

## Pharmacy Benefit Manager's Contribution to Higher Drug Prices

by: Craig M. Burridge, M.S., CAE

### Overview:

I am currently the CEO of the South Carolina Pharmacy Association and was formerly the CEO of the Pharmacists Society of the State of New York for 20 years. I have been tracking and researching Pharmacy Benefit Managers for over 20 years. My expertise in this arena led to my being invited to train, first the CMS Region II staff on PBM abuses and later conducted a live national seminar on the same subject for all other CMS regions. This was done as Medicare was starting the Medicare Part D program and had little knowledge of the drug distribution or payment system, unlike Medicaid. I was invited to come to Washington, D.C. to the HHS's Office of the Inspector General to provide the PBM 101 training to over 60 attorneys in the investigation unit. There were other attorneys present from the DOJ and FTC. A month later, I was asked to return to D.C. to provide the same program to DOJ attorneys.

The following year (2009), I was once again invited to the U.S. HHS' OIG office to train more than 100 investigators. Present at this training was the head of CMS Audit Office out of Philadelphia, PA. He vocalized his frustration by stating that: "We are in year three of the Part D program and we haven't been able to complete a single audit of a Part D plan because the PBMs refused to provide critical information to the health plans – that being rebate contract information with drug manufacturers." The PBMs kept telling the plans that it was "proprietary information." CMS says their contract is with the plan and not the PBM and their hands were tied. It was suggested by me that investigators or auditors use the Fraud, Waste & Abuse law to audit the PBMs. I explained that the law authorized the auditing for fraud, waste or abuse of the plans and "any downstream entity." I then explained that if pharmacies were considered downstream entities, then so are the "Middle-Men" PBMs." I find it interesting that in March of 2011, the HHS OIG's office released a document called: "*Concerns With Rebates in the Medicare Part D Program.*" In it, the OIG states that even though the Medicare Part D program is similar in size to the Medicaid program (covered lives), the rebates only average around 10% in the Part D program and the amounts varied wildly across Part D plans. Also, that some plans steered people to certain drugs to collect rebates. Finally, that Part D plans woefully underestimated drug rebates which led to higher than needed premiums.

### PBM Tricks of the Trade:

While researching the State of New York's Employee Prescription Drug program (Empire Plan) back in the early 2000's, it was discovered that the contracted PBM (Express Scripts) was keeping millions of tax payers dollars through manipulation of branded drug pricing and hiding drug manufacturer rebates by calling them something else. This led to my filing a complaint with the

State Comptroller's Office (oversees state contracts) and the Attorney General, Elliott Spitzer. In the summer of 2004, the state Attorney General filed a \$100 million lawsuit against Express Scripts. A few months later, I also filed a RICO criminal complaint against Express Scripts with the Attorney General as evidence arose that corporate had training tapes used to teach contracting (sales) employees on how to answer contract questions or not, in order to mislead plan sponsors as to actual costs of the program. The criminal charges had to be dropped in order to settle the civil suit for \$27 million in the summer of 2008. There are approximately 30 bank boxes of ESI evidence still in storage at the AG's office in NY. Including the incriminating video training tapes showing a conspiracy to defraud plan sponsors. I continued to do research into court cases against the PBM industry and worked with several NYC union trust funds to assist them through training on PBM abuses thus, significantly reducing their drug costs for their members. These include: the NYS Sergeants Benevolent Association and the largest municipal union (NYC's - DC-37) Trust Fund. The trust funds moved away from the Big Three PBMs at the time and to a truly transparent PBM saving these NYC-based trust funds tens of millions of dollars each year. All those millions were "Hidden PBM Income."

#### **How Do I Fraud Thee, Let Me Count The Ways:**

Over the past 20 plus years, I have accumulated and verified a number of PBM schemes to hide income from plan sponsors that range from sleight of hand to outright fraud. I have listed the claims below starting with those made in the Empire Plan lawsuit against Express Scripts. These claims can be found in (*Appendix A - NYS AG ESI Lawsuit Press release*).

- ***"Enriched itself at the expense of the Empire Plan and its members by inflating the cost of generic drugs;*** (This is called "pricing spreads." PBMs use this in the Part D program among many. PBMs pay pharmacies one price based on Maximum Allowable Cost tables and bill the plan based on an Average Wholesale Price minus a percentage discount. These two prices are not even in the same ballpark);
- ***Diverted to itself millions of dollars in manufacturer rebates that belonged to the Empire Plan;*** (ESI called millions of dollars of drug rebates something else and kept the money even though the Empire Plan paid ESI to hand over 100% of the rebates)
- ***Engaged in fraud and deception to induce physicians to switch a patient's prescription from one drug to another for which the Express Scripts received money from the second drug manufacturer;*** (drug manufacturer's would pay a PBM for "market share movement" rebates on top of rebates for formulary placement. As market share of their products increase, the more money that was paid to the PBM. This was not known by most plan sponsors. In the past, this would be known at Radio Stations as *Payola* in the music recording industry)
- ***Sold or licensed data belonging to the Empire Plan to drug manufactures, data collection services and others without permission of the Empire Plan (self-explanatory);***
- ***Induced the state to enter into the contract by misleading the discounts the Empire Plan was receiving for the drugs purchased at retail pharmacies."*** (This was the sleight of

hand mastery of PBMs in training their contract sales people in the art of the deception. For example: The contract stated that if a member of the Empire Plan used a *local retail pharmacy* for a brand drug on the formulary, the state would be billed at a *rate of AWP-16%, plus a \$2.00 dispensing fee*. It then stated that if the Empire Plan member used the *mail order pharmacy*, owned by Express Scripts, then the Empire Plan would pay *AWP-20%, plus No Dispensing Fee*. At first blush, this would look like substantial savings for a program spending over \$1 billion annually at the time. The "deception" here is that the *AWP (starting price)* was not the same. Express used what industry calls "repacker" National Drug Code (NDC) numbers. (*see Appendix B – Ready Price, Actual pharmacy PC snap shots – Repacker Reimbursement vs. Retail*) Express Scripts need simply apply to the FDA for a repacker NDC number for a branded drug based on for example, a package size difference. So if the drug manufacturer didn't have 90-day packaging, the PBM could get a repacker NDC number for that drug. Why would a PBM do that? That new repacker NDC number has its "*OWN*" *Average Wholesale Price (AWP)* and that price was much higher than the brand manufacturer's published AWP. So, in the case of the Empire Plan, we looked at the top 15 most dispensed *branded* drugs for the plan and found in every single case that the AWP for the mail order repacker number was *substantially higher*. So, the 20% off the AWP and no dispensing fee still caused the Empire Plan to pay millions more a year than if the member had gone to the retail pharmacy and got three separate Rx fills instead of one 90-day at mail order and paid the \$2.00 dispensing fee each time. Both the Empire Plan and their members were *induced* to use Express Scripts mail order pharmacy thinking they were saving the plan (*taxpayers*) money.

#### Spreads on Generic Drug Prices:

PBMs saw the writing on the wall back in the early 2000's. From 2003-2005, the greatest number of branded drugs in the history of the industry were losing their patents and this would amount to losing hundreds of millions in PBM '*retained*' drug rebates. They needed another lucrative source of hidden income and in came '*spread pricing on generic drugs,*' drugs which cost pennies on the dollar in relation to their brand counterparts. PBMs must have assumed that health plans and employers were used to the high prices of branded drugs so here was their chance to give them cheaper generics, just not that cheap.

I was witness to the transition. I was on a conference call in early December of 2005. I had been asked to sit in on the call by some friends who worked on Wall Street (analysts) who needed some assistance in asking questions to the "then" CEO of Caremark (pre-CVS purchase). One of the questions I proposed was this: "With a record number of branded drugs losing their patents over the past four years, how is Caremark expected to maintain such high net profit levels with the continued loss of drug rebates?" The CEO said, without hesitation, "The spread pricing on generic drugs in the Medicare Part D program." The Part D program's launch date was just a few weeks away in January, 2006. It wasn't until 2008 that I was able to get permission from a Part D patient to use her full Medicare Part D, 2007 year Explanation of Benefits (EOB) to '*prove*' that

PBMs were spread pricing generic drugs. In this case it was Express Scripts who was the PBM for a not-for-profit, NYC-based Medicare Part D plan. This individual's plan was not only highly overcharged for her generics, these overcharges pushed this patient into the donut hole month's sooner than had she paid cash to the pharmacy. *(See Appendix C – DOB patient report, Actual pharmacy prescription receipts – PBM mail Order vs. Retail)*

The spread on one generic for another patient was hundreds of dollars. The plan was billed \$400 for one generic and the pharmacy was only paid \$12.00! There was a Wall Street journal article (Aug., 2012) about another patient taking 16 generics and the hundreds of dollars a month her plan was overcharged. Another fact is that the plan's PBM wanted to charge that patient the same overpriced cost they billed her plan for when she was pushed into the donut hole and had to pay cash for the second half of the year. Her pharmacist agreed to have her pay what he was being reimbursed by the PBM and saved her nearly \$900 a month. *(See Appendix D – Top 15 most dispensed generics 'spread pricing')*

### **Specialty Drugs or Anti-Competitive Behavior?**

What are Specialty Drugs? Well, currently they are not defined by the FDA. It was a made up term by PBMs once they acquired the nation's pharmacies who 'specialized' in particular 'disease states.' Pharmacies who specialized in certain disease states such as HIV/AIDS, Renal Failure or Transplants trained their staffs to be experts in the drugs used for these diseases. Once the large PBMs began buying up these pharmacies that specialized in certain disease states, they moved away from treating certain disease states to calling certain expensive drugs "specialty drugs." This was a way for them to 'steer' patients to their now **wholly-owned specialty pharmacies** as they now call them. It was a way for PBMs to side step *Any Willing Pharmacy state laws* or *No Mandatory Mail Order pharmacy laws* by calling more expensive drugs 'specialty drugs' and forcing plan members to use their mail order specialty pharmacies.

In May of 2009, David Balto, Esq. provided written testimony to the FTC as it relates to PBM anti-trust behavior. *(See Appendix E – page 9)* Mr. Balto is a senior fellow for the American Antitrust Institute. I wanted to point out one particular example he gives on PBM drug price manipulation. In the last paragraph of page 9 of his written commentary, Mr. Balto refers to Express Scripts acquisition of two specialty pharmacies called: Priority Healthcare and Curascript. With those acquisitions, ESI then went on to cut 'exclusive distribution' contract deals with drug manufacturers to provide certain drugs to their wholly-owned '*specialty pharmacies*.' With one of these exclusive distribution deals, ESI raised the price of a children's epilepsy drug called **H.P. Acthar Gel from \$1,600 a vial, to \$23,000 a vial**. This kind of price manipulation would have an immediate negative impact on patients and taxpayers as many of these children using this drug were on Medicaid.

As more and more states passed *Any Willing Pharmacy* and *No Mandatory Mail Order Pharmacy* laws, PBMs shifted their anti-competitive tactics by calling more and more drugs 'specialty drugs' and steering plan patients to their wholly-owned so-called specialty pharmacies. In addition,

PBMs created onerous 'certification' requirements for any pharmacy trying to participate in dispensing so-called specialty drugs. PBMs have required community-based pharmacies to get very expensive certification(s) made up by the PBM industry. These certifications can cost a single pharmacy \$45,000-\$60,000 depending on whether you are required to get one or two different certifications. Additionally, the pharmacy has to fill out the application (which may also require a fee) and which states that you are not guaranteed to be accepted into the network even after getting the required certifications! Another tactic some PBMs throw in on top of the cost prohibition is requiring that the pharmacy requesting to be in the 'specialty pharmacy' network be prohibited from participating in the regular pharmacy network which may be 100% of the pharmacy's current business. Finally, when a PBM picks up a new plan, they mail tens of thousands of letters to plan enrollees misleading them into thinking that they can only get their medications filled at the PBMs mail order or specialty pharmacy. They do not mention that there may be a local option.

### **PBMs Nickel and Diming Health Plans by the Millions!**

As PBMs get caught by plans and contracts get a little tighter on some of the more obvious PBM 'hidden-income' schemes, they now hide millions in what are referred to as '*Prior Authorization*' (PA) fees. The PBMs do not need to convince a health plan that 'specialty drugs' are expensive (whether it is due to PBM or manufacturers), so what they do is establish a prior authorization process in which the patient's doctor typically has to call or go online to get a prior authorization to prescribe certain expensive drugs. This is all well and good if it were used for its intended purpose instead of being used as a hidden treasure chest for the PBM. The PBM controls the specialty pharmacies filling the drug. The PBMs control 'which' drugs will be targeted and required to get a PA. The PBMs control 'which' drugs are on the national formulary the plans use. The PBMs control how many times a year the prescriber has to get a PA for the same drug and same patient. Each prior authorization can range from tens of dollars to a hundred or more. This 'new' source of hidden income adds tens, if not hundreds of millions of dollars to the cost of drugs each year.

