



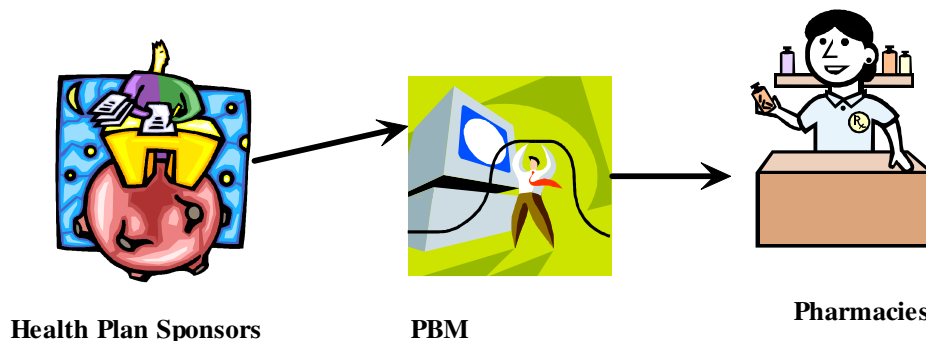
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What are PBMs?

Most health plan sponsors – employers, HMOs, insurance carriers and others – provide a prescription benefit as part of overall health insurance coverage. Because of the increasing size and complexity of pharmacy benefits, many plan sponsors contract with companies known as Pharmacy Benefit Managers (PBMs) to administer the process for them.

PBMs are third-party administrators of prescription drug benefits. They handle such administrative tasks as collecting funds from health plan sponsors and using those funds to pay providers, processing claims; answering questions posed by pharmacists, doctors and health plan participants; and negotiating with drug companies. They operate mail-order pharmacies which they force an increasing number of plan participants to use. PBMs have become a dominant, rapidly growing force in the pharmacy industry.



Three PBMs control about half of America's prescription drug transactions: Medco, Express Scripts and Caremark. They have become a lightning rod for controversy because of business practices described below.

Moreover, while PBMs represent themselves as prudent managers of drug benefits, prescription drug benefit costs to health plans are doubling every five years. At the same time, the major PBMs enjoy robust profits. Their business model yields incredibly high margins, largely at the expense of their customers, their recipients and their pharmacy providers.

How did PBMs begin?

Pharmacy Benefit Managers initially were formed in the 1960s when prescription drug benefits became available to employees, retirees and their dependents. The first significant medication benefit began in 1970 under a collective bargaining agreement between the United Auto Workers and vehicle manufacturers. At the outset, PBMs were simply pharmacy third-party administrators, manually processing paper claims for a per-claim fee.

How has the industry evolved?

PBMs have evolved into a potent industry that has changed the face of pharmacy and made the large PBMs extremely profitable. For example:

- PBMs now manage about 75% of all drug claims.
- Claims processing is fully automated. Pharmacies submit claims directly from in-store computers and they are processed online by the PBMs, typically in less than five seconds. In most cases, the pharmacy receives payment from the PBM about a month after the prescription is filled.
- While there are about 100 PBMs, three dominate the industry and manage over half of all retail prescriptions.
- The growth of PBMs has had a profound effect on the economics of retail pharmacy. PBMs have used their marketplace dominance to ratchet down reimbursements, resulting in significant savings to health plan sponsors – at the expense of drug retailers.
- All of the large PBMs are huge, publicly traded firms. There has been considerable consolidation.

