Improving Adherence and Containing Rx Costs: New Health Plan/PBM Strategies

Updated May 2011

Erin Trompeter, Editor
Angela Maas, Managing Editor
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Introduction

Although poor medication adherence can lead to increased hospitalizations and even death, many patients taking prescription drugs stop using them within a few months — costing payers billions in preventable expenses. To help solve these potentially deadly and expensive problems, health plans and PBMs have tested a variety of ways to combat poor adherence, including automated refill reminders, surveys on why medication was discontinued, physician and patient education, and incentives paid to patients with high adherence rates.

*Improving Adherence and Containing Rx Costs: New Health Plan/PBM Strategies* examines the pharmacy benefit management strategies that have been most successful at reducing payers’ costs, improving adherence and maximizing formulary value. It also details payers’ strategies including case studies, relevant data and thorough analysis.

We welcome your comments, suggestions and additional information for future editions of this report. Please send them to our book editor, Erin Trompeter, at etrompeter@aishealth.com. Thanks for your help in keeping us up to date with adherence and cost-saving strategies.
Adherence Strategies and Challenges

Some PBMs Make Performance Guarantees for Improvements in Statin Adherence

Health plans are tackling the big adherence problems surrounding cholesterol-lowering drugs with a range of strategies including barrier surveys, physician and patient communications, and incentive programs. And some PBMs as of December 2009 were offering performance guarantees to back up their promises that they will improve adherence with drugs, including statins.

“Adherence with statins falls off pretty precipitously in four to six months,” says Michael Cartier, executive vice president of Envision Pharmaceutical Services, Inc., a Twinsburg, Ohio-based PBM. “After a year, there’s only 40% to 45% compliance.” He adds that “it’s not any particular statin drug — it’s just statins in general.”

A study in the November/December 2009 Journal of Managed Care Pharmacy found that just 56% of patients prescribed statins continued to use the drugs six months later.

A 50% drop in adherence is significant, says George Van Antwerp, general manager of pharmacy solutions at Silverlink Communications, Inc., “because you know most people haven’t gotten their cholesterol back down where it should be.” One reason patients stop taking statins is because high cholesterol is an asymptomatic condition, so patients don’t notice health changes when they discontinue therapy, he adds.

Another issue is the gap in patient/physician communication, says Jan Berger, M.D., chief medical officer at Silverlink and the former chief clinical officer at CVS Caremark Corp. It’s not unusual for physicians to assume that the patient fills the medication. “Not until we see the patient back in the office six months or a year later do we have the conversation, ‘Did you take it? Did you stop taking it?’”

Recent studies that call into question the effectiveness of some statins may add to patients’ confusion over whether to take the drugs. An analysis released Nov. 18, 2009, by UnitedHealth Group subsidiary Prescription Solutions indicated that there is no significant difference in cardiovascular outcomes between patients on Merck & Co., Inc.’s Vytorin (a combination drug with ezetimibe and simvastatin), Pfizer Inc.’s Lipitor (atorvastatin) or simvastatin alone. Another study posted Nov. 15, 2009, on the New England Journal of Medicine Web site found that niacin was more effective than Merck’s Zetia at reducing thickness of carotid artery walls.

CVS Caremark is one PBM that has added adherence-related performance guarantees to contracts with employers and health plans.

Adherence is one of five areas in which CVS Caremark offers performance guarantees, says Anita Allemand, the PBM’s vice president of analytics and outcomes. The others are generic-drug utilization, preferred pharmacy choice, specialty drugs and utilization management. Although the results in each area are aggregated into one guarantee, CVS Caremark may adjust the importance of different areas to address specific issues faced by each client, she explained in late fall 2009.
For adherence, CVS Caremark analyzes relevant drug history over the previous 12-month period for patients with asthma, diabetes, heart failure, hyperlipidemia or hypertension. The PBM reviews not only adherence to medications, but also clinical gaps in care, such as members who should be on a different medication or who haven’t had a needed diagnostic test, Allemand says. Then CVS Caremark pledges to meet a goal for improved adherence by the end of the contract period, and agrees to make a dollar payment per patient if that goal isn’t met. She declines to discuss the specifics of calculations or amount to be paid.

“Our preference, especially for adherence [measures], is to be a three-year contract,” Allemand says, but she adds that CVS Caremark also has incorporated the provisions into one-year contracts.

**CVS Caremark Uses Refill Reminders**

Allemand emphasizes that the provision does not require any investment from the employer in the event that CVS Caremark meets the goal. Since contracts with performance guarantees still are fairly new, she declines to disclose outcomes, but says an “initial view” of the PBM’s success at meeting goals should be available in 2010.

Among the tools used by CVS Caremark are “timely messaging, education and interventions designed to help keep them adherent to medications for chronic conditions,” said spokesperson Chris Cramer. In late fall 2009 “These interventions include IVR [i.e., interactive voice response] and Web refill reminders, renewals and pick-up prompts. Patients who have stopped filling a maintenance prescription even receive a letter or call reminding them of the importance of staying on a prescribed therapy, and their health care provider is also notified.”

Medco Health Solutions, Inc. and CVS Caremark are the only major PBMs that now offer performance guarantees related to adherence, says Kristin Begley, national pharmacy practice leader at Hewitt Associates Inc. She says the PBMs’ willingness to put dollars at risk without asking the employer to share in that risk makes the concept unique. Begley says the payouts range from $800 to $1,300 per patient who has the condition, received interventions and still did not achieve treatment compliance.

PBMs and health plans use a range of strategies to actually improve compliance. Health Care Service Corp. (HCSC) saw a 25% increase in statin adherence in a pilot program it conducted at Blue Cross Blue Shield of Texas. HCSC in fall 2009 expanded the program to the other three Blues plans it operates, in Illinois, New Mexico and Oklahoma, according to Kevin Slavik, HCSC’s senior pharmacy director.

In the pilot program, the percentage of members with at least an 80% medication possession ratio (the days’ supply of medication divided by the days between refills) rose by 25% from the first six months of 2008 to the second half of the year. HCSC sent a letter to noncompliant members “explaining the importance of taking their medication,” Slavik says. A second letter to the patient’s physician included lab results, drug quantities filled, dispensed dates and refill due dates.

Van Antwerp cites his company’s experience with providing refill reminders to members of one health plan. The program targeted members who had filled a 90-day statin prescription, and then had gone three weeks without refilling the prescription. “Twenty percent of people who didn’t interact with the call came back to therapy anyway,” he says. “They were just late”
in getting refills. “But 40% of people who interacted with the call came back to therapy. So just by doing a pretty basic call reminding them about the need to refill and asking them some barrier questions if they said they were not planning to refill, we were able to double the percentage” who returned to statin therapy.

