Comparing Factors that Influence Pharmaceutical Pricing and Access in the US and five other Countries

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Policy Points:

- Policymakers have increasingly turned their attention to how foreign countries assess and negotiate drug prices without fully considering differences in payer purchasing power and incentives within the supply chain.
- The US is unique in that the purchasing power of its payers relies on a fragmented system of private, third-party intermediaries, resulting in many negotiated prices that are confidential to each payer. This creates considerable opportunity to generate revenue from spread pricing.
- In some cases, mechanisms used to manage prices abroad are also used stateside; however, the ways in which payers and supply chain participants interact results in different prices.

Abstract

Introduction. Drug prices in the United States are some of the highest in the world, which has triggered several policy proposals aimed at adopting pricing strategies used by other countries. However, the payment mechanisms and existing policies that govern how drug prices are determined and passed through the supply chains are poorly understood and may have important consequences for the potential impact of such reforms in the domestic context. This study compares the unique levers in the price negotiation process and supply chains of the US, Canada, Germany, Sweden, Australia, and Japan that allow for different prices for the same products.

Methods. Countries were selected based on their economies, geography, healthcare delivery, and prescription drug spending. Targeted literature reviews examined the journey of specialty self-administered drugs from initial marketing approval to patient dispensing, which were used to develop discussion guides for interviews with in-country experts. Country-specific findings were compared using an internal assessment tool designed to capture information about each step of a drugs' journey.

Findings. Compared to the US, other countries establish a single price through negotiation, and ensures that this is the benchmark price throughout the supply chain. In doing so, the ability for pharmacies and wholesalers to benefit from markups and spread pricing on high-priced products is limited, and the need for third-party administrators so heavily utilized in the US, are non-existent.

Conclusions. Proposals to reform US prescription drug prices by adopting negotiating strategies used in other countries should consider how these countries pull prices through their supply chains. Reforms in the absence of such policies may result in fewer savings than hoped; coupled with them, they might be further amplified.

Introduction

Prices and spending for prescription drugs in the United States are high and rising, comprising of approximately 10% of all healthcare spending.[1] Although other countries have experienced similar trends and spending pressures, Americans pay considerably more than patients elsewhere for the same innovator drugs,[2,3] and are more likely to abandon their prescriptions due to cost concerns.[4] Eroding affordability and declining access have triggered public outrage, and pressure to reform payment policy is mounting. Because nearly all other economically advanced countries spend less per capita and proportion of GDP than the US on prescription drugs,[5] several legislative efforts have been proposed to adopt pricing from other countries, either through reference pricing, importation, or government negotiations.[6-8]

However, critics have voiced concerns that the mechanisms by which these proposals aim to lower prices in the US are likely to have raise prices outside of the US, rendering them ineffective. Some suggest that instead, the US could formally conduct Health Technology Assessments (HTA), which is used extensively in other countries to determine coverage. These proposals are intuitively appealing, as they avoid the technical challenges of external price benchmarking. However, they fail to consider differences between the US and other countries' in how payers negotiate with pharmaceutical manufacturers and how supply-chain intermediaries are reimbursed. These factors play an important role in determining both the prices and overall costs of drugs, and how much patients pay. Absent parallel reform to the policies that shape these practices and incentives, efforts to conduct HTA and negotiate prices may be less impactful than expected. As policymakers increasingly turn their attention to how foreign countries use HTA and price negotiation, they should also be informed about how their supply chains and reimbursement policies compare with the US.

This report used qualitative methods to compare the factors that drive pharmaceutical pricing and market access in the US with five other high-income countries, considering not only HTA, but also the role of supply chain participants, healthcare providers, and their financial incentives relative to branded specialty drugs (drugs that are expensive, complex, and self-administered). This report follows the ways in which countries bring an SSA to market and how purchasing and reimbursement practices are managed within the supply chain. Generics and lower priced branded drugs were excluded.

Methods

Countries were selected based on stage of economic development (GDP per capita), geographic diversity, public and private healthcare delivery expenditures, and overall prescription drug expenditures to ensure that they closely matched US characteristics while offering variation in policy and practices within the health systems. Based on these criteria, Canada, Germany, Sweden, Australia, and Japan were comparable markets with which to compare US drug pricing dynamics (Table 1).

