

The Role Of PBMs In Implementing The Medicare Prescription Drug Benefit

The new law envisions being able to take advantage of PBMs' best capabilities in helping beneficiaries obtain needed drugs.

by **Robert F. Atlas**

ABSTRACT: In creating the Medicare prescription drug benefit and stipulating that it be managed by private-sector prescription drug insurance plans, Congress opened a huge business opportunity for pharmacy benefit managers (PBMs). Although hardly noticed by the general public, PBMs already administer prescription drug benefits for nearly everyone with employer coverage and for many Medicaid recipients. The new law contains requirements for Medicare drug plan sponsors that could challenge some PBMs—most notably, the requirement to assume insurance risk. This paper explores challenges to PBMs' business practices and provisions of the Medicare benefit that will require them to adapt their mode of operation.

THE MEDICARE PRESCRIPTION DRUG, Improvement, and Modernization Act (MMA) of 2003 is said to bring Medicare into the modern age of health insurance by adding the first outpatient prescription drug benefit in its four-decade history. Voluntary coverage for Medicare beneficiaries begins in January 2006. Until then, beneficiaries may obtain one of several dozen Medicare-endorsed prescription drug discount cards; for low-income beneficiaries, the cards offer a \$600 subsidy for drug spending in each of 2004 and 2005.

Implementation of the discount cards and the full Medicare prescription drug benefit relies heavily upon a small group of private companies known as pharmacy benefit managers (PBMs), which administer outpatient prescription drug benefits for most of the more than 160 million Americans having employer-based health care coverage.¹ PBMs heretofore have had little experience working with the federal government, although a few have serviced TRICARE, the managed care program for military dependents and retirees, and PBMs do serve the health insurers that underwrite the Federal Employees Health Benefits Program (FEHBP). PBMs have some experience serving senior citizens: a small fraction of Medicare beneficiaries who already get at least a modicum of drug coverage

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through Medicare+Choice (now Medicare Advantage, or MA) plans; Medicare-Medicaid dual eligibles who already get drug coverage under Medicaid (although fewer than half of the states use PBMs); others who have retiree coverage; and another small number who purchase individual Medicare supplemental (Medigap) coverage that includes drug benefits.

This paper reviews how PBMs came to be, what they do, their performance, and some issues that have arisen concerning their business practices. It also outlines the ways in which PBMs can participate in Medicare, and it explores the challenges that PBMs will face in filling MMA's specifications for the design and operation of Medicare Part D.² The paper is based on a review of published literature on the PBM industry, company reports, and recent public statements of PBM representatives regarding the Medicare drug benefit; and on the author's interviews of executives of PBMs and their trade association.³

PBMs Evolve As An Industry

■ **Origins of PBMs.** PBMs came into being four decades ago, when employment-based health benefits were gaining wide adoption. They trace their roots to four sources.

Prescription drug cards. In the 1960s companies emerged to offer add-on prescription drug benefits to private health insurance plans—most notably, those for unionized workers. Card holders could fill prescriptions at participating pharmacies for nominal copayments. Pharmaceutical Card System (PCS) is commonly identified as the innovator of this concept.⁴

Mail-service pharmacies. Around the same time cards appeared, specialized pharmacies were established to dispense medications for chronic conditions by mail. Mail service offered discount pricing because of low overhead and the convenience of home delivery. An early leader was PAID Prescriptions, the progenitor of today's Medco Health.

Third-party drug claims administrators. Companies such as Argus were created to fill a need for low-cost processing of drug claims. With the typical drug claim originally being quite small relative to a hospital or physician claim, insurers outsourced processing to specialists to keep processing costs for drug claims about the same in percentage terms. Today the cost of processing a drug claim is about thirty to forty cents, less than 1 percent of claim value.⁵

Health insurer pharmacy benefit departments. Some top health insurers and managed care firms have separately branded their in-house pharmacy benefit units. Most remain with the original parents—for example, WellPoint Pharmacy Management, Aetna Pharmacy Management, Anthem Prescription, and PacifiCare's Prescription Solutions—but serve other customers, too. Sometimes insurer-owned PBMs are spun out as separate companies: UnitedHealthcare's Diversified Pharmaceutical Services (DPS) was acquired in the early 1990s by a pharmaceutical manufacturer and later was absorbed by Express Scripts, a company that itself

was created inside New York Life's managed care unit.