Electronic prescribing also can assist, by providing a real-time feedback loop to physicians, PBMs and health plans about whether patients got a first fill or refills of medications, Berger adds.

Some Payers Use Adherence Incentives

Envision has had success in using value-based benefit designs to improve adherence to statins, Cartier says, such as by providing rewards to patients who remain compliant with statin treatment plans. Some employer clients also require patients to be active participants in high-cholesterol disease management (DM) programs in order to qualify for incentives. Envision assists DM vendors by supplying individual patients’ drug histories, Cartier says, to arm nurses who speak with patients who may insist that they are compliant. “We also send patients progress reports, kind of like you get in high school,” to tell patients how adherent they are with medication treatment plans, he tells AIS.

Well-Structured Adherence Programs Outweigh Cost of Higher Drug Use

Increased spending on compliance programs to help tackle the problem of nonadherence with medications may pay off, as new findings suggest that value-based benefit designs do not increase total medical spending.

Well-structured value-based insurance plans can successfully increase adherence to medications for some chronic conditions without increasing overall costs, Richard Feifer, M.D., vice president of clinical program development at Medco Health Solutions, Inc., told a Jan. 27, 2010, AIS audioconference on medication adherence.

“The traditional PBM role is a thing of the past,” Feifer says. About 10 years ago, he explains, the focus of the traditional PBM was on reining in total drug costs and drug utilization. “Now we’re all recognizing — and so are our clients — that adherence is a key driver of total health care costs. In some ways, we are seeing drug spend [and] drug costs go up, but in a way that we expect total health care costs to go down.”

As only half of all patients with chronic conditions are adherent with their medications, Feifer says nonadherence “has been called America’s other drug problem.” He adds that many patients don’t fill the prescriptions they are given or stop taking a medication before their supply runs out. In addition, nearly 25% of patients take less than the recommended dose of their medication. As a result, poor medication adherence can cost an estimated $290 billion annually in total direct and indirect health care costs. It also can have a significant impact on outcomes, as multiple studies have found a correlation between nonadherence and increases in coronary heart disease-related incidents. A study published in the February 2010 issue of Health Affairs helps prove Feifer’s assertion by demonstrating that an employer that used a value-based ben-
efit design was able to offset the costs associated with additional drug use by reducing the use of non-drug health care services.

For the study, one large employer reduced copayments for five classes of drugs used to treat certain chronic conditions, including ACE inhibitors and beta-blockers for high blood pressure. The copays were reduced for generic drugs from $5 to zero, preferred brand drugs from $25 to $12.50 and nonpreferred brand drugs from $45 to $22.50. The study found that the value-based design increased adherence by three percentage points, and cost the employer an average increase of $7.75 per employee per month in pharmacy costs. However, the costs of non-drug health care services decreased by the same amount.

Some PBMs are already offering performance guarantees to back up their promises that they will improve adherence with drugs. Other health plans are tackling adherence problems — particularly those surrounding cholesterol-lowering drugs — with a range of strategies including barrier surveys, physician and patient communications, and incentive programs.

**Plans Should Personalize Adherence Programs**

To have an effective value-based program, payers must first target the reasons why patients are nonadherent — which can range from person to person, Feifer says. Such reasons may include cost, forgetfulness, not knowing how to take the drug or not being able to get a drug filled or delivered.

But just knowing barriers to adherence is not enough, says Jan Berger, M.D., chief medical officer at Silverlink Communications, who also spoke at the AIS audioconference. “One of the things that I have learned is that [adherence] really is very individualized,” she says. “Personal issues, cost issues, proximity to a pharmacy — all these things come into play. So as you’re trying to address medication nonadherence, you really need to know an individual’s reasons.”

In addition to just forgetting to take medications or not refilling prescriptions because of costs, Feifer adds, nonadherence can occur because there is a lack of communication with the patient and their pharmacist or physician. He says the key to having a successful program is to target outreach to members who need it most by training pharmacists, who can give patients personalized attention.

Therapy management, or helping people get on the right medications and stay on the right medications and use them faithfully, tends to be done more successfully by pharmacists who are skilled, trained and doing this every day than by generalists who sometimes are nurses,” he says. “And so what we try to do is to carve out therapy management and adherence support to the pharmacists.”

**New Studies Seek Ways to Improve Adherence**

Four new studies examining medication adherence and prescribing practices were presented during the Academy of Managed Care Pharmacy’s 22nd annual meeting earlier in April 2010. They include the following:

- **Chronically ill patients who receive a three-month supply of their medications — rather than a 30-day supply — were 40% less likely to have adherence problems**, according to a study co-authored by Prime Therapeutics LLC and one of its Blue Cross Blue Shield clients. The
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A study compared adherence rates for patients filling a 90-day supply of medications to treat diabetes, high cholesterol or high blood pressure at a local pharmacy or by mail service to patients filling a 30-day supply at their local pharmacy. Although a number of previous studies had similar findings, none ever determined whether the delivery method (home versus mail order) or the extended supply contributed to better adherence rates, according to Prime. By contrast, this study “found that extended supply was the key factor, since there was little difference in adherence rates between patients who received their extended supplies through the mail or from a drug store,” the PBM says in a statement.

Three in 10 women at two Blues plans are taking breast cancer medications to treat infertility, even though the FDA considers the drug a pregnancy risk, according to a study by Prime Therapeutics. Doctors are prescribing breast cancer drug Femara (letrozole) — indicated for post-menopausal women with hormone-receptor positive breast cancer — off-label to treat infertility. However, the FDA has warned that the drug could increase risk to the fetus. Prime Therapeutics says a pharmacy benefit utilization management program for letrozole could help lower fetal risk and reduce costs, as the average price for members taking the drug is about $173 per claim.

One in six cancer patients with high out-of-pocket costs abandons their medications, according to another study by Prime Therapeutics. Patients at eight Blues plans paying more than $200 out of pocket were at least three times more likely to not fill their prescription than those who have to pay only $100 or less, the study found. About one in five patients surveyed had out-of-pocket costs greater than $100. The increase in prices of oral oncology drugs also is putting cost pressure on payers. In 2009, Prime Therapeutics on average paid $2,942 for a one-month supply of one brand oral oncology drug — a 17.6% increase over 2008. The study looked at patients taking several oral oncology drugs, including Gleevec, Iressa, Nexavar, Spryclel, Sutent, Tarceva, Tasigna and Tykerb.

