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PRESCRIPTION DRUG
PRICING

Implications for Retail
Pharmacies

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Mr. Chairman and Members of the Subcommittee:

It is a pleasure to be here this morning to discuss for the Subcommittee the results of our work on prescription drug pricing, a subject that has been the focus of congressional interest for the past decade.

In the late 1980s, congressional hearings highlighted the fact that the prices that consumers paid for prescription drugs were increasing at a rate more than two and one half times the general rate of inflation. In 1990, the Congress attempted to control expenditures for prescription drugs by significantly changing the way Medicaid pays for outpatient drugs. Then, in 1994, attention shifted toward vertical integration in the pharmaceutical market, particularly the mergers between large pharmaceutical manufacturers and companies that manage prescription drug benefits for health plans, called pharmacy benefit managers (PBMs).

My statement today will address three questions that relate to the recent concerns of retail pharmacies about drug pricing:

- How and why has the process by which drugs get from manufacturers to patients changed?
- What have been the consequences for retail pharmacies of changes in this process?
- What general strategies are retail pharmacies undertaking or proposing to respond to an increasingly competitive environment?

Our information is based on a review of the literature on drug pricing, interviews with representatives of the groups involved, and several GAO reports related to drug pricing.¹ These reports examine the effect of the Medicaid drug rebate law on prices, the role of PBMs in the health care industry, and efforts to control drug costs by the largest federal employee health plan.

In summary, the actions taken by health insurers to contain prescription drug costs have had important implications for retail pharmacies.² Specifically, the insurers' consolidation of purchasing power and ability to increase market share for manufacturers' drugs has allowed them and their representatives to often obtain drug discounts beyond those available to retail pharmacies. Further, in instances in which insurers and PBMs

¹See the attached list of related GAO products.

²The term "health insurers" is used to refer to all entities who pay for health care, including health maintenance organizations, self-insuring employers, and traditional third party payers.

contract with pharmacies to provide drugs and services to plan members, the plans have been able to control reimbursement rates to pharmacies for those drugs and services.

While these developments have helped health insurers control their pharmacy benefit costs, they have also created an anxious environment for retail pharmacists. In response, the pharmacists have adopted a number of steps to become more competitive and have taken legal and legislative action to try to ensure that they can obtain the same discounts as managed care plans and other large purchasers. Our analysis of federal legislation directed at reducing Medicaid drug costs, the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), indicates that the law's effect may well have resulted in higher outpatient drug costs to many large purchasers. In an era of great concern over health care costs, the potential of any legislation to increase costs must be considered.

Changes in How Drugs Get to Patients

In an earlier era, when there was less concern over the costs of health care, the process by which drugs reached patients was relatively simple. The patient went to a doctor, who, if convinced that the malady could be helped with medication, would prescribe a drug that the patient could obtain at the local pharmacy. If the patient's health insurance had a prescription drug benefit, the patient would be reimbursed for the purchase; if not, the patient would cover the costs out-of-pocket. The decisions regarding which drug would be prescribed were often left to physicians, while those regarding drug cost typically involved manufacturers and retail pharmacies. Further, the health insurer was usually not centrally involved in either decision.

Today, the ways in which drugs are prescribed and paid for are considerably more complex. To a great extent, this complexity has been introduced in direct response to concerns with the rapid growth in health care expenditures. Just as with hospital and physician services in an earlier day, insurers have recently begun to take concrete steps to control the costs of pharmacy benefits. Some steps require patients to bear a larger share of the costs of drugs through increased copayments, while others reduce the utilization of drugs and rely more on less-costly types of drugs. The most important steps, however, are directed at minimizing both how much insurers pay manufacturers for drugs and how much they pay pharmacies for their services.

Insurers take steps to reduce the acquisition costs of drugs by negotiating for discounts or rebates from drug manufacturers. A powerful tool in these negotiations is the formulary that the insurer or the PBM maintains.³ A formulary is a list of prescription drugs that are preferred by the insurer or the PBM. Drugs are included on formularies not only for reasons of medical effectiveness but also because of price. Because formularies can affect the utilization rates for drugs, it is in the interest of a drug manufacturer to have its products included. This is especially true when the insurer or PBM is successful in obtaining high rates of physician compliance with the formulary and when the insurer has a large number of enrollees. In these cases, the potential effect that placement on a formulary has on the sales and market share of a drug is so great that insurers can use such placement as a means of securing discounts or rebates from drug manufacturers.

Insurers and PBMs also negotiate for discounts directly with pharmacies to try to control how much they reimburse for services. In these negotiations, the position of insurers is strengthened not by formularies but by their ability to influence which pharmacies their enrollees use. As with the negotiations with manufacturers, the position of the insurer or the PBM is related to the number of enrollees represented by the plan.

The extent to which negotiated rebates and discounts with drug manufacturers and pharmacies have controlled costs can be substantial. For example, in our most recent examination of these strategies, a large insurer estimated that the combined savings that resulted from manufacturer rebates and pharmacy discounts exceeded \$300 million.⁴ Many retail pharmacists believe that the means used to achieve these savings have placed them at a comparative disadvantage in the rapidly changing health care environment.