### **Silence is Golden**

You might ask yourself, how is it that PBMs can get away with such things as charging *insured* patients generic drug co-pays that are significantly higher than the cash price? How is it that PBMs can reimburse a network pharmacy one price for a drug and bill the plan sponsor something much higher? How is it that PBMs can disregard state laws that are meant to protect patients for PBM profiteering? How can a PBM reimburse a pharmacy at point-of-service one price and months later take back a significant percentage of that payment by just calling it a DIR fee? Is it so the patient has to pay a higher co-pay? Is it a way for PBMs to get around MAC Price Transparency laws? Finally, why don't pharmacies tell health plan sponsors, patients and state officials about these fraudulent or misleading business practices that are adding hundreds of millions of dollars to the cost of obtaining drugs? Why? PBM pharmacy network contracts prohibit a pharmacy or pharmacist from contacting the plan sponsor or speaking with the patient

about any *'proprietary'* information such as co-pays, drug prices, etc. Failure to do so would be a violation of the network contract and subject the pharmacy to removal from the network. With only two behemoth PBMs left, that would be business suicide. Losing participation in just one major PBM could also be a business killer. PBMs control 90-95% of a community pharmacy's business. The contracts are 'take it, or go out of business now.'

The PBMs demand and get proprietary information from their network competitors every time they transmit a prescription for payment yet, the PBM's proprietary information is kept a dark secret even from their clients who include the federal government. Anti-competitive practices, drug price manipulation and non-PBM transparency all contribute to much higher drug prices by as much as 50%. Until PBM pricing practices see the light of day, drug prices will continue to go up. It is in the PBM's best interest that drug prices go up. As prices rise, so do retained drug rebates to PBMs. In a time when inexpensive generic drugs rule the market place providing 90% of all drugs dispensed, then why are drug prices skyrocketing? You need to follow the money. Who controls the distribution of the drugs? Who controls the pricing information? Is there really competition in a PBM-run pharmacy network, or just a false perception? Are plan sponsors paying the same as what the pharmacy was paid or billions more?

Finally, recent PBM contracts have surfaced that now *'prohibit'* a pharmacy or pharmacist from supporting legislation that may be detrimental to a PBM's business model. That's right, PBMs have been allowed to grow so big as to contract the right to free speech and the right to petition the government away from the profession of pharmacy.

PBMs (via PCMA) continue to fight every state who dares attempt to regulate their business practices. They have, and continue to argue when convenient that they are "Not a fiduciary" as it relates to whether or not they are covered by federal ERISA laws AND that they are protected under federal ERISA laws, sometimes in the same legal argument. Which is it? Since they claim that they have no fiduciary responsibilities (as in the NY AG case), then they should not be protected under ERISA. That argument alone reduced the \$100 million claim by the NY AG (2003) by over \$70 million when the court agreed. ESI argued that even though the state of NY paid them \$600,000 to collect and turn over 100% of collected rebates, ESI argues that they had no fiduciary duty to the state and that they alone could determine what is and isn't a drug rebate.

PBMs continue their abusive tactics under different names. When CMS changed the Medicare Part D regulations back in 2010, as it relates to 'drug price spreads,' the PBMs simply changed the 'timing' of when they overcharged patients. Price spreads on generics began to show up only during the 'out-of-pocket' cash phase of drug coverage in the beginning of the year and when the patient was artificially pushed into the donut hole. This way, PBMs provided administrative cover for Part D plan sponsors who would have had to claim those price spreads as administrative income under the new regulations.

Today, PBMs are still using many of the tactics of three card Monty in hiding drug price overcharges by continuing to 'control the information' between pharmacies and plan sponsors

and between PBM and plan sponsors. Today, they are targeting Medicaid Managed Care programs and Medicare Part D programs by significantly dropping generic drug reimbursements to network pharmacies (80-90% reduction in reimbursements) in the fourth quarter of the fiscal year as a way to 'balance' their profit margins, even when these price drops can be hundreds of dollars below a pharmacy's drug acquisition cost. This is going on right now as I write these comments. It has been going on since October 26 of this year. Patients are being turned away at the counter as the pharmacy cannot afford to dispense the drug at such a loss.

PBMs have little to no accountability and until such time, we can expect that drug prices will continue to skyrocket beyond normal market forces.

# Appendix A

## Press Releases

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For Immediate Release  
August 4, 2004

# EXPRESS SCRIPTS ACCUSED OF DEFRAUDING STATE AND CONSUMERS OUT OF MILLIONS OF DOLLARS

Lawsuit Alleges Pharmacy Benefit Manager Inflated Cost of Drugs and Diverted  
Rebates

Attorney General Eliot Spitzer and State Civil Service Commissioner Daniel E. Wall today announced a lawsuit against Express Scripts, Inc., the nation's third largest pharmacy benefit manager, for conducting elaborate schemes that inflated by millions of dollars the costs of prescription drugs to New York State's largest employee health plan, the Empire Plan.

"New Yorkers and all Americans, are facing an ongoing health care crisis – a crisis of access and affordability driven to a large degree by the enormous growth in the cost of prescription drugs, Spitzer said. "Rather than being part of the solution to this crisis by keeping drug costs as low as possible, we discovered that Express Scripts engaged in a series of deceptive schemes. It improperly lined its pockets at the expense of health plans and consumers, driving up the very drug costs it is supposed to lower," said Spitzer.

"We are proud of the steps the Governor has taken to ensure that New Yorkers have access to quality health care, and a key part of his efforts has been increasing access to affordable prescription drugs," Commissioner of Civil Service Daniel E. Wall. "By taking this strong action against these deceptive practices, we are demonstrating our commitment to protecting the more than one million New Yorkers covered by the Empire Plan, as well as state and local taxpayers."

The lawsuit, a result of a one-year investigation by Spitzer's office in cooperation with the Department of Civil Service and the Office of State Comptroller (OSC), is being filed today in New York State Supreme Court in Albany County. The investigation was sparked by audits of Express Scripts conducted by OSC in 2002. The lawsuit alleges that Express Scripts:

- Enriched itself at the expense of the Empire Plan and its members by inflating the cost of generic drugs;
- Diverted to itself millions of dollars in manufacturer rebates that belonged to the Empire Plan;
- Engaged in fraud and deception to induce physicians to switch a patient's

- prescription from one prescribed drug to another for which Express Scripts received money from the second drug's manufacturer;
- Sold and licensed data belonging to the Empire Plan to drug manufacturers, data collection services and others without the permission of the Empire Plan and in violation of the State's contract; and
- Induced the State to enter into the contract by misrepresenting the discounts the Empire Plan was receiving for drugs purchased at retail pharmacies.

While pharmacy benefit managers (PBMs), including Express Scripts, have been under increasing scrutiny by federal and state regulators and law enforcement agencies, New York is the first to allege that Express Scripts enriched itself at its client's expense through a complicated pricing scheme. The scheme hinged on Express Scripts' ability to manipulate its pricing arrangements with its clients.

Express Scripts has two types of pricing arrangements with its clients: "pass-through" and "spread" pricing. Under "pass-through" pricing (used by the Empire Plan for in-state pharmacies), the amount charged to the Empire Plan for a drug would be the same amount paid by Express Scripts to the pharmacy. Under "spread" pricing, the plan negotiates a guaranteed price for drugs with Express Scripts. If Express Scripts can negotiate a lower price with the pharmacy, Express Scripts retains the difference or "spread" between what it pays the retail pharmacy for the drug and what it charges the plan.

Express Scripts developed and carried out a scheme through which it paid certain retail pharmacy chains higher prices for generic drugs for members of plans with "pass-through" pricing, such as the Empire Plan. These higher prices were then "passed through" to such plans. Because they were receiving higher prices from Express Scripts for the Empire Plan and other "pass through" plans, these same pharmacy chains accepted lower prices from Express Scripts for the same drugs dispensed to the members of Express Scripts's "spread" plans, where Express Scripts could charge the plan more than it paid the pharmacy. Thus, Express Scripts employed this scheme to maximize the "spread" that it retained for itself, enriching itself to the detriment of the Empire Plan and its other client plans.

The lawsuit also alleges, that in furtherance of its scheme to divert and retain manufacturer rebates that belonged to the Empire Plan, Express Scripts disguised millions of dollars in rebates as "administrative fees," "management fees," "performance fees," "professional services fees," and other names.

The lawsuit further alleges that the drug switches caused by Express Scripts often resulted in higher costs for plans and members. For example, Express Scripts received funding from brand drug manufacturers to steer members away from less expensive generic drugs when a brand name drug was about to be subject to generic competition. In the period before the introduction of the generic, Express Scripts would switch members from a brand drug losing patent protection to another made by the same manufacturer that was not facing generic competition. These switch initiatives increased prescription drug costs for plans and members, while simultaneously enriching Express Scripts.

The Empire Plan provides health and prescription drug coverage for more than one million active and retired State and local government employees and their

dependants. In 2003, the Empire Plan spent more than \$1 billion on prescription drug claims. The State Department of Civil Service (DCS) administers the Empire Plan and, since 1998, has contracted with Connecticut General Life Insurance Company (CIGNA) to manage the Plan's prescription drug benefit. CIGNA, which is also named as a defendant in the State's lawsuit, subcontracts with Express Scripts to administer the operation of the program.

Express Scripts is paid a per claim administration fee for processing the prescription drug claims of Empire Plan members. Express Scripts is also responsible for negotiating the prices of drugs with pharmacies that fill prescriptions for Plan members, and for collecting and passing on to the Plan any rebates that it receives from drug manufacturers as a result of Plan members' use of the manufacturers' drugs.

Express Scripts provides PBM services for approximately 52 million people in approximately 19,000 client groups that include health maintenance organizations, health insurers, third-party administrators and government health programs. From 1998 to 2003, Express Scripts's revenues from its PBM services were in excess of \$46 billion.

CIGNA is among the largest insurers in the United States. The CIGNA network of companies collected over \$15.7 billion in premiums and fees nationally in 2002.

Spitzer thanked State Comptroller Alan Hevesi for his office's assistance in this matter.

The case is being handled jointly by lawyers from the Attorney General's Health Care, Consumer Frauds and Protection, Antitrust and Litigation Bureaus led by Health Care Bureau Albany Section Chief Troy Oechsner. The investigation has been aided by staff from both DCS, led by Special Counsel Tom Brennan, and OSC, led by Ronald Pisani.

Consumers with questions or concerns about health care matters may call the Attorney General's Health Care Bureau at 1-800-771-7755 (Option 3) or visit [www.oag.state.ny.us/health/health\\_care.html](http://www.oag.state.ny.us/health/health_care.html)

**Attachment:**

- o [Complaint \(PDF\)](#)
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# Appendix B