Automated phone messaging, fax alerts to physicians and copayment waivers for generic drugs are all tools that can improve medication adherence, according to new studies by CVS Caremark Corp. One of the studies, which examined the effectiveness of interactive voice response programs to improve adherence with mail-order drugs, found that patients were 70.6% more likely to refill their medications if they used IVR. Another study examined the effectiveness of faxed alerts to physicians “to resolve potential gaps in therapy,” CVS Caremark says in a statement. The study looked at three areas: an osteoporosis-preventive agent for women on long-term glucocorticosteroids, an ACE inhibitor for adults with hypertension and diabetes, and a lipid-lowering agent for patients over 30 with diabetes. The study determined that gap closure rates were significantly higher (8.4% for the osteoporosis patients and 5.5% for the high cholesterol patients) for individuals whose physician received a fax alert. A third study examined the sustained generic dispensing rate that results from generic copay waiver programs. The study examined members who continued using the generics even after the copay waivers expired. It found an 88% sustained generic dispensing rate for members who received two copay waivers and a 71% rate for members who received only one copay waiver.
Drug Trend Increases Can Be Offset by Changing Common Patient Behaviors

Although drug spending dramatically increased in 2009, Express Scripts, Inc. said in spring 2010 that it has uncovered a significant source of savings in the form of easy-to-change patient behaviors. In its new 2009 Drug Trend Report — which is the first to link spending to both market forces and patient behavior — the PBM says payers can save billions of dollars by modifying how they communicate with members when addressing nonadherence and switching to lower-cost drug choices.

Reversing a long and desirable pattern of low drug trend increases, overall drug spend for Express Scripts swelled to 6.4% in 2009 — a 3.4% jump from 2008, according to the report. Spend for traditional drugs grew by 4.6%, while specialty drugs jumped 19.5%. Drug-price inflation for branded medications was the single most important factor driving up cost per unit — especially for therapy classes that have limited generic availability, the report says. Among specialty drugs, for example, inflation was 11.5% compared to 9.1% for branded traditional drugs.

The top therapy classes, representing approximately one-third of total traditional drug spending, include therapies to treat cardiovascular disease, diabetes and depression. For specialty drugs, the top three therapy classes, representing 67% of total specialty spend, were anti-inflammatory and multiple sclerosis and cancer drugs. And because approximately 55% of total spending for specialty drugs occurs on the medical benefit (because they must be administered in a physician’s office), total spending may soon approach $250 per member per year for some plan sponsors.

At the same time, market forces that drove trend up by 8.3% were offset by positive member behaviors that drove down trend by nearly 2%. For example, market influence on spending for high cholesterol drugs — such as prevalence, cost per unit and the introduction of new drugs — drove trend up 6.3%. However, behavioral factors decreased overall trend by 5.5%, as many patients started using generic Zocor (simvastatin).

Improved member behavior is where the PBM says payers should target their efforts to save money. "Historically, we’ve always looked at market forces — like the prevalence of a disease or the inflation factor driving increased costs year over year,” says Steve Miller, M.D., Express Scripts’ chief medical officer. But in 2010, the focus should be on critical behavior patterns that payers "could actually influence,” including drug choice, medication adherence and movement to mail-order delivery.

Express Scripts estimated that it lost approximately $163 billion in wasteful spending from the following modifiable patient behaviors:

◆ $106 billion from medical costs of nonadherence to therapy;
◆ $51 billion in “missed opportunities” related to patients not choosing lower-cost medication alternatives — both brand and generic; and
◆ $6 billion related to patients not using lower-cost options for drug delivery, such as mail order.
“The reality is that members would do what we recommend in those three areas,” Miller maintains.

Drugs to treat diabetes, for example, affected 5% of the population and grew almost 10% in 2009 — making it the second most costly traditional therapy class for the first time. “But there’s also some good news here,” Miller says. “The number of diabetes patients that adhered to their treatment plan went up this last year....So while the pharmacy spend went up, hopefully we’ll eventually see some offsets on the medical side.”

**Spend, Utilization Could Rise by 2% to 5%**

Express Scripts predicts the overall trend for traditional drugs will continue to grow between 2% and 5% annually over the next three years. A flat-to-negative trend is expected after that, as blockbuster brands — such as Effexor ER, Lipitor and Seroquel — lose their patents.

Meanwhile, utilization is expected to grow at about 3% annually, as the population ages and the obesity epidemic affects more people. As a result, the PBM anticipates a large number of patients will need medications to control diabetes, high cholesterol and cardiovascular disease. At the same time, “updates to treatment guidelines for cholesterol and high blood pressure likely will...require earlier and more intense medication-related interventions,” the report says.

Expectations for specialty drugs, on the other hand, stand in stark contrast to the traditional market, as the overall trend is predicted to expand at a 20% to 23.5% annual rate over the next three years. Per-member-per-year spend for specialty is expected to nearly double during that same period from $111 to $204. Only taking into consideration drugs covered under the pharmacy benefit, Express Scripts forecasts that drug cost and utilization will both continue to increase between 10% and 12% on an annual basis because of brand inflation and drug mix. Respiratory conditions, pulmonary hypertension and hepatitis C could also see “significant overall trend increases” due to new drug approvals.

The solution to controlling the rising trend, the report says, is to think beyond financial incentives, mandatory benefit designs and clinical programs. Such methods “are simply insufficient to maximize health outcomes and wring out all the waste from the pharmacy benefit,” the report adds.

According to Robert Nease, Ph.D., chief scientist at Express Scripts, something as simple as more effective phrasing could change patient behavior. For example, he says, telling patients that they’re losing money by not switching to a lower-cost generic, instead of promising savings, makes them more willing to choose generics. “And that’s because we know people are adverse to losses,” he explains. “When you change the words from ‘start saving’ to ‘stop wasting,’ you see a significant pickup in terms of performance.”

He recommends that payers start getting the basics right, including tighter formulary management and plan design. ♦
Should Patients Be Paid for Adherence? Strategy Could Yield Savings or Cost Hikes

Medication nonadherence is recognized by most payers as a major driver of pharmacy costs, but nobody can get their hands on a foolproof solution to the problem. As a result, PBMs and health plans are experimenting with a new method that some critics view as a last resort: paying people to take their drugs appropriately.

“There is no silver bullet when it comes to adherence, because it’s not that straightforward,” George Van Antwerp, vice president of the Solutions Strategy Group at Silverlink Communications, told AIS in June 2010. “However, it is an issue where everyone is aligned because there are a lot of potential savings.”

Finding the “motivational mechanisms” behind why patients don’t take their medicines as prescribed has evolved into a large and diverse field, he adds. It’s one that allows payers to experiment with new initiatives. And the latest trend in this space seems to be financial incentive programs, which pay patients money to comply with their treatment regimens. According to an analysis by The New York Times, this “seemingly counterintuitive” method of saving costs is gaining much interest among payers.

