Rewarding Career

As Patients, Doctors Feel Pinch, Insurer's CEO Makes a Billion

UnitedHealth Directors Strive To Please 'Brilliant' Chief; New Questions on Options

Selling Trout for 40¢ a Pound

By George Anders

MINNETONKA, Minn.—When William McGuire switched careers in 1986, he was so restless that a pay cut of more than 30% didn't faze him. Health maintenance organizations were booming, and Dr. McGuire wanted to help run one. So he jettisoned a six-figure income as a pulmonologist in favor of an HMO management job that paid about $70,000 a year.

Savvy move. Today, the 58-year-old Dr. McGuire is chief executive officer of UnitedHealth Group Inc., one of the nation's largest health-care companies. He draws $8 million a year in salary plus bonus, enjoying perks such as personal use of the company jet. He also has amassed one of the largest stock-options fortunes of all time.

Unrealized gains on Dr. McGuire's options totaled $1.6 billion, according to UnitedHealth's proxy statement released this month. Even celebrated CEOs such as General Electric Co.'s Jack Welch or International Business Machines Corp.'s Louis Gerstner never were granted so much during their time at the top.

Dr. McGuire's story shows how an elite group of companies is getting rich from the nation's fraying health-care system. Many of them aren't discovering drugs or treating patients. They're middlemen who process the paperwork, fill the pill bottles and otherwise connect the pieces of a $2 trillion industry.

The middlemen credit themselves with keeping the health system humming and restraining costs. They're bringing in robust profits—and their executives are among the country's most richly paid—as doctors, patients, hospitals and even drug makers are feeling a financial squeeze. Some 46 million Americans lack health insurance.

UnitedHealth's main business is offering health plans to employers and Medicare beneficiaries. Bigger employers usually pay employees' medical bills out of their own coffers and hire UnitedHealth to administer the health benefit. Smaller employers pay an annual insurance premium to UnitedHealth in exchange for having the insurer take on the risk of covering employees' health care.

The "risk" business has been a particular gold mine for UnitedHealth and its rivals in recent years. As health-care inflation eased, insurers still raised premiums at double-digit rates. UnitedHealth's stock price tripled between January 2003 and January 2006, helped by acquisitions, although it has fallen back somewhat since the beginning of this year. UnitedHealth's net income in 2005 totaled $3.3 billion, nearly four times the figure in 2001.

UnitedHealth directors in the late 1990s allowed Dr. McGuire the rare freedom to time his stock-option grants. In several cases the grants carried dates when the company's share price was particularly low, allowing him to profit when it recovered. The company's options-granting practices were among several scrutinized in a page-one article in The Wall Street Journal last month and are being examined by the Securities and Exchange Commission. (See related article on page A3.)

William McGuire

The Journal's analysis of 12 options grants to Dr. McGuire from 1994 to mid-2002 found that if the options had been randomly dated, the odds of their occurring at such propitious times were about 1 in 200 million. It raised the possibility that the options grants were backdated. Backdating an options grant isn't necessarily illegal, but civil or criminal actions could be brought if disclosure of the

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As Patients, Doctors Feel Pinch, CEO Makes a Billion

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practice were inadequate, securities lawyers say. A UnitedHealth spokesman said the grants were appropriate, but the company's board is reviewing options-granting procedures.

The arrival of the $1 billion CEO would be a head-turner in any industry. But it's especially controversial in health care, where "people tend to view each dollar of executive pay as money that isn't spent on them," says Jonathan Weiner, a health-policy expert at Johns Hopkins University. Dr. McGuire and his supporters say the U.S. would be in even worse shape if it weren't for insurers such as UnitedHealth weeding out unnecessary treatments, bargaining with doctors and encouraging patients to seek out the highest-quality care.

Ever since missing a stock-market windfall in the late 1980s, Dr. McGuire has pursued stock-options wealth tirelessly, as an iron-willed leader surrounded by an admiring board. He declined to discuss his pay, but current and former directors talked at length about their desire to do whatever is necessary to keep Dr. McGuire happy.

"We're so lucky to have Bill," says Mary Mundinger, a UnitedHealth director who sits on the company's compensation committee. "He's brilliant." She says his income gives him extra credibility in health-policy debates because it shows his success. "He needs to be compensated appropriately so that his business model has believability in the market," says Ms. Mundinger, who is dean of the nursing school at Columbia University.

Robert Ryan, another UnitedHealth director, notes that the company's stock-market capitalization has climbed 112-fold since Dr. McGuire took over in 1991. "A lot of the board's job here is to keep him motivated," says Mr. Ryan, a retired chief financial officer of Medtronic Inc.

Bill McGuire was born in Troy, N.Y., but moved to Texas as a boy when his father got a job as an oil-company engineer. He grew up in League City, Texas, a blue-collar town near Galveston. Friends remember him as shy, pleasant and dead-certain of his expertise in areas ranging from sports to math.

He grew to be 6-foot-6, and as a high-school senior he was the starting center on a basketball team that nearly won the state championship. "Bill did all my scouting reports for me," recalls Bill Krueger, who was in his first year as coach. "I'd never played our opponents before. Bill had. He remembered all the other players' strengths and weaknesses."

After college, Bill McGuire attended medical school in Galveston, Texas, at the urging of family doctor Ned Dudney. Varsity athletes who go into medicine often end up as surgeons. But Dr. Dudney pegged his young friend as more of an intellectual problem-solver and pointed him toward internal medicine. "Bill liked the challenge of diagnosing the rare, complicated disease," Dr. Dudney recalls.

At medical school, Dr. McGuire became famous for his side income as a commercial fisherman, selling speckled trout to Galveston's best restaurants at 40 cents a pound. The night before one exam, he slipped away to the Gulf of Mexico and spent hours catching fish.

"It flabbergasted us," recalls classmate Robert Hendler. "The rest of us were struggling to learn the material. Bill had it down cold. He could go fishing and still get one of the best scores on the test."

In the early 1980s, Dr. McGuire settled into private practice as a lung-disease specialist in Colorado Springs, Colo. Much of his job involved hospital care of the desperately sick at all hours of the day and night. In one case, Dr. McGuire—who wasn't certified as a cardiac surgeon—reopened the chest incision of a critically ill patient in the emergency room and massaged his heart. That audacious step kept the patient alive until a surgeon arrived.

Looking for a new challenge, Dr. McGuire joined Peak Health Plan Inc. in 1984 as its assistant medical director. He helped found a smaller health plan, CostGuard Inc., in which he took a 10% ownership stake. "Bill gave us a lot of credibility," recalls Stephen Hyde, Peak's CEO at the time. "I was trying to expand our provider network, and I couldn't get doctors to come to our recruiting meetings. Bill could."

Within two years, both Peak and CostGuard were sold to UnitedHealth, a larger Minnesota company that had been founded in 1974, for a total of about $95 million. Dr. McGuire was irked that the company he had recently joined was suddenly sold, associates say. He earned about $1 million on his CostGuard stake but he didn't own any Peak stock, so he missed out on bigger windfalls that Peak's three founders collected. "Bill didn't let me forget about it for years," Mr. Hyde says.

The managed-care industry in the late 1980s was experiencing booming but chaotic growth. Big corporations, instead of simply paying whatever medical bills their employees submitted, tried steering them into more restrictive HMOs to hold down runaway costs. Members streamed in so fast that many health plans' computer systems buckled.

Dr. McGuire moved to UnitedHealth's headquarters in Minnesota, where he quickly became the company's No. 2 executive. In 1988 and 1989, he performed the business world's version of emergency surgery on a company that was stretched too thin. After he helped sell or close a half-dozen regional plans that weren't working out, UnitedHealth became a smaller but more profitable company.

"When we saw Bill's talent and potential, we started providing him with some big stock options to give him some incentives," recalls Robert Ditmore, a former UnitedHealth director in the late 1980s. By the end of 1990, Dr. McGuire had options on 229,277 shares, or 0.7% of the company.

This was the beginning of a period when U.S. corporations began making options a big part of pay packages, seeking to align the interests of executives and shareholders. Traditionally, hired CEOs enjoyed big salaries but their puny stockholdings left them no hope of approaching the epic wealth of the Rockefellers or DuPonts.

But as stock options took off, highflying bosses such as Dr. McGuire propelled themselves into the top ranks of their companies' shareholder registries. As stock prices rose, these bosses became tycoons, too.

In the early 1990s, the HMO boom continued and Dr. McGuire found more ways for his company to pull ahead of the pack. He spent heavily on information technology, ensuring that UnitedHealth could handle its fast-growing membership even as rivals got snarled in data blowups. And he showed a knack for acquisitions, picking up smaller plans that fit well into UnitedHealth's networks.

The stock jumped 10-fold during Dr. McGuire's first five years at the company. Directors purred. "We knew we had a really strong leader in Bill," recalls Walter Mondale, the former presidential candidate, who was a member of the UnitedHealth board's compensation committee in the early 1990s. "We wanted to keep him and help him with incentives."

During his first seven years as CEO, Dr. McGuire's base salary more than tripled, to $1.3 million in 1998. His bonus jumped nearly as briskly for a few years. Then in 1997 and 1998, Dr. McGuire told directors that he would forgo his bonus. The company's stock price and earnings growth had stalled amid a backlash against restrictive health plans.

His sacrifice impressed directors. As the expiration of his contract approached in mid-1999, the directors and the CEO met repeatedly to talk about a new contract.

Dr. McGuire at the end of 1998 had unrealized gains of $22 million on his existing options. That might have seemed like a huge sum a decade earlier. But laughably brief, but UnitedHealth kept rising. As the industry consolidated—spurred by several deals Dr. McGuire engineered—health-plan operators found it easier to raise prices. Employers rarely complained, or if they did they directed their anger at the health-care system generally.

