

Nuts and Bolts of Pharmacy Reimbursement: Why It Should Matter To You

By Lisa L. Causey, J.D., LL.M. Candidate
lisalcausey@comcast.net

Spending in the United States for prescription drugs was \$216.7 billion in 2006.¹ Prescription drug costs, while a relatively small proportion of national health-care spending,² is increasing rapidly.³ Given that Walgreen's, CVS, and grocery store pharmacies are being built on every corner, one may assume that retail pharmacies are profiting from this increase in spending on prescriptions. But in reality, the profit margin on prescription drug sales is slim, and it continues to narrow due to low reimbursement rates set by private and government third-party payors.⁴

Most people who walk through the front doors of a pharmacy with a prescription from the doctor in one hand and an insurance card in the other may not consider how a pharmacy receives reimbursement, other than the co-payment.⁵ Health-care consumers, however, should be aware that cutting into the profit margins of their retail pharmacy could lead to their community pharmacy⁶ closing its doors. And in many rural communities, the retail pharmacy is a critical point of access into the health-care delivery system.⁷ This article explores the nuts and bolts of pharmacy reimbursement and how it impacts more than just the pharmacy's bottom line.

¹ Kaiser Family Found., *Prescription Drug Trends* 1 (Sept. 2008), available at http://www.kff.org/rxdrugs/upload/3057_07.pdf (last visited May 4, 2009).

² See *id.*; Spending on prescription is still below other health-care expenditures such as physician and hospital reimbursement.

³ *Id.* at 5; According to the Prescription Drug Trends update in September 2008, the Dep't of Health and Human Services projects that spending on prescription drugs will increase to \$515.7 billion, which is a 138% increase in spending over the next 11 years.

⁴ Nat'l Assoc. of Chain Drug Stores, *NACDS Fact Sheet on Medicaid*, available at http://www.nacds.org/user-assets/pdfs/gov_affairs/Issues/Medicaid/Medicaid_Fact_Sheet.pdf (last visited May 13, 2009); Leonard Felson, *Small Pharmacies Struggle to Survive*, N.Y. TIMES, (Aug. 15, 1993), available at 1993 WLNR 3424319; Donna Kutt Nahas, *When Prescriptions Cost Less, Who Pays?*, N.Y. TIMES, (Mar. 13, 2005), available at 2005 WLNR 3883703; J. Alex Tarquinio, *SUNDAY MONEY: INVESTING; Drugstores Are Looking More Like a Growth Story*, N.Y. TIMES 37, (Sept. 10, 2006), available at 2006 WLNR 15688782; Janet Levaux, *Ports In The Storm; As Prices For Raw Materials Fall and Consumers Look for Bargains, Certain Industry Sectors, Sub-Sectors and Companies are Poised to Benefit, Analysts Say*, 31 RESEARCH MAG. 95, (Dec. 1, 2008), available at 2008 WLNR 25317090 (discussing growth in front-end sales and CVS's purchase of Caremark, a Pharmacy Benefit Manager ("PBM")); *Tough Times Raise the Stakes for Category Management*, CHAIN DRUG REV. 27, (Nov. 24, 2008), available at 2008 WLNR 25099148.

⁵ *Study Indicates Strong Consumer Preference to Fix Medicare Part D and Medicaid Flaws Threatening Access to Prescription Drugs Medicare and Medicaid*, OBESITY, FITNESS, WELLNESS WEEK 3169, (Jan. 5, 2008), available at 2008 WLNR 21837.

⁶ Sen. Max Baucus, News Release, *Baucus Says CMS Rule Would Hurt Small And Rural Pharmacies, Medicaid Beneficiaries*, available at <http://www.ascp.com/advocacy/federal/upload/BaucusCMSRule.pdf> (last visited May 15, 2009).