“Some plans will do whatever it takes to get patients to be adherent to their therapy or engaged in better behaviors,” Bob Nease, Ph.D., chief scientist and vice president of marketing at Express Scripts, Inc., told AIS in June 2010. While the PBM hasn’t launched its own program yet, Nease says it will be following the trend closely. “The use of lotteries is very interesting and it has potential,” he adds.

Aetna Inc. is one health plan that has helped fund a recent financial incentive program. The pilot, conducted in Philadelphia, entered patients taking anti-blood clotting drug warfarin into a lottery when they took their medication. A computerized pillbox recorded which patients were taking their drugs and would give them the chance to win either $10 or $100 each day they were compliant.

CVS Caremark has said it is also considering the lottery approach, as well as a program that pays patients $10 per month to be adherent.

Van Antwerp is skeptical about whether such programs will be successful. He warns that paying people could just lead to long-term dependency by patients who will take their medication only if they receive money. “There is no way to ensure that people are actually taking their pills,” he adds. “So I’m sure some people will game the system.”

There is also an issue of fairness at play, Antwerp says, because adherent patients might resent that they’re not receiving the same benefits. “Why should my neighbor get paid for forgetting?” he asks.

Van Antwerp maintains that while there is nothing wrong with incentives, patients should be rewarded for good behavior — not bad. Insurers should be focusing on helping people understand and afford their medications through educational programs that inform patients about their conditions, he says.

Nease agrees that many plan sponsors are skittish about getting into a situation in which they’re essentially rewarding people for bad behavior. However, he adds, whether a plan can
“build good habits” by offering lottery incentives is still an open question. “If the answer is yes, then this might be a viable solution,” he maintains. At the same time, “if a plan is really on the hook to pay people for the duration of the patient’s therapy, they might hesitate to offer such a program.”

While it’s too early to determine whether these programs will be successful or deliver savings, Nease argues, there are many reasons why offering patients financial incentives would work to improve adherence, “and there are some ways to make it even better.”

**Patients Focus on Dollar Rewards**

First of all, he says, people overestimate the likelihood of small probabilities. For example, most people have a difficult time distinguishing between one in 100 and one in 1,000. “So if I’m going to have a lottery, and I want to make it work financially, I could make it a small chance of a relatively large reward,” he explains. “We focus more on the dollar value than the chances because we have more experience with that.”

The second method would be to take advantage of what Express Scripts terms “loss aversion,” meaning people will work harder to avoid losses than to pursue gains. “Losses sting more than gains feel good,” Nease maintains. “And one suggestion — which has been used by us — is to let people know that they would have won the lottery had they taken their pills better….Now that really hurts.”

In the end, he adds, “if you get past the issues of fairness and whether plan sponsors will continue to pay, you still need a scalable platform for measuring whether patients take their medications or not.” However, he maintains, “none of these challenges are insurmountable.”

While Van Antwerp disagrees with such financial incentive programs, he still says he would “love to be proven wrong and see us throw money at people and change the health care cost curve.”

**Payers Should Look to Pharmacists to Improve Medication Adherence**

As technology enables automation of more routine pharmacy functions, pharmacists are becoming increasingly available to play a greater role in patient counseling and medication therapy management services — a trend many payers have not been taking advantage of. Realizing this, one PBM is rolling out a new program that focuses on face-to-face interactions with pharmacists, which have been proven to play a key role in helping manage patient adherence and close gaps in care.

“The pharmacist is an under-utilized resource today,” George Van Antwerp, vice president of the Solutions Strategy Group at Silverlink Communications, told AIS in July 2010. “They go to school to work with patients and often end up simply filling bottles.” But with more programs that encourage pharmacist participation, that could soon change.

According to CVS Caremark Corp., pharmacist interventions consistently rank as highly effective compared with those from other providers. And pharmacists intervening at the pharmacy are typically the most effective, followed by those in hospitals and clinical settings.
“There’s a real opportunity for payers to leverage the role of the pharmacists,” Len Greer, CVS Caremark’s senior vice president of marketing for the PBM unit, told AIS in July 2010. “We feel that the pharmacists can play a very helpful role in patient care. And this sentiment is growing.”

As proof, in its 2010 Insight Report the company touts the results of one yearlong study conducted in Polk County, Fla., which offered one-on-one pharmacist counseling and drug copayment waivers for 564 diabetes patients. For the study, participating members had to sign a contract saying they would schedule and attend appointments, self-monitor their blood glucose and blood pressure levels, and take medications as prescribed.

As a result of the program, the majority of participants had an overall reduction of blood glucose levels. There was also a 30% decrease in hospitalizations from all causes and a 24% reduction in emergency room visits — all leading to long-term savings.

Realizing the benefits of pharmacist interventions, CVS Caremark plans to roll out a new program called Pharmacy Advisor in January 2011. This program will provide one-on-one pharmacist counseling for patients with chronic conditions, with the aim of improving member adherence and closing gaps in care. While the program will initially focus on managing diabetes patients, it will eventually expand to patients with cardiovascular disease and other chronic conditions.

**Pharmacist Counseling Can Save $600 Per Member Per Year**

CVS Caremark completed a six-month pilot program for Pharmacy Advisor earlier in 2010 that studied diabetes patients employed by a large global steel company. The pilot program used a multistep process to identify and counsel members about gaps in care and adherence issues. Results demonstrated that this process closed a “significantly higher number of gaps in care” compared with a control group who was not counseled. Specifically, the averages were 58% higher for patients who received phone counseling and 90% higher for patients who had face-to-face counseling. In addition, members receiving counseling were more likely to be adherent in every targeted medication class.

The pilot found that payers could save an estimated $600 per member per year by using pharmacist counseling. Altogether, a client with 50,000 employees whose population has an average prevalence of diabetes could save approximately $3.3 million a year and up to $6 million a year if there is a high prevalence of the disease, according to CVS Caremark.

Greer says the PBM’s clients have fully embraced the program because of patients’ “clear improvements in overall health, which were proven in the pilot.” He says CVS Caremark has been able to demonstrate that the program can close gaps in care at twice the normal rate in the pharmacy. For example, he explains, in many cases, diabetes patients should be taking some kind of lipid-lowering medication, “so if our consumer engagement agent identifies a patient with diabetes that does not have one of those medications in their profile, we would then have a discussion with the member.”

While the benefits of pharmacist intervention are undeniable, Van Antwerp says, the challenge is finding the right balance of face-to-face interaction and automation. Issues also include getting a good return on investment for such services by condition and the fact that only an estimated 60% of the people picking up prescriptions are the patients themselves. In addi-
tion, “the staffing model right now would be stressed if pharmacists were spending significant
time on cognitive services,” he maintains.

