How Pharmacy Networks Could Save Medicare, Medicaid, and Commercial Payers $115 Billion

Prepared for

PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

January 2013

Contents

Major Findings on Savings from Pharmacy Networks

Over the past twenty years, pharmacy networks have generated significant savings. Today, there is even greater potential savings available through preferred and limited pharmacy network options:

- Large number of pharmacies creates competition: Today, there are more pharmacies in the U.S. than McDonald's, Burger Kings, Pizza Huts, Wendy's, Taco Bells, Kentucky Fried Chickens, Domino's Pizzas, and Dunkin' Donuts combined, creating a highly competitive environment.

- Greater use of preferred and limited pharmacy networks generates savings: Greater use of preferred and limited pharmacy networks could save payers an additional $115 billion over the next ten years.

- Savings achievable while meeting Medicare's pharmacy access standards: All payers can achieve the savings estimated below while meeting Medicare's pharmacy access standards.

Ten-Year Savings from Preferred and Limited Pharmacy Networks			
Medicaid	**Medicare**	**Commercial Sector**	**Total**
$26 billion	$35 billion	$54 billion	$115 billion

Three Types of Retail Pharmacy Networks and Relative Savings

1. Open Pharmacy Network: Plans create a broad network open to virtually all drugstores that agree to offer basic discounts to the plans. A plan's enrollees can use their prescription drug benefits at all network pharmacies for the same copay/cost share. This is currently the most widely used type of retail pharmacy network.

2. Preferred Pharmacy Network: Plans create a select group of **preferred** pharmacies within a broader network of **non-preferred** drugstores. Preferred pharmacies offer plans better discounts than the non-preferred drugstores, and plans, in turn, lower copays/cost sharing for enrollees who choose them. Use of preferred networks is growing and can lower prescription costs by an estimated 5% compared to open networks while meeting Medicare's pharmacy access standards nationally.

3. Limited Pharmacy Network: Plans create a network limited to drugstores that offer deep discounts. Plan enrollees have the same copay at all pharmacies in the network. Compared to open networks, limited networks can lower costs by up to 10% or more.

Public Policies Undermine Preferred and Limited Pharmacy Networks

Many drugstores have an economic incentive to minimize the competition and discounting required to join pharmacy networks and often pursue legislation, regulation, and litigation to undermine the ability of payers to implement preferred and limited pharmacy networks in Medicaid, Medicare, and the commercial sector.

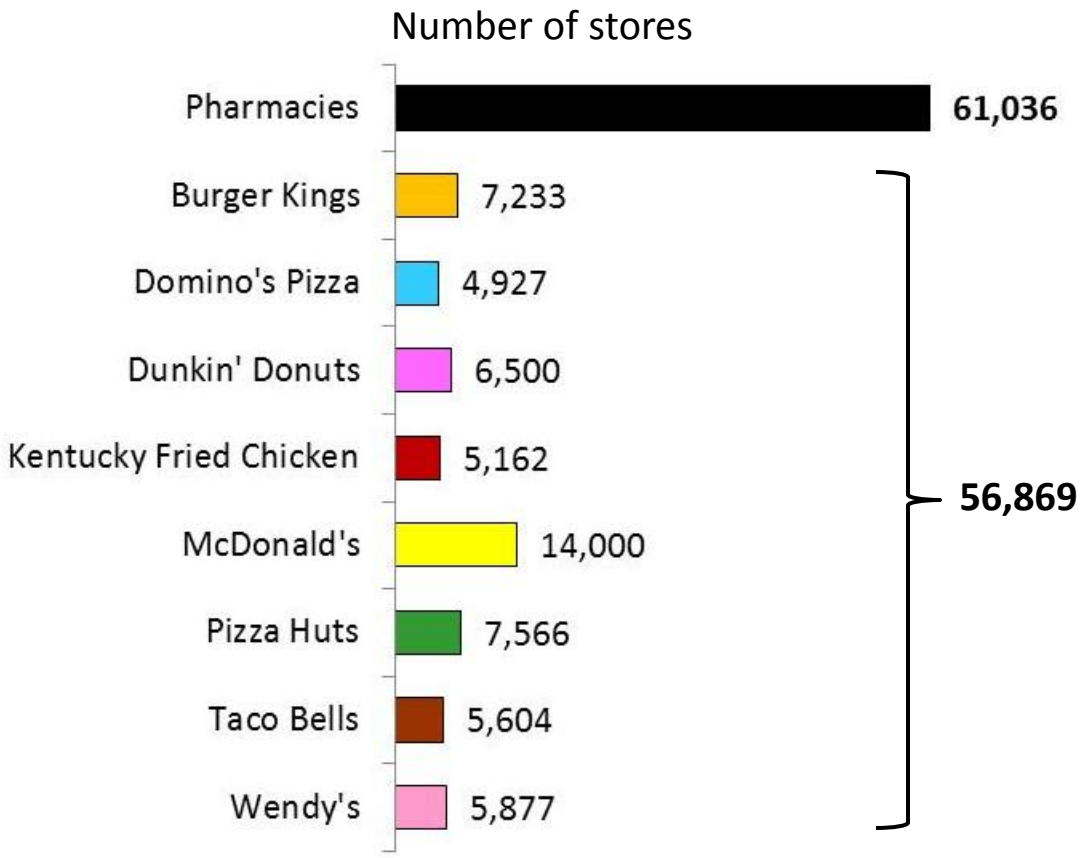
- "Any Willing Pharmacy" policies—These are laws and regulations that force plans to contract with pharmacies that don't meet their quality standards or geographic access needs. According to the Federal Trade Commission, such policies discourage competition and limit access to affordable healthcare.