⁷ *Pharmacies Seek Congressional Support for Upcoming AMP Fix Bill*, FDA WEEK, (May 8, 2009), available at 2009 WLNR 8793181; *Final CMS Medicaid Reimbursement Rule Shows Reckless Disregard for Patient Welfare by Threatening Viability of Independent Community Pharmacies, Says...Medicare and Medicaid*, SCIENCE LTR. 780, (July 24, 2007), available at 2007 WLNR 13813226; Nat'l Comm.

Third-Party Payors

Medicaid

Medicaid funded 26 percent of the \$216.7 billion in prescription drug expenditures in 2006.⁸ Therefore, Medicaid reimbursement is a significant portion of a pharmacies' profit. Traditionally, prescription drug coverage has only been provided by Medicaid, which is a state entitlement program administered by state agencies.⁹ In the 1990s, an amendment to the Social Security Act was enacted to federally mandate that drug manufacturers provide rebates to the State Medicaid Programs for any drugs dispensed to Medicaid patients.¹⁰ In 2005, as part of the Deficit Reduction Act, Congress changed the basis for determining the prescription drug cost reimbursement rate for Medicaid from the Average Wholesale Price ("AWP") to the Average Manufacturer's Price ("AMP").¹¹ Although scheduled to take effect in July 2008, a federal district court issued an injunction delaying the change to AMP until October 2009.¹² Additionally, the Medicare Improvements Patients and Providers Act of 2008 ("MIPPA") passed in July 2008, also delaying the change to the AMP rate until September 30, 2009 as well as the disclosure of AMP rates until that time.¹³

Currently, Medicaid uses AMP to calculate federally mandated rebates.¹⁴ Rebates are paid on both brand and generic drugs and is equal to 15.1 percent of AMP per unit for the innovator drug,¹⁵ or the difference between AMP and the best price per unit, whichever is greater.¹⁶ For purposes of calculating the rebates, the AMP for a drug is published to the Centers for Medicaid Services ("CMS"), but is not publicly available.¹⁷ Note that AMP

Pharmacists Ass'n, *Community Pharmacy Recommendations for Health Care Reform*, (Apr. 2009), available at <http://www.ncpanet.org/pdf/leg/2009ncpa-healthcarereform.pdf> (last visited May 13, 2009).

⁸ See Kaiser Family Found., *supra* note 1.

⁹ Centers for Medicare and Medicaid Service, *Medicaid—General Information Overview*, available at <http://www.cms.hhs.gov/MedicaidDrugRebateProgram/> (last visited Feb. 27, 2009).

¹⁰ 42 U.S.C. § 1396; Centers for Medicare and Medicaid Service, *Medicaid Reimbursement Program-Overview*, available at: <http://www.cms.hhs.gov/MedicaidDrugRebateProgram/> (last visited Feb. 27, 2009).

¹¹ Medicaid Program; Prescription Drugs, 72 Fed. Reg. 39142 (July 17, 2007) (to be codified at 42 C.F.R. Part 447, available at 2007 WL 2030690 (F.R.)).

¹² *Nat'l Assoc. of Chain Drug Stores v. Leavitt*, Order, available at <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/AMPPIOrder.pdf> (last visited May 6, 2009).

¹³ See Memorandum, available at http://www.reedsmith.com/_db/_documents/hc0805.pdf (last visited May 13, 2009) (summarizing MIPPA).

¹⁴ *Medicaid Cuts Create Problems*, CHAIN DRUG REV. 72, (May 21, 2007), available at 2007 WLNR 11400669; *Medicaid Drug Rebate Program Unit Rebate Amount Calculation*, available at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/13_UnitRebateCalc.asp (last visited May 12, 2009).

¹⁵ The rebate for generics is AMP minus 11% or best available price. Department of Health and Human Services, Office of Inspector General, *Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid*, available at: <http://www.oig.hhs.gov/oei/reports/oei-03-07-00350.pdf> (last visited May 12, 2009).

¹⁶ Memorandum, *supra* note 13.