Table 1. Country Selection Criteria

Criteria	US	Australia	Canada	Germany	Japan	Sweden
GDP per capita (in USD)[a]	$59,958	$54,067	$45,149	$44,350	$38,389	$53,792
Geographic Location	North America	Oceania	North America	Western Europe	Asia Pacific	Nordic Countries
Total HC Spend per capita, USD[b]	$10,246	$5,332	$4,755	$5,033	$4,169	$5,905
Public HC Spend[c]	50%	69%	74%	78%	84%	84%
Private HC Spend[d]	50%	31%	26%	22%	16%	16%
Pharma spend per capita[e]	$1,268	$665	$845	$847	$806	$513
Global ranking, pharma spend per capita[f]	1	6	3	2	5	22

[a]World Bank, 2017[9]
[b]WHO, 2017[5]
[c]WHO, Domestic general government health expenditure as a percent of current health expenditure, 2017[5].
[d]WHO, Domestic private health expenditure as a percent of current health expenditure, 2017[5].
[e]OECD, 2017[10]
[f]OECD, based on latest data available[10]

A targeted literature review was conducted to develop an initial understanding of each country's drug approval procedures, reimbursement negotiation process, and supply chain. This was used to develop discussion guides for semi-structured one-hour interviews with key industry stakeholders in each country recruited by the authors and consultants.

Country-specific findings were then compared using an internal structured assessment tool designed to capture information about each step of a drugs' journey to the patient. For consistency, we harmonized terms and definitions across countries (see Glossary).

Findings

Bringing an SSA to market

Regardless of the country, manufacturers must effectively navigate three different mechanisms to market their drug. The first is regulatory review to obtain marketing approval for the drug on the basis of its safety and efficacy. This generally entails assessment by the country's ministry of health or another regulatory agency with authority over pharmaceutical products, such as the Food and Drug Administration (FDA) in the US or European Medicines Agency (EMA) in the European Union. Manufacturers initiate the process by supplying information about the drug's indication, molecular characteristics, and evidence from clinical trials to the relevant agency, which then determines whether the drug should receive marketing authorization.

Though necessary, authorization alone is insufficient to successfully commercialize a drug in a country's market. This is ensured by the second mechanism: negotiations between the manufacturer and payer to determine under what conditions the drug will be covered and how much the payer will reimburse for it. The third mechanism is for the country's supply chain to arrange for its delivery from manufacturer to patient.

Of these mechanisms, the latter two are particularly important for drug pricing. Coverage and reimbursement negotiations effectively determine a drug's price in the market, while purchasing and reimbursement practices shape its impact on the revenues of supply chain participants, including wholesalers and pharmacies. The following sections compare country-specific approaches to each of these mechanisms in broad terms.

Coverage and price negotiations

In virtually all countries, including the US, coverage negotiations are also price negotiations, and this process proceeds similarly across countries. In broad terms, manufacturers either propose an ask price for their drug, or the payer may make an opening offer. The counterparty may accept or decline and appeal. Although the subsequent steps of negotiation vary by country, the price ultimately agreed to will reflect whether other treatments exist, the treatment benefits relative to such other treatments, and the buying and negotiating power of the payer, both in size of its beneficiary population and ability to decline coverage.

In this respect, there are two important distinctions that set the US apart from other countries, with important consequences for price levels and reimbursement to the rest of the supply chain. One is that the US approach to aggregating the buyer power of its payers relies on a system of commercial third-party intermediaries, while other countries rely on negotiating collectives or a national decision-making body. This results in not one, but many negotiated prices in the US, specific to each payer. The other is that the publicly listed price used for reimbursement in the US supply chain is not directly related to these negotiated prices.

How countries aggregate payer negotiating power

The US relies on individual private and public sector health plans to assess new drugs and make coverage determinations. The benefits offered by such plans are generally split into two categories. Drugs dispensed to patients through pharmacies, such as SSA drugs, are covered through a plan's pharmacy benefit, while those administered by healthcare providers, such as infusions, are covered under the medical benefit. Drugs covered on a health plan's pharmacy benefit are listed on one of the tiers in its formulary, which can also require utilization management (UM), such as step edits, prior authorization, and quantity limits. Upon FDA approval, a plan's Pharmacy and Therapeutics (P&T) committee assesses the drug's efficacy and safety to determine whether it should be covered. If the P&T committee determines the drug should be covered, a contracting group then engages in negotiations with the manufacturer, who may offer rebates and discounts in exchange for a favorable position on the formulary and fewer UM criteria.

Decisions about whether to list a drug on formulary can be made by the health plans themselves, or outsourced to Pharmacy Benefit Managers (PBMs), which are companies that specialize in administering pharmacy benefits. Three PBMs - Express Scripts, CVS Caremark, and Optum Rx – dominate the US market. As a result of their scale, they can negotiate better than many individual plans can on their own.