HP	DP	DBC	PROD/MFR	NDC	AWP	DP	DBC
			<b>CEFUROXIME NOVAPLUS (Sandoz)</b>				
			cefuroxime sodium				
			PDS, 11 (PRIVATE LABEL)				
		AB	1.5 gm, ea	00781-9206-80	13.46		AP
		AB	(PHARMACY BULK PACKAGE)				
		AB	7.5 gm, ea	00781-9207-46	65.94		AP
			(PRIVATE LABEL)				
		AB	750 mg, ea	00781-9205-70	6.76		AP
			<b>CEFUROXIME SODIUM (APP)</b>				
			PDS, 11 (VIAL PF)				
		AB	1.5 gm, ea	63323-0353-20	23.90		AB
			(BULK PACKAGE PF)				
		AB	7.5 gm, 10s ea	63323-0354-61	1167.00		AB
			(VIAL PF)				
		AB	750 mg, ea	63323-0362-10	12.80		AB
			(B. Braun)				
			SOL, IV (DUPLEX)				
		AB	1.5 gm/50 ml, ea	00264-3114-11	16.80		AB
			(DUPLEX SYSTEM)				
		AB	750 mg/50 ml, ea	00264-3112-11	10.72		AB
			(Baxter)				
			PDS, 11 (USP)				
		EE	1.5 gm, ea	10019-0621-20	6.38		EE
			(20ML VIAL)				
		EE	1.5 gm, 25s ea	10019-0621-03	159.60		EE
			(USP)				
		EE	7.5 gm, ea	10019-0622-11	28.80		EE
			(100ML VIAL BULK PKG)				
			7.5 gm, 10s ea	10019-0622-05	288.00		
			750 mg, ea	10019-0620-10	3.01		
			(10ML VIAL)				
			750 mg, 25s ea	10019-0620-01	75.30		
			(Cura Pharm) See CEFUROXIME				
			(Cura Pharm)				
		AB	PDS, 11, 1.5 gm, 25s ea	66860-0031-03	336.00		AB
			750 mg, 25s ea	66860-0030-03	169.00		AB
			(Difaxo) See ZINACEF				
			(Hospira) See CEFUROXIME				
			(Sagehl) See CEFUROXIME				
			(Sandoz) See CEFUROXIME NOVAPLUS				
			(West Ward)				
			PDS, 11, 750 mg, 25s ea	00143-9979-90	6.40		
			(USP)				
			750 mg, 25s ea	00143-9979-22	160.00		
			IV, 1.5 gm, 25s ea	00143-9977-90	336.00		
			(USP)				
			1.5 gm, 25s ea	00143-9977-22	336.00		
			(BULK PACKAGE)				
		AB	7.5 gm, 10s ea	00143-9976-91	65.95		AP
			(USP BULK PACKAGE)				
		AB	7.5 gm, 10s ea	00143-9976-03	659.50		AP
			<b>CEFZIL (A-S Medication)</b>				
			cefprozil				
		AB	PDR, PO, 125 mg/5 ml				
		AB	100 ml	54669-3743-00	46.50		
		AB	250 mg/5 ml				
			100 ml	54669-3630-00	84.25		
			TAB, PO, 250 mg, 20s ea	54669-3652-00	97.31		
			(Bryant Ranch)				
			TAB, PO, 250 mg, 20s ea	63629-3189-01	148.10		
			(Pharmacia) See				
			<b>REZABI</b>				
		AB	TAB, PO, 500 mg, 20s ea	52959-0349-20	727.12		AB
			(Phys Total Care)				
			<b>REPACK</b>				
			PDR, PO, 250 mg/5 ml				
			50 ml	54868-2017-01	51.05		
			100 ml	54868-2017-00	99.08		
		AB	TAB, PO, 250 mg, 10s ea	54868-3343-00	58.88		AB
			15s ea	54868-3343-01	86.62		
			20s ea	54868-3343-03	114.88		
			30s ea	54868-3343-02	161.95		
			500 mg, 10s ea	54868-2444-00	104.13		
			(Southwood)				
			<b>REPACK</b>				
			PDR, PO, 125 mg/5 ml				
			100 ml	58016-4148-01	44.64		
			250 mg/5 ml				
			100 ml	58016-4147-01	80.88		
			TAB, PO, 250 mg, 12s ea	58016-0810-12	56.05		
			15s ea	58016-0810-15	70.07		
			30s ea	58016-0810-30	140.13		
			60s ea	58016-0810-60	282.70		
			100s ea	58016-0810-00	467.10		

PROD/MFR	NDC	AWP	DP	DBC
<b>CELEBREX (Pfizer)</b>				
celecoxib				
CAP, PO, 50 mg, 60s ea	00025-1516-01	75.74	63.12	
100 mg, 100s ea	00025-1520-31	270.13	225.11	
(10X10)				
100 mg, 100s ea UD	00025-1520-34	270.13	225.11	
500s ea	00025-1520-51	1350.66	1125.55	
200 mg, 100s ea	00025-1525-31	443.08	369.23	
(10X10)				
200 mg, 100s ea UD	00025-1525-34	443.08	369.23	
500s ea	00025-1525-51	2215.38	1845.15	
400 mg, 60s ea	00025-1530-02	398.77	332.31	
100s ea UD	00025-1536-01	654.63	553.86	
(Au)				
<b>REPACK</b>				
CAP, PO, 100 mg, 30s ea	42549-0642-30	172.68		
200 mg, 30s ea	42549-0505-30	246.34		
(A-S Medication)				
<b>REPACK</b>				
CAP, PO, 100 mg, 14s ea	54569-4671-04	37.52		
20s ea	54569-4671-01	53.60		
30s ea	54569-4671-02	80.40		
60s ea	54569-4671-00	200.67		
200 mg, 10s ea	54569-4672-05	43.86		
14s ea	54569-4672-01	61.54		
20s ea	54569-4672-05	87.91		
28s ea	54569-4672-02	123.08		
30s ea	54569-4672-00	131.87		
60s ea	54569-4672-04	329.14		
90s ea	54569-4672-09	493.72		
(Aldorex)				
<b>REPACK</b>				
CAP, PO, 100 mg, 7s ea	33261-0653-07	17.99		
21s ea	33261-0653-21	53.97		
30s ea	33261-0653-30	77.10		
60s ea	33261-0653-60	154.20		
200 mg, 14s ea	33261-0019-14	65.49		
30s ea	33261-0019-30	130.97		
60s ea	33261-0019-60	261.94		
90s ea	33261-0019-90	392.91		
(Aitura)				
<b>REPACK</b>				
CAP, PO, 100 mg, 10s ea	63874-0517-10	20.80		
12s ea	63874-0517-12	24.96		
14s ea	63874-0517-14	28.12		
15s ea	63874-0517-15	31.20		
20s ea	63874-0517-20	41.60		
21s ea	63874-0517-21	43.68		
24s ea	63874-0517-24	49.92		
25s ea	63874-0517-25	52.00		
28s ea	63874-0517-28	58.24		
30s ea	63874-0517-30	62.40		
60s ea	63874-0517-60	124.80		
90s ea	63874-0517-90	187.20		
100s ea	63874-0517-01	208.00		
200 mg, 6s ea	63874-0495-05	17.75		
7s ea	63874-0495-07	24.85		
10s ea	63874-0495-10	35.50		
12s ea	63874-0495-12	42.60		
14s ea	63874-0495-14	61.54		
15s ea	63874-0495-15	63.25		
20s ea	63874-0495-20	87.92		
21s ea	63874-0495-21	74.58		
28s ea	63874-0495-28	99.40		
30s ea	63874-0495-30	131.87		
60s ea	63874-0495-60	213.00		
90s ea	63874-0495-90	319.50		
100s ea	63874-0495-01	355.00		
(AQ)				
<b>REPACK</b>				
CAP, PO, 100 mg, 100s ea	66105-0105-10	272.99		
200 mg, 20s ea	66105-0105-03	250.55		
100s ea	66105-0106-10	835.14		
(Bryant Ranch)				
<b>REPACK</b>				
CAP, PO, 200 mg, 20s ea	63629-3021-02	67.35		
30s ea	63629-3021-01	191.33		
60s ea	63629-3021-04	382.60		
(Core)				
<b>REPACK</b>				
CAP, PO, 100 mg, 14s ea	33358-0069-14	37.90		
20s ea	33358-0069-20	61.44		
30s ea	33358-0069-30	90.41		
60s ea	33358-0069-60	131.29		
200 mg, 10s ea	33358-0070-10	46.36		
14s ea	33358-0070-14	47.63		
15s ea	33358-0070-15	65.06		
20s ea	33358-0070-20	86.51		
30s ea	33358-0070-30	159.21		
60s ea	33358-0070-60	203.21		
90s ea	33358-0070-90	302.35		

Brand cost/lot  
4.43 per unit

7.87 per unit  
↑  
Repacker

3.55 per unit

8.35 per unit

6.37 per unit

PROD/MFR	NDC	AWP	DP	OBG
<b>(DHS, Inc.)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 20s ea	55887-0412-20	59.09		
30s ea	55887-0412-30	88.64		
200 mg, 10s ea	55887-0736-10	49.59		
14s ea	55887-0736-14	63.42		
15s ea	55887-0736-15	65.54		
90s ea	55887-0736-90	423.00		
<b>(Direct Pharmaceutical, Inc.)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 30s ea UD	67801-0328-03	253.80		
200 mg, 30s ea UD	67801-0329-03	258.23		
<b>(Dispensing Solutions)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 10s ea	55045-2671-01	30.00		
20s ea	55045-2671-07	60.00		
30s ea	55045-2671-08	90.00		
60s ea	55045-2671-09	180.00		
200 mg, 7s ea	55045-2680-02	42.00		
10s ea	55045-2680-01	60.00		
10s ea	55045-2680-01	60.00		
14s ea	55045-2680-01	71.03		
15s ea	55045-2680-06	80.00		
15s ea	55045-2680-06	80.00		
20s ea	55045-2680-07	120.00		
20s ea	55045-2680-07	120.00		
30s ea	55045-2680-08	180.00		
30s ea	55045-2680-08	180.00		
30s ea	55045-2680-09	152.21		
60s ea	55045-2680-09	360.00		
60s ea	55045-2680-09	360.00		
90s ea	55045-2680-09	540.00		
90s ea	55045-2680-09	540.00		
<b>(Hormaid)</b>				
<b>REPACK</b>				
CAP, PO, 200 mg, 14s ea	51655-0327-84	100.69		
<b>(IFI)</b>				
<b>REPACK</b>				
CAP, PO, 200 mg, 20s ea	18837-0024-20	97.81		
90s ea	18837-0024-90	395.61		
180s ea	18837-0024-96	791.21		
<b>(Kollman Pharma, Inc.)</b>				
<b>REPACK</b>				
CAP, PO, 200 mg, 15s ea	66387-0552-16	129.12		
30s ea	66387-0552-30	258.23		
60s ea	66387-0552-60	516.46		
<b>(LWF)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 30s ea	64036-0030-30	61.96		
60s ea	64036-0030-60	118.92		
100s ea	64036-0030-01	194.65		
200 mg, 30s ea	64036-0031-30	98.43		
60s ea	64036-0031-60	191.85		
100s ea	64036-0031-01	316.41		
<b>(Nucare Pharm)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 14s ea	66267-0046-14	74.37		
20s ea	66267-0046-20	106.25		
30s ea	66267-0046-30	159.37		
60s ea	66267-0046-60	318.74		
200 mg, 7s ea	66267-0048-07	51.34		
10s ea	66267-0048-10	78.33		
15s ea	66267-0048-15	109.99		
20s ea	66267-0048-20	146.67		
30s ea	66267-0048-30	229.83		
60s ea	66267-0048-60	440.00		
<b>(Palmetto)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 20s ea	23490-7273-01	60.84		
20s ea	23490-9110-02	77.22		
30s ea	23490-9110-03	115.83		
200 mg, 7s ea	23490-7274-07	35.37		
10s ea	23490-7274-01	45.91		
14s ea	23490-7274-04	69.06		
15s ea	23490-7274-00	74.01		
20s ea	23490-7274-02	92.48		
30s ea	23490-7274-03	124.80		
60s ea	23490-7274-05	249.61		
<b>(PD-Rx Pharm)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 14s ea	55289-0451-14	55.92		
20s ea	55289-0451-20	79.89		
30s ea	55289-0451-30	119.84		
<b>(REDI-SCRIPT)</b>				
100 mg, 30s ea	55289-0475-10	76.15		
200 mg, 10s ea	55289-0475-10	85.52		
14s ea	55289-0475-14	81.73		
20s ea	55289-0475-20	131.03		
20s ea	55289-0475-20	131.03		
30s ea	55289-0475-30	196.58		
30s ea	55289-0475-30	196.58		

PROD/MFR	NDC	AWP	DP	OBG
<b>(REDI-SCRIPT)</b>				
200 mg, 30s ea	55864-0709-30	149.82		
30s ea	55289-0475-60	393.09		
90s ea	55289-0475-90	568.83		
180s ea	55289-0475-93	179.90		
<b>(Pharma Pac)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 14s ea	52959-0540-14	43.43		
15s ea	52959-0540-15	46.47		
20s ea	52959-0540-20	59.94		
21s ea	52959-0540-21	61.97		
28s ea	52959-0540-28	82.41		
30s ea	52959-0540-30	88.20		
40s ea	52959-0540-40	102.22		
60s ea	52959-0540-60	153.30		
200 mg, 5s ea	52959-0539-05	38.00		
7s ea	52959-0539-07	53.13		
10s ea	52959-0539-10	75.90		
14s ea	52959-0539-14	105.88		
15s ea	52959-0539-15	113.40		
21s ea	52959-0539-21	151.00		
21s ea	52959-0539-21	158.46		
28s ea	52959-0539-28	210.70		
30s ea	52959-0539-30	224.50		
40s ea	52959-0539-40	293.24		
45s ea	52959-0539-45	321.30		
50s ea	52959-0539-50	347.00		
60s ea	52959-0539-60	399.60		
90s ea	52959-0539-90	477.00		
100s ea	52959-0539-90	490.00		
400 mg, 30s ea	52959-0904-30	150.05		
<b>(Phys Total Care)</b>				
<b>REPACK</b>				
CAP, PO, 400 mg, 10s ea	54868-4107-03	92.67		
20s ea	54868-4107-01	63.98		
30s ea	54868-4107-00	94.09		
60s ea	54868-4107-02	175.98		
200 mg, 5s ea	54868-4101-06	30.38		
10s ea	54868-4101-04	58.15		
15s ea	54868-4101-03	85.92		
20s ea	54868-4101-02	113.68		
30s ea	54868-4101-01	159.96		
60s ea	54868-4101-06	317.31		
90s ea	54868-4101-05	474.85		
100s ea	54868-4101-07	477.04		
100s ea	54868-4101-08	509.53		
400 mg, 60s ea	54868-5006-00	401.11		
<b>(Physician Partner)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 15s ea	21695-0022-15	95.34		
30s ea	21695-0022-30	162.08		
60s ea	21695-0022-60	324.16		
100s ea	21695-0022-00	540.26		
120s ea	21695-0022-72	762.72		
200 mg, 10s ea	21695-0023-10	82.06		
14s ea	21695-0023-14	148.96		
15s ea	21695-0023-15	156.38		
20s ea	21695-0023-20	184.11		
30s ea	21695-0023-30	265.85		
60s ea	21695-0023-60	531.70		
<b>(Quality Care Prod)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 10s ea	49999-0363-10	84.60		
14s ea	49999-0363-14	118.44		
20s ea	49999-0363-20	169.20		
30s ea	49999-0363-30	253.80		
60s ea	49999-0363-60	507.60		
200 mg, 5s ea	49999-0004-05	55.86		
10s ea	49999-0004-10	93.08		
14s ea	49999-0004-14	118.44		
20s ea	49999-0004-20	169.20		
30s ea	49999-0004-30	279.19		
60s ea	49999-0004-60	558.38		
100s ea	49999-0004-00	931.40		
<b>(Southwood)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 10s ea	58016-0169-10	24.50		
12s ea	58016-0169-12	29.40		
20s ea	58016-0169-20	49.00		
21s ea	58016-0169-21	51.45		
28s ea	58016-0169-28	68.61		
30s ea	58016-0169-30	73.51		
60s ea	58016-0169-60	147.01		
90s ea	58016-0169-90	220.52		
100s ea	58016-0169-00	245.02		
200 mg, 10s ea	58016-0223-10	40.19		
12s ea	58016-0223-12	48.23		
14s ea	58016-0223-14	55.26		
15s ea	58016-0223-15	60.28		
20s ea	58016-0223-20	80.38		
21s ea	58016-0223-21	84.39		

