NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

PBM Revenue Streams & Lack of Transparency

Pharmacy benefit managers (PBMs) are middlemen that design, negotiate and manage prescription drug benefits for a variety of health plans, including large organizations such as employers, unions, insurance plans and the government. PBMs wield significant power in the healthcare market by determining the details of prescription drug benefits available to patients through their plans. For instance, PBMs develop formularies (i.e., lists of covered and preferred drug products), negotiate discounts and rebates with drug manufacturers and establish plan networks that mandate how, when and where patients fill their prescriptions (for example, a 90-day supply through the PBM's mail order facilities or a 30-day supply through the patient's neighborhood pharmacy).

Since 2000, the number of PBMs has declined significantly and market concentration, particularly among the largest PBMs, has increased as a result of several mergers and acquisitions in the industry. The largest full service PBMs in the country, known as the "Big Three" – Express Scripts, Medco Health Solutions and CVS Caremark – control 50-60% of the national overall prescription drug volume.[1] Despite their tremendous impact on U.S. healthcare, PBMs remain virtually unregulated as an industry and typically unfamiliar to most patients and consumers.

PBMs also have employed increasingly complex business models in negotiating and implementing contracts with many players in the pharmaceutical supply chain, including plan sponsors, pharmacies and drug manufacturers. This brief primer explains how PBMs generate windfall profits by using these agreements to generate four key revenue streams that have allowed the Big Three's profits to grow into the billions of dollars:[2] (1) rebates from pharmaceutical manufacturers for driving brand drug utilization and market share; (2) spreads, i.e., markups on drug pricing, that financially benefit PBMs; (3) dispensing fees and pricing markups from PBM-owned mail order and specialty pharmaceuticals sold to health plans; and (4) administrative fees charged by PBMs to plan sponsors. It also touches on the related lack of transparency in the PBM industry.

Manufacturer Rebates

Pharmaceutical manufacturers provide rebates and discounts to PBMs as "rewards" for placing their brand drugs on formularies,[3] promoting these products and driving brand drug usage. In the process, PBMs act as "double agents" working simultaneously for employers/plans (administering members' pharmacy benefits) and drug manufacturers (maximizing market share via formulary inclusion). PBMs often tout their ability to negotiate these rebates and cost savings and claim that they benefit plans and consumers. However, there is no proof that PBMs pass along any savings to plans, employers or consumers, nor do they generally disclose the rebates. In practice, many PBMs retain a large percentage of these rebates even though they are generated by the plans' pharmacy spend. Formularies and rebates drive the usage of selected drugs, thereby maximizing the rebates PBMs can extract from drug manufacturers and incentivizing PBMs to increase the dispensing of certain

drugs, even if it increases the plans' costs (i.e., by dispensing brand name rather than generic drugs). These rebates and discounts represent a significant source of PBM revenue, which often creates a conflict of interest between the PBMs and the patient's and plan's interests. In addition, rebates and discounts create an incentive for PBM-owned mail order pharmacies to dispense and charge plans for more expensive brand name drugs. Consequently, Express Scripts' and Medco's mail order facilities have lower generic dispensing rates than local pharmacies, resulting in higher overall healthcare costs.[4]

Spread Pricing

Simply stated, spread pricing is the difference between the amount plans/employers pay PBMs and what the PBMs pay pharmacies for a drug. PBMs maximize their profits by reimbursing retail pharmacies for a drug at one price, charging health plans and other payors a steeper price for the same drug and then pocketing the difference, i.e., the spread. For example, a PBM may offer an employer a seemingly competitive overall discount of the equivalent of 55% off the Average Wholesale Price (AWP)[5] for generic drug X to gain the employer's business. On a drug with an AWP of $266, the employer believes it obtained the maximum discount -- a savings of about $146. The pharmacies that then dispense drug X to patients are paid around $25, the Maximum Allowable Cost (MAC) price set by PBMs. The PBM then pockets the difference of $95 on each bottle of drug x tablets dispensed to a patient.[6]

These practices encourage PBMs to push drugs with the highest spreads by manipulating formularies and pricing without revealing their actual costs, payment amounts or resulting spreads. Often plans are unaware that such manipulations are happening due to a lack of true transparency in the contracts. Because PBMs have the ability to mandate "take it or leave it" contracts, they can restrict or limit disclosure and reporting regarding health plan drug expenditures and PBM profits.

Mail Order & Specialty

The Big Three own and operate the predominant mail order facilities in the U.S., which fill and ship prescription drugs across the country. In addition, the Big Three control 67% of the specialty pharmacy market based on 2009 data.[7] This market power allows Express Scripts and Medco to force consumers and plans to use their captive mail and speciality operations and command higher prices for these drugs.

