

Myth: Drug discount cards do not save money.

In a January 2002 report, the General Accounting Office (GAO) showed that discount cards on average save consumers 32 to 55 percent on generic medications and 6 to 32 percent on brand medications compared to average retail pharmacy prices without a discount card. For the entire basket of drugs surveyed, consumers save an average of 11 percent on drugs purchased through a discount card compared to walk-in retail pharmacy prices.

Savings achieved by individual consumers will vary depending on what drugs they need, and where they live, and how much their local pharmacy marks up drugs for walk-in customers without insurance. Discount cards were shown to have the greatest benefit for rural seniors. Consumers purchasing their medications in a rural retail setting are paying considerably more, sometimes up to three times more, than consumers using discount cards and are paying up to twice the amount as those consumers purchasing their drugs in urban retail settings, according to the January GAO study (which used prices in rural Georgia retail setting). The savings achieved on generics are larger because retail pharmacies mark them up more aggressively. Data from one discount card program showed that individuals in the top 1.5 percent of spending saved over \$1,000 annually by consistently using the discount card.

GAO's report also understates the savings achieved through discount cards. In some cases retail pharmacies charge cash paying customers less for a specific drug than the rate negotiated by the discount card program with the pharmacy. The discount card programs generally capture these savings for persons enrolled in the discount card program. Since contractually the pharmacy must charge the patient the "lower of" its cash price or the negotiated price, the patient always benefits where the pharmacy has a lower cash price. GAO did not account for this in its calculation of savings.

Myth: Retail pharmacies are forced to participate in these programs and cannot make a reasonable profit when complying with discount card terms.

Participation in discount card programs is entirely voluntary. Pharmacies choose to participate in these programs because they still profit, even when they pass lower prices on to consumers. Discount card programs require participating pharmacies to charge consumers rates that are equivalent to prices they must charge for patients with drug coverage through their health plans. Pharmacies do feel

competitive pressure to participate in discount card programs. If a pharmacy makes a business decision not to participate in discount card program, it must determine whether it will benefit financially by its decision. Pharmacies that accept discount programs also benefit from increased customer loyalty and foot traffic that results in increased sales of other items.

Some pharmacies even offer their own discount card programs. For example, in September 2001, CVS launched the CVS Health Savings Pass, which provides people age 50 and over with discounts on prescriptions and other health care services. Cardholders also have access to vision, dental and hearing services, a 24-hour nurse line, and a fax medication alert service in addition to the discounted prescriptions. CVS also accepts many other commercially available discount cards.

Myth: PBMs have a higher than average per prescription cost than cash-paying customers.

Retail pharmacies charge their highest prices to consumers without drug coverage. In funded prescription drug programs either the health plan or its PBM negotiates discounted reimbursement rates from pharmacies. Cash paying customers don't have a PBM to help reduce their drug costs - unless they enroll in a discount card program. The Rite Aid drugstore chain recently settled a lawsuit with the state of New Jersey, which alleged that the store and its pharmacists had raised prices for consumers not covered by insurance or discount cards. Further, New Jersey state officials found that among the top nine drugs used by the elderly for a variety of ailments, the uninsured paid 81 to 183 percent than consumers with coverage.

Retail pharmacy pricing is one of the reasons cash paying consumers pay high prices for prescription drugs. However, the major reason for high prescription drug costs is the prices charged by drug manufacturers. Drug discount cards also attempt to address this problem by negotiating pricing concessions from drug manufacturers and passing on savings to the consumers enrolled in their plans.

Myth: Discount cards will hinder patient choice and pharmacist/patient relationships, and reduce quality of care.

Discount cards do nothing to prevent consumers from seeing any pharmacist they want. They simply enable the consumer to access lower prices. Seniors who have trouble paying for drugs often try to skip doses or simply fail to refill their medications. Pharmacists who

are concerned with their patients' overall well-being should want to ensure that they are able to access the lowest possible prices.

