

DRUG BENEFIT NEWS

News, Data and Business Strategies for Health Plans, Employers, PBMs and Pharma Companies

Contents

- 3** PBM Employee Plans Use New Tactics to Manage Drug Costs
- 3** Table: PBMs Incentivize Mail Order in Employees' Drug Benefit Design
- 4** Ohio Purchasing Group Delivers 10% Rx Savings to New Employers
- 5** PBMs Push Mail Order, but Retail Volume Is Growing Faster
- 6** Wal-Mart Adds More Employers to Its Retail Pharmacy Program
- 8** News Briefs

Health Reform Update

House Bill's Part D Rx Price Negotiation, PBM Disclosure Mandate Likely Won't Pass

Pharmacy-related provisions in the version of H.R. 3200, "America's Affordable Health Choices Act," approved July 31 by the House Energy and Commerce Committee, could make sweeping changes to pharmacy benefit plans, particularly those for Medicare beneficiaries. But some provisions — such as ones authorizing HHS to negotiate Medicare Part D drug prices and requiring PBM disclosure of payment data — aren't likely to be included in the final bill, some experts predict. Other provisions, such as a measure that would eliminate the Part D coverage gap, are more likely to win passage.

The comprehensive health care reform bill also would establish a standard benefit package and a health insurance exchange, create a pathway for FDA approval of bio-similar drugs with 12-year data exclusivity (*DBN 7/3/09, p. 1*), increase drug companies' rebates to the Medicaid program, and prohibit brand-name drugs from reaching pay-to-delay settlements with generic drug makers (*DBN 7/3/09, p. 8*).

During the August recess, versions of the bill approved by the Energy and Commerce, Ways and Means, and Education and Labor committees will be merged into a single bill for consideration by the full House of Representatives when it returns Sept. 8.

Among the key drug-related provisions:

(1) Medicare drug price negotiation: Under an amendment proposed by Rep. Jan Schakowsky (D-Ill.), "the Secretary [of HHS] shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged" to Medicare Part D plans for covered drugs.

continued on p. 6

Payers Use Generic Promotions, Formulary Placement to Counteract Copay Waivers

Health insurers say they are growing increasingly concerned about drug producers' practice of waiving copayments to incentivize members with commercial insurance to use brand-name drugs. Payers say they don't yet know the impact of such programs, but one health plan is launching a study to identify how widely used such waivers are, while another uses contract provisions to try to guard against program costs being passed on to payers.

Copay waiver programs, highlighted in a July article in *The Wall Street Journal*, are more common for specialty pharmaceuticals, but are used increasingly often for brand-name drugs. For example, AstraZeneca offers a copay waiver program for its statin drug Crestor. The program limits out-of-pocket costs to no more than \$25 per month for patients with commercial drug coverage. Similarly, Pfizer Inc. supplies patients with a copay card for its statin Lipitor. A company Web site explains that "if your insurance copay is \$35 or greater, you can instantly receive \$15 toward your copay, up to 12 times per year (\$180 in savings)."

continued

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"We're concerned that these sort of copay subsidies could really impact the health and safety of our members," says Brian Sweet, chief pharmacy officer at WellPoint, Inc. The insurer places some drugs on higher formulary tiers "because the drug lacks evidence that it actually works...and/or because there may be safety issues that make it less safe than other therapeutic alternatives." But the drug companies offering copay waivers don't take such issues into account, he contends.

He cites as an example short-acting beta-agonists, used as a "rescue" medication for asthmatics. "We're trying to advocate controller medications, not rescue medications" for asthmatics. "Yet a copay waiver program may actually encourage...overuse and may actually cause negative health consequences."

For example, GlaxoSmithKline offers a coupon on its Web site for the short-acting beta-agonist Ventolin. The drug company will cover up to \$15 per prescription to

defray copays for patients with commercial insurance, with a limit of four refills per year.

Another concern is the effect of such programs on affordability and cost, Sweet says, particularly since the copay waivers last for a limited time period, and "then the member may go back to the higher cost" when the program is phased out.

