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Corporate Policy Makers and Drug Dealers: A Perspective on the Toxic Predicament of American Healthcare

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Corporate policy makers and drug dealers: a perspective on the toxic predicament of American healthcare

Chelsea Caterino Bonfiglio

Who writes your prescriptions? Your doctor, or your insurance company? Who is in charge of filling those prescriptions? Your pharmacist, or the company that manufactures them? This paper is a comprehensive look at healthcare delivery in America in 2010, and why it is that the people we train to take care of us don't hold the reins.

The American health care delivery system is in shambles. We spend more money per person than any other country, more than double our closest competitor. Many doctors don't listen to their patients as thoroughly as they should and spend very little time with them, that is if you can get in to see a doctor when you really need to. We are facing a primary physician shortage in the face of the aging baby boomer generation. Pharmacists are becoming drug dispensing factory line workers with no time to truly counsel patients one-on-one. We have extremely high rates of chronic conditions and we are not treating them properly. A recent survey showed that only 16% of Americans are happy with the healthcare system. And, these are only a few of the issues with the current system. The question is, why? Why is our system ailing? When we spend so much per person, why do we still have much higher chronic disease rates and lower satisfaction rates? This paper will attempt to answer these questions.

In order to diagnose the cause of a disease, you first have to understand it. The American health care delivery system is controlled by a dangerous triad; the government, insurance companies, and drug manufacturers. These three entities are caught up in a love triangle that has put our health care system in its current predicament. Insurance companies'

and drug manufacturers' corporate job is to work together to find a way to make the most profit, and they have devised ways to pay off the political powers to allow them to do this in ways that are illegal for most businesses in this country. So, here is my number one question: who do you want writing your prescriptions, your doctor or your insurance company?

Insurance Companies

If insurance companies were working the way they were supposed to, they would make a small profit off of every person they insured to cover the price of doing the paperwork and handling the money. Instead they are making a massive profit, as can be seen in their corporate salaries. In 2008, Aetna's CEO, Ronald Williams made $24,300,112.00. That's $467,309.86 a week. He makes a house most of us would be more than happy to own, every week. Cigna's CEO H. Edward Hanway made $12,236,740.00. Humana's CEO Michael McCallister made $4,764,309.00. The lowest of the major health insurance CEOs in 2008 was U. Health Group's Stephen Hemsley who came in at a modest $3,241,042.00. Just in case you feel bad for him, he still made $62,327.00 a week (Ricciardelli, 2009). So how is it possible for insurance companies to make these profits? Here is where that dangerous triad I mentioned earlier comes in.

Insurance companies are the head of this triad. Insurance companies are supposed to be a tool for the consumer to spread the risk of health care crises. We pay X amount every month so that if we break a leg, or get cancer, we can get the treatment we need. Anyone that has ever had to deal with an insurance company knows that this is not how it actually works. It is a huge for-profit industry. We pay high rates and deductibles for treatment and prescriptions, but when it comes to getting the help we need the insurance companies main goal is to get out of paying for it. Finding loopholes in their own contracts is only one of the ways that insurance companies maximize profit. They also choose which drugs they will cover, and they force practitioners into take it or leave it contracts.

Here is a rundown on how our current insurance system works, starting with Medicare. If you are eligible, you have Medicare, and you can add a Medicare Supplement if you want to pay for it. If you aren't eligible you can get insurance through your employer, pay for your own, or go without and take the risks. Medicare covers people over the age of 65, some people with disabilities under 65, and all people with End-Stage Renal Disease (Medicare, 2009). It pays a percentage for most procedures based on the national average cost for that procedure, how much healthcare workers in your area are paid, and whether or not you are having multiple procedures at one time (Medicare, 2009).

Medicare part D is the prescription drug part of the Medicare legislation. It was designed by and is run by the private insurance industry but is paid for by the federal government – we the people. For covered drugs, Medicare pays 75% of a patient's costs after a $310.00 deductable has been met and up until $2,830.00 has been expended in total drug costs. After this, no more is paid for by Medicare D until another $4,550.00 has been spent. This brings the total out of pocket amount to $6,440.00 plus the patient must continue to pay the monthly premiums to the private insurance company – yes, the private insurance company, not the government. From this point on it pays 95% of prescription costs through the end of the calendar year. You can change plans every year but only between November 15th and December 31st but, if you do not lock in a plan at this time you will either be stuck with your old one, or you may be changed to a different plan by the government and your local pharmacy may not be in this new plan (Medicare 2010). Lastly, if you choose not to join a plan when you are first eligible, when you do choose one you will be charged an additional penalty on top of each monthly premium for choosing one late (David Bonfiglio, R.Ph).