The better UnitedHealth fared, the more valuable Dr. McGuire's options became. Since 2000, he has cashed out $488 million of options, yet the value of his remaining options keeps rising. The 1999 grant has proved about seven times as valuable as the company projected when it was issued.

In Minnesota, such riches have infuriated some people. Joel Albers, a Minneapolis pharmacist, regularly impersonates Dr. McGuire at state fairs, donning a tuxedo, holding up an enlarged picture of Dr. McGuire on a stick and handing out leaflets denouncing corporate greed. Most people chuckle and walk on. But Mr. Albers says he has a serious point. He has been urging Dr. McGuire to spend his options proceeds on providing free health coverage for Minnesota's 77,000 uninsured children.

UnitedHealth executive John Penshorn says outsiders' efforts to tell Dr. McGuire how to spend his money are "very parochial" because "the issues are broader than just Minnesota." Dr. McGuire has been speaking out about national health system reform and UnitedHealth has opened advanced clinics that serve some of the nation's poorest neighborhoods. Dr. McGuire also has set up a family foundation that gives away millions on behalf of education, science and the arts.

Some of Dr. McGuire's most eye-catching gifts are unrelated to health care. In January, he announced he was giving $10 million to help thousands of disadvantaged Minnesota children attend college. Dr. McGuire also has given nearly $10 million to the University of Florida for a biodiversity center that includes one of the world's largest butterfly research institutes. An avid lepidopterist himself, Dr. McGuire discovered the brown Texas butterfly *Euphyes mcguirei*.

As long as UnitedHealth stock keeps climbing, big shareholders say they aren't likely to badger Dr. McGuire for a pay cut. "It's hard to say what someone like that is worth," says Tom Marsico, head of Marsico Capital in Denver, which owns about 5% of UnitedHealth's shares. "But compared with hedge-fund managers or athletes, he's probably doing more to improve the world."

Even so, UnitedHealth directors huddled several times last year to discuss whether they have showered Dr. McGuire with too many options. His 1999 employment contract obligated the company to award him further options on 2.6 million shares each year, adjusted for splits.

"The number [of options] became larger than we were comfortable with," says Mr. Spears, a member of the UnitedHealth compensation committee. Directors in August 2005 eliminated the options guarantee. Dr. McGuire received options last year on 1.7 million shares, down 35% from the previous year.

But several directors say they have no desire to peel away some of the CEO's longtime perks, such as a $139,000 travel allowance and $69,100 of financial planning last year—even though Dr. McGuire is long past the point of needing help with everyday living costs.

"If we did reduce these things, Bill would take it as a signal that directors weren't enthusiastic about his leadership," says Mr. Spears. "That would be a distraction, at the very least. Bill takes these things as a benchmark of how directors feel about him."

During their August 2005 overhaul of Dr. McGuire's contract, directors did eliminate an unusual provision that let Dr. McGuire choose when his options would be awarded. As this newspaper reported on March 18, option grants to Dr. McGuire in 1997, 1999 and 2000 carried dates on which UnitedHealth's stock hit its low for the year. Mr. Spears said in March that he wasn't aware of anything inappropriate about the options grants.

In an SEC filing April 7, UnitedHealth said a committee of independent directors will work with outside lawyers to review the company's "current and historic stock option grant procedures." The company said the board review was Dr. McGuire's idea.

Bill McGuire *(No. 20) starred on the Clear Creek High basketball team in League City, Texas, in 1966.*

Leonard Abramson, the founder of U.S. Healthcare Inc., netted about $900 million when he sold his company to Aetna Inc. in 1996. And dot-com mania was at its peak. CEOs of health-care start-ups such as WebMD Inc. held 5% or bigger stakes in their companies, which looked like passports to great wealth.

In contract negotiations, Dr. McGuire pushed for more options, and directors agreed. When his contract was renewed, effective Oct. 13, 1999, he got options equivalent to 2% of UnitedHealth's shares outstanding. That was the biggest slice Dr. McGuire had ever received. "Clearly we were aware of people getting huge gains on Internet-stock situations. That was perhaps a factor in our mind," says director William Spears.

The dot-coms' onslaught proved

Strategic Position

Selling Generic Drugs by Mail Turns Into Lucrative Business

Benefit Managers Say They Save Employers Money, As Their Own Profits Rise

Off-Patent Bonanza Ahead

By Barbara Martinez

In many industries, middlemen scrape by on small margins. Not so in generic drugs.

Documents from 2001 filed in an Ohio court case show that Medco Health Solutions Inc. paid $90 that year for the pills to fill 114 prescriptions for a generic copy of Valium. Medco sent its client, the State Teachers Retirement System of Ohio, a bill of $1,028 for the drugs, which also reflected its dispensing costs. Medco paid $766 for the pills to fill hundreds of prescriptions for the blood-pressure medicine atenolol. It billed the Ohio teachers $25,628.

HEALTH-CARE GOLD MINES
Middlemen Strike It Rich
Second in a Series

Today, Caremark Rx Inc., another middleman, charges the federal government and employees $96.88 for 90 pills of generic Prozac, according to a Caremark Web site. The same pills can be bought wholesale for less than $5.

Medco, Caremark and Express Scripts Inc. are the big three "pharmacy benefit managers," or PBMs. Employers that offer prescription-drug coverage hire PBMs to do the paperwork and keep costs down when an employee needs a prescription filled. More than 100 million Americans carry a card with the logo of one of the big three, using it at the pharmacy to show they're covered.

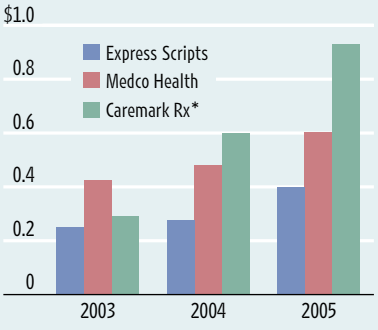
It's a hugely lucrative place in the food chain. Generic drugs are popular because they save money by offering alternatives to expensive brand-name drugs. But the PBMs have figured out how to use mail order to turn generics into a bonanza. Buying in bulk, the PBMs typically pay a few cents per pill, then turn around and bill employers a quarter, 50 cents or even a dollar a pill. A Medco spokeswoman, Ann Smith, says final profit is much smaller than that spread because of administrative and dispensing costs.

For the employers, the generic prices look like a bargain because they're generally still much lower than those of brand-name drugs. The employers often don't know the spreads enjoyed by the PBMs.

The big three PBMs' perch could grow even more valuable over the next five years as brand-name drugs with $47 billion in annual sales lose patent protection. Copies of top sellers such as the cholesterol drug Zocor and antidepressant Zoloft will take a big bite out of the drug industry's profits, while giving PBMs more chances to sell high-margin generics.

Moving Up

Net profit for the big three pharmacy-benefit managers, in billions:



*Caremark merged with AdvancePCS in 2004.
Source: the companies

More than half of Medco's net income comes from filling generic-drug prescriptions at its mail-order facilities, although the mail business including brand-name drugs represents just 37% of revenue. Collectively, the big three recorded net income of nearly $2 billion last year.

The business has brought gains for PBM shareholders and made some PBM executives rich, chiefly from valuable stock options, even as many employers and employees struggle to afford health insurance. Caremark's chief executive, Edwin M. "Mac" Crawford, has sold $185 million in stock since November. (See article on page A10.) At Express Scripts, Chairman Barrett Toan has sold $64.8 million in stock since last fall.

It helps the PBMs that many employers are unfamiliar with the economics of manufacturing pills. While a brand-name pill such as Lipitor or Prozac may cost employers $2 or more, most of that goes into marketing, research into future drugs and profit for the drug company. The cost of actually producing the pills is usually only a few cents each.

After the patent on a drug expires, brand-name makers lose the monopoly that allowed them to charge a high price. But for customers accustomed to the old prices, it may seem like a bargain to get pills that used to cost $2 for just 50 cents.

The PBMs defend their lofty margins on generics, saying that they need the profits there to make up for overhead costs and losses or slim margins on brand-name drugs. They say employers benefit from their efforts to switch patients to generics. Pharmacies also add huge markups on generic drugs for some customers, such as uninsured people who pay for medicines out of pocket.

Recently, some states have been pushing back against PBMs, weighing laws to force the middlemen to reveal where their profits come from. The laws would also make PBMs fiduciaries of their cli-

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Selling Drugs by Mail Turns Into Lucrative Business

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ents, just like accountants or lawyers. That would limit the PBMs' ability to grab lucrative margins through pricing methods that employers find hard to follow. Meanwhile, a handful of employers are looking for ways to buy generics for a price closer to what they cost to make.

But for now, the generic mail-order business is booming. It represents the latest evolution of an industry that has played a key behind-the-scenes role in the $250 billion U.S. pharmaceuticals business.

The PBMs started out by promising to liberate employers from the grunt work of offering a prescription-drug benefit for employees. They could handle the paperwork when prescriptions were filled at pharmacies and make sure employers paid only for approved drugs.

PBMs were early adopters of technology. When people needed a prescription filled, they could simply hand over their Medco or Caremark card to the pharmacist, who could tap into the PBM database to confirm coverage and figure out how much the employee owed out of pocket.

For a while, a good chunk of the PBMs' profits came from incentives provided by drug makers. PBMs would try to badger doctors into switching prescriptions to a particular brand. The PBMs could reap lucrative rebates from drug makers for doing this. After an outcry about the practice a few years ago, PBMs started sharing more of the rebates with employers.

Early on, PBMs came up with the idea of cutting pharmacies out of the equation altogether. Many people fill prescriptions on regular schedules, and have no need to go to a drugstore every time. PBMs could receive orders by phone or online and send pills directly to patients. It would be more convenient for patients and reduce the risk of errors.

It took a while, but gradually employers warmed to the mail-order idea. PBMs sold it in part by promising to switch employees as quickly as possible to cheaper generic copies whenever they were available. Even if the prescription was for a patent-protected drug, the PBMs would try to switch it to a similar generic. PBMs also offered lower prices on brand-name drugs if employees used mail order.