³The emergence of PBMs is perhaps the most symbolic evidence of how the pharmaceutical delivery sector of health care has changed. The number of PBMs, whose primary function is to manage drug benefits for insurers, has mushroomed in recent years. As of 1993, they managed drug benefits for approximately 40 percent of the U.S. population.

⁴U.S. General Accounting Office, Blue Cross and Blue Shield: Change in Pharmacy Benefits Affects Federal Enrollees, GAO/T-HEHS-96-206 (Washington, D.C.: Sept. 5, 1996).

Consequences for Retail Pharmacists of a Changing Health Care Environment

The current environment is viewed with anxiety by many retail pharmacists. The success of insurers and other institutional buyers in using their consolidated buying power to reduce the price they pay for drugs has not been shared by retail pharmacists. As a consequence, retail pharmacies are sometimes charged more for similar products than are health insurers such as health maintenance organizations, self insured health plans, and other institutional buyers. The best evidence we were able to obtain that differential pricing existed comes from a recent study of drug pricing in Wisconsin.⁵ Table 1 summarizes the results from that study.

Table 1: Drug Price Differences Between Institutional Buyers and Retail Pharmacies in Wisconsin

Type of drug	No. of drugs in class	Number of drugs for which price differences			
		Were greater than 10%		Are not justified by volume of purchase	
		No.	%	No.	%
Single-source brand name	31	9	29	5	16
Multi-source brand name	24	12	50	8	33
Generic	21	6	29	3	14

As can be seen from the table, differences in prices of greater than 10 percent were found for more than one third of all products (27 out of 76 drugs), and in more than one half of those cases (21 percent of all cases), the differences could not be justified by volume of purchase. In placing these findings in a larger perspective, it is important to note that Wisconsin has what is often referred to as a “unitary pricing” law that “requires sellers to offer drugs . . . to every purchaser under the same terms and conditions afforded to the most favored purchaser.”

The data from Wisconsin support the conclusion of many that differential pricing exists.⁶ The differences in prices may well reflect the relative abilities of insurers and retail pharmacies to influence market share. That is, some purchasers of drugs, primarily those who can influence the specific drugs that are prescribed for large numbers of patients, may pay less for drugs because of that ability.

⁵Wisconsin Department of Agriculture, Trade and Consumer Protection, Wholesale Pricing of Prescription Drugs in Wisconsin (Madison: July 28, 1995).

⁶See, for example, Congressional Budget Office, How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry (Washington, D.C.: Jan. 1996).

The increasing concern among insurers with controlling costs and the consequent reliance on their consolidated purchasing power also have affected how much pharmacies are reimbursed for the drugs they sell to customers. As health insurers and the PBMs that represent them cover more people, they use the size of their member populations as leverage to help reduce the amounts that they reimburse pharmacies for prescriptions dispensed to those populations. Although a pharmacy can refuse to participate in an insurer's network of pharmacies willing to provide prescription discounts, it is difficult for the pharmacy to face the possibility of losing the business. For example, each of the two largest PBMs represents more than 40 million people nationwide. As we were told by one independent retail pharmacist, "either I agreed to the new reimbursement schedule, or I lose 40 percent of my patients."

In addition to the pressures of how much retail pharmacists pay for drugs and how much they can charge for their services, they have been facing pressure from new sources of competition. The expansion of supermarkets into the pharmaceutical area has been under way for some time, but the more immediate threat to the viability of retail pharmacies may be posed by the reliance of insurers on mail order pharmacies. Mail order firms have made significant inroads into the market in recent years, especially in providing drugs for the chronically ill. In an effort to promote the use of mail order pharmacies, some insurers provide enrollees with considerable financial incentives. For example, the largest plan under the federal employee health benefits program provides enrollees drugs free of charge if they obtain them through the mail order program yet requires a 20-percent copayment from most enrollees for drugs purchased at retail pharmacies.⁷

All these pressures on retail pharmacies have had a considerable effect. For example, in the case described above, a change in pharmacy benefits that affected many of the plan's enrollees reduced payments to retail pharmacies. During the first 5 months of 1996, the total amount that retail pharmacies were paid for the prescriptions they dispensed to enrollees affected by the benefit change decreased by about 36 percent, or about \$95 million, from the amount paid during the same period in 1995.⁸

⁷U.S. General Accounting Office, Sept. 5, 1996.

⁸U.S. General Accounting Office, Sept. 5, 1996.

Responses of Retail Pharmacists

Retail pharmacists have resorted to three different types of action in response to the changes in pharmaceutical pricing: litigation, adoption of competitive strategies, and calls for legislation.

A large lawsuit regarding drug pricing was recently settled, at least in part. The suit was a class action by tens of thousands of independent and chain pharmacies against virtually all the leading manufacturers and wholesalers of brand-name prescription drugs. The pharmacies argued that the manufacturers and wholesalers, by granting discounts to managed care organizations that were not available to the pharmacies, were engaged in a price-fixing conspiracy in violation of federal antitrust law.