- Drugstore payments in Medicaid set by political officials, not market forces—State government officials ***set*** pharmacy reimbursement rates for Medicaid that are often higher than those ***negotiated*** by health plans in Medicare and the commercial market. When plans are not allowed to negotiate, drugstores have less incentive to offer discounts in exchange for being included in networks.

- Litigation by independent drugstores—Independent drugstores have launched a wave of lawsuits aimed at hobbling the ability of Medicaid and Medicare to implement preferred and limited pharmacy networks.

Analysis

Huge Number of Pharmacies Compete for Foot Traffic



✓ There are more pharmacies in the U.S. than McDonald's, Burger Kings, Pizza Huts, Dunkin' Donuts, Wendy's, Taco Bells, Kentucky Fried Chickens, and Domino's Pizzas **combined**

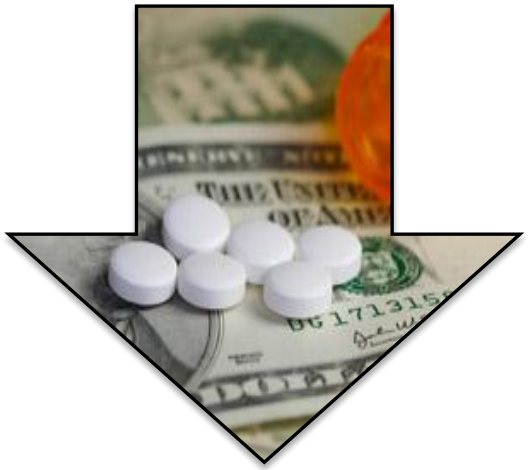
Source: 2011-2012 Chain Pharmacy Profile, National Association of Chain Drug Stores, 2011, and "10 Largest Fast Food Chains in the U.S. by Location," ezlocal.com, 2010.

Analysis

How Pharmacy Networks Lower Prescription Costs

Joining a pharmacy network increases a drugstore's pharmacy and "front-end" sales

Drugstores are motivated to join a plan's network to increase foot traffic of plan enrollees who purchase prescriptions and "front-end" merchandise like shampoo and toothpaste.



Pharmacy networks encourage drugstores to reduce costs

Drugstores offer better discounts than their local competitors in order to be included in a plan's network and gain foot traffic from plan enrollees.

Analysis

Employers and Consumers Want Lower-Cost Pharmacy Networks

Employers:

- 84% of large businesses are willing to implement preferred pharmacy networks. Of the remaining 16%, most have already implemented preferred pharmacy networks.
- 78% of small businesses say employers "should be able to reduce prescription costs as much as possible, even if this means that drugstores make less profit."
- 61% of small businesses say it is a good idea to "allow employers to choose lower-cost plans that exclude the most expensive drugstores from their coverage network."

