

Medicare Part D and Preferred Provider Pharmacy Networks

By

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Despite early skepticism about the degree of corporate interest in sponsoring Medicare Part D prescription drug plans, it now appears that competition for sponsorship will be lively. Plan sponsors must be state-licensed insurance companies. However, pharmacy benefit managers (PBMs) will be making most of the discretionary managed care choices. This includes captive PBM operations of health insurance companies such as Wellpoint, Aetna, and Pacificare. It also includes large independent PBMs such as Medco Health Solutions, Express Scripts, and Caremark Rx, and PBM operations owned by large drugstore chains such as CVS and Walgreen.

There are several reasons advanced for the unexpected level of private sector interest in Medicare Part D. Some point to provisions that transfer financial risk from plan sponsors to the federal government in the early years of the program. Others point to the unexpected flexibility given to PBMs to use traditional managed care techniques. This includes a manageable number of therapeutic classes in the Medicare formulary and a disclaimer that negotiated rebates cannot be counted as Medicaid "best prices". Both of these provisions tend to favor large independent PBMs whose size gives them a competitive advantage in rebate negotiations with brand name drug companies.

The purpose of this note is to present the case that another provision in Medicare Part D has contributed significantly to the interest in sponsorship. This provision allows for the creation of preferred provider retail pharmacy networks with highly differentiated co-payments. PBMs of large drugstore chains are in the best position to take advantage of this provision. Battered by discriminatory practices used by independent PBMs to swing business away from retail pharmacies to their captive mail order operations, the drugstore chains are poised to unleash their PBMs in a counterattack.

Although the Medicare discount card program was not designed specifically to be a stepping-stone to the full benefit plan, it has provided a showcase for the cost-reducing potential of preferred provider retail pharmacy networks. Evidence of this potential comes from data compiled by the AARP Public Policy Institute. (Lind KD, *Medicare Drug Discount Card Program*, Washington, D.C.: AARP Public Policy Institute No.2004-16, p. 39. Available at <http://research.aarp.org/health/>) . The data was extracted from a Medicare website during the week of September 20, 2004 for all pharmacies listed within a 6 mile radius in the Chicago, Ill metropolitan area. Unfortunately, all price data for Walgreen were missing from the website for that week. The average retail price to cardholders for top selling brand drugs was calculated for 25 national Medicare card programs.

PharmaCare, the PBM operation of the largest drugstore chain CVS, was the price leader among 25 cards with a weighted average of \$78.96 for brand name prescriptions dispensed by their retail network. The card managed by Express Scripts, the third largest independent PBM, and sponsored by the Pharmacy Care Alliance (PCA)— *ad hoc* association of chain and community pharmacies – was a retail price laggard with a weighted average of \$86.13. The average price available to CVS cardholders was \$7.17 or 8% less than the average price available to PCA cardholders. This difference is comparable to the average price reduction available to Medicare discount cardholders using mail order instead of retail.

The reason for the difference is not so much the size of the network, but the approach taken by the managing PBM in passing along intra-network cost differences. Generally, the creation of a health care provider network begins with the inclusion of the lowest cost suppliers. PBMs then expand the network beyond this core by adding higher cost retail pharmacies to meet customer convenience preferences. The result is an “upward sloping supply curve” reflecting the marginal cost of adding additional suppliers. PBMs have the option of reimbursing all providers in the network at a uniform rate. This allows the most efficient providers to retain profit differentials or what economists call “economic rent”. PBMs also have the option of negotiating different reimbursement rates with each provider eliminating all profit differentials among network providers. PBMs have similar options when negotiating reimbursement prices with plans sponsors or cardholders. They can set a uniform price, retaining any accrued “economic rent”, or they can differentiate price by cost, thereby passing on accrued “economic rent” to plans or cardholders.

The relatively high average price of the PCA card reflects an “any willing provider” orientation that dampens intra-network cost differences with fairly uniform pricing. The low average price of the CVS card reflects a “preferred provider” orientation that allows price differences to reflect cost differences. The AARP study confirmed that CVS priced prescriptions dispensed by its own pharmacies significantly lower than prescriptions dispensed from non-CVS owned pharmacies.

There is an “any willing provider” provision in Medicare Part D, but that is counterbalanced by another provision that allows plans to separate retail pharmacy network providers into “preferred” and “non-preferred” and to set co-payments accordingly. The Medicare card data suggests that the PBMs of the large drugstore chains can counter the competitive advantages of large independent PBMs by creating a retail network with a highly differentiated co-payment structure.

Medicare Part D allows plans to differentiate co-payments or co-insurance by provider, channel of distribution, and drug type. However, after deductions, the actuarial average for each plan must

be 25% of beneficiary costs. This limit could be satisfied by the typical \$10/\$20 generic/brand co-pay rule.

But, we have made a rough calculation that the 25% rule could also be met by chain drugstore PBMs offering a \$0/\$10 co-pay for prescription dispensed by their own preferred retail pharmacies, jumping up to \$20/\$40 co-pay for prescriptions dispensed by non-preferred retail pharmacies. Coupling this differential with a 90-day retail option and the drugstore chains become a genuine co-pay competitive threat to captive mail order operations of independent PBMs.