Minnesota Pharmacy
MN-Prescription Drug Affordability Presentation

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Jeremy Faulks, PharmD

VP Pharmacy Operations at Thrifty White Pharmacy

Regional chain pharmacies

Scott Soefje, PharmD, MBA, BCOP, FCCP, FHOPA

Director, Pharmacy Cancer Care Services at Mayo Clinic, Rochester

Associate Professor in the Mayo Clinic College of Medicine and Science

Andrew Russell, PharmD

New Market Family Pharmacy in Elko New Market, MN

Independent pharmacy Owner

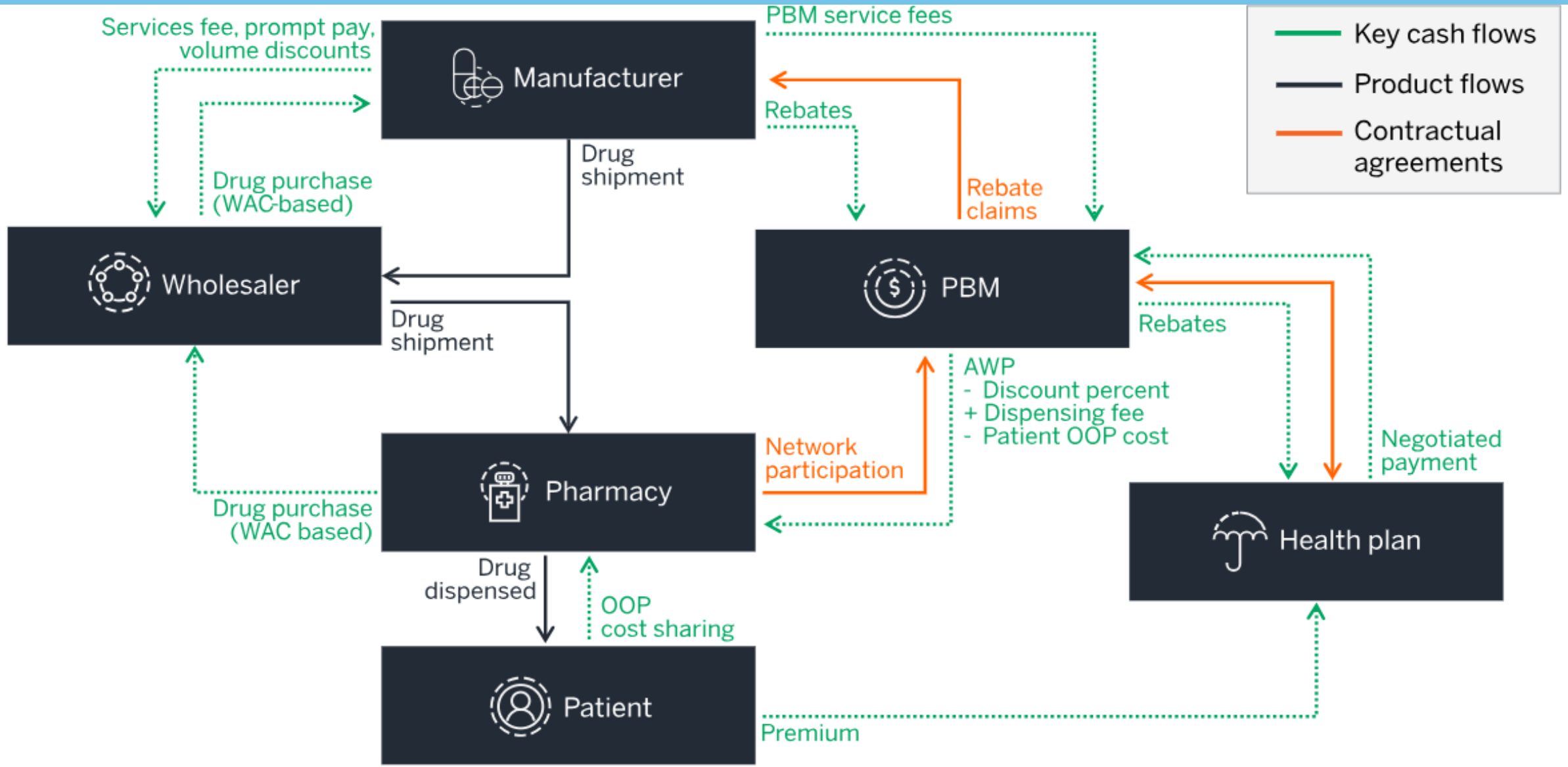
Community Pharmacy

Economics & Prescription Medication Pricing and Costs Overview

Key Terms and Structure

- WAC = Wholesale Acquisition Cost
- AWP = Average Wholesale Price
  - For Brand drugs, AWP is generally set at 120% of WAC
- Pharmacies contract with PBMs using AWP minus rates (ex. AWP-21%)
- Pharmacies purchase products from Wholesalers at a discount off WAC. Typically 3.5%-5%, depending on contracts
- There is very little leverage in either improving purchasing, or improving reimbursement rates. Most contracts are take-it-or-leave-it

