As the House and Senate move quickly forward on a new Medicare drug benefit, legislators are grinding out the bill’s language on the go. And that is how, if a bill finally passes—and chances now seem good that one will—the formulary requirements for the new program will get written without a great deal of contemplation. That is the reason some wags call Congress “the sausage factory.”

If the proverbial sausage does end up having a bitter aftertaste, however, the pharmacy benefit management (PBM) industry will bear part of the blame.

Detailed questions directed to the Pharmaceutical Care Management Association (PCMA) during the Senate and House mark-up of their respective bills were answered with generalities or not at all. E-mails to major PBMs such as Caremark and Express Scripts also went unanswered. Of course, it is possible that the association and industry stalwarts were working behind the scenes to ensure positive language; however, we will never know. It is worth noting, though, that the National Association of Chain Drug Stores, one of the PCMA’s main rivals, had a comprehensive statement on its Web site stating that the House bill was preferable and why this was so.

Certainly, major pharmacy network and formulary issues are up for grabs. In the case of the former, the retail pharmacy industry wants the networks to be unrestricted; moreover, the pharmacy industry doesn’t want PBMs to charge preferential, lower co-pays for drugs purchased by mail order. Right now, the House bill seems to be more sympathetic to the pharmacies than to the PBMs. The drug manufacturers want therapeutic formulary categories to be as narrow as possible because that would force PBMs to offer more drugs on their formularies.

This is what all the pushing and shoving within the pharmacy industry is going to be about as the House and Senate rush to complete their work by the August recess. Bills will be amended in committee, then on each respective floor, and then again when they go to conference. President Bush very much wants to sign the finished product, but no one knows whether he will object to the conference bill.

The Senate and House bills parallel each other in many respects. Both anticipate that insurance companies in various regions will be competing with one another to provide drug plans to Medicare beneficiaries. Most beneficiaries would remain within the conventional fee-for-service program. They would simply purchase, if they wished, a separate drug plan from an insurance company.

Some senior citizens would be moving into preferred provider organizations (PPOs) chiefly because of their better coverage of preventive services, lower deductibles, and additional services not offered by fee-for-service plans. The PPOs would provide the drug plan, again, via the regional insurance companies. PPO members would have the same choice of drug plans at the same price as what is offered in fee-for-service plans in the same region.

As for the construction of the plan, the Senate and House are headed in similar directions. As an example, retirees might pay $35 a month, for which they would receive approximately 50% to 80% of their first $3,000 in annual drug costs, paid for after an annual deductible of perhaps $300.

Again, the insurance company would contract with a PBM, which would construct a pharmacy network and a formulary based on the plan sponsor’s dictates; some aspects of both, though, would be mandated by federal law. The Senate’s committee bill says that all plans would have to include within their networks “a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access.” From a PBM standpoint, nothing is too objectionable about that language, although one might envision some pulling and tugging between pharmacies and PBMs when it comes time for the federal government to define “convenient access” and “sufficient numbers.”

The Senate bill’s language on formularies also seems standard. The plan would have to offer drugs, but it doesn’t say how many (which might also be controversial when the Medicare program writes the rules for the program based on the bill) in all drug classes. Those classes would be defined according to listings in the U.S. Pharmacopoeia and other recognized sources of drug classifications and categorizations as the Administrator determines to be appropriate.

Finally, the particulars of the Senate and House bills would differ on formularies and networks. How those differences get sliced will dictates how this particular piece of congressional sausage goes down. ■