In the case of CVS Caremark, the PBM is picking up the bill at no extra cost to its clients. Why it would do this is simply “because it is good business,” Van Antwerp says. “This takes them out of the claims-processing and mail-fulfillment business and puts them in the critical path of improving health outcomes.” In addition, the use of their retail assets and large pharmacist base “is a strategic opportunity for them to differentiate themselves and continues to validate the combined entity.” ♦

**Plans Curb Specialty Spend by Tweaking Formularies, Dispensing**

As hundreds of exorbitant specialty drugs continue to flood the market, payers are modifying their benefit plan designs to absorb the shock. Balancing member access against costs that can be tens, and even hundreds, of thousands of dollars per member per year, PBMs are deploying every tool at their disposal to tame the torrent, including formulary management, limited-quantity prescription fills and close monitoring of clinical outcomes. Emergent data has already indicated some of these strategies work. More time will tell if these tools can control skyrocketing specialty drug costs.

“Right now there are over 400 drugs in late stage development — that’s stage two or three,” Kristen Reimers, director of clinical operations and the integrated specialty pharmacy program for Excellus Health Plans, Inc., said in a December 2010 AIS webinar. Reimers cited Express Scripts, Inc.’s 2009 Drug Trend Report as calculating specialty drug trend over the past year at 19.5%. “What’s really staggering about that increase is that three-quarters of it is due solely to inflation or manufacturers’ price increases,” she said.

Reimers noted that about 40% of specialty drugs are for treating cancer. “Traditionally, the cost of these therapies was being managed on the medical side of the benefit,” she said. “Now they are falling onto the pharmacy benefit at costs that are sometimes greater than $40,000 per person per year.” She offered one example of an employer with 200 employees that had a plan member diagnosed with metastatic breast cancer; the employee’s specialty drug regimen incurred costs to the plan of $50,000 a year, an amount made more egregious by the fact that it represented approximately a quarter of the employer’s annual drug costs.

One of the foremost stratagems benefit managers have pitted against inflating costs is tighter management of their formularies. “Our optimal plan design recommendation has been — and continues to be — a four-tier plan that places preferred and non-preferred specialty drugs on separate tiers,” Peter Wickersham, vice president of cost of care at Prime Therapeutics, Inc., tells AIS. Making sure that member out-of-pocket costs are affordable is also important with multiple-tier formularies. “For preferred specialty drugs, we recommend a maximum member cost share of $100. Our research has determined that higher out-of-pocket costs may cause patients to abandon drug therapy, potentially resulting in serious health complications.”

Ed Pezalla, M.D., national medical director for pharmacy policy and strategy at Aetna Inc., and a co-presenter at the AIS webinar, agreed that rigorous management of formularies was
one of benefit managers’ first lines of defense. “We’re going to do more tiering of specialty formularies,” Pezalla said. “Right now many plans have just a coinsurance level and that’s it. We’re going to do more tiering to allow us to make provisions for biogenerics.”

Tighter formulary management is only scratching the surface when it comes to solving the conundrum of cost vs. therapeutic efficacy. Plans will get more bang for their buck if they limit prescription quantities and implement step therapy, Michael Jacobs, a senior consultant at Buck Consultants, Inc., tells AIS. “Employers are asking their specialty providers to one, limit the amount of drugs dispensed,” Jacobs says. “Dispense only 30 days at a time, not 90. That addresses some of the waste issue and limits the financial outlay for the employee, who can now afford it, and the employer, who can spread out the payments.”

**Tracking Clinical Outcomes**

Also, Jacobs recommends to benefits managers, “Don’t refill automatically. Before reauthorizing, see if they’re taking it, see if it works and what the results are. Because at $3,000 a month or $100 a day, frankly, I don’t want to pay for something that isn’t working.”

“Employers are demanding those types of measures,” Jacobs adds.

Making the right decision sometimes means returning to the traditional tools that PBMs have always used to squeeze value and efficiency out of a benefit plan. “[Plans] are going back to protocols that worked on small molecule and oral drugs,” Jacobs says. Among those that make the most sense when applied to specialty drugs is “step therapy, starting with the least expensive therapies and working your way up through the formulary, documenting treatment failures as you go along.”

“We’re making sure you’re using the most cost-effective drugs first before you go right to the specialty medications,” Eric Elliott, president and CEO of Prime Therapeutics, tells AIS. Monitoring clinical outcomes to make sure patients are responding to therapy is another way that the PBM makes sure that medications are truly offering value.

Elliott offers as an example protocols around hepatitis C medications, citing clinical lab tests that can be administered at 24 weeks after first taking a drug to evaluate its efficacy. “At that point, 30% of hep C patients should discontinue taking that particular drug,” Elliott says. “At 48 weeks, there is a complete discontinuation of service [if the medication is not getting results] because all the clinical guidelines for hep C say medication serves no purpose beyond that duration.”

CIGNA, Corp. has adopted an even more intensive, integrated response toward managing its plan members’ responses to medication. “We believe the first priority should be to make sure someone actually needs a specific medication,” Thom Stambaugh, vice president of specialty pharmacy for CIGNA, tells AIS. “We focus on what we call an advanced utilization approach for these high cost specialty medications, making sure the individual is getting the right drug, staying on that drug appropriately, in the most appropriate setting for administering the drug, and from the most efficient pharmacy.”

CIGNA has minted its approach to managing specialty drug therapies under the rubric TheraCare, which targets 15 conditions. The program includes medical, behavioral and pharmacy clinicians to help patients adhere to their medications and manage some of the side effects associated with these drugs. As their therapy progresses, patients are taught to evaluate
drug efficacy, expedite refills and determine if it is possible to move to an alternative, cheaper administration of the drug, e.g., moving from infusion in a doctor’s office or infusion center to administering the drug themselves at home. “This often overlooked step can significantly reduce costs for an individual and his/her plan sponsor,” Stambaugh says. “And for many individuals, the option of receiving the drug in their home may be preferable to going to a medical office or facility.”

Waiting for CER

Some benefit managers are increasingly weighing comparative effectiveness research (CER) to help them make the most judicious decisions in specialty therapies. To that end, CER can aid them in placing the most effective drugs on formularies and in steering patients with specific conditions toward the drugs that are most likely to get results. Buck’s Jacobs lauds recent federal laws for their emphasis on CER, earmarking a billion dollars for activities that include the creation of a national information clearinghouse and research center.

Although plans are beginning to scrutinize what data there is, research is scant in the nascent field of CER. Faced with a dearth of clinical outcomes data, some PBMs like Medco Health Solutions, Inc. and plans like The Regence group are conducting their own research, but this is still in the early stages (and the federal effort, while it’s received a lot of funding, has not advanced very far at this point).

