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Commentary

Reimbursement for Drugs Under Third-Party Programs

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Third-party drug reimbursement in this country has a history which dates back approximately 25 or 30 years. Prior to that time, pharmacists purchased drugs from wholesalers or manufacturers and dispensed them to consumers, adding a percentage mark-up as their profit. In the days before third-party reimbursement, individual pharmacists often subsidized the poor living in their area. With the advent of state-sponsored welfare programs, now known as Medicaid (operated largely with federal funding), the method of charging for outpatient drugs began to change. The percentage mark-up method evolved into the cost plus fee method, where the pharmacist added to the amount he or she paid for the drug a flat fee for dispensing each prescription. Eventually, other third-party programs, such as private insurance companies, followed this type of reimbursement methodology. In addition, there were a number of variations on the theme including sliding fees and combinations of mark-up and fee.

Now third parties, including Medicaid programs, pay for approximately 35% of the amount expended for outpatient prescription drugs in this country. Medicare, which is a government-sponsored health insurance program for the elderly, recently entered the outpatient drug program arena with the passage of the Medicare Catastrophic Act of 1988.

Today, third-party drug coverage varies considerably depending on whether the prescription drug is provided on an inpatient (in the hospital) or outpatient basis. Charges for inpatient prescription drugs are included in the overall hospital bill and are not billed separately to the third-party program, whether a program such as Medicare or Medicaid or a private insurance program. For federally financed programs and some private programs, hospitals presently operate under a reimbursement system using Diagnosis-Related Groups (DRGs). Under the DRG system, hospitals receive a fixed payment for certain diagnoses for each patient. For example, for a certain illness, the DRG may specify that the patient is entitled to 3 days of hospitalization and the program will limit payment to 3 days only. The hospital is under tremendous pressure to keep overall costs down because some patients may be required to stay longer at the hospital's expense. The pressures on the hospital are exerted downward on the hospital pharmacy. A hospital pharmacy generally operates on a fixed budget which includes products and staff, and if too much of this budget must be allocated to drug products, the pharmacy may have to reduce its staff and perhaps quality in the process.

Outpatient drug programs generally use the cost plus fee method of reimbursement. This includes the recently enacted Medicare outpatient drug program. In an outpatient drug program, there are many small claims, and administrative costs are very high compared to the cost of the medical service rendered. In some instances, it may cost as much to process the claim for a prescription as the cost of the drug itself. Contrast this to the hospital setting, where hospital claims include drugs but are submitted as a total bill. This represents only one claim for a large amount of money (hospital room, nursing care, drugs, lab tests, etc.). Therefore, the administrative costs of a hospital claim are quite low as a percentage of the total cost of the medical service.

Several other important issues have emerged over the years, and these can have a tremendous impact on the practice of pharmacy and the continued provision of quality drug products by the pharmaceutical industry.

Pharmacists' fees have been an emotionally charged subject ever since the cost plus fee method was adopted for use by third-party programs. Medicaid regulations, many years ago, mandated the states to conduct cost of dispensing studies to consider when determining a dispensing fee for pharmacies. The regulations, however, did not require the states to raise the fees to at least cover the cost of dispensing. Dispensing fees have continued to lag behind dispensing costs, and pharmacists have been forced to make up the difference through prudent purchasing of products as well as higher charges to non-third-party patients. Fees in state Medicaid programs presently range from $2.00 to $4.26. Under the new Medicare outpatient drug program, the dispensing fee in 1991 would be $4.50. Under the new law, this fee would increase in accordance with the Gross National Product deflator on an annual basis. Even profits to pharmacies from this program, however, would be eroded, as the cost of drugs from the manufacturers increases at a rate which exceeds any annual increases in the dispensing fee.

The cost of the drug product itself is a major issue. Prior to the advent of third-party programs, the pharmacist was free to price the product as he or she saw fit. However, with the advent of the cost plus fee method, third-party payers

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have been keenly interested in the amount which the pharmacist submits as the cost. Traditionally, the cost has been based on what is known as the average wholesale price (AWP). This may not be the price which the pharmacist actually pays for the product because of discounts, etc. The price which the pharmacist actually pays is generally known as the actual acquisition cost (AAC). Over the years there have been many approaches to dealing with the issue of the cost of the drug product. The most celebrated is probably the maximum allowable cost (MAC) program, which placed price ceilings on some single source products and established a mechanism for reimbursing multiple-source products (i.e., generic drugs) at an estimated acquisition cost (EAC). Even the latter mechanism has since been modified for state Medicaid programs. The new Medicare law also contains formulas for reimbursment for both single and multiple source products.

Thus, pricing by pharmaceutical companies is becoming a critical issue. Senator Pryor (Arkansas) held hearings on drug pricing on July 18, 1989. One major factor which was brought sharply into focus is the differential between the prices which the Medicare program will pay and those enjoyed by some other government health-care providers such as the Veterans Administration (VA). In fact, the VA estimates that it pays 41% less than the list price for single-source drugs.

The VA and other federal entities such as the Department of Defense (DOD) provide medical care directly to patients. Under the new Medicare law, the federal government would reimburse providers outside the government. A patient is free to go to his or her private physician or pharmacy. The Health Care Financing Administration (HCFA) administers the Medicare program and it would obviously object to paying more for outpatient drugs than its counterparts in the VA or DOD, despite the fact that they do not operate under a reimbursement system but provide medical care directly to patients. This reluctance of HCFA to pay more will exert downward pressure on the prices which industry can charge. And as the government pays for a larger portion of the nation's drug bill, it is going to demand lower prices. Pharmaceutical companies may have no choice but to capitulate, and as they do, industry prices will erode and there will be fewer dollars to support such functions as research and development, with potentially negative effects on the new drug pipeline.

The industry must now develop a rational policy to deal with these unfolding events, and this policy should be developed before events envelop the industry.