¹⁷ Nat'l Health Forum Policy, *The Basics: Medicaid Reimbursement Program*, available at http://www.nhpf.org/library/the-basics/Basics_MedicaidDrugRebate_04-13-09.pdf (last visited May 12, 2009).

is currently used for calculating rebates and is not used for calculating reimbursements.

Medicare

In 2006, Medicare funded 53 percent of the \$216.7 billion in prescription drug expenditures.¹⁸ The Medicare Prescription Drug Improvement Modernization Act (MMA) of 2003 created the prescription drug benefit program, Medicare Part D, which was implemented on January 1, 2006. Pharmacy reimbursement under Part D is based on negotiated prices, which is usually based on the AWP minus a percentage discount plus a dispensing fee.¹⁹

Private Third-Party Payors

Private third-party payors currently base their reimbursement formula on AWP.²⁰ Private insurers, however, have traditionally followed the government's lead and adopt reimbursement formulas set by the government.²¹

The Two Components of Pharmacy Reimbursement

Dispensing Fee

A dispensing fee compensates the pharmacy for transferring the drug from the pharmacy to the patient; overhead, such as stocking and storing medications; and patient counseling.²² The national average cost of dispensing medications is \$10.50 per prescription, but Medicaid only reimburses a dispensing fee on average of \$4.50 per prescription.²³ Under the Medicare drug reimbursement system, the pharmacist is paid \$2.27 per prescription.²⁴ In group-health plans or private insurance, a PBM negotiates the dispensing fee with the individual pharmacies typically at 40 percent off the usual and customary dispensing fee charge.²⁵

¹⁸ Kaiser Family Found., *supra* note 1.

¹⁹ Dep't of Health and Human Services, *supra* note 15.

²⁰ Alex Sugeran-Brozan and James Woolman, 13 HEALTH CARE POLICY REPORT 36, available at <http://healthcenterbna.com/pic2/hc.nsf/id/BNAP-6G8NPZ?OpenDocument&PrintVersion=Yes> (last visited Apr. 12, 2009).

²¹ Patrick Mullen, *The Arrival of Average Sales Price*, available at <http://www.biotechnologyhealthcare.com/journal/fulltext/4/3/BH0403048.pdf> (last visited Apr. 10, 2009) (discussing shift in Medicare Part B to reimbursement based on the Average Sales Price ("ASP") and the private payor adoption of ASP as the standard for reimbursement).

²² See Allison Garret and Robert Garis, *Leveling the Playing Field in the Pharmaceutical Benefit Manager Industry*, 42 VAL. U. L. REV. 33, 40 (Fall 2007).

²³ Sandra Levy, *Dispensing Fees Woefully Inadequate, Says Study*, (Feb. 19, 2007), available at <http://drugtopics.modernmedicine.com/drugtopics/article/articleDetail.jsp?id=404988> (last visited Apr. 10, 2009).

²⁴ *Thin Margins for Community Pharmacies*, 29:3 HEALTH MNGMT. TECH., (Mar. 1, 2008), available at http://findarticles.com/p/articles/mi_m0DUD/is_3_29/ai_n24923697/?tag=content;col1 (last visited May 15, 2009).

²⁵ Regina Sharlow Johnson, *Analyzing the Laws, Regulations, and Policies Affecting FDA-Regulated Products: PBMs Ripe for Regulation*, 57 FOOD & DRUG L.J. 323, at fn. 99 (2002).

