To:	SUSAN B. MEYER(ipdocket@grsm.com)
Subject:	U.S. Trademark Application Serial No. 97253721 - MEDPAY - BMIMP1095805
Sent:	December 22, 2023 04:54:51 PM EST
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Attachments

screencapture-en-wikipedia-org-wiki-Pharmacy_benefit_management-17032701255631
screencapture-www-cvshealth-com-services-prescription-drug-coverage-pharmacy-benefits-management-html-17032702413471
screencapture-content-naic-org-cipr-topics-pharmacy-benefit-managers-17032714575821
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screencapture-www-commonwealthfund-org-publications-explainer-2019-apr-pharmacy-benefit-managers-and-their-role-drug-spending-17032716915371
screencapture-www-wbur-org-onpoint-2023-12-14-pharmacy-benefit-managers-the-middleman-that-decides-what-you-pay-for-medications-17032718833331
screencapture-www-vox-com-2023-5-10-23709448-what-are-pbms-pharmacy-benefit-managers-bernie-sanders-17032729117461
screencapture-newcityinsurance-com-pharmacy-benefit-managers-and-their-role-in-rising-prescription-drug-costs-and-spending-17032737150021
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United States Patent and Trademark Office (USPTO)

Office Action (Official Letter) About Applicant's Trademark Application

U.S. Application Serial No. 97253721

Mark: MEDPAY

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Reference/Docket No. BMIMP1095805

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REQUEST FOR RECONSIDERATION AFTER FINAL ACTION DENIED

Issue date: December 22, 2023

Applicant's request for reconsideration is denied. *See* 37 C.F.R. §2.63(b)(3). The trademark examining attorney has carefully reviewed applicant's request and determined the request did not: (1) raise a new issue, (2) resolve all the outstanding issue(s), (3) provide any new or compelling evidence with regard to the outstanding issue(s), or (4) present analysis and arguments that were persuasive or shed new light on the outstanding issue(s). TMEP §§715.03(a)(ii)(B), 715.04(a).

Accordingly, the following requirement(s) and/or refusal(s) made final in the Office action dated May 30, 2023 are **maintained and continued**:

- Mere Descriptiveness Refusal
- Request for Information

See TMEP §§715.03(a)(ii)(B), 715.04(a).

In addition, the following requirement(s) and/or refusal(s) made final in that Office action are **satisfied**:

- Identification of Services

See TMEP §§715.03(a)(ii)(B), 715.04(a).

SECTION 2(e)(1) REFUSAL - MERELY DESCRIPTIVE

The refusal under Trademark Act Section 2(e)(1) is maintained and continued for the reasons set forth below. *See* 15 U.S.C. §1052(e)(1); 37 C.F.R. §2.63(b).

Applicant has applied to register the mark MEDPAY, for use with *Administering healthcare management programs, namely, cost management and consultation for the healthcare and prescription drug benefit plans of others; administering healthcare management programs, namely, cost management for the healthcare benefit plans of others via healthcare and prescription drug benefit plan utilization review programs and pharmaceutical cost management services; administering healthcare management programs, namely, cost management for the healthcare benefit plans of others via drug utilization review programs; administering healthcare management programs, namely, cost management for the healthcare benefit plans of others featuring prescription drug mail order and specialty drug programs and integrated healthcare wellness programs; Healthcare benefit*

management services in the nature of healthcare cost review, namely, monitoring and analyzing information regarding consumer prescription drug use and healthcare habits to identify potential cost savings and improvements to business administration of integrated healthcare wellness programs, in Class 35;*Healthcare benefit management services, namely, insurance administration and insurance claims processing of healthcare and prescription drug benefit plans; Healthcare benefit management services, namely, administering a network of pharmacy providers for the purpose of insurance administration of healthcare benefits; Healthcare benefit management services, namely, insurance advisory services and insurance consultancy regarding healthcare and prescription drug benefit plans; Healthcare benefit management services, namely, provision of insurance information and analysis in the fields of healthcare and prescription drug benefits; Healthcare benefit management services, namely, insurance claims processing for healthcare benefits in the nature of verification and processing of consumer healthcare benefits and prior authorization requests*, in Class 36;*Providing temporary use of on-line non-downloadable software for database management and for the collection, editing, organizing, modifying, book marking, transmission, storage and sharing of data and information for healthcare management services*, in Class 35; and *Healthcare management services in the nature of providing information and consultation in the field of health*, in Class 44.

A mark is merely descriptive if it describes an ingredient, quality, characteristic, function, feature, purpose, or use of an applicant's goods and/or services. TMEP §1209.01(b); *see, e.g.*, *In re TriVita, Inc.*, 783 F.3d 872, 874, 114 USPQ2d 1574, 1575 (Fed. Cir. 2015) (quoting *In re Oppedahl & Larson LLP*, 373 F.3d 1171, 1173, 71 USPQ2d 1370, 1371 (Fed. Cir. 2004)); *In re Steelbuilding.com*, 415 F.3d 1293, 1297, 75 USPQ2d 1420, 1421 (Fed. Cir. 2005) (citing *Estate of P.D. Beckwith, Inc. v. Comm'r of Patents*, 252 U.S. 538, 543 (1920)).

Applicant argues that the mark is not descriptive of the services because it does not answer all possible questions about the payments, including who is paid, why they are paid, and in what manner they are paid. Relatedly, applicant argues that the mark cannot be descriptive because applicant does not offer medical clinic services. However, applicant's services are clearly used in making payment decisions and in the payment for medical costs. The attached articles discuss the role that pharmacy benefit managers such as applicant play in determining how much consumers pay for their medicines, as well as their roll in paying for medicines. These articles include the following:

- The Wikipedia entry noting that a pharmacy benefit manager (PBM) is a third-party administrator of prescription drug programs whose responsibilities include negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims.
- AMedical News Today article notes that PBMs represent health insurance providers when making agreements with drug manufacturers, explaining that "Drug manufacturers pay PBMs rebates. PBMs will also make payments to pharmacies, on behalf of the health insurance providers, for the drugs the insurer dispenses."
- A WBUR radio presentation that refers to PBMs as "The middlemen who decide what you pay for medications."
- The Sana Benefits page explains that the PBM determines the amount that the health plan will pay for a claim, and the pharmacy is then paid by the PBM.

The fact that the mark does not provide all of the salient information about the payment for medical services does not mean that it does not still describe an ingredient, quality, characteristic, function, feature, purpose, or use of an applicant's services. Furthermore, "A mark may be merely descriptive even if it does not describe the 'full scope and extent' of the applicant's goods or services." *In re*

Oppedahl & Larson LLP, 373 F.3d 1171, 1173, 71 USPQ2d 1370, 1371 (Fed. Cir. 2004) (citing *In re Dial-A-Mattress Operating Corp.*, 240 F.3d 1341, 1346, 57 USPQ2d 1807, 1812 (Fed. Cir. 2001)); TMEP §1209.01(b). It is enough if a mark describes only one significant function, attribute, or property. *In re The Chamber of Commerce of the U.S.*, 675 F.3d 1297, 1300, 102 USPQ2d 1217, 1219 (Fed. Cir. 2012); TMEP §1209.01(b); *see In re Oppedahl & Larson LLP*, 373 F.3d at 1173, 71 USPQ2d at 1371.

In addition to the evidence showing that pharmacy benefit managers are involved in paying for medical costs, additional evidence shows that MEDPAY is a term of art in the insurance industry. Applicant's identification of services is broad enough to encompass such services, and therefore, the mark is also descriptive.

Applicant argues that any doubt regarding the mark's descriptiveness should be resolved on applicant's behalf. *E.g.*, *In re Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 828 F.2d 1567, 1571, 4 USPQ2d 1141, 1144 (Fed. Cir. 1987); *In re Zuma Array Ltd.*, 2022 USPQ2d 736, at *8 (TTAB 2022) (quoting *In re Fallon*, 2020 USPQ2d 11249, at *8 (TTAB 2020)). However, in the present case, the evidence of record leaves no doubt that the mark is merely descriptive.

For the foregoing reasons, applicant's arguments have been considered and found unpersuasive. Therefore, the refusal to register the mark under Trademark Act Section 2(e)(1) is made FINAL.

REQUEST FOR INFORMATION

Applicant has once again provided a very broad statement in response to the requirement for additional information, which does not address the specific questions posed in the Office action, nor has applicant presented any of the additional suggested materials to further explain the nature of applicant's services. Specifically
, applicant has not clarified whether the software is used in the payment of medical bills, or otherwise used in payment processing, or in the medical field. Therefore, this requirement is maintained and continued.

To permit proper examination of the application, applicant must submit additional information about applicant's services. *See* 37 C.F.R. §2.61(b); TMEP §814. The required information should include fact sheets, brochures, and/or advertisements. If these materials are unavailable, applicant should submit similar documentation for services of the same type, explaining how its own services will differ. If the services feature new technology and no information regarding competing services is available, applicant must provide a detailed factual description of the services.

Factual information about the services must clearly indicate what the services are and how they are rendered, their salient features, and their prospective customers and channels of trade. Conclusory statements regarding the services will not satisfy this requirement for information.

If applicant submits webpage evidence to satisfy this requirement, applicant must provide (1) an image of the webpage, (2) the date it was accessed or printed, and (3) the complete URL address. *In re ADCO Indus.-Techs., L.P.*, 2020 USPQ2d 53786, at *2 (TTAB 2020) (citing *In re I-Coat Co.*, 126 USPQ2d 1730, 1733 (TTAB 2018)); TMEP §710.01(b). Providing only a website address or hyperlink to the webpage is not sufficient to make the materials of record. *In re ADCO Indus.-Techs., L.P.*, 2020

USPQ2d 53786, at *2 (citing *In re Olin Corp.*, 124 USPQ2d 1327, 1331 n.15 (TTAB 2017); *In re HSB Solomon Assocs., LLC*, 102 USPQ2d 1269, 1274 (TTAB 2012); TBMP §1208.03); TMEP §814.

Applicant has a duty to respond directly and completely to this requirement for information. *See In re Ocean Tech., Inc.*, 2019 USPQ2d 450686, at *2 (TTAB 2019) (citing *In re AOP LLC*, 107 USPQ2d 1644, 1651 (TTAB 2013)); TMEP §814. Failure to comply with a requirement for information is an independent ground for refusing registration. *In re SICPA Holding SA*, 2021 USPQ2d 613, at *6 (TTAB 2021) (citing *In re Cheezwhse.com, Inc.*, 85 USPQ2d 1917, 1919 (TTAB 2008); *In re DTI P'ship LLP*, 67 USPQ2d 1699, 1701-02 (TTAB 2003); TMEP §814).

If applicant has already filed an appeal with the Trademark Trial and Appeal Board, the Board will be notified to resume the appeal. *See* TMEP §715.04(a).

If applicant has not filed an appeal and time remains in the response period for the final Office action, applicant has the remainder of that time to (1) file another request for reconsideration that complies with and/or overcomes any outstanding final requirement(s) and/or refusal(s), and/or (2) file a notice of appeal to the Board. TMEP §715.03(a)(ii)(B).

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https://en.wikipedia.org/wiki/Pharmacy_benefit_management at 01:35:32, 12/22/2023

Pharmacy benefit management

3 languages

From Wikipedia, the free encyclopedia

This article **may rely excessively on sources too closely associated with the subject**, potentially preventing the article from being verifiable and neutral. Please help improve it by replacing them with more appropriate citations to reliable, independent, third-party sources. *(April 2019)* *(Learn how and when to remove this template message)*

In the United States, a **pharmacy benefit manager** (**PBM**) is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.[1][2] According to the American Pharmacists Association, "PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims."[3][4] PBMs operate inside of integrated healthcare systems (e.g., Kaiser Permanente or Veterans Health Administration), as part of retail pharmacies (e.g., CVS Pharmacy), and as part of insurance companies (e.g., UnitedHealth Group).[1][4]

As of 2016, PBMs managed pharmacy benefits for 266 million Americans. In 2017, the largest PBMs had higher revenue than the largest pharmaceutical manufacturers, indicating their increasingly large role in healthcare in the United States.[5] However, in 2016 there were fewer than 30 major PBM companies in this category in the US,[1] and three major PBMs (Express Scripts, CVS Caremark, and OptumRx of UnitedHealth Group) comprise 78% of the market and cover 180 million enrollees.[1][6]

Business model [edit]

In the United States, health insurance providers often hire an outside company to handle price negotiations, insurance claims, and distribution of prescription drugs. Providers which use such pharmacy benefit managers include commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.[1] PBMs are designed to aggregate the collective buying power of enrollees through their client health plans, enabling plan sponsors and individuals to obtain lower prices for their prescription drugs. PBMs negotiate price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and mail-service pharmacies which home-deliver prescriptions without consulting face-to-face with a pharmacist.[7]

Pharmacy benefit management companies can make revenue in several ways. First, they collect administrative and service fees from the original insurance plan. They can also collect rebates from the manufacturer. Traditional PBMs do not disclose the negotiated net price of the prescription drugs, allowing them to resell drugs at a public list price (also known as a sticker price) which is higher than the net price they negotiate with the manufacturer.[8] This practice is known as "spread pricing".[9] Savings are generally considered trade secrets.[10] Pharmacies and insurance companies are often prohibited by the PBM from discussing costs and reimbursements. This leads to lack of transparency. Therefore, states are often unaware of how much money they lose due to spread pricing, and the extent to which drug rebates are passed on to enrollees of Medicare plans. In response, states like Ohio, West Virginia, and Louisiana have taken action to regulate PBMs within their Medicaid programs. For instance, they have created new contracts that require all discounts and rebates to be reported to the states. In return, Medicaid pays PBMs a flat administrative fee.[11]

The formulary [edit]

Main article: Formulary (pharmacy)

PBMs advise their clients on ways to "structure drug benefits" and offer complex selections at a variety of price rates from which clients choose. This happens by constructing a "formulary" or list of specific drugs that will be covered by the healthcare plan. The formulary is usually divided into several "tiers" of preference, with low tiers being assigned a higher copay to incentivize consumers to buy drugs on a preferred tier. Drugs which do not appear on the formulary at all mean consumers must pay the full list price. To get drugs listed on the formulary, manufacturers are usually required to pay the PBM a manufacturer's rebate, which lowers the net price of the drug, while keeping the list price the same.[12] Pharmaceutical manufacturers say that in order to cover the cost of these rebates, they are forced to raise the price of drugs. For example, the president of Eli Lilly and Company claims the cost of discounts and rebates accounts for 75% of the list price of insulin. PBMs such as Express Scripts claim rebates are a response to rising list prices, and are not the cause of them.[13]

The complex pricing structure of the formulary can have unexpected consequences. When filing an insurance claim, patients usually are charged an insurance copayment which is based on the public list price, and not the confidential net price. Around a quarter of the time, the cost of the insurance copayment on the list price is more than the entire price of the drug bought directly in cash. The PBM can then pocket the difference, in a practice known as a "clawback".[14] Consumers can choose to buy the drug in cash, but in their contracts with pharmacies, PBMs would forbid pharmacists from telling

as a "clawback".[14] Consumers can choose to buy the drug in cash, but in their contracts with pharmacies, PBMs would forbid pharmacists from telling consumers about the possibility of buying their medication for a cheaper price without an insurance claim, unless consumers directly ask about it.[15] Since 2017, six states have passed legislation making such "gag clauses" illegal.[16] This has recently been followed by a federal bans on gag orders[17] for private insurance effective Oct 2018,[18] and for Medicare effective Jan 2020.[19]

Net effect on consumers [edit]

Overall, the PBM industry claims to provide significant cost savings for end users. For example, in 2015, CVS Caremark said that it reduced its plan members' prescription drug spending to 5%, down from 11.8% in 2014.[20] However, such conclusions can be controversial. A 2013 investigation of PBM marketing from Fortune Magazine showed: Drug pricing is difficult to untangle and customers have no way of knowing how much they are saving.[21]

History [edit]

In 1968, the first PBM was founded when Pharmaceutical Card System Inc. (PCS, later AdvancePCS) invented the plastic benefit card.[1] By the "1970s, [they] serve[d] as fiscal intermediaries by adjudicating prescription drug claims by paper and then, in the 1980s, electronically".[22]:34

By the late 1980s, PBMs had become a major force "as health care and prescription costs were escalating".[23] Diversified Pharmaceutical Services was one of the earliest examples of a PBM which came from within a national health maintenance organization United HealthCare (now United HealthGroup).[24]:304[25] After SmithKline Beecham acquired DPS in 1994, Diversified played a pivotal role in its Healthcare Service division and by 1999 UnitedHealth Group accounted for 44% of Diversified Pharmaceutical Services's total membership.[25] Express Scripts acquired Diversified in April 1999 and consolidated itself as a leading PBM for managed care organizations.[25]

In August 2002, the Wall Street Journal wrote that while PBMs had "steered doctors to cheaper drugs, especially low-cost generic copies of branded drugs from big pharmaceutical companies" from 1992 through 2002, they had "quietly moved" into marketing expensive brand name drugs.[26]

In 2007, when CVS acquired Caremark,[1] the function of PBMs changed "from simply processing prescription transactions to managing the pharmacy benefit for health plans",[22]:34 negotiating "drug discounts with pharmaceutical manufacturers",[22]:34 and providing "drug utilization reviews and disease management".[22]:34 PBMs also created a formulary to encourage or even require "health plan participants to use preferred formulary products to treat their conditions".[22]:34 In 2012, Express Scripts and CVS Caremark transitioned from using tiered formularies, to those that excluded drugs from their formulary.[1][27]