Major Stakeholders and Interactions of Pharmacy Supply Chain



Pharmacy Economics Example

Example Product X

AWP = $671.49

WAC = $559.58

	National Chain	Independents
Reimbursement		
Today (AWP-21%)	$530.48	$530.48
Tomorrow (AWP-22.5%)	$523.77	$523.77
Enhanced Services / Data		
First Fill / Refill	-	-
Cost to Serve		
First Fill / Refill	$12.63	$15.79
Acquisition Cost		
Purchase Discount	3.5%	5%
Acquisition Cost	$539.99	$531.60

Today (AWP-21%)	Net Margin	($22.14)	($16.91)
Tomorrow (AWP-22%)	Net Margin	($28.85)	($23.62)

PBM Reimbursement

- Reimbursement tends to fall every year
- Reimbursement on brands is typically less than acquisition cost
- Generic reimbursement is better, but there are continued downward pressures
- Total reimbursement (Brands and Generics) continues to decrease to the point where it is near our costs to dispense medications
- Where do we go from here?
  - COST + reimbursement is where the industry needs to go in order for pharmacies to survive
  - Iowa passed a law requiring NADAC + $10.68 as minimum reimbursement for pharmacies

UPL Structure Concerns

- **Cost vs Reimbursement** – Need to ensure it addresses the buy-side economics for pharmacy as well
- **Patient Access** – If reimbursement is below acquisition cost, then pharmacies will not carry these medications, reducing patient access in Minnesota
- **Complexity and Cash Flow** – Implementation should be structured to not increase administrative burden, claims processing, and cash flow impacts to local pharmacies
- **Claims submission** – Typically pharmacies submit U&C Pricing, then the PBM returns the 'approved' amount. Pharmacy systems are not designed to submit varying amounts based on plan type
- **Benefit Design disruption –** Will PBMs avoid these products or change formulary tiers? We are starting to get some insight into these changes with 2026 Medicare MFP products
- **Federal vs State regulation** – How does this interact with MFPs and MFNs being implemented nationally?

Key Cost Terms

AWP	WAC	ASP	340B Price	MFP

• Important for new to market infusion medications
• Applies heavily to Retail Pharmacy reimbursement
• The highest published price point
  • 1.20-1.33x WAC (varies)
	• Standard Price to consider for infusion medications
	• Default price if no contracting offered
	• May be used for charge markups
		• Established with the 2003 Medicare Modernization Act
		• Must be provided by the manufacturers quarterly
		• Medicare Reimburses ASP + 6%
			• Only for eligible sites
			  • Numbers increased after Affordable Care Act (ACA)
			• Changes quarterly
			• The lowest published price point
				• Price CMS negotiates for Medicare
				• Single source brand name drugs/biologics
				• Drugs selected
				  • 2024 – 10 drugs Part D
				  • 2025 – 15 drugs Part D
				  • 2027 – Part D and Part B

Anderson LA. Average wholesale price (AWP) as pricing benchmark. Drugs.com website. April 4, 2025.. https://www.drugs.com/article/average-wholesale-price-awp.html. Accessed 7/16/25

Curtiss FR., *JMCP.* 2010;16(7):492-501.

Cubanski J. FAQ about the Inflation Reduction Act's Medicare drug price negotiation program. Kaiser Family Foundation. January 23, 2025. Accessed 7/16/25. https://www.kff.org/medicare/issue-brief/faqs-about-the-inflation-reduction-acts-medicare-drug-price-negotiation-program/#drugs-qualify-for-price-negotiation.

What are the Drivers of Cost?

- Market Economics
  - » Price
  - » Competition
- Brand vs generic (biosimilar) vs 505(b)(2)
- Drug Shortages

Fox ER. Pharmacotherapy 2017;37(1):36-42. https://doi.org/10.1002/phar.1861
Sheckel CJ. Mayo Clin Proc. December 2021: 96(12):2947-2957. https://doi.org/10.1016/j.mayocp.2021.08.001

Calculating Costs - Discounts

- Group Purchasing Organization (GPO)
  - » Negotiated on behalf of a large membership
- Direct Purchase Discounts
  - » Negotiated between a healthcare institution and manufacturer point of sale discount (e.g. WAC-5%)
- Rebates
  - » Back-end discount paid back to the insurer or healthcare provider

Leibowitz J, Five things to know about the role of GPOs in the healthcare supply chain. Managed Healthcare Executive website. September 14, 2017. https://www.managedhealthcareexecutive.com/view/five-things-know-about-role-gpos-healthcare-supply-chain. Assessed 7/16/25..