The court rejected an initial settlement but approved a modified settlement with most of the manufacturer-defendants on June 21, 1996.⁹ (The wholesalers are not parties to this settlement because the court earlier granted summary judgment in their favor.¹⁰) The litigation is not entirely over because not all parties have agreed to the settlement, and a number of issues remain on appeal in the Court of Appeals for the 7th Circuit.

The modified settlement satisfied the concerns about future pricing conduct that led the court to reject the initial proposal. Specifically, the current settlement provides that (1) the manufacturers will not refuse discounts solely on the basis that the buyer is a retailer and (2) retail pharmacies and buying groups that are able to demonstrate an ability to affect market share will be entitled to discounts based on that ability, to the same extent that managed care organizations would get such discounts.

In addition to pursuing legal remedies, retail pharmacies are beginning to adopt some strategies designed specifically to become more competitive in the new environment. Some pharmacies are offering services not traditionally found in them (such as food products and optical care), while some are trying to follow the lead of institutional drug purchasers. For example, some retailers are creating buying groups, and others are considering ways to influence the choice of drugs by contacting patients directly and informing them of the relative merits of the different drugs that might be available. If contacting patients directly is successful, it will provide retail pharmacies with the commodity that makes institutional

⁹In re: Brand Name Prescription Drugs Antitrust Litigation, 94 C 897, MDL 997, 1996 U.S. Dist. LEXIS 4335 (D. Ill. April 4, 1996); *id.*, at LEXIS 8817, June 21, 1996.

¹⁰*Id.* at LEXIS 6754, April 4, 1996.

buyers so powerful—namely, the ability to influence market share. Although we cannot predict how successful any of these strategies will be, the large chain pharmacies are more likely to succeed as they try to compete with managed care organizations and mail order pharmacies than are the smaller, independent retail pharmacies.

Finally, retail pharmacists and their representatives have been strong proponents for legislative solutions. Depending on ideological affiliation, these are alternatively referred to as “unitary pricing” or “equal access to discount” laws, and they have been considered in one form or another by the majority of state legislatures. Although it is difficult to predict all the consequences of legislation in such a complex area as drug pricing, we can look to the last instance in which the federal government attempted a legislative solution to a problem involving drug costs: the Medicaid rebate on prescription drugs. In OBRA 1990, the Congress tried to reduce Medicaid’s prescription drug costs by requiring that drug manufacturers give state Medicaid programs rebates for outpatient drugs. The rebates were based on the lowest of “best” prices that drug manufacturers charged other purchasers, such as health maintenance organizations and hospitals.

In our study of this legislation, we found that the average best price for outpatient drugs paid by large purchasers increased.¹¹ In its evaluation, the Congressional Budget Office concluded that the program had reduced Medicaid spending on prescription drug benefits by almost \$2 billion. However, at the same time, the budget office study’s conclusion was consistent with ours in that “spending on prescription drugs by non-Medicaid patients may have increased as a result of the Medicaid rebate program.” Although the issues involved with the differential pricing between institutional and retail pharmacies are likely to be distinct from those the Congress confronted in the Medicaid prescription drug benefit, the lessons of OBRA 1990 cannot be ignored at a time when controlling health care costs is of such critical importance.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that the Subcommittee might have.

For more information about this testimony, please call George Silberman, Assistant Director, at 202-512-5885. Other major contributors include David G. Bernet, Joel A. Hamilton, and John C. Hansen.

¹¹Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals (GAO/HEHS-94-194FS, Aug. 5, 1994).

Related GAO Products

Blue Cross FEHB Pharmacy Benefits (GAO/HEHS-96-182R, July 19, 1996).

Pharmacy Benefit Managers: Early Results on Ventures with Drug Manufacturers (GAO/HEHS-96-45, Nov. 9, 1995).

Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals (GAO/HEHS-94-194FS, Aug. 5, 1994).

Prescription Drugs and the Elderly: Many Still Receive Potentially Harmful Drugs Despite Recent Improvements (GAO/HEHS-95-152, July 24, 1995).

Prescription Drug Prices: Official Index Overstates Producer Price Inflation (GAO/HEHS-95-90, Apr. 28, 1995).

Prescription Drugs: Spending Controls in Four European Countries (GAO/HEHS-94-30, May 17, 1994).

Prescription Drugs: Companies Typically Charge More in the United States Than in the United Kingdom (GAO/HEHS-94-29, Jan. 12, 1994).

Medicaid: Outpatient Drug Costs and Reimbursements for Selected Pharmacies in Illinois and Maryland (GAO/HRD-93-55FS, Mar. 18, 1993).

Prescription Drug Prices: Analysis of Canada's Patented Medicine Prices Review Board (GAO/HRD-93-51, Feb. 17, 1993).

Medicaid: Changes in Drug Prices Paid by HMOs and Hospitals Since Enactment of Rebate Provisions (GAO/HRD-93-43, Jan. 15, 1993).

Prescription Drugs: Companies Typically Charge More in the United States Than in Canada (GAO/HRD-92-110, Sept. 30, 1992).

Prescription Drugs: Changes in Prices for Selected Drugs (GAO/HRD-92-128, Aug. 24, 1992).

Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions (GAO/HRD-91-139, Sept. 18, 1991).

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