■ **Full-service capabilities.** Notwithstanding their different origins, today's PBMs have all developed comparable full-service capabilities. Much of the buildup of capability and capacity has come via consolidation. There are now an estimated forty to fifty companies of meaningful size in the PBM field, although three firms dominate: Caremark Rx (which recently acquired former leader AdvancePCS), Medco Health Solutions, and Express Scripts. These three companies will take in combined revenues of perhaps \$80 billion in 2004, which suggests that they manage more than one-third of the estimated \$208 billion in U.S. drug spending.⁶ Exhibit 1 identifies PBMs with at least five million covered lives.

■ **PBMs' competencies.** PBMs typically offer the following capabilities, with different PBMs excelling in different areas.⁷

Pharmacy networks. PBMs contract with retail pharmacies to fill members' prescriptions. Pricing typically entails two components: an ingredient cost, usually set at a discount from the most commonly used benchmark price, the average wholesale price (AWP) for brand-name drugs or the maximum allowable cost (MAC) for generics; and a dispensing fee, meant to compensate the pharmacy for its effort in filling the prescription. The larger PBMs all contract with about 90–95 percent of the nation's nearly 60,000 retail pharmacies.

Mail service. Most PBMs offer the option of mail service for maintenance prescriptions that do not need to be filled instantaneously. A growing trend among employer-based plans is to mandate mail service for long-term prescriptions or to strongly encourage its use through cost-sharing incentives. The top PBMs all run

**EXHIBIT 1
Pharmacy Benefit Managers (PBMs) Claiming More Than Five Million Covered Lives, 2004**

Company	Ownership	Millions of covered lives
Caremark Rx	Publicly traded	80
Medco Health Solutions	Publicly traded	60
Express Scripts	Publicly traded	50
WellPoint Pharmacy Management	Insurer—WellPoint	36
PharmaCare	Pharmacy chain—CVS	30
MedImpact	Privately held	27
Argus Health	Privately held	24
Prime Therapeutics	Insurer—8 BCBS plans	9
CIGNA Healthcare	Insurer—CIGNA	9
Aetna Pharmacy Management	Insurer—Aetna	8
Prescription Solutions	Insurer—PacifiCare	8
Anthem Prescription	Insurer—Anthem	7

SOURCES: Information compiled from company Web sites, Securities and Exchange Commission (SEC) filings, and personal contact with company officials. Figures are not independently verifiable.

NOTES: Values should not be summed, as double counting could result. Two PBMs may deliver unbundled services to the same client, such as when one provides a retail pharmacy network and another provides mail service. BCBS is Blue Cross and Blue Shield.

their own mail-service operations, which are highly mechanized to speed processing and minimize labor costs.

Claims administration. PBMs pay claims on behalf of plan sponsors and tell pharmacies how much cost sharing to collect from beneficiaries. Some 98–99 percent of pharmacy claims today are paperless, because of the early adoption of standards for claim formats and drug product identification through the National Council for Prescription Drug Plans (NCPDP).

Formulary management. Working through quasi-independent panels known as pharmacy and therapeutics (P&T) committees, PBMs define lists of drugs approved for reimbursement by their clients. Formularies are set with both clinical appropriateness and financial factors in mind. Where multiple therapeutically equivalent drugs exist in a class of drugs, the P&T committee may designate which drugs are to be preferred. Preferred drug lists often underpin benefit plan designs, whereby low-cost generic drugs demand the least beneficiary cost sharing, preferred brand-name drugs require mid-level cost sharing, and nonpreferred drugs have high cost sharing.