Total Cost – The Wholistic Picture

More than just the drug…

- Fluids
- Needles
- Syringes
- Closed-system Transfer Devices
- IV lines
- Mixing time
- Labor
- Clean room costs
- Administrative time
  - Prior authorization
  - Inventory management
  - Treatment plan management

2022 Enterprise Total Costs
158 Chairs in the Oncology Infusion Centers

Category	Annual Costs
Supplies	$2,194,287
Salaries & Benefits	$6,326,177
Other expenses*	$949,235
Total	**$9,469,599**
Pharmaceuticals	$406,172,467
Total with drugs	**$415,642,166**

* = includes summation of administrative expenses, equipment maintenances agreements, leases, repair costs, and equipment depreciation

Pharmacy Cost to Consider

Assuming 258 operating days, 158 chairs, and 106,625 infusions

	w/o drugs	w/ drugs
Total Expenses	$9,469,599	$415,642,166
Cost per operating day	$36,704	$1,611,016
Cost per infusion chair per day	$232	$10,186
Cost per infusion	$88	$3,898

* Not all expenses are included (e.g. travel, facilities, overhead, equipment depreciation)

Medicare Reimbursement – Infusion Centers

Service	Reimbursement	
	Hospital Based	Physician Based
New Drugs (until ASP is established)	WAC + 3% or 95% of AWP	WAC + 3% or 95% of AWP
Packaging threshold • Drugs that cost less than the threshold are bundled into one payment	$140 per day	No
Separately payable drugs	ASP + 6%	ASP + 6%
Biosimilars	ASP + 8% of the ASP of the reference product for 5 years starting in Oct 2022	ASP + 8% of the ASP of the reference product for 5 years starting in Oct 2022
Administration fee	Fee schedule	Fee schedule
Facilities fee	Vary widely	Not allowed

Weidner S, et.al. AJMC. 2021;27(4): SP156-160.
CMS. Hospital Outpatient PPS. July 15, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient. Accessed 7/16/25

Commercial Reimbursement - Fee for Service

Service	Reimbursement
Drugs	Negotiated percent of charges
Administration	Negotiated percent of charges
Reimbursement	Linked to quantity of care
Payments	Annual fee schedule Charges for individual tests and procedures

Royce TJ. JCO Oncol Pract. 2020;16:276-284.
Snively E. What you need to know about value-based payment models. ACDIS. https://acdis.org/articles/what-you-need-know-about-value-based-payment-models. Accessed 7/15/25.

Community Pharmacies in Minnesota

- **Pharmacies are a crucial access point for healthcare in MN communities**
- **Current State of MN Pharmacy**
  - » Community pharmacies in MN are operating on razor-thin margins
  - » Minimal control over drug costs or reimbursement
  - » Limited patient access to high cost/low reimbursement drugs, particularly in rural and underserved communities

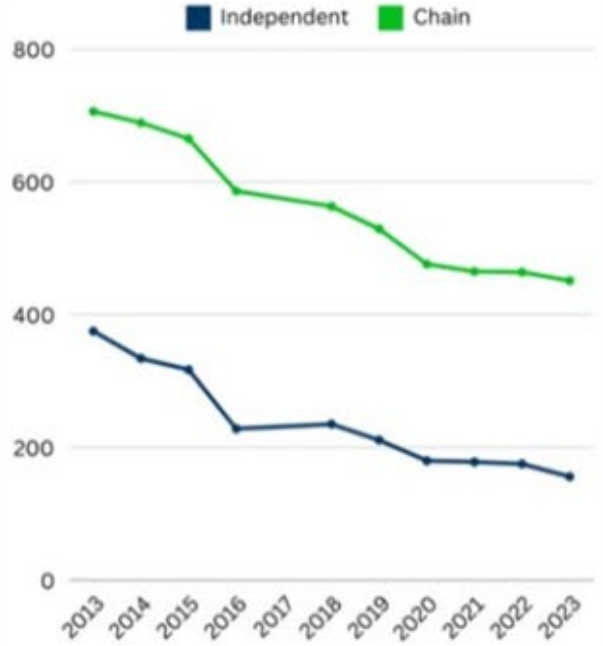
PATIENT ACCESS STARTS WITH AN OPEN PHARMACY

