

*Everything
you always
wanted to know about*
**Pharmacy Benefit
Managers**



*.....that they don't
want you to know!*

prepared and presented by

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TPA Network, Inc.



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OVERVIEW AND SUMMARY

This document focuses on the practices of pharmacy benefit managers (PBMs) that are generally, unknown to those who design, purchase, administer, and manage pharmacy benefit plans.

For years, PBMs have operated in a largely oligopolistic business environment in which there has been virtually no accountability and little competition of which to speak. Recently however, the practices of PBMs have come under great scrutiny as more and more becomes known about how they operate. The public is learning that many PBMs have engaged in unfair, deceptive and self-dealing practices designed to increase their profits by aligning themselves with the price maximization policies of drug makers. Indeed, employers, brokers and patients alike are reading headlines in the Ft. Worth Star, Wall Street Journal, Boston Globe, New York Times, and in other leading publications such as:

"Pharmacy Benefit Managers Are Sued Over Secret Dealings"

"Lawsuit Highlights Hidden Role Of Drug Purchasers"

"Eyes On The Middleman"

The result is that the image of PBMs is moving from organizations that were expected to act as an advocate for healthcare plans by negotiating lower drug costs for them, to ones that now focus on earning excessive profits at their clients' expense. Indeed, more and more people are reaching the conclusion that PBMs may possibly be Public Enemy No. 1.

At the same time, increases in drug costs and utilization continue at a rate that is far higher than that of general medical services. More and more expensive drugs are coming on to the market and the number of high-cost biotech drugs (where treatments often cost thousands of dollars per month) will more than double in the short term. As a result, the pharmacy component of most healthcare plans now makes up as much as 20% of total costs.

Understanding this, payors -- whether they be TPAs, health insurers, HMOs, or at-risk provider groups -- have begun to look more carefully at their PBMs with an eye toward learning how they operate so that they may regain control over their pharmacy benefit expenditures. Employers, too, have begun to take action on their pharmacy benefits by engaging a new breed of consultant who focuses exclusively on pharmacy benefits. These consultants are making their mark by conducting audits of PBMs (and payors) and exposing hidden income and misplaced incentives. ***The author has commissioned studies of large numbers of prescription claims, from multiple payors, that have generating savings from the undisclosed questionable activities discussed herein of more than \$5⁰⁰ per employee per month!***

This document is intended to provide the reader with an overview of the PBM industry and insight into what has been characterized as the abusive, fraudulent, deceptive and unethical policies and practices that are being engaged in by many of the industry's largest companies. It will alert you to the crisis situation that has arisen for payors and their clients as a result of these practices and the phenomenal amount of press that has been focused on this issue.

As a byproduct, the authors hope that your learning about the inner workings of pharmacy benefit managers will encourage you to investigate and question the activities of your PBM. Indeed, we hope to spur you to become more proactive and to take better control of your pharmacy costs, stay clear of questionable industry practices, and to better understand and eliminate possible ERISA compliance violations. As we see it, any one of these reasons should warrant the further investigation of this topic.

PHARMACY BENEFIT MANAGEMENT

In the late 1970s, a new type of healthcare administrator emerged that specialized in prescription drug benefits. At that time, prescription drugs were covered under what was then known as the "major medical" benefit. Drug receipts were "shoe boxed" and submitted for payment after satisfaction of an annual deductible. The advent of the prescription drug card was viewed as a mechanism that made the purchase of pharmaceuticals easier, less expensive and less cumbersome to administer.

Over time, the cost of pharmaceuticals began to escalate at a much more rapid rate than general medical services and pharmacy card administrators evolved into "pharmacy benefit managers" or "PBMs". PBMs took on the role of fiscal intermediaries between payors and pharmacies with a mission to help control the cost of drug coverage through their extensive networks of pharmacies, benefit-specific utilization management programs, and "formularies". *

In many ways, PBMs operate much like any other managed care organization or TPA. PBMs process claims, perform utilization review and formulary management functions, handle customer service issues, develop and manage provider networks, maintain eligibility data, conduct sales and marketing campaigns, etc. In addition, they facilitate mail order and specialty drug dispensing services. Each of these functions is either performed in-house or through an outsourced entity.

