



## The Diminishing Pharmacy Benefit

---



By David J. Gibson, MD

**Consumers can look forward to deductibles, generic drugs and on-line Canadian purchases.**

FUNDAMENTAL CHANGE IN HEALTH PLAN coverage is sweeping through the California market and beyond. As discussed in the last issue ("Bad Times for Physicians"), managed care and its prepackaged benefit structure is rapidly receding. Employers are turning to catastrophic coverage with high deductibles and limited benefits that cover hospital services only. Physician services and pharmacy benefits are available as "wrap" products with limits on financial liability.

### Changes in the Pharmacy Benefit

Before managed care, there was no pharmacy benefit. There were no Pharmacy Benefit Managers (PBMs). There were no formularies or rebates. Patients paid for prescribed pharmaceuticals out of pocket.

During the early 1990's HMOs realized that a pharmacy benefit in their basic product design was a marketing advantage. The pharmacy benefit quickly became the most attractive and most used benefit, and helped drive fee-for-service products from the market. The pharmacy benefit became the most attractive reason for seniors to switch from traditional indemnity based Medicare to HMOs.

Over the past five years, the pharmacy benefit has increased at a 15 to 20 percent compounded rate each year, finally reaching the current unsustainable threshold for employers.

As a result, the pharmacy benefit is now no longer pre-packaged by PBMs and third party administrators (TPA's) into the basic benefit design. In fact, its exclusion is the basis for much lower monthly premiums.

Employers can add a pharmacy benefit to the major medical policy with a "wrap" structure similar to that of Medicare "Medigap" policies. Typically, for a \$40 per month increase in premium, an underwriter will provide a pharmacy benefit capped at \$500 per year for an individual or a family.

### Consumer Behavior

Milton Freedman once observed that no one spends another's money as carefully as his or her own. Under current employer health care plans, consumers demand extensive local pharmacy network coverage. They demand expensive brand drugs over equally effective generics that are not advertised. In short, cost is not a factor for the beneficiary. Consumers rarely use mail-order pharmacies that provide products at a significantly lower cost.

This behavior reverses when a third party limits its financial liability. Now the burden of

cost shifts to the consumer. Within this context, TPAs are notifying beneficiaries that they can now order pharmaceutical products through an Internet site in Canada at discounts of 60 percent or more (see table) as opposed to mid-teen level discounts from local pharmacies or mail order facilities. The beneficiary orders and purchases the product, submits the bill to the TPA and is reimbursed to the limit of the underwriter's liability after the deductible has been reached.

This market is evolving. Between 300 and 400 Internet sites — about half outside the U.S. — sell FDA-approved prescription drugs to consumers, according to the General Accounting Office. In the province of Manitoba alone, 27 pharmacies have gone on line in the last two years.

If a product's ingredient is FDA-approved, blue chip underwriters such as Blue Cross, Blue Shield and Humana will now reimburse the beneficiary for internationally dispensed drugs. United Health Group recently made headlines by telling thousands of AARP health plan members that it will reimburse for prescriptions purchased outside the United States.

Although it is not legal to buy even approved drugs from outside the United States, the FDA does not prosecute individuals who buy from foreign pharmacies. Any politician perceived as inhibiting grandma from obtaining life sustaining pharmaceuticals at a reasonable cost had better plan on a new career. This is not a news flash — the elderly vote.

TPAs administering these new insurance products report that most beneficiaries are electing to seek the Internet-based discounts. This is quite a change in behavior. In the past, beneficiaries obtained only 5 to 8 percent of chronic medications from less costly mail-order sources. Patients are now acting as informed consumers and not as entitled beneficiaries — a requirement for any market to function.

In this evolving market, only generic products will compete at the local pharmacy. In the future, brand products will be purchased internationally through a real-time, fluctuating "spot market." Without governmental intervention, the entire U.S. pharmaceutical distribution system will rapidly restructure.

## **Observations**

The real strength of America's economy lies in its pragmatic roots. We have traditionally experimented with new concepts in the market but quickly discarded those that do not work. Managed care was an idea that did not work. It provided rich benefits and eliminated the patient from the risk equation — the perfect inflation engine with no governor.

Fortunately, Congress has thus far avoided a pharmacy benefit for Medicare. Such a move would have eliminated any incentive for creative market solutions.

In the evolving indemnity market, the pharmaceutical manufacturers and PBMs will no longer be able to play insider games with rebates that deliver less than 6 percent discounts for the most expensive branded products within any class of drugs in the market.

PBMs now get most of their revenue from manufacturer rebates for pushing expensive brand-name drugs through their formulary structure.

Growing choruses of critics say that PBMs are now manipulated by pharmaceutical manufacturers through pricing schemes and sweetheart promotional deals to push the most expensive drugs on the market and keep the rebate revenue for themselves. For example, between 1995 and 1999, Medco Health has been accused of keeping \$2.85 billion in rebates from drug makers rather than pass that amount on to its clients.

Pharmaceutical manufacturers are now facing consumers armed with the ability to purchase in the international arena. It should be a very interesting contest but the outcome

is pre-determined. Informed consumers always win.

Pharmaceutical manufacturers will have to compete based upon the cost and efficacy of their products. Hidden rebate kickbacks to PBMs will no longer work.

It would be hard not to feel optimistic about the future.

dgibson@email.msn.com

DRUG NAME	STRENGTH	QTY.	CANADIAN PRICE	AARP PRICE	U.S. RX. CHAIN
Celebrex Caps	100 mg	100	72.36	136.95	154.86
Claritin	10 mg	10	18.69	27.02	28.30
Glucophage	500 mg	100	20.49	71.90	82.77
Lipitor Tablets	20 mg	90	191.92	258.90	290.15
Premarin	0.9 mg	100	21.92	80.95	80.11
Synthroid	.175 mcg	100	15.26	57.55	54.99
Tamoxifen	20 mg	100	42.52	334.00	323.30
Vioxx Tablets	12.5 mg	30	50.93	73.50	86.13
Zantec	300 mg	100	83.87	300.45	316.63

Sierra Sacramento Valley Medical Society  
 5380 Elvas Avenue #100 • Sacramento, CA 95819  
 916.452.2671 PH • 916.452.2690 FX • Email: info@ssvms.org

Copyright © 2000-2008 Sierra Sacramento Valley Medical Society - All Right's Reserved