If you have independent insurance through your employer or yourself, you pay a premium for a chosen plan and that plan covers some set amount of your costs. If you choose a plan with a lot of coverage and a low deductible, you are going to get more widespread coverage with a higher roof (maximum

allowed/year) and a higher cost and vice-versa if you choose a lower coverage plan with a high deductible. What does this mean for your doctor and pharmacist? If you go to the doctor or to get a prescription filled, you hand over your insurance card and the office or pharmacy bills your insurance company. Your insurance company sends a check for the amount they say they will pay in your contract and you may be billed the remaining balance up to the amount the insurance allows with the provider taking a loss on the difference.

Now this all seems generally fair. You choose your plan and are covered accordingly. The problem is that this is not how it works. Insurance companies have changed. In its infancy, insurance was a way to "spread the cost" so to speak. Insurance works off of what is referred to as the 80/20 rule. This means that in an average calendar year, 20% of the people covered by any company account for 80% of the expenditures, and the remaining 80% of people account for the remaining 20% of costs. So, in any given year the majority of the population pays for the costs of the few. So you really pay most of your own medical bills, you help other people out when they need it, and they help you out when you do. Insurance has morphed from being an entity to help spread heath care cost risks to a business whose main goal is to make money, and they are very good at finding ways to do it.

There are several important steps that insurance companies have devised to not only allow them to pull in these large profits, but to ensure that no one stops them. The first is that they contribute large sums of money to both sides of congress to make certain their voice is heard above all others so the government will pass legislation that is favorable to them. They have convinced our government to pass laws that exempt them from the consumer protection laws in our country that all other businesses must adhere to. This is where we get into the politics side of the story. There are four times as many health care lobbyists as there are members of congress (Beckel, 2009). The health care industry gave 14 million dollars in 2004 to the eleven elected officials who are largely credited with negotiating the Medicare Part D bill. More than three million of that came from big pharmaceutical company PAC's, their families, and employees (CAF, 2004). According to the Congressional Budget Office, the Medicare Part D plan is projected to hand out $848 billion to the drug industry and health insurance industry over the ten-year period of 2006-2016 (CUSCBO, 2007). In the third quarter of 2009, the pharmaceutical and health product industry spent $65,689,497.00 on federal lobbying, up 12.6% from the same time the year before (Beckel, 2009). And, what happened after the bills they wanted were passed? Directly after Medicare part D was passed, fourteen congressional aides went to work for the health insurance lobbying industry. One of the major ones is Billy

Tauzin. Billy Tauzin spent several years as the chairman of the House group that oversees the pharmaceutical industry. It oversees their budget, makes sure they are following the rules, etc. After serving a major role in passing the Medicare Part D bill, he took a job as the president and CEO of the health insurance industry's top lobbying group for a payout of $2 million a year. Who knew that being a health insurance lobbyist could pay so well? The bill that they wanted passed, Medicare Part D, has become one of the major issues in doctors frustration picking a drug treatment plan and pharmacists not being paid what they bill.

The main government influence that allows insurance companies to do as they wish and make these obscene profit margins is an exemption to antitrust legislation. Antitrust law is legislation that is meant to regulate trade and business though prevention of monopolies and price fixation. It was enacted to promote competition and ensure that consumer demands would be met though production of quality goods and services at the lowest reasonable prices (Lehman & Phelps, 2005). Essentially, antitrust law is meant to govern American business to make sure they behave. Its foundation is the belief that fair trade and competition benefit the economy, businesses and the consumer (Lehman & Phelps, 2005). The MaCarran-Ferguson Act passed in 1945 provides that state law will govern insurance companies, and that federal law will not invalidate state law unless the federal law

specifically relates to the business of insurance. In short, it allows the 'business of insurance and every person engaged therein' exemption from federal antitrust legislation (Lehman & Phelps, 2005). What this means to those of us that aren't lawyers; insurance companies aren't governed by the law that protects us from unfair price fixation and monopolization of business. Most of the businesses in America are subject to this law, meaning that they cannot team up and fix prices at whatever they please to make the most profits. The exemption of insurance companies from this law allows them to do just that, and is one major way in which the interaction of insurance and politics has become unhealthy.