Sources: "Takeaways from Our Proprietary PBM Survey," J.P. Morgan, 2012; "Key Findings from National Survey of Small Businesses Regarding Prescription Drug Coverage Goals and Priorities ," Ayres McHenry & Associates, 2011.

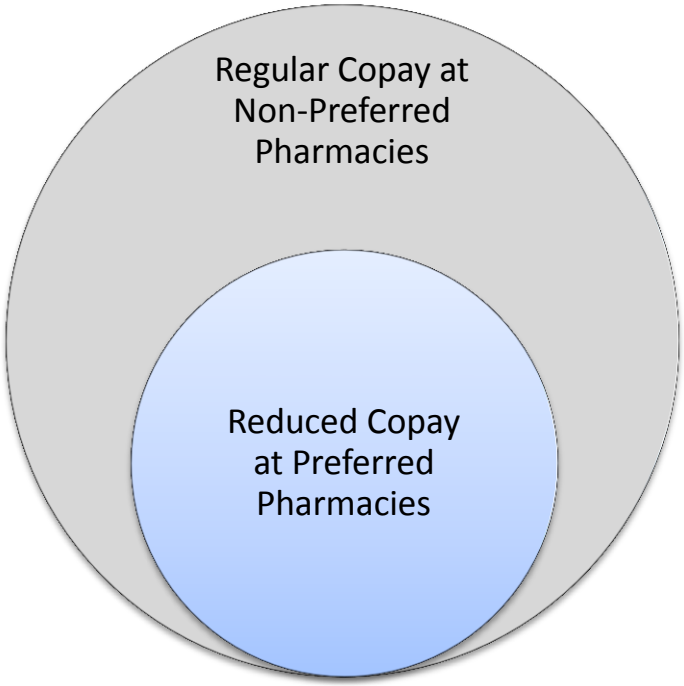
Consumers:

- Consumers say affordability is most important.
- More than 80% of insured consumers are unwilling to pay higher premiums to gain access to more drugstores.
- More than 40% of Medicare beneficiaries in Part D Prescription Drug Plans (PDPs) choose plans with preferred pharmacy networks.

Sources: "Pharmacy Satisfaction Pulse 2011 Household Study," Boehringer Ingelheim, 2011; "Key Findings from the National Consumer Survey of Adults with Prescription Drug Coverage," Ayres McHenry & Associates, 2011.

Analysis

How Preferred Pharmacy Networks Work



- Preferred pharmacies offer lower copays/cost sharing than non-preferred pharmacies in the network
- Non-preferred pharmacies in the network offer regular copay/cost sharing
- Consumers can choose either preferred or non-preferred pharmacies
- Use of preferred pharmacy networks is growing in Medicare and the commercial sector

Analysis

Potential Savings if Medicare, Medicaid, and the Commercial Sector Make Greater Use of Preferred and Limited Pharmacy Networks

- Greater use of preferred pharmacy networks could save Medicare and its beneficiaries up to $35 billion over the next ten years, above what current networks will save. These added savings can be achieved while meeting Medicare's pharmacy access standards.

- State Medicaid programs and the federal government could save up to $26 billion over the next ten years if Medicaid adopted limited pharmacy networks for all enrollees. These savings can be achieved while meeting the same pharmacy access standards used by Medicare.

- Employers, unions, and other commercial sector payers and their enrollees could save up to $54 billion over the next ten years by using preferred pharmacy networks that meet Medicare's pharmacy access standards.

Note: Estimated dollar savings are above and beyond savings that would accrue to payers from continuing their currently selected pharmacy network options.

Analysis

Obstacles to Greater Use of Preferred and Limited Pharmacy Networks: "Any Willing Pharmacy" Laws

- "Any Willing Pharmacy" laws and regulations make plans contract with pharmacies that don't meet their quality standards or geographic access needs.
- Peer-reviewed research shows that "Any Willing Pharmacy" laws are associated with higher costs.[1]
- FTC has held that "Any Willing Pharmacy" laws discourage competition, restrict consumer access to affordable health care, and limit consumer choice to enroll in the health benefit program that best suits their needs.[2]
- GAO has suggested that preferred networks can help curb fraud, waste, and abuse in Medicare.[3] "Any Willing Pharmacy" laws hamper these efforts.