PROD/MFR	NDC	AWP	DP	OBG
28s ea	58016-0223-28	112.53		
30s ea	58016-0223-30	120.56		
60s ea	58016-0223-60	241.12		
90s ea	58016-0223-90	361.68		
100s ea	58016-0223-00	401.68		
120s ea	58016-0223-02	482.26		
400 mg, 30s ea	58016-0724-30	130.65		
60s ea	58016-0724-60	217.75		
90s ea	58016-0724-90	326.55		
100s ea	58016-0724-00	360.24		
<b>(St. Mary's HPP)</b>				
<b>REPACK</b>				
CAP, PO, 200 mg, 20s ea	60760-0625-20	102.99		
30s ea	60760-0625-30	154.48		
60s ea	60760-0625-60	308.96		
<b>(Stat Rx)</b>				
<b>REPACK</b>				
CAP, PO, 100 mg, 30s ea	16590-0045-30	159.72		
50s ea	16590-0045-50	79.86		
60s ea	16590-0045-60	95.82		
200 mg, 10s ea	16590-0046-10	20.27		
15s ea	16590-0046-15	30.41		
20s ea	16590-0046-20	40.54		
28s ea	16590-0046-28	70.74		
30s ea	16590-0046-30	75.85		
50s ea	16590-0046-50	126.42		
60s ea	16590-0046-60	151.68		
90s ea	16590-0046-90	227.52		
<b>CELECOXIB (Pfizer) See CELEBREX</b>				
<b>CELESTONE (Schering)</b>				
betamethasone				
SYN, PO, 0.6 mg/5 ml				
118 ml	00065-0942-05	702		
<b>CELESTONE SOLUSPAN (Schering)</b>				
betamethasone ac/betamethasone				
SUS, JJ (M.D.V.)				
3 mg/ml 3 mg/ml				
5 ml	00095-0576-03	102		
<b>(Phys Total Care)</b>				
<b>REPACK</b>				
SUS, JJ (M.D.V.)				
3 mg/ml 3 mg/ml				
5 ml	54868-0216-00	327		
<b>(Quality Care Prod)</b>				
<b>REPACK</b>				
SUS, JJ (M.D.V.)				
3 mg/ml 3 mg/ml				
5 ml	54868-0216-00	327		
<b>(Southwood)</b>				
<b>REPACK</b>				
SUS, JJ (M.D.V.)				
3 mg/ml 3 mg/ml				
5 ml	58016-0216-00	327		
<b>CELEZA (Forest Pharm)</b>				
citalopram hydrobromide				

STL 90

CSEA

Edm

Prescription Fill Information

3rd Party Plan	MEDCO HEALTH SOLUTIONS
Dispensed Product	CELEBREX 200 MG CAPSULE QLC
Quantity Dispensed	180
Package Size	100
Prod Unit Cost	9.3140
Prod Pkg Cost	400.00
Prod Acquis Cost	720.00

Payment Request Information

Claim Payment Information

Drug Cost	1676.52	Drug Cost	1408.28
Dispensing Fee	7.00	Dispensing Fee	1.50
Tax	0.00	Tax	0.00
Total Price	1683.52	3pty Pay	1379.78
		Copay	30.00

3rd Party Messages

Authorization	OPNM9DQ	T/A	0.00
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Stylesheet:HTML-TOCAccept - \$Revision: 153 \$

Repacker # ↓

NDC 49999 0004 00

(repack)

State 90 day  
CSEA

Print

Prescription Fill Information

3rd Party Plan	MEDCO HEALTH SOLUTIONS
Dispensed Product	CELEBREX 200 MG CAPSULE
Quantity Dispensed	180
Package Size	100
Prod Unit Cost	4.1863
Prod Pkg Cost	327.53
Prod Acquls Cost	589.55

Payment Request Information

Claim Payment Information

Drug Cost	753.53	Drug Cost	632.97
Dispensing Fee	4.50	Dispensing Fee	1.50
Tax	0.00	Tax	0.00
Total Price	758.03	3pty Pay	604.47
		Copay	30.00

3rd Party Messages

Authorization	MX1PMD7	T/A	0.00
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Stylesheet:HTML-TCCAccept - SRRevision: 163 \$

Pfizer #  
NDC 00025152531  
(Manufacturer)

# Appendix C



### Detailed Prescription History

**THIS IS NOT A BILL. Keep this notice for your records.**

**Explanation of Benefits**

For period beginning 01/01/2007 and ending 06/30/2007

Dates of Service	Name of Drug	Quantity Dispensed	Cost of Prescription	Amount Paid by Healthfirst	Amount Paid by You	Notes
03/22/2007	METOPROLOL 25 MG TABLET	60.000	\$13.29	\$13.29 *6.86	\$0.00	# actually paid to pharmacy
04/07/2007	SIMVASTATIN 40 MG TABLET	30.000	\$45.89	\$45.89 *6.86	\$0.00	
04/07/2007	OMACOR CAPSULE	120.000	\$132.64	\$97.64	\$35.00	*133.92 - 35.00 - actual cost of Rx
04/23/2007	GLYBURID- METFORMIN 5-500 MG TB	60.000	\$25.76	\$25.76 *21.12	\$0.00	
04/23/2007	METOPROLOL 25 MG TABLET	60.000	\$13.46	\$13.46 *7.86	\$0.00	
04/23/2007	AVANDIA 4 MG TABLET	30.000	\$97.12	\$62.12	\$35.00	98.19 + 35.00 - actual cost of Rx
05/03/2007	SIMVASTATIN 40 MG TABLET	30.000	\$45.89	\$45.89 *16.86	\$0.00	
05/12/2007	OMACOR CAPSULE	60.000	\$67.12	\$32.12	\$35.00	68.01 - actual cost of Rx
05/23/2007	OMACOR CAPSULE	120.000	\$132.64	\$97.64	\$35.00	*133.92 - actual cost of Rx
05/23/2007	METOPROLOL 25 MG TABLET	60.000	\$13.46	\$13.46 *7.86	\$0.00	
05/23/2007	ENALAPRIL MALEATE 20 MG TAB	30.000	\$14.70	\$14.70 *6.71	\$0.00	
05/23/2007	GLYBURID- METFORMIN 5-500 MG TB	60.000	\$26.76	\$26.76 *12.85	\$0.00	
06/11/2007	SIMVASTATIN 40 MG TABLET	30.000	\$45.89	\$45.89 *16.86	\$0.00	
06/20/2007	ENALAPRIL MALEATE 20 MG TAB	60.000	\$27.80	\$27.80 *16.51	\$0.00	
06/23/2007	METOPROLOL 25 MG TABLET	60.000	\$13.46	\$13.46 *9.86	\$0.00	

10/10/07 10:00 AM

Mandatory Mail Order



02/23/11 JG S

AMLODIPINE 5 MG TAB # 90  
Generic For NORVASC TAB 5MG  
NDC#86882-0122-08  
NO REFILLS LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#0 RBT  
11054313903404

02/02/11 RMF S

PRAVASTATIN 20 MG TAB # 80  
Generic For PRAVACHOL 20MG TABS  
NDC#00093-7201-18  
NO REFILLS LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#3 RBT  
11033342358110

01/31/11 IC E

SIMVASTATIN 20 MG TAB # 80  
Generic For ZOCOR 20MG  
NDC#18714-0833-03  
1 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#2 RBT  
11031573548201

03/09/11 AMV E

PAROXETINE HCL 30MG TAB # 90  
Generic For PAXIL 30MG TABS  
NDC#86882-0158-03  
REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#0  
11087848640507

Pass thru for Retail or Mail

7/11 AMV S

AMLODIPINE 5 MG TAB # 90  
Generic For NORVASC TAB 5MG  
NDC#86882-0122-08  
NO REFILLS LEFT  
ACCEPTED TDI

COPAY: \$20.00

DISP#1 RBT  
11169430978111

05/23/11 KLB S

PRAVASTATIN 20 MG TAB # 80  
Generic For PRAVACHOL 20MG TABS  
NDC#00093-7201-18  
3 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$20.00

DISP#0 RBT  
11143363701607

06/21/11 KLB E

SIMVASTATIN 20 MG TAB # 80  
Generic For ZOCOR 20MG  
NDC#18714-0833-03  
3 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$20.00

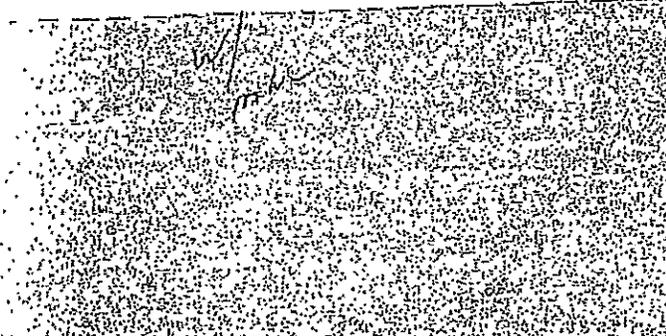
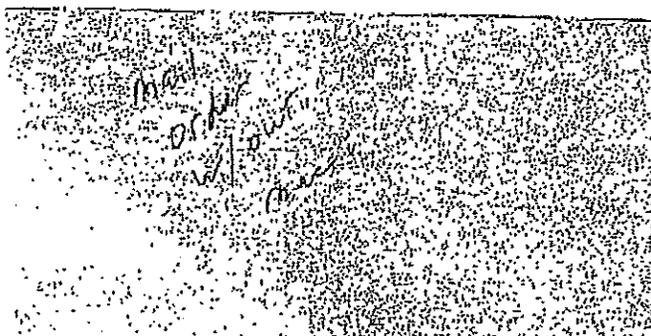
DISP#0 RBT  
11172404934701

06/06/11 RMF E

PAROXETINE HCL 30MG TAB # 90  
Generic For PAXIL 30MG TABS  
NDC#86882-0158-03  
2 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$20.00

DISP#1  
11157627850367



**Mandatory Mail Order**



02/05/11 CTH E

WARFARIN 3 MG TAB  
Generic For: COUMADIN 3MG TABS  
NDC#51672-4030-03

# 80 TARG  
INS. PAID: \$26.84

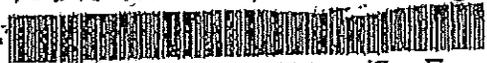
1 REFILL(S) LEFT  
ACCEPTED TDI  
BILL CREDITCARD

COPAY: \$16.00

DISP#1  
11036730912111



**Retail or Mail - Pass-through Pricing**



05/07/11 JG E

WARFARIN 3 MG TAB  
Generic For: COUMADIN 3MG TABS  
NDC#51672-4030-03

# 90 TARG  
INS. PAID: \$5.70

1 REFILL(S) LEFT  
ACCEPTED TDI  
BILL CREDITCARD

COPAY: \$20.00

DISP#2  
11127421510305



02/24/11 CTH E

METOPROLOL SUCC XL 100MG(TC# 90  
Generic For: TOPROL XL 100MG  
NDC#62037-0832-01

# 90 WATSON  
INS. PAID: \$95.50

1 REFILL(S) LEFT  
ACCEPTED TDI  
BILL CREDITCARD

COPAY: \$16.00

DISP#1 RBT  
11055475708707



05/22/11 AMV E

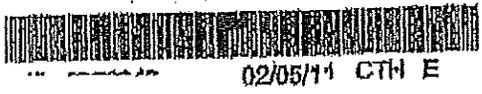
METOPROLOL SUCC XL 100MG(TC# 90  
Generic For: TOPROL XL 100MG  
NDC#62037-0832-01