Another method that insurance companies use to maximize profit is getting out of paying claims. You see, even the fully insured average American is not actually safe, because the first thing that your insurance company will do when you submit a claim is try to find a way out of paying it. Top insurance companies, including Aetna, Blue Cross Blue Shield, Cigna and PacifiCare give bonuses to employees who were able to deny the most claims, and found excuses to fire those who were not. In the first six months of 2009, PacifiCare denied 36.9% of their claims. Cigna denied 32.7%, and HealthNet denied 30%. They deny claims calling procedures "investigational" or "experimental, even if those procedures have been passed by the FDA (NNM, 2009). One of their number one reasons for refusal is the use of pre-existing

conditions. PacifiCare's list includes 150 pre-existing conditions including diabetes, cancer, obesity, ADD, Acne, and "Expectant Father". So when you submit a claim, your insurance company will dig through your history, trying to find any thing possible so that they can deny it. If you need a major surgery, and your health insurance company finds out that you were an expectant father before you signed up (they define what this is) they have the right to terminate your claim. And, of course, this is all in your contract (PacifiCare, 2003).

While working for True Care HMO in Oklahoma, Bill Geserick, M.D. was told by the board of directors to try not to order any CT Scans. A CT Scan (or CAT Scan) is a Computed Axial Tomography test that is used to take a high tech x-ray picture. It looks for abnormalities such as cancer in the body. The doctors were told that they were over budget for the next couple of months, so, if they could order as few CT scans as possible, that would be great. These are tests that could catch cancer, but the insurance companies priority awas their bottom line.

Now, this is all assuming you are lucky enough to have health care coverage. There are around 50 million Americans who are currently uninsured. According to the Center for Disease Control and Prevention's estimates from the National Health Survey in 2006 there were almost 50

million Americans without health insurance for at least a portion of the year (CDC, 2006). To add to these numbers, the number of uninsured is rising every year as the cost to insure oneself continues to increase. There was a 2.2 million person increase in uninsured between 2005 and 2006, adding to an overall almost 8 million increase in the total number of uninsured in America between 2001 and 2006 (Leighton, 2007). The most recent data shows that in 2008, the total number of uninsured Americans was 15.4%, or 46.3 million (Sherman et al., 2009). Most of this increase has been due to a decrease in employer-based healthcare coverage, a fact that has much to do with the increase in insurance company premiums and overall costs accompanied by the economic decline. The U.S. government is attempting to slow this growth in the total number of uninsured through an expansion of public insurance options (Sherman et al., 2009). The increase in premiums goes back to that antitrust legislation exemption; our government needs to take some steps to introduce more competition into the industry, in order to lower these prices.

Drug Manufacturing Companies

Up until now we have talked about two thirds of the triad, so where do drug manufacturers come in? IMS health is a private company that collects and sells information on the pharmaceutical industry worldwide. According to a report done in May 2008, there are 20 major drug-manufacturing

companies in the world. The following are the top five, with their profits. AstraZeneca comes in at number five with US sales of 15.47 billion. Johnson and Johnson was number four with US sales of 16.28 billion. Number three in 2008 was Merck and Co. with US sales of 17.64 billion. GlaxoSmithKlein was number two with 20.14 billion in US profits, and coming in at number one in 2008 was Pfizer, making 23.52 billion (MM&M, 2008). Pfizer is the manufacturer of the popular drugs Celebrex, Lipitor, and Viagra.