In addition, copay waiver programs could be contributing to the overall rising cost of drugs, says Helen Sherman, Pharm.D., chief pharmacy officer at RegenceRx, the PBM division of The Regence Group, which operates Blue Cross and Blue Shield plans in the Northwest. "Are the pharma companies truly absorbing the costs of the copays, or will the overall costs of the drugs be increased?"

But she emphasizes that "anything that lowers the cost of drugs is a good thing, so we don't necessarily see these copay waiver programs as positive or negative at the starting point."

One major PBM dismisses the impact of such programs on it. The practice by drug companies of offering copay waiver programs "is a very bad thing to do because...it takes prudent behavior out of the system, and just generally speaking, I think, should not be allowed," said David Snow, CEO of Medco Health Solutions, Inc., speaking during a July 29 conference call to discuss second-quarter 2009 financial results. But he added that "it really hasn't affected Medco, because for the most part these programs are being offered in the biotech space more so than the chemistry space where the real generic waste is occurring."

WellPoint Examines Impact

It's unclear how many copay waiver programs exist and how popular they are, Sweet says. "It does seem as if there are more on the market now than before — but I can't put a number on it, which is part of the reason why we're going to be looking at our data." WellPoint's HealthCore subsidiary, which performs health outcomes research, is examining the impact of copay subsidies on cost and quality of care for its members, he explains.

One complicating factor is that the claims submitted by pharmacies may not make it clear whether a copay coupon was used, Sweet says. "It very much depends on how the [drug company] sponsor sets up the adjudication logic."

The drug company typically uses a claims processor to administer coupon claims, and supplies a bank identification number (BIN) on the coupon itself. "Depending on how the pharmacist submits to that BIN number and sends it back to the plan," the copay may appear on the health plan claim to have been paid in cash or paid using a coupon. "So there's not a consistent methodology," he says. "That's part of our research right now, understand-

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ing what other ways we can look at our data and work with our pharmacies" to assess the impact.

Another line of defense is for the health plan to try to protect itself against drug companies passing the costs of copay waiver programs onto payers in the form of higher drug prices. That's something RegenceRx is "watching very closely...in our contracts with pharma companies," Sherman says. "We look at CPI [i.e., the consumer price index], and we look at [drug] trend over time. We look at the average and if there is any product spiking higher than that trend." For example, if most drug prices are rising 8% and one shoots up 25%, "that is a red flag — and that happens."

RegenceRx uses a clause in its contracts with drug companies to protect against sudden increases. "As an example, if a price increases over a certain percentage point, the pharma company will then discount our rebate by X portion." She adds that "it's generally tied to a cap on increases which we feel are reasonable for the marketplace."

PBMs Use Generic Promotion

Health plans' generic promotion and substitution programs are another effective tool, payers say. After all, WellPoint's own generic copay waiver program "certainly gets the member's attention, because it lowers their out-of-pocket costs," Sweet says.

The Regence Group uses step therapy to prevent patients from moving to drugs like Lipitor that have copay waiver programs, Sherman says. RegenceRx members would qualify for Lipitor only "in cases where a high level of cholesterol lowering would be needed... So for our members, ...once they've reached Lipitor, all the other higher-value options [such as generic statins or Crestor, which is a preferred formulary drug] have been ruled out. So as long as Pfizer hasn't inflated the drug prices — which is something that we watch — it might not be a bad thing" to have a copay waiver program, she says.

Although drug companies launch such programs on a drug-by-drug basis, it's not feasible for a PBM or payer to make benefit design changes to respond to campaigns for a particular drug, says Michael Cartier, chief clinical officer at Twinsburg, Ohio-based PBM Envision Pharmaceutical Services. "While we have been supporting greater [tier] differentials in the aggregate, to do it on a drug-by-drug basis becomes one of those difficult processes to maintain," particularly since copay waiver programs are for a limited duration and may only operate in certain parts of the country.

Health plans also analyze the pipeline in an effort to track new copay waiver programs. "I do think it is possible to predict" where drug companies will focus resources next, says Nancy Cotter, manager of clinical pharmacy programs at Blue Cross and Blue Shield of Florida.