Prescription Drug Cost

As discussed above, the prescription drug cost component of reimbursement is in the process of being reformulated. Currently, most third-party payors pay for prescription drug costs based on a fixed discount from the Average Wholesale Price (“AWP”); e.g., AWP minus 10 percent.²⁶ Every prescription drug sold in the United States has an AWP, which is reported in a commercial publication like Red Book, First Databank, and Medispan.²⁷ The drug manufacturers report the average price a wholesaler pays to a manufacturer for their drug to these publications and uses the reported number as the benchmark for reimbursement.²⁸

Problems with Using AWP as a Benchmark

AWP “has not been defined in law or regulation, and it has no empirical basis in actual market transactions.”²⁹ “AWPs are fictitious and are rarely, if ever prices paid by . . . pharmacies.”³⁰ Drug companies, therefore, can easily game the system by inflating AWP.³¹ Drug companies, by inflating AWP, increase the spread between the pharmacy’s actual acquisition cost for a drug and the AWP.³² This provides incentives to providers to prescribe certain drugs or pharmacies to stock certain drugs based on the potential profit that can be realized from the spread in relation to the margins on competing brand name or generic drugs.³³ Drug manufactures then “market the spread” to physicians who prescribe the drug and to pharmacists who can decide which generic to carry.³⁴ In turn, drug manufacturers with the highest spread capture market share.³⁵ This incentive results in drug companies inflating AWP in order to create a higher spread.³⁶

Problems with Using AMP as a Benchmark

In an attempt to realign the reimbursement rates with the actual pharmacy acquisition costs, a new pricing formula has been proposed based on the Average Manufacturers Price (“AMP”).³⁷ AMP is the price actually paid by wholesalers to drug manufacturers.³⁸

²⁶Sugerman-Brozan, *supra* note 20; *In re Pharmaceutical Industry Average Wholesale Price Litigation*, 491 F.Supp.2d 20, 32 (D. Mass. 2007) (hereinafter referenced as *In re AWP*).

²⁷*In re AWP*, 491 F. Supp. 2nd at 32.

²⁸Sugerman-Brozan, *supra* note 20.

²⁹*Id.*

³⁰*In re AWP*, 491 F. Supp. 2d at 94.

³¹Sugerman-Brozan, *supra* note 20.

³²*Id.*

³³Patricia M. Danzon, Gail R. Wilensky, and Kathleen E. Means, *Alternative Strategies for Medicare Payment of Outpatient Prescription Drugs—Part B and Beyond*, 11:3 AM. J. OF MANAGED CARE 174, (Mar. 2005), available at <http://hc.wharton.upenn.edu/danzon/PDF%20Files/Alt%20Strat%20Medicare%20Payments%20Part%20B%20-%20Am%20J%20of%20Managed%20Care%20March%2005.pdf> (last visited Mar. 25, 2009).

³⁴Sugerman-Brozan, *supra* note 20.

³⁵*Id.*

³⁶*Id.*

³⁷Garret and Robert Garis, *supra* note 23.

³⁸*Id.*

The AMP is statutorily defined and its calculation is based on actual sales transactions,³⁹ and reflects cash discounts and other reductions for the actual price paid.⁴⁰ Because AMP is calculated from sales that have already occurred, it is a retrospective price and is significantly lower than the AWP.⁴¹ Using the AMP-based reimbursement formula for drug costs can result in the pharmacy being reimbursed below its acquisition cost. An example adapted from the *In re AWP* litigation is illustrative:

Drug X has an AWP of \$100, which is 25% above the wholesaler's acquisition cost of \$80. The pharmacy's actual acquisition cost for Drug X is \$80, which corresponds with the wholesale acquisition cost. If a pharmacy is reimbursed for the product based on AWP-15% pursuant to its third-party payor contract, then the pharmacy will receive \$85, which is a \$5 profit margin. If the AWP is reduced to align more closely with the actual acquisition cost, the pharmacy reimbursement rate is still at the contracted rate of the prescription drug cost minus 15%. If, for example, \$88 is the AMP, then the pharmacy will only be reimbursed \$74.80 from the third-party payor. Since the actual acquisition cost for Drug X is \$80, the pharmacy will lose \$5.20 on each Drug X prescription filled.⁴²

As this hypothetical demonstrates, the pharmacy will lose money on the cost of each prescription drug where the benchmark for reimbursement is decreased without a restructuring of the applicable discount and dispensing fee. Moreover, AMP is subject to the same price manipulation as AWP without the ability to verify and audit the AMP.⁴³ Therefore, there is no guarantee that AMP will be more accurate than AWP, and this change does not discourage the drug manufacturers practice of marking up a drugs cost, especially if AMP is not subject to audit or verification.