Discount cards improve the quality of care received by consumers who enroll in those plans. Unlike consumers with a funded drug benefit, there is no systematic screening for drug interactions or other avoidable problems (e.g. incorrect dosing or drug/allergy interactions). Consumers enrolled in discount card programs have all of their prescriptions recorded in a central database, which not only tells the pharmacist what to charge for the prescription, but also alerts the pharmacist to potential medical issues. Individual pharmacies often perform this service, but only for prescriptions filled by that pharmacy or pharmacy chain. Discount card programs expand that protection regardless of where the consumer fills a prescription.

Discount cards programs usually provide consumers with a large array of pharmacies to choose from. A patient can always choose to forgo the benefit of a discount cards and patronize a pharmacy that does not participate in the program. The argument that discount cards interfere with pharmacist/patient relationship is disingenuous at best since it is the pharmacy has elected not to participate. If a pharmacy participates in a card programs, there is no interference or interruption in the relationship between the patient and pharmacy or pharmacies used.

Myth: The issuers of these discount cards are under no statutory provision -- either state or federal -- to protect the confidential nature of a patient's drug regimen.

In fact, the groups issuing these cards ARE subject to all state and federal statutes governing the privacy of medical information. They are directly regulated in their capacity as state licensed, certified or registered entities, e.g., a pharmacy, a non-resident pharmacy, a third party administrator, a utilization review organization and/or a preferred provider organization. They are also directly regulated when they engage in certain activities falling under the jurisdiction of state or Federal agencies (e.g., the Federal Trade Commission requirements concerning fair business practices apply to mail order services).

Under the administrative simplification provisions of Health Insurance Portability and Accountability Act (HIPAA), which address standard electronic transactions, privacy of health care information and security of health care information, pharmacies that transmit information in electronic form are "covered entities." Covered entities must comply with a broad range of complex regulations concerning their use and disclosure of health care information and conduct of electronic transactions. HHS has authority to audit pharmacies' compliance with

the administrative simplification provisions and to impose sanctions on pharmacies that fail to comply. Under HIPAA, consumer information cannot be used for marketing purposes unless the individual explicitly states a desire.

Myth: PBMs, the entities that often provide drug discount cards, shift seniors to high-cost brand name products rather than a less expensive generic.

Generic substitution is widely embraced and enthusiastically promoted by PBMs. In fact, substitution of lower cost products is a cornerstone of how PBMs save their customers money. PBMs provide financial and contractual incentives to pharmacists to encourage generic drug use. These requirements typically are written into PBM contracts with employers, state governments, and other PBM clients.

Generic substitution rates for mail order pharmacies are actually higher than retail pharmacy. One PBM recently calculated the generic dispensing rate for the top 50 drugs dispensed through its mail order facility for third-party plans using co-payments for both mail service and retail prescriptions. About 100,000 prescriptions were dispensed through mail order with a generic dispensing rate of 31.3 percent. For the same drugs filled through retail pharmacies, 340,000 prescriptions, the dispensing rate was 27.7 percent.

Another PBM recently succeeded in implementing one of the most aggressive generic substitution programs. In August of 2001, Prozac, the blockbuster anti-depressant, lost its patent. Within one week of generic availability, Merck-Medco, a PBM that supplies prescription drugs to more than 65 million beneficiaries, switched 80 percent of home-delivery subscribers from Prozac to the generic. On the day the generic version of Prozac was available, Merck-Medco informed top-prescribing physicians as well as patients of the availability and potential savings.

The GAO similarly concluded that PBMs frequently use generic substitution. The Federal Employees Health Benefit Plans (FEHBP) began to contract with PBMs to lower drug costs in the early 1990s. By 1995, over 58 percent of FEHBP recipients were enrolled with a PBM. According to the GAO, generic substitution accounted for about \$4 million in estimated savings. By 1995, where applicable, generic equivalents were substituted over three quarters (77 percent) of the time.¹

Myth: Discount card programs force patients to use mail order services, reducing access to pharmacy counseling.

