

# DRUG BENEFIT NEWS

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

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## CIGNA, Health Alliance Launch Programs With Drug Firms Based on Rx Performance

The era of money-back-guarantees for pharmaceuticals appears to have arrived. Two health plans in April unveiled apparently unique programs that require drug manufacturers to back up product claims with financial guarantees. Pharmacy executives tell *DBN* that so-called "performance-based" contracts — that link reimbursements and other payments to how well the therapy performs — could soon spread throughout the industry, especially as health-reform and comparative-effectiveness initiatives gain traction.

The latest move comes from CIGNA Corp., which has been seeking to implement performance-based Rx programs for the past several years (*DBN* 8/3/07, p. 1). In a deal unveiled April 23, CIGNA said that Merck & Co., Inc. would provide additional discounts on its oral diabetes drugs Januvia (sitagliptin) and Janumet (sitagliptin/metformin) based on members reaching benchmarks for Rx compliance and improved blood-sugar levels.

And on April 14, Health Alliance Medical Plans, Inc. unveiled a program under which drug firms Procter & Gamble Pharmaceuticals (P&G) and sanofi-aventis will cover medical expenses of members who suffer bone fractures while taking the osteoporosis drug Actonel (risedronate) correctly.

*continued on p. 6*

## Expected 340B Pharmacy Rule May Open Discounted Drug Prices to More Rx Payers

HHS is expected soon to issue a final rule that would allow safety-net hospitals and health clinics to dispense deeply discounted so-called 340B pharmaceuticals at multiple pharmacies — a move that some Rx payers are eyeing as a means to lowering their own drug spending. Under current regulations, 340B-qualified entities are required, in most cases, to dispense outpatient drugs from an on-site pharmacy or a single contract pharmacy. Establishing multiple 340B pharmacies, sources tell *DBN*, would not only offer convenience for 340B patients, but also could allow some employers and health plans to tap 340B pricing, which is roughly 50% below average wholesale price (AWP).

The drug discounts are part of Section 340B in the Public Health Service Act. Under the law, pharmaceutical manufacturers that sell drugs to 340B "covered entities" agree to charge prices based on a statutory formula, according to the Health Resources and Services Administration (HRSA), a unit of HHS that administers the program.

Covered entities include "disproportionate share hospitals," which serve large proportions of indigent populations, and "federally qualified health centers," which provide care for the poor. The program aims to help lower costs to providers that serve these populations.

Eligibility for 340B drugs, however, is not determined by a patient's income level, but rather by the fact that an individual is a patient of a 340B entity. In some cases, employees with generous health insurance and Rx coverage already have their "medical homes"

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at 340B entities, and may not be aware of that fact. Such is the case at the University of Michigan, where roughly half of the university's staff receives its medical care from UM Hospitals and Health Centers (UMHHC), which qualifies under 340B.

Last year, roughly 150 UM members participated in a 340B specialty pharmacy program at UMHHC, resulting in 2008 ingredient cost savings of approximately \$891,000, or about \$610 per prescription. That's according to a February 2009 UM proposal to expand the 340B program, as well as UM's "own use" pricing program, which is another federal discount pricing tool available to nonprofit institutions.

Fully utilizing the 340B program at UM has been hampered by limitations of UMHHC's pharmacies, and by the fact that most UM members fill their prescriptions at community pharmacies, according to Keith Bruhnson, manager of UM's prescription drug plan. UM is seeking HRSA approval for an alternative method demonstration

project (AMDP) that would allow for the establishment of a 340B pharmacy network. The network would result in more than \$6 million in annual savings, Bruhnson tells *DBN*.

The AMDP request follows delays in the expected approval of the final multiple-pharmacy rule. Many 340B observers had expected HRSA to issue the rule before the end of the Bush administration last January.

HRSA spokesman Dan Bowman tells *DBN* that a *Federal Register* notice on multiple 340B contract pharmacies "is being prepared for clearance, and will be submitted soon." Bowman also points out that the law limits use of 340B covered drugs to only "outpatients of participating clinics and hospitals."