Today, big facilities like Medco's can fill prescriptions in minutes and put them in the mail with barely a human hand intervening. At its Willingboro, N.J., facility, which Medco calls the world's largest automated pharmacy, trays of bottles get filled from 1,200 bins containing almost every major pill for chronic diseases prescribed in the U.S. Robots cap and seal the bottles after their two-mile journey and drop them into plastic mailing bags. The factory churns out more than a million mail-order prescriptions a week.

When the allergy drug Flonase lost patent protection this March, Medco says it converted 95% of brand prescriptions to generics within two days. A similar conversion in 2001 when Prozac went off-patent took more than six months, it says.

An even bigger opportunity is coming in June, when Merck's cholesterol fighter Zocor goes off-patent. Medco vice president Ken Malley says Medco has a "very overt, very aggressive program" to push generic Zocor. Medco will fax letters to 50,000 doctors urging them to put their patients on the generic pill. The letters say, "Help keep your patients' benefits affordable."

Timothy Wentworth, a top Medco executive, says switching to generics will lower employers' costs. Medco plans to waive co-payments for six months for Zocor patients who switch to its mail-order pharmacy from a retail store. That's the longest waiver it has offered, and Medco says experience with shorter waivers suggests many patients will sign up. "We are incredibly motivated" to get patients on generics quickly, says Mr. Wentworth. "Every day we make more money."

Medco's spread can be wide, as documents from the Ohio court case show. In one case in 2001, Medco paid $514 for the pills to fill 666 prescriptions for a blood-pressure drug. It charged the Ohio teachers' retirement system $5,806. In 2000, the group paid $10.5 million in total for generic drugs that cost Medco $2.3 million.

Medco says that after overhead its profit margin on mail-order generic drugs for the retired Ohio teachers was only 23% and its total margin, after losses on brand-name drugs, was 1%. Ms. Smith, the Medco spokeswoman, adds: "To make generalizations on five-year-old pricing of a selective sampling of drugs would be misleading."

The state of Ohio sued Medco, accusing the PBM of cheating the teachers. Medco denied that, saying it acted according to their contract. The judge told the jury to disregard the margins on generics because contracts allowed them. The jury ruled that Medco should pay the teachers' retirement system $7.8 million for fraud and for breaching what the jury called its fiduciary duty. Medco is appealing.

The Ohio data are unusual: Even today, it's difficult to find clear numbers on how much PBMs pay for drugs and how much they charge for them. However, some examples come from a Web site operated by Caremark, which manages the prescription-drug benefit for federal-government employees. The site says it shows federal employees how much Caremark bills the government for many drugs.

According to the site, 90 pills of generic Prozac cost $96.88 via Caremark's mail-order pharmacy—a bill that the federal government must foot, minus a small co-payment by the employee. Pharmacies, whose business is threatened by PBMs, say those pills cost less than $5 to acquire wholesale. On its Web site, Costco Wholesale Corp. sells 100 pills of generic Prozac to retail customers who lack insurance for $13.59.

In some other cases, the government is also getting a worse deal from mail order than it would if employees filled their prescriptions the old-fashioned way at a pharmacy. According to the Caremark Web site, the government's cost for a full year of atenolol, the widely prescribed blood-pressure pill, is $28.92 if the employee goes to a pharmacy. But when the drug is ordered through the mail, the government's cost rises to $81.12. The employee's co-payment would be higher, too: $40 instead of $9.60.

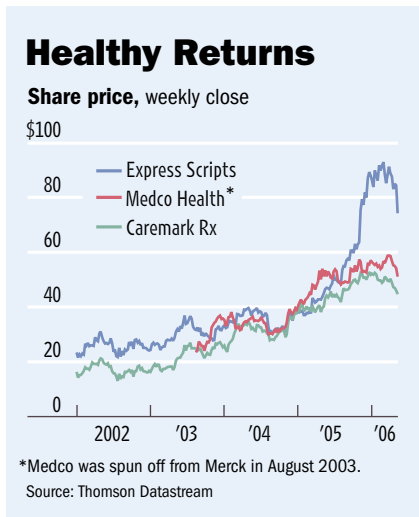
Mr. Crawford, Caremark's chief executive, says it's irrelevant to look at the price of one drug because PBMs negotiate a pricing system with clients that saves them overall. He says Caremark "loses a lot of money on branded drugs" because of competition with other PBMs. He adds that Caremark has invested significantly in its mail-order facilities and needs to earn a return.

A Caremark spokesman says the prices on the Web site shouldn't be considered actual prices because the company's contract with the federal government "is not based on pricing per individual prescription." Nancy Kichak, a federal government official who oversees benefits for employees, says the government does pay for individual prescriptions. "What you see on the Web site is very close to what we're paying," she says.

Ms. Kichak agrees with Mr. Crawford that just because the government is paying five to 10 times the wholesale cost in some cases doesn't mean it's being taken to the cleaners. "We have to get the absolute best deal possible in total," says Ms. Kichak, associate director for strategic human-resources policy at the Office of Personnel Management. She notes that the government's biggest expense is still for brand-name drugs, not generics.

Ron Lyon, who until recently was a consultant at Towers Perrin helping employers negotiate contracts with PBMs, says some consultants are beginning to insist that PBMs eliminate the big gap between the mail-order price and pharmacy price. But employers won't get that guarantee unless they ask for it—and many aren't savvy enough to do so, Mr. Lyon says.

Gabriela Garcia is head of human resources at Alamo Group Inc., a Seguin, Texas, manufacturer of tractor-mounted mowing and other equipment with 1,500 employees. Ms. Garcia says she never used to look at individual prescription claims to estimate how much profit Alamo's PBM, one of the big three, was making on generic drugs. When a smaller rival showed her some figures a year and a half ago, "the amount of the markups were a surprise," she says. Alamo switched to the smaller PBM, Hyde Rx Services Corp.



A big part of the PBMs' strategy is selling employers on the idea of requiring patients to fill all prescriptions, except in emergencies, through the mail-order pharmacy. General Motors Corp., International Business Machines Corp., and Southwest Airlines have "mandatory mail" programs. About eight million beneficiaries served by Medco come from employers with such rules, up from two million in 2003.

Medco says clients save 8% to 10% with the program because it has a good track record of switching mail-order patients to generics. According to Medco, the current generic substitution rate for chronic medicines through its mail pharmacy is 95.3% while at a retail pharmacy it is 92.6%.

The results didn't please one customer, Horizon Blue Cross Blue Shield of New Jersey. Medco "sold us on mail order to say it would be cheaper and sometimes it turned out not to be cheaper," says Debra M. Lightner, Horizon's associate general counsel.

The health insurer hired Medco in 1993 to manage pharmacy benefits for its three million members. Now, Horizon is suing Medco in New Jersey state court. It alleges that Medco violated contract terms. However, in recent weeks Horizon dropped its claims that Medco's mail-order pricing violated the contract. Ms. Lightner says that was designed to "streamline" the case as it heads for trial, perhaps next year. Ms. Smith of Medco says the abandoning of the claim "speaks for itself."

PBMs typically advertise that they offer attractive discounts—sometimes 50% or more—off the "average wholesale price" of a drug. Publishers of drug-sales data report this price but it rarely reflects actual market prices. The average wholesale price for generic Prozac, as reported by one pharmacy-pricing magazine, is $2.60 a pill, nearly 100 times what generics manufacturers actually charge wholesale customers.

In several states, legislators are pushing bills aimed at bringing more transparency to PBM pricing, but they have run into stiff opposition from the PBMs. The first such law was passed in Maine two years ago, requiring PBMs to reveal where their profits come from. It was recently upheld by a federal appeals court. The Pharmaceutical Care Management Association, which represents PBMs, asked the U.S. Supreme Court last month to review the case. Legislators in about a dozen other states are working on similar legislation.

PBMs say their services are part of health benefits that are governed by federal law, and states can't impose their own laws. They also say that requiring them to disclose proprietary information violates the Fifth Amendment of the Constitution, which bars the government from taking private property except for public use and with just compensation.

For Caremark's Chief Executive, Outsize Rewards

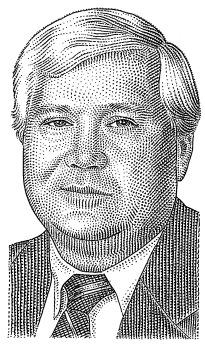
Amid the success of big pharmacy-benefit managers, the chief executive who has prospered the most is Edwin M. "Mac" Crawford of Caremark Rx Inc. Aside from a bonanza in stock options, he has also received some unusual perks—including $2.9 million for relocation even though his family has yet to leave his old house after more than two years.

Mr. Crawford, a former fullback on Auburn University's football team, was a veteran health-industry executive when he was tapped in 1998 by Richard Scrushy for a new job in Birmingham, Ala. Mr. Scrushy at the time was chief executive of HealthSouth Corp. and also chairman of a little company called MedPartners that specialized in managing doctors' practices. That operation had fallen into deep trouble, and MedPartners' only bright spot was a unit called Caremark that managed employers' prescription-drug benefit programs.

Mr. Crawford quickly jettisoned the failing part of the business to focus on the drug side, and renamed the company Caremark Rx. The Caremark board awarded Mr. Crawford 3.875 million stock options dated March 8, 2000. The options gave him the right to buy shares for 15% more than the stock's closing price that day, $3.88, which turned out to be tied for the low point of the year. The company said Mr. Crawford agreed to forgo his bonus for four years—2000 through 2003—in exchange for the large grant.

A company spokesman, Robert Mead, says the March 8 grant was made at a scheduled board meeting and came at the time of year when options were typically awarded.

Mr. Scrushy left the Caremark board in 2001, two years before his own troubles started to surface at HealthSouth. He was later accused of massive accounting fraud but acquitted by a Birmingham jury.