Again we find ourselves looking at a for profit industry that is making too much money, and has too much influence in how our healthcare system is run. So how do drug manufactures make their billions? Well, they sell drugs. In truth there is much more to it than a simple drug deal though. Companies like Pfizer employ all shapes and sizes of people to get from a promising chemical to a possibly life saving drug. It is neither a short road nor an inexpensive one. According to Pfizer's website, it takes 6 - 15 years and between 800 million and 1.7 billion dollars to develop a new medication and bring it to the market (Pfizer, 2010). The first step in drug research and development is getting a patent. This allows the drug company exclusive access to a specific chemical formula, generally for about seventeen years. This is where their researchers can get to work. They start with a chemical that their scientists believe has medicinal potential and it is developed into an experimental drug. It then goes through very rigorous clinical testing before

it is released on the market. So making drugs isn't cheap, but that doesn't mean that the price of medication is fair. According to Marcia Angell, M.D., the price of the popular allergy prescription Claritin was raised thirteen times before its patent ran out, for an increase of over four times that of inflation. This is definitely not an abnormal story. Drug companies have exclusive rights to the chemical in their patent for around seventeen years, so if it takes around 7-10 to develop a satisfactory drug, they have the next 7-10 years to set the price at whatever they want. The markup of non-generic prescriptions is an outrageous percentage, but if you are sick and there is only one company making the medication you need, you have no choice but to pay their price. And, even if there are multiple brand name options, they are all priced in the same ballpark to ensure these same profits for each company. In 2006, GlaxoSmithKlein (GSK) was sued for price inflation. In a nationwide class-action settlement, GSK agreed to pay 70 million dollars to cancer patients and plans that were overcharged for eleven of their medications (Prescription Access Litigation, 2007). This is just one example of many telling the same story. 70 million dollars is a lot, but it's nothing to a company that can make over 20 billion dollars a year by continuing the practice.

Drug companies are similar to the insurance companies in that they have several methods that they use in this money making game. The first is

massive markup on patented drugs. The second is scamming with the insurance companies. Here is where we see the love triangle of insurance company, government and drug company completed. Here is what happens. A drug company comes out with a new medication for heartburn. They call up their buddies over at their favorite big insurance company and make a deal. If the insurance company will force everyone they cover on heartburn medication to switch to their new drug by putting it on their formulary and making it very hard to get any other drug, the drug company will give them kickbacks. In other words, the drug company pays the insurance company to switch a lot of the people they cover to their new drug. Your doctor has very little say in it. Your doctor has to change the medication, jump through insurance company hoops with the hopes of getting a prior authorization approval or you may choose to foot the bill yourself. According to Bill Geserick, M.D., this happens all the time. "I can have an elderly patient that has been on the same medication for years and years, and the insurance company all of a sudden just stops paying for it and tells me to switch him/her to the new drug. They don't care that the new one might not work as well, or what possible side effects there may be in switching medications on a 70-year-old woman, they're in it for the money. (Bill Geserick, M.D.)"

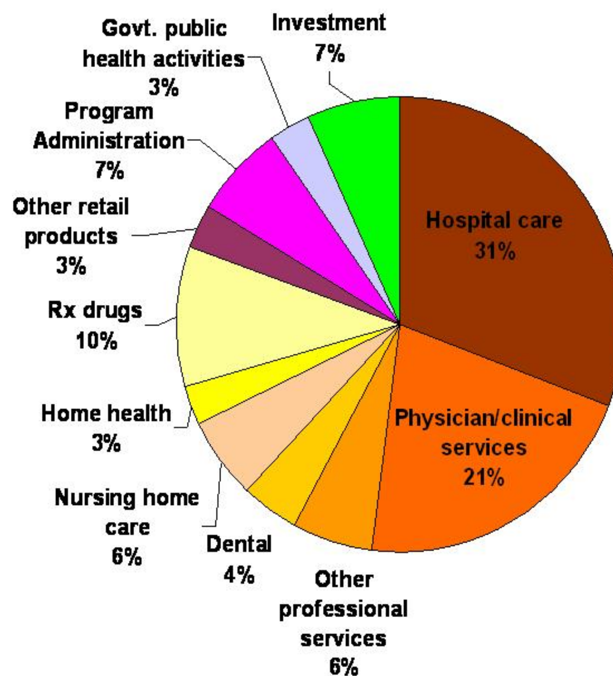
Another one of the main methods that drug manufacturers use is direct to consumer (DTC) advertising. This is the practice of advertising new drugs