Analysis

Obstacles to Greater Use of Preferred and Limited Pharmacy Networks: Legislated Prices in State Medicaid Programs

- In most state fee-for-service Medicaid programs, pharmacy reimbursements are set by state officials, not the marketplace.
- Set reimbursement rates remove the incentive for drugstores to offer pharmacy network discounts.
- As a result, Medicaid reimbursements are often higher than those paid by Medicare and the commercial sector.

Analysis

Obstacles to Greater Use of Preferred and Limited Pharmacy Networks: Lawsuits by Independent Drugstores

Independent drugstores have launched a wave of lawsuits to undermine the use of preferred and limited pharmacy networks in Medicaid and Medicare. Recent cases include:

- Lawsuit against Florida Medicaid to nullify the state's approval of a limited pharmacy network and to block future approval of such networks.[4]
- Lawsuit against Texas Medicaid to prevent the state from replacing legislated pharmacy prices with a competitive approach using pharmacy networks.[5]
- Lawsuit against New York Medicaid to block reforms based on competitive pharmacy reimbursements, including pharmacy networks.[6]
- Lawsuit against CMS aimed at rolling back the use of preferred pharmacy networks in Medicare Part D.

Methodology

Evidence on savings associated with affordable pharmacy networks:

- A preferred network can save 5% more than open pharmacy networks, according to a major PBM.[7]
- Visante analysis of costs listed on Medicare Plan Finder indicates approximately 12% savings at preferred pharmacies within a network.[8]
- A major chain states that employers see average savings in the 13% to 18% range from limited pharmacy networks, adding that savings can be as high as 45% below open networks.[9]
- A limited pharmacy network guarantees clients a 10% savings compared to an open network.[10]
- A large employer implemented a preferred network with two large chains preferred, with reimbursement rates discounted approximately 10%.[11]
- A Milliman analysis concluded that an employer could achieve savings up to 13% with a limited pharmacy network.[12]

Methodology

To estimate percentage savings with open pharmacy networks:

- We used CMS National Average Retail Price (NARP) data for 2012, which includes prices paid for drugs to retail community pharmacies for individuals with Medicaid, cash-paying customers, and those with third-party insurance, including managed Medicaid and Part D.
- We identified 264 unique drugs based on a combined list of the top 200 by 2011 sales and the top 200 by 2011 prescriptions based on IMS data published in *Drug Topics* magazine. Of these, 145 had NARP cash prices (61 brands, 84 generics).
- We found that the average savings for the commercial sector and Medicare (i.e., third-party prescriptions) vs. drugstore usual and customary (U&C), or "cash," prices was 17%.
  - Since these third-party prescriptions include some use of preferred networks, we adjusted the estimate down to 15% for pure open-network reimbursement, which is consistent with other published estimates.
- We found that prescription reimbursement under Medicaid is 5% higher than other third-party prescriptions.

