Should Medicare Finance E-Prescribing?

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A Brief History of the Financing of PBM Computer Networks

The computerization of pharmacy benefits began with the porting of claims processing to the pharmacy point-of-sale in the 1980's when client-server networks were in their infancy. Before that, patients first had to pay for the prescriptions themselves and then submit a paper claim to their insurance company for reimbursement. The high transaction costs associated with covering out-patient prescriptions was a deterrent to offering such a benefit in the first place. Today, the cost of posting a claim from the point-of-sale directly into a payer's computer is less than $.10.

The development of pharmacy claims processing systems was largely financed by insurance companies, often outsourced to networking specialists called pharmacy benefits managers (PBMs). Both the clients (retail pharmacies) and the servers (PBMs and insurance plans) stood to reap financial benefits. Retail pharmacies gladly financed the installation and training because they knew that the growth of insurance coverage for drugs would expand their market as providers. Also, retailers welcomed PBMs as network development partners in the 1980s because mail order operations owned by PBMs did not pose a threat until the early 2000s.

These point-of-sale systems have evolved from single purpose claims processing systems to full-fledged pharmacy benefit management systems. A look-up table of preferred drugs was added to trigger switches to lower cost generic substitutes and therapeutic equivalents. A complete history of patient drug usage was added to detect potential adverse drug interactions and to detect over- and under-utilization by patients with chronic illnesses like diabetes, depression, and hypertension.

Efforts have been underway since the early 1990's to port pharmacy benefits management to the point-of-care – the physician's office. This development, known as "e-prescribing", involves not one, but two new computer networks: (1) between physicians and dispensing pharmacies, and (2) between physicians and PBMs.

One of the first "e-prescribing" initiatives – Pre-Scribe -- was developed by Walgreens in the early 1990s at its own expense. It was a closed system with EDI links between Florida physicians and Walgreens stores.[1] There was no electronic connectivity to PBM systems. Being closed to all servers but one – Walgreens' --avoided public goods issues on the client-side, but it also limited the network's potential to expand its reach cheaply by adding additional servers (retailers) instead of adding relatively costly clients (physicians).

Walgreens sold Pre-Scribe to IBM in 1995, only to get it back in 1997 so it could flip it to ProxyMed.[2] ProxyMed then inked a deal with Eckerd to deploy Pre-Scribe as a closed network between physicians and Eckerd retail pharmacies. It appears that ProxyMed operated two separate networks with physicians locked into either Walgreens or Eckerd.

ProxyMed adopted an application service provider business model, charging Eckerd on a per script transaction basis. It is not clear who paid for the remote terminals and training – the physician or Eckerd. Or, it may have been ProxyMed who paid the up-front costs and then added the amortized expenses to transaction fees.

The limited success of these closed systems eventually led to the creation of two companies in 2001 with missions to market open systems. SureScript was created by a consortium of retail pharmacies including Walgreen and CVS.[3] RxHub was created by a consortium of PBMs including the Big 3 – Medco, Express Scripts, and Caremark.[4] Both companies focused on developing connectivity software. While both companies profess channel neutrality and

openness, there was early friction between the two over interoperability. Neither has committed to financing hardware and physician training, due to the public goods nature of clients of multi-server networks.

The Case for Collective Action in the Financing of E-Prescribing

There is near unanimous agreement that monetary benefits of e-prescribing far outweigh the costs of computer equipment, software, and training. Many benefits derive from the principle of "getting it right the first time" -- fewer errors due to poor handwriting and reduced call-backs by pharmacists after discovery of potential drug interactions or conflicts with insurance coverage requirements.

Despite the prospects of a very favorable rate-of-return, the growth of e-prescribing has been very disappointing. According to a Gorman Health Group report discussed in more detail later, only 3 % (30,000 of 900,000 prescribing physicians) actively use e-prescribing.[5]   If nothing is done to underwrite client-side equipment and training, Gorman estimates that there will be only an 18% penetration by 2010.

An open access, client-server network carries with it potential public goods issues on the client side. Once clients (pharmacies or physicians) are equipped, trained, and connected to a network, there are virtually no additional costs incurred on the client side as additional servers (PBMs) are added to the network. Clients are excludable, but non-rival, public goods to servers. Non-rivalry means that one server's access (consumption) to a client in no way reduces another server's access (consumption) to that same client. Unless some sort of collective action is taken in financing clients (assuming, of course, that self-financing is not in the clients own best interest from a benefit-cost perspective), the network will fail to reach it most economic size. As a result, there is a call for government financing of e-prescribing to overcome "market failure".