Market and competition [edit]

As of 2004, the Federal Trade Commission found PBMs operated in a marketplace with "vigorous competition".[28] And as of 2013, in the United States, a majority of the large managed prescription drug benefit expenditures were conducted by about 60 PBMs.[29] Few PBMs are independently owned and operated. PBM's operate inside of integrated healthcare systems (e.g., Kaiser Permanente or Veterans Health Administration), as part of retail pharmacies, major chain drug stores (e.g., CVS Pharmacy or Rite-Aid), and as subsidiaries of managed care plans or insurance companies (e.g., UnitedHealth Group).[1][4] However, in 2016 fewer than 30 major PBM companies were in this category in the US,[1] and only three major PBMs (Express Scripts, CVS Health, and OptumRx of UnitedHealth Group) comprised 78% of the market, covering 180 million enrollees.[1][29]

In 2015, the three largest public PBMs were Express Scripts, CVS Health (formerly CVS Caremark) and United Health/OptumRx/Catamaran.[30][31][32] As of 2018, the three largest PBMs controlled more than 80% of the market.[33]

Express Scripts [edit]

In 2012 Express Scripts acquired rival Medco Health Solutions for $29.1 billion and became "a powerhouse in managing prescription drug benefits".[34] As of 2015, Express Scripts Holding Company was the largest pharmacy benefit management organization in the United States,[35] with 2013 revenues of $104.62 billion.[36]

In October 2015 Express Scripts began reviewing pharmacy programs run by AbbVie Inc and Teva Pharmaceuticals Industries Ltd regarding the potential use of tactics that "can allow drugmakers to work around reimbursement restrictions" from Express Scripts and other insurers. These reviews resulted from investigations into "questionable practices" at Valeant Pharmaceuticals International Inc's partner pharmacy, Philidor Rx Services.[35]

CVS Health [edit]

In 1994, CVS launched PharmaCare, a pharmacy benefit management company providing a wide range of services to employers, managed care organizations, insurance companies, unions and government agencies.[37] By 2002 CVS' specialty pharmacy ProCare, the "largest integrated retail/mail provider of specialty pharmacy services" in the United States,[38]:10 was consolidated with their pharmacy benefit management company, PharmaCare.[38][39]:4 Caremark Rx was founded as a unit of Baxter International and in 1992 spun off from Baxter as a publicly traded company. In March 2007, CVS Corporation acquired Caremark to create CVS Caremark, later re-branded as CVS Health.[40]

In 2011 Caremark Rx was the nation's second-largest PBM. Caremark Rx was subject to a class action lawsuit in Tennessee, which alleged that Caremark kept discounts from drug manufacturers instead of sharing them with member benefit plans, secretly negotiated rebates for drugs and kept the money, and provided plan members with more expensive drugs when less expensive alternatives were available. CVS Caremark paid $20 million to three states over fraud allegations.[41]

UnitedHealth Group [edit]

OptumRx, one of the Optum businesses of UnitedHealth Group Inc, has been a leading PBM.[42] In March 2015 UnitedHealth Group acquired Catamaran Corporation for about $12.8 billion to extend this PBM business.[43][44]

Advocacy and lobbying [edit]

Many Pharmacy benefit managers are represented by the trade association the Pharmaceutical Care Management Association.

Biosimilars [edit]

Main article: Biosimilars

PBMs have been strong proponents in the creation of a U.S. Food and Drug Administration pathway to approve biosimilar versions of expensive specialty drugs which treat conditions like Alzheimer's, rheumatoid arthritis and multiple sclerosis.[45] PBM's support so-called biosimilar legislation which does not grant brand name drug manufacturers monopoly pricing power.[46] In 2015 the Federal Trade Commission found that patents for biologic products already provide enough incentives for innovation and that additional periods of exclusivity would "not spur the creation of a new biologic drug or indication" and "imperils" the benefits of the approval process.[47]

Controversies and litigation [edit]

In 1998, PBMs were under investigation by Assistant U.S. Attorney James Sheehan of the federal Justice Department, and their effectiveness in reducing prescription costs and saving clients money was questioned.[23]

In 2004, litigation added to the uncertainty about PBM practices.[41][46] In 2015, there were seven lawsuits against PBMs involving fraud, deception, or antitrust claims.[1][8]

State legislatures have been using "transparency," "fiduciary," and "disclosure" provisions to improve the business practices of PBMs.[48] In 2011, the Mississippi Board of Pharmacy formed a new division of the Pharmacy Benefit Managers, with a mandate to license and regulate PBMs.[49]

A 2013 Centers for Medicare & Medicaid Services study found negotiated prices at mail order pharmacy to be up to 83% higher than the negotiated prices at community pharmacies.[50]

A 2014 ERISA (Employee Retirement Income Security Act of 1974) hearing noted that vertically integrated PBMs may pose conflicts of interest, and that PBMs' health plan sponsors "face considerable obstacles in...determin[ing] compliance with PBM contracts including direct and indirect PBM compensation contract terms".[51]

In 2017, the Los Angeles times wrote that PBMs cause an inflation in drug costs, especially within the area of diabetes drugs.[52]

United States Secretary of Health and Human Services Alex Azar stated regarding PBMs, "Everybody wins when list prices rise, except for the patient. It's rather a startling and perverse system that has evolved over time."[53]

On January 31, 2019, Health and Human Services released a proposed rule to remove Anti-kickback Statute, safe harbor protections for PBMs and other plan sponsors, that previously allowed PBMs to seek rebates from drug manufacturers.[54]

Ron Wyden said in April 2019 that they were as "clear a middleman rip-off as you are going to find", because they make more money when they pick a higher priced drug over a lower priced drug.[55]

See also [edit]

- Online pharmacy
- Preferred pharmacy network

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History
Market and competition
Express Scripts
CVS Health
UnitedHealth Group

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External links [edit]

- Pharmacy Benefit Management Institute list of PBM companies

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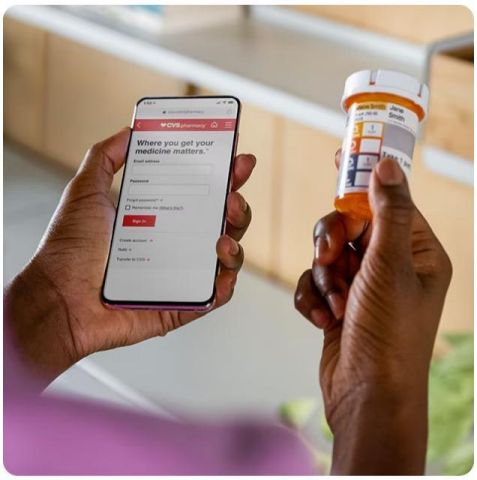

The impact of pharmacy benefit managers (PBMs)

As part of CVS Health®, CVS Caremark® plays a critical role in the health care system by negotiating low net costs for our customers while supporting safe and clinically effective products for consumers. Beyond traditional PBMs, we use an integrated model to increase

access to care, deliver better health outcomes and help lower overall health care costs.

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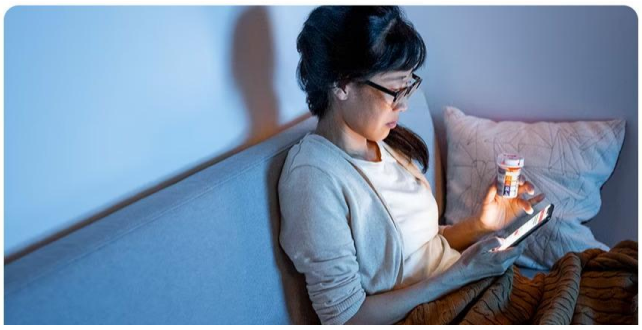
Get to know pharmacy benefit managers

What are PBMs

Pharmacy benefit managers, or PBMs, manage prescription drug benefits for clients ranging from health insurers and Medicare Part D drug plans to large employers. PBMs are one of the few parts of the prescription drug supply chain specifically dedicated to lowering costs.

How Caremark helps lower costs



People are more likely to take their prescribed medications when they know they can afford them. CVS Caremark® negotiates lower costs for our customers and expands coverage to affordable medications that people need to stay healthy. We are transparent about medication costs and prioritize a high quality and more affordable approach to health care.

Our approach begins with the latest clinical research, guidelines and best practices — and our formulary decisions are overseen by a committee of independent, unaffiliated clinical pharmacists and physicians. Across every therapeutic category, we strive to achieve low costs for our clients and their members. That means managing the two fundamental forces behind drug spending: price and utilization.

As one example of how we help lower out-of-pocket prescription costs, our members may use our proprietary online search tool for savings options that work with their prescription plan.

Find ways CVS Caremark helps keep drug costs down >

Which essential services do PBMs provide

The basic services PBMs provide include:

- Negotiating low drug costs and rebates with pharmaceutical manufacturers
- Creating and administering retail pharmacy networks

- Creating and administering retail pharmacy networks
- Helping members understand the best use of pharmacy benefits
- Developing and maintaining formularies, which are lists of covered drugs
- Providing mail pharmacy and home delivery services
- Ensuring providers have the latest clinical information to prescribe clinically appropriate medications
- Processing pharmacy claims

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Why PBMs may provide additional services

CVS Caremark goes above and beyond these basic services: We provide adherence counseling to make sure members take medications as prescribed, help close gaps in care, support members with chronic and specialty conditions, provide disease management support, and more.

All in all, the goal of these added services is to help improve health outcomes, which helps lower long-term and overall health care costs. Almost half of our members use our digital tools to manage their prescriptions, find lower-cost alternatives and stay on track with their treatments.

Discover our approach to care management ›

How PBMs are different from an insurance company

With traditional medical health insurance, medical bills are covered by insurance benefits for hospital, doctors and other health care provider costs. Traditional medical health insurance also covers medications administered directly by the provider in the office or at the hospital.

The prescription drug benefit covers medications that are typically picked up at the pharmacy or delivered to the home.

PBMs work alongside health plans and employers to administer prescription drug benefits. Depending on a person's insurance, they may be able to use their health insurance card when they pick up prescriptions at the pharmacy, or they may have a separate card specifically for prescription drug coverage.

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PHARMACY BENEFIT MANAGERS

Last Updated 6/1/2023

Issue: Pharmacy Benefit Managers (PBMs) are third party companies that function as intermediaries between insurance providers and pharmaceutical manufacturers. PBMs create formularies, negotiate rebates (discounts paid by a drug manufacturer to a PBM) with manufacturers, process claims, create pharmacy networks, review drug utilization, and occasionally manage mail-order specialty pharmacies.

In light of rising **health care** costs, the role of PBMs are being reviewed due to the cost of prescription drugs and the effects on consumers. The cost of insulin and EpiPens has been the focus of much of the news coverage, with patients being forced to ration medicine when they cannot afford copays.

Background: When insurance companies began offering prescription drugs as a health plan benefit in the 1960s, PBMs were created to help insurers contain drug spending. Originally, PBMs decided which drugs were offered in formularies and administered drug claims. In the 1970s, PBMs began to adjudicate prescription drug claims. In the 1990s, drug manufacturers began acquiring PBMs. Concerns about conflicts of interest caused federal orders for divestment from the Federal Trade Commission, sparking a trend of mergers and acquisitions within the PBM field.

Today, there are 66 PBM companies, with the three largest – Express Scripts (an independent publicly-traded company), CVS Caremark (the pharmacy service segment of CVS Health and a subsidiary of the CVS drugstore chain), and OptumRx (the pharmacy service segment of UnitedHealth Group Insurance) – controlling **approximately 89%** of the market and serving about **270 million** Americans.

PBMs work in conjunction with drug manufacturers, wholesalers, pharmacies, and **health insurance** providers but play no direct role in the physical distribution of prescription drugs, only handling negotiations and payments within the supply chain. When a new drug is available, the manufacturer negotiates with wholesalers who then sell and distribute drugs to pharmacies. PBMs negotiate agreements with drug manufacturers on behalf of insurers and are paid rebates by drug manufacturers. Pharmacy Services Administrative Organizations (PSAOs) negotiate reimbursements with PBMs on behalf of pharmacies. PBMs then pay pharmacies on behalf of health insurance providers for drugs dispensed to patients. PSAOs and PBMs are both third party companies with different functions and purposes. PSAOs represent and offer services to independent pharmacies and PBMs represent health insurers.

Committees Related to This Topic

Pharmacy Benefit Manager Regulatory Issues (B) Subgroup

Additional Resources

Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation
NAIC, April 2023

Compilation of State Pharmacy Benefit Manager Business Practice Laws
NAIC, February 2023

Prescription Drug Insurance Plans: Potential Cost Reductions and the Pass-Through of Manufacturer Pharmaceutical Rebates to Premiums
Journal of Insurance Regulation, 2019

Health Care and Pharmaceutical Cost Drivers and Regional Cost Variation: Regulatory Strategies, Options and Solutions
CIPR Research Brief, August 2019

Rising Health Care Costs: Drivers, Challenges and Solutions
CIPR Study, August 2019

Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization

Pharmacy Benefit Managers earn profits primarily through administrative fees charged for their services, through spread pricing (the difference between what is paid to pharmacies and the negotiated payment from health plans), and shared savings where the PBM keeps part of the rebates or discounts negotiated with drug manufacturers. Concerns with PBM business practices focus on transparency to consumers regarding rebates and reimbursements. 'Gag clauses,' provisions in contracts between PBMs and pharmacies that prevent pharmacists from telling patients when the cash price of a drug is less than the insurance copay price, were banned in 2018 by the **Patient Right to Know Drug Prices Act, S.2554** and the **Know the Lowest Price Act, S.2553** to promote transparency toward patients. In a 2019 study, the Government Accountability Office reported that PBMs retain less than 1 percent of rebates in a review of Medicare Part D plans, while passing the rest on to consumers. Medicare Part D rebates accounted for **$18 billion** of the $26.7 billion in rebates in 2016. A study conducted by the Office of Inspector General found that in Part D, rebate-adjusted unit costs increased at almost the same rate as non-rebate-adjusted costs in a 5-year period.

Status: The NAIC currently has two model laws that protect the drug benefits of consumers. The Health Carrier Prescription Drug Benefit Management Model Act #22 provides standards for the establishment, maintenance and management of prescription drug formularies and other procedures used by health carriers that provide prescription drug benefits. The Health Benefit Plan Network Access and Adequacy **Model Act #74** establishes standards for the creation and maintenance of **networks by health carriers** to ensure the adequacy, accessibility and quality of health care services offered under a managed care plan.

In order to address pharmaceutical cost drivers and the increasing concern, the NAIC created the **Pharmacy Benefit Manager Regulatory Issues (B) Subgroup** under the Health Insurance and Managed Care (B) Committee in November 2018. The Subgroup was tasked with creating a new NAIC Model Law to establish a licensing or registration process for pharmacy benefit managers.

A draft **model**, focusing on regulating PBMs through a standardized licensing or registration process, was adopted by the subgroup in 2020. However, ultimately the model was not adopted by the NAIC membership. **Several individual states** have passed legislation regarding the licensure of PBMs, spread pricing, rebate transparency, and fees.

In 2023, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup will:

1. Develop a white paper to: 1) analyze and assess the role PBM, PSAO and other supply chain entities, play in the provision of prescription drug benefits; 2) describe state regulatory approaches to PBM business practices; and 3) discuss challenges the states have encountered in implementing such regulations.
2. Developing a new NAIC model to establish a licensing or registration process for PBMs.

On April 16th 2023, a **white paper draft** was proposed by Pharmacy Benefit Manager Regulatory Issues (B) Subgroup, providing an overview of PBM industry, key stakeholders, functional issues, and state regulations.

Utilization
US. GAO, July 2019

Pharmacy Benefit Managers, Rebates, and Drug Prices: Conflicts of Interest in the Market for Prescription Drugs
Yale Law & Policy Review, March 2019

Increases in Reimbursement for Brand-Name Drugs in Part D
US. OIG, June 2018

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What is a pharmacy benefit manager and what do they do?

Medically reviewed by Alisha D. Sellers, BS Pharmacy, PharmD — By Beth Sissons on November 15, 2022

Pharmacy benefit managers work as third parties that go between health insurance providers and drug manufacturers.

Pharmacy benefit managers (PBMs) help negotiate costs and payments between drug manufacturers, pharmacies, and healthcare insurance providers. PBMs also create prescription drug lists, called formularies.

This article looks at the role of PBMs, formularies, and prescription medication costs.

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What are they?

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PBMs are companies that work as a third party between healthcare insurance providers and pharmaceutical companies.

PBMs help control drug costs, public access to medications, and how much payment pharmacies receive.

What do they do?

PBMs are not involved directly in distributing prescription medications, according to the National Association of Insurance Commissioners. PBMs deal with negotiations and payments throughout the supply chain, from manufacturers to health insurance providers.

PBMs work alongside:

- drug manufacturers
- wholesalers
- pharmacies
- health insurance providers

Once a new medication becomes available, a drug manufacturer will negotiate with wholesalers. The wholesalers will sell the drug and provide pharmacies with it.