The US is unique in its reliance on PBMs to aggregate negotiating power, though PBMs in Canada are growing. However, the problem that PBMs solve – fragmentation of beneficiaries across different payers - is not unique. Delegation to regional and private sector health plans is a prominent feature in all other countries but Australia. The differences in their approaches, however, have significant and meaningful consequences for the prices arrived at through the negotiation process.

Canada and Germany use collective negotiation in making their coverage determinations. Although Canada's universal coverage of medical care does not extend to pharmacy drugs, most Canadians are covered by some form of pharmacy benefit through a mix of private and public payers. These plans are provided by provinces and employers and are free to make independent coverage determinations. Most public plans are members of a negotiating collective, the pan-Canadian Pharmaceutical Alliance (pCPA), which controls access for a large number of Canadians. Their decisions are informed by recommendations from the Canadian Agency for Drugs and Technologies in Health (CADTH), an independent and not-for-profit organization that provides economic assessments on drugs. CADTH reports are made public and are often used by private health plans as well. In Germany, the GKV-SV, which represents the country's numerous health plans, negotiates on their behalf to make a national coverage determination.[11]

By contrast, Sweden and Japan make coverage determinations at the national level, which are then managed at the regional level. In Sweden, coverage determinations are made by the Dental and Pharmaceutical Benefits Agency (TLV), which are then financed and delivered by the country's 21 county councils representing the country's six health care regions. Japan follows a similar model, with its Central Social Insurance Medical Council (*Chuikyo*) setting terms of coverage that the country's health plans then finance and implement. Australia also makes a national coverage determination through the Pharmaceutical Benefits Advisory Committee (PBAC) but administers it at the federal level.

Establishing public price benchmarks in coverage negotiations

One of the consequences of the US approach to aggregating payer power is that it results in multiple negotiated prices in the market, and that they remain confidential. This leaves the supply chain with only the manufacturer's ask price as the reference price for their reimbursement. However, the net price of SSAs, particularly in competitive therapeutic areas, can be substantially below their ask

price. That, in turn, has implications for how supply chain stakeholders make their money, and how their financial incentives relate to drug prices. (see Purchasing and reimbursement practices)

This is not the case in other countries, where the publicly listed price is the outcome, not the starting point of the negotiation. In Japan, *Chuikyo* starts the negotiation with a price calculated through reference pricing or a "cost plus method", which factors in production costs, profits, and taxes. This process of presenting a price to the manufacturer with a cost calculation is unique to Japan. Once both parties agree on the price, it is listed on the national formulary (NHI Drug Price Standard) where it becomes the price reimbursed to pharmacies. In Germany, Australia, and Sweden, approved drugs are listed on the national drug list alongside the price at which the GKV-SV, PBS, and TLV, respectively, will reimburse.

Although both Canada and Sweden delegate some of the negotiating authority to regional payers, they also have in place mechanisms that limit the reimbursement price at which regional negotiations proceed. In addition to relying on CADTH for HTA and reimbursement recommendations, Canada also has the Patented Medicine Prices Review Board (PMPRB), who sets the ceiling price (or Maximum Average Potential Price) at which a patented drug can be sold in Canada. The Board also has a unique regulatory authority to ensure patented drugs are not "excessively priced".

In effect, these countries, either through negotiation or through a national price benchmark that ties the price manufacturers can ask for, set an upper bound for the rest of the stakeholders within the supply chain, with some countries further regulating the markup and fees wholesalers and pharmacies can charge.

Connecting price benchmarks to supply chain incentives

The final step of bringing an SSA to market is to ensure its distribution through the supply chain. For a drug to be dispensed to the patient, it must pass through a series of exchanges between manufacturers, wholesalers, and pharmacies, with terms set forth in contractual arrangements between them. In the US, this supply chain is set in motion when a clinician prescribes a drug to the patient, who then fills the prescription through a pharmacy. Specialty self-administered prescriptions are commonly handled through specialty pharmacies, as in Canada. Although specialty pharmacies may be associated with a retail pharmacy, they are often standalone, have a centralized-fill system that allows for mail order capabilities, and can be owned and operated by PBMs or manufacturers.

Other countries follow a similar model, with the exception that specialty pharmacies do not play a prominent role. Outside the US and Canada, community and hospital pharmacies dispense SSAs along with more conventional outpatient drugs.