44% (474) of pharmacies have closed in the past 10 years

Of these, 58% (219) were independent (non-chain) pharmacies

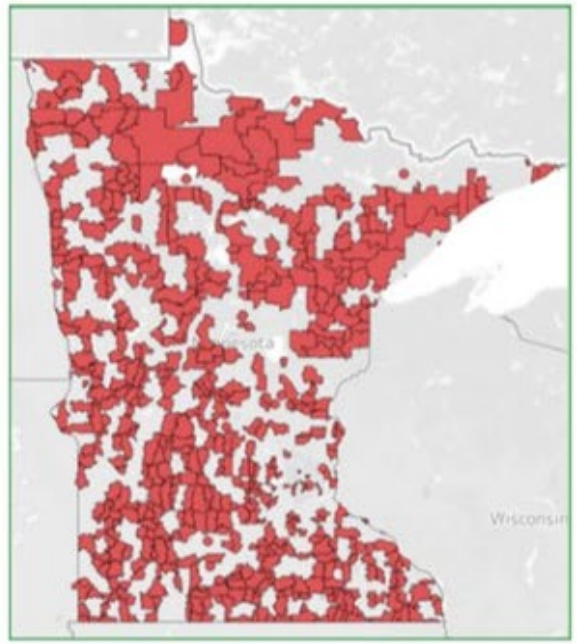
Data from MN Board of Pharmacy

Both independent & chain pharmacies are rapidly closing



Data from MN Board of Pharmacy

Zip codes without pharmacies (in red) are growing



Data from MN Board of Pharmacy. Map by Luke Slindee, PharmD.

AFFECTING BOTH URBAN & RURAL AREAS

Minnesota Department of Health (MDH) estimates that **more than one-third** of residents in Minneapolis, St. Paul, and the first-ring suburbs are living in pharmacy deserts.The risk for pharmacy closures is higher in predominantly Black and Latino neighborhoods, as well as in rural areas. In a 2024 study, MN ranked **10th** in the nation for the largest proportion of residents living in a pharmacy desert.

2024 Study Referenced: Locations and characteristics of pharmacy deserts in the United States: a geospatial study, Health Affairs Scholar, 2024, 2(4), qxae035
https://doi.org/10.1093/haschl/qxae035 Advance access publication: March 16, 2024

Independent/Community Pharmacy Role in the Drug Supply Chain

- Pharmacies are the **final access point** where most patients encounter drug pricing, coverage gaps, and affordability challenges.
- Where wholesaler, PBM/Payer, and patient costs converge
- Decisions made upstream by regulators, manufacturers, wholesalers, PBMs, and payers can have **massive implications for pharmacy viability**
- Vertically integrated corporations introduce considerable **conflicts of interest** and in many instances lead to increased list prices and drug spend

Potential Unintended Consequences of Upper Payment Limits (UPLs)

- **Increased administrative burden** to already strained pharmacies
- **May lead to overlap** with Medicare drug price negotiation, CMS payment methodologies, and state regulatory authority
- Setting UPL without guaranteeing cost (+) reimbursement **shifts financial burden onto pharmacies**
- Potential to increase incidence of **non-medical switching** to avoid UPL drugs
- Copays and coinsurance are still determined by insurers and PBMs
- Independent and rural pharmacies are the most likely to be pushed below cost when payment limits are imposed

Questions to Consider

- How will pharmacies purchase UPL drugs? What entity is intended to cover the difference between the UPL and the pharmacy's cost to acquire and dispense a targeted UPL medication?
- Saving money in complex disease states is important, but will pharmacies carry the financial burden while patients pay the ultimate price in compromised care and decreased access to UPL drugs?
- Medicare D and Self Funded/ERISA plans are excluded from complying with a UPL, will this create an environment where PBM owned pharmacies or pharmacies in narrow networks can be reimbursed in excess of a UPL regardless of what the pharmacy bills? does this create the opportunity for an unfair market advantage for PBM owned pharmacies? Will PBMs specifically steer prescriptions to out of state pharmacies to avoid UPL implications?
- IF the PDAB does decide to implement a UPL for certain medications, will the PDAB commit to specific language protecting community pharmacies from incurring losses due to underwater claims?

Closing Perspective

- Reducing patient cost and increasing access is a shared goal
- UPL implementation **without explicit protections** for acquisition cost recovery and an **appropriate dispensing fee** for pharmacy providers is likely to lead to reduced patient medication access.
- Ensure pharmacy reimbursement does not fall below acquisition costs
- Practicing community pharmacist representation on PDAB Advisory Council should be considered.
- Any affordability reforms considered by PDAB must strengthen—not destabilize—the point of care Minnesota patients rely on, including community pharmacies.

Patient access starts with an open pharmacy