PBMs represent health insurance providers when making agreements with drug manufacturers. Drug manufacturers pay PBMs rebates. PBMs will also make payments to pharmacies, on behalf of the health insurance providers, for the drugs the insurer dispenses.

PBMs are responsible for negotiating costs with drug manufacturers, including discounts and rebates.


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Formulary

PBMs also create and maintain formularies. A formulary is a list of prescription medications that a health insurance plan will cover.

A formulary is an up-to-date list of evidence-based medications that healthcare experts currently recommend to treat medical conditions. The main role of a formulary is to promote the safe and effective use of the medications that are the most affordable.

If necessary, healthcare professionals may also access medications not listed on the formulary.

Each healthcare insurance plan will have its own formulary. Usually, they will include an online link to the formulary alongside the plan details. People will then be able to search the formulary to ensure it includes the prescription drug they require.

If the formulary is not available online, people can contact the insurance provider to learn what is on the formulary.

If the formulary does not contain a person's specific medication, a similar drug should be available.

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Four-tier drug benefit

Healthcare plans categorize prescription drugs into four tiers, based on out-of-pocket costs, drug availability, and the medication's clinical effectiveness.

The tiers are:

- **Tier 1:** These are usually generic versions of brand-name drugs and have the lowest copayment costs.
- **Tier 2:** These are usually brand-name drugs that are more affordable, with medium copayment costs.
- **Tier 3:** These are usually brand-name drugs that have a generic version available, with the highest copayment costs.
- **Tier 4:** These are specialty drugs to treat severe health conditions.

Tier 1 and tier 2 drugs have a lower copayment costs because they are the preferred drugs of choice on the formulary. Tier 3 drugs are non-preferred and tier 4 drugs are specialty drugs, so these two tiers have higher copayment costs.

For non-Medicare members

People who are not Medicare members may be able to access tier 4 drugs only at certain pharmacies within their state.

People will need to check with a healthcare professional or insurance provider to find out how much a tier 4 drug will cost them and where it is available.

For Medicare members

Medicare members may also be able to get tier 4 drugs only from certain specialty pharmacies.

In some cases, if a healthcare professional prescribes a higher-tier drug because they believe it is necessary, people may be able to ask for an exception in their Medicare plan. This exception may lower the copayment or coinsurance costs of the drug.

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Prescription drug benefit

A prescription drug benefit helps cover the costs of prescription drugs.

For people without Medicare, specialty drugs will be listed under a higher tier, and people may have to pay a set copayment for each prescription they fill. This will count toward a person's total federal out-of-pocket limit.

In some cases, insurance providers may not cover non-preferred drugs or specialty drugs outside of specific pharmacies.

For people with Medicare, specialty drugs will count as tier 4 drugs. People will pay a copayment when they fill their prescription, which will count toward their tier 4 out-of-pocket limit.

What will a person's prescription drug cost?

The cost of a prescription drug may vary depending on which tier the drug is in and what healthcare insurance a person has.

People can find out how much a prescription drug will cost them by looking at the formulary of their insurance plan. Insurance providers can update formularies, though, so costs may change over time.

Prescription drug costs may vary between different pharmacies. For people without healthcare insurance, NeedyMeds provide a search tool to figure out prescription drug costs, as well as support for covering costs.

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ID cards

Some pharmacies may require people to have two ID cards — one card from their healthcare insurance plan and one from the PBM company.

Why did a person get the generic drug instead of the brand-name drug?

A person may get a generic drug instead of a brand-name drug if it is an equivalent medication or provides the same proven benefits. This is done to lower costs.

In most cases, generic drugs will be lower tier, or preferred, on a formulary than brand-name drugs.

The Food and Drug Administration (FDA) requires generic drugs to have the same clinical benefits, risks, dosage, and quality as the brand-name equivalent.

Why did a person get the brand-name drug instead of the generic drug?

If a person cannot take a generic drug for medical reasons, a doctor may write a prescription with "dispense as written (DAW)." This means a pharmacist will give a person the brand-name

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drug rather than the generic equivalent.

A doctor can file an FDA MedWatch form if a person needs a brand-name drug instead of an available generic equivalent, which means the person has to pay only coinsurance.

Without this form, a person will have to pay coinsurance plus the difference in cost between the two drugs.

Examples

The Wisconsin Department of Employee Trust Funds provides the following examples of the potential cost differences between a brand-name prescription and a generic prescription, with and without an FDA form.

The cost of a 30-day supply of statins for a person who has no medical need for a brand-name drug instead of the generic version, without an FDA MedWatch form:

	Cost with insurance	Cost before insurance
Brand-name statin	$1,250	$2,000
Generic equivalent	$5	$900

If a person had a medical need for the brand-name drug and the doctor filled out the FDA MedWatch form, the cost for the same medication above would be $150 for the brand-name drug with insurance and $2,000 for the same drug before insurance.

Summary

A PBM works as a third party between drug manufacturers, pharmacies, and health insurance providers.

PBMs also create and maintain formularies, which are lists of approved prescription medications. A formulary is split into different tiers, depending on drug availability and costs.

People may pay more for higher tier drugs, which may be specialty drugs. If a generic version is available of a brand-name drug, it will be an equivalent medication but will usually have lower copayment costs.

Last medically reviewed on November 15, 2022

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Pharmacy Benefit Managers and Their Role in Drug Spending

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Pharmacy benefit manager have a significant behind-the-scenes impact in determining drug costs and patients' access to medications

Some experts think pharmacy benefit managers need to move their business model away from securing rebates from drugmakers and toward encouraging better value in pharmaceutical spending

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What are pharmacy benefit managers?

Pharmacy benefit managers, or PBMs, are companies that manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers, and other payers. By negotiating with drug manufacturers and pharmacies to control drug spending, PBMs have a significant behind-the-scenes impact in determining total drug

costs for insurers, shaping patients' access to medications, and determining how much pharmacies are paid.[1] PBMs have faced growing scrutiny about their role in rising prescription drug costs and spending.

What role do PBMs play in how much we spend on prescription drugs?

PBMs operate in the middle of the distribution chain for prescription drugs. That's because they:

- develop and maintain lists, or formularies, of covered medications on behalf of health insurers, which influence which drugs individuals use and determine out-of-pocket costs
- use their purchasing power to negotiate rebates and discounts from drug manufacturers
- contract directly with individual pharmacies to reimburse for drugs dispensed to beneficiaries.[2]

The federal Centers for Medicare and Medicaid Services found that PBMs' ability to negotiate larger rebates from manufacturers has helped lower drug prices and slow the growth of drug spending over the last three years. But PBMs may also have an incentive to favor high-priced drugs over drugs that are more cost-effective. Because they often receive rebates that are calculated as a percentage of the manufacturer's list price, PBMs receive a larger rebate for expensive drugs than they do for ones that may provide better value at lower cost. As a result, people who have a high-deductible plan or have copays based on a drug's list price may incur higher out-of-pocket costs.[3]

What's the controversy over the rebates PBMs receive from drug companies?

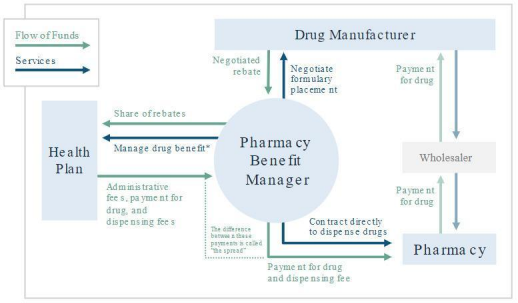
Drug manufacturers argue that the growing rebates they pay PBMs are forcing them to raise list prices for their products. According to a recent analysis, manufacturer rebates to PBMs increased from $39.7 billion in 2012 to $89.5 billion in 2016, partially offsetting list price increases.[4] PBMs counter that they have been passing along a larger share of the rebates to insurers.

There is a lot of debate over whether PBMs should be able to keep the rebates they receive from drug manufacturers, which generally aren't publicly disclosed. Some believe PBMs should be compelled to "pass through" all or a larger portion of these savings to health insurers and other payers. If PBMs were required to do this, insurers could use the savings to further reduce people's premiums and cost-sharing payments. A recent study found

that the share of rebates PBMs passed through to insurers and payers increased from 78 percent in 2012 to 91 percent in 2016.[5] But many small insurers and employers say they do not receive this share of savings.[6]

A separate controversy involves a PBM practice known as "spread pricing," whereby PBMs are reimbursed by health plans and employers a higher price for generic drugs than what the PBMs actually pay pharmacies for these drugs. The PBMs then keep the difference. Again, a lack of transparency allows this to happen: the payment schedules PBMs generate for pharmacies are kept confidential from health plans.

Role of a Pharmacy Benefit Manager in Providing Services and Flow of Funds for Prescription Drugs



* Includes establishing formulary and patient adherence programs and implementing utilization management tools – such as prior authorization, step therapy, and tiering – to steer patients toward certain drugs on formulary.

Data: Adapted from Congressional Budget Office, "Prescription Drug Pricing in the Private Sector," January 2007.

What reforms have been proposed to regulate PBMs?

Policymakers have considered three principal reforms to regulate PBMS:

- **Require greater transparency around rebates.** Federal and state policymakers likely need more data on the rebates PBMs receive to gain a more complete understanding of pharmaceutical spending and where reforms may be needed.
- **Ban spread pricing.** Policymakers could ban the practice to ensure that payers and employers are not overpaying PBMs for prescription drugs. A more limited proposal would mandate that PBMs update their cost schedules with pharmacies to reflect price increases for generic drugs.[7]
- **Require PBMs to pass through rebates to payers or to patients.** To preserve some of their incentive to negotiate price reductions with drugmakers, PBMs could be required to pass through 90 percent of their rebate savings to payers. Alternatively, PBMs could be required to pass through rebates to patients. The federal government has, in fact, proposed requiring PBMs contracted with Medicare Part D plans to pass through to patients at least one-third of the rebates and price concessions they receive.

Some experts think that PBMs also need to reorient their business model away from securing rebates and more toward improving value in pharmaceutical spending. For example, health plans and PBMs could do more to support physicians in prescribing the most cost-effective medications on their patient's formularies. And PBMs could base formulary decisions and price negotiations on a drug's health benefits as well as its effect on the total cost of patient care.

NOTES

1 Health Policy Brief Series: Prescription Drug Pricing (*Health Affairs*, Sept. 2017).

2 Elizabeth Seeley and Aaron S, Kesselheim, *Pharmaceutical Benefit Managers: Practices, Controversies, and What Lies Ahead* (Commonwealth Fund, March 2019).

3 Seely and Kesselheim, Pharmacy Benefit Managers.

4 Susan K. Urahn et al., *The Prescription Drug Landscape, Explored* (Pew Charitable Trusts, March 2019).

5 Urahn et al., *The Prescription Drug Landscape, Explored*.

6 Seeley and Kesselheim, Pharmacy Benefit Managers.

7 Seeley and Kesselheim, Pharmacy Benefit Managers.

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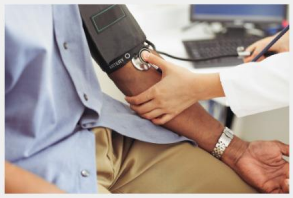

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Pharmacy benefit managers: The middlemen who decide what you pay for medications

December 14, 2023

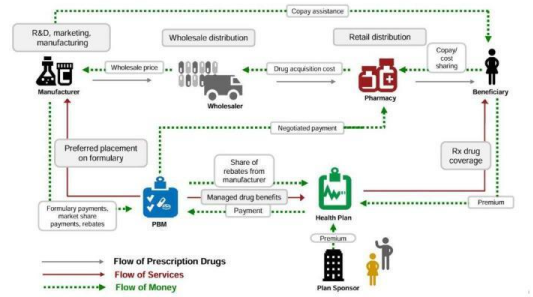

Chart from Erin Trish's presentation/Adapted from The Flow of Money Through the Pharmaceutical Distribution System/USC Schaeffer.

Americans pay too much for prescription drugs. Big Pharma has gotten most of the blame. But there's a middleman between you and the pharmaceutical companies.

That 'middleman' is a set of companies making huge profits from drug prices. They're called pharmacy benefit managers, or PBMs.

"It's remarkable the number of ways in which the PBMs are using this market to make money for themselves in ways that are not transparent to you or your employer or the American public," Kevin Schulman, a professor of medicine at Stanford, says.

Today, *On Point:* The middlemen who decide what you pay for medications.

Guest

Erin Trish, co-director of the USC Schaeffer Center for Health Policy Economics.

Also Featured

David Balto, former attorney advisor to the chairman of the FTC.

Marion Mass, urgent care pediatrician in Philadelphia and co-founder of Practicing Physicians of America.

Related Reading

USC Schaeffer: "Flow of Money Through the Pharmaceutical Distribution System" — "US spending on prescription drugs has been growing rapidly, prompting calls for government intervention to slow the upward trend."

Transcript

Part I

MEGHNA CHAKRABARTI: Given the news, earlier this month might have as well been last century since there's so much happening in the world and it's hard to remember or keep track of what's going on. So let's dust off our memories and pull up a clip from a show we did on December 4th. It was about the staffing crisis at America's pharmacies.

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Sara Sirota, a policy analyst at the American Economic Liberties Project, told us why that crisis is happening, including this reason.

SARA SIROTA: And then on the other end is the way that they get reimbursed through entities called pharmacy benefit managers that represent the insurance industry. And they too are represented by three major companies.

Express Scripts, Caremark, and OptumRx, and they, too, hold monopoly power and are systemically under reimbursing pharmacies, potentially even below their costs.

CHAKRABARTI: So let me ask you one quick thing. So just to be clear, because the world of pharmacy services, anything related to American health care is extremely confusing. I'm a visual learner, so I want to be sure I understood what you said.

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So that we've been seeing sort of a consolidation in the end point pharmacies, right? The corporate pharmacies, because as you said, they're driving the smaller independent ones out of business. Then regarding the pharmacy benefit managers, did I hear you right when you said there's only three companies there?

There's three companies that pretty much own about 80% of the market.

CHAKRABARTI: Okay, pausing there because as I listen back to that cut. It was still confusing. Now even though that hour was about end point pharmacies, the places where you actually go to pick up or get your prescription drugs, these things called pharmacy benefit managers kept coming up over and over again in that hour.

So let's jump back into the show. This is a little bit later and you're going to hear from Shane Jerominski, practicing pharmacist.

SHANE JEROMINSKI: It's very difficult to have an independent pharmacy. And that's the reason why I would say if we don't have wide scale PBM reform, 10 years from now, there'll be very little independent pharmacies left.

CHAKRABARTI: Pharmacy benefit managers are one of the sort of less understood parts of the American health care system that I haven't gotten my head fully around yet, so I'm thinking we need to do some explainer shows about that.

CHAKRABARTI: I'm Meghna Chakrabarti, and at On Point, we like to think of ourselves as a promise made, promise kept outfit.

So today, what are pharmacy benefit managers, and why do they have such a huge influence on your prescription drug prices? And by the way, today's show doesn't just

influence on your prescription drug prices. And by the way, today's show doesn't just come out of the blue. CVS Caremark, one of those PBMs, recently announced some major changes to their service in order to get ahead of increasing scrutiny on PBM Practices.

We'll talk about that more in a couple of minutes. But joining us today to disentangle this web of pharma prices is Erin Trish. She's co-director of the USC Schaeffer Center for Health Policy and Economics. Erin Trish, welcome to On Point.

ERIN TRISH: Thank you for having me.

CHAKRABARTI: I'm going to rely on you a lot to help us disentangle this web.

So as I said earlier in that clip from December 4th, I am a very visual learner. And I'm actually looking at a chart that you wrote here about how, what the relationships are like between the different organizations that lead to you picking up a prescription drug at a pharmacy. So can we pretend like we've got a big whiteboard in front of us?

Right now, Erin? You and I.

TRISH: Yes indeed.

CHAKRABARTI: And let's help me trace the path of how a drug comes from, let's start all the way back from the development in a pharmaceutical company and then its manufacturer. Where does it go then?

TRISH: So if we're talking about one, one reason why this is complex is that there are different sets of boxes and arrows that talk about the physical product, the physical flow of the product itself versus the financial flow.

CHAKRABARTI: So we're considering, we're all about the financial flow today, right? Given what PBMs are.

TRISH: Indeed, yes. PBMs sit in the middle of the financial flow of it.

CHAKRABARTI: Alright, so let's follow the money. What happens, what's the first place that we should think about?

TRISH: So you're right that the kind of physical drug is manufactured by a drug manufacturer, goes through a wholesalers and distributors to land at the pharmacy where the patient picks it up.

And so in that sense, that's a market like any other good. What gets complicated is when you think about how do we determine the price of that? And the way that the dollars flow, and follow the money, as you say, and that's where it starts to get extra complex and excessively complex in some ways.

So PBMs sit in the sort of center of several different pricing transactions. One that you and your previous guests referred to is that they're the ones deciding how much a pharmacy is actually going to get paid for dispensing that drug to a patient, when the patient picks it up. But there's two other key kind of pricing negotiations or decisions that they're involved in.

One of the others is that they're also contracting with health insurers or employers or Medicare Part D plans to determine how much they're going to charge the end insurer when that patient picks it up. So there's nothing that actually guarantees that how much they're charging the insurer is the same as how much they're paying the pharmacy.