"Blockbuster drugs that are nearing the end of their patent life are high on the list," she says, as are "new-to-market drugs that are in an already-crowded therapeutic class in which they are trying to differentiate themselves from existing brands." She cites as an example Abbott Laboratories, which "has begun couponing their new fibrate, Trilipix. They are trying to move market share from their other brand fibrate, Tricor, to their newer product."

After all, she says, copay waiver programs are "a big issue today, and will become bigger as manufacturers lose more money due to patent expirations."

Contact Cotter through Florida Blues spokesperson Mark Wright at mark.wright@bcbsfl.com, Regence spokesperson Samantha Meese for Sherman at sxmeese@regence.com or Sweet through WellPoint spokesperson Lori McLaughlin at (317) 488-6898. ♦

PBM Employee Plans Use New Tactics to Manage Drug Costs

Just as PBMs provide pharmacy benefits to their members, they have to create plans for their employees that balance low drug costs and worker satisfaction. Four major PBMs (one of them a unit of a health plan) told *DBN* that the strategies they use to manage this balancing act include testing new cost-saving strategies on employees, providing incentives for filling mail-order prescriptions and mandating prior authorization for drugs with generic alternatives. As a result, each of the four companies, with the exception of Medco Health Solutions, Inc., says it has been able to achieve a lower rate of drug spending on its employees versus its members as a whole.

Tim Humphreys, vice president of operations at HealthTrans, says PBM employees can serve as models to understand consumer behavior. His company and Express Scripts, Inc. both test new strategies in their benefits programs on their employees to get a sense of how

PBMs Incentivize Mail Order in Employees' Drug Benefit Design*			
	Generic	Preferred Brand Name	Non-Preferred Brand Name
Medco Health Solutions, Inc.	\$10 retail \$0 mail order	\$25 retail \$30 mail order	\$40 retail \$50 mail order
The Regence Group	\$5 retail	\$25 retail or 25%, whichever is greater	\$45 or 50%, whichever is greater
HealthTrans	\$5 retail \$0 in-house pharmacy \$0 mail order	\$30 retail \$30 in-house pharmacy \$60 mail order	\$50 retail \$100 mail order
SOURCE: Compiled by Atlantic Information Services, Inc.			
*All retail amounts represent copayments for 30-day supplies, while mail-order amounts are for 90-day supplies.			

successful such design plans will be on their members in lowering costs. HealthTrans, for example, soon will be conducting health screening to test employees for conditions such as high blood pressure and high cholesterol. It will use the data to adjust its pharmacy benefit design. While the company plans on incurring huge up-front costs with the program, "if we can manage these conditions, going forward we can reduce costs over time," Robert Shofi, vice president of human resources, tells *DBN*. "Through these types of activities, we can encourage our client groups to take similar steps because we can prove...that we can reduce our overall costs."

Express Scripts also conducts pilot studies on its employees to see what drives behavior. "We're taking advantage of our own employee population on [testing new design plans] as soon as they're available with pretty much anything we're working with clients on," says Matthew Herzberg, vice president of human resources.

Along the same lines, Medco believes that if it's a good benefits program for its clients, then it should also be applied to the PBM's employees, according to Ed Redling, vice president of compensation and benefits. He attributes Medco's higher rate of drug spending to employee compliance with taking preventive medications.

Each of the four PBMs has a three-tier formulary structure as part of its employee benefit design. As with their members, the PBMs encourage their employees to use first-tier medications by offering lower, or in some cases zero, copayments for such drugs. Most of the PBMs also consider formulary exceptions for their employees on a case-by-case basis. Medco employees, for example, have the opportunity to petition for lower copays for non-formulary drugs through the company's appeals system. If approved, the copay is reduced to the second-tier brand amount.

Regence Uses Prior-Authorization Process

On the other hand, health plan operator The Regence Group has a prior-authorization process for medications that have a generic alternative. According to Regence spokesperson Samantha Meese, the company's employees also have a slightly lower out-of-pocket annual maximum than is used in its standard group plans.