Manufacturer price negotiation. PBMs negotiate with drug makers for the prices of all of the drugs they manage. This is true even though PBMs do not actually take possession of many of the drugs their enrollees consume: those dispensed in retail pharmacies. Deals usually are structured to generate rebates from manufacturers based upon either the total volume of drugs purchased or, for drugs in competitive therapeutic categories in which a PBM may identify one drug as preferred, a percentage share of the market. PBMs profit in part by keeping a share of the rebates. Large PBM clients—health plans and self-funded employers—increasingly demand that PBMs pass more of the rebates through to them. PBMs' deals with manufacturers may also net administrative fees for the PBM, such as for acting as the rebate conduit between the manufacturer and the ultimate customer.

Utilization review. PBMs may use their databases and real-time claim-payment technology to check for medication problems at the point of dispensing: for example, adverse interactions between two or more drugs prescribed to a patient, or over- and underuse, as when a beneficiary refills a prescription too early or too late. When a problem is found, the PBM may alert the dispensing pharmacist or the prescribing physician(s). The same data sets also allow PBMs' health plan clients to profile physicians' prescribing patterns.

Medication therapy management. Some PBMs also employ techniques to improve the quality or cost, or both, of pharmaceutical care. Tools may include prior authorization requirements for selected drugs known to be prescribed widely for off-label uses or to be costly compared to therapeutically similar alternatives; consumer education, such as mailers discussing the conditions indicated by the drugs received by beneficiaries; physician education, conveying evidence that counters pharmaceutical manufacturers' detailing; compliance and persistency programs meant to make sure that patients actually take their medications; and disease

management programs, which enroll patients having targeted chronic conditions and help them manage those diseases to avoid flare-ups.

Electronic prescribing. Not yet widely adopted but strongly encouraged by MMA provisions, electronic prescribing allows physicians to write prescriptions directly into computers or wireless handheld devices. The device shows current information on patients' eligibility, coverage, and formulary limitations, which may help in choosing the most appropriate drug that will cost the patient and the payer the least. The prescription can be transmitted instantly to the patient's chosen participating pharmacy and to the PBM for payment at the same time. The major PBMs have created an electronic prescribing utility, RxHub, to distribute formulary and medication history information. Similarly, the top pharmacy chains have created a mechanism called SureScript to transmit prescriptions between physicians and pharmacies.

■ **Service enhancements.** With the market for PBM services largely saturated, PBMs are growing via service enhancements. A recent industry thrust has been into higher-margin specialty pharmacy—that is, drugs used by small numbers of seriously ill people who require costly, often hard-to-deliver medications via injection or infusion. Many such drugs are physician-administered and are already covered under Medicare Part B. Traditionally, physicians purchased these drugs and then billed payers, including Medicare, at prices well above the acquisition cost. To control costs, some health plans now buy directly from specialty pharmacies, which then deliver the drugs to physicians' offices.

PBM Performance

In the run-up to the creation of the Medicare drug benefit, federal agencies and other bodies studied the effectiveness of PBMs. The prevailing tenor of the findings is that PBMs are capable of managing prescription drug benefits cost-effectively. None of the analyses explored PBMs' impact on clinical quality, however.

The Congressional Budget Office (CBO) concluded that PBMs could save up to 30 percent in total drug spending relative to unmanaged purchases of prescription drugs, if they would employ the full array of price discounts, rebates, and utilization management tools.⁸

The U.S. Government Accountability Office (GAO) assessed savings produced by PBMs in three health plans in the FEHBP that accounted for more than half of the 8.3 million people the FEHBP covered in 2002. The GAO determined that PBMs saved money in three ways: (1) pharmacy price discounts, ranging from 18 percent below cash price for brand-name drugs purchased at retail pharmacies to 53 percent for generic drugs purchased through mail-service pharmacies; (2) rebates from pharmaceutical manufacturers, worth 3–9 percent; and (3) cost/care management techniques such as those discussed above, valued at 1–9 percent.⁹

A PricewaterhouseCoopers (PwC) analysis of PBMs' impact on drug spending, commissioned by a PBM trade group, the Pharmaceutical Care Management Asso-

ciation (PCMA), estimated that PBMs' interventions in the management of private benefit plans save 25 percent. PwC values these savings at \$268 per enrollee in 2005 or a total of \$53 billion.¹⁰