CHAKRABARTI: Okay. So Erin, if I may, I am just really very determined to understand this well enough by the end of the year that I could write a paper on it, not like a university paper, but at least a high school level paper. So you'll have to forgive me if I keep going over some questions just to be sure that we're rock solid on them.

TRISH: Of course.

CHAKRABARTI: So in the somewhat linear flow of money here, I'm actually looking at the chart that you made, okay back in last year, last summer. And it says there's a green line that goes from manufacturer to PBMs to pharmacy benefit managers. And in that green line that says formulary payments, market share payments, and rebates.

What is that?

TRISH: So this is the third kind of arm of the financial negotiation that PBMs are doing. And this is with the drug manufacturers themselves. So you may have heard of something called a list price of a drug, or essentially the price that is set by the drug manufacturers. So in particular, this is for manufacturers of branded drugs.

When they're selling their product into the market, they're selling it at a list price. And so when you go to the pharmacy, that's the kind of price that you would see if you look at the receipt. But what PBMs are doing is they're going to that manufacturer and saying, "Look, I want a discount.

I'm here to negotiate a discount off of that list price with you." And in exchange for that, I'm going to construct something called a formulary, which is a list of drugs that are covered by this PBM. And I, the PBM, have the ability to puts your drug on a preferred tier where the patients will pay be encouraged to use your drug over a competing product.

And in exchange for that, I want a bigger discount, or what's called a rebate, and it's paid after the fact. And so this is one of the reasons why it's so complicated to talk

about drug prices in the U.S. Because there's these list prices that you see on the receipt, but then the net dollars that the manufacturer is receiving, or the net price from the drug manufacturer's perspective, is something quite different.

Because there's all of these other after the fact rebates and discounts.

CHAKRABARTI: Is it lower or higher?

TRISH: So the net price is generally lower than the list price, right? On average, rebates vary quite widely across different types of drugs. But if you look at, for example, the Medicare Part D program, which is the program that provides prescription drug coverage for the elderly, about 50 million Americans, there, the average rebate off of the list price is about 30%.

So PBMs are negotiating on average about 30% discounts off those drugs. But like I said, there's some drug classes where that's upwards of a 70% or 80% discount off the list price, or a huge wedge between the list and the net price of the drug.

CHAKRABARTI: Okay, so let's introduce a fictional drug here, and add some fictional numbers, okay?

Say I am drug manufacturer MeghnaTech. And my list price for drug X we'll call it, Vita Awesome is $100. So I say, hey PBM, pharmacy benefit manager, here's my list price, and they say, we're going to put you on a preferred one, the customer is going to see that $100 list price, but instead what I'm going to give you is $80.

Is that plausible?

TRISH: So essentially it would be, after the fact, you, as the drug manufacturer are going to send a $20 per drug check back to the PBM.

CHAKRABARTI: Oh, okay. Okay. I had that all wrong. Okay. Got it. So I'm sending the PBM MeghnaTech is sending 20 to the pharmacy benefit manager. Okay.

Okay. Got it. Now looking at your chart. This is going to take up the whole hour, but I swear I'm determined to understand this. There's a line that goes from the PBM, there's several, but the PBM to the pharmacy itself, so your neighborhood pharmacy, and there it says negotiated payment. What is that?

So this is the PBM is determining when that patient goes and picks up the drug that you manufactured at the pharmacy in their community or through some other pharmacy. The PBM is also negotiating or setting a contract with that pharmacy about how much they're going to pay the pharmacy when the patient picks up the drug there.

CHAKRABARTI: How much they're going to pay the pharmacy. Okay, so back to Vita Awesome made by MeghnaTech. We have a net price from the manufacturer of $80. And

Awesome made by MeghnaTech. We have a net price from the manufacturer of $80. And so then the PBM tells the pharmacy, what?

TRISH: So the pharmacy is essentially acquiring the physical drug from typically a wholesale or a distributor and they're acquiring that at a given price.

Now they separately have this contract with the PBM about how much the PBM is going to pay them for that drug. And so the PBM, the amount that it's going to pay the pharmacy, when the patient actually picks up the product there, that's its own kind of transaction or contract in and of itself.

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And so the manufacturer, the contract between the PBM and you, the drug manufacturer, is completely separate from the contract between the PBM and the pharmacy. And so those two different prices are not directly tied together.

Part II

CHAKRABARTI: Erin, let's pick up where we left off. You talked about how pharmacy benefit managers do this negotiated payment to the pharmacies themselves, who physically have the drug, saying this is how much we're going to reimburse you.

For the sake of our fictional example here, the drug Vita Awesome from MeghnaTech, recalling that the original list price is $100, but that itself could change. Generally, what do PBMs reimburse to pharmacies? Do they reimburse the full cost that the pharmacy paid to get the drug?

TRISH: So that depends and can vary quite a bit.

And one of the reasons why this is so hard to understand, and why it's so complex, is that this isn't necessarily publicly known. There's not a lot of transparency into how PBMs are paying pharmacies. And so it can vary the kind of way that they determine that payment, whether it's a branded drug or a generic drug, But ultimately, that's the result of the contract between the PBM and the pharmacy itself.

CHAKRABARTI: Okay. Understood about the lack of transparency. But as you heard from the clips from the other show that we did on December 4th, we had several guests on asserting that, who were pharmacists themselves, that the PBMs were not reimbursing the pharmacies anywhere near what the pharmacies had to pay.

TRISH: So it's certainly the case that there's a lot of, I think, volatility in the way that essentially the prices that PBMs pay to pharmacies are not necessarily aligned with the acquisition costs of those drugs. And that's particularly a problem for any given transaction, pharmacy can have paid more to get the drug than they're ultimately reimbursed for selling or dispensing that drug to a patient.

And I think what we've seen over the last few years is that's become an increasing problem. And just to add to the complexity. Because there's not just this determination of how much the PBM is going to pay the pharmacy, but there's been a proliferation of these after the fact fees that the PBM is actually clawing back from the pharmacy as well.

So you have the volatility on, those are something called DIR or direct and indirect remuneration fees, or sometimes they're called clawbacks from the pharmacies. And so not only do you have this kind of volatility or a lack of, lack of guarantee that the PBM is going to pay the pharmacy more than what they acquired the drug for, there's also these after the fact kind of fees that they're taking back from the pharmacies.

And that's, I think, part of what's led to a lot of the concern about the viability of pharmacies in this country.

CHAKRABARTI: Okay. So potentially lower reimbursement rate to pharmacies and fees that the PBMs are charging them as well. Okay. Let's look at the flow of money in the other direction from, let's say, the point of view of the person picking up their medication from the pharmacy.

Obviously, most Americans or a lot of Americans pay a copay right then and there, right? That goes directly to the pharmacy. Does that copay go anywhere else?

TRISH: So that copay typically sits with the pharmacy as part of the reimbursement to the pharmacy.

CHAKRABARTI: Okay, but then, of course, there's just the monthly premium that people pay for their prescription drug coverage.

That's obviously going to the health plan itself. Then, how does that health plan, its flow of income relate to any financial exchanges between it and the pharmacy benefit manager?

TRISH: The Pharmacy Benefit Manager is basically the entity that's paying. If we think about how much does the pharmacy needs to get paid or what's the contractually obligated amount that the PBM is going to pay the pharmacy?

When this drug gets dispensed, a portion of that is going to be paid by the beneficiary, and then the remainder will be paid by the PBM. Then separately, the PBM has yet

another contract with the health plans that it's servicing to say, "When one of your enrollees goes and picks up this drug, this is how much we're going to charge you."

And essentially, you might be confused and rightfully so, about why are we talking about these two different things, but there's no guarantee that the amount that the PBM is paying the pharmacy is actually the same amount that it's charging the health plan for the existence of that transaction or basically for that pharmacy fill.

CHAKRABARTI: Erin, my eye's twitching a little bit because I fear that I'm failing in my goal to completely make it clear what PBMs do. We did the best that we could. A little later, I'm going to ask our producers, the chart that you made is excellent. I'm going to ask them to put it on our website.

... So thank you for trying to guide us through. Let's see if we can summarize what we just learned. Pharmacy benefit managers, they are essentially a middleman that's organizing the rebates that we talked about, from manufacturers, costs that pharmacies, not that they pay for the drugs, but the amount they'll get reimbursed, including the fees a PBM might charge.

And then also there's the interesting relationship between PBMs and health plans. So would you have a way to summarize the role of pharmacy benefit managers in this really complex system?

TRISH: I think the sort of best way to think about it is that the PBM sits in the middle of the financial flows for prescription drugs in the U.S.

There's more touch points than I think you might appreciate if you didn't have this Set of boxes and arrows and realize just how complex this is, but they're essentially doing three major functions in terms of those financial negotiations. 1, is they're negotiating or determining what the drug manufacturer, what are any rebates or after the fact discounts that the manufacturer is going to give back to the PBM.

So they're essentially negotiating discounts off the list price of the drug with the manufacturer. That's part one. Part two is that they're determining how much the pharmacy is going to be paid when a patient comes and picks up that drug at the pharmacy. And then point three is that they're negotiating with employers or health plans about how much those employers or health plans are going to pay.

When their enrollee goes and picks up that drug, and part of that negotiation as well is to what extent are they going to share some of those rebates that they negotiated with the manufacturer back with the employer, or the end health plan or any other types of negotiations with that health plan, as well.

CHAKRABARTI: I'm just grimacing here. On this end of the radio, Erin, because I consider myself a semi confident person that usually is able to understand systems

pretty well, but this one still just keeps stumping me a little bit. So let me ask you this. We've been hearing more about PBMs or even just like their existence over the past couple of years and not prior to that, have they always been around and just not really known by the public or are they a new part of the financial flows in the pharmaceutical system in this country?

So they've actually been around for quite a while and started back in the '70s and '80s really to gain traction. I think their role back then was really to start thinking about the organization of pharmacy benefits.

But importantly, and they played a very important and impressive role in helping transition patients quickly to generic drugs, when those generic drugs became available. And that was their historical role.

I think one of the reasons that we've heard about them more and more over the last few years or the last decade or so, is that they've played an increasingly prominent role in the U.S. health care system and particularly in the pharmaceutical system. So I think part of this is they've gotten bigger. We have 3 representing about 80% of the fills or the kind of prescription drug claims in the U.S. today.

They've also gotten vertically integrated, so they're now often owned by an insurance company, they typically own pharmacies as well. And so their kind of presence as entities has expanded in the U.S. health care system. But I think there's also an increasing attention being paid finally to the role that they play in ultimately the drug prices, particularly that patients face at the pharmacy counter.

CHAKRABARTI: Okay, we're going to get to that, because that's really the thing that people care about. But the three companies that you said that control 80% of the market here CVS Caremark, Express Scripts, and the third one's --

TRISH: OptumRx, which is part of United, yes.

CHAKRABARTI: Okay, I should know that one because that's my plan. So we reached out to the Pharmaceutical Care Management Association, the national association that represents pharmacy benefit managers. They sent us back a statement which read, in part, pharmacy benefit companies welcome and support competition in the marketplace.

The PBM market is extremely competitive, and employers and health plans have the flexibility to choose the pharmacy benefit design that works best for their business. Today there are 73 full-service pharmacy benefit companies operating in the U.S., and the number of PBMs competing for clients increased 10% in the last two years alone.

So yes, there may be 73 full service PBMs, but they have a whopping, basically, 70 of them have to split 20% of the market between them.

TRISH: That's correct, and I think even, often those numbers are thought to be even a little, the 80% is thought to be even a little under exaggerated in some sense, because some of many of the smaller PBMs, will what's called rent the contracts or kind of have separate side contracts with the big PBMs to get the benefits of some of their either pharmacy networks or other kind of rebate agreements.

CHAKRABARTI: Okay, we're going to take a quick pause here because I've got to say, I'm Meghna Chakrabarti. This is On Point. Okay, Erin. We've got, we've gotten to the place now. And thank you so much for holding my hand through all this. Like I said, just we, at this show, we really feel it's important to talk about stuff that like barely anybody understands, but has a really outsized impact on our lives.

And I can't think of anything bigger than how the hidden players that are determining how much we pay for our highly priced prescription drugs in this country.

So if you stick with me for another minute, we really wanted to dig into how the PBMs mushroomed into these huge, complicated conglomerates. As you mentioned, only three of them control 80% to 85% of the market. Here's a little history lesson. You're going to meet David Balto. He advocates for more competition and transparency in prescription drugs, and runs a website called pbmwatch.com.

DAVID BALTO: I used to be the attorney advisor to the chairman of the Federal Trade Commission and the policy director of the FTC. And I've spent decades trying to police the anti-competitive conduct of PBMs. We looked at 2 efforts by pharmaceutical manufacturers to buy PBMs, and we saw an inherent conflict of interest that the PBMs would be able to favor those companies' own drugs.

So we put a stop to those deals as they were structured.

CHAKRABARTI: Now, the mergers he's referring to were Merck acquiring Medco, and Lilly acquiring PCS Health Systems. But in 2011, when two of the largest PBMs, Express Scripts and Medco, wanted to merge into an even larger company, The Federal Trade Commission did not stop it.

BALTO: Over 70 congressmen wrote to the FTC and said, "Please just say no." But the FTC approved the merger and people were very puzzled by that. And what really happened was the FTC and the Obama administration had fundamentally made a Faustian bargain with the PBMs. The PBMs had come to the administration and said, "You want the largest entity possible to negotiate with drug companies to restrain drug prices."

So Obamacare could really succeed, and Obamacare was in its infancy then and the administration, the FTC bought into that argument and like any Faustian bargain, it was a bad deal.

CHAKRABARTI: Now, to make what he's saying clear, if Congress was not going to allow the government to really flex its negotiating power as the largest purchaser of prescription drugs in this country, PBMs argued you need a giant private sector organization or company to do that instead.

Now, Balto really chafes at some of the things PBMs are doing now to reap bigger profits. For example --

BALTO: For decades, PBMs prevented pharmacists from telling consumers that there was a lower cost way of getting their drug. Oftentimes, drugs are cheaper when you don't use your PBM card, you don't go through the PBM, but you just buy it with cash.

But if a pharmacist told you that, the pharmacist would be terminated from the network and lose all their customers. So fundamentally, pharmacists were gagged from telling consumers what choices they had. Now, eventually, during the Trump administration, Congress passed legislation to prevent those gag clauses, but it's a sign that PBMs make money by hiding information and deceiving consumers.

CHAKRABARTI: Now recall, David Balto is a former member of the Federal Trade Commission, and he says agencies like the FTC and FDA have not protected the American's consumer, or patient, as those agencies are supposed to.

BALTO: If the enforcement agencies were graded on how they've used the antitrust laws to protect consumers against and anti-competitive conduct of PBMs, they would get a failing grade. They permitted tremendous consolidation among PBMs and have taken no enforcement actions to stop egregious anti-competitive conduct by PBMs.

CHAKRABARTI: That was David Balto, former attorney advisor to the chairman of the Federal Trade Commission. He's now a lawyer and advocates for more competitive drug pricing markets.

Erin Trish, tell me what your response is to what David said. Are we at a point where PBMs are behaving like virtual monopolies?

TRISH: So I think there's a lot to unpack in those comments. I think it's certainly the case, right, that the view back in the time of the Express Scripts, Medco merger.

And if you think about who at the FTC was really reviewing this, it's sat in the part of the agency that's really focused on the pharmaceutical industry. And from their view, I think they saw it as, we need some entity to negotiate with drug manufacturers over the price of drugs, right? We do this for hospital and physician services as well, right?

We have insurers who negotiate networks of physicians or hospitals in exchange for those hospitals or physicians accepting discounts or lower prices rather than their version of list prices. And so the concern, though, is that it's unclear that, it's certainly clear that PBMs have effectively negotiated lower net prices with drug manufacturers

clear that PBMs have effectively negotiated lower net prices with drug manufacturers.

What's less clear is whether they've actually passed on those savings to really benefit consumers and patients at the pharmacy counter.

Part III

CHAKRABARTI: Now, we reached out to the biggest PBMs in this country, and we heard back from CVS Caremark. We heard back from Phil Blando, who's the Executive Director for Corporate Communications at CVS Caremark. And in a statement he sent us, he said, quote, he said the following quote, "We're making health care more affordable and accessible for the millions of people we serve every day.

We work to negotiate the lowest net cost for drugs, identify safe and clinically effective products for patients and support the unique needs of our customers, driving better health outcomes and lower out of pockets costs for consumers." He goes on to say, "If **PBMs** did not exist, they'd have to be invented, because we are the only part of the supply chain that drives drug costs down, going head-to-head with manufacturers to negotiate the lowest net cost for our customers.

No industry does more to make the use of prescription drugs safer and more affordable." So that's from CVS Caremark. A different view comes from Kevin Schulman, who's a doctor and health care economist at Stanford. And he said because of PBMs, the cost of a vial of insulin, I should say, is vastly different on either side of the U.S. Canada border.

KEVIN SCHULMAN: At one point, about two years ago, insulin cost about $270 some odd dollars in the United States. And about $32 in Canada for the same vial of insulin. Detroit's right across the bridge from Windsor, Ontario. One side it's $278, the other side it's mid thirties.

CHAKRABARTI: Okay, so Erin, how would you describe or analyze the impact that PBMs have on that final payment that people are making when they need their medications?