In addition to the advent of CER, pharmacy managers are looking to the future for relief from the financial pressures of the specialty category. One development on which many pin significant hope is potential competitive price reductions due to the introduction of biosimilars. But Jacobs cautions that “some of the pending legislation for biosimilars is going to be fought for a very long time.”
Formulary Control

2010 Specialty Drug Pipeline Could Mean Formulary Management Issues for Payers

Health plans have done well managing and controlling their spend on many drugs, but one area is eluding most payers’ efforts — specialty pharmacy drugs. 2010 could very well see new specialty entrants for conditions that already have a number of expensive therapies available, which could lead to new management options.

All signs indicate that there probably won’t be any relief from specialty drugs’ high costs anytime soon. The pharmaceutical pipeline is full of hundreds of specialty therapies focused on a wide array of conditions. And because there now is no pathway for the FDA to approve biosimilar drugs, specialty biologic drugs do not have any generic competition to allow less-expensive options. Even if the final federal health reform legislation contains a follow-on biologic provision, most experts agree it would be at least a couple of years before the first of these drugs hits the U.S. marketplace.

In addition to new specialty drugs, 2010 will see changes to how those drugs are managed, contends Nick Opalich, managing principal at Strategica Health Partners. “Newer features adopted by employer-driven health plans will include an increase of value-based plan design, greater management of specialty drugs under the formulary, higher management of the specialty class by mail service and a certain increase of plans offering a specialty pharmacy option,” he told AIS in early 2010. Second, third and fourth tiers “will include combinations of generics at retail and mail, as well as brands at retail and brands at mail.” Brands will be further distinguished as preferred or nonpreferred, he says.

Multiple sclerosis (MS) and rheumatoid arthritis (RA)/anti-inflammatory therapies consistently rank as two of the top drivers of pharmacy spend within the specialty drug category, according to various PBM drug trend reports. Patrick Gleason, Pharm.D., director of clinical outcomes assessment at Prime Therapeutics LLC, tells AIS that from 2007 to 2008, the utilization of self-injected MS drugs among the 8 million Prime members actually went down a little, yet the drugs “represent $1 of every $40 spent” at the company. This ratio, he says, should be fairly similar to that of any other commercial plan. Anti-tumor necrosis factor (TNF) therapies for auto-inflammatory conditions such as RA and psoriasis represent $1 of every $33 spent at Prime, he adds. The PBM estimates that 40% of the pharmacy benefit spend goes to MS drugs and TNF blockers, he says.

Both MS and RA already have a number of biologic therapies available for patients, and 2010 should bring even more of these options. More alternatives for patients could well result in some therapies being placed on different drug formulary tiers, rather than just placing all the biologics on the highest tier. In fact, according to the fifth edition of the EMD Serono Injectables Digest — which surveyed 69 health plans with more than 83 million covered lives representing commercial, Medicare Advantage prescription drug plan and managed Medicaid lines of business on their specialty pharmacy management — 56% of respondents had at least one preferred product in MS, as well as in RA.
The Novartis Pharmaceuticals Corp. MS drug Extavia (interferon beta-1b) entered the U.S. marketplace in late 2009 and may give payers the ability to prefer some of the self-injected MS products even more. The drug is clinically identical to Betaseron (interferon beta-1b), a therapy that has been available for more than 16 years. Extavia “will find its place [on payer formularies] if plans want to be more aggressive with their contracting and product preferencing,” said Nick Calla, vice president of trade relations for Walgreens Specialty Pharmacy, in January 2010.

**First Oral MS Drug Could Be Approved**

Extavia is the first of two MS treatments expected from Novartis, but it’s FTY720 (fingolimod) that physicians and patients alike seem to be most excited about. The drug could be the first oral MS therapy in a market dominated by self-injected, as well as a few infused, treatments.

“I imagine that an oral product would be embraced if it had clinical benefit, and because it’s oral, it may be considered favorably,” says Sean Karbowicz, Pharm.D., manager of clinical pharmacy services for RegenceRx, The Regence Group’s PBM. However, because MS “is a severe disease and very frightening, I don’t know if an injectable is a barrier to use.” The drug could hit the U.S. marketplace by late 2010.

Acorda Therapeutics Inc. submitted a new drug application to the FDA in 2009 for Amaya (fampridine), with a proposed indication of improving walking ability in people with MS. Approval is expected in January 2010, says Renee Rayburg, director of clinical services for BioScrip, Inc., who adds that there “could be significant utilization” among the 350,000+ people in the U.S. with MS.

The RA drug Actemra (tocilizumab) is expected to hit the U.S. marketplace in 2010 as the newest entrant to a crowded group of therapies that welcomed a pair of new drugs in 2009. Genentech, Inc., now part of the Roche Group, and Chugai Pharmaceutical Co. co-developed the drug, which was submitted for FDA approval in 2007. An FDA advisory committee in 2008 recommended the drug be approved, but the FDA has requested additional information, which Roche says it is working with the FDA to provide. Approved in several other countries, Actemra has a different mechanism of action from currently approved therapies and would be aimed at helping those patients who do not respond to TNF inhibitors or disease modifying anti-rheumatic drugs. There are now eight biologic therapies approved for RA, five of which are anti-TNF agents.

Out of 100 U.S. rheumatologists surveyed, 98% said they will prescribe the drug after it launches, with most respondents pointing to efficacy that is comparable to that of the TNF inhibitors, according to a report from Decision Resources, a research and advisory group for pharmaceutical and health care issues. Among the 20 surveyed pharmacy directors at managed care organizations, 75% said they would likely cover the drug, but most said they would not give it more favorable reimbursement than other RA therapies, says the report, released in November 2009.

The following conditions are also expected to see specialty therapies approved in 2010:

- **Chronic hepatitis C**: FDA approval of Zalbin (albinterferon alfa-2b) is expected in third-quarter 2010, Rayburg says. It is administered subcutaneously once every two weeks and is a
long-acting formulation of interferon alpha 2b, she says. It is being developed by Human Genome Sciences and Novartis. “A new [hepatitis C] drug will need to be a star to change well-entrenched prescriber preferences,” contends Bill Sullivan, principal consultant with Specialty Pharmacy Solutions, LLC.

**Lupus:** According to the Lupus Foundation of American, lupus has not had a new therapeutic option in more than 50 years — but that could change with the expected FDA approval of Benlysta (belimumab), formerly LymphoStat-B, in late 2010. The drug was co-developed by Human Genome Sciences and GlaxoSmithKline. Compared with some of the other market entries for 2010, “Benlysta will have an easier time establishing itself since there are few therapy options for lupus,” Sullivan says.