The use of mail order services is optional in almost all drug discount card programs. Many seniors - particularly those who have trouble getting to the drug store or those who live in remote rural areas - greatly value the ability to get their drugs through the mail. Mail order pharmaceuticals often are less expensive because of packaging efficiencies and lower dispensing fees. All mail service pharmacies must comply with the counseling requirements of OBRA '90. The reality is that many, probably most retail pharmacies provide little if any counseling to patients. Often, the only interaction between a patient and pharmacy personnel is with a clerk at the counter. Mail service provides patients the opportunity to talk with a pharmacist, at the time chosen by the patient, and in a private, secure setting i.e., the privacy of their own homes. Many patients simply are not comfortable talking to a pharmacist in a busy retail pharmacy with other customers nearby.

While retail pharmacists have expressed concerns that mail order pharmacies steer beneficiaries away, there is evidence to suggest otherwise. In its 1997 study, the GAO found that over two-thirds of all prescriptions by FEHBP beneficiaries were filled by retail pharmacies despite beneficiaries' access to mail order services. Additionally, the study concluded that enrollee access to retail pharmacy services has not been substantially limited. In 1995, enrollees could purchase discounted prescriptions at between 44,000 and 55,000 retail pharmacies or between 80 and 97 percent of pharmacies nationwide.

Myth: Discount cards eliminate the need for a Medicare drug benefit.

Discount cards are no substitute for a prescription drug benefit. The Medicare benefit was crafted in 1965, prior to the introduction of most pharmaceutical therapies. Pharmaceuticals are an integral part of modern medicine, and should be included to ensure best outcomes for Medicare beneficiaries.

A drug benefit also would improve quality of care. Senior citizens face a fragmented health care delivery system. The elderly often have multiple, and sometimes chronic, conditions which require that they see several physicians on a regular basis (i.e., specialists, primary care physician). Streamlining prescriptions and coordinating the overall care is increasingly difficult, but especially important, for elderly patients.

PBMs also are better able to contain costs with their insurance products. It is not uncommon for PBMs to save 20 to 30 percent of

total pharmacy costs for employers and health plans that hire them to manage drug spending. For example, the GAO found that in the FEHBP, PBMs saved their plans over \$600 million in 1995 compared previous years without PBM management. These savings reduced the pharmacy benefit costs each plan believes it would have paid without using a PBM by between 20-27 percent. Examples from the private sector frequently are cited in industry analyst reports.

PBMs achieve these savings because they deploy a range of techniques to control costs while also improving quality. They contact physicians to ensure that they are aware of what drugs are preferred by the plan. They employ tiered cost sharing and formularies to give beneficiaries direct financial incentives to use less expensive equivalent drugs. They also offer disease management programs to ensure that chronic diseases such as asthma and heart failure are addressed properly and that patients get the best care.

Myth: The cost savings resulting from discount cards will hurt patient quality.

PBMs have a strong history of controlling costs while improving the quality of care provided to patients. In 2000, PBMs coordinated the pharmacy benefits of over 200 million people in the U.S. PBMs have evolved over the last three decades from claims administrators to complex organizations offering a wide range of prescription drug management tools.

PBMs provide essential clinical programs and services to help beneficiaries avoid medication errors, improve drug safety and increase patient compliance, education and awareness. These services are required by many employers, state governments, and other PBM clients because they improve overall clinical outcomes for beneficiaries and result in a healthier population and better quality of life. Through their knowledge, clinical information and expertise, and in accordance with strict confidentiality standards, PBMs provide critical clinical information and support to patients, physicians and pharmacists.

PBMs have succeeded in addressing the two fundamental goals: holding down prescription drug costs and improving the quality of care provided to beneficiaries. They have done this by developing a broad spectrum of tools (e.g., formularies, generic and therapeutic substitution, disease management programs), which are increasingly being adopted by other entities (e.g., state Medicaid programs).

1 The General Accounting Office. GAO/HEHS-97-47, February 1997.