TRISH: So essentially, PBMs are you can think of them as the firefighters of drug prices, but they're also the arsonists, right? They have every incentive to push the list price of drugs up. Because typically their compensation is tied to some portion of either the discount or the rebate that they negotiate, or some other type of fee.

That's tied back to the list price of the drug. And yes, it's true. They're negotiating lower net prices, but they're also playing this important kind of part in pushing the list price of the drug up. So you talked about insulin. Let's take a specific example there.

My colleagues at the Schaefer Center in a study led by Karen Van Nuys and colleagues looked very specifically at the insulin market from 2014 to 2018. What they found in that study was that the list prices of insulin increased quite a bit over that time period.

But the net prices or the revenue that manufacturers actually received was falling over that time period. And what was happening was that more of, we were basically spending about the same amount of money.

But more of those dollars were going to PBMs and other intermediaries in the supply chain. To the extent where more than half of the spending on insulin in 2018 was going to these intermediaries rather than the drug manufacturers themselves, the share of spending captured by PBMS increased by about 155% over that 5 year period.

And ultimately what that means is that more and more of the dollars that we're spending on these drugs, like in this example, insulin, are going to PBMs rather than to the drug manufacturers.

CHAKRABARTI: Okay. And then we also have, sorry, I'm just pausing because 155% is a really large number. But then we also have, as you mentioned earlier, and just want to talk about this for another quick second, that vertical integration, right?

I've mentioned CVS Caremark, obviously there's the CVS portion of it, their actual pharmacies, and the Caremark portion, the PBM. That's one form of vertical integration. The PBMs themselves also offer mail order pharmaceuticals, and did I also hear you say there's some integration between health plans and PBMs themselves?

TRISH: Yes, so Cigna is integrated. Cigna, the health insurer is integrated with Express Scripts and likewise Aetna is integrated with CVS Caremark.

CHAKRABARTI: Okay. Wow. That's another show in and of itself, although I may not, I don't know if I'll actually get to it. This is so helpful, Erin, because again, just in the past couple of years, there's been more expression of public or public expression of disgruntlement over the impact PBMs are having on the financial flows in pharma in this country.

So much that the pharmaceutical trade group, the major pharmaceutical trade group in this country, Pharma. Now these are the Merck's and the Eli Lilly's of the world. This is their representative group in Washington called Pharma. They are actually running ads right now that are really maligning PBMs themselves.

For example, here's an ad in which, this is a television ad, where a guy in a suit from a patient's pharmacy benefit manager walks up to a woman who's standing at the pharmaceutical sorry, at the pharmacy counter. Okay, so she's there. Guy in a suit walks up, and he takes her to another pharmacy. And here's why in the ad he says he's doing that.

ADVERTISEMENT: Did you know there's a middleman making decisions about your medicines? That's me, your pharmacy benefit manager. Let me take you to a pharmacy where I make more money on that. Come on.

CHAKRABARTI: Erin, what does it mean to you that the pharmaceutical companies themselves are now saying, "Hey, there's a problem here with PBMs?"

TRISH: I think a big part of this is that pharmaceutical manufacturers have taken a lot of the kind of policy attention over the last decade or so about drug prices. And I think it's clear to those of us who have studied the industry, that play a very important part in drug prices, and they had largely been left out of the policy discussion for quite some time.

Now, that's changed recently. But I think if you think about what do patients care about, right? They care about what they're spending on drugs and the dollars that they're facing, the cost that they face when they pick up that drug at the pharmacy counter. And PBMs are, have played a pretty important role in, as I said, the incentives to increase the list prices of drugs.

And there's a particular issue that oftentimes beneficiary cost sharing, if they're in their deductible or if they pay a co-insurance, that's a percent of the list price of the drug. Or if they don't have insurance, right? The price they're paying is tied to that list price rather than the net price of the drug.

So the PBM may be effectively negotiating some discount, but ultimately the patient is paying more because their price that they pay out of pocket is tied to that inflated list price. This is particularly problematic because it creates this issue where sicker patients are the ones who they're taking these highly rebated products, but they're paying much more at the out of pocket at the pharmacy counter.

And essentially, you have this world where these sicker patients are paying more to subsidize the premiums for the healthier beneficiaries. And that's the opposite of how we think insurance is supposed to work.

And so I think getting back to your question about pharmaceutical manufacturers, as they've been taking the hit for drug pricing and the consternation that, rightfully so, patients experience or express from the drug prices, that they're from the out-of-pocket prices that they pay when they go pick up that drug. It's really the PBMs that are an important part of this conversation and had been left out of it. In the kind of discussion of drug pricing policy reforms for quite some time.

CHAKRABARTI: Okay. But I think they know that they're no longer going to be left out of that conversation, because in a few minutes we'll talk about some changes that CVS says it's making and also maybe some activity in Congress.

But there still is this lingering question of not only just cost, but is it having an impact on the care upstream at the doctor's office that people are even receiving? Dr. Marion Mass thinks yes. She's an urgent care pediatrician in Philadelphia and co-founder of

Practicing Physicians of America.

MARION MASS: You, the patient in America, have thought probably all along that it was your doctor who was making the decisions as to what medication that you get.

CHAKRABARTI: She says there are two ways that pharmacy benefit managers constrain doctors who manage your health. One is called, quote, non-medical switching.

MASS: This is a scenario in which a patient is rolling along and maybe they're stable on a drug.

So imagine you're a patient with a seizure disorder. You have epilepsy. You've achieved stability on drug X. And then along comes the PBM and says, "Nope, I'm going to switch you." It's a non-medical switch because they didn't do it for medical reasons. They switch a patient to a drug that maybe it's not going to control the patient's seizures.

Now you put yourself in the shoes of that patient. Wow, it's a lot of stress if you have a seizure disorder. You've got to be afraid when you're driving or operating any kind of machinery or if you're taking care of your child. You have a seizure, you might hurt yourself, but you could hurt someone else.

CHAKRABARTI: Dr. Mass says that in one Florida study, they found that 67% of patients who were non-medically switched from a drug that was working eventually complained of worse side effects on the new drug.

When that happens, many patients just stop taking those new drugs, which, of course, worries themselves, their families, and their doctors.

Another way PBMs affect the care you get, according to Dr. Mass, is called formulary exclusion, which means medicines doctors want to give their patients off their list, or these are medical medications, excuse me, that are off the list. The formularies.

MASS: So in 2016, you took those three PBMs.

There were only two oncology medications excluded. But in 2022 there was almost 100. These three companies controlling 80% of America's prescription drug benefits, they went from excluding two cancer drugs to excluding almost 100 and some of these are drugs for which there is only one formulation.

In other words, there's a brand name and there's nothing else.

CHAKRABARTI: For Dr. Mass, medicine practiced in America today is done so by two kinds of people. This is what she says. She calls them the scrubs and the suits.

MASS: A scrub is someone who trains for years, whether as a physician or a nurse or they're

the ones that are actually seeing the patient day to day.

And you as a scrub are the ones that actually see the patient, but it's the suits that are making the decision without any medical training. Functionally, they're practicing medicine without a license as far as I'm concerned.

CHAKRABARTI: So finally, how does medicine by PBM or the suits as Dr. Mass calls them, how does it affect doctors themselves?

MASS: It's really embarrassing to have gone through your four years of college, your four years of medical school, your three years of training, and then maybe an additional four to five, and then you have to be the one to look your patient in the eye and say, "I'm sorry, I, the scrub with all this training, can't fix the problem for you."

It's downright embarrassing.

CHAKRABARTI: That was Dr. Marion Mass, an urgent care pediatrician in Philadelphia and co-founder of Practicing Physicians of America. And by the way, I just have to say that CVS Caremark, again, in the statement they sent us, they insist that they are making decisions made specifically in order to achieve better health outcomes and lower out of pocket costs for their consumers, and they say, quote, again, I'll read this quote again, "Every day we work to negotiate the lowest net cost for drugs and identify safe and clinically effective products for patients," end quote.

Okay, Erin, so just a couple of minutes left. We got to talk about whether, is this a market that is in need of reform now? In a sense, the pharmacy benefit managers themselves are saying, yeah, maybe they're trying to get ahead of it. Because CVS, of course, just made this big announcement that they're going to make some changes, they say, to how pharmaceuticals are delivered and paid for by patients.

They say they're going to price drugs based on the amount the company actually paid for them, plus a defined markup and additional fee to cover pharmacist costs of handling and dispensing the prescriptions. What do you make of this change by CVS?

TRISH: So I think this is one of those examples where the devil is in the details, and we don't yet know all the details, but at a high level, I think it's indicative of the consternation that people that are participating in this market are feeling, right?

So you do have policy activity going on very actively by the House of Representatives and the Senate and a lot of interest in moving forward with some federal level. Policy initiatives to reform or change the type of behavior in the PBM market, or at least increase transparency and get better information on what's going on.

But you also are seeing private market responses, right? Where you're seeing employers, increasing frustration or patients, increasing frustration and the proliferation of sort of alternative options. We're seeing increasing numbers of patients going to, for example

alternative options. We're seeing increasing numbers of patients going to, for example, the Mark Cuban cost plus drug company where they're implementing a true cost-plus formula, chart the prices that they charge for drugs.

You're starting to see, for example, Blue Shield of California announced a pretty significant shake up in their relationship earlier this year. And so I do think some of this is responding to the recognition that employers and health plans have a better handle on that. They're frustrated and that they want something different.

And so this is a response from PBMs to perhaps react or respond to some of those concerns on beat from their clients, essentially. But like I said, we don't fully know what this looks like as it plays out.

This program aired on December 14, 2023.

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HEALTH CARE POLICY

The mysterious middlemen being blamed for America's sky-high drug prices

How pharmacy benefit managers found themselves the targets of a bipartisan push on drug prices.

By Dylan Scott | @dylanlscott | May 10, 2023, 7:00am EDT

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Dylan Scott covers health care for Vox. He has reported on health policy for more than 10 years, writing for Governing magazine, Talking Points Memo and STAT before joining Vox in 2017.

Democrats, Republicans, and pharmaceutical companies don't always agree on everything about **high prescription drug prices**. But over the past few years, they've increasingly found common ground on one thing: pharmacy benefit managers are part of the problem.

Pharmacy benefit managers are companies that, behind the scenes, determine what patients have to pay for medications. They manage insurance benefits for prescription drugs, dictating which drugs are covered by insurers and what costs patients will face when they fill their prescriptions.

To do that, they negotiate discounts, or rebates, with drug manufacturers and afford privileged status to the companies that give them the best deals.

And over the past few decades, as the prescription drug market has evolved and become more lucrative, so have PBMs. They run their own mail-order and specialty pharmacies. More recently, they have begun merging with health insurers, creating behemoth companies with the power to determine where and how billions of dollars are spent within the US health system.

Pharmacy benefit managers have become known as the mysterious middlemen of the pharma trade — and as a useful scapegoat for drug companies seeking to deflect blame from their own pricing practices.

Now the Senate, as part of forthcoming prescription drug legislation, appears poised to impose new rules on them. The committee overseeing health care debated last week a slew of measures requiring PBMs to be more transparent about their business and cracking down on some of their moneymaking practices. Several PBM CEOs will testify before the committee on Wednesday.

"While the pharmaceutical industry blames the PBMs for high drug prices, the PBMs blame the pharmaceutical industry for high drug prices," Sen. Bernie Sanders (I-VT) said to open last week's hearing. "The reality is both of them are right."

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Experts generally agree that these companies play a role in driving up drug costs for some US patients, even as they negotiate discounts with drugmakers that benefit others, and that the amount of secrecy about their financial arrangements warrants scrutiny.

But reforms to the PBM industry aren't a cure-all for making drugs more affordable: Sanders said the PBM measures being considered in the Senate would not meaningfully lower the cost of medicine for most people, even if they would bring more accountability and transparency to the sector.

So reforming PBMs can't be the end of the country's debate over drug prices. But it's an important step.

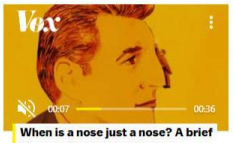
How PBMs evolved to play a critical role in US health care

If you've ever had a prescription filled, you've likely dealt with a pharmacy benefit manager — whether you realized it or not. Most people have their benefits managed by one of three companies: Express Scripts, CVS Caremark, and OptumRx, which together control about 80 percent of the market.

The primary function of pharmacy benefit managers is exactly what it sounds like: managing coverage for prescription drugs on behalf of health insurers.

In the 1960s, when the precursors to modern-day PBMs first emerged, most people paid for their medications out of pocket. This was in part because there were comparatively few drugs to take — certainly not the highly specialized treatments for hypertension, high cholesterol, and other chronic conditions that are commonplace today; while data from 60 years ago is scarce, **the number of drugs being prescribed per American** has grown by almost 50 percent **since just the mid-1990s**.

When Medicare was first created in 1965, it was **"common"** for private health plans to exclude coverage for prescription drugs. (Medicare did not begin covering outpatient prescription



When is a nose just a nose? A brief history of non-Jews playing Jews onscreen.

drugs until the mid-2000s.) But the US pharmaceutical industry soon began to develop more advanced, costlier drugs, and employers and their health insurers realized they would need to pick up some of the cost for those new treatments.

As they added that coverage in the 1970s and '80s, the first PBMs formed within health insurers, according to Taylor Christensen, a physician who has researched their history and business practices. They were made up of early coders who connected the health insurer's formulary, the information on the drugs the plan would cover and at what cost to the patient, to pharmacies across the country. This meant that, instead of filing a claim with their insurer, the patient could pay the out-of-pocket price at the pharmacy.

Soon, the employees specializing in pharmacy benefits saw a business opportunity. Through their work, they had a clearer look at how the costs of prescription drugs affect people's behavior. They saw that lowering a drug's copay, for example, led to more people taking that medicine versus a more expensive option, which saves the insurance company money. And rather than conduct that work for one company in-house, they realized they could spin their business off and become independent.

In the 1980s and '90s, the modern standalone PBMs were founded with a simple pitch to health insurers: We can save you money if you delegate your prescription drug benefits to us. "They figured out they could do it better than each in-house insurance group," Christensen said.

Health insurers decided that was a good deal. Then PBMs saw another business opportunity. Already in business with insurance companies, they turned around and made a pitch to drug companies, too: Through our formularies — which can give priority to certain medications with those lower copays — we can direct more customers to your medications.

But PBMs wanted a deal in exchange, and drug rebates were born.

Unlike more conventional commercial rebates, prescription drug rebates **are invisible** to the

patient. When a patient fills their prescription, the drug company pays a pre-negotiated rebate to the PBM, providing a discount off the list price. The PBM then passes all or most of that rebate to the health plan; in the latter case, it keeps a cut for itself.

And so the modern pharmaceutical market took shape. Drug manufacturers develop (or acquire) medications. After FDA approval, they produce these drugs. They sell those medicines to wholesalers, who distribute them to individual pharmacies. Health insurers contract with PBMs to determine copays, and the PBMs negotiate rebates with drug companies.

All this determines what a patient pays in the pharmacy when it's time to pick up their meds.

Over time, the importance of PBMs grew. Breakthrough treatments for all kinds of serious conditions that plague Americans came onto the market, with ever-increasing price tags. The launch of Medicare Part D in 2006 provided prescription drug coverage to the people who use prescription drugs the most: seniors.

According to **the Congressional Budget Office,** patients paid almost 60 percent of the cost of their medications out of pocket in 1990. That share had fallen to 15 percent by 2018. Insurers, in turn, picked up more and more of the tab, with their share of drug costs doubling from 26 percent in 1990 to nearly 50 percent in recent years.

PBMs expanded their operations to grab a bigger share of the pie. They started operating mail-in pharmacies, cutting out the brick-and-mortar stores, and specialty pharmacies that handle certain high-cost medications. They also merged with one another — so much so that Express Scripts, CVS Caremark, and OptumRx now dominate the PBM market.

And in recent years, PBMs, their pharmacy businesses in tow, have begun reintegrating with the health insurers from which they were spawned. Today, CVS **owns** the health insurer Aetna, in addition to its own PBM business and its own specialty pharmacy business. Cigna and United Healthcare have purchased Express Scripts and OptumRX, respectively, and their parent companies have their own specialty pharmacies. Those deals gave the insurers a better window into the mysterious finances of the PBMs and let them keep all of the rebates being negotiated with drugmakers.

These business arrangements have created a lot of anxiety among policy experts and lawmakers — and with good reason.

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Why PBMs are under scrutiny from lawmakers

The trouble starts here: Nobody outside of the PBMs and drug manufacturers really knows the size of the rebates being negotiated.

PBMs argue that is a necessary condition of their

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job. If everybody knew the size of the rebates they are securing, they would start to lose their leverage and thus their ability to get a better deal for their customers. But this impenetrability has helped create the image of PBMs as a mysterious conduit in the pipeline between pharma and patients.

"Over time, questions have been raised whether PBMs are overcompensated for their services," said Stacie Dusetzina, a health policy professor at Vanderbilt University. "The lack of transparency makes it impossible to judge and makes everyone suspicious. There is a dramatic lack of clarity on how their business model typically works."

PBMs generally make money in one of two ways: Either they earn a percentage of the rebates they negotiate with drug companies on health plans' behalf or on a per-prescription fee basis paid by the insurer. But because their books are locked in a proverbial black box — even for a publicly traded company like Express Scripts, their contracts with drugmakers are generally considered to be trade secrets — it can be difficult to tell from the outside how a company makes its money.

