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Opinion

# Providing Fair Payment for Prescription Medications in the United States

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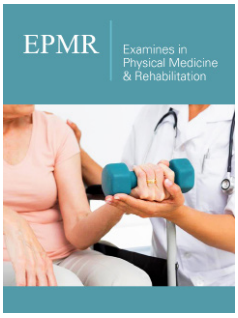


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## Opinion

With US health care costs now approaching $3 trillion per year, strenuous efforts to restrain cost growth continue to focus the efforts of policymakers at the federal and state levels. With pharmaceuticals contributing about 20% of total domestic health expenditures, pharmaceuticals are a natural target of cost control efforts. A primary means of attempting to control pharmaceutical costs in the use of Pharmacy Benefit Managers (PBMs), intermediary firms which function as go-betweens in the payer-provider relationship. Medicare, most state Medicaid programs, and many private managed care organizations use PBMs to manage pharmaceutical use for their beneficiaries.

However, a recent review of regulatory efforts combined with the complaints of many retail community pharmacies raises questions as to whether PBMs always act in the best interest of patients, and whether their benefit management practices are harming independent community retail pharmacies. Arnold [1] indicates that PBMs generate their revenues from three primary sources: fees generated from the supply chain, rebates provided by manufacturers and "spreads," the difference between what the insurer pays the PBM and what the PBM pays the pharmacy which dispenses the medication.

A noted lack of transparency in PBM operations arises from two of those revenues streams. Critics have argued that payers are not benefitting fully from the rebates which PBMs receive from pharmaceutical manufacturers. In addition, pharmacies argue that PBMs are not adequately reimbursing them and are retaining an undue share of the revenues derived from the payers. The market dynamic of PBMs is further complicated by the fact that three large PBMs control 76% of the market of PBM services, and each of the three is owned by a major health insurance company which stands to benefit financially from decisions made by its affiliated PBM Morgan [2].

Smaller independent retail pharmacies complain that they do not have the ability to negotiate favorable acquisition costs and that PBMs reimburse them at less than their acquisition costs for certain prescriptions and charge the pharmacies back for certain patient management discrepancies. Such practices put the pharmacies in a tenuous financial position, leading some to believe they may close. Several large regional grocery store chains that maintained pharmacy counters in their stores are closing or selling those services Terlep [3].

These concerns have been brought to the attention of the US Senate Finance Committee which has written to the US Department of Health and Human Services requesting that it reform the Direct and Indirect Remuneration System by which PBMs remit funds to Medicare Morgan [4]. State legislators are expected to address PBM issues, including rebates to state Medicaid programs and private health insurance companies.

Some suggested areas for consideration in reforming PBM practices are:

### Require that all pharmaceutical company rebates be paid to the insurance carrier

Medicare currently requires that all manufacturer rebates be paid back to the program in order to help reduce Part D prescription drug benefits. Such a requirement should be put in place for all payers using PBMs.

### Devise a standardized administrative fee protocol

Rather than tying administrative fees together with manufacturer rebates as the Medicare DIR mechanism does, separate the two so as to clarify fees from rebates. Fees can then be regulated as a percentage of rebate payments.

### Regulate the "spread" between PBM payments to pharmacies for prescriptions and the acquisition costs which the pharmacies incur

Smaller independent retail pharmacies should not be penalized for the acquisition costs they pay. They should be assured of a fair reimbursement tied to their acquisition costs.

### Investigate PBM-insurer relationships for anti-competitive practices

Since the three largest PBMs are owned by large national insurance companies, they have the ability to favor their insurance companies to the detriment of the pharmacies with which they deal. Concerns lie not only with reimbursement rates paid to pharmacies but with the control PBMs exert over provider network configuration.

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