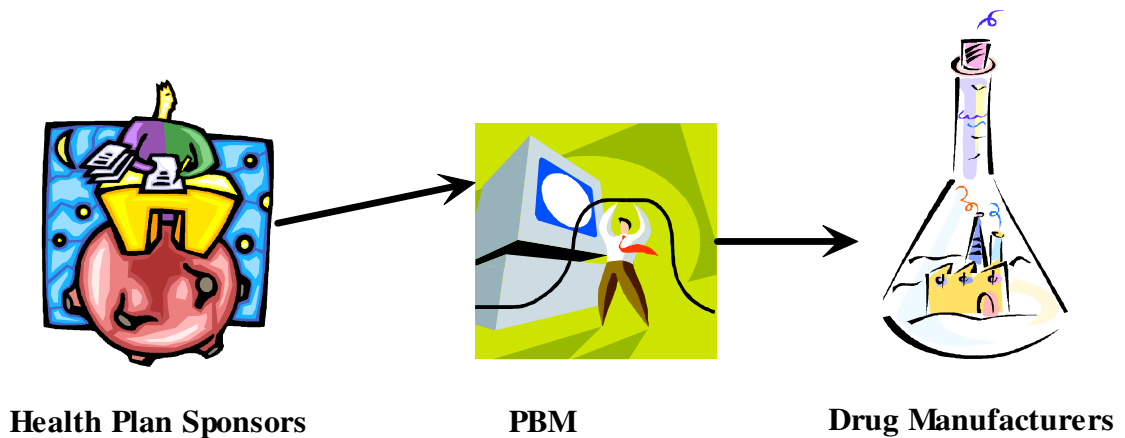
How have PBM services evolved?

While PBMs continue as pharmacy claims processors for plan sponsors, they have evolved into something more. Some years ago they decided to act as principals in managing prescription claims, to enable them to show ‘top-line’ revenue for these claims. Accordingly, many believe the PBMs now act as fiduciaries. But PBMs, as a rule, refuse to accept this responsibility because acknowledging this expanded role would sharply curb many of their highly profitable business practices. This issue is at the forefront of much of the litigation aimed at PBMs.

PBMs also perform a wide array of expanded services. These include:

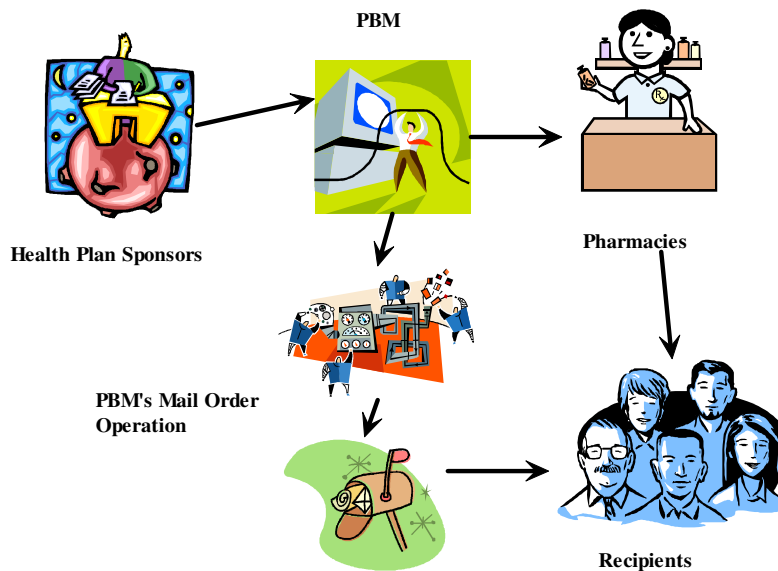
- **Clinical services, such as Drug Utilization Review**

Clinical services involve controls on adverse drug reactions, fraud and abuse controls, limits on the amount of drug that can be dispensed at one time and more. Critics say these services encroach on the practice of pharmacy, and a number of states have considered regulating PBMs through their Boards of Pharmacy.



- **Formulary and rebate management**

Simply put, a formulary is a list of drugs that are covered under the benefit provided by the plan sponsor. PBMs negotiate with drug manufacturers to include or exclude their products from such a list. Manufacturers pay rebates to the PBM for the privilege of including their drugs. Typically these rebates are based on helping a drug company reach a particular share of the market for a given therapeutic class. PBMs share some – but not all – of these rebates with plan sponsors.