# 90 WATSON  
INS. PAID: \$75.28

3 REFILL(S) LEFT  
ACCEPTED TDI  
BILL CREDITCARD

COPAY: \$20.00

DISP#2 RBT  
11142308210710



02/05/11 CTH E

SERTRALINE 50MG TABS

# 90 NORTH  
INS. PAID: \$103.05

NDC#16714-0812-05  
NO REFILLS LEFT  
ACCEPTED TDI  
BILL CREDITCARD

COPAY: \$16.00

DISP#2 RBT  
11055780011912



04/29/11 CTH E

SERTRALINE 50MG TABS

# 90 NORTH  
INS. PAID: \$8.00

NDC#16714-0812-05  
NO REFILLS LEFT  
ACCEPTED TDI  
BILL CREDITCARD

COPAY: \$20.00

DISP#3 RBT  
11119805527201



*mail  
order  
mail*

Mandatory Mail Order



01/8

RD,

TAMSULOSIN CAP 0.4MG # 90  
Generic For FLOMAX CAP 0.4 MG  
NDC 00228-2900-50  
0 REFILLS LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#2 RBT  
11031573820202



03/01/11 AMV E

LISINAPRIL 5MG TABS # 90  
NDC 00172-3758-80  
2 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#0 RBT  
11080510801610



03/01/11 AMV E

GLIMEPIRIDE 4 MG TAB # 90  
Generic For AMARIL 4 MG TAB  
NDC 010093-7266-52  
2 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$16.00

DISP#0 RBT  
11032397118210



Retail or Mail Order w/ Pass-through pricing



05/03/11 DP E

TAMSULOSIN CAP 0.4MG # 90  
Generic For FLOMAX CAP 0.4 MG  
NDC 00228-2900-50  
NO REFILLS LEFT  
ACCEPTED TDI

COPAY: \$20.00

DISP#3 RBT  
11123033414504



LISINAPRIL 5MG TABS # 90  
NDC 00172-3758-80  
2 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$20.00

DISP#1 RBT  
11105303685204



05/09/11 RMF E

NY

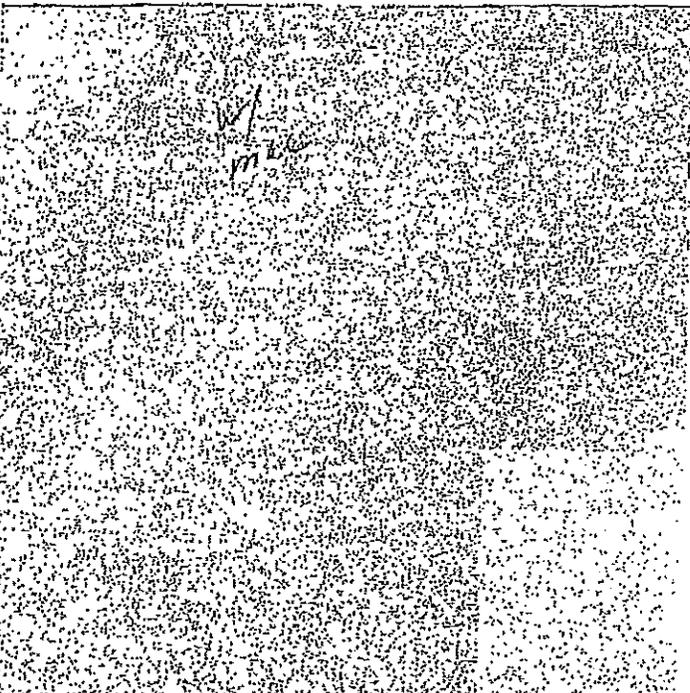
GLIMEPIRIDE 4 MG TAB # 90  
Generic For AMARIL 4 MG TAB  
NDC 010093-7266-52  
2 REFILL(S) LEFT  
ACCEPTED TDI

COPAY: \$20.00

DISP#1 RBT  
11129450372101



mail order w/ pass-through pricing



# Appendix D

Drug Name	Strength	Quantity	Actual Acquisition Cost per unit	Cost per Script	Average Wholesale Price per Script	Medco Charge	Gross Profit	Discount from AWP	Claims	Revenue
Furosemide	40 MG	90	\$ 0.01	\$ 0.90	\$ 18.40	\$ 5.43	\$ 4.53	70%	55	\$ 249.15
Simvastatin	40 MG	90	\$ 0.07	\$ 6.30	\$ 442.60	\$ 88.84	\$ 82.54	80%	250	\$ 20,635.00
Hydrocodone/Acetaminophen	5/500 MG	180	\$ 0.03	\$ 5.40	\$ 82.80	\$ 21.40	\$ 16.00	74%	372	\$ 5,952.00
Levothyroxine Sodium	.01 MG	90	\$ 0.09	\$ 8.10	\$ 26.10	\$ 25.10	\$ 17.00	4%	94	\$ 1,598.00
Lisinopril	20 MG	90	\$ 0.04	\$ 3.60	\$ 94.50	\$ 23.35	\$ 19.75	75%	226	\$ 4,463.50
Metformin HCL	500 MG	180	\$ 0.02	\$ 3.60	\$ 128.00	\$ 39.52	\$ 35.92	69%	174	\$ 6,250.08
Hydrochlorothiazide	50 MG	90	\$ 0.02	\$ 1.80	\$ 19.00	\$ 7.78	\$ 5.98	59%	156	\$ 932.88
Atenolol	50 MG	90	\$ 0.02	\$ 1.80	\$ 76.50	\$ 8.92	\$ 7.12	88%	133	\$ 946.96
Metoprolol Tartate	50 MG	90	\$ 0.02	\$ 1.80	\$ 48.60	\$ 11.93	\$ 10.13	75%	194	\$ 1,965.22
Amlodipine Besylate	10 MG	90	\$ 0.05	\$ 4.50	\$ 213.88	\$ 124.10	\$ 119.60	42%	132	\$ 15,787.20
Lovastatin	20 MG	90	\$ 0.10	\$ 9.00	\$ 213.30	\$ 67.38	\$ 58.38	68%	104	\$ 6,071.52
Sertraline HCL	50 MG	90	\$ 0.06	\$ 5.40	\$ 244.80	\$ 97.70	\$ 92.30	60%	132	\$ 12,183.60
Alprazolam	.25 MG	90	\$ 0.02	\$ 1.80	\$ 61.20	\$ 6.46	\$ 4.66	89%	194	\$ 904.04
Zolpidem Tartrate	5 MG	90	\$ 0.03	\$ 2.70	\$ 415.80	\$ 153.18	\$ 150.48	63%	77	\$ 11,586.96
Triamterene HCTZ	37.5/25 MG	90	\$ 0.03	\$ 2.70	\$ 34.20	\$ 12.60	\$ 9.90	63%	82	\$ 811.80
Totals				\$ 59.40	\$ 2,119.68	\$ 693.69	\$ 634.29	67%	2,375	\$ 90,337.91
Per Script				\$ 3.96	\$ 141.31	\$ 46.25	\$ 42.29			

A sample of generic drug prescriptions charged to payer by Medco Health. Note gross profit of \$42.29 per prescription!

Drug Name	Strength	Quantity	Actual Acquisition Cost per unit	Cost per Script	Average Wholesale Price per Script	Charge	Gross Profit	Discount from AWP	Claims	Revenue
Furosemide	40 MG	90	\$ 0.01	\$ 0.90	\$ 18.40	\$ 3.08	\$ 2.18	83%	55	\$119.90
Simvastatin	40 MG	90	\$ 0.07	\$ 6.30	\$ 442.60	\$ 19.80	\$ 13.50	96%	250	\$3,375.00
Hydrocodone/Acetaminophen	5/500 MG	180	\$ 0.03	\$ 5.40	\$ 82.80	\$ 16.00	\$ 10.60	81%	372	\$3,943.20
Levothyroxine Sodium	.01 MG	90	\$ 0.09	\$ 8.10	\$ 26.10	\$ 17.00	\$ 8.90	35%	94	\$836.60
Lisinopril	20 MG	90	\$ 0.04	\$ 3.60	\$ 94.50	\$ 13.50	\$ 9.90	86%	226	\$2,237.40
Metformin HCL	500 MG	180	\$ 0.02	\$ 3.60	\$ 128.00	\$ 10.80	\$ 7.20	92%	174	\$1,252.80
Hydrochlorothiazide	50 MG	90	\$ 0.02	\$ 1.80	\$ 19.00	\$ 6.23	\$ 4.43	67%	156	\$691.08
Atenolol	50 MG	90	\$ 0.02	\$ 1.80	\$ 76.50	\$ 5.17	\$ 3.37	93%	133	\$448.21
Meloprolol Tartate	50 MG	90	\$ 0.02	\$ 1.80	\$ 48.60	\$ 3.42	\$ 1.62	93%	194	\$314.28
Amlodipine Besylate	10 MG	90	\$ 0.05	\$ 4.50	\$ 213.88	\$ 8.10	\$ 3.60	96%	132	\$475.20
Lovastatin	20 MG	90	\$ 0.10	\$ 9.00	\$ 213.30	\$ 22.50	\$ 13.50	89%	104	\$1,404.00
Sertraline HCL	50 MG	90	\$ 0.06	\$ 5.40	\$ 244.80	\$ 11.70	\$ 6.30	95%	132	\$831.60
Alprazolam	.25 MG	90	\$ 0.02	\$ 1.80	\$ 61.20	\$ 6.46	\$ 4.66	89%	194	\$904.04
Zolpidem Tartrate	5 MG	90	\$ 0.03	\$ 2.70	\$ 415.80	\$ 17.01	\$ 14.31	96%	77	\$1,101.87
Triamterene HCTZ	37.5/25 MG	90	\$ 0.03	\$ 2.70	\$ 34.20	\$ 4.79	\$ 2.09	86%	82	\$171.38
<b>Totals</b>				\$ 59.40	\$ 2,119.68	\$ 165.56	\$ 106.16	92%	2,375	\$ 18,106.56
<b>Per Script</b>				\$ 3.96	\$ 141.31	\$ 11.04	\$ 7.08			

The same prescriptions using a pass-through, transparent pricing model: gross profit = \$7.08 per prescription.

# Appendix E



The American Antitrust Institute

5/11/09

## Commentary: The FTC Should Issue a Second Request on Express Scripts' Proposed Acquisition of Wellpoint's PBM Business

An AAI White Paper

David Balto<sup>1</sup>

On April 13, 2009, Express Scripts, Inc. ("Express Scripts") announced its proposed acquisition of Wellpoint's Pharmacy Benefit Manager ("PBM") subsidiary, Next RX. The American Antitrust Institute ("AAI")<sup>2</sup> believes that this acquisition poses a threat of significant anticompetitive harm in the PBM services market by combining two of the four largest national PBMs. Accordingly, the AAI urges the Federal Trade Commission ("FTC") to issue a Second Request and conduct a thorough investigation of the competitive effects of this merger.

### Executive Summary

The AAI urges the FTC to conduct a full Second Request investigation of the Express Scripts/Wellpoint transaction for the following reasons:

- *The merger is likely to reduce competition for the provision of PBM services to some group of plan sponsors, especially large plan sponsors.*<sup>3</sup> Currently, CVS/Caremark, Express Scripts, and Medco are, by far, the three largest PBMs serving large plan sponsors. Express Scripts' proposed acquisition of WellPoint's Next RX business reduces the key providers of PBM services to large plan sponsors and may result in higher prices, less innovation, and increased barriers to entry. After the merger the three largest PBMs will have a combined market share exceeding 80%. Moreover, the three national PBMs

<sup>1</sup> The author is a senior fellow for the American Antitrust Institute and also of the Center for American Progress. He served as the Assistant Director for the Office of Policy & Evaluation in the Bureau of Competition of the Federal Trade Commission. This paper relies entirely on public information. With its investigatory power, the FTC may find additional or contrary facts that could change this paper's analysis or conclusions.

<sup>2</sup> The American Antitrust Institute is an independent Washington-based non-profit education, research, and advocacy organization. Our mission is to increase the role of competition, assure that competition works in the interests of consumers, and challenge abuses of concentrated economic power in the American and world economy. For more information, please see [www.antitrustinstitute.org](http://www.antitrustinstitute.org). This paper has been approved by the AAI Board of Directors. A list of our contributors of \$1,000 or more is available on request.