An arm of the PBM industry, the Pharmacy Benefit Management Institute (PBMI), annually surveys PBM customer satisfaction. As reported in PwC's study of PBMs done for the Centers for Medicare and Medicaid Services (CMS), overall customer satisfaction with PBM services rose between 1995 and 2000, from 7.1 in 1995 to 7.5 in 2000 on a ten-point scale. Aspects of PBM services rated most favorably were pharmacy network quality and size (8.8); claims processing (7.7); drug-card production and distribution (7.6); and value for administrative cost (7.4). Features rated least favorably were disease management (6.3); utilization and benefit management consulting (6.4); proactive account management (6.6); and the dollar amount of manufacturer rebates (6.7).¹¹

■ **Opposition to PBMs.** Not everyone who deals with PBMs is enamored of them. Retail pharmacies assert that PBMs profit at their expense by paying too little for both dispensing and ingredient costs. Retailers also complain that PBMs steer prescription volume to mail-service pharmacies—which the PBMs themselves usually operate—thus depriving them of business. Independent pharmacies, which make up approximately 30 percent of all retail outlets, are most opposed to PBMs, both because they lack the wholesale buying power of big drugstore chains and because they depend more heavily than the chains do on sales of prescription drugs—versus over-the-counter drugs and nondrug products. The National Community Pharmacists Association (NCPA), representing independent pharmacies, has sued PBMs and declared that “counteracting PBMs is our number 1 priority.”¹²

Others opposed to PBMs include some regulators and consumer advocates, who argue that manufacturer rebate money causes PBMs to favor more costly brand-name drugs over generics or lower-cost, therapeutically equivalent brand-name drugs. These arrangements are seen as posing conflicts of interest that escalate costs for employers and consumers. In the past two years, thirty-two state legislatures have considered laws to regulate PBMs; six states have enacted such legislation. Regulations generally require PBMs to be licensed and to report data on their business practices, including information on transactions with drug companies.¹³

In August 2004 New York's attorney general filed suit against the PBM that services state employees, Express Scripts, accusing the company of failing to pass on manufacturer rebates as contractually required and effectively defrauding the state of tens of millions of dollars. Express Scripts strongly denied the claim, saying that it actually had saved the state \$2 billion since 1998.¹⁴

Another of the three largest PBMs, Caremark Rx, also faces regulatory scrutiny. In August 2004 Caremark revealed that it had received “civil investigative demands” pursuant to consumer protection statutes from five states and the District of Columbia and that eighteen additional states would be making similar requests

for information about Caremark's business practices.¹⁵

Cries of PBM bias first grew loud during the early 1990s, when drug companies paid handsomely to acquire several leading PBMs. Eli Lilly bought PCS, Merck bought Medco, and SmithKline Beecham (now GlaxoSmithKline) bought DPS. Shortly after these acquisitions occurred, however, the Federal Trade Commission (FTC) ruled that these PBMs had to erect so-called firewalls to prevent undue influence by their drug company parents. PCS and DPS soon were sold off at prices well below what the drug companies had paid. Merck, not wanting to take a write-off, clung to Medco until spinning it out to shareholders in 2003. Even after regaining its independence, Medco faced accusations that it favored Merck drugs over less costly alternatives. As part of a settlement with twenty state attorneys general and the U.S. Department of Justice (DOJ), in early 2004 Medco publicized a new policy stating that no rebate arrangement or other form of manufacturer compensation will operate to raise customer costs.¹⁶

PBMs also are being challenged by some of their largest customers. A coalition of fifty-four employers, representing 5.5 million beneficiaries, intends in 2005 to negotiate pricing directly with pharmaceutical manufacturers and to use PBMs strictly for administrative services.¹⁷

Ways For PBMs To Participate In Medicare

It seems likely that the entire Medicare prescription drug benefit will be touched by PBMs. Already, the Medicare-endorsed drug discount cards either are offered directly by PBMs or are operated by PBMs while branded and marketed by other organizations. When the full Part D drug benefit goes live in January 2006, PBMs will have three avenues for participation.