Edwin M. 'Mac' Crawford

In recent years Caremark's stock has risen sharply, making the 57-year-old Mr. Crawford a rich man. In addition to selling $185 million worth of stock since last October, he is sitting on about $184 million in unexercised stock options. Mr. Crawford says his big stock sales recently were for estate and tax-planning purposes. He says he used the money to set up a trust for his family.

In 2003, Caremark moved its headquarters to Nashville, Tenn., from Birmingham. It introduced a program for some employees under which a relocation company acting on Caremark's behalf would buy the employees' homes. The relocation company would then sell the homes and hand over the proceeds to Caremark, which would incur any losses if a home was sold for less than what the employee was paid.

According to the proxy, Mr. Crawford was part of the relocation program and received $2.9 million. However, his 5,000-square-foot house in Birmingham, with three bedrooms and four bathrooms, never went on the market. Mr. Mead, the spokesman, says Mr. Crawford's wife, who is being treated for a serious illness, continues to live in the Birmingham home. Mr. Mead says Mr. Crawford is renovating a home in Nashville, and the Birmingham home will be put on the market when the renovation is complete.

The proxy calls the $2.9 million payment an "equity advance" but is vague on its exact nature. Mr. Mead says the money is "not a loan" and "the company will retain the proceeds of the sale when the house is sold." He declined to say whether the company considers the advance taxable compensation for Mr. Crawford.

Mr. Crawford's son, Andrew, has also succeeded at Caremark. He joined the company in 2002 as vice president and assistant to the president—his father. The younger Mr. Crawford's salary and bonus then totaled $177,439. In each of the next three years, his total compensation increased at least 50%. In 2005, the 32-year-old made $673,325 with a title of senior vice president for industry analysis and underwriting.

Mr. Mead says Andrew Crawford earlier worked at a large accounting firm and now manages pricing and underwriting for all of Caremark's contracts.

—Barbara Martinez

UAL Swings to Profit, Aided by Hefty Gain

By Susan Carey

United Airlines parent **UAL** Corp. reported first-quarter net income of $22.9 billion, as a huge accounting gain related to its lengthy stay in bankruptcy offset a disappointing loss. The company pledged to redouble its efforts to improve revenue and find more costs to pare.

Excluding the gain, the Chicago-based carrier reported a loss of $306 million. That compared with a net loss of nearly $1.1 billion a year earlier, or $302 million excluding reorganization items. Revenue for the quarter rose 14% to $4.47 billion from $3.92 billion.

The U.S.'s second-largest airline by traffic after **AMR** Corp.'s American Airlines said its unit revenue, or the amount of revenue generated for a mainline passenger flown a mile, increased 11%, and the amount generated by its regional airline partners rose more than 13%. Those gains were strong but didn't significantly expense in the first quarter.

UAL spent 33% more on fuel in the latest quarter than a year earlier, paying $1.95 a gallon instead of $1.47 a gallon. Nearly a third of UAL's fuel consumption was hedged in the first quarter but the company has no hedges in the place for the rest of the year. It expects to pay $2.15 a gallon on fuel in the current quarter and $2.06 a gallon for the full year.

Leaving fuel aside, "we are dissatisfied with our cost performance," said

For Caremark's Chief Executive, Outsize Rewards

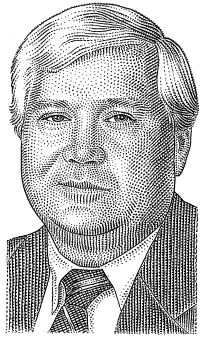
Amid the success of big pharmacy-benefit managers, the chief executive who has prospered the most is Edwin M. "Mac" Crawford of Caremark Rx Inc. Aside from a bonanza in stock options, he has also received some unusual perks—including $2.9 million for relocation even though his family has yet to leave his old house after more than two years.

Mr. Crawford, a former fullback on Auburn University's football team, was a veteran health-industry executive when he was tapped in 1998 by Richard Scrushy for a new job in Birmingham, Ala. Mr. Scrushy at the time was chief executive of HealthSouth Corp. and also chairman of a little company called MedPartners that specialized in managing doctors' practices. That operation had fallen into deep trouble, and MedPartners' only bright spot was a unit called Caremark that managed employers' prescription-drug benefit programs.

Mr. Crawford quickly jettisoned the failing part of the business to focus on the drug side, and renamed the company Caremark Rx. The Caremark board awarded Mr. Crawford 3.875 million stock options dated March 8, 2000. The options gave him the right to buy shares for 15% more than the stock's closing price that day, $3.88, which turned out to be tied for the low point of the year. The company said Mr. Crawford agreed to forgo his bonus for four years—2000 through 2003—in exchange for the large grant.

A company spokesman, Robert Mead, says the March 8 grant was made at a scheduled board meeting and came at the time of year when options were typically awarded.

Mr. Scrushy left the Caremark board in 2001, two years before his own troubles started to surface at HealthSouth. He was later accused of massive accounting fraud but acquitted by a Birmingham jury.



Edwin M. 'Mac' Crawford

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—Barbara Martinez

Double Bypass

Health-Care Consultants Reap Fees From Those They Evaluate

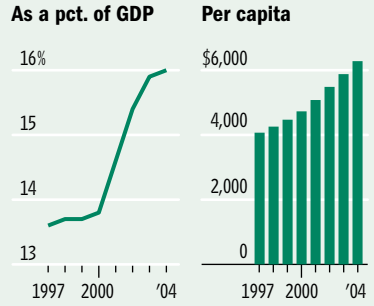
As Insurance, Drug Costs Rise, Employers Seeking Advice Often Discover Conflicts

A Superintendent's Surprise

By Barbara Martinez

When Kevin Grady took over as an employee-benefits consultant for the Columbus Public Schools District in 2001, he signed a contract promising to act "in the best interest" of the schools. The Ohio district agreed to pay him $35,000 a year to help it choose a health insurer. Officials thought that was all Mr. Grady was getting out of the deal.

It wasn't. After the district switched its health insurance to UnitedHealth Group Inc. on what it says was Mr. Grady's recommendation, he started getting payments and other compensation from the big Minnetonka, Minn., insurer. "Thank you and United for the steaks," Mr. Grady wrote in a Dec. 20, 2001, email to a UnitedHealth employee. "We'll have those on Christmas eve."



All told, UnitedHealth paid Mr. Grady $517,138 for helping it get the district's business. The district says it learned about the payments two years ago after a new human-resources chief came on the job. It canceled Mr. Grady's contract. Last month, the Ohio Department of Insurance suspended Mr. Grady's license for three years, accusing him of "deception." He was ordered to pay $137,000 in restitution to the Columbus district and a $25,000 civil penalty. Earlier this year, UnitedHealth agreed to pay a $125,000 penalty to settle the matter without admitting wrongdoing.

HEALTH-CARE GOLDMINES
Middlemen Strike It Rich
Third in a Series

The episode spotlights a widespread and largely invisible practice that critics say boosts the cost of health care. Many consultants and brokers who are hired to help employers get the best deal on health insurance or prescription-drug coverage have significant financial ties with the health vendors they are supposed to be scrutinizing. The ties may take the form of bonuses for bringing in business, commissions or consulting fees. Often they are disclosed only partly or not at all.

Mr. Grady's son, Joe, who is president of the family consulting business, says his father is appealing the suspension and did nothing wrong because the payments he received are standard in the industry. "All [insurance] companies offer bonuses," says Joe Grady. "It's a way to sell the product and saves them from hiring 20,000 agents." He denies that his father pushed the district to choose UnitedHealth and contends the district knew all along about the payments. The insurer declined to discuss the specifics of the Columbus case.

Consultants and other middlemen are prospering even as employers struggle with spiraling health-care costs. Some employers are dropping health coverage or raising workers' payments. That has contributed to an increase in the number of Americans without health insurance to 46.6 million last year from 45.3 million in 2004, according to the Census Bureau.

Tamar Frankel, a professor at Boston University Law School, says employers who hire middlemen need to ask: "Are you recommending me someone who is now paying you?" If the answer is yes, she says, it is best to hire someone else.

Consultants play down the importance

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Want to Unwind? Ride Around the Yard On Your Bulldozer

* * *

Extreme Gardeners Dig, Mow, Grind, Plow and Grapple; Harrison Ford Is a HOWA

By Timothy Aeppel

Tom Dunham bought a compact bulldozer to move dirt and arrange boulders at his home, which is on six acres outside Washington.

"Some people mow their lawns, but that just doesn't do it for me," says the 42-year-old patent attorney. His 80-horsepower ASV, made by ASV Inc. in Grand Rapids, Minn., runs on rubber tracks that enable it to crawl over obstacles without bouncing the driver up and down.

It retails for $47,000. He also has bought several attachments, including a stump grinder, a snowplow and a grapple for picking up tree trunks. The whole

Tom Dunham

Tom Dunham, *with his ASV bulldozer*

setup has cost him about $65,000. He still has got his eye on a flail mower—an at-

Health-Care Consultants Reap Fees From Those They Evaluate

Continued From First Page

of their financial ties to vendors and say they are part of the solution to rising health-care costs. "Health-care finance and delivery are...not the core mission of most employers," says Robert O'Brien, the head of health and benefits consulting at Mercer, a unit of Marsh & McLennan Cos. "We help employers manage the expense and complexity of their health and benefits programs in a way that maximizes their value for employees."

A handful of consulting giants such as Mercer, Hewitt Associates, Lincolnshire, Ill., and Towers Perrin, Stamford, Conn., dominate the benefits-consulting business, but smaller ones also thrive working with local employers. Mercer says it expects its health-benefits consulting business to bring in revenue of $526 million this year.

An Ohio Case

Payments to a consultant are at issue in an Ohio case involving the South-Western City School District, which encompasses suburbs southwest of Columbus in the central part of the state. In 1996 the district hired Joseph James & Associates of Dublin, Ohio, to help it choose a health insurer.