With the exception of Regence, all of the PBMs said requiring or incentivizing the use of mail-order services for their employees contributes to significant savings on drug costs. Express Scripts, for example, requires the use of mail order for its employees taking maintenance medications for chronic conditions.

Because it has a mail-order pharmacy on site, HealthTrans offers its employees a zero copay for using home-delivery services for generic drugs. "Essentially,

this is less costly for us and a great deal for our employees," Humphreys says.

Similar to Express Scripts, Medco uses retail refill allowances, as well as a "members-pay-the-difference program," to incentivize its employees to use mail order for drugs. For example, Redling says, generic maintenance medications have a two-refill limit at retail and, after that, the member is responsible for the entire medication's cost unless they use mail order. If employees choose to use a brand-name drug, they are required to pay the difference between the generic copay and the cost of the branded drug. "This balances the company's imperative to achieve the highest value and the desire of some patients for broader choice," Redling adds.

Contact Jennifer Luddy for Redling at (201) 269-6402, Laura Casanova for Humphreys at lcasanova@healthtrans.com and Missy Britan for Herzberg at (202) 530-4531. Contact Meese at (503) 225-5332.↵

Ohio Purchasing Group Delivers 10% Rx Savings to New Employers

As purchasing pools grow in size, so does the level of savings they're able to deliver to employers that previously used independent PBMs or those owned by their health insurers. One example is Ohio, where a purchasing pool expects to reach 500,000 participants by Jan. 1, 2010, and reports saving some employers 8% to 10% on Rx costs.

The Rx Ohio Collaborative (RxOC, pronounced like "the Rock") recently became available to all Ohio public-sector entities, including government, school-district and higher-education employers, and now has about a dozen participants. The RxOC started in January 2008 as a collaboration between The Ohio State University (OSU), the Ohio Public Employees Retirement System, the School Employees Retirement System of Ohio and the State Teachers Retirement System of Ohio (*DBN* 9/14/07, p. 1).

"We've identified others that are going to be beginning with us Jan. 1, 2010," says Scott Streator, CEO and executive director of OSU Managed Health Care Systems, Inc., which manages health benefit plans for OSU and other groups and houses the RxOC. "We expect to see 500,000 lives total, but would rather not disclose those [new employers]."

The purchasing pool has added 100,000 lives over the past year. OSU and the state retirement systems are by far the largest members, but "the beauty of the RxOC is we're able to allow small employers, such as Belmont County (2,000 lives), Seneca County (700 lives) and Columbus City Schools (16,000 lives) to benefit from the volume discounts," explains OSU Managed Health Care Systems spokesperson Joni Bentz Seal.

Among the RxOC's most recent additions is Wright State University, which moved from WellPoint, Inc.'s NextRx PBM to the RxOC effective July 1. Wright State projects savings of more than \$300,000, or about 9% of its \$3.3 million annual pharmacy spending, with the RxOC. The savings figures were estimated by an independent third party, says Patti Nussle, strategic pharmacy development director at OSU Managed Health Care Systems.

Wright State is "about a 4,000-life university here in Ohio," she tells *DBN*. "They were just so surprised at what their estimated drug savings were going to be. I said that's because you're getting 400,000-life pricing, not 4,000-life pricing." Under the contract with Express Scripts, Inc., which provides PBM services to the RxOC, public-sector employers also receive 100% of drug-company rebates.

The pharmacy cost savings figures are driven primarily by lower unit costs rather than by pharmacy benefit design changes, says Diane Brake, a sales director at Express Scripts. "A lot of it is based on aggressive pricing," she explains. Depending on the employer, "I see savings from 5% to 7% all the way up to 20%... just depending on what kind of contract they have with the carrier PBM."

Employers participating in the RxOC are not expected to adopt a standard formulary or pharmacy benefits design, Streater tells *DBN*. That's one concern that state agencies have when considering the model. "Any time a large purchasing organization says, 'Hey, we want to help others,'...the concern is, 'Oh, it's Big Brother,'" he says. "The usual perception is, 'Oh, you're going to tell me how the plan design is going to be, and you're going to tell me what to prescribe.'"