PBMs often boast that discounts for mail order drugs are greater than retail. In practice, however, they may not be cheaper. PBMs limit competition by (a) refusing to allow other mail order pharmacies to fill prescriptions for their client plans, (b) refusing to allow community pharmacies to dispense the same 90-day supplies dispensed by PBM-owned mail order facilities, (c) making retail pharmacies appear more expensive to *consumers* by charging higher patient co-pays that are incommensurate to any alleged difference in the true costs of mail and retail, and (d) making retail pharmacies appear more expensive to *plans* by charging a large spread for drugs dispensed by retail pharmacies and using that spread to subsidize lower prices for the PBM-owned mail order pharmacy, thus making the mail order pharmacy *appear* less expensive. PBMs with their own mail order facilities also increase their profits through practices such as repackaging medications into smaller packages, but charging the

same or more for the drugs under a custom, PBM-established National Drug Code (NDC). In addition, Express Scripts' and Medco's mail order facilities typically have lower generic dispensing rates than local pharmacies, which contribute significantly to overall healthcare costs.[8] IMS Health concluded that every 2% increase in generic utilization in Medicaid saves taxpayers $1 billion annually.[9]

Administrative Fees

PBMs generate substantial revenue by charging clients administrative fees for processing claims. With their significant market power, Express Scripts and Medco can dictate contract terms that allow them to set these fees at their discretion. For instance, PBMs often charge rebate management fees to health plans that are above and beyond the PBM's retention of client-generated manufacturer rebates. In addition, PBMs often use contract terms such as "claims," which are not clearly defined or defined in ways to allow them to bill clients for duplicate, reversed or rejected claims. Auditors have estimated that 20% of all "claims" come from these duplicate, reversed or rejected claims.[10] Similarly, PBMs charge processing fees to the pharmacies for administering the same claims. Thus, PBMs are able in essence to "double dip" for the very same claims.

Lack of Transparency

As PBM business plans have become more complex, greater transparency has not followed at the Big Three level. Audits are a reasonable check on a PBM's practices; however, the largest PBMs typically require "mutual approval" of any auditor designated by the plan to conduct an audit. Such provisions allow PBMs to veto selected auditors, as well as limit the number and frequency of audits examining their business practices. It is our understanding that when audits do occur, the PBMs require auditors to sign confidentiality agreements that prohibit auditors from disclosing key information to their own clients -- the health plans that requested the audit. PBMs similarly limit information based on proprietary claims. This lack of transparency and accountability allows PBMs to continue the practices described above with regard to rebates, spread pricing, mail order and specialty, and administrative fees, thereby allowing the PBMs to obtain profit windfalls.

[1] Atlantic Information Services, 2010 data; J.P. Morgan, Healthcare Technology & Distribution, Gill's Guide to Rx Channel – An Investor Handbook, May 10, 2011. If the Express Scripts-Medco merger is approved, approximately 1/3 of all Americans (roughly 135 million people) would rely on the new "mega PBM" to manage their prescriptions. Bloomberg, Express Scripts-Medco Deal May Spur Purchases by Rivals, July 22, 2011.
[2] For instance, Medco's 2010 net revenues were nearly $66 billion. See http://www.medcohealth.com/medco/corporate/home.jsp?ltSess=y&articleID=CorpAlertMedco_listWorldMostAdmired4y.
[3] Formularies are lists of drugs "preferred" above other drugs in a therapeutic class, which is a group of similar drugs approved for treatment of specific conditions. Patients are offered financial incentives (lower co-payments, for example) to use drugs that appear on their employer's formulary. C. Rentmeester & R. Garis, *Rebates and Spreads: Pharmacy Benefit Management Practices and Corporate Citizenship*, Journal of Health Politics, Policy and Law, Vo. 33, No. 5 (Oct. 2008).
[4] See 2010-2011 Prescription Drug Cost and Plan Benefit Design Report at 28, http://www.benefitdesignreport.com/Portals/0/2010-2011_BDR_R1.pdf.
[5] AWP is akin to the sticker price on a new car. It is the published or suggested cost of pharmaceuticals, which forms the basis for most third party prescription reimbursement. It is "fictitious" and rarely, if ever, the price actually paid for the drug(s). For a detailed explanation and history of AWP, see *In re Pharmaceutical Industry Average Wholesale Price Litigation*, 491 F. Supp. 2d 20 (D. Mass. 2007).
[6] This illustration is explained in detail in the following report: C. Rentmeester & R. Garis, *Rebates and Spreads: Pharmacy Benefit Management Practices and Corporate Citizenship*, Journal of Health Politics, Policy and Law, Vo. 33, No. 5 (Oct. 2008).
[7] Pembroke Consulting, 2010-2011 Economic Report on Retail and Specialty Pharmacies (Medco's Accredo Health = 35%; Express Script's CuraScript Pharmacy = 17%; and CVS Caremark = 15%). Specialty pharmaceuticals are high cost drugs for patients undergoing intensive therapies for chronic, complex, relatively rare and/or potentially life-threatening diseases.
[8] See 2010-2011 Prescription Drug Cost and Plan Benefit Design Report at 28, http://www.benefitdesignreport.com/Portals/0/2010-2011_BDR_R1.pdf.
[9] IMS Health, July 26, 2010, "Every 2% uptick in the substitution of generic drugs for brand-name products saves Medicaid $1 billion a year," cited by NCPA, http://ncpanet.wordpress.com/2011/05/05/community-pharmacies-reducing-costs-through-generic-drug-use-mail-order-pharmacies-continue-to-lag-behind/.
[10] NCPA, PBM Manual, "PBM Practices," submitted to the FTC by NCPA on October 6, 2011.