The district had fired its previous consultant after learning he had financial ties to health insurers. Superintendent Kirk Hamilton says the district made clear that it expected Joseph James not to take money from district health-care vendors. "We wanted to make sure the people representing us were solely working in our best interest," he says.

Each time the health-insurance contract came up for bidding in subsequent years, Joseph James managed the process. Each time, UnitedHealth won the business. Over 10 years, the district paid the consulting firm about $380,000 for its services.

Earlier this year, Dr. Hamilton discovered that Joseph James also was getting paid by UnitedHealth. The district quickly sued both the consultant and the insurer in Franklin County Common Pleas Court. Documents filed in the suit showed that Joseph James was receiving 1% of premium dollars paid by the district. The consultant received more than $645,000 from UnitedHealth from 1999 to 2004 for bringing in the district's business, according to the documents. Joseph James, in court filings, says it became eligible for the bonus as part of a "recognition program" by UnitedHealth rewarding its "overall contributions."

Undercovered

Employers are dropping or reducing health coverage, leading some to go without it. Percentage of Americans without health insurance:

Source: Census Bureau

In its lawsuit, the school district contends the deal gave Joseph James a financial incentive to continue choosing UnitedHealth and to ensure that the district's premiums kept rising. The premiums increased to more than $21 million this year from $5.2 million in 1996, according to Dr. Hamilton. He says it is possible "we could have negotiated lower premiums" if not for the behind-the-scenes deal.

In court documents, Joseph James argues that bonuses from insurers are an accepted and legal practice in the insurance business and it didn't need to disclose them to the school district. The consulting firm's lawyer, Kort Gatterdam, says: "There's no evidence of steering. They provided an excellent service to South-Western schools and saved them millions of dollars." He says Joseph James helped the district move in the late 1990s to a managed-care plan that saved $6 million and after that the consultant worked hard to squeeze the best rates out of UnitedHealth.

UnitedHealth declined to comment on the South-Western case. A spokesman said that in general, bonuses and other rewards for consultants who bring in a large amount of business "are not built into premiums or fees that customers pay" and don't raise the cost of health care.

The practices of brokers and middlemen in other forms of insurance were the target of a widely publicized investigation two years ago by New York state Attorney General Eliot Spitzer. He was particularly concerned about payments brokers received from insurers for bringing in a certain volume of business from corporations buying property, casualty or life insurance. Mr. Spitzer said the corporations were entitled to an unbiased opinion from their brokers rather than one potentially influenced by so-called contingent commissions.

High-Profile Settlements

Mr. Spitzer reached several high-profile settlements with insurance brokers and consultants. Marsh & McLennan, New York, agreed to pay $850 million and stop accepting contingent commissions. Only a handful of brokers agreed to settlements, and the probe didn't delve into health-benefits consulting. Major health insurers including UnitedHealth, Aetna Inc., Hartford, Conn., and WellPoint Inc. of Indianapolis say they continue to offer contingent commissions.

Aetna gives brokers a "retention bonus" for staying loyal. If a broker keeps 90% of his Aetna clients with the insurer for another year, he gets a bonus equal to 0.75% of the clients' total premiums. If 100% stay, the bonus rises to 1.25% of total premiums. Though employers typically put their health-insurance contracts up for bid every few years, such bonuses are one factor encouraging brokers to keep their clients on the same plan.

A spokeswoman for Aetna said the insurer requires consultants and brokers to disclose such fees to customers. She said Aetna also makes its broker fees public via its Web site and in annual disclosures to clients. Many other insurers don't detail their contingent commissions on public Web sites.

Consultants also may have financial ties with pharmacy-benefit managers, or PBMs, which administer prescription-drug benefits for employers. Mercer, the big benefits consultant, has done consulting work for a leading PBM, Medco Health Solutions Inc., even as it was advising employers choosing among PBMs including Medco, of Franklin Lakes, N.J. In a proposal for a 1998 job handled by Mercer Management Consulting, Mercer said it could help Medco "refine its pricing to increase its profitability." Mercer also said it would help Medco "improve relationship with key benefit consultants to better position [Medco] for winning target accounts."

In 2000, the top Mercer pharmacy-benefits consultant, Nicholas K. Vasilopoulos, gave a written declaration in a lawsuit by Medco clients who accused the PBM of overcharging them for drugs. In it he defended Medco as "forthright" in its business dealings. Mr. Vasilopoulos said he advised employers seeking advice on PBMs—and advised Medco in assessing its competitiveness against other PBMs.

In an email, Mr. Vasilopoulos said "there were no conflicts of interest" when he was a Mercer consultant. He said Mercer had no reason to favor any particular PBM because it provided advice to all the major ones over the years. This advisory role gave Mercer a "more thorough understanding" of each PBM's offerings, which benefited Mercer's employer clients, he said.

> Bonuses are one factor encouraging brokers to keep their clients on the same plan.

Lisa Zeitel, a senior consultant at Mercer's pharmacy-benefits consulting practice, said much of the work for Medco was done by the management-consulting side of Mercer, which is "totally separate" from her unit. She said her own unit occasionally undertakes small assignments for PBMs, but this "in no way interferes with the work that we do for individual clients."

Joseph Sawicki Jr., the comptroller of Suffolk County on Long Island, N.Y., discovered the ties between consultants and PBMs after the county sought a routine audit of its PBM, Express Scripts Inc., in 2003. The county hired Mercer for the job. Mr. Sawicki says officials didn't realize at first that Mercer also serves as Express Scripts's employee-benefits consultant and had other consulting arrangements with the PBM. Mercer says it did disclose the ties.

Mr. Sawicki wasn't happy with the audit's results, which initially found that Express Scripts had overbilled the county by more than $1.1 million but later suggested that the overbilling amounted to only $14,000. Mercer charged the county $93,000. Mr. Sawicki withheld half the payment and asked Mercer to return the half it already had received, saying he doesn't pay for "shoddy" work. A spokeswoman for Mercer, Stephanie Poe, says Mercer made clear its initial estimate was likely to be reduced and it did a good job on the audit although it wasn't allowed to complete its work. The dispute over the $93,000 is unresolved.

The county didn't pursue any refunds from Express Scripts in connection with the billing Mercer had audited. It then hired another auditor to review Express Scripts's billing in subsequent years. That review led to a settlement in which Express Scripts paid the county $865,000. A spokesman for Express Scripts said the company has saved "millions of dollars" for Suffolk County. He declined to comment on the settlement.

Back in Columbus, school-district human-resources chief Craig Bickley wants consultants who aren't getting money from the same people they are supposed to be evaluating. He was annoyed to discover that under the previous consultant, Kevin Grady, the district switched to UnitedHealth from Anthem (now part of WellPoint) even though UnitedHealth's administrative fees were $776,000 a year higher. Mr. Grady's son, Joe, says UnitedHealth offered more coverage for the money.

Mr. Bickley says his first question to consultants nowadays is: "Who are you working in the best interest of, yourself or the client?" The district insisted that the consultant replacing Mr. Grady forgo commissions and bonuses it might otherwise receive from health insurers for bringing in the district's business. Mercer won the contract and agreed to do so.

—Raymund Flandez contributed to this article.

When Employers Get Drug Advice, Price Can Be Steep

By Barbara Martinez

Some consultants who advise employers on prescription-drug benefits have come up with a way to earn a lot of money—without charging their clients anything directly. The fees come instead from the same pharmacy-benefit managers, or PBMs, whom the consultants are scrutinizing. It is another example of how healthcare middlemen can reap profits even as employers and patients face big cuts.

PBMs administer drug benefits for employers and negotiate prices on drugs. Employers want to be sure their PBM will battle hard to get the best prices, and they sometimes turn to consultants for help in picking one.

Last year, the United Brotherhood of Carpenters and Joiners of America, which represents more than 500,000 workers, retained consultant Pharmaceutical Strategies Group of Irving, Texas. In December, the union chose Medco Health Solutions Inc., one of the big three companies in the PBM field.

Medco agreed to pay 25 cents to the consultant for each prescription union members filled. Because of the union's size, that deal could bring Pharmaceutical Strategies more than $1 million over the three-year contract—more than the consultant would typically earn if it charged an employer or union directly, people in the industry say.

The carpenters' union contract allows Medco to pay retail pharmacies one price for a drug but charge the union a higher price. Under the contract, when union members fill a prescription they sometimes must pay an out-of-pocket charge that exceeds the cost of the drug being prescribed. The contract also limits the union's rights to audit its drug bills to see if it is getting a good deal.

A Medco spokeswoman said, "Pricing provisions in this contract were at the discretion of the client." She said that in general, "audit rights are subject to negotiation."

Tim Watson, a principal at Pharmaceutical Strategies, says clients choose how they want to pay for his firm's services, and the per-prescription method isn't necessarily more expensive. "It's a funding mechanism is all that it is," Mr. Watson says. "It's up to clients on how they want to work with us. Some clients want a straight retainer, some want the administrative fee paid by the PBM."

Mr. Watson says clients are getting their money's worth. "If you paid us $500,000 and we saved you $50 million, how do you feel about the $500,000?" he asks.

In an emailed statement, the carpenters' union concurred with Mr. Watson's analysis, saying it expects to save more than $30 million under its new prescription-drug program and is "extremely satisfied" with it.

One blue-chip client of Pharmaceutical Strategies is Exelon Corp., an electric utility in Chicago with 17,000 employees. A 2003 internal document from a consulting firm later purchased by Pharmaceutical Strategies says the firm received revenue of $629,012 from a PBM, Caremark Rx Inc., of Nashville, Tenn., in connection with the Exelon business. The document doesn't specify a time period. Exelon's head of health benefits, Carole Schecter, says the company ended the arrangement last year and now pays Pharmaceutical Strategies directly. The company declined to discuss its reason for the change, and Caremark declined to comment.