**Osteoporosis:** FDA approval of the Amgen Inc. therapy Prolia (denosumab) for the treatment of osteoporosis is expected in mid-2010, says Rayburg. The therapy is a subcutaneous injection every six months, which is “very favorable for compliance — oral therapies range from daily to once a month,” she explains.

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**Payers, Not MDs, Have More Influence Over Rx Prescribing**

Payers’ restrictive formularies and more rigorous evaluation of new therapies is changing the way pharmaceutical companies market their products by putting a greater emphasis on published research results. That could give PBMs and health plans greater influence over which drugs are prescribed, said some industry analysts in early spring 2010.

“As cost control pressure mounts, those paying for and managing prescription drug plans will have the greatest influence over what products will be available for the physician to prescribe,” Mike Wokasch, executive advisor at Wokasch Consulting, LLC, and author of the Pharmareform.com blog, tells AIS. As a result, plans and PBMs “will become increasingly important marketing targets for pharmaceutical companies.” That’s because “the realities of health care reform will come with an increased need for cost control at the payer level, and prescription drugs are an easy target.”

While physicians ultimately make the prescribing decisions, Wokasch argues that they have become increasingly constrained by formularies and influenced by payer guidelines. Insurers’ broader generic drug portfolios, restrictive formularies and more rigorous evaluation of products “have diminished physician product choice and are replacing the physician as the primary driver of prescription drug use,” he explains.

The results of this changing dynamic could have an impact on how drug prices are determined. For example, when a drug company decides how to pitch its new product to payers, it will have to prove not only why the product is superior to all the other therapy options, but also why health plans should pay more for it. If drug companies have solid published clinical and economic value data, “they will be able to charge pretty much what they want,” Wokasch asserts.

He adds that this is very different from the days when mediocre products could be transformed into blockbusters with “creative marketing and commercial horsepower,” which in reality meant “big budgets and large sales organizations.”
By contrast, David Clark, vice president of pharmacy services for Regence BlueCross BlueShield and president of RegenceRx, contends that “it is not likely that the [health reform] law passed will give payers more influence over which drugs are prescribed” — especially for Medicare Part D. “When Part D passed, the federal government was strongly lobbied to prevent too many controls over medications by plans,” he tells AIS. “As a result of all efforts, Part D plans are now required to cover all medications in several therapeutic classes.”

For instance, CMS requires that Part D formularies include all or substantially all drugs in six drug classes: antidepressant, antipsychotic, anticonvulsant, immunosuppressant, antiretroviral and some chemotherapy drugs that aren’t generally covered under Medicare Part B.

In fact, Clark adds, “if health care decisions are not made on a scientific basis, payers’ influence over appropriate therapy could be decreased.” For example, he explains, even drugs that are backed by weak scientific evidence with poor ratings are sometimes still approved by the FDA. And even when Regence’s pharmacy and therapeutics committee votes to not include a certain drug on its formulary, CMS could require the PBM to cover it in Part D products.

Such government mandates, especially those requiring specific coverage of products or treatments, also could have the unintended consequence of increased costs, Clark warns. “Mandates limit payer ability to negotiate price or coverage based on the clinical value of the product or treatment.”

**Payers Demand Better Clinical Evidence**

Regence currently requests access to all of a drug maker’s studies when reviewing new products, “to help us find the evidence that provides sound enough information to help guide better clinical decisions,” Clark says. “What we have seen is that a large number of studies are so poorly done they cannot be used to make clinical decisions and that only about 10% of new products provide more value clinically than previously available products.”

Wokasch agrees that drug companies will have to step up their game to offer proven, clinically meaningful products that stand out over other therapeutic options. “They will have to develop and publish the data to support the clinical claims and prove the value of products they want used, especially if they are expecting premium pricing to other therapeutic options,” he says.

In addition, drug companies will have to increase their use of sales and marketing executives with expertise in managed care markets “to navigate the labyrinth of decision making and negotiate favorable positions for product use within the plan,” Wokasch says. “They will need the assistance of scientifically credible resources (not sales people) to help them discuss the technical aspects of their products.”

While Wokasch acknowledges that many of these marketing tactics are being used today by drug makers, “the level of managed market expertise and the robustness of the clinical data needed will increase proportionately with the cost control intensity of health care reform,” he argues.

Still, marketing directly to plans will prove tough, given payers’ increased level of scrutiny over new therapies. “We focus on science, not marketing,” Clark maintains. “We are already approached by pharmaceutical companies and we will continue to require valid evidence to support the relative value of their products.”
Wokasch agrees that payers won’t tolerate traditional drug company marketing and sales tactics. “As cost control becomes increasingly important, I believe they will further distance themselves from industry influence,” he explains. “Pharmaceutical companies with anything short of definitive published clinical data to support the claims for use and purported value will be met with skepticism and more likely just be dismissed.”

**Payers Demand Better Evidence From Drug Firms When Making Formulary Decisions**

While randomized, controlled clinical trials are the gold standard for obtaining reliable efficacy and safety information on new drugs, a growing number of payers are recognizing that such studies may not be sufficient for making formulary decisions — so they’re taking matters into their own hands. Some are increasing the number of comparative effectiveness research (CER) studies they conduct in-house, while others are building closer relationships with manufacturers to ensure they get the full picture they need.

“The pharmaceutical industry has realized that the market has shifted, and about 70% to 80% of their drugs are now being paid by third-party payers,” Brian Sweet, WellPoint, Inc.’s chief pharmacy officer, told AIS in July 2010. “And they will have to meet our standards to get access.” Up until now, he adds, the problem has been that some drug companies either don’t have or refuse to give payers the data they need to determine if the drug is equivalent to others on the market.

Recognizing this, WellPoint recently developed standardized CER guidelines to evaluate different drugs’ ability to improve health outcomes. These guidelines — the first developed by a health plan — provide the company “with a consistent road map” to evaluate CER, and are used to complement randomized clinical trial studies to make formulary and copayment decisions, Sweet explains.

“The guidelines are basically rigorous criteria that we use to evaluate studies so that we know what works and what doesn’t,” he says. “We want pharmaceutical companies to understand what we’re using to evaluate their drugs and what types of studies we find to be acceptable and not acceptable.”

The company recently tested its new guidelines on two CER studies that it conducted in 2009, one of which resulted in limiting the use of popular osteoporosis drug Boniva (ibandronate).

