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Spending Bypass

As Health Middlemen Thrive, Employers Try to Tame Them

Some Seek More Transparency, Deal With Doctors Directly; Fighting for Drug Rebates

Caterpillar Uses Its Leverage

By DAVID WESSEL, BERNARD WYSOCKI JR. and BARBARA MARTINEZ
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Chicken producer Perdue Farms Inc. used to hire a big health insurer to bargain with doctors. Gradually, over a decade it cut out the middleman, dealing directly with doctors and hospitals just as Wal-Mart Stores Inc. often buys directly from manufacturers instead of using wholesalers. That has helped Perdue keep its health costs below the national average.

Caterpillar Inc. used to rely on a middleman to provide prescription-drug benefits to employees, but -- like many U.S. employers -- it didn't have any way to know how much it was paying for drugs and how much was going to the middleman's bottom line. It demanded a different, more transparent deal, and its drug costs fell.

Perdue and Caterpillar are grappling with a big issue in U.S. health care: the role of middlemen. Employers are trying to make sure they get their money's worth from intermediaries, some of whom are reaping bonanzas as they stand between patients, doctors and those who pay the bills.

HEALTH-CARE GOLD MINES

Middlemen Strike It Rich.

This article is the **last** in a series. Earlier installments:

• In Nursing Homes, a Drug Middleman Finds Big Profits[1]
Dec. 23

• In Medicaid, Private HMOs Take a Big, and Lucrative, Role,[2]
Nov. 15.

• How Quiet Moves by a Publisher Sway Billions in Drug Spending,[3]
Oct. 6.

• Health-Care Consultants Reap Fees From

A lot of the money that goes to health-care middlemen is well spent. It allows employers to combine their purchasing power for leverage with hospitals and drug makers. It harvests data to uncover which new procedures are valuable and which aren't. Middlemen offer health-care expertise to employers who don't have it and don't want to hire it.

But a lot of the money goes more toward fattening middlemen's bottom lines than toward improving the quality or efficiency of American health care. "At the end of the day, the only reasonable conclusion is that we waste a huge amount of money on the most nuttily cumbersome administrative system in the world," says Henry Aaron, a Brookings Institution economist.

While the middleman business booms, health-care costs keep rising, the ranks of the uninsured grow, and paperwork expands as each party in the system tries to enlarge its slice of the pie. "There's more money to be made by monitoring cash flow than monitoring

Those They Evaluate,[4]
Sept. 18

• Selling Generic Drugs by Mail Turns Into Lucrative Business,[5]
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• As Patients, Doctors Feel Pinch, Insurer's CEO Makes a Billion,[6]
April 18

patients," says David Cutler, a prominent Harvard University health economist.

Middlemen aren't unique to health care. Banks serve as middlemen between saver and lender. In the age of Orbitz and airline Web sites, some people still find travel agencies worth the fees. Distributors and wholesalers remain a vital cog in much of U.S. manufacturing.

But while the Internet, deregulation and relentless corporate cost-cutting have squeezed middlemen elsewhere, the health-care middlemen are prospering. The three largest pharmaceutical benefit managers, for instance, had net income of $1.9 billion last year, a sum that exceeds the annual operating budget of New York's Memorial Sloan-Kettering Cancer Center. In corners of the system such as Medicaid managed care and nursing-home drugs, little-known intermediaries rack up tens or hundreds of millions of dollars in profit.

With health-care spending now at 16.5% of the nation's economy and climbing, an urgent question is how to squeeze out the waste connected with middlemen -- without squeezing the valuable services they can provide. Some say the only solution is a top-to-bottom overhaul of the American health-care system. But that's far from a universally held view and is politically impractical.

In some other countries, a single government entity does the health-care buying, keeps a lid on prices and limits the availability of care. That's not the American way, at least not now. The fear is that rampaging bureaucracy could do more damage than any middleman. Uwe Reinhardt, a Princeton health economist, says the conventional wisdom in the U.S. is: "Because you cannot trust government to do anything right, you always have these private middlemen, who cost more money." From its birth, for instance, Medicare has always used private companies to handle claims and bill-paying paperwork.

Decades ago, there was little to stop doctors and hospitals from piling on visits and procedures to boost their income. Gradually those paying for care developed ways to counteract these perverse incentives, encouraging the rise of middlemen. Today, each player in the health-care business seems determined to get a bigger share of the money pot and prevent others from taking unfair advantage.

A unit of health insurance giant UnitedHealth Group Inc. called Ingenix offers technological weaponry to all sides in this arms race. It sells software to doctors to "achieve optimal reimbursement" and "increase cash flow" and to hospitals to "optimize every aspect of a facility's revenue cycle." It also sells software to insurers for "effective cost-control initiatives" and to government agencies to "significantly reduce claim expenses." Ingenix revenues are running at a rate of $1 billion a year. Its pretax operating profit margin was an impressive 23% in the quarter ended Sept. 30.