<sup>3</sup> A plan sponsor is the employer insurance company, union, or other entity which purchases PBM services on behalf of its employees or members.

have significant cost advantages from economies of scale and scope in drug purchasing, mail order distribution, and specialty pharmaceuticals. The remaining PBMs will be unable to constrain anticompetitive conduct because of their smaller size, geographic limitations, and lack of ability to secure rebates.

- *The merger poses a significant threat of coordinated interaction by eliminating a disruptive firm from the market.* We believe that there is a significant risk of coordinated interaction in the PBM market. The market is dominated by a small number of firms and there are substantial entry barriers. Moreover, a lack of transparency makes it difficult for plan sponsors to determine whether they are receiving the full benefits from their arrangement with the PBM. The acquisition of WellPoint's PBM business increases the risk of coordinated interaction. WellPoint offered PBM services on a capitated basis, sharing the risks of increased drug spend with the plan sponsors. Moreover, since Next RX is owned by an integrated insurance company its incentives to join and facilitate collusion are significantly different than the three largest PBMs whose revenue is solely based on their PBM business. Eliminating the potentially disruptive force of Next RX will pose the threat of significant harm to consumers.
- *The merger may lead to increased prices in the distribution of certain specialty pharmaceuticals.*<sup>4</sup> Specialty pharmaceuticals, which are more costly than traditional pharmaceuticals, are an increasingly important area of concern for cost-conscious plan sponsors and a major source of revenue for PBMs. Each of the major PBMs has acquired specialty pharmaceutical companies in the past three years, demonstrating the competitive significance of internalizing these operations. Those PBMs have rapidly increased the prices of those specialty pharmaceuticals after those acquisitions were consummated. In particular, Express Scripts has imposed substantial price increases on several specialty pharmaceuticals after acquiring specialty pharmaceutical manufacturers or entering into exclusive distribution arrangements. By acquiring, WellPoint's specialty pharmaceutical business Express Scripts will be able to exercise market power and increase prices for these vital drugs.
- *The merger will increase the threat of monopsony or oligopsony power in the reduction of services for the delivery of pharmaceutical services.* The national full service PBMs already possess the ability and incentive to exercise market power over retail independent and chain pharmacies, and do so by reducing reimbursement rates and engaging in deceptive and fraudulent conduct. Reimbursement from PBMs is a major source of revenue for retail pharmacies. The merger could allow the three remaining large national PBMs to decrease compensation to the retail pharmacies below competitive levels, ultimately leading to diminished service for consumers.
- *The FTC should conduct a complete Second Request investigation and not cut short the investigation.* In the past Administration the FTC cleared significant PBM mergers

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<sup>4</sup> Specialty pharmaceuticals are very expensive drugs, typically biotech-developed and protein based drugs that are typically not distributed at a retail pharmacy store. These drugs often require special handling, such as refrigeration. Therefore, there is a need for special distribution capabilities and patient support services.

without an extensive investigation. The CVS/Caremark merger was cleared without a Second Request and the Caremark/AdvancePCS merger was cleared based only on a "quick look" review.<sup>5</sup> During the past decade there have been a series of PBM mergers which have significantly increased concentration in the market. Since the CVS/Caremark and Caremark/AdvancePCS mergers were consummated, concentration levels in the national full service PBM market have become more problematic as the largest PBMs have grown significantly. There is little evidence that these mergers have led to more efficiency or lower prices. Indeed the profits of the largest PBMs have grown and the largest PBM, CVS/Caremark has used its merger to stifle competition and increase costs to consumers. As the AAI Transition Report, The Next Antitrust Agenda, observed: "[a]bandoning enforcement in these key areas leads to significant harm to consumers."<sup>6</sup> This merger eliminates an important competitor from the national market, increasing concentration and the threat of higher prices.

### THE IMPORTANT COMPETITIVE CONCERNS OF PBM MERGERS

As the country tackles the difficult issue of health care reform, the role of health care intermediaries, such as PBMs and health insurance companies, should receive considerably greater attention. There is increasing evidence that these intermediaries often fail to fulfill the interests of consumers and patients. In part, that is because of the lack of transparency and the opportunities for deception. There are two elements necessary for markets to perform effectively: transparency and choice. Unfortunately the PBM market, dominated by a tight oligopoly which engages in deceptive practices lacks both of these necessary elements to a well functioning market. As the AAI Transition Report observed, there has been a tremendous amount of consolidation in both PBM and health insurance markets and this consolidation has not benefitted consumers of competition.<sup>7</sup>

A recent series of articles in the Wall Street Journal observed that these intermediaries and in particular PBMs have not functioned effectively in the health care context and middlemen often seem to exercise market power:

[W]hile the Internet, deregulation and relentless corporate cost-cutting have squeezed middlemen elsewhere, the health-care middlemen are prospering. The three largest pharmaceutical benefit managers, for instance, had net income of \$1.9 billion last year, a sum that exceeds the annual operating budget of New York's Sloan Kettering cancer center. In corners of the system such as Medicaid

<sup>5</sup> We note the law firm that represented one of the parties in the Caremark/AdvancePCS merger observed that the investigation was closed on a "quick look" review. See [http://www.jonesday.com/experience/experience\\_detail.aspx?exID=S9298](http://www.jonesday.com/experience/experience_detail.aspx?exID=S9298). This means that the Commission did not conduct a full investigation of that merger.

<sup>6</sup> American Antitrust Institute, The Next Antitrust Agenda 317 (2008).

<sup>7</sup> *Id.*

managed care and nursing-home drugs, little-known intermediaries rack up tens or hundreds of millions of dollars in profit.<sup>8</sup>

The lack of transparency and the extensive deceptive and fraudulent practices only exacerbate the competitive problems. The PBM industry is plagued with substantial fraudulent, deceptive, and anticompetitive conduct. In the past five years alone, cases brought by a coalition of over 30 State Attorneys Generals (AGs) have secured over \$370 million in penalties and fines for deceptive and fraudulent conduct by the three major PBMs. (See Appendix A for list of cases). These cases were brought based on allegations of fraud, misrepresentation to plans, patients and providers, pocketing the plans funds through spread pricing, improper therapeutic substitution, unjust enrichment through secretive kickback schemes, and failure to meet ethical and safety standards. Specifically the states found that the PBMs accepted rebates from manufacturers in return for placing higher priced medications on the formulary, played the "spread" between the prices paid by clients and the price paid at the pharmacy, and favored higher priced drugs that provided PBMs with greater incentives and switched customers from low-cost to the higher-cost medications.

Several investigations of the major PBMs continue by a group of AGs. As a bipartisan group of state legislators has noted:

We know of no other market in which there has been such a significant number of prominent enforcement actions and investigations, especially in a market with such a significant impact on taxpayers. Simply put, throughout the United States, numerous states are devoting considerable enforcement resources to combating fraudulent and anticompetitive conduct by PBMs. This is because those activities are taking millions of taxpayer dollars and denying government buyers the opportunity to drive the best bargain for the state.<sup>9</sup>

A central problem with the lack of competition is the lack of transparency. In an important decision upholding state regulation of PBMs, one federal court observed, "[w]hether and how a PBM actually saves an individual benefits provider money with respect to the purchase of a particular prescription drug is largely a mystery to the benefits provider." The court elaborated:

This lack of transparency also has a tendency to undermine a benefits provider's ability to determine which is the best among competing proposals from PBMs. For example, if a benefits provider had proposals from three different PBMs for pharmacy benefits management services, each guaranteeing a particular dollar amount of rebate per prescription, the PBM proposal offering the highest rebate for each prescription filled could actually be the worst proposal as far as net savings are concerned, because that PBM might have a deal with the manufacturer that gives it an incentive to sell, or restrict its formulary, to the most expensive drugs. In other words, although PBMs afford a valuable bundle of services to benefits providers, they also introduce a layer of fog to the

<sup>8</sup> Barbara Martinez, et al., "Health-Care Goldmines: Middlemen Strike it Rich," *Wall Street Journal*, A1 (December 29, 2006).

<sup>9</sup> Letter from Senator Mark Montigny to FTC Chairman Deborah Platt Majoras (May 11, 2005).

market that prevents benefits providers from fully understanding how to best minimize their net prescription drug costs.<sup>10</sup>

The current concentrated nature of the national full service PBM market only exacerbates these problems and it increases the need for both government enforcement and potential oversight of the PBM industry. Careful scrutiny of the proposed Express Scripts/WellPoint merger is necessary to assure that these problems are not heightened by the increased concentration resulting from the merger.

## ANALYSIS

### The Provision of PBM Services to Large Plan Sponsors May Be Harmed By the Acquisition

The proposed merger could significantly reduce competition in the market for the provision of PBM services to large plan sponsors.<sup>11</sup> In the Caremark/AdvancePCS merger, the FTC reaffirmed that the provision of PBM services to large plan sponsors is a relevant market. (This market was first defined in the Lilly/PCS enforcement action in 1994). This market retains its vitality today. Large employers and unions are dependent on the full range of services that national full service PBMs provide. These entities usually must rely on national full service PBMs, which possess the economies of scale and scope that small PBMs lack.

In this market there are four major PBMs that offer services

PBM	Covered Lives (in millions)
CVS/Caremark	134 - "sketchy #'s" - includes all CVS cos
Medco	65
Express Scripts	50
Wellpoint	39

This merger will combine the third and fourth largest PBMs, resulting in the second largest PBM with over 89 million covered lives. After the big three, the next largest PBM, MedImpact, has only 27 million covered lives.

Since the approval of the CVS/Caremark and Caremark/AdvancePCS acquisitions, the role of the leading national PBMs has become increasingly developed and prominent. The national full service PBMs have created the broadest range of pharmacy networks and the strongest and lowest cost mail order systems. This buying power by aggregating covered lives and distribution systems provide them significant cost advantages over smaller PBMs. That is why customers are reluctant to move from one of the top tier PBMs.

<sup>10</sup> Pharm. Care Mgmt. Ass'n v. Rowe, 2005 U.S. Dist. LEXIS 2339, at \*7-8 (D. Me. Feb. 2, 2005), *aff'd*, 429 F.3d 294 (1st Cir. 2005).

<sup>11</sup> We identify large plan sponsors as one group of customers that could be harmed by the merger because the Commission addressed those customers in the CVS/Caremark/AdvancePCS investigation. However, even smaller plan sponsors may be adversely affected by the merger and the Commission should investigate that question. Smaller plan sponsors may have even fewer options than large plan sponsors.

In addition, since the CVS/Caremark and Caremark/AdvancePCS mergers, the major PBMs have acquired specialty pharmaceutical firms which provide another substantial competitive distinction. Specialty pharmaceuticals are increasingly a critical part of the services sophisticated PBMs offer plan sponsors. This is because specialty pharmaceuticals are far more costly than traditional drugs and plan sponsors are demanding coverage of a broad range of these drugs for their subscribers. Moreover, specialty pharmaceuticals are a major source of revenue for PBMs. In the past three years, each of the four national full service PBMs acquired some of the largest specialty pharmaceutical firms, therefore giving them a significant advantage over non-integrated PBMs.<sup>12</sup>

In light of the foregoing developments, it is very likely that smaller second-tier PBMs could not constrain any post-merger anticompetitive conduct.<sup>13</sup> In the Caremark/AdvancePCS merger, the FTC predicted that competition among the remaining full service PBMs, along with "significant additional competition from several health plans and several retail pharmacy chains offering PBM services should suffice to prevent this acquisition from giving rise to a potentially anticompetitive price increase."<sup>14</sup> However, the FTC's predictions about the ability of second-tier PBMs to restrain potential anticompetitive conduct of the four national full service PBMs appear to have missed the mark. First, many of the retail pharmacy PBMs have disappeared (one of the largest, RxAmerica was acquired by CVS). Second, none of the second tier PBMs has grown substantially, in terms of covered lives or prescriptions in the past several years. Finally, the four top tier PBMs consistently retain over 90% of their business. To the extent that each of the major PBMs have lost business, they have primarily lost business to each other rather than to the second-tier PBMs.<sup>15</sup> In fact, the major PBMs suggest that the only competitive threat they face is from each other.

The fact that second-tier PBMs have not gained more business from the largest PBMs is not surprising. The largest PBMs possess substantial economies of scale in terms of purchasing power, mail order operations, and specialty pharmaceuticals that give them a significant cost advantage over the second tier PBMs. To illustrate this difference, consider the simple issue of buying power. CVS/Caremark has over 130 million covered lives, the combined Express Scripts/Wellpoint will have almost 90 million covered lives, and Medco will have over 50 million. The next largest PBM has only 27 million covered lives. If Express Scripts acquires Wellpoint, the three largest PBMs will potentially be able to secure even substantially greater

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<sup>12</sup> The fact that the major PBMs acquired other specialty pharmaceutical firms rather than expanding their own specialty pharmaceutical operations suggests that internal growth by smaller PBMs into specialty pharmaceuticals is difficult.

<sup>13</sup> By non-integrated we mean PBMs without mail order or specialty pharmaceutical operations.