to the consumer, instead of the doctor and pharmacist. From 1997 to 2005 the amount of money spent on DTC advertising nearly quadrupled, going from 1.1 billion spent in 1997 to 4.2 billion spent in 2005. (Huh & Langteau, 2007) In an article published by the Public Library of Science, it is shown that pharmaceutical companies spend nearly twice as much on advertising annually as they do on research and development. (Gagnon & Lexchin, 2009). Why would they spend so much money on DTC advertising? Because it works. Consumers see a well-advertised drug on T.V. and decide that it will fix their problems. They march into their doctor's office and demand a prescription for an ailment that they very well may not have at all! What is the point of someone going through the time and money and stress it takes to get through medical school if everyone can just decide what they need to take based on a commercial?

Marcia Angell, M.D. is now a chief lecturer at Harvard Medical School after stepping down as Editor-in-Chief of the *New England Journal of Medicine* in 2000 (Huffington Post, 2010). In an article published in the New York Review in 2004, Angell revealed that the American population spends $200 billion dollars on prescription drugs every year, and that is a number that is increasing by 12% annually (Angell, 2004). Prescription medications are the largest portion of the tab that Americans pick up out of pocket for healthcare (Angell, 2004). It surpasses visits to the doctor's office and pricey tests, even

ambulance rides and all the extra fees that come along with an unfortunate hospital visit. And yet, as a percentage of U.S. health care expenditures in 2008, prescription costs are still only 10% of the total (U.S. Center for Medicare & Medicaid Services). When you pile all these costs together and take into account the earlier discussion about the increasing problems with health insurance, the reasons for our population's suffering health and lack of pocket change aren't so ambiguous.

National Health Expenditures (CMMS, 2009)



This whole time I have been talking about the insurance, drug manufacturer and government triad as the main cause of the current downfall. Now I am going to switch to a new triad to explain the place this has put the little guys in - the doctor, the pharmacist, and the patient, and what I

think we can do to turn this situation around. We are facing a shortage of primary care physicians as we stare down the throat of the aging baby boomer generation. More and more independent pharmacists are throwing in the towel and going to work for big companies like Wall-Mart because they just can't make ends meet anymore. As a patient you get to see your doctor for 10 minutes maybe, and soon there won't be any more independent pharmacists to sit down and talk to you about your medication questions, an alternative therapy or which products or supplements you can take for the pain in your joints.

The little guys

So how does all of this affect the practitioner, and therefore the patient? I earlier discussed the fact that insurance companies try to get out of paying all together as a way to raise their bottom line. Another way in which they do this is by requiring prior authorizations. When you sign a contract with an insurance company you agree to pay them monthly premiums, and they agree to pay your medical bills in whatever capacity is outlined in your contract. Fairly cut and dried right? So what happens when your doctor prescribes a test or drug that they don't want to pay for? They require prior authorization. Insurance companies instituted prior authorizations supposedly to lower costs and increase quality of care. What they actually

translate into is one more way your insurance company can get out of or delay payment. This is how it works: You go to your doctor with abdominal pain. Your doctor orders the necessary tests to diagnose the problem. Before those tests can be run, the doctor must send a form to the insurance company asking their permission to run these tests. It may take anywhere from 24 hours to a week to receive a reply. Meanwhile, you are waiting for a very important test. Because of this step, your doctor has had to hire someone to do all of this prior auth. paperwork, spending valuable time and money. You have to wait for their permission though because, if you go ahead and get the test, your insurance may not cover it. Even if it could be approved with a prior auth but you didn't get one that is reason enough to deny your claim. If you have cancer and need chemotherapy, you may not be able to get it without first asking permission from your insurance company, or they won't cover it! (Bill Geserick, M.D.) The doctor wastes money paying someone to jump through the insurance paperwork hoops, while the patient is getting sicker waiting on their insurance. If they do finally come through and pay, it could be up to six months or a year later that the doctor gets their money! So I ask again, who is controlling your healthcare, your doctor, who spent over ten years in training to learn how to best take care of you, or your insurance company?