PBMs process hundreds of millions of pharmaceutical claims each day and manage drug benefits for more than 200 million Americans. Because PBMs influence the purchase of huge volumes of pharmaceuticals, their bulk purchasing power enables them to negotiate both rebates from drug manufacturers and discounts from retail pharmacies. Control over the development of formularies gives PBMs tremendous clout with drug companies as manufacturers typically compete -- and give PBMs significant financial incentives -- to secure the most favorable placement of their products on a PBM's formulary.

For years, PBMs have operated in an environment in which there has been no accountability. In part, this is because the drug industry and its distribution channels were largely misunderstood. Moreover, there has been tremendous industry consolidation, with the three largest PBMs (Express Scripts, Advance PCS/Caremark Rx, and Medco Health) comprising an estimated 75% of the total employer (non-government) healthcare market. Through a variety of means (described herein), these companies greatly influence drug purchasing in the U.S. Yet, until recently, the practices of these PBMs have gone largely unchallenged.

Within the past few years, however, the practices of PBMs have come under great scrutiny as more and more becomes known about how they operate. Consumer-, payor- and government-sponsored lawsuits now abound, with many alleging that PBMs have done more to increase the cost of pharmacy benefits than control them, as they were entrusted to do. Indeed, many now view PBMs as Public Enemy No. 1.

* A formulary is a list of drugs able to be prescribed by a physician for use by a plan's participants. Formularies are intended to help manage drug spending by including drugs that are both efficacious and less expensive. By charging less for certain brands of drugs, PBM formularies are intended to encourage patients and their physicians to use specific drugs for a particular therapeutic need. Patients pay a higher co-pay (and the plan pays the PBM more) for drugs that are not "preferred" category drugs on the PBM formulary. Some plans do not cover non-formulary drugs.

QUESTIONABLE INDUSTRY PRACTICES

This section will expose many of the questionable industry practices that are engaged in by most large PBMs. For the most part, these have been willfully hidden from payors, employers, and patients.

- **Background**

Many payors view PBMs as a black box: they know what they should do but they don't know if and how they do it. In the authors' view, this is not by accident, but by design. In great part, this is because most PBMs engage in questionable practices that have become commonplace in the industry. These practices, although not new, have been recently unearthed and publicized by consumer organizations, trade groups, and industry regulators alike. As a result, the public is learning that PBMs engage in unfair and deceptive practices designed to increase their profits by aligning themselves with the price maximization policies of drug makers. These practices are causing payors, employers, providers, and patients alike to question the integrity of PBMs. Indeed, several lawsuits have been filed against PBMs that charge them with illegal pricing and deceptive trade practices and which seek *retroactive* restitution (see www.prescriptionaccesslitigation.org and www.hagens-berman.com).



In March 2003, the Prescription Access Litigation (PAL) Project, with the American Federation of State, County and Municipal Employees (AFSCME), filed suit against the largest PBMs in America: Medco Health, Express Scripts; and Advance PCS/Caremark Rx. PAL charged that, through a variety of questionable business practices, these PBMs have reaped billions of dollars in illegal and maximized profits by

- influencing the choice of pharmaceuticals prescribed by physicians and purchased by a substantial portion of U.S. citizens,
- inflating prescription drug prices by development of a pricing system based on the AWP that is widely considered an inflated "sticker" price set by the drug companies, and
- consistently failing to pass the savings negotiated via their bulk purchasing power to their clients.