- **Mail order pharmacy**

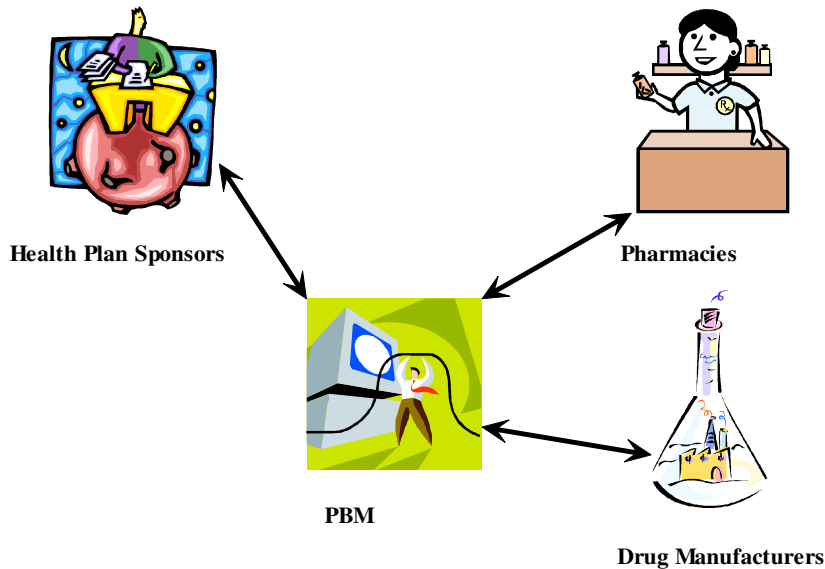
PBMs learned that by operating mail order pharmacies, they could become both managers and providers. This lets them skew benefit design and pricing in ways that maximize profits. *Nowhere else in health care is the benefits manager also allowed to be a provider. This lack of checks and balances is akin to allowing the coach to also be the umpire!*

All large PBMs own and run mail-order pharmacies, which have become vital profit centers that account for about 20 percent of all retail prescription sales in the United States. PBMs have convinced their customers that MOPs can achieve significant savings through automation.

The growth of the PBM mail-order business is remarkable since they can fill only prescriptions for what are called “maintenance” drugs taken for chronic conditions. Because there is typically a two-week turnaround between order submission and receipt of shipment, prescriptions for antibiotics and other acute care drugs can be filled only by community pharmacies.

By being both manager and provider, PBMs find ways to promote themselves and maximize profits. Typically, they design the payment system so that plan sponsors often experience higher unit drug costs by mail than from the community pharmacies.

Mail order pharmacies are regulated by almost all states. Interstate commerce laws leave the state powerless to stop mail order pharmacies located elsewhere from shipping drugs into the state. To be sure, virtually all states have promulgated regulations to provide them with some oversight of the out-of-state mail order operators



Note that the PBM controls each of these relationships and that they have no contact with one another, except through the PBM!

Why are PBM business practices increasingly being scrutinized?

As publicly owned firms, PBMs focus on increasing shareholder value. This has encouraged them to develop a number of tactics that increase their profits at the expense of health plan sponsors, recipients and providers. In times of skyrocketing healthcare costs, such practices are viewed with increasing suspicion. These practices include:

- Paying providers at a lower price than the PBM charges health plans. When this happens, the PBM pockets the difference.
- This ‘spread’ between PBM payments to pharmacies and billings to health plans is most evident for generic drugs, where the PBMs have separate pricing rules. In effect, PBMs have a ‘Billing-MAC’ and a ‘Payment-MAC’. The difference is often several dollars per claim.
- Selling detailed claims data on prescribing and dispensing history. Drug companies often use these data to target sales efforts to prescribers.
- Soft-money or rebate arrangements under which drug makers provide economic rewards that PBMs don’t share with plan sponsors as part of the rebate split.
- Formulary and rebate arrangements that are skewed by the PBM to favor more expensive products, simply to provide higher rebates to the PBM.

PBMs sometimes engage in practices that not only are ethically questionable, but also may be illegal. As a result, they have been subject to several class-action and whistleblower lawsuits.

There is a push to require PBMs to become more transparent in their business practices. Purchasing coalitions have been formed for this purpose and several states now mandate more open business practices. In addition, there are now a number of new PBMs that operate with full transparency and at much lower costs to plan sponsors.

Finally, many health plan sponsors are becoming smarter in dealing with PBMs. They are negotiating better agreements and are auditing the performance of their PBMs. These audits are generally 'productive' in that there are significant recoveries, due to errors in pricing, coverage parameters and more.