Not only are insurance companies increasing the cost of doing business for doctors and pharmacists, they don't pay what they are billed. Two to six months after your doctor billed for a test or your pharmacist billed for a prescription and after much paperwork and hassle, they might finally get paid. Minus 20% of what they billed. On average, insurance pays 20% less than they are billed. You see, the patient is not the only one forced into contracts with insurance companies. Your doctor and pharmacist also have to enter agreements with them, or they can't see or fill prescriptions for anyone covered by that insurance. Not only can your insurance company dictate what drugs your doctor can prescribe to you and what tests they can order, they can also dictate what doctor or pharmacist you get to use. Insurance companies have a list of approved providers that you are allowed to see. That is, you can see anyone you want, but if they aren't on the list your insurance won't cover it. So in order to keep their patients, doctors and pharmacists are required to sign contracts that are usually non-negotiable with these companies dictating what they will reimburse for any one service. General healthcare markup is 50%, meaning that 50% of whatever the doctor bills goes to covering overhead, and the other 50% is profit. Insurance companies pay the billed amount discounted 20%, cutting profit to 30%. Medicare generally pays 50% of what is billed – no profit made. Medicaid, which mainly covers the elderly, pays 40%. Your doctor and pharmacist are now losing

10% with every transaction. (Bill Geserick, M.D.) According to Dr. Geserick, it's just not even worth the time, stress and money to track down the little bills. Consider this scenario: a service costs $50.00 to perform, and $100.00 is billed. $15.00 is spent paying someone to do the paperwork for the transaction, and finally $80.00 is paid. The doctor just made $15.00 on the time they spent. "I retired early because I was so sick of dealing with all of the crap, of jumping through ten hoops to schedule a CT scan for someone who needed it and then not getting paid for it. It is so frustrating trying to make any profit that it is not worth doing something that we once loved doing." (Bill Geserick, M.D.)

With these lower and lower profit margins, the only way for doctors to increase profit is to see more and more patients. This has contributed greatly to the decrease in quality of care seen today. Doctors are forced to trade quality of care and time with patients to try to make ends meet. That $15.00 per patient visit that the doctor receives won't add up to much if they give each patient the time they deserve and thus only see an average of 3-4 patients an hour. When you add unpaid time to research the patient's symptoms and decide on a treatment regimen plus do the dictation and other required work plus pay the bills to keep the office going, the doctor wouldn't make enough to stay in business. All of these reasons, along with the stress and annoyance that is added by DTC advertising pushing patients to tell the

doctor which drug they need, it is no wonder that more and more general practitioners are getting out of the business and less are coming in. The average medical student graduates with $140,000.00 in school debt. (Pear, 2009) New doctors are choosing to specialize instead of going into general practice in order to try to make more money. Fewer and fewer new doctors want to deal with all of the nonsense and frustration that comes along with being a family doctor in today's society – so they don't. Now the question is; who is going to take care of the baby boomers as they age and need care?

That explains much of the impact on doctors, but what about pharmacists? Pharmacists are affected just as negatively by the re-imbursement issues earlier outlined, but they have other issues all their own. Independent pharmacists are a different kind of health care provider. They exist to not only fill prescriptions, but to give advice on the medications, how to take them, when and with what to take them or what to avoid, helping to keep them from extra visits to the doctor or potentially from unnecessary drug related hospital visits. My father owns and operates an independent pharmacy in a small town high in the Rocky Mountains. I have spent the past 5 summers working as a pharmacy technician there, watching and learning from him. Patients from all over northern Coloradoand even some around the United States come to my dad for all sorts of advice on everything from aching backs to acid reflux. As a small town pharmacist, my dad helps people

with their ailments by not only providing their prescription drugs but also providing advice on natural remedies for just about everything. He tries to spend time with every patient that comes in or calls on the phone explaining anything that they might need to know about their medication, and answering any questions that they have about their treatment regimen. He fills their prescriptions and makes sure that there aren't any possible drug interactions with everything else they are taking. He switches them to a generic where he can, anything to save the customer money. Out of all of that, the only thing he gets paid for is filling the prescriptions, and that amount gets reduced every year by insurance company contracts. My dad is currently trying to negotiate a contract that has a clause saying his pharmacy will receive a lower percent reimbursement every year for the next 5 years. Whose business costs are going down every year that you know?