In so doing, this lawsuit charges that these PBMs have willfully contributed to escalating drug costs and failed in their fiduciary duty to their clients. Congress, the Departments of Justice, HHS, and several state Attorneys General are investigating drug manufacturers and PBMs alleging that they participated in many fraudulent and unlawful pricing, billing, reporting and marketing schemes. In recent Congressional hearings aimed at investigating drug manufacturers and PBMs, Rep. Pete Stark articulated what may be the general feeling of the government agencies that are investigating drug manufacturers and PBMs in stating that they have

- "falsely inflated drug prices to create de facto improper kickbacks for their customers..."
- "engaged in fraudulent price manipulation in order to arrange de facto kickbacks for their customers at a cost of billions of dollars..."
- "arranged kickbacks to improperly influence physician medical decisions and judgements"
- "engaged in illegal price manipulation in order to increase utilization of their drugs beyond that which is necessary and appropriate based on the exercise of independent medical judgement not affected by improper financial incentives".

As this passage indicates, while the courts have yet to determine the outcome of the many suits against PBMs, it is not difficult to see that the government sentiment against them is well established.

- ***Redefining Average Wholesale Price***

There are some 65,000 different drug products in the U.S., including various dosages and package sizes of the same drug. The industry-wide fee basis for these drugs are published prices, specifically Average Wholesale Price (AWP). AWP is *represented* to be an average of list prices charged by wholesalers to pharmacies. In fact, AWP's are *set by drug manufacturers* and provided for publication in various pharmaceutical compendia and databases. It is noteworthy to mention that there is no independent review conducted of the prices supplied by the manufacturers for accuracy and, because they control the prices listed as the AWP's for their drug, they are widely viewed as a "sticker price" and well known to be very inflated. Here are some examples of how PBMs manipulate drug prices.

- PBMs deliberately use a variation of AWP to create an artificial "spread" between the price charged to their clients and that paid to pharmacies. To appear as if they are offering a deal, PBMs often charge payors AWP less a specified discount even though *this amount has no relationship to what they pay pharmacies*. By example, a PBM may charge a client AWP-12%, yet pay the pharmacy AWP-17%, generating an *undisclosed* 5% spread for the PBM. The authors have performed studies of large numbers of Rx claims and, expressed in other terms, it is typical for the undisclosed spread to average from \$3 - 6^{.00} per script, or \$4 - 5^{.50} per employee per month.
- Some AWP-based pricing includes "effective" discounts which incorporate an *undisclosed* add-on value to the PBM of 3-5% for "UCR values".
- Regarding generics, PBMs often use one Maximum Acquisition Cost ("MAC") list to charge clients and another list (with much lower prices) to pay pharmacies. The spread can be several percent.
- PBMs keep the entire spread on mail order drugs as there is no pharmacy with which to share it.

Since PBMs consider their relationship with retail and mail order pharmacies to be confidential, payors are not informed of the reimbursement amount paid by PBMs to the pharmacies -- *even if they ask*. It is no wonder, as this essentially amounts to marking-up the cost of claims -- something that no legitimate payor or administrator would ever consider, and that no employer would ever tolerate.

Industry critics view this artificially inflated AWP drug pricing system as a fraudulent manipulation of pharmaceutical prices. They are right. They see the spread as essentially being funded by over-payments made by payors and patients to create unreasonably large profit margins for PBMs. Moreover, the spread gives PBMs a financial incentive to encourage the use of drugs with higher AWP prices -- and corresponding higher spreads -- by listing those drugs on their formularies.

What to do about AWP manipulation

Payors must act to stop the AWP scam by requiring their PBMs to identify and use either the lowest pricing source for each drug or the pricing source that represents, on average, the lowest AWP prices. *First DataBank's* AWP database, a widely used source, is not intended to represent the wholesale price suggested by the manufacturer. Instead, FDB claims that it conducts periodic surveys of national wholesalers to determine the actual wholesale acquisition cost of a product and the average mark up applied to that cost. Be aware that while most PBMs mention FDB in their AWP definition, they word the definition loosely so that FDB need not be strictly followed. When negotiating contracts use language similar to "FDB or other pricing sources as determined by PBM".

Many PBMs use multiple MAC lists and ones with a very limited number of generics. Insist that your PBM use a very comprehensive MAC list (e.g., the CMS FFP MAC published in the Federal Register) and that the price charged is the price paid to the pharmacist -- the acquisition cost. And have an independent PharmD review the MAC list.