<sup>14</sup> See Federal Trade Commission, "Statement, In the Matter of Caremark Rx, Inc./AdvancePCS," (February 11, 2004), available at <http://www.ftc.gov/opa/2004/02/Caremarkadvance.htm>.

<sup>15</sup> See Lehman Brothers, "Medco Health Solutions 5" (December 4, 2006) (observing that in 2006, 29 percent of Medco's new business was from Caremark and 31 percent was from Express Scripts; in 2007, 33 percent was from Caremark and 26 percent was from Express Scripts).

rebates on pharmaceuticals purchased, providing a significant cost advantage over second-tier PBMs.

There is a similar disparity in size between the Express Scripts/Wellpoint, CVS/Caremark, Medco, and remaining PBMs in terms of the number of claims processed and prescriptions dispensed. PBMs are primarily distribution and claims processing businesses and economies of scale are central to cost differences in these types of business. These economies of scale are again a significant differentiating factor between the largest and smaller PBMs. Moreover, the largest PBMs have more sophisticated claims adjudication software, which is critical to handling multiple plans.

Scale economies are also critical in the development of drug cost containment programs and new forms of clinical and therapeutic innovation. Clinical cost containment programs are most effective when supported by a strong database based on a large number of covered lives. Moreover, these clinical cost containment programs have large fixed costs associated with having pharmacists, RNs, and qualified staffs interact with physician and patients. The largest PBMs are more effective at these types of clinical and therapeutic programs and that is another important distinction recognized by plan sponsors. Moreover, the success of new clinical innovation strategies is dependent on these economies of scale.<sup>16</sup>

The foregoing analysis does not criticize the exercise of buyer power by PBMs or their efforts to assist plan sponsors in controlling costs. Rather, it recognizes that only competition can ensure that the benefits of the exercise of buyer power are actually passed on to the ultimate consumers – the plan sponsors who purchase PBM services. Without competition, consumers cannot be assured that increased buying power will lead to lower prices.

### There are Significant Barriers to Entry and Expansion

The parties may suggest that second-tier PBMs serve as a competitive restraint, or could expand to become a more significant restraint. The facts belie this possibility. The four largest PBMs consistently report that they retain over 90 percent of their business when contracts are rebid.<sup>17</sup> The covered lives of smaller PBMs have not increased significantly over the past several years. Smaller PBMs primarily have adopted a niche strategy aimed at smaller governmental and private plan sponsors. The fact that PBMs owned by health plans are being divested suggests that these smaller PBMs have limited viability. These smaller PBMs lack the economies of scale and scope to effectively compete with the four major PBMs. Not surprisingly, on the rare occasions where the large PBMs lose business, it is primarily to other large PBMs.

The following may be significant barriers to expansion by the second-tier firms:

- Second-tier PBMs operate at a significant cost disadvantage;

<sup>16</sup> Medco Health Solutions, Presentation at Wachovia Securities Healthcare Conference (January 30, 2007).

<sup>17</sup> The fact that the same 3-4 firms have dominated the market since at least the time of the Lilly/PCS consent decree should create a significant level of skepticism about claims of ready expansion into the top tier. The 90 percent retention rate suggests that there are significant switching costs to converting to other PBMs.

- Second-tier PBMs lack mail order and specialty pharmaceutical operations and the lack of such operations only increases their cost disadvantage;
- Second-tier PBMs lack the reputation to handle large plan sponsors; and
- There are significant switching costs involved in moving from one PBM to another.

Reputational barriers can be an important barrier to expansion. PBM services—especially claims processing and clinical management—are heavily dependent on economies of scale and the ability to guarantee the highest level of performance. Thus, large plan sponsors will look for a proven track record and the experience of handling other sophisticated plan sponsors before seriously considering other PBMs.<sup>18</sup> That explains why the retention rate of the largest PBMs is so high.

In other mergers, the courts have found these types of impediments to be significant barriers to entry and expansion. For example, as the court observed in the FTC's successful challenge to the drug wholesalers mergers: "[t]he sheer economies of scale and scale and strength of reputation that the Defendants already have over these wholesalers serve as barriers to competitors as they attempt to grow in size."<sup>19</sup> We believe the same conclusion will be true for the PBM market.

#### The Merger Poses a Significant Risk of Coordinated Interaction

The merger may pose a particular threat of coordinated action in the provision of PBM services to large plan sponsors. Structurally, the market is susceptible to coordination—it is highly concentrated and that level of concentration has increased over time. It seems clear there are significant barriers to entry and expansion.

In the FTC actions against the Lilly/PCS and Merck/Medco mergers the FTC recognized and alleged the potential risks of coordinated interaction. Those risks have become more significant as concentration has increased. Moreover, there are several bases for coordination among PBMs, including coordination on customers, types of services offered, pricing to pharmacies, terms of service, pricing and other factors.

The unique role of WellPoint is important to the analysis. Of the four major PBMs, Next RX is the only one owned by a health insurance company. As such it has different financial incentives and capabilities than the three other large PBMs. PBM services are an ancillary product for WellPoint—thus, it has less of an incentive to exercise market power in PBM services and has greater financial resources to disrupt the market. Not surprisingly, WellPoint has never been the subject of any of the numerous multistate enforcement actions, since it has less of an incentive to “game the system.” Unlike one of the three largest PBMs, Wellpoint has much more to lose in its overall insurance business if a plan sponsor finds out there has been fraud or deception.

<sup>18</sup> See *United States v. United Tote, Inc.*, 768 F. Supp. 1064, 1078 (D. Del. 1991) (describing importance of reputational barriers).

<sup>19</sup> *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 34, 57 (D.D.C. 1998); see *United States v. Rockford Memorial Hosp.*, 898 F.2d 1278, 1283-84 (7<sup>th</sup> Cir. 1990) (“the fact [that fringe firms] are so small suggests that they would incur sharply rising costs in trying almost to double their output ... it is this prospect which keeps them small”).

Similarly, unlike the big three PBMs, mail order is not a significant profit center for WellPoint, so there is less of an incentive to impose egregious policies to force consumers to mail order.<sup>20</sup> Simply, because of its ownership by an insurance company, Next RX is more likely to remain an "honest broker" for plan sponsors and is less likely to follow coordination by the three largest firms.

Next RX has already demonstrated its potentially disruptive role in the market. Unlike the three dominant PBMs, it offers capitated contracts to plan sponsors in which it shares the risk of increased drug spend. These capitated contracts service as an important competitive constraint in the market and dampen the ability of the large PBMs to coordinate and change higher prices. Moreover, they are a different product offering which makes coordination more difficult. Thus, WellPoint may act as a maverick in the market. The DOJ and FTC have successfully challenged mergers in the past where the merger would eliminate a maverick in the market. Thus, the FTC should fully explore this issue in its investigation.

### The Provision of Specialty Pharmacy Distribution Services May be Harmed by the Acquisition

Express Scripts' acquisition of WellPoint's PBM business could pose competitive problems in the distribution of specialty pharmaceuticals. Specialty pharmaceuticals are expensive drugs, which often must be taken in the maintenance basis. In the past <sup>place</sup> few years, each of the large PBMs recognized the competitive significance of the distribution of specialty pharmaceuticals by acquiring major specialty pharmaceutical distributors in the past three years. In other cases the major PBMs have entered into exclusive distribution arrangements. Express Scripts is currently the second largest specialty pharmaceutical distributor in the U.S. behind Medco. The proposed transaction would make the combined entity even more dominant in individual specialty pharmaceutical markets.

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These recent acquisitions of specialty pharmaceutical manufacturers by PBMs have already resulted in significant competitive harm. Express Scripts has acquired two specialty pharmaceutical manufacturers -- Priority Healthcare and Curascript. In addition it has entered into exclusivity arrangements with some manufacturers. Many of those acquisitions or distribution alliances have led to substantial increases in the prices of several specialty pharmaceuticals. Perhaps the most troubling example, involves Express Scripts. Once it secured exclusive distribution rights it raised the price of a vital drug to treat thousands of children suffering from epilepsy, H.P. Acthar Gel, from \$1,600 a vial to \$23,000 a vial, an increase of over 1400%. This is just one of several examples of PBMs imposing dramatic price increases. As the New York Times observed "in recent years, drug benefit managers like Express Scripts have built lucrative side businesses seemingly at odds with [the mission of delivering the best price]."<sup>21</sup>

<sup>20</sup> Only 10% of WellPoint's prescriptions are through mail order compared to 24% for Express Scripts.

<sup>21</sup> Milt Freudenheim, "The Middleman's Markup" April 19, 2008, available at <http://query.nytimes.com/gst/fullpage.html?res=940DEED6143DF93AA25757C0A96E9C8B63&sec=&spn=&pagewanted=all>.

As the Commission recognized in its recent enforcement action against Ovation, there is tremendous potential for pharmaceutical firms, including PBMs to acquire drugs for highly vulnerable populations and rapidly increase prices in an anticompetitive fashion. In the Ovation matter Commissioner Rosch explained how an acquisition of this type might be anticompetitive, even if it did not eliminate a horizontal competitor, because it eliminated a reputational barrier that prevented anticompetitive conduct.<sup>22</sup>

We urge the Commission to explore Commissioner Rosch's theory in this and other matters involving pharmaceutical manufacturers. Controlling pharmaceutical costs is increasingly critical to the nation's efforts to manage its overall exploding healthcare costs. Pharmaceutical manufacturers and PBMs are increasingly looking for opportunities to find and exploit untapped market power. The specialty pharmaceutical acquisitions by PBMs, including the Express Scripts/WellPoint merger are a good place for the Commission to explore this new form of harmful conduct.

In addition, the FTC should explore if this merger will lead to anticompetitive effects in the PBM service market through the loss of a reputational constraint. Currently, WellPoint does not have an incentive to use its PBM services to exploit consumers or exercise its potential market power. Exploiting that power might convince customers to go elsewhere for other more lucrative products that WellPoint produces, primarily its health insurance products. In the Ovation matter, that reputational constraint prevented Merck from fully exploiting any potential monopoly power over the drugs it sold to Ovation; once that constraint was removed Ovation rapidly increased prices. Express Scripts has already shown its willingness to engage in this type of strategy in the Acthar Gel example. This merger should be scrutinized to determine if the elimination of a reputational barrier would harm consumers in the PBM services market.

Finally, the Commission should consider the evidence from these past acquisitions of specialty pharmaceutical manufacturers in evaluating the parties' alleged claims that this merger will be efficient or will benefit consumers. Although the PBMs may suggest their recent acquisitions, such as acquisitions of specialty pharmaceutical firms, have benefitted consumers, the reality is to the contrary.

#### The Acquisition May Lessen Competition in the Purchase by PBMs of Pharmacy Services from Retail Pharmacies Harming Consumers through a Reduction in Service and Choice

The acquisition poses competitive concerns over the exercise of monopsony power. One of the most important aspects of PBM services is the provision of distribution of drugs through pharmacies. As the Commission is aware, pharmacies play a critical role in providing services to consumers and educating them about the different alternatives in the market place. Pharmacies have also played an essential role in the creation and implementation of Medicare's pharmaceutical benefit program.

As a general matter, buyer power issues need greater scrutiny in merger investigations, especially those involving healthcare providers. As AAI observed in The Next Antitrust

<sup>22</sup> Concurring Statement of Commissioner J. Thomas Rosch, *Federal Trade Commission v. Ovation Pharmaceuticals, Inc.* available at <http://www2.ftc.gov/os/caselist/0810156/081216ovationroschstmt.pdf>.

Agenda, there were very few recent mergers challenged based on buyer power concerns. The relatively lax approach may be based on several mistaken assumptions. Buyer power does not necessarily result in benefits to consumers especially where the buyer also possesses market power in the downstream market. Moreover, when the PBM buys pharmacy services it may not be acting in the interest of the ultimate consumer – its interests may be to expand its own retail or mail order sales and raise the costs of the rival pharmacy. Thus, it has the incentive to use reduced reimbursement to drive its rivals from the market, which ultimately may harm consumers in reduced service, convenience and choice.

The Next Antitrust Agenda provided an in depth review of how buyer power can harm competition in a variety of environments. It focused on how the lack of seller alternatives could ultimately harm consumers and how buyer power could occur at lower market shares than seller power. The Report specifically analyzed how a PBM merger could harm consumers through the loss of service, diversity and choice. It discusses a hypothetical merger among PBMs and noted that increased buyer power would not necessarily benefit competition or consumers. The Report observes that because of a PBM merger that increases buyer power “[d]iversity and consumer choice are more likely when individually owned pharmacies compete in the retail market,” but as a result of the merger “many of these small pharmacies may find it difficult to survive.”<sup>23</sup> That loss of service, convenience, and consumer choice is a significant concern for consumers who rely on community pharmacies for their greater level of service and convenience.

