

US Pharmacy 2006—A Time of Transition, A Time of Opportunity

a report by
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The US pharmacy system is currently undergoing a transformation that presents challenges and opportunities for consumers, pharmacists, doctors, drugstores, and payors alike. More than ever, consumers are relying on a wide range of brand-name and generic prescription drugs as the cornerstone of a modern health program. In an historic shift, more than 40 million seniors and disabled Americans now have a prescription-drug benefit in Medicare. Public and private payors are demanding more accountability from the system to ensure value-based purchasing. Pharmacists continue to be in great demand and new pharmacies are sprouting up daily. Innovations such as electronic-prescribing (e-prescribing) technology and mail-service pharmacies are no longer seen as untested theories, but instead are viewed as solutions that can save lives, reduce costs, and improve quality.

Pharmacy benefit managers have a critical role to play in helping to meet these challenges and realizing the tremendous opportunities facing all stakeholders. Pharmacy benefit managers are hired by Fortune 500 employers, health insurance plans, labor unions, federal and state-employee benefit plans, and Medicare to expand pharmacy choices and promote access to cost-effective prescription drugs for more than 200 million Americans. The pharmacy benefit manager's track record for delivering savings and quality benefits is achieved through a variety of cost containment and utilization management tools: pharmacy network management; pharmacy management tools, including formularies, drug utilization review, step therapy, and prior authorization; mail-service pharmacy; therapeutic interchange; generic substitution; and consumer and physician education.

Pharmacy benefit managers play a necessary and vital

role in the US healthcare system. By fostering competition throughout the system, pharmacy benefit managers are able to generate efficiencies and make drug manufacturers and drug stores compete on cost and quality. Numerous, independent government data have demonstrated the cost-savings value provided by . The nation's most sophisticated private purchasers rely on pharmacy benefit managers to help them provide high-quality, prescription drug benefits. Public programs—most notably Medicare—have made pharmacy management tools pioneered by pharmacy benefit managers the centerpiece of the new prescription drug benefit.

Moreover, these tools are yielding results. In January 2006, researchers at the US Centers for Medicare and Medicaid (CMS) announced that the rate of growth in prescription-drug spending had slowed to its lowest level in a decade, rising 8.2%. As recently as 1999, the rate of growth had been more than twice that level. CMS researchers attributed this historic decline to four key factors: the increased use of over-the-counter (OTC) medications; greater emphasis on mail-order dispensing; growth of lower-priced generics in the marketplace; and reduced consumption of existing drugs over new safety concerns.¹

In the commercial marketplace, pharmacy benefit managers typically provide savings to consumers and payors averaging 25%. According to Pharmaceutical Care Management Association (PCMA)-commissioned research, by 2014, total savings from pharmacy benefit management techniques will total about US\$1.3 trillion.² In Medicare Part D, drug plans are achieving discounts averaging 27%, up markedly from earlier projections.³

1. Smith, Cowan, Heffler, et al, "National Health Accounts in 2004: Recent Slowdown Led by Prescription Drug Spending", *Health Affairs* (2006); 25(1): pp. 186–196). Available at www.healthaffairs.org
2. PricewaterhouseCoopers, "The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation", commissioned by PCMA, July 2004. Available at www.pcmnet.org
3. National Health Statistics Group, Office of the Actuary, US Centers for Medicare & Medicaid Services, "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs*, no. 2 (2006):25(2): pp. w61–w73. Available at www.healthaffairs.org

Clearly, these data reflect progress and are a testament to the hard work of not just PBMs, but also pharmacists, doctors, payors, and others in the drug-supply chain to provide consumers with more choices and improved information. While these data are encouraging, these gains cannot and should not be assumed. There are a number of issues confronting policy-makers that, depending on their outcome, could have adverse consequences for patients and the entire system.

Medicare Part D

Instituted in January 2006, the new Medicare prescription drug benefit is the greatest change to the US pharmacy system in years and has required an unprecedented level of collaboration among patients, doctors, pharmacists, pharmacy benefit managers, Medicare drug plans, and the CMS.

Given that the drug benefit is the largest expansion in Medicare since its inception 40 years ago, it is hardly unexpected that early challenges arose. Because of incomplete data files, some beneficiaries were inadvertently enrolled in two plans or disenrolled from the plan of their choice. Another early challenge involved some beneficiaries not understanding what drugs were covered by their plan. Pharmacists worked hard to assist beneficiaries through this process. Benefit plans supported this effort and did their part by voluntarily expanding transitional drug coverage for certain groups of beneficiaries for an additional 60 days.