Instead, "just like any other Express Scripts client, they have the ability to select their network, and they have the ability to completely design their benefit to their liking," says Kim Frericks, director of the RxOC's client and member services.

"Every group is looked at individually because some of them have unions within them," Brake explains. "Even though the union piece is smaller, they drive what the benefits are going to be" for the entire employer group.

Newer groups also can build on the experience of the four founding employers, modeling pharmacy benefit design changes the original groups have implemented

PBMs Push Mail Order, but Retail Volume Is Growing Faster

PBMs are continuing to urge customers to use mail order for maintenance medications, because it both reduces costs for payers and boosts earnings for the PBMs themselves. But the percentage of prescriptions filled at retail pharmacies is growing at a faster rate. For example, Medco Health Solutions, Inc. reported a 13.5% increase in total adjusted prescription volume during the second quarter of 2009, driven by significantly higher retail prescription volume among new clients. That caused a drop in the company's adjusted mail-order penetration rate. CVS Caremark Corp.

said its mail-order penetration rate fell over the past year, partly because of its Maintenance Choice program, which allows members to pick up a 90-day supply of maintenance medications at any CVS/pharmacy store. Those prescriptions are reported as retail claims, the company said. Express Scripts, Inc. said it had lower mail-order claims volume during the most recent quarter compared with the year-ago period, and attributed the lower rate to "the loss of low-margin clients." Here are some key measures from the three big PBMs' second-quarter 2009 financial reports:

	Medco Health Solutions, Inc.		Express Scripts, Inc.		CVS Caremark Corp.	
	2Q09	2Q08	2Q09	2Q08	2Q09	2Q08
Total adjusted prescription volume*	224.9 million	198.1 million	125.5 million	127.9 million	164.1 million	151.3 million
Adjusted mail-order penetration rate*	34.4%	39.7%	17.4%	17.6%	22.9%	23.5%
Overall generic dispensing rate	67.3%	63.7%	69.2%	67.0%	67.8%	64.5%
Net income	\$312.1 million	\$262.7 million	\$192.3 million	\$190.2 million	\$886.5 million	\$774.8 million
Earnings per share	\$0.64	\$0.51	\$0.74	\$0.75	\$0.60	\$0.53

* Mail-order prescription figures are adjusted for the difference in days of supply between mail order and retail.

SOURCE: Compiled by Atlantic Information Services, Inc. from company financial reports and AIS calculations.

and getting advice on “how to negotiate with the unions to get them through,” Brake adds.

Contact Seal at (614) 292-4405 or Express Scripts spokesperson Erin Mohan at (314) 684-6310. ✦

Wal-Mart Adds More Employers To Its Retail Pharmacy Program

Wal-Mart Stores, Inc. says it has added more employers to the pharmacy fulfillment program it launched with Caterpillar Inc. last fall. The retail giant also is piloting a mail-order pharmacy service in Michigan, but says it won't integrate the two until it sees results from the mail-order program. Wal-Mart maintains that it's not planning to jump into the PBM business, however.

Mike Struhs, director of business development at Wal-Mart Health and Wellness, tells *DBN* that the new employer clients are a “variety of sizes in different parts of the company,” although he declines to name specific companies. The Wal-Mart Health Solutions Affordable Prescription Program is aimed at “providing [pharmacy] pricing directly to the payers, whether that be self-insured employers or health plans.” He declines to say whether any of the new clients are health plans.

Under the Caterpillar program, the employer's 70,000 workers, retirees and dependents can fill generic drugs for free at Walmart stores and obtain generics at other pharmacies for the normal \$5 copayment (*DBN* 4/10/09, p. 1). The deals with other employers are “similar in the fact that the employer has an incentive to encourage their employees to use Walmart pharmacies because of the preferred pricing at Walmart,” Struhs says. “So they do modify their plan design in some ways.”