Purchasing and reimbursement practices

Supply chain

Supply chain revenue attributable to prescription drugs are inherently linked to payer reimbursement, which typically reference the publicly listed price. In the US, this price is the manufacturer's ask price (typically known as the list price or WAC). Wholesalers typically negotiate a 2%-5% discount from this price from the manufacturer. In turn, they sell drugs to pharmacies at a markup over their purchase price, plus distribution fees. Similarly, pharmacies negotiate discounts and rebates from the manufacturer or wholesaler whenever possible and add markups and dispensing fees in their claims for reimbursement from payers. The confidential nature of these negotiations allows for

rich spread-pricing and markup opportunities particularly for expensive SSAs and can contribute substantially to their overall cost.

Although most other countries take a similar approach to distribution, with manufacturers, wholesalers, and pharmacies contracting amongst each other, there are several differences in how they are reimbursed, which set their financial interests apart from supply chain intermediaries in the US (Table 2).

Table 2. Supply chain margin regulation and oversight

	Wholesale regulation / oversight	**Pharmacy regulation / oversight**
USA	n/a	No regulation or oversight for commercial plans and Medicare. Medicaid and Veterans Health Administration sets a floor and ceiling price, and regulates fees.
Canada[a]	Markup regulation varies by province	Markup regulation varies by province
Germany[b]	Markup regulated by unions alongside the government	Markup regulated by unions alongside the government
Sweden[c]	n/a	Markup regulated by TLV
Australia[d]	Markup regulated by unions alongside the federal government	Markup and fees regulated by unions alongside the federal government
Japan	n/a	Markup indirectly managed by reimbursement price, regulated dispensing and service fees

[a]Fees in detail[12]
[b]Fees in detail[13]
[c]Fees in detail[14]
[d]Fees in detail[15]

A number of countries cap markup and spread-pricing opportunities by determining the reimbursement price in coverage negotiations. For example, Japanese payers reimburse at the NHI price in addition to fees for pharmacy administration and dispensing that are set by the government under the National Fee Schedule. As in the US, a pharmacy may make a profit from the spread

between the NHI reimbursement price and the purchase price from the wholesaler. Wholesalers in turn negotiate discounts from the manufacturer, and subsequently add a markup to their sales to pharmacies. Unlike the US, the NHI reimbursement rate caps the economic opportunity, as the US reimburses on the ask price with pharmacy margins established by the payers, which can vary by pharmacy and network type.

In addition to listing the national reimbursement price, another approach to mitigating supply chain inflation is to directly regulate the margins of intermediaries. Because the TLV in Sweden only regulates the markup for pharmacies, the publicly listed price becomes the benchmark for negotiations between wholesalers and manufacturers, which typically results in a 2% to 3% bulk purchasing discount.

In Canada, drug plans participating in the National Prescription Drug Utilization Information System have policies to limit wholesale and pharmacy markups, with varying allowances regulated at the discretion of each province.[12] Pharmacies in provinces that do not directly regulate markups must submit the acquisition cost of a drug to the patient's insurer, which align with the Maximum Average Potential Price (MAPP), set by the PMPRB, to receive full reimbursement. Arrangements with private payers are similar to those in the US, with profit margins subject to negotiating power of the pharmacy and the payer.

In Australia and Germany, both wholesale and pharmacy markups are regulated by an agreement with unions and federal government. In Australia, additional fees may apply if the drug has special considerations, such as a dangerous drug, specially packaged, or falls under the highly specialized drug list. Wholesale markups are fixed to a threshold depending on the acquisition cost from the manufacturer. For instance, if the acquisition cost is below AUD$930.06, the wholesale markup is 7.52%; markup is capped at AUD$69.94 if acquisition costs exceed AUD$930.06. Germany, on the other hand, further requires that pharmacies return a share of these payments as rebates to payers.[16]

Prescribing physicians

Most countries and their payers also exert some level of control over utilization through physicians to ensure that pharmaceutical products are used according to the criteria established in coverage and reimbursement negotiations. Their approaches, however, vary widely.

