Who speaks for the patient?

When it comes to medication access and affordability, the answer is you.

BY ANDREW KANTOR

It's about trust. America’s healthcare system is huge. It's complex. Every day patients find themselves faced with new diagnoses, new treatments, new medications, and new kinds of practitioners treating them.

That means they are — to a great extent — dependent on the knowledge and expertise of their healthcare team, from their pharmacist and physicians to the companies that make and pay for their treatments. They trust that team is doing right by them.

And the healthcare team does have their best interests in mind (even if we may not always agree on the right way to achieve them). Pharmacists, doctors, nurses — we all thrive when our patients thrive. And we all advocate for patients, as do so many organizations: AARP, the American Cancer Society, the National Alliance on Mental Illness, the March of Dimes, and so on.

But pharmacists are in a unique position, often literally. They’re usually the closest, most accessible healthcare professional. In many rural areas they may be the only healthcare professional within at least a 25-mile radius.

Standing at the counter, they are closer to the intersection of treatment and cost than most other healthcare providers. And, especially when it comes to the issue of prescription drugs, they are more knowledgeable and better able to speak to the medication access and affordability issues facing — and, let’s be honest, threatening — so many patients.
When someone needs medicine, he expects to be receiving what’s best for him based on sound science and medicine. That’s what doctors and pharmacists are trained to provide. But behind the scenes, that’s not always how it works.

Hidden in the complexities of today’s healthcare systems are forces that often jeopardize that quality of care — despite the best efforts of pharmacists and physicians alike. There are practices that can reduce patient choice, chill pharmacy-patient communication, and increase healthcare costs for patients, insurers, employers and taxpayers.

**A MATTER OF CHOICE**

Meet Mrs. Jones. She’s been diagnosed with mild depression, and her doctor prescribes joferinex. (Note: We’re using fictitious products here. Just go with it.) It’s one of the common first-round SSRIs, and it’s got some side effects Mrs. Jones has been cautioned to watch for.

When she tries to fill her prescription at the local pharmacy she’s used for years, Mrs. Jones’s pharmacist tells her he can’t fill it. ”Mail-order required,” says his screen.

Or maybe she does fill it at her pharmacist, but her co-pay is $50 … or more. Then she receives a letter from her health insurer — or, rather, her insurer’s pharmacy benefit manager or PBM: If she fills her prescription at a particular mail-order pharmacy, her co-pay will only be $5. Or even zero.

Welcome to ‘mandatory mail-order,’ where PBMs — companies that handle pharmacy claims on behalf of health insurers, employers, and others — sometimes require (or strongly incentivize) patients to use mail-order pharmacies, rather than the local, community practitioners they may have been using for years. And yes, some PBMs own those mail-order pharmacies. If you think that smacks a bit of conflict of interest, you’re not alone.

The number-one issue with mandatory mail-order has nothing to do with costs. The issue is that it’s bad — perhaps even dangerous — from a clinical perspective.

Using a faceless pharmacy means patients give up any kind of medication adherence assistance; just because it’s *delivered* doesn’t mean it’s being taken or taken properly. Complications, side effects, adverse
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reactions ... especially with new or changed medication, none of these are accounted for.

If Mrs. Jones finds herself getting dizzy after starting on joiferinex, a quick call to her local pharmacist might have told her that those symptoms only last a day or two. But is she likely to call a faceless mail-order house? Would she get to speak to a human being if she did? Would she wait to try to reach her physician?

And if there’s anything wrong with her shipment, well… hopefully the mail-order house has an efficient customer service department. “Your call is important to us.”

There’s a reason pharmacists consistently rank at or near the top on lists of “trusted professions.” Patients know they can access and trust their community pharmacist for medication questions.

And once a patient goes down that mail-order rabbit hole, getting out isn’t always easy. As the National Community Pharmacists Association explains:

No patient can “fire” their PBM-owned mail service. Once you’re in — you are locked in. The patient is “captive” to a single PBM-owned mail service — no matter how poorly it performs. Patients have reported numerous delivery issues that have caused patients to be unable to take medications that are vital to their health and well-being including delays in receiving medications, temperature-sensitive drugs being left outside or on delivery trucks, drugs lost in transit, medication switching and even the wrong drugs being shipped.

As for costs, it turns out that mail-order can cost insurers and other plan sponsors more money. A study from the University of Arkansas Medical Sciences College of Pharmacy found that, while per-pill costs might be lower with mail order, overall costs were actually higher, thanks in part to waste: “Waste appeared to be a function of prescription changes, adverse drug reactions, and diminished needs.”

In other words, even if a patient stops or changes a medication, the mail-order pharmacy keeps sending it — and billing for it.