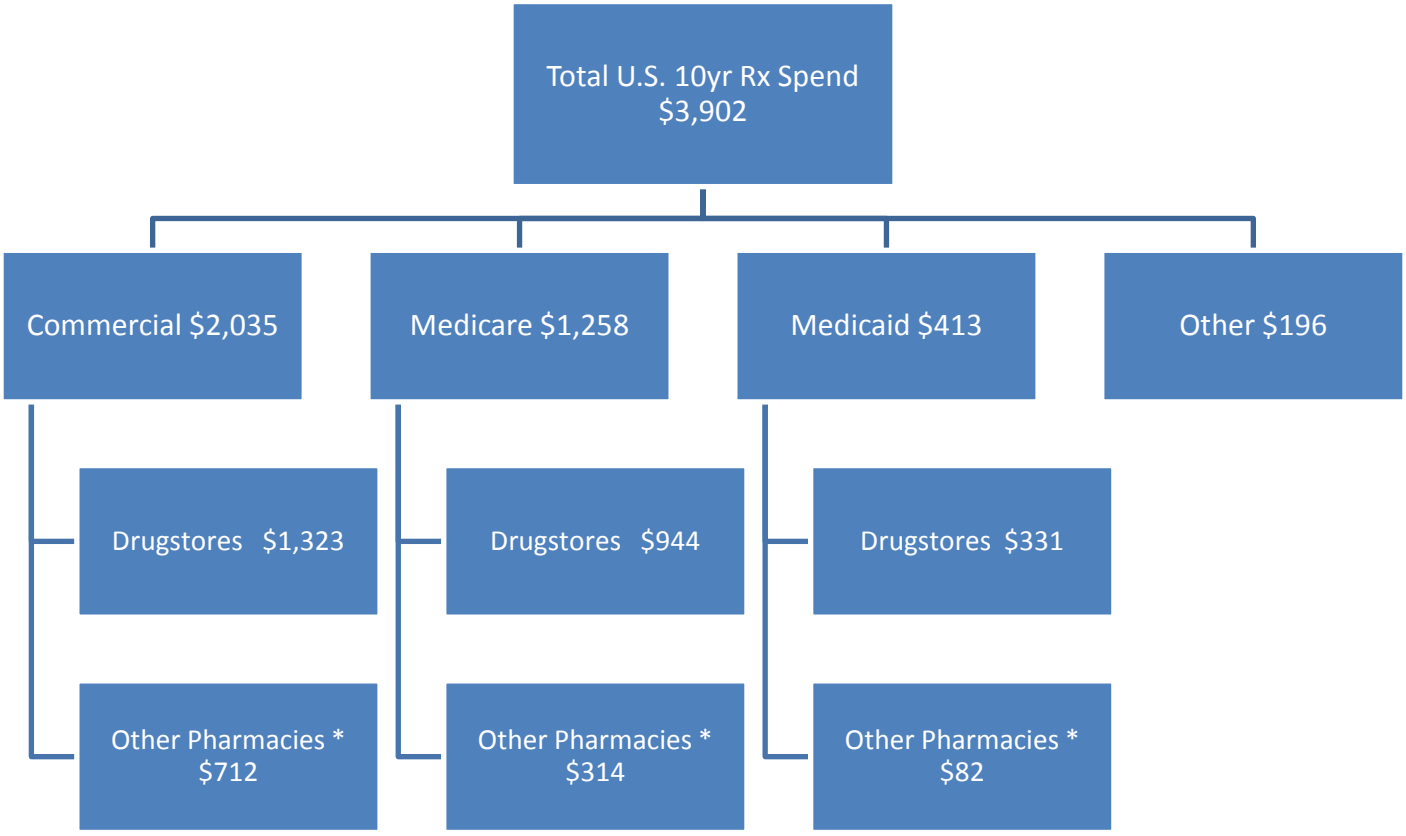
Methodology

To calculate drug expenditures flowing through retail pharmacy networks in each payer segment:

- We assume CMS national health expenditure projections reflect anticipated changes in the healthcare marketplace, including coverage expansion through the ACA, as well as current use of pharmacy networks.
- IMS data show that 68% of total U.S. drug spend is dispensed through retail pharmacy networks.[13]
- We assume retail networks account for 65% of commercial, 75% of Medicare, and 80% of Medicaid spend, derived from the following three factors:
    - The portion of non-specialty drug spend through mail-service pharmacies is approximately 25% in commercial, 15% in Medicare, and less than 1% in FFS Medicaid.[14]
    - Specialty pharmacy accounts for 18% commercial, 13% Medicare, and 22% Medicaid.[15]
    - Specialty drug spend reimbursed under the pharmacy benefit breaks down as 30% retail, 20% mail, and 50% other (other includes specialty, home infusion, etc.)[16]
- Visante assumes the percent of drug spend via the retail channel is constant over a ten-year period.