### Ensuring That 340B Entities Receive Savings

"Any patient who meets the strict definition of 'patient' per the 340B program guidelines can have his or her prescriptions qualify for 340B program prices," Bruhnson says. "Organizations that are both payers and safety nets are in a unique position to use this program to achieve savings."

Furthermore, the proposed UM program actually supports the mission of 340B by creating additional savings and revenue for the UM health system, he asserts. "In turn, [UMHHC] would then be able to do more for their population as a disproportionate share hospital."

Others underscore the importance of ensuring that 340B-qualified entities benefit financially from the program.

Some organizations in the past have tried to game the system, according to Robert Judge, general manager and executive vice president of contract pharmacy services at Wellpartner, Inc., a nationwide vendor of Rx services for health plans and safety-net providers, among others.

"There were organizations that said, 'Hey, do annual wellness checks [at 340B entities], and if you do annual wellness checks, any prescription that is written will qualify,'" Judge tells *DBN*. "That's just an abuse of the program. The organizations that are promoting 340B need to demonstrate some depth and understanding of the program, because it can be quite expensive to the qualified entity if they mess up." The law has some "very strong rules" around drug diversion and double dipping on Medicaid rebates, Judge says.

If done right, however, third-party payers can leverage the 340B program to lower their drug costs, Judge adds. "There are opportunities for organizations that desire to do so to create special arrangements with qualified entities, where the entity enjoys a benefit and the insurer enjoys a benefit by collaborating," he says.

**Drug Benefit News** (ISSN: 1530-3438) is published 24 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, [www.AISHealth.com](http://www.AISHealth.com).

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Managing Editor, Neal Learner; Executive Editor, James Gutman; Director, Databases and Directories, Susan Namovicz-Peat; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Coordinator, Darren Jensen.

Call Neal Learner at 800-521-4323 with story ideas for future issues.

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Jason Hardaway, a senior director at Wellpartner, says it is fairly common for employees of eligible hospitals, for example, to take advantage of 340B pricing. "A lot of the hospitals will waive the copayment in that case," he tells *DBN*. But other commercial payers seeking to establish 340B pricing must overcome some significant hurdles, he adds. These include:

◆ **Establishing eligibility for 340B access.** Beneficiaries must be patients of a qualified entity in order to be eligible for 340B-priced medications. "This requirement can create member disruption if a payer asks or requires its beneficiaries to change providers to qualified entity providers in order to access 340B program prices," Hardaway says. "However, by [instead] changing benefit design the payer can incent member changes in a purely voluntary manner," he adds.

◆ **Creating a model for sharing 340B savings between a covered entity and a payer.** The differential between the 340B acquisition cost and the third-party reimbursement, known as the "spread," legally belongs to the covered entity, Hardaway says. "If a payer would like to benefit from the 340B program price, it is necessary for the payer to create an incentive for a covered entity to share some of this spread back with the payer," he explains. "This is usually accomplished through the creation of a 'savings share' arrangement, wherein a payer creates a benefit design change to incent utilization of the covered entity's pharmacy by its beneficiaries in exchange for the covered entity sharing some of the spread back to the payer. This model has been developed only recently and is operating in several instances across the safety-net community."

The Regence Group has looked into the feasibility of health plans applying a model that incorporates 340B, says Lynn Nishida, director of pharmacy services for RegenceRx, the insurer's PBM unit. While there is not a direct way for commercial insurers to benefit from 340B program pricing, there have been business models that propose entering into "cost sharing" arrangements with 340B entities, she tells *DBN*.

Under these models, the insurer may provide services to the 340B entity, such as member education or developing the 340B entity's pharmacy network. "While these models have good intentions, concerns have been around the transparency, underlying philosophy, and financial incentives that may be driving these business models, rather than the focus on under- or uninsured patients," Nishida says.