■ **Traditional behind-the-scenes support of plan sponsors.** PBMs will administer drug benefits to be offered by managed care plans participating as at-risk, full-service MA plans under Medicare Part C. The extra funding Congress appropriated for MA is reinvigorating that program. PBMs also will deliver services to insurance companies that offer stand-alone prescription drug plans (PDPs) authorized by MMA. In addition, PBMs will continue to support employer-based retiree plans. Those plans, if deemed qualified under MMA, may receive federal subsidies—\$89 billion over ten years, according to CBO estimates—to promote the continuation of private drug coverage.¹⁸

■ **Risk assumption in stand-alone PDPs.** Although PBMs could offer their own insured PDPs, doing so would require them to do something they have shied away from in the past: accept risk for the actual pharmacy claims costs incurred by enrollees. I return to this point shortly.

■ **Operation of government fallback plan.** MMA calls for the federal government to offer a publicly run option in areas where no more than one private PDP operates. The CMS will engage private contractors to administer this option. However, MMA requires PBMs effectively to declare themselves on one side or the other up

front. Any firm that bids to be a regional PDP, whether as a prime contractor or as a subcontractor, will be ineligible to bid on fallback plan contracts. Also, the companies administering fallback plans cannot brand or actively market them.

Main Medicare Challenge For PBMs: Risk

For PBMs not owned by insurers, the most formidable challenge presented by the Medicare prescription drug benefit is taking risk as an insurer. PBMs today are not in the business of insurance. Most do not hold state insurance licenses, they do not maintain reserves in the way that insurers do, and they lack the capabilities that insurers have to underwrite—that is, to assess risk and set premiums. PBMs also assert that their slim operating margins—typically 1–3 percent—leave them insufficient cushioning to absorb losses should claims costs exceed premium income. There are valid concerns about the risk in a Medicare PDP, a novel concept that entails voluntary individual enrollment in a drug-only insurance plan.

■ **Unpredictability.** Absent any directly pertinent history, predicting use and costs in a stand-alone drug plan is challenging. Data from existing full-spectrum health benefit plans will be useful but will not be reliable when translated to a single-benefit plan design. Also limiting the ability to forecast use and costs is the ever-changing drug market. Existing drugs may start being used for new indications, whether approved or not by the U.S. Food and Drug Administration (FDA). New drugs, many with very high price tags, come onto the market regularly, and it is uncertain whether some new drugs will fall under Medicare Part B or Part D. This all gives an unstable basis upon which to compute premiums.

■ **Lack of control.** PDPs will lack contractual relationships with the most forceful drivers of pharmacy benefit costs: physicians who prescribe medications for their patients. PDPs can try to educate physicians, and they can try to influence prescribing behavior through benefit plan and formulary design, but they cannot sanction physicians whom they evaluate as having costly or otherwise inappropriate prescribing patterns.

■ **Adverse selection.** Enrollment in Medicare PDPs will be voluntary and will be free only to beneficiaries with the lowest incomes. These qualities make the program fertile ground for adverse selection, in which the people most likely to enroll are the ones who know that their costs will exceed the premiums they pay. Congress sought to thwart adverse selection by penalizing any beneficiary who fails to enroll in a PDP when first eligible, but the penalty—now set at 1 percent of premium for each month of delayed enrollment—may be too low, particularly at the start of the program, to prevent people from signing on late if their medication costs rise in the future.

Congress did try to mitigate PDP risk. MMA stipulates that would-be PDPs lacking state insurance licensure can instead satisfy a federal solvency requirement to be defined in regulation. Congress also designed a less-than-full-risk model that applies in the early years. Under that model the government will share

in PDP underwriting losses—and in gains as well. The protections afforded are largest in 2006–2007, then tail down in 2008–2011, then phase out. The law also allows PDPs to propose alternative arrangements that lessen their exposure, but any PDP doing so will be gambling. The secretary of health and human services (HHS) must give priority to PDPs that accept the most risk and may only approve limited-risk proposals if needed to ensure that beneficiaries in a region have access to private PDPs.

Other Medicare Challenges For PBMs

MMA contemplates having Medicare taking advantage of PBMs' best capabilities, but the statute does not leave everything up to the vendors. The act contains myriad stipulations about PDPs' functionality, some of which mirror the demands that private-sector clients place on PBMs but others of which impose expectations or constraints that PBMs have not seen before.