But the employers maintain their relationships with PBMs. “This program is all about passing on savings and hopefully adding efficiencies and access to the system,” Struhs emphasizes. “This program is not about claims processing.” He says Wal-Mart is not offering to perform claims adjudication, pharmacy network management or other traditional PBM services.

“Wal-Mart, from my perspective, is not out to become a bigger PBM, but instead to change the nature of the relationships that currently exist within the payer/manufacturer/PBM/beneficiary relationship,” says Adam Fein, Ph.D., president of Pembroke Consulting, Inc., a Philadelphia-based management advisory and business research firm, and the author of the *DrugChannels.net* blog. “What Wal-Mart is doing here is they are trying to attack a fundamental profit source for PBMs without becoming a PBM themselves.”

There are many Walmart locations in Illinois, where Caterpillar employees are primarily based. Struhs says

“this program works for any employer who may have employees who are generally close to a Walmart. That doesn't always mean that it's their corporate office employees — it could be plant locations.” Wal-Mart has 4,100 pharmacies across the country, including 500 in Sam's Club warehouse stores.

Wal-Mart is continuing to use a cost-plus pricing methodology in its employer contracts, as it did with Caterpillar. “We based it on what we pay for a drug, and then we have a proprietary formula for the drug which we apply to cover our costs for overhead and pharmacists' salaries and electric bills. . . and come up with the cost that the employer will pay for that drug,” he says.

“The amount of savings [employers get by making Wal-Mart the preferred pharmacy] can vary on an employer-by-employer basis, depending on their mix of drugs and what they're currently spending,” Struhs says. “We typically find we can save employers about 30% to 35% on generic drug costs and usually some savings on brand drugs as well.”

Wal-Mart also launched a pilot mail-order program in May 2009 under which Michigan residents can get a 90-day supply of any of 300 generic prescriptions for \$10, including delivery. The goal is to expand access to Walmart pharmacies “whether or not they live close to a Walmart pharmacy location,” the company explained. The free mail delivery program also includes 3,000 other brand and generic prescriptions through Wal-Mart's Dallas-based mail-order facility.

The company has offered a ship-to-home pharmacy program for several years, Struhs says, but it has not yet been incorporated into the Employer Solutions program offered to payers. “I don't think that the decision would be made until we know the effects of the pilot program,” he adds.

Contact Struhs through Wal-Mart spokesperson Christi Gallagher at christi.gallagher@wal-mart.com or Fein at afein@pembrokeconsulting.com. ✦

Some Drug Provisions May Not Pass

continued from p. 1

The bill does not require the Part D program to move to a standard formulary, however. “In order to get the best prices, there has to be steerage to certain products or consequences to manufacturers that their products not be used,” says Helen Sherman, Pharm.D., chief pharmacy officer at RegenceRx, the PBM division of The Regence Group, which operates Blue Cross and Blue Shield plans in the Northwest. Individual Part D plans use tools such as formulary placement or utilization management to reward drug companies for giving the best price, she explains. But HHS will have no incentives to offer drug com-

panies — and thus no bargaining chip to use to achieve better prices than PBMs and plans already negotiate.

The Congressional Budget Office (CBO) has not projected any significant savings associated with directing HHS to negotiate drug prices, notes William Hermelin, director of government affairs and general counsel at the Academy of Managed Care Pharmacy (AMCP). “So it’s kind of concerning... that you would try to make a fundamental change to the program where there’s nothing on the record — other than, I guess, the intuitiveness that some members of the Democratic party have that this will save more money,” he says. Hermelin predicts that the provision will not be included in the Senate Finance Committee bill.

(2) *Closing the Medicare “doughnut hole.”* H.R. 3200 calls for phasing out the Medicare Part D coverage gap, which in 2009 starts when total drug spending reaches \$2,700 and ends when out-of-pocket expenses reach \$4,350. From 2011 to 2023, HHS would increase the initial coverage limit and decrease the catastrophic coverage threshold until the coverage gap is eliminated.