William von Oehsen, president and general counsel of Safety Net Hospitals for Pharmaceutical Access, a Washington, D.C.-based advocacy group, says it's possible more Rx payers will start tapping into 340B pricing.

But they should be aware of political sensitivities about using the program, he cautions.

"That's because really the program was intended to save money for safety-net providers, so they could provide comprehensive pharmacy services and other services to indigent populations," von Oehsen tells *DBN*. "Benefiting an employer and employee group — one could argue that falls outside of the scope of the covered entity's safety-net mission. But you could also argue that such an arrangement would generate revenue for the safety-net institution, which could then invest that money in further safety-net activities. We haven't seen much of that. I could see the pharmaceutical industry complaining that that's pushing the envelope too far."

To read the proposed rule on expanding 340B pharmacies, visit <http://www.hrsa.gov/opa/frn011207.htm>. ♦

## Express Scripts to Buy NextRx; Move Stokes 'Carve-in/out' Debate

Express Scripts, Inc.'s agreement in mid-April to acquire WellPoint, Inc.'s in-house PBM NextRx for nearly \$4.7 billion has stoked debate on the merits of stand-alone versus health plan-owned PBMs. The head of NextRx — the country's largest health plan-owned PBM — tells *DBN* that the deal taps the best of both models, but he also reiterates the argument that having an "integrated view" of pharmacy and medical data is the best way to manage members' health.

Nevertheless, a recent study finds that more and more employers are contracting directly with PBMs and "carving out" the Rx benefit from the medical benefit.

Ren Elder, president of NextRx, says market implications of the Express Scripts/NextRx deal, including on the question of carve-in versus carve-out PBMs, remain to be seen. "At the end of the day, employers want to know that their health insurance benefits are integrated and that their benefits are being integrated holistically, utilizing both medical and pharmacy information," he tells *DBN*.

"Clearly, as there becomes even more proof statements and data sets to demonstrate the benefits of a vendor who can look at both the medical and pharmacy [benefit], and understand the interplay between both, there is going to be increasing propensity for employers to look at the carve-in option," Elder says of PBMs owned by health plans.

The trend, however, appears to be moving in the other direction. Between January 2008 and July 2008, enrollment in "carve-out" PBMs increased by more than 6 million lives to 55.9 million, a nearly 13% increase, according to data released April 6 by market research firm HealthLeaders-InterStudy. An analyst for the study said this trend is likely to continue as PBMs offer more options for benefit designs and copayment structures.

*continued*

Renewed interest in these trends spiked on April 13 when Express Scripts said it had signed a definitive agreement to purchase NextRx for \$4.68 billion in cash and stock.

The planned sale also rekindled speculation that other health plans may want to unload their PBMs. But several insurers, including Aetna Inc., CIGNA Corp. and UnitedHealth Group, tell *DBN* they have no intention of selling.

Ed Feaver, Pharm.D., president of Prescription Solutions, the PBM unit of UnitedHealth, says employers are looking for the most cost-effective approach to achieving their pharmacy management objectives. "Depending on their objective, some employers may prefer to carve in pharmacy while others may look at carve-out options," he tells *DBN*. "However, we are in a position to serve employers regardless if their preference is to carve in or carve out pharmacy benefit management."

## CVS Caremark Tops *DBN*'s 1Q '09 Survey of PBMs and Related Companies

CVS Caremark Corp. occupies the No. 1 market position among pharmacy benefit firms as measured by covered lives, according to *DBN*'s latest survey of PBMs and related companies, including Rx claims processing and specialty pharmacy. But Express Scripts, Inc.'s planned purchase of WellPoint NextRx would allow the combined entity to take the lead (see story, p. 3). Express Scripts/NextRx would have roughly a 13% market share as measured by covered lives. Contact Susan Namovicz-Peat, *DBN*'s databases and directories director, at [snpeat@aispub.com](mailto:snpeat@aispub.com).