Fortunately, the early challenges of Medicare Part D are largely behind us. Because of the strong cooperative spirit among pharmacy benefit managers, benefit plans, and 55,000 pharmacists, beneficiary satisfaction with Part D is growing.

This partnership also underscores what is at stake in Part D. For Medicare Part D to work as intended Pharmacy benefit managers health plans, pharmacy benefit managers, and pharmacies must all work together. Part D is based on a competitive model. Competition inevitably creates tension—and it is that healthy tension that serves to lower drug costs for consumers. A competitive marketplace in Part D has yielded deeper-than-expected discounts and lower-than-expected premiums.⁴

There are some in Washington that prefer a different approach to Part D; one in which the federal government would ‘negotiate’ drug prices for beneficiaries. This approach would be a setback for all who want to inject more choice and competition into the system. In addition, this approach would likely mean fewer choices of drugs and higher drug costs in other parts of the system.⁵

The success or failure of Medicare Part D is a referendum on the ability of the private market to work productively with public programs. For Medicare Part D to work, it requires a new paradigm of collaboration and a recognition of the value that all stakeholders bring to the system.

Generics

As public and private payors continue to work to rein in healthcare spending, increased use of generic drugs provides a ready-made solution for reducing costs without sacrificing quality. Generic drugs now account for about 12% of the US\$250 billion annual US drug spend and more than 53% of prescriptions filled. IMS Health, a company that tracks the industry, predicts that the market share of generics will exceed 65% within four years as several blockbuster drugs go off patent. According to one analysis, seniors and the Medicare program stand potentially to save at least US\$23 billion over the next five years as 14 major brand-name drugs commonly used by seniors are expected to become available in generic form. The same analysis found the savings across the entire health system would be US\$49 billion as a result of these drugs going generic.⁶

Expanding generic utilization aligns incentives across the drug-supply chain—consumers, pharmacies, pharmacy benefit managers, and payors all benefit from increased use of generic drugs. However, brand-name drug manufacturers are working to undermine consumers’ access to generic drugs and are blocking legislation that could speed generic entry to market.⁷

e-Prescribing

e-Prescribing technology is an innovation poised to transform pharmacy. By connecting patients, doctors,

4. US Centers for Medicare & Medicaid Services, Press Release, “Medicare Drugs Costs Drop Substantially,” February 2, 2006. Available at www.cms.hhs.gov

5. US General Accounting Office, “Expanding Access to Federal Prices Could Cause Other Price Changes,” August 2000. GAO/HEHS-00-118. Available at www.gao.gov

6. PCMA analysis, “Potential Savings to Medicare from New Generic Drugs Becoming Available,” April 18, 2006. Available at www.pcmamet.org

7. *The Washington Post*, “Obstacles to Generic Drugs Criticized; Drugmakers’ Control of Branded Products Affects Possible Savings,” April 19, 2006.

pharmacies, and payors—electronically and in realtime—e-prescribing holds great promise in reducing the more than 1.5 million estimated medication errors that occur annually.

e-Prescribing instantly links healthcare providers, pharmacies, and payors by allowing physicians to send prescriptions from their office to a retail or mail-service pharmacy through a handheld device or from a desktop computer. The prescribing physician has a patient's benefit information and medication history available when prescribing. This information allows the physician to see patient cost-sharing, discuss therapeutic alternatives, and check for potential interactions with other medications a patient may be taking. The pharmacy benefit managers role is to provide the data and information that allows the physician to see this information at the point of prescribing. e-Prescribing also has the potential to significantly reduce “the hassle factor” at the pharmacy counter by resolving coverage issues at the point of prescribing.