There is some evidence of clever accounting on the part of PBMs: A 2019 Government Accountability Office report **concluded** that PBMs kept just 1 percent of rebates, but Christensen **interviewed** a former PBM employee who said the real share is closer to 20 percent. From the outside, it's impossible to know which is true.

"No one has clear information about how they're getting paid, so it's hard to say if they're getting paid too much," Dusetzina said.

The rebate structure also can create perverse economic incentives that could result in patients paying more money for medications. Drugmakers now know that they will have to negotiate rebates with PBMs, which can motivate them to set higher list prices — prices that are eventually borne by some consumers or, in the case of Medicare patients, by the government.

"When the starting price of a drug rises, and the PBM negotiates a rebate, the PBM appears successful," said Robin Feldman, a law professor at UC Hastings who studies the pharma market. "It's like a store that raises the price of a coat before putting it on sale."

PBMs can also now use their contracts to funnel business away from retail pharmacies to the specialty pharmacies they own, creating a potential conflict of interest, and there is some **evidence** that this practice is becoming more common.

PBMs could also provide a way around federal regulations that require insurers to spend a certain percentage of their revenue on actual medical claims. As the scholars at the Brookings Institution **recently wrote**, insurer payments to other entities owned by the same parent company — such as PBMs — can still count as medical spending under those rules, even if the money ultimately ends up staying inside the larger business organization.

How a bipartisan Senate deal would affect PBMs

When the drug company Mylan was criticized in 2016 for the EpiPen's egregious price hikes, Mylan CEO Heather Bresch and other leaders in the drug industry testified before a Senate committee and **pointed the finger** squarely at PBMs.

"So you get this pressure year after year that tends to escalate the price increases," Ron Cohen, then the chairman of the Biotechnology Innovation Organization, a biotech trade group, told the committee, explaining how the rebates negotiated by PBMs drove up list prices.

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Until that hearing, PBMs had been frequently ignored in the US health care discourse. One person who was working at the Department of Health and Human Services at the time told me the CEO's comments were what brought PBMs to their attention.

In response, those companies have argued that focusing on their business is a distraction from the egregious pricing practices perpetrated by pharmaceutical companies.

"EpiPens are expensive because Mylan raised the price of EpiPens," Steve Miller, chief medical officer at Express Scripts, **said** in a 2016 interview. "To blame it on distributors ... is just ridiculous."

But in the view of many lawmakers and experts, as Sanders articulated at last week's hearing, both sectors bear part of the blame.

The EpiPen price scandal of 2016 was just one of many controversies (Martin Shkreli, Valeant Pharmaceuticals, the ever-growing cost of insulin, the enormous opening prices of the hepatitis-C cures) that have made drug prices one of Congress's top priorities in recent years. Last year, lawmakers for the first time authorized Medicare to negotiate prices for a limited number of drugs directly with drugmakers. They also placed a cap on out-of-pocket costs for insulin for people on Medicare.

But Bresch, intentionally or not, also put PBMs on the radar — and seven years later, Congress is on the verge of acting to rein in the industry. Sanders and his Republican counterpart on the health committee, Bill Cassidy of Louisiana, recently **announced** a deal on legislation that would be the first significant attempt by Congress to address the PBM industry. It is expected to clear the Senate health committee this week.

Experts and lawmakers alike caution that these provisions are a first step. The bill starts chiefly with simply forcing more transparency from PBMs. They would be required to share more information with health plans on prescriptions and discounts; they would also need to disclose information about, for example, any arrangements that could lead to prescriptions being funneled to the mail-order or specialty pharmacies owned by the PBM. They would be required to submit the same information to the federal government too. Another provision would ban

to submit the same information to the federal government too. Another provision would ban the practice of "spread pricing," in which a PBM charges the health insurer more money for a drug than is paid to the pharmacy to acquire it.

Eventually, the plan is for these measures to be folded into a larger legislative package focused on drug pricing that Senate Majority Leader Chuck Schumer **hopes to bring to the Senate floor** in the coming weeks.

Still, reforming PBMs doesn't fundamentally change a US pharmaceutical market that gives companies carte blanche to set whatever list prices they want for new drugs. It doesn't affect the gamesmanship that can prevent generic drugs from coming to the market and thereby keeping prices elevated long after the initial patents expire. It also doesn't change the long-running trend of health plans shifting more of the cost of medical care onto patients through high-deductible plans and other benefit designs.

Some of those issues will be addressed in the legislative package the Senate is pulling together. But others will be part of a later debate — one that Sanders, even as he excoriated PBMs for their worst practices, promised would be coming.

"For anyone here who believes this is going to be end of the work we do here on prescription drugs, I have bad news for you," Sanders said at his committee's hearing last week. "This isn't the end, but the beginning."

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Pharmacy Benefit Managers And Their Role In Rising Prescription Drug Costs And Spending

October 31, 2022, by New City Insurance

Americans spend more on prescription medications than people in any other country in the world. High prescription drug costs have created affordability issues for many patients in the health-care system. According to a new report published by the US Department of **Health & Human Services (HHS)**, the average prescription list price increased by nearly $150 per drug in January 2022 and $250 per drug in July 2022.

Pharmacy benefit managers (PBMs) play a direct role in the management of prescription drug benefits in the US. These powerful companies perform on behalf of large employers, **health insurers**, Medicare Part D drug plans, and other payers to better control drug spending. Learn more about PBMs and their role in rising prescription drug costs and spending.

Pharmacy benefit managers (PBMs) play a key role in the prescription drug market. These companies negotiate with pharmacies and **drug** manufacturers to gain control over drug spending. Their

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significant role in the industry directly impacts the total drug cost for insurance companies. PBMs also help shape patients' access to prescription drugs and have a say in how much pharmacies are paid.

In the United States, pharmacy benefit managers operate in the middle of the prescription drug distribution chain. They perform a variety of tasks, such as:

- Create formularies or lists of covered prescription drugs on behalf of health insurance companies. This has a direct impact on which medications patients use and the out-of-pocket expenses that they pay for drugs.
- Use their purchasing power and experience in the industry to negotiate discounts and rebates directly from drug manufacturers. The savings from these discounts and rebates are often passed onto patients.
- Contract with individual pharmacies to get reimbursements for drugs that are dispensed to beneficiaries.

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Navigating the Objectives of a Pharmacy Benefit Manager

PBMs generally work alongside corporate employers, labor unions, health plan providers, and other organizations that offer health-care benefits to members or employees.

The primary objective of a PBM is to facilitate a positive health outcome for patients by making prescription drugs more accessible and affordable through retail pharmacies and insurance providers.

There are several key responsibilities of PBMs, including the following:

- Negotiate prescription drug rebates
- Process and file claims
- Review patient compliance
- Conduct drug usage reviews
- Provide specialty pharmaceutical services
- Oversee the distribution of prescription drugs within networks
- Maintain formularies

PBMs have extensive technical knowledge and possess the interpersonal skills needed to retrieve the best discounts and rebates on medications. They also use these skills to assess economic factors, public health needs, and business strategies to help create fair pricing guidelines.

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A Pharmacy Benefit Manager's Power of Negotiation

There are many different parties at play within the insurance industry. From underwriters and reinsurers to pharmacy **benefit management** companies, each party plays a critical role in prescription drug costs and spending.

PBMs are often referred to as the middlemen as they are responsible for negotiating discounts and rebates with drug manufacturers on behalf of insurance companies in exchange for getting the manufacturer's medications in front of patients. PBMs also negotiate contracts with pharmacies to develop networks of pharmacies for successful drug distribution.

PBMs are known to exploit multiple revenue streams, such as by charging fees for operating mail-order pharmacies, processing prescriptions, and negotiating with insurance companies, pharmacies, and drug manufacturers. When PBMs contract with larger insurance companies, it gives them even more power over negotiations with pharmacies and drug manufacturers.

Common Criticisms of the Pharmacy Benefit Manager Role

PBMs have long been targets of government scrutiny and lawsuits. A PBM is a third-party negotiator, meaning they are not required to always disclose discounts, rebates, the percent of savings passed onto insurance companies or even itemized billing statements. This has resulted in some criticisms of PBM practices.

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Legislatures in many states are continuing to push for greater transparency among PBMs, as well as disclosure provisions to help regulate these companies. There is also ongoing pressure to place a fiduciary duty on PBMs which would force them to always act in the best interest of insurance companies and health-care plans. However, tighter regulations in the prescription drug market could possibly impact future profitability.

Policymakers across the US are looking to reform **pharmaceutical reimbursement** beyond common

practices like rebates. However, these policyholders must also consider how these changes could impact new market competitors due to recent mergers between insurers and PBMs.

How Pharmacy Benefit Managers Handle Rebates

Prescription drug rebates have been around for decades and were initially paid for by nearly every brand-name medication on the market. However, drug manufacturers began to consolidate these rebates over time into fewer drugs. When more specialty drugs became available, PBMs were able to define which medications were eligible for specialty drug rebates.

Rebates are typically paid on a per-claim basis. The amount of the rebate may be held constant depending on the PBM, resulting in a higher rebate yield. Most rebates are connected to more expensive prescription drug brands, as well as specialty medications. PBMs may include or exclude some types of prescription drugs from rebate guarantees when quoting rebates that are relative to specialty drugs.

The biggest issue in how PBMs handle rebates deals with transparency. Many policymakers agree that drug pricing should not be kept secret and that price discrimination, in which no one really knows what anyone else is pricing, leads to larger discounts. Regardless, transparency is still needed to maintain a well-operating prescription drug market.

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Pharmacy Benefit Managers Control Pharmacy Choice

There has been ongoing confusion over who really controls drug pricing in the prescription medication sector. PBMs claim that they work directly for insurance companies and negotiate to get low-cost medications from drug manufacturers. However, PBMs also claim that it is the drug manufacturers that are solely responsible for setting drug prices.

According to the Drug Channels Institute, PBMs increase drug costs by nearly 30 percent due to rebates charged to drug manufacturers to remain on their formularies. In 2019, PBM rebates reached $143 billion which adds almost 30 cents per dollar to the cost that consumers pay for their prescription medications.

So, who really benefits from prescription drug rebates? It is not the pharmacies or even the patients. Instead, it is the bottom line of PBMs and their executives that benefits most.

Instead, it is the bottom line of PBMs and their executives that benefits most.

Passing the Savings to Employees with Competitive Plans

PBMs are believed to be driving up the cost of prescription drugs for patients across the US. Many employers are struggling to keep up with increasing health-care costs while continuing to provide their employees with the best coverage possible. Working with an experienced employee **benefits consulting firm** can help businesses overcome these struggles.

New City's innovative solution to problems surrounding PBMs is to work with a transparent pharmacy benefit manager that charges only a small flat fee each time that a prescription drug is dispensed rather than face the large inflation of cost that is commonly seen with PBMs. For more information or to **schedule a consultation** with a member of our team, **contact New City Insurance**.

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Pharmacy benefit managers (PBMs) have become an entangled part of the U.S. healthcare system. First established in 1968 with the advent of plastic benefit cards, PBMs became a major player in the system by the 1980s, and have since continued to expand their reach and influence in the healthcare industry.

What is a PBM?

A pharmacy benefit manager, or PBM, is a third-party service that manages prescription drug programs, acting as an intermediary between drug manufacturers, pharmacies, and health plan sponsors.

How does a PBM work?

In theory, PBMs are responsible for making sure medications are available at an affordable price and that

Hi. Need any help?

healthcare providers have access to the right medications. So now is this accomplished?

Negotiates prices with drug manufacturers

A PBM negotiates prices with drug manufacturers through a variety of strategies that include volume purchase agreements, competitive bidding, and rebate programs.

Volume purchase agreements involve the PBM and drug manufacturer agreeing on a set price per unit for an entire purchase order. This strategy ensures the PBM gets a lower cost per unit.

With competitive bidding, the PBM solicits bids from multiple drug manufacturers and then selects the lowest bidder.

For rebate programs, the PBM and drug manufacturer agree on a set price, with the manufacturer providing rebates on sales after a certain volume is reached. This way, the PBM gets a better price over time.

Utilizes formularies

A formulary is a list of approved medications that a health plan will cover. PBMs develop and maintain these lists by analyzing clinical data, evaluating drug safety and effectiveness, and negotiating with the drug manufacturers (see above). PBMs will utilize these formularies to promote the use of clinically appropriate, cost-effective, lower-cost generic medications.

Processes pharmacy claims

In order to process pharmacy claims, a PBM first verifies all the information on the claim, such as the patient's eligibility and the medication prescribed. Then the PBM determines the amount that the health plan will pay for that claim (based on the health plan's formulary and reimbursement levels). The pharmacy is then paid by the PBM, who turns around and bills the health plan for the claim.

Common services offered by PBMs

Aside from the administrative processes listed above, PMBs offer additional services in an effort to improve the quality and effectiveness of healthcare for their patients.

Mail order services

Many PBMs offer mail order pharmacy services to their customers, allowing them to fill their prescriptions online or by phone. This inexpensive (or free-to-use) home delivery service is often convenient and saves the customers time and money.

Disease management programs

Another common service provided by PBMs is a personalized program for the customer that involves

closely monitoring the patient's condition and medications to ensure the correct dosage is taken, and that the medications are working as intended. The PBM might also identify and suggest alternate treatments or therapies that would be more affordable for the client.

The pros and cons of PBMs

There's no doubt that pharmacy benefit managers have become a giant influence in the healthcare industry, and with this comes a growing debate over their benefits and drawbacks.

The benefits of a PBM

- **Cost savings** — Purportedly, the negotiations by a PBM can result in significant savings for all parties involved.
- **Convenience** — Mail order and digital tools help patients access their medications.
- **Medication management** — By flagging potential drug interactions or other issues, the PBM can help improve patient outcomes.

The cons of a PBM

- **Lack of transparency** — PBMs rarely disclose their pricing agreements to the public.
- **Conflict of interest** — PBMs are incentivized to send patients to certain drugs and pharmacies.
- **Monopolization or reduced competition** — results in higher prices and fewer options for patients
-

Do PBMs help contain prescription drug costs?

Generally speaking, no.

Three PBMs control the lion's share of the market, giving them disproportionate control over the cost and accessibility of drugs in the U.S.:

- CVS Caremark — 34% of total PBM market share, by adjusted claims in 2021
- Express Scripts — 25%
- OptumRx — 21%

Unfortunately, the largest PBMs notoriously use "arcane" and "anti-competitive practices" to prevent patients from accessing the cheapest drugs, thus lining their own pockets. Such practices include:

- Placing name-brand drugs on the formulary instead of generics because they receive a larger rebate for

higher-priced drugs

- Requiring pharmacies to sign contracts promising the PBM their lowest prices, which discourages pharmacies from offering lower cash prices to self-pay clients
- Keeping the difference when a patient's prescription drug costs less than the copay to fill it, which is known as a "clawback"
- Including "gag clauses" in contracts with pharmacies that prohibit pharmacists from telling patients they could save money by paying in cash instead of using their insurance
- Charging the insurer more for a drug than they paid the pharmacy for it and keeping the profit, which is known as "spread pricing"
- Hiding their profit margins
- Using formulary exclusions to force extra negotiation leverage against manufacturers, often to the detriment of patients

Together, these practices lead to consumers overpaying for generic drugs — or being unable to access generic drugs — all too often.

This is bad news for individual consumers, who overpay for generic drug prescriptions by as much as 20%.

It is also bad news for taxpayers and the U.S. healthcare system because generics save the system money. According to the FDA, "Generic drugs have the same active ingredients and effects as brand-name drugs, but they can cost 30 percent to 80 percent less."

PBMs' profit margins have only increased over time due to a persistent lack of oversight: Between 2017 and 2019, PBMs' gross profit increased by 12%. In 2021, the market size for PBMs stood at over $400 billion.

Their commitment to opacity has also increased. According to a 2021 report by the PBM Accountability Project:

"Between 2019 and 2021, all three of the largest PBMs formed their own rebate aggregators or group purchasing organizations (GPOs) as consolidated contracting entities to handle rebate negotiations on behalf of themselves and other PBMs. Industry experts believe these GPO entities, Ascent, Zinc, and Emisar are an attempt to introduce an additional non-transparent layer to the pharmaceutical supply chain and will be used to extract increasing and new fees that are more difficult for customers to track and audit."

What is a transparent PBM?

A transparent PBM is a pharmacy benefits manager that does not engage in the opaque and predatory practices listed above — clawbacks, gag clauses, spread pricing, rebate holding, etc.

Instead, transparent PBMs operate on a "pass-through" or "transparent" model, in which they pass some or all discounts and rebates they receive along to the insurer in exchange for a higher (but fixed) administrative fee. Because administrative fees, mail order fees, and data sales are transparent PBMs' only revenue sources, they have no reason not to negotiate the lowest possible drug prices. This helps the health plan and its members predict and contain prescription drug costs.

One such transparent PBM is Sana's partner, SmithRx, which "is working to reduce pharmacy costs by reimagining the traditional PBM as a Drug Acquisition Platform built on transparent modern technology that aligns with the needs of our customers." Through transparency, SmithRx helps health plans and their members save up to 50% on their Rx spend.

With SmithRx and Sana, you and your employees can reap the savings. Get a quote.