The point isn’t that Mrs. Jones shouldn’t use a mail-order pharmacy. It’s that her choice of pharmacy should be hers, not the PBM’s. Several states, in fact, prohibit PBMs or insurers from charging more if a patient wants to use her community pharmacy rather than a mail-order house.

And get this: The Georgia legislature has already outlawed mandatory mail order — back in the early 1990s, but only for “group or blanket accident and sickness insurers.” So how can PBMs require it? Simple: The law was written when the health insurance landscape was very different — and it doesn’t apply specifically to PBMs.

But we can fix this. Ensuring freedom of pharmacy choice is a matter of clarifying existing Georgia law and removing that technical loophole: applying those same prohibitions to PBMs. That would go a long way toward protecting patients.

On the dark side

Keeping everyone in the dark — insurers, pharmacists, patients — is standard operating procedure for some PBMs; they consider their pricing deals to be trade secrets. But that secrecy isn’t just about not giving their competitors leverage. It’s also about securing more profits at the patients’ and insurers’ expense.

For example, some PBMs charge fees to pharmacies for the prescriptions they fill. That’s right — first they reimburse the pharmacy, then they charge what’s called a “clawback” fee to get some of it back. Why the convoluted process? Because it masks the lower cost of the medication. An insurer looking into costs and pricing (perhaps to negotiate with a PBM) will see the pharmacy’s share, not realizing that part of that actually ends up back with the PBM.

Result: Insurers’ and patients’ costs go up. And with so many people on government-run plans (Medicare and Medicaid), that means taxpayers’ costs go up, too.

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CLAWING BACK

Now meet Mr. Smith. He’s given a prescription for neflalon (fictional names, remember?) for his high blood pressure. It’s an older drug but it works well for him.

He fills it at Williams and Son pharmacy, where he pays his $50 copay as always. Later that day, though, he’s talking with a friend who also happens
to take neflateron — but who mentions it only costing $12.

“Great insurance you have,” says Mr. Smith. “Only $12 co-pay?”

“Oh, no,” says his friend. “I don’t use my insurance. That’s just the price.”

“Where is that the price?”

“Williams and Son.”

So Mr. Jones goes back the pharmacist and asks her outright about the price. Yes, she explains, the full retail price of neflateron is only $12.00.

“Then why do I pay $50?” asks Mr. Smith.

“That’s what your insurance has you pay,” the pharmacist explains.

“And you didn’t tell me?”

The fact is, Mr. Smith’s pharmacist can’t tell him — or at least she’s pretty sure she can’t. Her contract with Mr. Smith’s PBM prohibits her from disclosing information about costs and reimbursements, at least as she understands it. Plus she’s heard enough stories about PBM’s suing pharmacists that she doesn’t want to risk losing dozens of customers.

Mr. Smith experienced what’s called a claw-back: The difference in price between the (lower) retail cost of his medication and the (higher) copay demanded by his PBM. That difference goes straight into the PBM’s pocket. It’s only possible because Mr. Smith, like most of us, would never think to ask, “Would this be cheaper without my insurance?”

It’s not all that uncommon, either. While Mr. Smith — like most patients — assumes that using his health insurance means he’s paying less for his medication, that’s not always true. (If a patient asks outright, “How much would this cost if I didn’t use my insurance?” a pharmacist is in a bind. “I can’t tell you because of my contract with your PBM” isn’t going to satisfy most people.)

Even worse, perhaps, is that kind of gag order (and let’s face it — that’s essentially what it is) also prohibits pharmacists from telling patients about a cheaper therapeutically equivalent treatment — a generic over a brand name, for example, or a different medication entirely.

Those contracts become an end-around that bypasses pharmacists’ training and knowledge. What’s the point of being a medication expert if your PBM contract prohibits you from using that expertise? It’s not a matter of a technicality, either.

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No skin off my nose

You might think PBMs would want patients to take generic equivalent drugs. After all, they cost less for everyone, right? That turns out not to be the case.

A patient might easily be told to get a brand-name drug instead of a generic. Her co-pay might even be the same, but the higher price of the brand-name drug would be picked up by the insurer or employer — and in the case of government programs, the taxpayer.

If a PBM can make a $10 spread on a brand-name drug, but only a $6 spread on the generic equivalent, it’s happy to have the insurance company (and the patient) pay more for the brand name. And because PBMs’ costs and pricing are secret, no one is the wiser.

For insurers, employers, and others who rely on PBMs to handle the pharmacy end — including Medicare and Medicaid — that secrecy can mean they spend a lot more than they have to.

If the idea of patients unnecessarily taking brand-name drugs sounds unlikely, check the numbers: According to data from the National Community Pharmacists Association, generic drugs typically account for 69 percent of retail pharmacies’ prescriptions (in 2009). But when you look only at prescriptions where a PBM is involved, only 58 percent are generic.

