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OPINION | REVIEW & OUTLOOK

Why CVS Loves ObamaCare

Medicaid expansion helps big business reduce competition. Ohio is a case study.

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By The Editorial Board
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Big business feasts on big government, and ObamaCare has been a bonanza for companies that have figured out how to exploit it. Witness how CVS Health is dining out on Ohio's Medicaid expansion.

In addition to retail pharmacies, CVS operates a pharmaceutical benefit manager (PBM) that acts as a middleman between insurers, pharmacies and drug manufacturers. PBMs decide which drugs are listed on a formulary, how much pharmacies are reimbursed and how much insurers pay.

Ohio contracts with five managed-care organizations (MCOs) to administer Medicaid benefits, four of which outsource their drug benefits management to CVS Caremark, the CVS PBM. The state uses drug claims data to set its annual drug budget. So if claims increase, the state will allocate more Medicaid funds for drugs the following year.

Yet CVS appears to be billing the state for far more than what it is paying pharmacies, driving up taxpayer costs. CVS's actual drug payments aren't transparent to the state or MCOs.

CVS is also attempting to drive independent pharmacists out of business and expand its retail market share. We spoke with eight current or former independent pharmacists in Ohio who complained that CVS has slashed payment rates below the pharmacists' wholesale drug costs. They say CVS is pocketing the increased "spread pricing"—that is, the difference between what the PBM pays pharmacies and charges the state.

The precondition for this Medicaid machination is ObamaCare. In the last decade Ohio's Medicaid enrollment has swelled by more than half to 21.4% of the state population, driven in large part by ObamaCare's expansion to people earning up to 133% of the poverty line. Medicaid is now the biggest insurer in many rural areas where independent pharmacies predominate.

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Independent pharmacists say they first noticed a decline in Medicaid payment rates three years ago. CVS slashed them further last fall. For 35 years Larry Hildebrand ran a pharmacy in Marengo, a town with a few hundred people. When he started to lose money from declining Medicaid payments, he sold his pharmacy to CVS, which bought his drug inventory and prescription files. After he closed, his customers had to travel 25 more miles to get prescription filled at CVS.

Dominic Bartone has been a pharmacist for 41 years and operated three retail pharmacies in Dayton and two in Lebanon. After CVS cut payment rates last fall, his Lebanon pharmacies were losing money on between 40 to 50 prescriptions a day. When Mr. Bartone complained to the MCOs about below-cost reimbursements, he didn't get a response. Eventually he had to stop delivering prescriptions to patients in institutions. In February he and his business partners sold the stores to CVS.

Most pharmacists don't want to be publicly identified because their CVS contract bars them from disclosing payment rates. But one said he was getting paid 18 cents per capsule of the generic antidepressant duloxetine while his wholesale cost is about 23 cents. According to Centers for Medicare and Medicaid Services data, PBMs in Ohio last fall were charging Medicaid $1.53 per duloxetine pill. The spread pricing for a 60 mg dosage of duloxetine during the first nine months of 2017 totaled $6.3 million.

Several pharmacists said that they were losing between $60 and $100 last fall on each prescription of buprenorphine, a generic opioid addiction treatment.

Ohio state Senator Dave Burke, who runs an independent pharmacy and serves on the state Joint Medicaid Oversight Committee, says two-thirds of the Medicaid drug claims he processes are below his drug acquisition cost. He's fortunate that Medicaid patients make up less than a quarter of his customers.

CVS payment rates, he says, are “take it or leave it.” Independent pharmacists have no negotiating leverage. If pharmacists refuse to accept Medicaid prescriptions, they risk losing CVS contracts for Medicare Part D and commercial plans that typically pay more.

Some pharmacists said that after the Medicaid payment reductions they received solicitations from CVS Pharmacy Regional Director of Acquisitions Shane Stockton saying: “I’m a pharmacist myself. I know what independents are experiencing right now; declining reimbursements; increasing costs, a more complex regulatory environments. Mounting challenges like these make selling your store to CVS Pharmacy an attractive and practical option.”

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In the last three years, Ohio has lost 164 independent pharmacies while CVS has added 68. A CVS Caremark spokesperson told us that the company maintains a firewall between its PBM and retail pharmacies as required by a 2007 Federal Trade Commission merger agreement. CVS also says it pays independent pharmacies on an aggregate basis more than chains, though the spokesperson didn’t define aggregate.

When Arkansas Independent Pharmacies obtained insurance explanation of benefits data from Medicaid patients, they found that CVS Caremark billed Medicaid plans more than twice as much on average as what their pharmacies got paid. Data from fully-insured commercial health plans showed that CVS paid itself over $60 on average more per prescription than independent pharmacists.

ObamaCare requires MCOs to spend at least 85% of all taxpayer dollars on patient medical claims and care improvements. The rest can be split among overhead, marketing and profits. Contracting with PBMs allows MCOs to off-load administrative costs and thus take more profit. Rising drug claims also let them pocket more money. Mr. Burke, the Ohio legislator, says this dynamic encourages a “don’t ask, don’t tell” relationship between PBMs and MCOs.

States ostensibly have an incentive to curb their Medicaid spending and scrutinize PBM payments. Yet many may be turning a blind eye because they can pass on the bills to the federal government, which picks up 63% of the costs for Ohio’s pre-ObamaCare population and 94% for the expansion population.

But as neighborhood pharmacies close, health-care access for low-income patients diminishes. That at the very least should concern politicians.

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