However, there were public goods issues involved in the computerization of point-of-sale pharmacy networks in the 1980s and 1990s.   This did not seem to deter the private financing of such systems back then. Are there additional complications involved in the development of e-prescribing networks that were not present during the development of point-of-sale networks? If so, then the case for collective action now becomes stronger.

We can think of two. One is the rise of PBM mail order operations as a competitive threat to retail pharmacies. E-prescribing has the potential to be another in a list of exclusionary devices created by PBMs to funnel prescriptions to mail order. The list includes mandating mail order for users of drugs to treat long term illnesses and mandating that only mail order operations can dispense 90-day prescriptions. In order to induce retailers to participate in e-prescribing, it may be necessary for government intervention to insure that point-of-care networks are not used unfairly by PBMs to funnel prescriptions to their captive mail order operations.

The other difference between the point-of-sales systems and e-prescribing systems is the distribution of benefits between clients (pharmacy and physician) and servers (PBMs). As we mentioned earlier, point-of-sales systems in the 1980s facilitated insurance coverage for drugs in the first place. This greatly expanded the demand for outpatient prescriptions, a benefit accruing solely to clients (pharmacies). Servers (PBMs) benefited early on by greatly reduced transaction costs for claims processing and later on, from the ability to sell management services and negotiate rebates with Pharma. Because the benefits accruing to clients (pharmacies) were so substantial, it was in their own self-interest to fully finance the cost of equipment, installation and training.

The distribution of benefits is quite different with e-prescribing as almost all of the benefits accrue to the servers (PBMs) . E-prescribing does not look like it will expand markets for drugs or physician services, benefits that would have accrued to clients. Retail pharmacies stand to benefit some from reduced call-backs, but to a large extent they are compensated for these costs. We

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believe that benefits accruing to clients (physicians) are small to none. The only possible benefit to physicians might be from reduced lawsuits claiming damages from physician writing errors or unforeseen drug interactions. No wonder physicians have been reluctant to install e-prescribing at their own expense.

Should Medicare Finance E-Prescribing?

In 2004, the largest expansion of entitlement programs in the United States in decades – the Medicare Modernization Act (Medicare Part D) – was passed. Seniors now are eligible for subsidized insurance covering outpatient drug prescriptions. The plans are managed by private sector insurance companies, who often outsource management to independent PBMs.

As with most major pieces of legislation, there were many "special interest" riders attached to the Medicare Modernization Act. One section specified that the federal government use its sponsorship of Medicare Part D to promote the development of e-prescribing. This involved the following initiatives: (1) mandating standards for the network between private sector plans and Medicare; (2) making Medicare e-prescribing voluntary for physicians, but (3) mandating national standards for Medicare e-prescribing that would pre-empt any state law.

Recently, the Pharmaceutical Care Management Association (PCMA), a trade group representing large PBMs -- both independents like Medco and Express Scripts and the captives of Aetna, CIGNA, and Wellpoint -- has suggested that the federal government to go further and make Medicare e-prescribing mandatory for physicians with the costs underwritten by Medicare.

A report by the Gorman Health Group, a firm hired by the PCMA, has estimated that the net benefits to the federal government of this initiative would be $29 Billion in reduced Medicare Part D expenses over the next decade.[5] The training and implementation costs were estimated at $2,700 per office for the first year and then $700 each year thereafter. The total cost over a

period of 10 years from 2008-2017 would be $7 Billion. This would be financed through reimbursements from Medicare to each physician equaling 1% of the cost of Medicare Part D drugs they prescribed, or about $9 Billion.

A Call for Free Market E-Prescribing

We agree with the PCMA that the benefit-cost ratio of e-prescribing is compelling and that government leadership in setting e-prescribing standards setting is appropriate. We also believe that there is a good argument for collective action in financing client-side e-prescribing.

However, the case for collective financing does not necessarily mean it should be through government. Large PBMs have already created a corporation, RxHub, to supply physicians with e-prescribing systems. The PBMs now should underwrite $7 Billion in loans to RxHub so that it might supply Medicare-compliant systems to physicians. The loans would be paid back by PBMs to RxHub from fees levied on each Medicare Part D script managed by individual PBMs.