■ **Access.** (1) PDPs must cover whole geographic regions with pharmacy networks that match the access standards of the Defense Department's TRICARE program: 90 percent of urban enrollees must have a participating pharmacy within two miles of home; 90 percent of suburban enrollees must have a pharmacy within five miles; and 70 percent of rural enrollees must have a pharmacy within fifteen miles.¹⁹ This rule is not a major barrier for the largest PBMs. In fact, the top PBMs will probably seek new contracts with pharmacies specifically for Medicare, so that they can structure their networks to meet the access standards. The access requirement will present a hurdle for less well established players. (2) The statute also contains an "any willing pharmacy" provision, meaning that a PBM cannot exclude pharmacies that agree to its terms of participation. This rule could handcuff some PBMs whose strategy is to limit the numbers of pharmacies to extract deeper discounts, although imposing higher copayments for use of less favored pharmacies might be a way around this barrier. (3) The law states that PDPs must allow enrollees to fill ninety-day prescriptions—typical of chronic medications—at community pharmacies as long as they pay the difference in charges between that and the mail-service cost. This provision could diminish PBMs' opportunities to profit from their own mail-service operations; again, though, copayment structures can be used to steer beneficiaries where the PBM wants them to go.

■ **Formulary.** (1) Medicare PDPs must offer drugs within each therapeutic category and class. The plural word "drugs" in the statute has been interpreted by the CMS to mean that a PDP must offer more than one drug in each therapeutic category. This feature conceivably could limit PBMs' ability to move market share to selected manufacturers' products and win favorable rebate deals. PBMs do not expect this constraint to limit their bargaining leverage, though, for two reasons. First, any PDP that covers only one drug per category would not attract many enrollees. Second, PDPs will have latitude to define benefit tiers so that even when two or more drugs in a category are covered, the PDP could give richer coverage to just one drug.

(2) The statute assigns the United States Pharmacopeia (USP), which must consult with PBMs and other stakeholders, the task of defining therapeutic categories and classes to guide PDPs in structuring formularies. Having the independent USP create guidelines is a way to keep PDPs from skewing formularies away from the drugs needed by beneficiaries with the costliest conditions. Also, the more classes and categories that are created—each containing a smaller number of drugs—the less latitude PDPs will have in setting up formularies. A draft of the USP plan dated 16 August 2004 listed 146 classes. PBMs reportedly were advocating for there to be no more than 90 classes, whereas pharmaceutical manufacturers were pushing to have more than 200 classes.²⁰ (3) A PDP must notify the HHS secretary and “affected enrollees, physicians, pharmacies and pharmacists” of the removal of a drug from its formulary or any change in a drug’s coverage status from a preferred to a nonpreferred tier. The CMS has stated that Web-site postings alone will not suffice as notice; written formats also will be required. This requirement poses an administrative burden and cost for PBMs operating PDPs.

■ **Exceptions and appeals process.** MMA requires a PDP to have an appeals process similar to that required of MA plans. The process must deal with coverage denials based on application of the formulary. A beneficiary may appeal a denial if the prescribing physician determines that covered drugs in any formulary tier would not be as effective for the individual as a nonformulary drug, or would have an adverse effect for the patient, or both. Appeal rights extend to situations where a drug is on the PDP’s formulary but in a nonpreferred tier. Some PBMs worry that the appeals process could become unwieldy, but others think that the volume of appeals will not be large because physicians will resist taking on the unpaid task of helping their patients to appeal.