Methodology

These assumptions created the following baseline 2013-2022 expenditures through the retail pharmacy channel *(billions $)*:



** Other Pharmacies include mail-service, specialty, long-term care, and home infusion.*

Methodology

To estimate the current use of preferred and limited pharmacy networks:

- Medicare enrollment data indicates that 43.5% of all PDP enrollees are now in a plan with a preferred pharmacy network design.[17] More than 20% of commercial plans are also using preferred networks.[18,19]
- For commercial insurance, we assume 30% of drug spend is currently in plans with preferred networks. For Medicare, we assume 43.5% in plans with preferred networks.
- Medicaid plans do not use preferred networks with tiered copays.
- Data available for Medicare PDPs suggests current preferred pharmacy networks are a combination of an open network with 20% to 40% of pharmacies preferred.
- Visante analysis of 2012 Medicare PDP "preferred network" membership indicates approximately 75% of such networks prefer 40% of pharmacies, and 25% of such networks prefer 20% of pharmacies.
- According to published PBM industry data, current use of limited networks accounts for approximately 5% of expenditures in the commercial sector, 8.5% of expenditures in Medicare, and 18% of expenditures in Managed Medicaid.[20]

Methodology

To estimate the percentage of spending that flows through preferred pharmacies vs. non-preferred pharmacies in a network:

- Visante assumes that, in the absence of copay incentives, prescription volume would be evenly distributed throughout all network pharmacies.
- Visante used evidence on the impact of differential copays on the use of mail-service pharmacies as a proxy for predicting the impact of differential copays on the use of preferred pharmacies.
  - Medicare plans have no copay incentive for mail vs. retail, and approximately 15% of adjusted non-specialty prescriptions flow through mail.
  - Commercial plans typically have a copay incentives for mail, and approximately 25% of adjusted prescriptions flow through mail.
  - Therefore, Visante assumes that of the 85% of prescriptions that might be filled at retail without copay incentives, 12% of those move to mail due to copay incentives.
- We therefore assume that copay incentives will cause 12% of the prescriptions that might otherwise be filled in non-preferred pharmacies to move to the preferred pharmacies.

Methodology

To estimate potential savings if payers used preferred pharmacy networks in Medicare and the commercial sector:

- For purposes of calculating potential savings, an open pharmacy network is considered "baseline."
- We modeled a preferred pharmacy network option meeting Medicare Part D access standards nationally, comprised of:
  - Non-preferred pharmacies saving 2% vs. open networks
  - Preferred pharmacies saving 10% vs. open networks
- We then projected (A) what ten-year drug expenditures would be using the preferred pharmacy network.
- Then we projected (B) what ten-year drug expenditures would be using the current mix of open and preferred pharmacy networks.
- We then subtracted B from A to get ten-year potential savings from preferred pharmacy networks, which does not include savings associated with current use of such networks.

Methodology

To estimate potential savings from the use of limited pharmacy networks in Medicaid, we used the same methodology adjusted for factors unique to the Medicaid program:

- We assume no limited pharmacy networks are currently used in FFS Medicaid.
- Within Managed Medicaid Care Organizations (MCOs):
  - No use of preferred pharmacy networks in MCOs because Medicaid does not have tiered copays.
  - Some use of limited pharmacy networks, ranging in competitiveness.
- Visante assumes 18% of MCOs use limited pharmacy networks,[21] with 15% in networks with drugstore prices 2% below open networks and 3% percent in networks with drugstore prices 5% below open networks.
- Visante analysis of CMS NARP data found that prescription reimbursement under Medicaid FFS is 5% higher than third-party prescriptions.
- We projected drug expenditures for FFS and Managed Medicaid based on:
  - Medicaid using limited networks with average savings of 5% vs. open networks.[22]

Methodology

We used commercially available software [23] to analyze the impact of different pharmacy networks on patient geographic access to pharmacies for the Medicare, Medicaid, and commercial sector populations.

- To estimate pharmacy access for commercial and Medicare populations, we used a nationally representative sample of Medicare beneficiaries.
- As a proxy for Medicaid, we used the population below 138% of the federal poverty level.
- Medicare pharmacy network access standards are:
  - 90% of urban beneficiaries have access to one pharmacy within two miles
  - 90% of suburban beneficiaries have access to one pharmacy within five miles
  - 70% of rural beneficiaries have access to one pharmacy within fifteen miles
- We examined a range of current preferred and limited pharmacy networks typical of those currently operating in the marketplace to assess options that achieved the highest savings while meeting Medicare pharmacy network access standards on a national basis for each population.
- Potential dollar savings estimates presented in this study are for pharmacy network options that meet Medicare access standards.

Endnotes

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