Conclusion

As this demonstrates, the key to a fair reimbursement policy is an accurate, transparent benchmark, whether reimbursement for drug cost is based on AMP, AWP, or otherwise.

³⁹ Dep't of Health and Human Services, Off. of Insp. Gen., *Medicaid Drug Price Comparisons: Average Manufacturers Prices to Published Prices*, (June 2005), available at <http://www.oig.hhs.gov/oei/reports/oei-05-05-00240.pdf> (last visited Feb. 12, 2009).

⁴⁰ Nat'l Health Forum, *supra* note 17.

⁴¹ *Id.*; AMP-based pharmacy reimbursement limits are, on average, 36% below pharmacy acquisition cost. Dep't of Health and Human Services, Off. of Insp. Gen., *Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program* at pgs. iii and 11, (June 2007), available at <http://www.oig.hhs.gov/oei/reports/oei-03-06-00400.pdf> (last visited May 15, 2009); Frank Kopenski, MANAGED HEALTHCARE EXEC., (Feb. 1, 2009), available at <http://managedhealthcareexecutive.modernmedicine.com/mhe/Exclusives/Alternative-price-bases-could-replace-AWP/ArticleStandard/Article/detail/577614> (last visited May 15, 2009) (stating that AMP is, on average, about 25% lower than AWP for patent-protected brand-name medications, and about 65% lower than AWP for generics).

⁴² See Report of Independent Expert Professor Ernst R. Berndt to Judge Patti B. Saris in *In re AWP*, 491 F. Supp. 2nd 20 (D. Mass. 2007), available at 2005 WL 5533042.

⁴³ Sugerman-Brozan, *supra* note 20.

Without any method to audit or verify the reported drug costs, the benchmark in the reimbursement formula for drug costs can be easily manipulated.

Another key element to fair reimbursement policy for pharmacies will be to provide pharmacies with some negotiating leverage for reimbursement of both drug costs and dispensing fee components of pharmacy reimbursement. When small retail pharmacies have little negotiation power, third-party payors provide a take-it-or-leave-it contract with low reimbursement rates that put the pharmacies in a catch-22; i.e., sign the contract with a low-reimbursement rate or loose customers that have that insurers health plan.⁴⁴ Since Medicare Part D and all private third-party payors negotiate the reimbursement rates with the pharmacy, it is essential that the pharmacies have more leverage with the third-party payors for purposes of setting the reimbursement rates without fear of violating any antitrust law. Leverage in negotiating becomes increasingly important if the AMP Rule is adopted as the benchmark in the industry for reimbursement rates.

Although health-care reform is needed, squeezing profits from the pharmacy does not fix the problem. In fact, the low-reimbursement rates at below acquisition cost and without a significant increase in the dispensing fee will inevitably result in some pharmacies closing their doors and could substantially impede access to many patients who rely on their retail pharmacy to provide critical care. Health-care reform, therefore, should target another player in the drug delivery system for purposes of reducing health care costs. In my opinion, that player should be the PBM.⁴⁵

Health Law Perspectives (June 2009), available at:
<http://www.law.uh.edu/healthlaw/perspectives/homepage.asp>

⁴⁴ For example, a pharmacy is located in a small town where most employees work at one company that has health-care coverage through XYZ Insurance Company. If that pharmacy refuses to sign the take-it-or-leave-it contract offered by XYZ Insurance Company or its PBM, then the pharmacy's customers will have to take their business elsewhere. In some small, rural towns, there may not be another option for a retail pharmacy. Moreover, the pharmacy has little negotiating power since most of population of this small town has this one insurer; therefore, the pharmacy, in reality, has no choice but to sign a contract.

⁴⁵Garret and Garis, *supra* note 23.