The Cleveland Clinic Health System, which employs workers at 12 Ohio hospitals, still has the per-prescription arrangement, according to Estay Greene, director of pharmacy benefits. A document from Pharmaceutical Strategies to PBMs seeking the clinic's business says PBMs should pay the consultant 45 cents a prescription, an amount Mr. Greene declined to confirm. The clinic's PBM is currently Caremark.

Mr. Greene says he counts on the consultant because it is "constantly monitoring" the PBM. "We operate 10 different plan designs," he says. Without the service, "I would have to hire another full-time person."

How Quiet Moves by a Publisher Sway Billions in Drug Spending

Lawsuit Forces Hearst Unit To Lower Prices on List Widely Used as Benchmark

A 'Survey' of One Company

By Barbara Martinez

For years, a little-known unit of publishing giant Hearst Corp. called First DataBank has played a powerful role in determining what Americans pay for prescription drugs. First DataBank doesn't buy or sell drugs—it publishes lists of drug prices. Health plans and state Medicaid programs use those prices as a benchmark in determining what they pay pharmacies.

If the benchmark goes up, so do costs for these payers. That's what happened in 2002, when First DataBank suddenly made broad revisions to its key published list. The new prices had the effect of fattening the profits of pharmacies, out of the view of patients and companies who pay for the soaring cost of health care.

HEALTH-CARE GOLDMINES
Middlemen Strike It Rich
Fourth in a Series

A 2002 email by a manager at one of the nation's largest drug wholesalers, San Francisco-based McKesson Corp., describes how pharmacies would be able to more than double their profit for dispensing the cholesterol drug Lipitor and adds, "that is awesome!!"

Now a tentative legal settlement, reached quietly this week in a Boston court, could reduce annual U.S. drug costs by billions of dollars. An economist hired by the plaintiffs puts the savings in 2007 alone at $4 billion. The actual amount could be lower if pharmacies negotiate higher fees to make up for what they are losing.

In the settlement, which is awaiting approval by a judge, First DataBank, of San Bruno, Calif., agrees to reduce many of the prices on its published list by five percentage points. It denies any wrongdoing and isn't paying any damages to the plaintiffs.

Documents made public as part of the litigation suggest that McKesson had a key part in the rise of the published benchmark prices in 2002. The documents suggest that McKesson's motive was to resolve an administrative headache. The McKesson manager's emails later noted a side benefit: The company's pharmacy customers would enjoy bigger profits.

First DataBank had long said its prices reflected a survey of national wholesalers. But a manager at the publisher said in a deposition that from 2003 only one company, McKesson, participated in the survey. In the litigation, First DataBank also said that only two of its 225 employees were trained to collect and update pricing information.

One of the most important parts of the proposed settlement in U.S. District Court involves the benchmark price at issue in the litigation, known as average wholesale price or AWP. The term is a misnomer because it no longer represents a price paid to wholesalers and is not an average of anything. An old industry joke holds that AWP stands for "ain't what's paid." First DataBank agreed that two years after the settlement is final it

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New Profits

In 2002 health-care information company First DataBank raised benchmark prices for drugs. Wholesaler McKesson projected that pharmacies would see increased profits, such as:

DRUG	PACKAGE SIZE	OLD PROFIT	PROJECTED NEW PROFIT
Lipitor	90 pills	$6.86	$17.18
Prilosec	30 pills	$4.22	$8.92
Allegra	100 pills	$3.97	$8.16
Advair Diskus	60 doses	$5.11	$11.70

Source: McKesson internal memo, March 22, 2002.

Lawsuit Forces Drop in Prices on Widely Used List

Continued From First Page

will stop publishing the AWP.

As AWP loses sway, employers, Medicaid programs and other drug payers may need to find new ways to figure out how much pharmacies are paying for drugs so that the pharmacies can be reimbursed at a fair, but not excessive, profit margin.

Mark Erlich, executive secretary-treasurer of the New England Regional Council of Carpenters, is one of the plaintiffs settling the case with First DataBank. He expects the settlement will save about $400,000 a year for his union's health fund, which covers 22,000 people and spent $10 million on prescription drugs last year. Mr. Erlich calls the earlier rise in First DataBank's published prices "a rip-off of consumers across the country." It affects the union, he says, because its contract with the company managing its pharmacy benefits specifies that the drug prices the union pays will be based on First DataBank's AWP benchmarks.

In a statement, First DataBank said it isn't responsible for what companies involved in drug distribution do with its data. "First DataBank does not set pharmaceutical prices. First DataBank is a reporter and publisher of information that is collected from third parties," the statement said. Hearst is a major media company whose holdings include the San Francisco Chronicle and Good Housekeeping magazine. It is a partner with Dow Jones & Co., publisher of The Wall Street Journal, in publishing SmartMoney magazine.

The changes in First DataBank's published prices are responsible for only a portion of the increase in drug prices in recent years. The prices of drugs are set, first and foremost, by drug manufacturers. From 2000 to 2005, manufacturer prices on the most popular brand drugs grew by about 40.5%, according to a study by AARP, the advocacy group for Americans over age 50.

Between the manufacturer and the end user stand a variety of middlemen who take their cuts. These include wholesalers such as McKesson, who distribute drugs obtained from manufacturers, and pharmacies where patients go to get prescriptions filled. First DataBank plays a key but little-noticed role in drug pricing as a source of data used by middlemen to set their prices.

Another group of middlemen are pharmacy benefit managers or PBMs, which manage employers' drug benefits and often act as pharmacies themselves by filling employees' prescriptions through mail order. PBMs also frequently use AWP as a benchmark. Changes in AWP may also affect people without insurance who pay out of pocket because pharmacies sometimes use AWP in setting their cash prices.

Even as patients face higher co-payments and other out-of-pocket medical costs, many pharmacies and PBMs are prospering. The Dow Jones index of U.S. drug-retailer stocks has risen about 40% since the beginning of 2002, roughly in line with major indexes. A few big chains are doing especially well: Walgreen Co.'s net income has nearly doubled in the past five years and CVS Corp.'s has tripled. Share prices of the three major PBMs are also sharply up over the past few years.

Vestige of Old System

Average wholesale price "is a vestige of a drug-distribution system that disappeared in the early 1980s," says E.M. Kolassa of Medical Marketing Economics, an Oxford, Miss., consulting firm. In the late 1960s, the California Medicaid program needed a standardized way to reimburse pharmacies for drugs because "every claim was a paper claim based on whatever the pharmacist was charging," Dr. Kolassa says. Two consultants came up with "average wholesale price" after surmising that drug wholesalers generally charged retail pharmacies about 20% more than they paid manufacturers for drugs. California decided to pay pharmacies this new AWP, plus an additional dispensing fee.

Within a few years, Medicaid systems throughout the country had adopted AWP, and publishers such as First DataBank made a business of disseminating the pricing data. When commercial health insurers and employers began to reimburse for drugs and demand discounts from pharmacies in the 1980s and 1990s, they too adopted Medicaid's AWP system.

Gradually the 20% estimated markup became an anachronism. Wholesalers consolidated and became more efficient amid competition. They were selling drugs to pharmacies for just 2% to 3% more than what they paid. The compilers of AWPs, however, continued to report a 20% markup. States and employers adjusted by demanding discounts of 5% to 15% off the AWP.

First DataBank, founded in 1977, was bought by Hearst in 1980. Hearst bought another major publisher of AWPs, Medi-Span, for $38 million in 1998, but had to sell Medi-Span to Wolters Kluwer NV of the Netherlands in 2001 after a complaint by the Federal Trade Commission. The FTC said the acquisition gave Hearst "monopoly power" in drug data and led to "drastic price increases to customers, and reductions in product quality and customer service."

Thomson Corp.'s Red Book also publishes AWPs but First DataBank's figures are most commonly used in the industry, says Sean Brandle, a pharmacy benefits consultant to major employers and unions at Segal Co. in New York.

The trigger for litigation was a sudden rise in First DataBank's AWPs in 2002. Previously the 20% markup beyond the wholesaler's acquisition cost was common, although not universal. Suddenly First DataBank started revising its AWPs so that the markup was almost always 25%. According to internal McKesson documents, by 2004 nearly 99% of drugs carried the larger 25% markup. The cumulative effect, according to the plaintiffs, was that employers and others paid an extra $7 billion between August 2001 and March 2005 on drugs covered by the suit.

Pricing the Pills

A price benchmark published by health-care information company First DataBank often influences how much pharmacies profit. An example:

❶ **Drug maker charges wholesaler: $100.00**

❷ **Wholesaler charges pharmacy:**
$100 + $3 markup = **$103.00**

❸ **Pharmacy charges insurance:**

$100	x	1.25	–	15% = **$106.25**
wholesale price		*multiplier to calculate First DataBank benchmark*		*standard discount to insurance company*

Pharmacy's profit:
$106.25 – $103 = **$3.25**

Note: Insurer typically also pays pharmacy a flat dispensing fee.
Source: WSJ research

Employers often have difficulty learning what they are paying for specific drugs.

Documents from the period make clear that McKesson influenced the shift to an across-the-board 25% markup. The drug wholesaler's motivation was to simplify its system: Its computers recorded a "suggested sales price" for each drug that corresponded to the AWP, and it was easier if the markup was always the same. But McKesson managers also recognized that if the markup were to be standardized, it would be beneficial to standardize it at a high level—that is, at 25%. The result would be higher margins for its pharmacy customers.

In an internal email on Jan. 7, 2002, McKesson's director of brand pharmaceutical product management, Robert James, wrote that "our successes recently and during this past year include raising the AWP spreads" on many drugs. As a result, he wrote, "we have an opportunity to 'market' our efforts now" to retail pharmacies who would appreciate that McKesson was working on their behalf. In a competitive market where pharmacies have a choice among wholesalers, such marketing could give McKesson an edge.