It is rare for the PCMA to call for more government involvement in PBM affairs. Their focus is overwhelmingly on fighting government initiatives to regulate PBMs. This includes attempts to by state legislatures to pass full disclosure fiduciary laws and attempts to pass laws forcing PBMs to give up exclusionary practices that favor their captive mail order operations.

The PCMA should stick to its free market principles. Physicians should be willing to install systems in their office voluntarily if their costs are adequately covered. The government has already done its part by including a clause in Medicare Part D relaxing anti-kickback laws in cases where a physician chooses to implement Medicare e-prescribing voluntarily.

PCMA might want to reconsider its call for government financing of Medicare e-prescribing. It may be opening a Pandora's Box. Specifically, if Medicare e-prescribing is made mandatory and

government financed, we would call out for e-prescribing to implement the "any willing provider" provision in Medicare Part D:[6]

> Section 1860D-4
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> "(b) ACCESS TO COVERED PART D DRUGS.—
> "(1) ASSURING PHARMACY ACCESS—
> "(A) PARTICIPATION OF ANY WILLING PHARMACY.—A prescription drug plan shall permit the participation of any pharmacy that meets the terms and conditions under the plan.

Part D also specifies that Medicare e-prescribing systems provide information on the availability of lower cost alternatives and allow for the patient to choose a dispensing pharmacy based on this information:

> Section 1860-D4 (e) ELECTRONIC PRESCRIPTION PROGRAM.—
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> "(2)(A) PROVISION OF INFORMATION TO PRESCRIBING
> HEALTH CARE PROFESSIONAL AND DISPENSING PHARMACIES AND PHARMACISTS.—An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional
> …
> (ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.
>
> (3)(B) OBJECTIVES.—Such standards shall be consistent with the objectives of improving…
> (iii) efficiencies, including cost savings, in the delivery of care.
>
> (3)(E) PERMITTING PATIENT DESIGNATION OF DISPENSING PHARMACY.—
> "(i) IN GENERAL.—…such standards shall permit a part D eligible individual to designate a particular pharmacy to dispense a prescribed drug.

The question is what should Medicare do if a provider is willing to **exceed** the terms and conditions of a plan? What if a Wal-Mart, Costco, or Target, is willing to offer generic prescriptions to Medicare for $4 and this is below the terms set in PBM contracts with retailers and their captive mail order operations? Should Medicare refuse to intervene and allow PBMs to set plan reimbursements for generic drugs above prevailing market prices?

Medicare e-prescribing, like consumer directed healthcare, presents an opportunity to break-up the Big 3 PBMs' stranglehold on generic drug pricing [7] They key is to make drug prices transparent and give consumers the opportunity to make choices based on market prices rather than artificial co-payment differentials set by PBMs. One solution is to allow co-payments to be a % of "any willing provider" offer prices as long as such co-payments are below standard fixed dollar co-payments set by PBMs.

Notes:

(1) "Pre-Scribe Rx link changes hands again - Walgreen Co. to sell electronic prescription network to ProxyMed Inc," Drug Store News, July 14, 1997 Available at http://findarticles.com/p/articles/mi_m3374/is_n11_v19/ai_19597671

(2) **"**ProxyMed inks deals with two chains," Chain Drug Review, July 1997 Available at http://findarticles.com/p/articles/mi_hb3007/is_199707/ai_n8018025

(3) See company website at www.surescripts.com

(4) See company website at www.rxhub.net

(5) The Gorman Health Group, "Options to Increase E-Prescribing in Medicare", July 2007. Available at http://www.pcmanet.org/newsroom/2007/Documents/GHG-PCMA%20Options%20to%20Increase%20E-prescribing%20in%20Medicare%20July%202007%20FINAL.pdf

(6) Public Law 108-173. Medicare Prescription Drug, Improvement, and Modernization Act of 2003**.** Available at www.ustreas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf

(7) LW Abrams, "Pharmacy Benefit Managers as Conflicted Countervailing Powers," January 2007. LW Abrams, "Show Me the Display! A Review of an ESI Study of Consumer-Directed Pharmacy Benefits," July 2007. Both are available at http://www.nu-retail.com

Disclosures:

I have not received any remuneration for this paper nor have I any financial interest in any company cited in this paper.

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