Lastly, insist that your PBM either sign on as a fiduciary to the plan or disclose all sources of income.

- **Rebates and Rebate Disguising**

Rebating is the process by which drug manufacturers reward PBMs for promoting their products. As indicated below, rebates come in many forms and are a *very* significant source of PBM income:

- *access rebates -- for placement of products on the PBM's formulary*
- *market share rebates -- for garnering market share greater than established targets*
- *administrative fee rebates -- for assembling data to verify market results, and*
- *rebate fees for services to encourage physicians to change prescribing patterns.*

Manufacturer rebates are considerable. On average, they can amount to \$2-3⁵⁰ per script. Most PBMs earn and use rebates to increase and hide revenues at the expense of their clients through a variety of means. PBMs promote newer, brand name drugs that pay the highest rebates, but that may not be the most efficacious option, or the one in the patient's best interest. When pushed, PBMs share rebates with their largest clients; however, many disguise a large portion of their rebates as “administrative expenses” to secretly reduce the shared rebate amount. Others link rebates to formulary savings to hide all of the rebates on these drugs. PBMs rarely disclose specific rebate amounts other than in the aggregate to prevent clients from learning the true rebate amount earned on their account.

What to do about rebates

Rebates cannot be entirely avoided as a reasonably large number of dispenses earn some type of rebate. Payors should insist that all rebate revenue be fully disclosed and shared.

- **Rebate Pumping**

When a PBM creates a formulary that substitutes low cost drugs for newer, high cost drugs that pay larger rebates (and creates greater spreads), even though they are often not the best drug in a therapeutic class, this is rebate pumping (see the examples below). This is a serious conflict of interest as PBMs should act to lower a plan's cost, but often act to maximize their profits at the client's expense through formulary development performed in their self interest. It is wrong.

Ulcer Therapy - PPIs			
	Protonix 40 mg		Prevacid 30 mg
AWP/30-day Rx	\$	114.90	\$ 145.80
Rebate Available	\$	12.67	\$ 19.15
Net AWP to Plan	\$	102.23	\$ 126.65
<i>Plan Savings</i>		19.28%	

Cholesterol Lowering - HMGs			
	Lipitor 10 mg		Zocor 20 mg
AWP/30-day Rx	\$	77.40	\$ 143.70
Rebate Available	\$	9.25	\$ 15.87
Net AWP to Plan	\$	68.15	\$ 127.83
<i>Plan Savings</i>		46.69%	

Anti-depressants - SSRIs			
	Lexapro 10 mg		Zoloft 50 mg
AWP/30-day Rx	\$	69.30	\$ 86.10
Rebate Available	\$	7.12	\$ 10.11
Net AWP to Plan	\$	62.18	\$ 75.99
<i>Plan Savings</i>		18.17%	

Migraines - Triptans			
	Zomig 2.5 mg		Amerge 2.5 mg
AWP/30-day Rx	\$	157.68	\$ 196.56
Rebate Available	\$	15.22	\$ 20.11
Net AWP to Plan	\$	142.46	\$ 176.45
<i>Plan Savings</i>		19.26%	

(Note: As of May 24, 2004)

What to do about rebate pumping

Include a prohibition against rebate pumping in the PBM contract and use an independent PharmD to develop the formulary strictly on the basis of therapeutic appropriateness and cost effectiveness.