Company	Covered Lives	Market Share
CVS Caremark Corp.	82,000,000	12.02%
Walgreens-OptionCare	75,000,000	10.99%
ICORE Healthcare, Inc.	60,000,000	8.79%
Medco Health Solutions, Inc.	60,000,000	8.79%
Express Scripts/CuraScript	55,000,000	8.06%
NovoLogix (formerly Ancillary Care Management)	40,000,000	5.86%
WellPoint NextRx	35,049,000	5.14%
Argus Health Systems, Inc.	28,600,000	4.19%
MedImpact Healthcare Systems, Inc.	27,000,000	3.96%
HealthTrans	15,300,000	2.24%
Prime Therapeutics, LLC	14,700,000	2.15%
Provider Synergies, LLC	14,000,000	2.05%
ACS, Inc.	14,000,000	2.05%
Health Information Designs, Inc.	12,000,000	1.76%
RxStrategies, Inc.	12,000,000	1.76%
ScriptSave	12,000,000	1.76%
Prescription Solutions	11,754,249	1.72%
Aetna Pharmacy Management (APM)	11,000,000	1.61%
First Health Services Corporation	10,000,000	1.47%
Walgreens Health Services Division	9,700,000	1.42%
CIGNA Pharmacy Management	6,400,000	0.94%
Catalyst Rx	6,028,140	0.88%
RESTAT, LLC	6,000,000	0.88%
Sanovia Corporation	5,000,000	0.73%
Axiom Healthcare Pharmacy, Inc.	5,000,000	0.73%
SXC Health Solutions, Inc.	4,900,330	0.72%

Company	Covered Lives	Market Share
BioScrip	4,656,614	0.68%
Acro Pharmaceutical Services	4,000,000	0.59%
CSI Specialty Infusion Services	3,625,000	0.53%
Scriptrax	3,400,000	0.50%
WellDyne RxWEST	3,000,000	0.44%
ScripNet, Inc.	3,000,000	0.44%
NationsHealth	3,000,000	0.44%
RegenceRx	3,000,000	0.44%
National Pharmaceutical Services	2,500,000	0.37%
FLRx	1,960,000	0.29%
PerformRx	1,600,000	0.23%
US Script, Inc.	1,500,000	0.22%
4D Pharmacy Management Systems, Inc.	1,500,000	0.22%
Commcare Pharmacies	1,500,000	0.22%
WMS Prescription Drug Plans	1,500,000	0.22%
FutureScripts	1,300,000	0.19%
MemberHealth, Inc. (MHI)	1,276,000	0.19%
PRAM Insurance Services, Inc.	1,200,000	0.18%
Navitus Health Solutions, LLC	850,000	0.12%
Northwest Pharmacy Services (NWPS)	700,000	0.10%
Envision Pharmaceutical Services, Inc.	500,000	0.07%
Pharmacy Provider Services Corporation	500,000	0.07%
Maxor National Pharmacy Services Corporation	450,000	0.07%
PBM Plus, Inc. An Omnicare Company	425,000	0.06%

SOURCE/METHODOLOGY: AIS's quarterly survey of more than 100 PBMs, specialty pharmacy providers and related companies, conducted for *DBN*. Membership is lives covered under any/all pharmacy benefit contracts served by the company; members may be served by multiple contracts held by a single company or by multiple companies, and so may be counted more than once. Company market shares are calculated as percentage of total industrywide membership identified in this database.

AIS's Pharmacy Benefit Survey Results can be downloaded for \$150 at [www.aishhealth.com/Products/gdq.html](http://www.aishhealth.com/Products/gdq.html). 1Q2009 results are now available.

Express Scripts is the third largest PBM and last year processed more than 500 million prescriptions. NextRx, by contrast, manages more than 265 million adjusted prescriptions annually and is the largest health plan-owned PBM. The proposed acquisition includes a 10-year contract for Express Scripts to provide services to WellPoint, which is one of the country's largest health plans with roughly 35 million covered lives.