In the US, Canada, and Australia, prescribing restrictions are generally imposed at the level of the physician-patient interaction. US and Canadian physicians may be required obtain prior authorization from the patient's health plan, which can include documenting details of the patient's diagnosis, clinical details, and imaging and tests. They may also be required to use step edits, in which other treatment alternatives must be tried first. In Australia, many of the SSAs that are subject to specialty pharmacy management in the US and Canada fall under the Section 100 Highly Specialised Drugs Program (HSD). Prescribing of drugs in the HSD program is often restricted to prescribers with specific training or affiliations, and requires written or telephone requests for approval.[17,18]

By contrast, Germany relies on population-level policies to control prescribing behavior. Germany's regional physicians' unions negotiate with health plans to establish annual budgets for delivering care to the plans' beneficiaries. The resulting agreements commit physicians to stay below agreed-to prescribing volume targets for certain drugs. Those who exceed the target by more than 12.5% receive a warning from the health plan and may be required to compensate it for the resulting spending overruns.[16] However, this penalty is rarely exercised. Conversely, targets are also used to encourage prescribing of some drugs. For example, some physicians in Berlin are held to a goal of 70% of antidepressants being citalopram or sertraline.[19]

Others avoid using these tools altogether. Sweden and Japan have historically maintained a more hands-off approach, both at the level of individual treatment decisions and at the population level**.** As a consequence, physicians in both countries have historically been able to prescribe without first

obtaining prior authorization or complying with other measures. However, recent exceptions suggest that both countries may be willing to become more proscriptive. In Sweden, county councils now require prior authorization for Spinraza (nusinersen), an expensive drug for spinal muscular atrophy, and extend prescribing authority to pharmacies for mandatory generic substitutions at the counter. Japan issued guidance to physicians to consider Taltz (ixekizumab), a high priced drug compared to the incumbent Cosentyx (secukinumab), as the last line of treatment for psoriasis.[20]

Discussion

In all countries, coverage and reimbursement negotiations determine a drug's price in the market, while purchasing and reimbursement practices shape its impact on the revenues of supply chain participants, including wholesalers and pharmacies. However, there are three main distinctions that set the US apart. The first is that the US approach to aggregating the purchasing power of its payers relies on a system of commercial third-party intermediaries, which results in many negotiated prices specific and confidential to each payer. The second is that the publicly listed price used for reimbursement in the US supply chain is not directly related to these lower negotiated prices, which creates inflationary incentives for supply chain stakeholders who generate revenue from the resulting spread pricing and markup opportunities. The third is that other countries rely on regulation to limit the degree to which wholesalers, pharmacies, and other supply chain participants can profit from higher drug prices. These factors together avoid price transparency and fosters a drug pricing ecosystem in which each stakeholder profits when the ask price is high.

What is often overlooked in US policy discussions are the ways insurance programs manage benefits for low-income beneficiaries and veterans. Many policies managing drug prices seen in foreign countries are also used in the US, despite the pharmaceutical industry claiming otherwise. Medicaid and the Department of Veterans Affairs (VA), both government health programs and collectively

covering about 19% of the population, negotiate directly with manufacturers on price and set upper payment limits with established fee schedules for pharmacies.[21] Because Medicaid is administered at the state level, states can negotiate as a coalition, similar to how regional authorities in Sweden and Canada aggregate negotiating power. Mandatory generic substitution is also required by the VA and by Medicaid in 19 states. In 2017, the VA and Medicare paid about 55% and 35% less per unit, respectively, for the top-selling branded drugs than Medicare, where these tools are not in place or, in some cases, prohibited by law.[22]

Some regulations intended to improve access unintentionally encourage high prices. For example, Medicare stipulates that its prescription drug plans must cover all drugs that fall under six protected class categories, including SSA oncology drugs. Without being subjected to competition, manufacturers are able to command high ask prices with full reimbursement, and wholesalers and pharmacies benefit since markup and fees are not regulated by Medicare. Medicaid has a similar rule, where coverage for all of a manufacturer's products hinge on mandatory rebates to net out at the "best price" paid among private payers. "Best price" sets a price floor that transcends to the private sector and can result in drugs that cost $0 but is often cited as the main reason against implementing innovative payment models tying clinical value to cost.

The emphasis on market competition and a growing pharmaceutical sector in the US in the 1970s led to more prominent administrative roles for supply chain intermediaries, most notably the PBM, whose business model is predicated on price secrecy and minimal government oversight. For instance, contractual agreements prohibit a pharmacy to disclose when a patient's copayment costs more than the retail price, and allows PBMs to clawback the difference, which further increases patient spending that is independent of the drug's ask price. The financial toxicity to the healthcare system and to Americans have also prompted manufacturers to provide copayment assistance, circumventing the

PBM's formulary restrictions, which was later met with PBMs introducing copayment accumulators to track manufacturer cash payments to patients. This type of competitive environment is unique to the US, where patient cost sharing for SSAs are typically a percentage (15%-35%) of the drug's ask price, not the net price, followed by high deductibles, and in Medicare, no annual out-of-pocket maximums. In all other countries except Canada, where prescription drug benefits are not universally covered, the pharmaceutical ecosystem simply does not allow for PBMs and manufacturer-sponsored copay assistance.