Related: Transparent vs. Traditional Pharmacy Benefit Management (PBM)

Pharmacy Benefit Manager FAQs

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- Is CVS a PBM?
- Who are the big three PBMs?
- How do PBMs make money?
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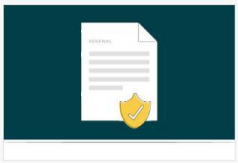

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What Is Medical Payments (MedPay) Coverage?


By Ashley Kilroy
Contributor


Fact Checked Jason Metz
Editor

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If you or your passengers get hurt in a car accident, it's good to have coverage that can help pay for the unexpected medical expenses.

Medical payments coverage is also known as MedPay. It's an optional car insurance coverage type that pays for your and your passengers' medical bills and other types of expenses, no matter who was at fault for the accident. But it's not available in every state and you may have better options.

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What Does MedPay Cover?

MedPay generally covers the following types of expenses for you and your passengers, no matter who is at fault for the car accident.

- Ambulance fees
- Dental procedures
- Doctor visits
- Funeral fees
- Health insurance deductible and copays
- Hospital visits and stays
- Nursing services

- Prostheses
- Rehabilitation costs
- Surgery
- X-rays

MedPay may also cover you if you're injured:

- In a car accident in someone else's car
- From a car accident when you were a pedestrian

The amount of MedPay coverage you buy represents the maximum amount available to each person who is covered under your policy. For example, if you purchase $2,000 of MedPay coverage and you and your passenger are hurt in a car accident, you'll have up to $2,000 each in MedPay coverage.

What's Not Covered by MedPay?

In addition to a coverage cap, there are certain expenses not covered, including:

- Lost wages if you can't work
- Medical expenses not related to the car accident
- Replacement services for tasks you cannot perform due to injuries, such as housekeeping or child care

Where Can I Buy Medical Payments Coverage?

MedPay coverage is widely available in most states. In the following states, MedPay is required or it must be offered.

- Arkansas
- Delaware
- Maryland
- New Hampshire
- Oregon
- South Dakota
- Texas
- Virginia
- Washington
- Wisconsin

In other states you may be able to buy MedPay insurance but there's no requirement for the purchase or that it be offered.

Do I Need Medical Payments Coverage?

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Car owners are required to buy medical payments coverage in two states:

- **Maine**: Car insurance in Maine requires at least $2,000 per person in MedPay.
- **New Hampshire**: You are not required to have car insurance in New Hampshire, but if you choose to buy it, you must purchase at least $1,000 in MedPay coverage.

In most states, you will have the option to purchase MedPay, but you may have some better options. For example, if you live in a state where personal injury protection (PIP) is required or available, it's generally the better option (read more about the differences between PIP and MedPay below).

If PIP is not available in your state, you may want to consider adding MedPay to your car insurance policy. If you or your passengers get hurt because of a car accident, it can help cover expenses that are not covered by health insurance, such as funeral costs and your health insurance deductibles and copays.

How Much MedPay Coverage Should I Buy?

MedPay is usually sold in small amounts between $1,000 and $5,000. When deciding how much coverage you need, a good place to start is looking at the health care coverage you already have in place, including your health insurance deductible.

MedPay covers certain expenses that your health insurance does not, such as funeral expenses and your health insurance deductible and copay.

For example, if you have a high deductible health plan, MedPay can help offset the deductible if you get hurt in a car accident.

What's the Difference Between Medical Payments Coverage and Personal Injury Protection?

MedPay and PIP are similar. While both cover medical expenses after a collision no matter who was at fault, a few key differences set them apart:

- PIP covers lost wages if you can't work due to accident injuries, while MedPay does not.
- PIP covers replacement services, such as other housekeeping or lawn care services, while MedPay coverage does not.
- PIP is required in 15 states and optional in four states and the District of Columbia, but is unavailable in other states. MedPay is available in most states and required in Maine and New Hampshire (if you choose to buy car insurance).
- MedPay is sold in small amounts (usually between $1,000 and $5,000) while PIP is sold in larger amounts, depending on your state.

In some states, you may have the option to buy both MedPay and PIP. Since PIP covers more expenses, it's generally considered the better option. You typically don't need to buy both since you would be buying redundant coverage.

MedPay vs. PIP

Expenses related to a car accident	Does MedPay cover it?	Does PIP cover it?
Doctor and ER visit	Yes	Yes
Medical expenses such as surgery, rehabilitation and medication	Yes	Yes
Lost wages	No	Yes
Replacement services (such as housekeeping or childcare)	No	Yes
Funeral expenses	Yes	Yes

What's the Difference Between Medical Payments Coverage and Liability Car Insurance?

MedPay and liability car insurance cover very different types of problems.

- **Liability car insurance** covers property damage and bodily injuries you accidentally cause *to others*. For example, if you cause a car accident and the other driver is hurt, liability car insurance pays for their medical expenses (up to your policy limit). It also covers your legal costs if you are sued because of an accident.
- **Medical payments coverage** pays for *you and your passengers'* medical costs and other expenses (up to your policy limit) no matter who is at fault for the accident. It does not cover property damage or your legal costs.

Liability car insurance is required in all states except New Hampshire and Virginia. If you get caught driving without car insurance, you could face fines, penalties and even jail time.

MedPay is an optional coverage in most states. It is required only in Maine and New Hampshire.

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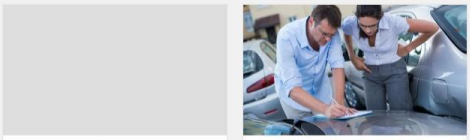

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So Does Med Pay Actually Pay?

November 29th, 2017


Posted By
Stephen Hoffman

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Medical Payments and PIP—What's the Difference?

Trick question. With some exceptions, they are essentially the same thing.

Medical payments, commonly referred to as "med pay," is also known as PIP, which stands for Personal Injury Protection. Both will be found in most automobile insurance policies.

Med pay will pay for your medical bills up to a dollar value cap if you are involved in a personal injury regardless of liability.

PIP is somewhat more expansive, depending on the policy definition and insurer, but essentially pays for your medical and other similar bills after an accident.

Give Me An Example

You are in a rush to pick up your daughter from soccer practice at 5, yet just remembered you have a conference call at 5:30 and still have to get your son at his friend's house. You aren't paying attention. Just like that, you've rear-ended the vehicle in front of you at the stop light.

The other driver claims his back is sore and the police come and prepare a report. You are given a ticket for failure to yield and a few other things. You notice your neck is beginning to hurt and even causing your arms to tingle.

You call your daughter and let her know the neighbor will pick her up, call the neighbor to let her know, and then call your son and his friend's mother to let them know the new arrangements.

While the other driver may have a claim against you for his injuries and property damage (and you will, of course, report this to your carrier as soon as possible), you are in pain and are going to the doctor tonight to get checked out. The doctor at the Immediate Care facility recommends 4 weeks of physical therapy.

Since you've just started a new job, you don't have health insurance yet. How will you pay your bills?

The answer lies in the "med pay" provision of your own auto insurance policy.

How Much Will My Insurance Pay?

Auto insurance in the State of Illinois must meet certain minimum standards. The bare minimal policy covers up to $25,000 per person per incident for personal injuries, up to $50,000 per incident (meaning if there are multiple individuals injured, that is the most available from that insurance policy), and up to $20,000 for property damage.

Notice that medical payments and PIP coverage, like Uninsured Motorist (UM) and Underinsured Motorist (UIM) coverages are not mandated.

While you are required to decline in writing the offer of UM/UIM coverage, which would normally mirror the liability limits, *you do not have to be offered medical payments or PIP coverage. That's right; some policies I've seen do not have any coverage for med pay!*

What Should You Do?

Purchase your insurance from a broker; not online.

Make sure you ask about your coverage. Make sure you ask for the dollar amount of med pay coverage you will have. I have seen some policies without any, some covering only $1,000, and most covering a mere $5,000. *It is rare that people think this through enough to purchase insurance with significant med pay limits of $20,000 or more. That is what you should have if possible!*

Does It Matter From What Company I Have Auto Insurance?

Message

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Yes, yes, and yes!

The low end ("substandard") carriers will always nickel and dime you. Your policy may actually say you have $5,000 in med pay coverage. So you go to the doctor, send in the bills, and the insurance refuses to pay all the bills.

Why? How?

Many lower end carriers will claim the bills were more than was a "reasonable" charge. Others will even require you to be examined by a doctor of their choosing as part of the policy, to see if the bills incurred were causally related to the accident claimed.

Do not let yourself be played like this. Read your policy. Talk to your broker. Make sure you understand your rights and what the insurance can and cannot do. Good companies will simply pay the bills without question.

Medical Payments Is a Must

It allows you to get bills paid (even the portions your health insurance won't pay) even when you are partly, or completely at fault, without any questions.

It covers people in your vehicle. Just think about your foreign au pair being your passenger in the crash we discussed earlier. Good med pay coverage would take care of all her bills without you having to worry or feel guilty.

Takeaways

- **Understanding medical payments coverage/PIP coverage**
- **Make sure you understand what is covered and in what amounts**
- **Buy from a good company and a broker**
- **Abide by your responsibilities under your policy**
- **Keep your policy limits as high as possible**

Contact Chicago Personal Injury Lawyer Stephen Hoffman

As in all cases involving injury and potential liability, immediately get medical treatment, report the crash to police and your own insurance company, and contact a personal injury lawyer.

If you've been in an accident and have questions, contact Chicago personal injury attorney Stephen L. Hoffman for a free consultation at (773) 944-9737. Stephen has nearly 30 years of legal experience and has collected millions of dollars for his clients. He has been named a *SuperLawyer*, has a 10.0 rating on Avvo, and is BBB A+ accredited.

Stephen handles personal injury and workers' compensation claims on a contingency fee basis, which means you don't pay anything upfront and he only gets paid if you do. Don't wait another day, contact Stephen now.

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December 6th, 2023

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LEGAL BLOG

How Does Medical Payment Insurance Work?

Written by Jared Staver

Read Jared's Bio

Jared Staver is a Personal Injury Lawyer based in Chicago, Illinois and has been practicing law for over 20 years.

CATEGORY: AUTO ACCIDENTS, INSURANCE, PERSONAL INJURY

After being hurt in a **car accident**, you need help with the bills. Whether it is your health insurance, your auto policy, or the other driver's coverage, you need someone's insurance to step up and pay – particularly when these medical costs are someone else's fault.

particularly when these medical costs are someone else's fault.

When money is an immediate factor, Medical Payment Insurance (MedPay) or Personal Injury Protection (PIP) is exactly what you need. These types of auto insurance policies can cover various medical expenses following an accident, ensuring you do not incur a significant amount of debt.

If you were in an auto accident and need help covering the expenses, contact a lawyer of Staver Accident Injury Lawyers, P.C. at **(312) 248-9536**.

What is MedPay?

MedPay is a type of auto insurance that pays for medical expenses associated with personal injuries arising from an accident. It is not the same as auto liability insurance or health insurance. Instead, it steps in to pay medical costs that may not be covered by your health insurance, when you do not have health insurance, or before you have an insurance or personal injury settlement. This type of coverage kicks in quickly, ensuring your medical bills are paid before you have to wait for a slow-coming auto insurance settlement or jury award. MedPay covers medical expenses for not only you, as the policyholder, but also passengers and family members who were in the car at the time of the collision. This type of coverage covers costs no matter who was at fault for the accident and has no deductible or co-pay.

MedPay insurance covers a number of of medical expenses arising from a collision, including:

- Health insurance deductibles and co-pays
- Ambulance fees
- Emergency department fees
- Physician fees
- The cost of a hospital stay
- X-rays and scans
- Surgery
- Prosthetics
- Dental care
- Funeral expenses

Your MedPay insurance pays your medical expenses immediately up to your policy limit, drastically reducing how much you pay out of pocket following an accident.

What is PIP?

PIP coverage is similar to MedPay. It will cover the medical costs directly related to your injuries

without any concern as to who caused the accident. However, it covers additional expenses beyond MedPay. PIP coverage will also pay for less-directly-related expenses like rehabilitation, mental health care, other professional services, lost wages, and even necessary child care. The exact costs covered by your PIP insurance will depend on your policy.

Is it Required?

Illinois does not require drivers to carry MedPay or PIP insurance. Illinois only requires liability insurance up to $25,000 for the injury or death of one person, $50,000 for the injury or death of two or more people, and $20,000 for property damage. However, while neither of these types of coverage are required, they can be incredibly helpful after an accident.

How Does it Work?

If you have MedPay or PIP coverage, you should immediately call your insurer following an accident. Your policy cannot kick in if your insurer is not notified of the collision and your injuries. You will also need to file a formal claim with your insurer, which can be a complicated process. You should work with a lawyer to cut through the red tape and make sure you benefit from the coverage you've been paying for.

In regard to MedPay or PIP coverage, how it works will depend on whether you are using it as your primary or secondary insurance. For instance, if your MedPay is used first, it will cover the medical costs up to your policy limit and you will not have to pay any out-of-pocket expenses. If it is secondary, you can use it to reimburse you for the co-pay and deductible you had to pay under your health insurance.

Contact a Lawyer Right Away

If you are not sure how to use your MedPay or PIP insurance, contact Staver Accident Injury Lawyers, P.C. immediately. We will work with your insurance provider to ensure your medical bills are paid quickly or that you are reimbursed. When you have paid premiums for MedPay or PIP coverage, you deserve to benefit as soon as possible. Additionally, we will help you file a third-party claim or a personal injury lawsuit to recover from the driver who caused the accident and your injuries. By working with the other driver's insurer or filing a personal injury claim, you may be able to recover for your property damage, **medical costs**, **lost wages**, **pain and suffering**, disability, and disfigurement.

Our car accident attorneys serve clients throughout the Chicago area, including **Aurora**, **Elgin**, **Hinsdale**, **Joliet**, **Naperville**, and **Waukegan**. Call Staver Accident Injury Lawyers, P.C. today at **(312) 248-9536** to schedule a consultation.

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WHO PAYS FOR CAR

IS AN "AT-FAULT" INSURANCE STATE

at after an auto accident, the driver who is found at fault for the accident is
amages (financial compensation) arising from the accident. If multiple

MEDICAL MALPRACTICE

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Brief description of your legal issue...

tially at fault for the accident, then liability is divided between them
ne principle of comparative negligence.

e ways to seek compensation for a car accident in Illinois:

m with your own insurance company (a "first party" claim).
m with the at-fault driver's insurance company (a "third party" claim).
suit in civil court against the at-fault driver.

here can potentially be compensation available through an at-fault driver's
ven members from the at-fault's household.

GHT TO COMPENSATION IN A FIRST PARTY CLAIM

your insurance policy, you may be entitled to certain benefits from your own insurance carrier in the event of an accident. Some of those benefits include:

- **Medical payments coverage (MedPay)**. This coverage pays your medical expenses arising from the crash, such as hospital bills and the cost of prescription medication, up to the policy limit.
- **Collision coverage**. This coverage pays for damage to your vehicle, or a replacement if your vehicle is declared a total loss.

If another driver was at fault for the accident, your insurance company may pursue reimbursement from the at-fault driver's insurance company. This is called *subrogation*,
g on the size and nature of your claim, it can make it more difficult for you to
ne compensation you need, as some of the damages you recover go to your
pany instead of you.

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xperienced car accident lawyer can negotiate with the insurance company
and help you get full compensation. We have experience working with
panies to reduce or waive subrogation in order to help our clients get all of
tion they need.

CTION AGAINST THE AT-FAULT DRIVER

e under your own insurance policy may provide you with some
, it is unlikely to cover the full cost of an accident causing significant injury.
ents coverage tends to be fairly limited and does not cover non-medical
as lost wages from time away from work. To recover for all of your losses,
ke action against the at-fault driver.

ollowing time limits, called the statute of limitation, apply to lawsuits arising
ident:

s after the date of the accident to seek compensation for your injuries.
s after the date of the accident to seek compensation for damage to

se limits only apply to filing lawsuits in civil court, and an insurance

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Technically, these limits only apply to filing lawsuits in civil court, and an insurance company could in theory pay a claim after the statute of limitations has expired. However, you will have much more leverage in negotiations with the insurance company if you still have the option of filing a lawsuit.

WHAT IF THE AT-FAULT DRIVER DOESN'T HAVE INSURANCE?

Under Illinois law, all motorists are required to carry liability insurance, but some drivers choose to break that law. If the at-fault driver does not have insurance, he or she can be held personally liable for damages caused in the accident. Likewise, if the motorist does gh liability coverage to pay for all of your expenses, he or she can be held ning above and beyond the policy limit.

at you still have the option of filing a lawsuit and trying to recover directly from the at-fault driver's assets. However, seizing an individual's h more complex, time-consuming and difficult process than recovering nce company, and the at-fault driver may not have significant assets to first place. A more practical option is to file an uninsured motorist claim with rance company.

otorists are required to carry uninsured motorist protection. If you are accident caused by an uninsured driver, your insurance company will pay for that would have been paid by the uninsured driver's liability coverage, up to . Uninsured motorist protection also applies if the at-fault driver's identity is a hit-and-run accident.

XPERIENCED CAR ACCIDENT RNEYS CAN HELP YOU RECOVER COMPENSATION

The process of filing a claim after a **car accident** is complex, and the insurance companies are experts at delaying, reducing and denying such claims. That's why it's so important to have a strong, legal advocate on your side, fighting for your rights. If you've been injured in an auto accident, the **Oak Park auto accident lawyers** at Coplan & Crane can help. **Contact us** today for a free, confidential consultation.