Under the deal, NextRx will retain control over its formularies, data analytics and integrated business management, as well as its clinical pharmacy programs, says Elder. The integrated pharmacy/medical view gives it a unique perspective on designing formularies, he explains.

"That approach has really led us to making different formulary decisions," Elder says. "Drug A may be less expensive than Drug B. But if Drug A is causing members to see a physician more frequently, or members on Drug A are visiting emergency rooms more frequently, then we can take that information, use that as part of our decision making on our formulary drug selection process."

CIGNA, similarly, touts its broad view of members' pharmacy and medical data as a crucial element in its new "performance-based" contract involving Merck & Co., Inc.'s diabetes drugs Januvia and Janumet (see story, p. 1). "These types of programs, where a medical outcome drives the [drug] discount, are something that only an integrated PBM can structure," Eric Elliott, president of CIGNA Pharmacy Management, tells *DBN*. "It's only with us that we actually have access to all of that data and can manage the contract accordingly."

### Deal Is Expected to Drive Down Costs

But Elder also is quick to underscore the advantages of partnering with Express Scripts, including the additional negotiating strength that comes from the combined entity and the potential to tap Express Scripts' research into consumer behavior to lower costs.

"Consumerism is pushing individuals to take more accountability for health care expenditures," Elder says. "The company that can really provide information to assist members in making quality cost-effective decisions will have some differentiating characteristics."

One area where savings will be achieved through enhanced mail-order Rx utilization, says WellPoint spokeswoman Lori McLaughlin. Mail-order utilization accounted for about 10% of NextRx's utilization in 2008, while Express Scripts' mail-order penetration was roughly 24% last year, she says. This was achieved "through strong, consumer-oriented marketing efforts," McLaughlin tells *DBN*.

Most analysts agree that the deal could lower Rx costs. The acquisition of NextRx gives Express Scripts enhanced size and negotiating leverage with drug companies, says

Sean Brandle, national Rx practice leader at consulting firm The Segal Company. The deal makes Express Scripts the No. 2 PBM in terms of members, moving it ahead of CVS Caremark Corp. Medco Health Solutions, Inc. remains the largest, he adds.

B. Kemp Dolliver, managing director at Cherrystone Hill Capital, also notes that Express Scripts would become a "very big player" in the Blues market. "Express Scripts does get the benefit now of the fact that their largest customer has got one of the best brand names in health care," he says.

Others, however, say pricing advantages may diminish as a new dynamic takes hold of the PBM industry. Pharmaceutical pricing parity, along with increasing utilization of Rx benefits tools (i.e., three-tiered formularies) and the potential for standardization of drug lists based on comparative research could blur the focus on a PBM's costs and claims advantages, asserts George Van Antwerp, vice president of the Solutions Strategy group at Silverlink, a company that helps health plans and PBMs communicate with members.

This changing landscape "makes things like data integration, member communications [and] therapeutic resource centers a more important tool," Van Antwerp tells *DBN*. "The question is, how do you value that and how do you get the payers [and] employers to look at you, the PBM, versus the managed care or stand-alone disease management company?"

The Express Scripts/NextRx transaction is expected to close in the second half of 2009, and is subject to the usual closing conditions and antitrust clearance.

Contact Elder through Lori McLaughlin at Lori.McLaughlin2@anthem.com, Elliott through Lindsay Shearer at Lindsay.Shearer@CIGNA.com and Feaver through David Himmel at david.himmel@phs.com. ✦

## Part D Plans Submit Formularies For '10, Split Generic Rx Tiers

Medicare Part D stand-alone Prescription Drug Plans and Medicare Advantage (MA) prescription drug plans submitted their 2010 formularies to CMS for approval by April 20. Some industry observers say that on first glance there appears to be more separation of generic-drug tiers and greater sophistication in general among plans for next year.

"I think in general people are going to continue to try to manage their costs a little better," especially given the thinning of MA rates for 2010, says Brett Swanson, an actuary in the Milwaukee office of Milliman, Inc. "Something that's become more prevalent in 2010 is separation of generic tiers," he says, explaining that more plans have

“preferred generics” and “standard generics.” While both have relatively low beneficiary copayments, the preferred tier is lowest.