The fragmented nature of the U.S. health-care system also increases demand for middlemen. Only a minority of Americans get health care from entities that integrate all facets of medical care, such as Group Health Cooperative Health System, a Seattle health-maintenance organization with 523,000 members. Group Health doesn't hire pharmacy-benefit managers. It employs its own pharmacists to devise a formulary and monitor usage. It also preaches the virtues of generics to doctors and patients. Group Health buys drugs directly from manufacturers, increasing its bargaining clout by teaming up with the nation's largest HMO, Kaiser Permanente, which has 8.4 million members.

Here are some of the other efforts to change the way middlemen are used:

Buy Direct

Most big companies in the U.S. are "self-insured," meaning they pay employees' medical bills out of their own coffers. These companies typically hire a health insurer such as UnitedHealth or **WellPoint** Inc. to

administer the health benefit -- negotiating rates with doctors and hospitals and deciding what care is covered.


Roger Merrill

Perdue Farms, the Salisbury, Md., poultry empire, contracts with doctors and hospitals directly. The company has 15 poultry plants and 22,000 employees scattered across rural communities in the eastern U.S., mostly in tiny towns such as Perry, Ga., where it is a dominant employer. That gives Roger Merrill, an internist who has been Perdue's chief medical officer since the early 1990s, a lot of bargaining clout with local doctors and hospitals. In exchange for favorable prices, he promises to pay bills within eight days, much quicker than the 60- to 70-day norm in health care. (Dr. Merrill relies on an outside contractor to handle billing paperwork.)

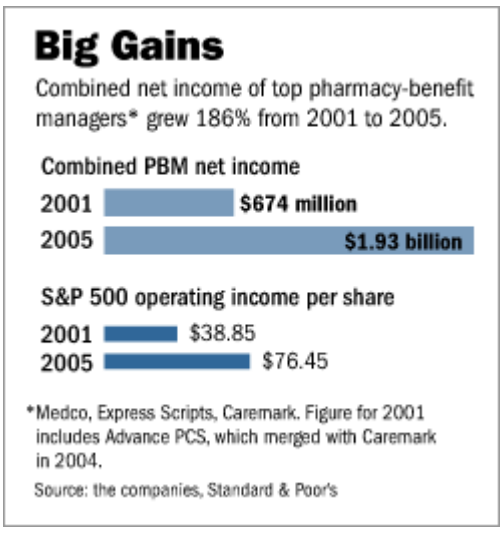
Perdue also avoids second-guessing hospitals or doctors over individual procedures. Dr. Merrill says patients usually get what they want and it isn't worth it trying to stop them. It's better, he says, to bump wasteful doctors out of Perdue's network. Like Medicare, Perdue pays hospitals fixed prices for patient stays, to discourage unnecessarily long hospitalizations. With help from a Houston consultant, Howard Lester, Perdue has struck deals with about 60 hospitals and 12,000 doctors, most in groups affiliated with those hospitals.

Dr. Merrill says he likes dealing directly with the suppliers. "I want to buy a product -- health -- rather than a process," he says.

Kenneth Sperling, senior vice president at **Cigna** Corp. -- the big health insurer Perdue used to use for claims processing -- says direct contracting "is an exception, not a rule." Most employers don't have the volume to make it work, he says, and "the more volume you have, the more leverage. It's true in health care, in paper clips or computers."

The approach requires more staff and expertise than most employers have. Southern California Edison used direct contracting in the early 1990s. It shaved 20% from its health-care bill after accounting for the extra staff it needed, says Jacques Sokolov, a physician who ran the effort and is now an independent consultant. "By every metric we had improved. And providers were satisfied. And every insurance company and HMO was unhappy that any corporation could manage their business," he says.

But handling all the negotiations and paperwork with doctors required a 300-person department. In 1995, new management switched to a conventional offering of coverage through insurers, says Dr. Sokolov. "The vast majority of large corporations don't really want to be in the business of managing health-care costs," he adds. A spokesman for Southern California Edison, part of Edison International, declined to comment.



Perdue's health-care tab is rising more slowly than other employers and runs less than half of the national average of roughly $7,000 per capita per year, according to Dr. Merrill. Direct contracting is only part of the company's strategy. It also has opened in-house clinics at most Perdue plants that screen employees for high blood pressure, diabetes and other chronic diseases that can be costly if not treated properly. The company does use conventional insurance in such cases as covering employees when they're traveling.