- ***Over-Promoting Mail Order and Specialty Pharmacy Dispenses***

PBMs that own mail order and specialty pharmacy facilities have an inherent conflict of interest when they do not disclose the manner in which they earn revenues from these sources. Moreover, many engage in a number of deceptive practices designed to support their interests rather than those of the payor. By example, PBMs promote the use of mail order services on the premise that this type of dispense results in more cost effective pharmaceutical purchases. They boast that mail order discounts are higher and that the dispensing fees and administration fees charged are less than for retail dispenses. While this might appear on the surface to be logical, the fact is that in actuality *over promoting the use of mail order services can significantly increase plan costs*. Here are a few reasons why this is the case:

- PBM owners of mail order and specialty pharmacy facilities benefit twice from every such dispense. First, they benefit by earning their regular PBM administration fee. Second, they benefit by profiting from the sale of the pharmaceutical, vs. allowing the sale to be made at the retail level.
- The average rebate earnings on mail-order dispenses is 250% of that earned on retail dispenses.
- PBM owners of mail order facilities can influence the dispense for their advantage by contacting the prescribing physician in an effort to switch the script from a generic or non-preferred brand product to a preferred brand name product to earn greater spreads and (market share) rebates. A 1993 study found that captive mail order facilities dispense 24% fewer generics than non-captive facilities.
- Mail order facilities can re-package and re-price drugs to fraudulently extract higher margins *while staying within their contract terms*. How? One way is to repackage the drug and bill for a (higher unit cost) lower package size NDC rather than the (lower unit cost) actual NDC that is dispensed using their own AWP price and proprietary NDC. Many PBM contracts allow them to charge the 100-unit package price (or less) even though the PBM buys the drugs in bulk and at a much lower cost. Another way is to re-package the drug, use a proprietary NDC with a highly inflated AWP (e.g., 180% of AWP) and then promote a *seemingly* large discount (e.g. AWP-40%) to the payor.
- Maximum Allowable Pricing (MAC) should be a part of all retail and mail order plans. PBM owners of mail order facilities often use one (higher) MAC pricing list to charge payors and another (lower) one to pay manufacturers, keeping the (often several hundred percent) spread.
- PBM owners of mail order facilities falsely promote plan designs that serve to drive mail order volume and *increase* rather than *decrease* the cost and utilization of pharmacy benefits. Here's how:
Studies show that requiring only two co-pays for a 90-day drug mail order supply, versus what would normally require three co-pays if purchased retail, often results in considerably higher costs to the plan -- as much as an additional \$10⁰⁰ per mail order script. Since the mail order facility is owned by the PBM, the PBM earns this additional amount. (A 2.5 mail order co-pay is often cost neutral.)
PBMs know that mail order scripts are filled for longer durations (90- vs. 30-days) and that many patients react adversely to new drugs. PBM mail order facility owners have no incentive to reduce waste by including (or enforcing) protocols that require patients to use retail pharmacies until they are certain to tolerate a drug. The result is great waste for the plan and increased revenues for the PBM.
- In addition to undisclosed bulk purchase discounts, PBMs earn prompt payment discounts from drug manufacturers -- commonly 2-3% of AWP! -- which are *rarely* passed back to the payor.

What to do about mail order and specialty drug over promotion

Eliminate self-dealing. Don't use a PBM that owns a mail order or specialty pharmacy facility. Conduct a semi-annual review of all mail order and specialty pharmacy dispenses to justify this modality of purchase and to validate the legitimacy of the plan designs employed. Prohibit drug switching, NDC upping, drug re-packaging, multiple MAC schedule use, etc. in the PBM contract.

- ***Formulary Steering***

Formulary steering occurs when a PBM influences a doctor to change his/her prescription to maximize their profits. It occurs with multi-tiered plans and open formulary plans (when there should be no steerage at all). By example, Astra-Zeneca paid ExpressScripts \$500,000 to call 22,000 doctors and ask them to switch their patients to Nexium (a high cost brand drug) from Prilosec, after Prilosec became available as a less costly generic. Formulary steering is a serious, costly practice as there are often many alternative drugs, and at least one generic product, available for most of the top therapeutic classes.

Formulary steering is increasing. The savings opportunity from generics alone has never been greater since the mass introduction of important generic entrants continues to increase. Indeed, over the next few years, patents on many brand drugs will expire that have combined market sales of \$30+ billion.

What to do about formulary steering

Prohibit formulary steering in the PBM contract. Monitor patient purchases and the prescribing patterns of physicians to identify formulary steering. Have a PharmD re-evaluate your formulary.