When generics first become available they are parity-priced with the brand drug but this usually changes over time and the generic price goes down, says Aaron Eaton, vice president of strategic development for consulting firm Gorman Health Group, LLC and a former CMS Part D formulary overseer.

“I do think we see a little bit more sophistication from the industry each year, as they add free ‘first-fill’ programs or coverage through the gap for certain drugs or tiers of drugs, Eaton says, adding that this is partly driven by CMS’s ongoing enhancement of automation.

Other required changes to Part D formularies from 2009 to 2010 will decrease Part D plans’ flexibility and could drive up costs, says Marissa Schlaifer, pharmacy affairs director for the Academy of Managed Care Pharmacy.

“One [change] that comes to mind is the fact that plans can no longer use medications with a non-FDA-approved indication,” she explains. “That will require plans to change the standard way they provide coverage for certain indications...and limit plans from making decisions on the most appropriate medications for their beneficiaries.”

Contact Eaton at (717) 793-1093, Swanson at (262) 784-2250 and Schlaifer through Carolyn Stables at (703) 683-8416, ext. 608. ✧

*The above article was excerpted from the April 23, 2009, issue of AIS’s biweekly newsletter Medicare Advantage News.*

## Topamax Blockbuster Goes Generic; BCBSA Generics Rate Hits 65%

The tsunami of generic drugs keeps on rolling. AstraZeneca’s \$2.2 billion seizure drug Topamax (topiramate) in April become the latest blockbuster brand to suffer under competition from multiple generic manufacturers. Meanwhile, a survey by the BlueCross BlueShield Association (BCBSA) finds that generic drug use among Blues plan members reached 65% in 2008, up from 60% the year before.

Like other Blues plans aiming to ride the generic wave, Excellus BlueCross BlueShield in 2005 launched a sustained community-based awareness campaign that it hopes will push the overall generic utilization rate to 70% and beyond. The percentage of physicians who have a 70% generic fill rate doubled from 28% in 2007 to 56% in 2008, said Joel Owerbach, Pharm.D., vice president and chief pharmacy officer at Excellus, which has 1.8 million members in upstate New York. The overall generic fill rate reached more than 68% in 2008, according to the plan.

“Since we started this program, the increase in generic fill rate has created a realized savings of over \$720 million,” Owerbach told an April 9 BCBSA news conference in Washington, D.C. “Out of that savings, we estimate that \$150 million of that is direct out-of-pocket savings that people had at the pharmacy during the year.”

Excellus’ campaign includes TV and radio commercials, press conferences and full-page newspaper ads. “Anything that we can do to get the message out with that tag line, ‘Ask your pharmacist or doctor for a lower-cost option,’” Owerbach said of the effort.

This message aims to address the “communications gap between patients and their physicians,” he added. A 2007 survey by Excellus found that 35% of members said they never asked their physician if a generic alternative was available, and 55% said their doctors had never asked them if the cost of a drug was a concern before prescribing it, Owerbach said.

Another opportunity to discuss generics came on April 2, when the FDA gave its green light for multiple generic manufacturers to start shipping versions of Topamax, which had annual sales of \$2.2 billion before the generic approvals, according to IMS Health.

Roughly 137,000 people in upstate New York are taking Topamax at a cost of \$45 million a year, Owerbach noted. “The cost of the generic on the market is one-tenth of the cost of the brand,” he said. “You’ve gone from \$300 a month of treatment per person to \$30.

Diane Mohorter, senior manager of benefits at Birds Eye Foods, Inc., said most employers would rather use generic education campaigns to change behavior than the more Draconian tools of step therapy and prior authorization “The carrot or the stick?” she asked the news conference. “We definitely want to go with the carrot.”