Conclusion

Many recent legislative proposals borrow from policies enacted in other countries, but the ways in which other countries gain control of drug spending extends beyond these mechanisms, reinforcing their effect. For instance, Australia references prices for drugs within the same therapeutic class as well as externally to the UK and New Zealand and conducts economic assessments where appropriate. Other countries similarly use a mix of cost containment strategies, such as mandatory generic substitution and cost-effectiveness analysis, but none rely solely on the assessments conducted by another country to manage prices, such as what drug importation and reference pricing policies imply. Recent policy changes, if enacted, would allow for Medicare, which covers nearly one-fifth of Americans, to also negotiate prices directly with manufacturers on select drugs post-exclusivity, thereby capping some of the highest spending drugs throughout the supply chain. Understanding how other economically comparable countries operate may provide insight into how stakeholder engagement and economic dynamics play that may be gleaned or adopted.

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Appendix

A.1 Glossary

Ask price	The initial price manufacturers ask to be paid for a drug, before any negotiations with payers. Typically referred to as WAC, list price, or ex-factory price depending on country.
Average Sales Price	Weighted average sales prices as reported by manufacturers for medical benefit drugs that US Medicare reimburses.
Benchmark price	The price used as a base for reimbursement to the supply chain.
Best Price	Lowest price offered to any wholesaler, retailer, or provider by the manufacturer.
Clawback	A contractual provision that requires a return of payment.
Discount	A reduction to the selling price before any purchase or transaction.
External reference pricing	Price benchmark that references foreign countries' prices for the same drug. This is typically used for novel drugs.
Formulary	A list of drugs that insurance will cover and any rules relating to its use. Also referred to as a "schedule" or "determination list".
Inpatient	Care received at a hospital that requires an overnight stay.
Internal reference pricing	Price benchmark for a drug that references the price of other drugs in the same therapeutic class.
Mail order/online pharmacy	Pharmacies that allow patients and consumers to fill prescriptions online and have the drug delivered to the home.
Medicaid	Government payer in the US that is managed at the state level and based on income.
Medicare	National government payer in the US, Australia, and Canada. No affiliation with each other.
Net price	Price after discounts and rebates.
Opening offer	Price offered by payer at the start of negotiations. In this report, Japan is the only country to negotiate in this way.
Outpatient	Care received within a hospital, doctor's office, or clinic that does not require an overnight stay. This can include day surgery, ambulatory services, and pharmacies.
Payer	Organization that pays for healthcare services, also referred to as "health insurer".
Pharmacy Benefit Manager (PBM)	Third-party administrators that negotiates price and formulary placement with manufacturers and pharmacies, often on behalf of a health plan.

Prior authorization	A form of utilization management implemented by the health plan in which prescribers must obtain pre-approval from the insurer before prescribing.
Quantity limits	A form of utilization management that restricts the drug quantity dispensed over a specific time frame, usually 30 to 90 days.
Rebate	An amount a manufacturer returns after pre-specified terms have been met.
Reimbursement price	The amount a payer reimburses to a pharmacy for the drug dispensed to the patient. Some countries publicly list the reimbursement price, and the price can be inclusive of stakeholder markups and fees. This is not the same as the net price. For instance, Sweden and Australia negotiate the reimbursement price, and can further enter into managed entry agreements for outcomes-based rebates.
Retail/community pharmacy	Brick-and-mortar pharmacy that dispenses prescription drugs to patients directly.
Retail price	Price at the pharmacy, inclusive of pharmacy markups and dispensing fees.
Specialty pharmacy	Pharmacies that dispense drugs used to treat complex diseases like cancer, multiple sclerosis, and rheumatoid arthritis; require special storage or shipping and handling specifications; or are high priced. Specialty pharmacies can be brick-and-mortar or mail order, and in some cases dispenses to a prescriber.
Specialty self-administered (SSA) drug	Specialty drugs that are generally managed through specialty pharmacies in the US and administered by the patient.
Spread pricing	Price differential between the amount charged and received.
Step edits or step therapy	A form of utilization management that requires the use a cheaper alternative before its more expensive alternative.
Utilization management	A set of managed care techniques that allow payers to steer beneficiaries towards specific drugs based on cost or benefit. See: prior authorization, quantity limits, and step therapy.