Past PBM mergers have led to a significant increase in monopsony or oligopsony power, harming the ability of pharmacies to deliver adequate services to consumers. These problems are far more severe in pharmacy markets than markets involving other health care providers, since PBMs are not only payment intermediaries, but also are competitors since PBMs have mail order operations that compete against pharmacies and the largest PBM. So PBMs have an even greater incentive and ability to foreclose pharmacies and raise their costs. The CVS/Caremark merger, which combined the largest pharmacy chain with the largest PBM have exacerbated these problems, creating a single firm which appears to use its PBM operations strategically to raise rivals costs, which ultimately will raise prices to consumers and limit consumer choice.

The proposed acquisition increases the harm from monopsony or oligopsony effects by enabling the combined firm, either alone or in combination with the other remaining national full service PBMs to reduce the dispensing fees paid to retail pharmacies. As we explain at length in The Next Antitrust Agenda, the “competitive effects of buyer power are quite different depending on whether it is monopsony power against powerless suppliers or countervailing power against large suppliers with market power.”<sup>24</sup> The former can be competitively beneficial, forcing suppliers to reduce costs (although there can be problematic effects from a wealth transfer or discrimination). Monopsony or oligopsony power can be problematic because it will lead to reduced output and higher prices.

In this case there is a significant threat on the exercise of monopsony power and an adverse impact on consumers and community pharmacies. Community pharmacies operate at very low

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<sup>23</sup> American Antitrust Institute, The Next Antitrust Agenda 125 (2008).

<sup>24</sup> *Id.* at 103.

margins. The vast majority of revenue for community pharmacies is from dispensing prescriptions. A reduction in dispensing fees by the merged firm could drive many community pharmacies out of business, or force them to reduce hours or the level of service. Recent litigation has demonstrated how a reduction in reimbursement in a relatively small set of drugs could drive thousands of community pharmacies out of business.<sup>25</sup> This merger poses an even greater threat to the service, convenience and choice offered by community pharmacies.

We respectfully disagree with the observations of the FTC in the Caremark/AdvancePCS merger that characteristics of the PBM market made such an exercise of monopsony power unlikely.<sup>26</sup> In that statement the FTC suggested that monopsony concerns were not significant because: (1) contracts are individually negotiated and (2) the post-merger market share is not great enough to expect a monopsony effect. Finally, the statement suggested that increased buying power would increase PBM margins and some of those margins would be passed on to PBM clients.

We believe the facts and economic theory do not support the FTC's conclusion. First, community pharmacies are not given the "privilege" of negotiating contracts with PBMs – PBMs present them contracts on a "take it or leave it basis." There is no evidence that community pharmacies have any type of negotiating power. Second, the FTC applied too high a threshold in analyzing the market shares necessary to raise monopsony or oligopsony concerns. The market shares in this merger are significant enough to pose monopsony concerns. As explained in The Next Antitrust Agenda, monopsony power concern can exist at relatively low market shares, even below 20%.<sup>27</sup> Third, the question of benefits to the plans is ambiguous at best. PBMs typically refuse to disclose to plans the amount of reimbursement to pharmacies and sometimes are deceptive about the reimbursement level. Because of the lack of transparency and market concentration, plans typically cannot bargain with PBMs to share the increased margins from reduced reimbursement. Indeed, the several AG enforcement actions and recent audits by state governments have found that PBMs often pocket the reductions in pharmacy costs. In any case, even if there were some alleged savings to the plans, the ultimate consumer may be harmed in a reduction of service and convenience if lower premiums force community pharmacies to cut back services, hours, or exit the market.

<sup>25</sup> In a recent consideration of a proposed settlement of Average Wholesale Price litigation Judge Patti Saris required the parties to renegotiate the settlement and narrow its scope because of the potential impact on community pharmacies, which would have diminished pharmacy services and threatened the viability of many pharmacies. *New England Carpenters Health Benefits Fund v. First DataBank, Inc. et al*, Case No. 05-cv-11148 (D. Mass 2005). The proposed settlement would have reduced the AWP of approximately 8000 National Drug Codes (NDCs) by 5%. There was evidence that this reduction could have driven up to 50% of community pharmacies out of business. In response, the Court ordered the settling parties to reduce the number of NDCs in the settlement to approximately 1400.

<sup>26</sup> See Federal Trade Commission, "Statement, In the Matter of Caremark Rx, Inc./AdvancePCS," (February 11, 2004), available at <http://www.ftc.gov/opa/2004/02/Caremarkadvance.htm> at pp 2-3. We urge the Commission to revisit its conclusions in that merger. First, the numerous state enforcement actions suggest that the benefits of any increased buying power may simply be pocketed by the PBMs. Second, the investigation was resolved by a quick look instead of a complete investigation.

<sup>27</sup> American Antitrust Institute, The Next Antitrust Agenda 104 (2008).

Finally, monopsony concerns are not new to the PBM market. There are several on-going private litigation cases alleging the exercise of monopsony power either by the national full service PBMs individually or collectively with each other.

### The FTC Should Issue a Second Request

There has been significant PBM consolidation in the past 8 years. Unfortunately, the FTC has failed to conduct a thorough investigation of any of these mergers. Most recently, the CVS/Caremark merger was cleared without a Second Request. That was unlike the Clinton Administration when Second Requests were issued in several PBM mergers and enforcement actions were taken against the Lilly/PCS and Merck/Medco mergers.

We believe this lack of enforcement has led to diminished competition and harm to consumers. In our Transition Team report we highlighted the important role of healthcare intermediaries, like PBMs and the lack of enforcement in the past Administration:

In the absence of federal enforcement, there has been a tremendous increase in consolidation in the health insurance and PBM markets and a significant number of state and private enforcement actions against all these entities. The health insurance market has experienced a rapid consolidation, and the vast majority of metropolitan markets have become highly concentrated. A similar trend has occurred in the PBM market. Abandoning enforcement in these key areas leads to significant harm to consumers.<sup>28</sup>

We hope the FTC takes a different direction. This merger is an critical opportunity for the FTC to reevaluate the assumptions and theoretical arguments that may have served as the basis for earlier non-enforcement decisions. Moreover, this merger may lead to increased PBM consolidation. Thus the FTC should conduct a thorough investigation to accurately assess the competitive impact of this merger.

### CONCLUSION

PBMs serve an important role in the health care delivery system. In light of increasing pharmaceutical expenditures and the critical role of PBMs in health care reform, it is even more important for the FTC to ensure that the PBM market is competitive. The promise of PBM cost containment is dependent on competition that compels PBMs to pass on cost savings to plan sponsors. Given the potential substantial harm to competition that may result from this merger, the AAI urges the FTC to issue a Second Request and conduct a thorough investigation.

### CONTACT INFORMATION

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<sup>28</sup> *Id.* at 317.

## Appendix A - -Federal and State Litigation Regarding Pharmacy Benefit Managers

January 2009

*From 2004 – 2008, the three major PBMs (Medco, CVS Caremark, and Express Scripts) faced six major federal or multidistrict cases over allegations of fraud; misrepresentation to plans, patients, and providers; improper therapeutic substitution; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases resulted in over \$371.9 million in damages to states, plans, and patients so far. The most prominent cases were brought by a coalition of over 30 states and the Department of Justice. Below is a summary of these six cases. Note that the regulatory provisions of many of these settlements will expire within the next 2-10 years.*

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1. *United States v. Merck & Co., Inc., et al* (also cited as *United States of America v. Merck-Medco Managed Care L.L.C., et al.*) (E.D. Pa.)

Settled: October 23, 2006

Damages: \$184.1 million

States participating: Arizona, California, Connecticut, Delaware, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Nevada, New York, North Carolina; Oregon, Pennsylvania, Texas, Vermont, Virginia, and Washington.

### Claims:

Whistleblower lawsuits, filed under the federal False Claims Act and state False Claims Acts against Medco Health Solutions, Inc., alleged that Medco:

- systematically defrauded government-funded health insurance by accepting kickbacks from manufacturers in exchange for steering patients to certain products;
- secretly accepted rebates from drug manufacturers;
- secretly increased long term drug costs by switching patients away from cheaper drugs; and
- failed to comply with state-mandated quality of care standards.

**Settlement:**

- A preliminary settlement in April of 2004:
  - Required Medco to pay \$29.1 million to participating states and affected patients;
  - Placed restrictions on the company's ability to switch drugs;
  - Imposed measures to increase transparency; and
  - Required Medco to adopt the American Pharmacists Association code of ethics for employees.
  
- The final settlement, brokered in October 2006 required Medco to:
  - Pay an additional \$155 million;
  - Enter into a consent decree regulating drugs switching and mandating greater transparency; and
  - Enter into a Corporate Integrity Agreement (CIA) as a condition of Medco's continued participation in government health programs.

The Corporate Integrity Agreement will expire in 2011.

**2. *United States of America, et al. v. AdvancePCS, Inc. (Case No. 02-cv-09236)(E.D. Pa.)***

**Filed: 2002**

**Settled: September 8, 2005**

**Damages: \$137.5 million**

**Claims:**

Whistleblower lawsuit, filed under the Federal False Claims Act, alleging that Advance PCS (now part of CVS Caremark):

- Knowingly solicited and received kickbacks from drug manufacturers in exchange for favorable treatment of those companies' products;
- Paid improper kickbacks to existing and potential customers to induce them to sign contracts with the PBM;
- Submitted false claims in connection with excess fees paid for fee-for-service agreements; and
- Received flat fee rebates for inclusion of certain heavily utilized drugs.

**Settlement:**

A settlement in September, 2005 required Advance PCS, Inc., to:

- Pay a \$137.5 million settlement and face a five-year injunction;
- Submit to regulations designed to promote transparency and restrict drug interchange programs;
- Enter into a five-year Corporate Integrity Agreement; and
- Develop procedures to ensure that any payments between them and pharmaceutical manufacturers, clients, and others do not violate the Anti-Kickback Statute of Stark Law.

**3. *United States of America, et al v. Caremark, Inc. (Case No. 99-cv-00914)(W.D. Tex.)***

**Filed: 1999**

*Pending as of January 2009*

*States participating: Arkansas, California, DC, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, New Hampshire, New Mexico, North Carolina, Tennessee, Texas, Utah and Virginia.*

**Claims:**

This case is prosecuted under the Federal False Claims Act and numerous state False Claims Statutes. It alleges that Caremark (now part of CVS Caremark):

- Submitted reverse false claims to the Government in order to avoid, decrease or conceal their obligation to pay the government under several federal health insurance programs including Medicaid, Indian Health Services, and Veterans Affairs/Military Treatment Facilities.

**4. *States Attorneys General v. Caremark, Inc.***

**Filed: February 14, 2008**

**Settled: February 14, 2008**

**Damages: \$41 million.**

*States participating: Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia and Washington.*

**Claims:**

Complaint against Caremark by 29 Attorneys General alleges that Caremark:

- Engaged in deceptive trade practices by encouraging doctors to switch patients from originally prescribed brand drugs to different brand name drugs.
- Did not inform clients that Caremark retained all the profits reaped from these drug switches; and
- Restocked and re-shipped previously dispensed drugs that had been returned to Caremark's mail order pharmacies.

**Settlement:**

In conjunction with the complaints, states issued a consent decree/final judgment that required Caremark to:

- Pay a collective settlement of \$41 million;
- Significantly change its business practices by imposing restrictions on drug switches and creating greater transparency;
- Apply a code of ethics and professional standards; and
- Refrain from restocking and re-shipping returned drugs unless permitted by law.

**5. State Attorneys General v. Express Scripts**

Settled: May 27, 2008

Damages: \$9.3 million to states, plus up to \$200,000 to affected patients

States participating: Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington.

**Claims:**

State Attorneys general settled consumer protection claims alleging that Express Scripts:

- Engaged in deceptive business practices by illegally encouraging doctors to switch their patients to different brand name drugs; and
- Illegally increased their spreads and rebates from manufacturers without passing the savings on to the plans.

**Settlement:**

The settlement required Express Scripts to:

- pay \$9.3 million to the states, plus up to \$200,000 in reimbursements to affected patients.
- Accept restrictions on drug switching practices;
- Increase transparency for plans, patients and providers; and
- Adopt a certain code of professional standards.

**6. *Local 153 Health Fund v. Express Scripts (In re Express Scripts, Inc. Pharmacy Benefits Management Litigation)* (Case No. 4:05-md-01672-SNL)**

Case consolidated: April 29, 2005

*Pending as of January 2009*

**Claims:**

This case, filed in the Eastern District of Missouri, alleges that Express Scripts:

- Retained undisclosed rebates from manufacturers;
- Enriched itself by creating a differential in fees;
- Failed to pass on or disclose discounted drug rates and dispensing fees;
- Gained kickbacks from drug manufacturers in exchange for favoring certain drugs on the formulary;
- Circumvented "Best Pricing" rules to artificially inflate AWP; and
- Enriched itself with bulk purchase discounts that it failed to pass on to the plaintiffs.