Contact Owerbach through Jim Redmond at jim.redmond@excellus.com and Frick through Kelly Miller at Kelly.miller@bcbsa.com. ✧

## Plans Base Rx Price on Performance

*continued from p. 1*

“To our knowledge, there is nothing like this contract currently in place” for osteoporosis drugs, says Christina Barrington, Pharm.D., director of pharmacy at Health Alliance, which covers 256,000 commercial lives in Illinois and Iowa.

She says similar contracts could soon follow at her health plan and industrywide. With the increasing emphasis on comparative effectiveness, manufacturers are going to have to demonstrate that their drugs offer enhanced value compared with others already on the market, not just with placebo, Barrington tells *DBN*. “They’re going to really have to stand behind their products,” she says.

Barrington took this message to P&G when the manufacturer approached her asking how it could help the health plan, she recalls.

"If they really believe that their product is superior and should have preferred [formulary] position, then you should share some of that risk," she says of her response. "If we don't get the outcomes that you say we should get, we should either get some money back or our members should be compensated. So Procter and Gamble took me up on that."

Actonel, which is placed on a preferred formulary tier, accounts for roughly 70% of market share in its therapeutic category, Barrington says.

The Fracture Protection Pilot Program is available to any Health Alliance female member between the ages of 35 and 64. To qualify, the member must have been on Actonel for at least nine months and have a "medication possession ratio" — which measures prescriptions filled and indicates adherence to product — of 67% or higher, Barrington explains. The insurer sends letters to members who are not at 67% to educate them about the program and inquire as to whether there are issues hindering their compliance.

If a qualifying member has a non-spinal osteoporotic fracture, then P&G will pay the plan up to a designated amount, including \$30,000 for a broken hip and \$3,000 for a broken wrist, Barrington says. The health plans will share that reimbursement with the members to cover their copayments, she adds.

"We really believe that everyone who is adherent and compliant should have positive outcomes, and we should see a reduction in fractures," Barrington maintains. "The goal isn't for us to make money or pay people back money

because they fracture. Our goal is to keep people on a very effective drug to prevent fractures."

The CIGNA/Merck agreement differs from the traditional notion of pay-for-performance contracts in that it provides additional discounts as members with Type 2 diabetes lower their HbA1c levels and improve their health, explains Eric Elliott, president of CIGNA Pharmacy Management, the insurer's PBM unit. He acknowledges that the program is somewhat "counterintuitive."

"Adherence goes up, your A1cs go down, it's all positive and there are further discounts from drug manufacturers... How does that happen?" he asks, noting that pay-for-performance usually requires manufacturers to pay up when goals are not met.

Under this contract model, Elliott tells *DBN*, CIGNA started with several key desired endpoints and then designed a contract that drives performance around four goals. They are:

- ◆ *Members are taking drugs that are identified to be very good products;*
- ◆ *Members are taking those drugs according to physicians' instructions;*
- ◆ *The right outcomes are achieved; and*
- ◆ *CIGNA has the best possible pricing for the drug.*

Merck's initial pricing concession involves placing the drugs on a preferential formulary tier, Elliott explains. The supplemental discounts kick in as adherence benchmarks are reached, and later as HbA1c goals are met, Elliott explains. He declined to specify the amounts of the supplemental discounts, but added that the arrangement overall should allow CIGNA to reduce its diabetes medication costs by 20%, and could result in even greater sav-

## **Complying With the New Federal Security Breach Notification Law: Strategies for HIPAA Covered Entities**

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- What your workforce members should know about the new breach law.
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ings on the medical side as fewer diabetic patients end up in the doctor's office or emergency rooms.

"We benefit, our clients benefit, the individuals benefit and Merck, obviously, benefits as well," he says.

Most pharmaceutical reimbursement arrangements are based on utilization. Tying a drug's performance with discounts is an emerging trend that Elliott says will increasingly gain traction. "Where you will see them is where the medical and pharmacy can be managed together," he says. "It will make sense to tie these types of outcomes-based contracts together."