- ***Profiting on Zero-Cost Scripts, Refunds, Reversals and Returns***

Up to 20% of all drug dispenses cost less than the patient co-pay yet many PBMs allow retail pharmacies to keep the entire patient co-pay (ex. \$15^{.00}), or some part thereof, even if the script is less (ex. \$7^{.00}). A credit (\$8^{.00}) may then accrue to the PBM, rather than passing on the true cost to the patient or plan.

A significant number of prescription payments are eligible for refunds and reversals due to pharmacy errors and changes, returned prescriptions, patients not picking up scripts, etc. However, audits of many PBMs have shown them to be "sloppy" with regard to properly crediting refunds and reversals.

What to do about profiting on zero-cost scripts, refunds, reversals and refunds

Profiting from these activities is illegal and may violate ERISA. Learn to identify zero-cost scripts, refunds, reversals, and returns. Audit your PBMs and their invoices often. Revise your PBM contract.

Proactive Strategies & Solutions

Dealing with PBMs that engage in these practices makes payors vulnerable as their commitment to act in the sole interest of plan participants may be questioned. Payors and plan sponsors should develop a well thought out and documented strategy for dealing fairly with PBMs. Here are some suggestions:

- *Take control of the PBM process. Obtain guidance to develop and manage a formulary that is in the exclusive interest of your clients. Control the drug pricing and pharmacy payment scheme. Maximize your cost containment efforts. Eliminate any means by which a third party can adversely influence the operation of your pharmacy program for their advantage. Conduct PBM audits.*
- *Analyze 2-3 months of Rx claims to identify existing problems and areas for improvement. Have the claims re-priced (vs. acquisition costs) to determine the true PBM spread. Ask the PBM to disclose the exact amount of rebate dollars available on each claim. Have an independent PharmD. determine if less expensive therapeutic substitutes are available and evaluate your drug formulary to eliminate rebate pumping. Have your PBM cost justify its mail order and specialty drug strategy.*
- *Become knowledgeable about both the routine and discretionary practices and policies of operating a PBM. Be certain to relate this information to your clients.*
- *Identify and eliminate all financial incentives that are not entirely aligned with maximizing plan participant value. Be transparent in your dealings and arrangements.*

REGULATORY ISSUES

The following is a discussion of the key regulatory issues pertaining to dealing with PBMs.

- ***PBMs as Parties-in-Interest and/or Fiduciaries under ERISA?***

ERISA defines a person who provides services to the plan as a *party-in-interest* and any person who, with respect to an employee benefit plan, exercises *any* discretionary authority or control with regard to managing a plan or its assets, as a *fiduciary*. Fiduciaries and parties-in-interest must act *prudently* and *solely in the interest of plan participants*, and their compensation must be *reasonable* and *disclosed*.

Given this, are PBMs parties-in-interest and/or fiduciaries under ERISA? Clearly, they are parties-in-interest. Although arguable, the DOL would likely say they are fiduciaries positing that they exercise both discretion and judgement. PBMs are engaged not only to *administer* pharmacy benefits but also to *negotiate fair deals* for their clients. PBMs *exercise discretion* in the creation of formularies and in the establishment of pricing structures for their clients and network pharmacies. PBMs argue that the administrative services they are hired to provide are ministerial, and not discretionary in nature: the "just-acting-on-orders" argument. We think otherwise.

- ***Do PBMs act like Parties-in-Interest and/or Fiduciaries?***

No. ERISA's prohibited transaction provisions apply not only to fiduciaries but also to parties-in-interest. Most PBMs earn *unreasonable* fees, they *do not* disclose them, and they certainly *do not* act in the sole interest of plan participants. Indeed, most have shirked their fiduciary responsibilities by engaging in deceptive policies and practices that put their interests ahead of those of their clients. PBMs should not use their client relationships, and resultant bulk purchasing power, to profit from the other side (the drug makers) without full disclosure to the plan. Double-dealing is dishonest, plain and simple.