Higher Utilization Seen as Likely

For Part D plan sponsors and administrators, the impact of the plan-design change would be “fairly modest,” said Steve Arbaugh, a principal with ATTAC Consulting Group, LLC, who spoke at an Aug. 6 AIS audioconference on Medicare Part D reform proposals. Part D plans likely will see higher utilization as beneficiaries incur lower out-of-pocket costs. That in turn will increase the number of members who qualify for Medication Therapy Management Programs, he added, particularly as the spending threshold for eligibility drops to \$3,000 in 2010 (*DBN 5/29/09, p. 3*).

It’s still unclear whether plans, beneficiaries or the government will foot the bill for closing the coverage gap, says Sherman. “That money has to come from somewhere, whether it comes from a change in copays or from bigger up-front deductibles or whether it comes from the Medicare system [itself]... It probably will be a combination of all of those.”

The Energy and Commerce bill also outlines the agreement by trade group Pharmaceutical Research and Manufacturers of America (PhRMA) to defray seniors’ drug expenses in the Medicare Part D “doughnut hole” coverage gap (*DBN 7/3/09, p. 3*). Under that deal, pharmaceutical and biotechnology companies agreed to provide most beneficiaries with a 50% discount on covered brand-name drugs when purchased in the doughnut hole.

The discount would be applied in the form of a “special rebate” to customers, explained Susan Hayes, a principal and founder of Pharmacy Outcome Specialists, who also spoke at the AIS audioconference. “The plan sponsors

are going to be responsible for submitting claims data to the manufacturers, and then getting the rebates back.”

Arbaugh predicted that the Senate Finance Committee’s forthcoming bill also is likely to “to incorporate the 50% discounts through the doughnut hole.”

PhRMA Stands by White House Deal

Although PhRMA criticized the Energy and Commerce Committee’s decision to support Medicare drug price negotiation, it reportedly is standing by its White House-brokered deal to provide the 50% doughnut-hole discount, and will continue to advocate for health care reform, including funding a series of pro-reform ads.

(3) *PBM disclosure rules:* Another provision would require PBMs to disclose price and other financial data. The amendment, proposed by Rep. Tammy Baldwin (D-Wis.), would allow PBMs to contract with health plans operating in the proposed exchange only if the PBM agrees to report certain data.

Annual reports would include the estimated aggregate average payment per prescription made by the PBM to retail and mail-order pharmacies and the average payment per prescription that the PBM received from the plan. PBMs also would have to disclose the estimated aggregate average payment per prescription received from drug companies, “including all rebates, discounts, price concessions, or administrative and other payments,” with a description of each type of payment and the amount that was shared with the plan.

The Pharmaceutical Care Management Association criticized the amendment, warning that “public disclosure of sensitive pricing information could result in drug manufacturers being made aware of their competitors’ negotiating strategies and raising prices accordingly.”

CVS Caremark Corp. CEO Thomas Ryan told investors he thought it unlikely that the disclosure provisions would be in the final bill. Speaking during an Aug. 4 conference call to discuss second-quarter 2009 financial results, he predicted that when the CBO “scores this, I’m not sure it will survive.”

But Arbaugh calls the disclosure provisions “fairly modest,” and predicts that they “will probably be included in the final markup of the House bill.”

Contact Regence spokesperson Samantha Meese for Sherman at sxmeese@regence.com, Hermelin through AMCP spokesperson Neal Learner at nlearner@amcp.org, Arbaugh at sarbaugh@attacconsulting.com or Hayes at susan.hayes@pharmout.com. ✦

To purchase a recording of the Aug. 6 audioconference on “Medicare Part D Reform: Strategies to Prepare for Potentially Enormous Changes in 2010,” please call (800) 521-4323 or visit www.AISHealth.com, and click on MarketPlace.

NEWS BRIEFS

◆ **The state of New Jersey said Aug. 11 that it selected Medco Health Solutions, Inc. to provide PBM services for state employees starting Jan. 1, 2010.** The State Department of Treasury's Division of Pensions and Benefits said the \$5.82 billion, five-year contract will save New Jersey taxpayers about \$540 million. The contract covers active and retired public workers and dependents in the State Health Benefits Program and the School Employees Health Benefits Program, with about 670,000 enrollees who receive coverage. This is the first time the state has carved out pharmacy benefits into a separate contract. Call spokesperson Robert Corrales at (609) 777-2600.