The arrangements work best when there is a "clear-cut tie between a drug and a medical outcome," he says, adding that diabetes drugs offer the ability to see distinct results. "In this case, A1c allows you to see if there is improvement or not."

Elliott and Barrington both say they are working on similar deals with other drugs, but they declined to name the products.

Barrington echoes the point about the need for medical and pharmacy integration. "There are some PBMs that can get medical claims and are integrated with health plans," she says. "But for the average regional health plan or employer group that directly contracts with a PBM, they're not as likely to be able to administer these types of contracts as a health plan like ourselves that has access to both medical claims and pharmacy claims data and the distribution of the product."

Contact Elliott through Lindsay Shearer at Lindsay.Shearer@CIGNA.com and Barrington through Penny Ransom at (217) 255-4512. ✧

## NEWS BRIEFS

◆ **Medco Health Solutions, Inc. on April 29 reported that first-quarter 2009 net income increased 7.7% to \$291 million, or 58 cents per share, from \$270.2 million, or 50 cents per share, in the first quarter of 2008.** Net revenues climbed 14.4% to a record \$14.8 billion. Specialty pharmacy revenues rose 21% to a record \$2.3 billion, and Medco's generic dispensing rate increased 3.5 percentage points from the 2008 period to a record 66.8%, the PBM said. The mail-order generic dispensing rate increased 3.6 percentage points to 57.2%, according to the company. Contact Jennifer Luddy at Jennifer\_Luddy@medco.com.

◆ **Express Scripts, Inc. on April 29 reported that first-quarter 2009 net income increased 21.2% to \$214.7 million, or 86 cents per share, from \$177.2 million, or 70 cents per share, in the first quarter of 2008.** Revenues slipped to \$5.42 billion from \$5.49 billion. The generic utilization rate increased to 67.7% from 65.1% in last year's period, the PBM said. Contact Maria Palumbo at MPalumbo@express-scripts.com.

◆ **The overall pharmacy cost trend for Express Scripts' clients increased 3% in 2008, down 2.5 percentage points from the 5.5% rate in 2007,** according to the PBM's annual drug trend report released April 20. Express Scripts said that generic drug usage rose 7.5% from 2007 to 2008, while utilization of brand drugs decreased 11%. By the end of 2008, 67.3% of all prescriptions filled by Express Scripts were for generic drugs, the PBM said. Contact Maria Palumbo at MPalumbo@express-scripts.com.

◆ **Prices for widely used brand drugs rose nearly 9% in 2008, marking the largest average annual increase in six years and exceeding the general inflation rate of 3.8%,** according to a report released April 16 by AARP. The study by AARP's Public Policy Institute also found that the prices of widely used generic drugs decreased in 2008 by an average of 10.6%. To read the *AARP Rx Watchdog Report*, visit [www.aarp.org/research/health/drugs/rx\\_watchdog.html](http://www.aarp.org/research/health/drugs/rx_watchdog.html). Contact Jordan McNerney at (202) 434-2560.

◆ **Workers' compensation pharmacy costs increased by 5.4% in 2008, compared with 3.3% in 2007,** according to the *2009 Annual Drug Trends Report*, released April 20 by PMSI, a vendor of pharmacy services for the workers' compensation market. Five classes — narcotic analgesics, anticonvulsants, non-steroidal anti-inflammatory drugs, skeletal muscle relaxants and antidepressants — represented 70% of total Rx costs and 74% of total transactions in 2008. Contact Shelia Chapman at Shelia.Chapman@pmsionline.com.

◆ **PEOPLE ON THE MOVE:** Prime Therapeutics LLC said **Timothy Dickman**, president and CEO, left the company to "pursue other interests" effective April 23. **Kim Mageau**, senior vice president and chief operating officer, will serve as interim president and CEO. Dickman had been president and CEO since 2002... UCare, a nonprofit Medicare Advantage plan, named **Alan Heaton, Pharm.D.**, pharmacy director. Heaton was director of pharmacy at BlueCross BlueShield of Minnesota.

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