Pharmacists get paid a certain amount for every prescription they fill, a price that is usually predetermined in the aforementioned contracts. Accordingto Paul Marva, R.Ph., he gets paid anywhere from .50 cents to 3.00 per prescription filled. This doesn't take into account the cost of the bottle, the cost of the label or all the other costs of being in business.

Another problem is that pharmacists are losing customers to insurance companies dictating where their clients can get their prescriptions filled.

Some insurance companies and large employers are starting to force their customers to either go mail order, or visit specific pharmacies. CVS-Caremark is one such example. In 2007, CVS, one of the country's largest pharmacy chains, bought Caremark, which is one of the largest pharmacy benefit firms. Pharmacy Benefit Managers (PBMs) are companies that work for insurance companies. Big insurance companies who handle thousands of companies and patients' claims hire a PBM like Caremark to handle all of their prescription claims. The PBM then becomes the middleman entity between pharmacies, drug companies and insurance companies. When a pharmacist fills a prescription and bills the insurance, it goes to the PBM. The PBM pays all of the pharmacy claims to all of the pharmacies and then bills the insurance company in one large bill. In addition, PBMs use this volume of prescriptions to make deals with drug companies to get kickbacks for steering patients to their drugs, and then tell doctors and pharmacists what drugs they will cover. They also handle prior authorizations and all of the other paperwork. The PBM charges the pharmacist a fee on every prescription filled plus charges the insurance company for their services. They often pay the pharmacy one price, say $80.00 for a prescription, but bill the insurance company or business client a higher price, say $110.00. The pharmacy makes $4.00-$8.00 for filling the prescription while the PBM makes $20.00-$30.00 just for processing the claim (David Bonfiglio, R.Ph.). The government authorized

merging of CVS and Caremark gave CVS an unfair trade advantage enabling them to force thousands of patients to get their prescriptions filled at CVS pharmacies only. They can do this because Caremark has access to thousands of patients through all of the insurance companies it works for. They use this access to turn around and send letters to all of those people stating that they either get discounts if they choose to go to a CVS, or actually force them to if they want their medications paid for, regardless of how much they like their local independent pharmacist or how far they have to drive. (Paul Marva, R.Ph.) This is not the only problem. These PBMs also work closely with and actually own some of the mail order companies that their patients plus other people are forced, or coerced in some cases, into using. Often times the mail order pharmacies give kickbacks to the PBM's or insurance companies for all of the patients who are shifted to their businesses. The result, insurance companies and their associates are getting richer and richer, while community pharmacists lose more and more money and business.

For independent pharmacists trying to cover overhead costs, it is getting ever harder to make ends meet. If you google search "independent pharmacies going out of business" you will get pages of links to small community pharmacies that are closing their doors once and for all due to all of the aforementioned problems. They just can't cover their overhead anymore with the way the system is run.

We have stripped control of our country's health care delivery from those who are trained to provide it and put it in the hands of those who care about nothing but making a profit. We have lost all sight of patient care and independence. The practice of medicine in this country that was once driven by the desire to increase quality of care is now driven by the desire to make more money. The interplay of the government, insurance companies, and drug companies has skillfully managed to bind the hands of our healthcare experts and bypass them on the highway to fortune. We have turned our healthcare delivery system into a nightmare. Doctors are retiring early and specializing to avoid it. Independent pharmacies are closing down left and right because they can't survive it. If we don't act to change something soon, we are going to turn around and find we have nowhere to go except large chain pharmacies that don't care about anything but money. We will have no general practitioners to see when we get sick or to handle the care of our families, our elderly and infirm. Our wait times for all of these services will increase drastically. This is not a problem, it is a crisis. So how do we fix it? We put the reins back in the hands of our healthcare professionals, and force insurance and drug companies to take a back seat and operate under the same rules as every other business in this country. We force the insurance companies to do what they are supposed to do, which is to spread the risk and process and pay claims. We allow the doctors, in conjunction with the

pharmacists and the patients, to choose the best and most cost effective drug therapy for each situation. We inject true competition into the insurance industry so their incentive is to streamline the process and make it simple and easy to understand and thus less expensive. In short, we stop allowing corporate insurance and drug company money to influence the decisions that our government makes regarding the healthcare of our nation. We must let our doctors write our prescriptions and our pharmacists fill them.

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