◆ **Catalyst Health Solutions, Inc. said its Catalyst Rx subsidiary acquired PBM Total Script for an undisclosed price.** Total Script, which serves small to midsize employers in the Midwest and manages pharmacy benefits for about 50,000 people, will extend Catalyst's presence in "a number of key markets and complements our efforts to work locally with self-funded groups." Catalyst also says it recently added "dozens of new clients," including the Hawaii State Teachers Association Voluntary Employees Beneficiary Trust. Contact Catalyst spokesperson Hai Tran at (301) 548-2900.

◆ **Three senators are urging the Federal Trade Commission (FTC) to re-examine the 2007 merger that formed CVS Caremark Corp.,** according to a letter sent to the FTC July 28. Sens. Byron Dorgan (D-N.D.), Russell Feingold (D-Wis.) and Amy Klobuchar (D-Minn.) said they've been hearing from constituents that the pharmacies they rely on are at a competitive disadvantage and are concerned the merger will drive independent pharmacies out of business. In the letter, the senators said only four large companies are now handling reimbursement of most prescription drug claims. The complaint followed a similar letter sent July 23 by Sens. Mark Pryor (D-Ark.) and Roger Widker (R-Miss.), who asked the FTC to take appropriate action if CVS Caremark engages in any anticompetitive practices. Last month, the FTC referred a similar complaint brought by the National Community Pharmacists Association to its Bureau of Competition (*DBN 7/3/09, p. 8*). In response, CVS Caremark spokesperson Christine Cramer says, "Any suggestions that our business practices are anti-competitive...are totally false." See the letter at tinyurl.com/mhvbeu.

◆ **The Arizona Department of Administration awarded MedImpact Healthcare Systems, Inc. a PBM contract** to provide cost-effective services for the state's more than 130,000 workers and retirees. The contract, previously held by Walgreens Health Initiative, takes effect Oct. 1 and covers a range of pharmacy benefit services, including new consumer and clinical programs. MedImpact also says it renewed its contract with Health Alliance Plan (HAP) to provide pharmacy benefit services for commercial and Medicare Part D business. Contact MedImpact spokesperson Dawn Anderson at (858) 790-6684.

◆ **The government said it will not intervene in a lawsuit accusing AstraZeneca PLC and Bristol-Myers Squibb Co. of bribing Medco Health Solutions, Inc. to purchase their drugs and then hiding the price discounts.** The suit was brought by Karl Schumann, a former vice president of Medco, on behalf of the U.S. government, 11 states and the District of Columbia. Schumann originally filed suit in the U.S. District Court for the Eastern District of Pennsylvania in 2003, under a seal granting him whistleblower protection. Because the government declined to get involved, the suit was unsealed in June and presented to AstraZeneca and Bristol-Myers last month, Dow Jones Newswire reports. According to the suit, Bristol-Myers wanted Medco to buy its anticoagulant drug Coumadin for use in Medco's mail-service pharmacies, rather than cheaper generic versions. The suit alleges that Bristol-Myers incentivized the PBM by offering it a steep discount using "sham rebates and data fees." AstraZeneca is being accused of using a similar strategy to persuade Medco to purchase heartburn drugs Prilosec and Nexium, and of hiding price discounts from the government. Drug maker DuPont Co. also was named as a defendant in the lawsuit for marketing Coumadin. AstraZeneca, Bristol-Myers and Medco did not respond to requests for comment by *DBN* press time.

◆ **PEOPLE ON THE MOVE:** American Health Care named **Paul Allen** chief operating officer. He previously was vice president of sales, marketing and account management for Rite Aid Health Solutions... Silverlink Communications Inc. appointed **Jan Berger, M.D.**, chief medical officer. She was senior vice president and chief clinical officer for CVS Caremark Corp.

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