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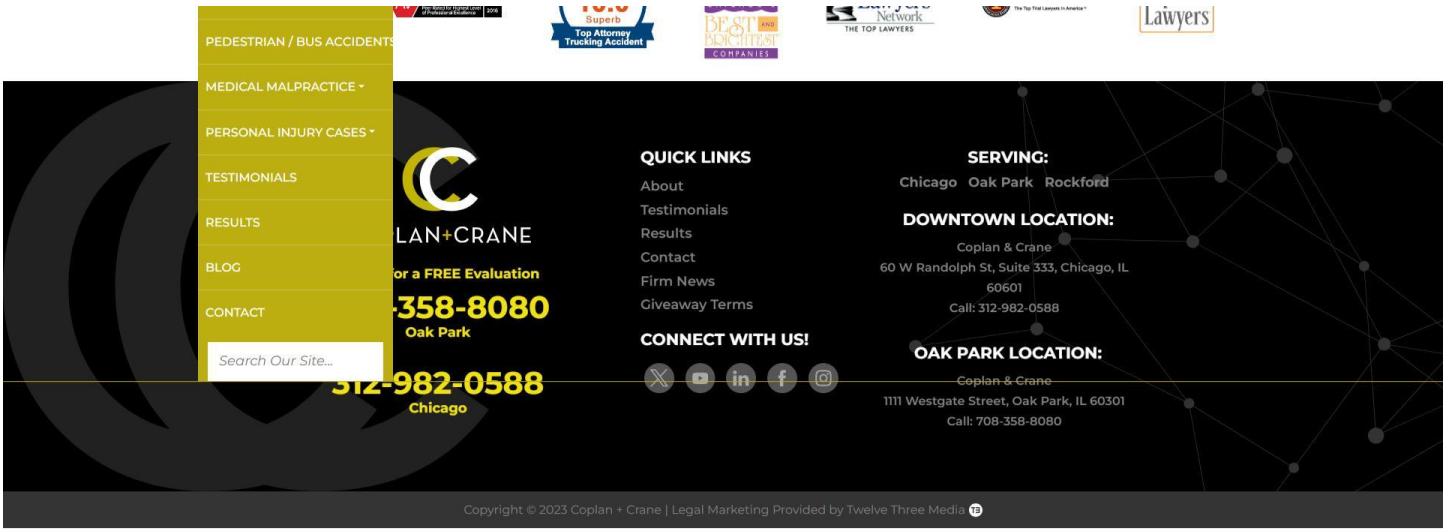
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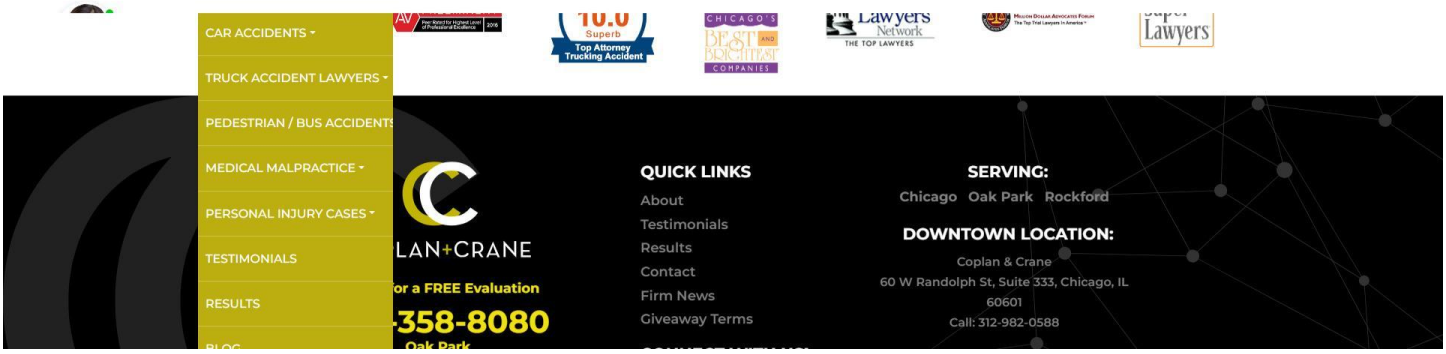
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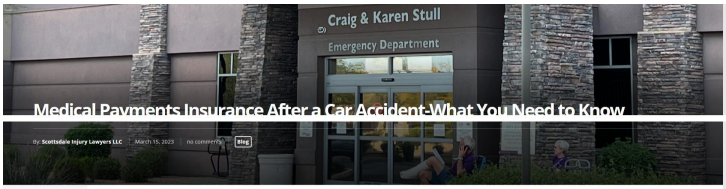

Medical Payments Insurance After a Car Accident-What You Need to Know

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Medical Payments Insurance After a Car Accident-What You Need to Know

Medical Payments insurance is a type of additional insurance coverage that you can obtain under your car or automobile insurance policy. The coverage is usually referred to as MedPay or Med Pay. The benefits from this coverage can be paid directly to you for medical expenses incurred as a result of an accident.

Is Med Pay or Medical Payments Coverage Mandatory in Arizona?

Med Pay or Medical Payments coverage is not a mandatory coverage in Arizona. It is an optional coverage that you can decide to purchase when you obtain auto insurance. The coverage can be obtained for different amounts. The higher the coverage you select the more expensive your premium will be.

The personal injury attorneys at our firm typically see Med Pay coverage limits in the amounts of $1,000, $5,000 and $10,000. However, we have seen Med Pay coverage limits as high as $100,000. This is extremely rare, but we have encountered it.

Is Med Pay or Medical Payments Coverage the Same Under All Insurance Policies?

Med Pay insurance differs from policy to policy. As such, you need to review your auto insurance policy to determine how much coverage you have and when it

receive Med Pay benefits in more situations.

Some insurance policies will allow individuals to receive Medical Payments benefits even if the injuries were not sustained from driving one of the covered vehicles. For example, many insurance policies will allow an individual to recover Med Pay benefits if the individual was a pedestrian and hit by a car. Others may allow an individual to recover these benefits if they were injured while riding a bicycle or public transportation. If you were in an accident and have Medical Payments coverage, it is important to consult with an attorney and have the attorney analyze your policy for coverage.

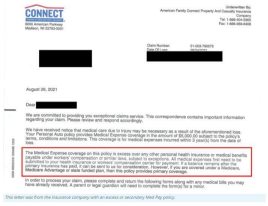
What does Med Pay Insurance Cover?

Medical Payments coverage allows you to recover for the reasonable medical expenses incurred for injuries treated as a result of a covered accident. This can include amounts ***owed*** for medical expenses, amounts ***paid*** for medical expenses, co-pays and out of pocket deductibles. Some policies allow for the payment of these benefits even if you have health insurance that paid the costs of the medical expenses. As discussed in the next section, other policies do not allow this.

What Is an Excess or Secondary Medical Payments Policy?

Some Medical Payments policies are written to only provide benefits after all other sources of insurance have been used. These types of policies are referred to as excess or secondary Medical Payments policies. The reason they are called excess is because they only pay the excess that may be owed after applying other health insurance benefits. The reason they are called secondary is because they are considered a secondary source of payment after another insurance is exhausted.

Our car accident attorneys encounter excess Medical Payments policies frequently written by American Family Connect insurance. This insurance is sold through Costco. Below is a Med Pay letter from American Family in a case our attorneys handled.



CONNECT

[redacted]

August 20, 2021

Dear [redacted]

We are committed to providing you exceptional claims service. This correspondence contains important information regarding your claim. Please review and respond accordingly.

We have received notice that medical care due to injury may be necessary as a result of the aforementioned loss. Your Personal Auto policy provides Medical Expense coverage in the amount of $5,000.00 subject to the policy's terms, conditions and limitations. This coverage is for medical expenses incurred within 3 year(s) from the date of loss.

The Medical Expense coverage on this policy is excess over any other personal health insurance or medical benefits payable under workers' compensation or similar laws, subject to exceptions. All medical expenses first need to be submitted to your health insurance or workers' compensation carrier for payment. If a balance remains after the primary insurance has paid, it can be submitted to us for consideration. If you are covered under a Medicare, Medicare Advantage or state funded plan, then this policy provides primary coverage.

In order to process your claim, please complete and return the following forms along with any medical bills you may have already received. A parent or legal guardian will need to complete the form(s) for a minor.

This letter was from the insurance company with an excess or secondary Med Pay policy.

The language from the letter specifically states that the "Medical Expense coverage on this policy is ***excess*** over any other personal health insurance or medical benefits payable. All medical expenses first need to be submitted to your health insurance. If a balance remains after the primary insurance has paid, it can be

benefits payable....All medical expenses that need to be submitted to your health insurance company before any benefits are paid. If there is a balance remaining after the primary insurance has paid, it can be sent to us for consideration." This is a classic excess Medical Payments policy. However, these policies are the exception and most do not require this.

Can You Collect Medical Payments Benefits Even if Your Health Insurance Has Paid Those Charges?

Most of the time, you can collect Med Pay benefits even if your health insurance has paid those same charges. In other words, most Medical Payments policies are not excess policies. They also do not refuse to pay benefits if your medical bills have already been paid by another source.

In other words, even if your health insurance has paid your medical bills, you can still collect your Med Pay benefits by submitting your medical bills. Most Medical Payments policies will pay benefits regardless of whether or not a balance is owed. All you need to do is present the charged amount of your bills and show the treatment was related to the car accident in order to collect these benefits.

Will the Insurance Company Pay Every Medical Bill Submitted Under the Medical Payments Coverage?

Insurance companies will only pay Medical Payments benefits for treatment received as a result of the car accident. In addition, insurance companies are only obligated to pay the reasonable amount of the services provided. As a result, you need to show that the medical treatment was necessitated by the crash. You will also have to show that the medical charges are the same as those customarily charged for the same services.

Some medical services may be more difficult to relate to the car accident. For example, an insurance company may deny payment of Medical Payments benefits if the treatment is too far removed from the car accident. Insurance companies may also refuse to pay for non-traditional medical treatment. For example, an insurance company may be unwilling to pay for acupuncture or massages if they do not believe that treatment is reasonable or indicated.

Emergency room treatment would be paid even if your normal doctor or medical services may be denied.

Finally, insurance companies will not pay Med Pay benefits if they find the charges are inflated or excessive. The insurance companies have databases that tell them what the customary and reasonable charges for a service are. For example, an insurance company will refuse to pay Medical Payments benefits for an MRI that costs $10,000 if their database shows that it typically costs $2,000. In that situation, they will only pay $2,000 which is the amount they conclude is reasonable.

Who Can Receive Med Pay Benefits?

Who can receive Medical Payments benefits depends on the insurance policy language. Typically, this includes any listed individual on the policy or any passengers in a covered vehicle. Also, any individuals in the vehicle may recover the benefits regardless of who was at fault for causing the car accident.

Our Law Firm Does Not Charge Any Fees on Med Pay Benefits Collected

Unlike other law firms, Scottsdale Injury Lawyers does not charge any fees for handling the Medical Payments portion of a case. We submit all Medical Payments claims and see that those benefits are collected. This is at no charge to the client.

> *We can make sure that the Medical Payments benefits are paid and collected in a way where the client receives the biggest financial benefit.*

This means that our clients receive every cent of the Medical Payments coverage and benefits paid. This can add up to a lot of money and help a client recover significant compensation for his or her car accident case. More importantly, ***we can make sure that the Medical Payments benefits are paid and collected in a way where the client receives the biggest financial benefit.*** This is described in greater detail in the section below.

Our Experienced Injury Attorneys Will Make Sure Your Medical Payments Benefits Are Not Wasted

It is important to have an experienced injury attorney who knows how best to manage the collection of Medical Payments benefits. This starts at the beginning of a case. Our attorneys will provide you with the information you need to make sure you receive the Medical Payments benefits and that those benefits are not paid to a medical provider who does not deserve it.

Often times, medical providers will make claims to the Med Pay benefits. If they do, they can receive the full amount of those benefits and exhaust them quickly. [illegible] your insurance policy.

> *The difference in the handling and collection of Medical Payments benefits could be the difference between the client receiving tens of thousands of dollars and zero.*

The difference in the handling and collection of Medical Payments benefits could be the difference between the client receiving tens of thousands of dollars and zero. It is important to consult with an experienced Arizona personal injury attorney if you have Medical Payments coverage and are in a car accident. Contact our law firm today to speak to an experienced Scottsdale car accident attorney.

Do the Medical Payments Benefits Need to Be Paid Back if There is a Settlement With the At-Fault Party?

Whether or not Medical Payments benefits need to be paid back from a settlement depends on a few things. First, insurance companies who pay Medical Payments benefits are not allowed to seek repayment of the first $5,000 paid under any circumstances. This practice is prohibited by Arizona law.

This is set forth in Arizona Revised Statutes § 20-259.1(J). This section sets forth the following:

"Any automobile liability or motor vehicle liability insurer that makes a payment under the medical payments coverage of a motor vehicle insurance policy to or on behalf of any insured for an injury that arises out of an accident that occurs after December 31, 1998 may have a lien against any amount in excess of $5,000 that is paid to or on behalf of that insured under the medical payments coverage of the policy for that accident."

What this section also provides is that the insurance companies can claim repayment for any Medical Payments benefits paid over $5,000 ***if there is a settlement with the at-fault party***. However, insurance companies are required by law to "compromise the lien in a fair and equitable manner." Our skilled car accident attorneys understand the law in this area and have strategies we employ to make sure the insurance companies compromise their repayment rights. Often times, we can negotiate complete waivers of these repayment amounts or significant reductions. When we do, the money goes directly into the pockets of our clients.

Contact a Scottsdale Car Accident Attorney to Help You With Your Case

If you or a loved one was injured in a car accident, contact our law firm today. Our car accident attorneys have handled hundreds of car accident cases. We understand the insurance coverages and what someone is entitled to recover. More importantly, we know the law that controls what insurance companies are allowed to do and what they are prohibited from doing.

Do not take on an insurance company by yourself or you will be taken advantage of. Contact us today for representation and we will maximize the amount of compensation you receive. A consultation is free and we only earn a fee if we recover for you.

About the author: The content on this page was provided by Scottsdale personal injury attorney and civil rights lawyer Tony Piccuta. Piccuta graduated with honors from Indiana University-Maurer School of Law in Bloomington, Indiana (Previously Ranked Top 35 US News & World Report). Piccuta took and passed the State bars of Arizona, California, Illinois and Nevada (all on the first try). He actively practices throughout Arizona and California. He is a trial attorney that regularly handles serious personal injury cases and civil rights lawsuits. He has obtained six and seven figure verdicts in both state and federal court. He has been recognized by Super Lawyers for six years straight. He is a member of the Arizona Association of Justice, Maricopa County Bar Association, Scottsdale Bar Association, American Association for Justice, National Police Accountability Project and Consumer Attorneys of California, among other organizations.

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References:

[1] https://www.azleg.gov/ars/20/00259-01.htm

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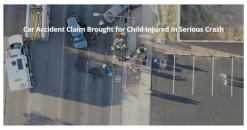

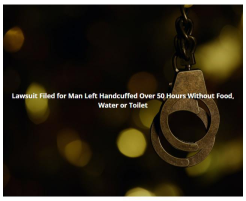

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United States Patent and Trademark Office (USPTO)

USPTO OFFICIAL NOTICE

Office Action (Official Letter) has issued
on December 22, 2023 for
U.S. Trademark Application Serial No. 97253721

A USPTO examining attorney has reviewed your trademark application and issued an Office action. You must respond to this Office action to avoid your application abandoning. Follow the steps below.

(1) Read the Office action. This email is NOT the Office action.

(2) Respond to the Office action by the deadline using the Trademark Electronic Application System (TEAS) or the Electronic System for Trademark Trials and Appeals (ESTTA), as appropriate. Your response and/or appeal must be received by the USPTO on or before 11:59 p.m. **Eastern Time** of the last day of the response deadline. Otherwise, your application will be abandoned. See the Office action itself regarding how to respond.

(3) Direct general questions about using USPTO electronic forms, the USPTO website, the application process, the status of your application, and whether there are outstanding deadlines to the Trademark Assistance Center (TAC).

After reading the Office action, address any question(s) regarding the specific content to the USPTO examining attorney identified in the Office action.

GENERAL GUIDANCE

- **Check the status of your application periodically** in the Trademark Status & Document Retrieval (TSDR) database to avoid missing critical deadlines.

- **Update your correspondence email address** to ensure you receive important USPTO notices about your application.

- **Beware of trademark-related scams**. Protect yourself from people and companies that may try to take financial advantage of you. Private companies may call you and pretend to be the USPTO or may send you communications that resemble official USPTO documents to trick you. We will never request your credit card number or social security number over the phone. Verify the correspondence originated from us by using your serial number in our database, TSDR, to confirm that it appears under the “Documents” tab, or contact the Trademark Assistance Center.

- **Hiring a U.S.-licensed attorney.** If you do not have an attorney and are not required to have one under the trademark rules, we encourage you to hire a U.S.-licensed attorney specializing in trademark law to help guide you through the registration process. The USPTO examining attorney is not your attorney and cannot give you legal advice, but rather works for and represents the USPTO in trademark matters.