■ **Financial disclosure.** MMA requires PDPs to disclose to the HHS secretary the aggregate value of price concessions they receive and pass through in the form of subsidies, lower beneficiary premiums, and lower prices through pharmacies and other dispensers (as when a beneficiary pays out of pocket when there is a gap in coverage). PBMs, which keep a close hold on their financial dealings with drug makers and others, say that they are not troubled by this requirement for disclosure of aggregated information. They successfully fought more granular disclosure requirements that were proposed during the crafting of MMA, and they continue to oppose similar state-level legislative proposals.²¹

■ **Marketing.** PDPs will have to adhere to the same marketing rules that apply to MA plans—rules prohibiting aggressive and deceptive practices. The challenge for PBMs that would offer their own PDPs is not the nature of the rules; it is the mere fact of selling directly to consumers. PBMs normally sell not to individuals but to group buyers such as employers and health plans. So a PBM that elects to offer its own PDP would have to build—or buy—marketing capability. A number of PBMs are using the Medicare-endorsed discount drug card program as an opportunity to develop such capability now.

■ **PBMs' intentions.** PBMs are undaunted by the requirements of PDPs that do not entail assuming insurance risk, but the insurance aspects do give them pause. PBM executives' public and off-the-record statements reveal that PBMs prefer functioning as behind-the-scenes managers working for insurers. Yet some are being more assertive. The head of Express Scripts has said that his company expects to participate both as a risk-taking PDP and as a partner to insurers.²² Subsequently, though, Express Scripts qualified its position, saying that the company "is reviewing options for participation in the new Medicare benefit when it begins in 2006 and expects to participate in the program in some fashion, either directly as a PDP or fallback plan, and/or in support of insurance/managed care clients who serve the program as Medicare Advantage plans."²³

Insurer-owned PBMs, meanwhile, are well positioned to team with their parents that do have risk-management machinery. One obvious candidate is Prescription Solutions, whose parent, PacifiCare, has long been strategically positioned as a Medicare risk-contracting plan. In contrast, WellPoint, which long resisted contracting with the federal government to enroll Medicare beneficiaries via Medicare+Choice, could be a holdout, at least in terms of marketing its own PDP.

Policy Implications And Measures Of Success

With the new Medicare Part D, the federal government is embarking on a vast experiment and is placing responsibility for implementation squarely on the PBM industry. The industry appears to have both the capacity and the technical capability to deliver the benefits, although many PBMs will likely partner with others more comfortable taking risk: insurers or the government itself.

PBMs will be given considerable power to define which drugs will have what level of coverage and to negotiate price deals with drug makers. Their leverage over formularies and pricing in the commercial sector has already led to PBMs' being accused of bias and self-dealing. The Medicare law, together with market dynamics, will have some influence on formulary design and pricing practices. Whether the protections are sufficient is today more a matter of speculation—and perhaps of one's political leanings—than of objective analysis.

Eventually, regulators and independent analysts will have the opportunity—indeed, the duty—to assess the effectiveness of PBMs' performance as operators of Medicare Part D. Measures of success will include the degree to which Medicare beneficiaries opt for the drug coverage, including how quickly they do so after January 2006 and whether they remain enrolled over time; the range of choices beneficiaries have, both of PDPs and of drugs covered by the PDPs; the costs that the government, PDPs, and beneficiaries incur relative to baseline projections; and the extent to which having better access to prescription drugs and to PBMs' interventions actually improves beneficiaries' health and quality of life.

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The author thanks Jennifer Bryant, vice president of the Lewin Group, for her insightful suggestions on this paper.

