What is a PBM's function and how does it make money? PBMs contract with payers (the client) to manage the pharmacy component of the health benefits that clients provide to their members, employees, enrollees, beneficiaries (depending on the program). Clients tell PBMs what they need, how they want the pharmacy benefit administered, and how they'll pay the PBM, through rebates, administrative fees, or some mix thereof. Each contract is different, depending on the needs of the client and client's member population. For example, a state Medicaid program that contracts with a PBM will have different needs than a large private employer that funds health care coverage for its own employees. The differences may be in rules and regulations that apply to the health coverage program, the health needs of the member/employee population, budget limitations, etc. There is no one-size-fits-all contract between PBMs and their payer clients, and thus there is no one-size-fits-all flow of money between PBMs and clients.

In all PBM-client relationships, however, PBMs and their clients are aligned in two respects: trying to keep the pharmacy benefit as *affordable* as possible, and ensuring that the client's members have *access* to clinically necessary medications. Overall, the PBM industry profit margin remains low, similar to health plans' and insurers'. It hovers around 2-5%. PricewaterhouseCoopers estimates "that, on average, pharmacy benefit management reduces prescription drug costs by 29 percent compared to retail purchases with no pharmacy benefit management support." The research firm Visante supports this conclusion, indicating PBMs save plan sponsors and consumers an average 30% compared to expenditures made without pharmacy benefit management (i.e., cash purchases by the uninsured).

What is competition like in the PBM industry? There are approximately 60 PBMs in the country, some small, some large. Some companies specialize in specific programs such as workers compensation or Medicaid, and some companies can serve all types of health coverage programs. Larger PBMs have the ability to aggregate buying power of their many clients, who collectively provide health coverage to tens of millions of people. This buying power allows PBMs to negotiate with drug manufacturers to secure discounts (called rebates) off of the "regular"/list prices of pharmaceuticals. Competition among PBMs is fierce. PBMs vie for client contracts, promising high-quality, efficient management of the pharmacy benefit within a reasonable budget.

What is the value of the 30-day notice of a price increase? PBMs would be able to work with their clients to assure access to a clinically effective treatment at the most affordable cost, given notice of the price increase. A prior notice period would allow payers to look for therapeutic alternatives if available and make adjustments to their coverage if needed. Doing so before the price increase goes into effect would make the transition smoother and minimize disruption in patient care.

What is the difference between brand and generics? Patents protect brand name drugs from competition for a set time period. After the patent expires, generic versions of the drug can be manufactured and sold by multiple competitors, after an exclusivity period. The availability (or lack thereof) of multiple brand name drugs that treat the same condition, and the availability (or lack thereof) of generic drugs made by competing manufacturers can impact drug prices significantly.