Mr. James wrote that in his discussions with customers, "one of the comments that was made was 'this would certainly be a good reason to renew our agreement with McKesson when it's time.' Talk about being good partners, wow!"

In an April 2002 email, Mr. James explained to colleagues that while pharmacies previously made a $6.86 profit dispensing Lipitor, with the new AWP they "will enjoy $17.18 profit…and that is awesome!!"

As Mr. James noted in his emails, many pharmacies say their profit margins have been squeezed in recent years. That is largely the result of efforts by the pharmacy-benefit managers hired by employers. PBMs have driven down reimbursements to pharmacies, passing on the savings to employers or keeping some of it for themselves.

Douglas Hoey, chief operating officer of the National Community Pharmacists Association, says any extra money pharmacies might have gained from the changes in First DataBank's prices meant little amid their woes. "We don't know where [the extra profits] went—we just know where it did not go and that's to the community pharmacies," Mr. Hoey says. The association says many small pharmacists have closed down or are considering doing so because of slim profit margins.

In a statement, McKesson says setting the AWPs was First DataBank's job. "A full reading of McKesson documents, including e-mails, demonstrates that McKesson did not enter into any agreement with First DataBank to raise published AWPs," the statement says.

McKesson, which is named in the lawsuit, isn't a party to the settlement. "We intend to continue to press the case against McKesson," said Thomas Sobol, the plaintiffs' attorney at Hagens Berman Sobol Shapiro LLP.

'Really Mad'

The price rises published by First DataBank met with anger among some in the industry. "We were really mad," says Tim Heady, head of the pharmacy-benefits division at health insurer UnitedHealth Group Inc. UnitedHealth called First DataBank for an explanation but couldn't get a satisfactory one, Mr. Heady says.

A vice president at drug maker GlaxoSmithKline PLC wrote to the president of First Data Bank in March 2002 asking why the publisher had increased the AWP for the asthma medication Advair even though Glaxo hadn't raised its prices. He complained that "First DataBank has not been willing to share any information" about the change.

Plaintiffs' lawyers first suspected that drug manufacturers were behind the AWP increase and sued them. The drug companies denied any role, and in 2004 both sides started inundating First DataBank with subpoenas looking for answers.

Many employers and other payers for drugs didn't notice the rise in First DataBank's benchmark prices and didn't attempt to roll them back. Drug manufacturers were raising their own prices frequently during the period. The escalating prices prompted employers to shift some costs to employees through higher co-payments. Employers often have difficulty learning what they are paying for specific drugs and what factors determine prices.

For years, First DataBank described its AWPs as the results of a survey of national wholesalers. The supposed survey didn't gather the actual prices the wholesalers were charging but rather their suggested markup based on the decades-old wholesaler margins.

It emerged in the litigation that the only wholesaler in the "survey," at least in its final years, was McKesson. There are three national wholesalers. Spokesmen for two of them—AmerisourceBergen Corp. and Cardinal Health Inc.—say their companies didn't participate in any First DataBank surveys during the period when the price increases were occurring and still don't.

In a January 2005 deposition, Kay Morgan, who was in charge of AWPs at First DataBank, was asked: "Was First DataBank receiving any information regarding markups from any other company other than McKesson?" Ms. Morgan answered: "No, sir, we were not." However, she said she believed the McKesson-only survey started toward the end of 2003. That contradicted the accounts of AmerisourceBergen and Cardinal Health, who say they didn't provide pricing information in earlier years either.

McKesson says it never knew it was the only wholesaler being surveyed. "First DataBank has testified under oath in an earlier lawsuit involving other parties that it never told McKesson that at times McKesson was the only wholesaler being surveyed," a McKesson spokesman says.

Two months after Ms. Morgan's deposition, First DataBank sent a letter to its customers announcing an end to the survey. It said from that point forward it would "freeze" the last markup "provided through the wholesaler survey process."

Jobless Claims Fell In the Latest Week

WASHINGTON—The Labor Department said 302,000 people filed initial jobless claims last week, fewer than the 319,000 who had done so the previous week.

Changes in claims from week to week can be volatile and are frequently revised, but last week was the second consecutive week when initial claims for unemployment benefits decreased. The four-week moving average of initial claims, a better indicator of trends in employment, declined slightly to 313,500 last week from 316,250 the previous week.

These levels suggest the slowdown in the broader economy stemming from higher interest rates and the housing market correction has yet to create a significant increase in layoffs or unemployment. The Labor Department will release its September employment figures today.

Healthy Industry

In Medicaid, Private HMOs Take a Big, and Lucrative, Role

Managing Care for the Poor, They Prosper by Cutting Beleaguered States' Costs

Dr. Polack Seeks an Antibiotic

By Barbara Martinez

Some 55 million poor and disabled Americans are covered by Medicaid. With an annual price tag topping $300 billion, it's among the biggest government programs around.

It's also a lucrative business for some private companies that act as middlemen between the government and patients. Instead of directly paying the bills when a Medicaid patient goes to the doctor, state governments increasingly outsource the job to private contractors. More than one in three Medicaid beneficiaries now receive care through a private insurer.

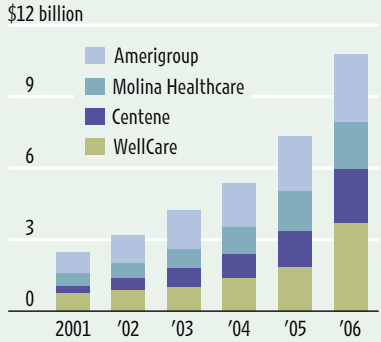
HEALTH-CARE GOLDMINES
Middlemen Strike It Rich
Fifth in a Series

The potential gains are big. Four years ago, a private-equity fund in which George Soros was the largest investor took a 70% stake in WellCare Health Plans Inc., a leading Medicaid health-maintenance organization. The fund finished cashing out the stake this August, bringing in a total of $870 million for an investment that originally cost $220 million.

Four of the biggest Medicaid HMOs—WellCare, Centene Corp., Molina Healthcare Inc. and Amerigroup Corp.—have seen their shares surge on the New York Stock Exchange over the past few years, although prices of the latter three have been volatile. WellCare's stock price has tripled since it began trading in July 2004, bringing the value of stock and options held by its chief executive, Todd S. Farha, to $77 million.

Seizing the Market

Combined annual revenue of some of the fastest-growing Medicaid HMOs:



Sources: the companies; Goldman Sachs

The companies are growing fast. Centene boasts nearly 1.2 million members and posted $1.5 billion in revenue last year. That compares with 142,000 members and $200 million in revenue six years earlier.

With the growth has come criticism from some doctors and patients who accuse Medicaid HMOs of scrimping on care. Even as they restrict medical tests and use of prescription drugs, the companies spend the money they get from states on items that don't have an obvious connection to patients. Centene has funded a multimillion-dollar arts center in St. Louis and paid to put its name on stadiums in Montana and Missouri. The HMOs are also big donors to political campaigns.

Executives say their profits are justly

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In State Medicaid Plans, Private HMOs Take a Big, and Lucrative, Role

Continued From First Page

earned and don't come at patients' expense. Traditional Medicaid is a fee-for-service program: The government pays each medical bill the patient racks up, with little or no effort to manage the costs. Medicaid HMOs, like other HMOs, seek to save money by eliminating unnecessary care and paying for preventive treatments. Centene Chief Executive Michael Neidorff says the company sometimes gives free child-safety car seats to pregnant women who attend all of their prenatal exams. "We save millions" by preventing premature births, he says.

Mr. Neidorff earned $1.85 million in salary and bonus last year and as of the end of last year held restricted stock valued at $26 million. The company also recorded $135,547 last year in compensation for Mr. Neidorff representing the value of personal trips he took on the corporate jet, a Bombardier Challenger that features an espresso machine on board, according to the lease agreement.

Centene spokesman Robert Schenk declined to say how much the company pays to lease the jet. He said the jet is needed because many of Centene's operations are hard to reach by commercial carriers, and the company's board requires Mr. Neidorff to use corporate transportation even on personal travel to ensure that he is secure and accessible.

Centene's business is managing the care of patients such as Melissa Bishop, 39 years old, of Phillipsburg, N.J. When she needed radiation for cancer near her pancreas this summer, she called Centene, her Medicaid HMO. She says she tried three facilities suggested by the company, but none of them were part of Centene's plan. "I was going round and round and round," says Ms. Bishop. "I was getting so aggravated."

Vickie Vickers

After she got an appointment at a fourth place, an administrator there told her it didn't accept her plan either. The administrator, Barbara Tofani of Hunterdon Regional Cancer Center in Flemington, N.J., says she called a dozen other centers in the region and struck out every time. Finally, Ms. Tofani called Centene and negotiated an ad-hoc deal to cover Ms. Bishop's treatment, although Ms. Tofani says the center will be lucky to break even.

Andrew Greenberg, Ms. Bishop's radiation oncologist, says that if it hadn't been for the special effort, "Melissa would have gotten lost in the system." Centene didn't provide comment on Ms. Bishop's case.

Each state runs its own Medicaid program but the majority of funding generally comes from the federal government. When states sign up HMOs to manage care, they often calculate what they would spend on Medicaid patients directly and pay the HMOs a per-patient premium below that amount. Florida, for instance, sets its HMO premium rates about 8% below what it would cost the state. WellCare, a big operator in Florida, says it saves the state $75 million a year. HMOs have an incentive to keep their costs under the premium because they keep the difference as profit.