Whether it’s a particular drug or a brand-name vs. a generic, PBMs can use their formularies to get doctors to prescribe — and patients and insurers to pay for — the drugs that make it the most money, rather than the drugs that doctors and pharmacists think is the best choice.
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We have seen firsthand examples of pharmacists threatened with retaliation by PBMs — including losing their contracts entirely — for speaking about pricing with patients.

Some states have put a stop to these gag orders. A 2010 Tennessee law, for example, requires that PBMs provide patients actual reimbursement information for medications (i.e., “We paid $10 for that drug, and your co-pay is $5”). It also prohibits PBMs from gagging pharmacists. The pharmacist can let patients know about lower potential prices.

Georgia, however, doesn’t have such a law. But we can fix this, too. Passing legislation that would prohibit PBMs from gagging or retaliating against pharmacists — from interfering with their patient relationships — would shine a bright, clear light on how the patient’s care (and wallet) is being affected.

PLAYING DOCTOR

Finally, meet Ms. Szulewski-Braithwaite. She’s got rheumatoid arthritis, and her doctor prescribes romexulib. When she visits her local pharmacist, she’s told it’s on the higher tier of her insurance company’s formulary; her co-pay will be $50.

Her pharmacist looks at her plan and finds that klingorenol is in the low-price tier. With her permission he calls her doctor and is told that yes, it’s fine to give Ms. Szulewski-Braithwaite the klingorenol instead.

What just happened may seem innocuous: Ms. Szulewski-Braithwaite’s pharmacist and doctor worked together to pick a medication that would work for her while being more affordable than the doctor’s first choice.

But it isn’t innocuous. Because the eventual choice of medication wasn’t based just on her medical needs, or even necessarily — as we’ll see — on what was most affordable for her.

Why? Because of the PBM again.

The PBM works for the insurer, with a goal of getting better prices for medication for the company (and for Ms. Szulewski-Braithwaite) by bargaining with pharmaceutical companies. That’s all well and good. But part of how the PBM itself makes money is through the difference in price between what it pays the drug maker and what the insurer pays it.

In Ms. Szulewski-Braithwaite’s case, the PBM might be able to bill her insurer $100 for either romexulib or klingorenol. But — and this is the important part — if the PBM has negotiated a better deal from the maker of romexulib, it’s going to want Ms. Szulewski-Braithwaite to take that instead.

When PBMs are able to get bigger discounts or rebates on certain drugs, they profit more when patients use those medications instead of something similar. So the PBM puts romexulib in a higher tier, more patients get klingorenol, and the PBM makes more money.

In Ms. Szulewski-Braithwaite’s case, she ended up not with the medication her physician and pharmacist chose, but with a mixture of “should work well” and “provides the biggest profit to the PBM.”

That’s a compromise in care no one should have to make. Why should a PBM be able to undermine the medical expertise of doctors and pharmacists, especially for reasons that have nothing to do with healthcare?

Oh, and if PBMs can’t negotiate a big enough discount from a drug maker? They can pull that medication from their formularies altogether. And they do. In November 2016, in a piece he wrote for Investor’s Business Daily, former FDA Associate Commissioner Peter J. Pitts pointed out that “Combined, the top two PBMs in the country deny
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coverage to 239 medicines.”
That means patients whose health insurers contract with those PBM giants cannot get access to those medications without paying 100 percent out-of-pocket. Why are they excluded from the formularies? Because, Pitts says, the PBM wants to “pressure the makers of other treatments into giving steeper discounts.”

Congratulations, Ms. Szulewski-Braithwaite. You’re now a bargaining chip.

STAYING CENTERED

The center of our healthcare system is the patient. Pharmacists, doctors, nurses, health insurers — they all work with the goal of making and keeping people healthy. Patients expect that.

As we’ve seen, though, it doesn’t always work that way. Sometimes, players in the game can take advantage of laws and regulations — or the lack of them — to insinuate themselves in the process and to claim a piece of the pie without adding any value.

No one begrudges a company providing a service and making a profit from it. But when those profits are made secretly, and more importantly when they interfere with or even jeopardize patient care, someone needs to step up and work to fix that.

Why not pharmacists?

Cheap and cheaper

Why would a PBM prefer one drug over another, even if they have a similar list price? It depends on the discount or rebate.

If two arthritis drugs both list for $100, but the PBM pays $60 for one and $70 for another, it’s going to want patients to take the $60 drug. Because — and this is the heart of the issue — the fact that it only pays $60 for drug #2 is a secret. For both drugs, it can still charge the insurer $75 and charge the patient a $5 co-pay.

One drug means an $18 profit for the PBM, one means an $8 profit.