NOTES

1. M.W. Serafini, "For Seniors, a New Card Game," *National Journal* (20 March 2004): 889–890.
2. Information about MMA's specifications for the Part D drug benefit is taken from the statute itself and from proposed rules issued by the CMS. See Centers for Medicare and Medicaid Services, Proposed Rule, 26 July 2004, cms.hhs.gov/medicarereform/mmaregions/CMS4068P.pdf (13 September 2004).
3. Organizations represented in interviews included Medco Health, Express Scripts, PacifiCare's Prescription Solutions, and the Pharmaceutical Care Management Association (PCMA).
4. PCS was acquired by another smaller PBM, Advance Paradigm, in 2000. The combined company was renamed AdvancePCS. Caremark Rx acquired AdvancePCS in March 2004.
5. PricewaterhouseCoopers, *Study of Pharmaceutical Benefit Management*, HCFA Contract no. 500-97-0399/0097, June 2001, cms.hhs.gov/researchers/reports/2001/cms.pdf (12 October 2004).
6. Estimated based upon April–June 2004 revenues as reported in corporate Form 10-Q reports filed with the U.S. Securities and Exchange Commission (SEC) in July or August 2004. Medco (\$8.8 billion): ccbn.tenkwizard.com/filing.php?repo=tenk&ipage=2920324&doc=1/ (8 October 2004). Caremark Rx (\$7.3 billion): www.caremark.com/wps/portal/_s.155/3370 (13 September 2004). Express Scripts (\$3.8 billion): ccbn.tenkwizard.com/contents.php?ipage=2910238&repo=tenk&TK=ESRX&CK=885721&FG=0&FC=000066&BK=ffffe0&SC=ON&TC1=ffffe0&TC2=ffffe0&LK=000000&AL=000099&VL=000000&CK2=885721 (13 September 2004). Also see CMS, "Table II: Prescription Drug Expenditures; Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1990–2013," 6 February 2004, cms.hhs.gov/statistics/nhe/projections-2003/t11.asp (13 September 2004).
7. Discussion adapted from Health Policy Alternatives, *Pharmacy Benefit Managers (PBMs): Tools for Managing Drug Benefit Costs, Quality, and Safety* (Washington: PCMA, August 2003).
8. U.S. Congressional Budget Office, *Issues in Designing a Prescription Drug Benefit for Medicare* (Washington: CBO, October 2002).
9. U.S. Government Accountability Office, *Federal Employee Health Benefits Program, Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies*, Pub. no. GAO-03-196 (Washington: GAO, 2003).
10. PricewaterhouseCoopers, *The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation*, July 2004, www.pcmant.org/keyfindings_pdfs/PricewaterhouseCoopers_Report_Value%20of%20PBMs_Impact_Proposed_LegislationJuly_2004.pdf (8 October 2004).
11. Pharmacy Benefit Management Institute, *The 2000 Pharmacy Benefit Manager Customer Satisfaction Survey Report* (Tempe, Ariz.: PBMI, October 2000).
12. J. Frederick, "Indies Target PBMs at NCPA's Annual Conference," *Drug Store News*, 17 November 2003.
13. J.A. MacDonald, "States Want Say on Drugs," *Hartford Courant*, 22 August 2004.
14. B. Martinez, "Express Scripts Accused of Fraud by New York State," *Wall Street Journal*, 5 August 2004.
15. Caremark Rx, Inc., quarterly report (Form 10-Q) to the Securities and Exchange Commission, 9 August 2004, www.shareholder.com/Common/Edgar/1000736/1193125-04-136098/04-00.pdf (28 August 2004).
16. M. Freudenheim, "Medco to Pay \$29.3 Million to Settle Claims of Drug Switching," *New York Times*, 27 April 2004.
17. M. Davis, "Medco and Its Peers Brace for Flank Attack," *TheStreet.com*, 16 August 2004, www.thestreet.com/_tscs/stocks/melissadavid/10178327.html (13 September 2004).
18. J.K. Iglehart, "The New Medicare Prescription Drug Benefit—A Pure Power Play," *New England Journal of Medicine* 350, no. 8 (2004): 826–833.
19. MMA calls for between ten and fifty regions. The CMS has until 1 January 2005 to define the regions. On 21 July 2004 the CMS presented six options of 10, 11, 32, 34, 37, and 50 regions. See CMS, "Agenda for the Open Public Meeting: Establishing Regions for Medicare Advantage Regional Plans and Prescription Drug Plans under the Medicare Modernization Act," 21 July 2004, cms.hhs.gov/medicarereform/mmaregions/All_Info_Materials.pdf (13 September 2004).
20. A.W. Matthews and S. Hensley, "Medicare Proposal May Aid Insurers," *Wall Street Journal*, 19 August 2004.
21. PwC, *The Value of Pharmacy Benefit Management*.
22. Remarks by Barrett Toan, chief executive officer, Express Scripts, and chairman of the board, PCMA, at the National Medicare Prescription Drug Congress, Washington, D.C., 26 February 2004.
23. Tom Mahowald, vice president for public affairs, Express Scripts, personal communication, 29 July 2004.

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