADNESS: A GAME OF TELEPHONE

Donald, an electrical engineer, husband, and college student, had been diagnosed with cancer and was scheduled for radiation therapy. The radiation doctor prescribed an oral chemotherapy alongside the radiation and faxed the prescription to the PBM-mandated specialty pharmacy. The pharmacy contacted Doree, Donald's wife, to clarify his prescription. Doree, without delay, and then, four

August 2018

## Dangerous Health Care Middlemen & Bureaucracies: Pharmacy Benefit Manager Horror Stories — Part V

The Pharmacy Benefit Manager (PBM) industry lobby claims that it successfully achieves drastic price reductions on medications. They say this comes from PBMs negotiating with competing drug companies and by "encouraging consumers to use the most cost-effective drugs."

Setting aside clear evidence that secretive PBM rebates and fees are actually driving drug prices higher, the last claim should give all Americans pause. How exactly does a PBM "encourage" a treating physician to use cost-effective but life-saving drugs? How do they know what is right for each individual patient and disease? What tactics or methods do PBMs use to do this? And are the changes in the patients' best interests, or simply to save money for PBM profit margins?

Unfortunately, time after time, PBMs have been exposed for abusing their position to do this, getting between the patient with cancer and their physician to dictate care. All too often, the PBM bureaucracy does this by simply and heartlessly delaying or denying make patients' access to needed medications. Perhaps most egregiously for patients facing a ticking clock of cancer, PBMs deny prescribed treatments and demand that patients first fail on a list of "approved" drugs before receiving the medication that their physician prescribed in the first place.

For patients with cancer, this intrusion into their care plans is painful, potentially life-threatening, and unnecessarily stressful. For oncologists it is yet another bureaucratic burden placed between them and caring for a patient, wasteful of scarce health care resources, and insulting to the doctors that went to medical school and prescribe treatment plans.

These and other monstrous by-products of the PBM system are further exposed here, as the Community Oncology Alliance (COA) presents the fifth in a series that focuses on the very real and negative impact PBMs continue to have on patients with cancer today. The infuriating stories presented here are real but made anonymous with personal details changed to protect the privacy of the patients.

### A NARROW WINDOW FOR TREATMENT

Brian, a married social worker with two young children, was in his early 30s in February 2014, when he was diagnosed with a relatively rare form of cancer in his appendix. Brian underwent surgery and chemo at a large hospital system, and for the next few years, his life went back to normal.

In late 2017, however, Brian suffered a relapse. He underwent surgery to remove all traces of the cancer, and his oncologist followed up with a round of chemotherapy. Despite the metastasis, Brian's doctors thought he had a good chance at survival, and recommended that he

immediately begin a six-month regimen of oral medication to help keep the cancer at bay. He was young, strong, and had everything to live for; they were optimistic the cancer might never return.

On February 8th, Brian's oncologist sent a prescription for the pills to the local pharmacy his clinic worked with. They informed him that while they had the medicine in stock, Brian's insurance and PBM prohibited them from filling the prescription. Instead, they forwarded the prescription to a PBM-mandated specialty pharmacy to receive prior authorization.

# COA's Efforts

- Detailed meetings with CMS and HHS
  - Pushing back on IPI model
  - Providing alternatives
- Working with Congress to fix PBM issues
- Launching major campaign to highlight PBM abuses
- Working hard on oncology payment reform



# Senate Hearing on PBMs



## Senate panel to hear from pharmacy middlemen on drug prices

BY NATHANIEL WEIXEL - 03/21/19 12:44 PM EDT

15 COMMENTS



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The Senate Finance Committee said Thursday that it has secured commitments from executives of five major pharmacy benefit managers (PBMs) to testify next month about the high costs of prescription drugs.



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# Thanks!

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