The adoption of e-prescribing technology may be at a turning point. In July 2006, the Institute of Medicine (IoM) issued a set of recommendations for identifying and preventing medication errors, including a call that all prescriptions be written electronically by 2010.⁸

One key barrier to achieving the IoM's recommendations lies with separate and sometimes conflicting state e-prescribing laws, as well as a different standard in Medicare. Senator Hillary Rodham Clinton, Democrat of New York, recently became the first Member of Congress to call for a uniform, national e-prescribing standard.⁹ In addition, consumer, labor, and employer representatives have also joined the call for a national e-prescribing standard. AARP, AFL-CIO, Consumers Union, and the US Chamber of Commerce recently joined with PCMA in urging the adoption of a national, uniform e-prescribing standard.¹⁰

Mail-service Pharmacies

Mail-service pharmacies provide consumers and payors with increased pharmacy options and more cost-

effective drug choices. Mail-service pharmacies will account for 18.5% of out-patient drug spending in 2006, or about US\$46.1 billion.¹¹

While patients with short-term acute-care needs typically receive their prescriptions in the retail pharmacy setting, those patients with chronic conditions such as high-blood pressure and high cholesterol may be better served by the home-delivery option offered by mail-service pharmacies. The mail-service pharmacy option offers increased savings and, since medications can be automatically delivered as each fill ends, helps consumers better comply with their prescription regimen. Furthermore, mail-service pharmacies have pharmacists available over the phone 24/7 to assure consumers the ability to ask and get the answers for any questions they may have about their medication(s). Pharmacy benefit managers employ an estimated 4,000 pharmacists nationwide at their mail-service pharmacies.

In recent years, large national chain drugstores have also set up their own mail-order pharmacies to compete with pharmacy benefit managers, although a government study found they do not yet provide the level of savings that pharmacy benefit managers-owned mail-service pharmacies do.¹²

Because mail-service pharmacies typically dispense 90-day supplies with only two co-payments (in contrast to the standard one co-payment requirement for each 30-day supply at retail pharmacies), mail-service pharmacies are able to achieve savings of about 10 percentage points beyond the discounts negotiated at retail pharmacies. In an effort to compete, some drugstores are starting to offer 90-day supplies, but it is unclear if they will be able to match the cost-savings provided through mail-service pharmacies.¹³

Sophisticated large purchasers—including International Business Machines Corp., Citigroup, Southwest Airlines Co., General Motors Corp., Exelon Corp., Ford Motor Co., and DaimlerChrysler AG—all rely on the mail-service pharmacy option to help them maintain high-quality, affordable drug benefits for their employees.

8. *The Institute of Medicine of the National Academy of Sciences, “Preventing Medication Errors: Quality Chasm Series,” July 20, 2006. Available at www.iom.edu*

9. *Statement of Senator Hillary Rodham Clinton on Institute of Medicine Report, July 22, 2006. Available at www.clinton.senate.gov*

10. *Congressional Quarterly Healthbeat News, “Groups Back Clinton’s Call for National E-Prescribing Standard,” August 4, 2006.*

11. *The Lewin Group, “Mail-Service Pharmacy Savings: A Ten-Year Outlook for Public & Private Purchasers,” Commissioned by PCMA, August 2, 2005. Available at http://www.pcmamet.org/newsroom/pr_08/pr_080205.htm*

12. *US Federal Trade Commission, “Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies: A Federal Trade Commission Report,” August 2005. Available at <http://www.ftc.gov/opa/2005/09/pharmbenefit.htm>*

13. *The New York Times, “In Switch, Insurer Lets Stores Fill 90-Day Prescriptions,” April 15, 2005.*

If all prescriptions that could appropriately be filled through mail-order were in fact filled through mail-order pharmacies, the Lewin Group estimates that drug expenditures would be reduced by an additional US\$99 billion from 2006–2015 beyond existing savings projections. This includes US\$42.2 billion for Medicare and US\$56.8 billion for the commercial sector.¹⁴

Without question, mail-service pharmacies represent increased competition in the pharmacy marketplace—competition that has resulted in lower costs for consumers and payors. Unfortunately, some in the pharmacy community have sought to use the legislative arena to undermine mail-service pharmacy options. These efforts are short-sighted and may well

backfire if consumers and payors see retail pharmacies as working to keep drug prices higher.

Conclusion

The state of the US pharmacy system is strong. While challenges do and will continue to exist among stakeholders, more unites us than divides us. Pharmacists, doctors, and payors are all focused on working together to ensure that consumers have access to a broad range of pharmacy choices providing clinically proven brand-name and generic drugs. Important progress has been made in 2006 and all parties have an interest in building on that record in 2007 and beyond. ■

14. The Lewin Group, "Mail-Service Pharmacy Savings: A Ten-Year Outlook for Public & Private Purchasers," Commissioned by PCMA, August 2, 2005. Available at http://www.pcmanet.org/newsroom/pr_08/pr_080205.htm