Fire the PBM

The University of Michigan once relied on **Caremark Rx** Inc., one of the big three U.S. pharmacy-benefit

managers, to administer its prescription-drug benefit. But Keith Bruhnsen, the university's assistant director of benefits, chafed at the common practice among PBMs of receiving rebates from drug makers. The rebates are usually in exchange for the PBM promoting the use of certain preferred drugs. PBMs may share their rebates with employers, but they don't always do so.

Mr. Bruhnsen thought Caremark was sometimes steering Michigan employees toward drugs for which it got rebates instead of the ones that would save the university the most money. "The drugs that they had negotiated rebates on were not best-value drugs," he says.

He was worried, for example, when he saw doctors receive information from Caremark plugging Concerta, a Johnson & Johnson drug for attention-deficit hyperactivity disorder. Concerta is an extended-release form of a medicine whose active ingredient is available more cheaply in generic form. (Caremark has noted in literature for medical professionals that generic ADHD drugs "should be considered the first line of prescribing.")

Big PBMs make their money from a variety of sources which aren't necessarily disclosed: drug-maker rebates, margins on drugs sold via the pharmacy counter or the PBMs' own mail-order operations, and other payments.

Mr. Bruhnsen replaced Caremark with SXC Health Solutions Inc. of Milton, Ontario, which has a different model. The university pays SXC the cost of the drug plus an administrative fee on each of its 900,000 claims per year. Mr. Bruhnsen won't disclose the fee but says it is less than $1 per prescription. If SXC gets any rebates, they go to the university.

Mr. Bruhnsen expects drug costs for the university's 80,000 covered workers and family members to rise about 6.2% this year to about $72 million this year. Last year, when Michigan was using Caremark, costs rose nearly 12%.

Caremark declined to comment. Mark Merritt, president of the PBM trade association, the Pharmaceutical Care Management Association, says, "Fee-based plans haven't had a lot of uptake in the marketplace." He says fee-based middlemen have little incentive to bargain hard with drug makers for discounts and rebates. He also says big PBMs strive harder to push employees to low-cost generics, making them the best choice for employers.


Sidney C. Banwart

Transparency

When Sidney Banwart became Caterpillar Inc.'s vice president for human services in 2004, he discovered a difference between suppliers of health-care services and suppliers of steel and tires. In health care, he says, "we were doing business in the manner in which the suppliers had established even though we were paying the bills."

The construction-equipment maker's PBM was Restat of West Bend, Wis., a unit of privately held F. Dohmen Co. Mr. Banwart found it hard to tell how much Caterpillar was paying for drugs and how much for Restat's services.

Mr. Banwart says he told Restat, "You've got to be transparent. We need to know what the costs of the drugs are." He insisted on a new method under which Caterpillar would get all the drug-company rebates and pay Restat specified fees for the services it provided.

Caterpillar started the new approach in 2005. Caterpillar's drug spending fell to $157 million that year from $166 million in 2004. This year, Mr. Banwart expects spending to be flat or slightly down. In the new year, using some of the savings, Caterpillar will eliminate co-payments on some drugs for chronic conditions, such as high cholesterol, to encourage employees to take them.

Restat Chief Executive Michael Clark, eager to hold onto a big customer that it had served since 1992, says he's happy with the outcome. "Caterpillar understands the PBM wants to make money, too, and we came to terms on what a fair reimbursement was," he says. About a third of Restat's customers have opted for fully transparent, fee-only deals similar to Caterpillar's, while many others prefer the old way, he says.

Now Mr. Banwart is at the forefront of a business campaign to press PBMs for more transparency. He is chairman of a coalition of 56 big companies sponsored by the HR Policy Association. Ten PBMs, including big ones such as Medco Health Solutions Inc., have agreed to comply with the coalition's transparency standards. Certified PBMs agree to hand drug-company rebates over to employers or employees. The standards also say that when a PBM pays a pharmacy for drugs dispensed, the PBM can pass on only that amount to the employer -- not tack on a margin. Participating employers say they've reduced drug spending 3.5% to 6.2% at a time when other employers are seeing drug costs rise.

The combined leverage of the employers was key, Mr. Banwart says. "A strong coalition of brand-name companies said we were serious about transparency," he says. "It's hard to argue about transparency. It's like motherhood and apple pie."

Some in the business question how far PBMs will open their books and whether employers can understand the numbers. In a recent report, Mercer Human Resource Consulting, part of **Marsh & McLennan** Cos., says "very few PBMs [are] willing to provide true (100 percent) transparent arrangement."

Mr. Merritt, the PBM trade association president, says transparency is a vague term and more of it may not save employers money. He warns against "micromanaging or creating something so ham-handed that there's no way for different players to find ways to save money in ways that are proprietary or innovative."

-- Heather Won Tesoriero contributed to this article.

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