National Association of Specialty Pharmacy Dismisses PBM-Funded Report Claiming Drug Cost Savings from Direct & Indirect Remuneration (DIR) Fees

DIR fees continue to inflate prescription drug costs for the sickest, most vulnerable seniors & threaten the specialty pharmacies that serve the unique needs of patients living with complex, life-altering, & often life-threatening diseases

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Washington, DC (August 4) — The National Association of Specialty Pharmacy's Executive Director, Sheila Arquette, released the following statement in response to the recent report commissioned by the Pharmaceutical Care Management Association (PCMA) on direct and indirect remuneration (DIR) fees:

"The Pharmaceutical Care Management Association (PCMA) recently commissioned a report about direct and indirect remuneration (DIR) fees, which speculated on how they may be beneficial to the federal government. The answer is simple: DIR fees collected from specialty pharmacies are neither beneficial to the taxpayer-funded Medicare Part D program, nor to the sick seniors enrolled in the vital safety net program.

While the report sought to address both DIR received from manufacturers (e.g., rebates) and DIR fees collected from pharmacies after the point-of-sale (POS), the report acknowledged that the overwhelming majority of all DIR (and alleged savings to Medicare) related to manufacturer rebates. Yet, DIR fees assessed against specialty pharmacies by big PBMs continue to inflate prescription drug costs for the sickest, most vulnerable seniors – the very patients the Medicare Part D program was designed to protect. Simultaneously, DIR fees threaten the specialty pharmacies that serve the unique needs of patients living with complex, life-altering, and often life-threatening diseases.

A recent JAMA paper showed that the structure of the Medicare Part D benefit design, rebates and remunerations – including DIR fees – actually increase patients' out of pocket costs. In fact, Dr. Peter Bach – director of Memorial Sloan Kettering Cancer Center's Center for Health Policy and Outcomes, and a co-author of the JAMA paper – calls current Medicare system "absolutely devastating for people on high-cost specialty drugs." Even PCMA's report conceded that DIR fees do not directly reduce Medicare beneficiary cost sharing at the POS.

Instead, through complex financial engineering, PBMs increase front-end reimbursement, and therefore patient out-of-pocket costs, only to then take DIR fees back on the back end. As a result, these egregious fees force sick and vulnerable seniors to pay more up front than they should. This runs contrary to the intent and purpose of Medicare's prescription drug program.

DIR fees impact out-of-pocket costs for sick seniors, and for Medicare beneficiaries being treated with a specialty drug, the impact is even more profound. That's because DIR fees push sick seniors into the donut hole faster, where patients are responsible for covering a much greater percentage of their prescription medication costs.

Then, when sick seniors pass through the donut hole to the catstrophic coverage phase of the Part D benefit, the taxpayer-funded Medicare program pays a much higher percentage of the overall cost of care. With nearly 41 million Medicare beneficiaries are enrolled in Medicare Part D plans, *it's putting a huge burden on Medicare in terms of costs for the program and costs to American taxpayers.*

That's why we're advocating to keep the point-of-sale negotiated drug prices as transparent as possible, so sick seniors can choose between one drug versus another based on the understanding of the actual out-of-pocket cost to them, in addition to the Medicare program. Currently, big PBMs are misusing DIR fee provisions.

Due to a supreme lack of transparency, we question the intent and benefit of this financial engineering, especially since drug costs keep increasing for sick seniors at the point of sale, in addition to negatively impacting specialty pharmacy's ability to continue to provide the highest level of patient care services to one of the most vulnerable patient populations.

This is just another in a long line of studies paid for by pharmacy benefit managers, attempting to validate monopolistic and opaque practices of charging specialty and independent pharmacies with capricious fees, months after the point of sale, and over which specialty pharmacies have little to no control.

Unfortunately for the PBMs, even this study does not support their argument. The report admits the difficulty in measuring performance, particularly in the specialty space. This is not surprising, as the performance measures currently being used do not apply to the drugs dispensed by specialty pharmacy, nor the patients or diseases that they manage.

This is having hugely disproportionate and negative impact on the ability of accredited specialty pharmacies to continue to serve seniors, and it needs to stop.

Specialty pharmacies and the sick seniors we treat need PBMs to demonstrate, in a way that is much more transparent, how they calculate reimbursement for specialty services and care. Increasing transparency within big PBMs would benefit the industry and the patients we serve, helping us to finally institute clear metrics and incentives that would be aligned with the services and patient outcomes that specialty pharmacy provides, and which also align with the foundational goals of the Medicare Part D program: quality, cost effectiveness, and patient satisfaction.

To continue providing much-needed, high-quality, white-glove care for sick seniors enrolled in Medicare, specialty pharmacies need a fair reimbursement structure for the drugs and services we provide."

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Specialty Pharmacy | Specialty pharmacy provides medications to treat patients with serious, chronic, rare, progressive, or debilitating or fatal if left untreated or undertreated. According to the Drug Channels Institute and other sources, specialty pharmacy drugs will represent 44% of the U.S. drug spend by the year 2020. Examples of illnesses that require specialty medications include cancer, hepatitis C, infectious disease, infertility, Crohn's disease, rheumatoid arthritis, psoriasis, HIV/AIDS, multiple sclerosis, Cystic Fibrosis, organ transplantation, human growth hormone deficiencies, hemophilia, and other bleeding disorders.

Direct and Indirect Remuneration (DIR) fees | One of the chief challenges facing the industry right now is: how to help CMS and Congress stop big PBMs from imposing unfair and opaque DIR fees that increase prescription drug costs for seniors and crush specialty pharmacy's ability to provide the care that sick seniors need. DIR fees are increasingly egregious and impose negative consequences by inflating prescription drug costs for the sickest, most vulnerable seniors – the very patients the Medicare Part D program was designed to protect. Not only that, DIR fees threaten the specialty pharmacies that serve the unique needs of patients living with complex, life-altering, and often life-threatening diseases.

National Association for Specialty Pharmacy (NASP) | NASP was founded in 2012 and is the only national trade association that represents specialty pharmacy, serving as the leading educational resource and national advocate for specialty pharmacy healthcare professionals and patients alike. In addition to providing medications to severely ill patients, specialty pharmacy also features support programs and services to ensure patients maximize the benefit from their medication, therapies and services, working to ease the treatment burden for patients, families and caregivers as they work to manage these tough conditions. NASP will convene its fifth annual conference from Sept. 18 to Sept. 20 in Washington, D.C., kicking off with a keynote speech from healthcare veteran and former Lilly USA President Alex Azar, followed by two days of thought-provoking discussions on the state of specialty pharmacy (full agenda here; RSVP to nasp@skdknick.com).

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