- ***Can TPAs, Employers, and other Payors be held Responsible for Questionable PBM Practices?***

In our opinion, yes. A PBM's standard of conduct should be of prime concern to payors and plan sponsors as they assume the burden of getting a fair and honest deal for plan participants. Payors are relied upon to research, evaluate, and recommend PBMs. Payors and plan sponsors who are aware of imprudent PBM practices run an enormous risk by dealing with them. Those who claim that they are not aware of such practices (e.g., regarding the creation of formulary and drug pricing) will not be excused. All forms of remuneration received from PBMs should be disclosed and justifiable with respect to the level of services rendered. All compensation paid by PBMs should be *reasonable*.

Under federal and state anti-kickback statutes, rebates, discounts or other remuneration paid by drug makers to an ERISA plan or its PBM may be deemed payment in exchange for *arranging* or *recommending* a particular item. If these monies are not properly reported, a plan may face exposure under the Federal Civil False Claims Act or the state equivalent; many questionable practices and policies of PBMs may be prohibited under common-law theories of fair dealing.

Summary & Conclusion

Payors will be held to a high standard by their clients with respect to their knowledge of questionable industry practices and their endorsement of PBM vendors who condone such practices. Regardless of what the letter of the law is, payors and plan sponsors run an enormous risk of violating (or being seen as violating) a real or imputed fiduciary responsibility to plan participants if they do not investigate their PBM regarding these activities. Being aware of these practices and the vendors who engage in them, without taking adequate measures to disclose them or to stop using such vendors, is dangerous.

ABOUT TPA Network

TPA Network has been at the forefront of innovation in the TPA industry since 1985. Indeed, our experience dates back to the beginning of the group health insurance industry, some 45 years ago.

Principals of our firm have helped to shape and develop some of the earliest forms of group health insurance in the '60s. We were there in the '70s and '80s when the TPA industry took hold and expanded rapidly. When federal legislation threatened to make the industry more cumbersome, we represented hundreds of TPAs (and millions of plan participants) at hearings before the U.S. Congress. We have counseled governments and think tanks, published numerous articles, and spoken extensively on topics of interest and concern to TPAs, health insurers and managed care organizations.

Our principals and associates have started and operated TPAs, managed care organizations, and business process outsourcing firms, both in the U.S. and abroad. We perform consulting assignments and operational reviews, affect mergers and acquisitions, raise capital, design products, assist in business development, and establish channels of distribution for emerging products, services, and technologies. We make connections and negotiate deals. And when a solution doesn't exist, we simply create one.

Over the years our clients have included a diverse group of small and large health insurance carriers, HMOs, and Fortune 500s with names such as Prudential, Fidelity Insurance Group, Xerox, NYLCare, UNYSIS, the American Healthcare Association, General de Seguros, and Computer Sciences Corporation. We have advised and represented several allied service vendors to the industry and have performed numerous research, consulting, valuation and merger and acquisition assignments. We have business and/or personal relationships with the principals and executive management of literally hundreds of TPAs, PPOs, HMOs, and health insurer carriers.

About the Author and this Report

This report was authored by Richard L. Nicholas. Mr. Nicholas has been in the TPA, managed care and employee benefits industries for 26 years, having served in executive capacities with the largest payors in the nation. He is the author of a book on corporate healthcare cost management techniques and he has written for, and been quoted in, numerous publications including the Wall Street Journal, USA Today and Healthcare Horizons. Mr. Nicholas has spoken extensively at industry conferences and has testified as an expert witness at hearings before the U.S. Congress, Committee on Ways and Means.

This report was written with information and data compiled from a review of the literature and interviews with drug company and PBM insiders, pharmacy and PBM auditors, attorneys, industry analysts and experts, prescription transaction processors, and the compilers of the leading pharmaceutical databases. Much of the findings noted herein are the result of a scientific analysis of several hundred thousand pharmacy claims that were recently processed by each of the largest PBMs.



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