Side Projects

Centene has bought stadium naming rights and made large donations:

BUILDING/OBJECT	LOCATION	AMOUNT PAID/GIVEN
Hanging eagle (airport sculpture)	Great Falls, Mont.	$7,000
Centene Stadium (baseball, Pioneer League)	Great Falls, Mont.	$200,000
Centene Stadium (high-school sports)	Clayton, Mo.	$400,000
Centene Center (performing arts auditorium)	Farmington, Mo.	$250,000
Centene Center for Arts and Education	St. Louis	Top donor to $9.5 million renovation

After several years of spiraling growth in Medicaid costs, there's some evidence that the tide is turning, although it's unclear how much HMOs have contributed. Total Medicaid spending grew in fiscal 2006 by just 2.8%, according to a report last month by the Kaiser Commission on Medicaid and the Uninsured. That was the lowest rate of growth since 1996. The commission said that for the first time in years many states aren't feeling pressure to cut people off Medicaid rolls.

Are Medicaid HMOs slashing necessary care to achieve cost savings and raise profits? Yes, says Jerry Flanagan, health-care policy director of a California group that wants to stop state governments from moving Medicaid beneficiaries into private managed care. "What's good for shareholders is bad for patients," he says. "What's really happening is we're giving less money for far, far fewer services."

Private companies "deliver a good-quality product at a reasonable price," counters Ruben Jose King-Shaw Jr., a former top federal Medicaid and Medicare official who joined WellCare's board in 2003. He notes that states often require private HMOs to achieve high rates of vaccination and other quality standards that weren't met when bureaucrats did all the work. Mr. King-Shaw, whose final annual salary in government was $142,500, has sold WellCare shares for $1.8 million. He owns shares and options valued at an additional $1.5 million. "You only do well in health care if you deliver value," he says.

States began experimenting with using managed care for Medicaid patients in the early 1980s, and the idea took off in the 1990s. Now many states are moving aggressively to put more Medicaid patients in HMOs. Last month, Ohio chose the winning bidders to provide Medicaid HMO services to 120,000 of the state's aged, blind and disabled population—a group that traditionally hasn't been placed in HMOs.

When states run their own Medicaid programs, they spend on average 4% to 6% on administrative costs, according to Martha Roherty, director of the National Association of State Medicaid Directors. The rest—94% to 96%—goes to paying for medical care. At Medicaid HMOs, only 80% to 85% of premium dollars generally go for medical costs. The rest covers other costs—including executive compensation, entertainment and political contributions—or becomes profit for shareholders.

States monitor the profit margins of Medicaid HMOs, which are generally reported as 5% or less. State officials say that with such a thin margin there's little room for further savings, although a review in New Jersey questioned whether one HMO was overcharging its subsidiary in the state for services. That could make the subsidiary's profits look lower.

While they spend fewer dollars on medical care, companies say they are more efficient and improve the health of patients. Elizabeth Douglas of Chicago says her 11-year-old son has kept up on his immunizations thanks to a WellCare program that gives her a free ride to the doctor's office.

Some patients and doctors have a different view. Kuldeep Singh, an internist in Valdosta, Ga., says that when Georgia began to move more than a million Medicaid recipients into HMOs this year, he suddenly faced hurdles not imposed by regular Medicaid. Recently, he says, one of his assistants had to wait on hold to get approval from WellCare for a hospital chest X-ray on a patient suspected of having pneumonia. "It was ridiculous," says Dr. Singh. A spokesman for WellCare says it sometimes requires such approval because hospital-based X-rays cost two to three times as much as those done in a doctor's office or imaging center.

Many doctors refuse to take patients in Medicaid HMOs because reimbursements are so low. (The same problem occurs in traditional Medicaid.) Noha Polack, a pediatrician in Union City, N.J., has an arrangement under which Centene pays her a fixed monthly sum per child to handle basic medical needs. Until a few months ago, that sum was $11.50 per month, equal to $138 a year—about half of what other Medicaid insurers pay, says Dr. Polack. A child who had a few colds or scrapes during a year would quickly put her in the red.

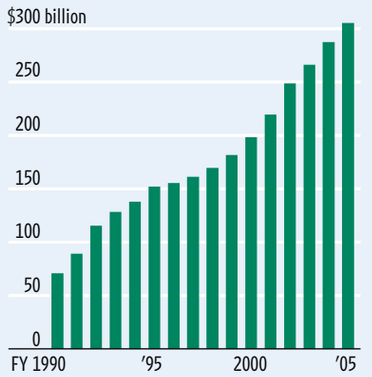
Dr. Polack threatened to drop all her Centene patients and recently got a raise—the amount of which is confidential, she says—but she still stopped accepting new Centene patients.

The HMO is stingy about drugs that others approve with little question, says Dr. Polack, naming the antibiotic Ceftin as an example. "Many times we have to make treatment decisions not depending on what would be best for the patient but what the patient can afford," she says. While she could ask for an exception to use Ceftin, "they are so notorious for not getting back to you" and there's little time when a child has an infection, she says.

Vickie Vickers, a 39-year-old Trenton, N.J., single mother on disability and Medicaid, learned about the difficulty of finding a doctor this year. She hurt her hand on Mother's Day while stooping to pick up playing cards that fell on the floor. She went to the hospital for a temporary cast but spent weeks with Centene trying to find an orthopedic doctor.

Expensive Item

Annual Medicaid spending:



Source: Kaiser Family Foundation

She finally found one an hour away. She says the orthopedist told her she needed an MRI or CT scan, but Centene wouldn't approve it. It took until late June for an orthopedist to fit her with a splint with metal bars.

Ms. Vickers rents a house in a rundown part of Trenton with a rusty fence outside and a leaky roof that has caused big water stains in the attic, bedroom, bathroom and kitchen. She wishes the old Medicaid were back because in the 1990s "you didn't have to call 50 doctors" to get an appointment.

Centene didn't provide comment on the complaints by Dr. Polack and Ms. Vickers.

Research on the quality of care in Medicaid HMOs is thin. A study of infant health last year by researchers at the University of Illinois-Chicago and the Urban Institute found that Medicaid managed care was correlated with a slight increase in inadequate prenatal care in some women but in general showed little difference from traditional Medicaid.

While some doctors and patients complain of Centene's stinginess, the company has been generous in regions where it has offices. Centene last year was the biggest donor for a $9.5 million renovation of an arts building in St. Louis, now called the Centene Center for Arts and Education, according to a spokeswoman for the center. The company paid $200,000 last year for the naming rights of a minor-league baseball stadium in Montana, where Centene employs 100 claims processors but doesn't have Medicaid clients. Centene also pledged $400,000 this year to the school district in Clayton, Mo., where the company has its headquarters, to rename the district's stadium.

Cynthia Schultz, director of the Great Falls International Airport in Montana, says Mr. Neidorff, the Centene CEO, once walked through the airport and heard that it couldn't afford artwork. Centene then commissioned and donated a $7,000 welded-metal sculpture of an eagle with a 16-foot wingspan that now hangs prominently in the airport, she says. The company confirmed the donation. "It's a great gift from someone who doesn't even live here," says Ms. Schultz.

Mr. Schenk, the Centene spokesman, said the donations show Centene is a "responsible and publicly focused corporation" and they help make the communities better places to live.

A few big U.S. insurers that serve large employers, including UnitedHealth Group and WellPoint Inc., also compete in the Medicaid HMO market. Many others don't. Medicaid HMOs assemble doctor networks in places with many people on Medicaid—such as big cities and poor rural areas—and deal with a single kind of customer, state governments. Those skills "are importantly different than what most commercial insurers have," says John W. Rowe, the former chief executive at Aetna Inc. and now a professor at Columbia University.

Medicaid HMOs have donated to candidates in state political races who support their existence. In 2005, five WellCare subsidiaries together donated $125,000 to Illinois Gov. Rod Blagojevich, a Democrat who won re-election this month. WellCare has 92,000 members in Illinois.

This year, 20 WellCare subsidiaries each donated the legal maximum of $500 to the campaign of Republican Tom Lee, who was narrowly defeated in his bid to become chief financial officer of Florida, WellCare's biggest market. WellCare donated $34,000 to the Republican Governors Association this year and contributed $100,000 to President Bush's second inaugural festivities in 2005.

"I call a governor, I usually get a call back within 24 to 48 hours," says Centene's Mr. Neidorff.

States keep track of the finances of Medicaid HMOs to ensure that the HMOs are spending a sufficient part of their revenue on medical costs. However, the numbers are subject to interpretation. A review of Centene's New Jersey subsidiary in 2004, by a unit of Marsh & McLennan Cos., said hundreds of thousands of dollars that Centene counted as medical costs should have been considered administrative costs.

The report also questioned cases where Centene's New Jersey subsidiary pays a national Centene subsidiary for specialized services such as mental-health or a nurse hotline. It said the New Jersey subsidiary was paying an above-market rate for some of these services. That would tend to increase the state subsidiary's medical costs and reduce its profit, without affecting the bottom line of Centene as a whole. Mr. Schenk of Centene declined to discuss the report in detail but said Centene has used the findings "to strengthen its operational efficiencies."

In Illinois, the state and the Justice Department asserted in a lawsuit that Amerigroup spent only $131 million on medical care from 2000 to 2004 despite taking in $243 million from the state. The lawsuit accused Amerigroup of fraudulently trying to exclude pregnant and sick patients to reduce its medical costs. A jury in Illinois state court agreed last month, finding Amerigroup liable to the government for $144 million. Internal Amerigroup emails filed in court show managers contemplated disciplinary action for employees who signed up women in the third trimester.

Amerigroup said it will appeal. The company says it discouraged transfers by pregnant women so their care wouldn't be disrupted. A spokesman said the figures in the suit are "extremely misleading," in part because they don't account for preventive health programs.

—Raymund Flandez contributed to this article.

Health-Care Gold Mines: Middlemen Strike It Rich

This article is the fifth in a series. Earlier articles:

- 'As Patients, Doctors Feel Pinch, Insurer's CEO Makes a Billion,' April 18
- 'Selling Generic Drugs by Mail Turns Into Lucrative Business,' May 9
- 'Health-Care Consultants Reap Fees From Those They Evaluate,' Sept. 18
- 'How Quiet Moves by a Publisher Sway Billions in Drug Spending,' Oct. 6