To determine if Boniva is more effective than more costly drugs Fosomax (alendronate) and Actonel (risedronate), the study looked at claims data for 26,000 of its members on osteoporosis drugs. WellPoint says that from randomized clinical trials, it would appear that the three drugs are equivalent. However, the plans’ research linked Boniva to higher fracture rates, lower patient compliance and higher total costs compared to its alternatives. As a result, WellPoint now requires patients to try the other therapies before they can be approved for Boniva.

Another study comparing oral asthma control drugs with inhaled steroids led to surprising results, Sweet says. “The drug literature and randomized trials would tell you that inhaled steroids are the gold standard for treatment in asthma and in controlling symptoms,” he ex-
 plains. But experts on WellPoint’s pharmacy and therapeutics committee encouraged the plan to take a closer look at oral controllers such as Singulair (montelukast).

After studying patient claims data, the plan found that a large population of patients were not compliant with their inhaled steroids, “no matter how much we reinforced compliance,” Sweet says. Patients taking Singulair, on the other hand, were more adherent, and as a result had lower emergency room visits and hospitalization rates.

“There is a significant amount of outcomes and safety information that you’re not going to get from randomized trials because people are observed very closely and told what to do,” Sweet maintains. “And in the real world setting, that’s just not the case.”

Sweet says that many drugs on WellPoint’s formulary have been through this process. And a number of additional studies are underway in various therapeutic areas via WellPoint subsidiary HealthCore, Inc.

**Study Reveals New Info on Diabetes Drugs**

On behalf of its plan clients, Medco Health Solutions, Inc. has been conducting similar studies to compare popular drugs.

In June 2010, Medco released the results of a study that examined the relationship between the risk of acute pancreatitis and two popular medications to treat diabetes, Byetta (exenatide) and Januvia (sitagliptin). While the drugs had been shown to lower a patient’s blood sugar without hypoglycemia or an increase in body weight, several reported cases of acute pancreatitis led the FDA to add warnings to the drugs’ labels to alert physicians and patients of the potential risk.

For the study, Medco analyzed pharmacy and medical claims data for more than 786,000 patients over a two-year period. The diabetic patients were divided into three groups based on the antidiabetic drug they were taking — Byetta, Januvia or other oral antidiabetic drugs — and compared with a nondiabetic control group.

The study revealed that patients taking either of these two medications were no more likely to develop acute pancreatitis than patients taking other antidiabetic drugs.

While such studies reveal a lot of useful information, plans should be careful when conducting their own CER studies, warns Sean Karbowicz, PharmD, manager of clinical pharmacy services at RegenceRx. He says that real-life, retrospective analyses of databases can reflect a correlation, but they may not necessarily prove cause and effect. “We need to be careful with some of this research, because it could potentially be misleading,” he tells AIS.

RegenceRx, The Regence Group’s PBM, is taking a slightly different approach to getting the information it needs to make formulary decisions. By building closer relationships with drug manufacturers, the PBM says it’s helping companies understand what kind of information is needed from clinical trials before some of the studies are even conducted.

“It’s a goal of ours to work collaboratively with manufacturers, because ultimately that will lead to better health outcomes for our members,” Karbowicz says. “We provide feedback to manufacturers after we review their information on what the elements are that we’re looking for.”
As a result, he adds, drug manufacturers “have been more open and more willing to provide additional details about their studies.” In fact, the method has been so successful that some drug companies are even planning what kinds of post-market studies they will conduct prior to getting FDA approval for their medications.

“Up until recently, the bar for manufacturers has been set low,” Karbowicz explains. “Obtaining FDA approval and demonstrating that a drug is effective is a very different question than the ones health plans often have when trying to discern differences between products.”

In a recent study, Regence found that on average, only one in 10 randomized clinical trials were of “fair quality” over the past several years. The study covered about 1,000 clinical trials per year between 2006 and 2009. At the beginning of 2009, no more than 8% of the studies were considered reliable.

Moreover, RegenceRx examined drugs approved by the FDA around the same time period and compared them with existing medications. The PBM found that just 15% offered improved effectiveness, only 1% had added safety, 4% yielded cost savings and 2% showed better adherence.

Karbowicz says that in order for drug makers to set their products apart, a different kind of research is needed.

“Because we often don’t have direct studies that compare one product or treatment to another, we have to look of the next best thing,” he explains. “That means looking at the overall body of scientific evidence and teasing out what’s reliable and looking at whatever data that is available and seeing how products can compare indirectly.”

More Firms Toss ‘Lower-Value’ Drugs Onto Fourth Tier

A growing number of employers have been switching to formularies with four or more tiers to curb their spending on lifestyle drugs and expensive medications — a practice that some criticize for passing more costs onto employees.

About 13% of covered employees are in a plan that has a formulary with four or more tiers for prescription drugs, according to the Employer Health Benefits 2010 Annual Survey, released Sept. 2, 2010, by the Kaiser Family Foundation and the Health Research and Educational Trust. For employees in plans with four-tier formularies, the report found that 46% have a copayment for drugs that fall into the highest tier and 24% have to pay coinsurance share. The average copay for fourth-tier drugs is about $89, while the average coinsurance share is 36%.

Four-tier plans are intended to offset payers’ costs and encourage lower utilization of expensive specialty or biologic drugs. However, some argue that four-tier plans could be counterproductive and ultimately more costly if they lead to nonadherence to therapy.

“I’ve seen a lot of opposition to four-tier plans because they’re looking to push more cost to employees, which may be the case in some situations,” Tim Heady, CEO of UnitedHealth Pharmaceutical Solutions at UnitedHealth Group, told AIS in September 2010. “Whether it’s a three- or four-tier plan, there is an element of cost sharing established in any cost design. However, we don’t think of using a fourth tier just to simply increase the cost to the employee, but rather we think of it based on relative value.”
According to Heady, if a drug is placed on the fourth tier, it is viewed as less valuable. “The idea of cost-shifting versus better decision making is simply a matter of choice,” he explains. “If there are no alternatives, and you simply throw whatever expensive items are onto a fourth tier, that’s clearly cost shifting.” However, if drugs that prove better clinical and economic value are placed on a lower tier, “that is to motivate member behavior towards the better-value choices,” he adds. “Then, if the individual spends more money, it’s by choice — not need.”

UnitedHealth recently launched a pilot program of its new four-tier plan offering, Brand-Plus Rx, which aims to “bridge potential coverage gaps” by making higher-cost brand and specialty drugs more affordable to small businesses by letting patients absorb the costs of their own lower-priced generics and over-the-counter medications. “The idea here is not cost-shifting, it’s responsible cost management,” Heady maintains.

Others contend that “more isn’t always better” when it comes to formularies. While a three-tier or four-tier benefit could provide greater rebates in transparent contract arrangements, “it doesn’t necessarily manage to lowest net cost,” argues Nadina Rosier, Towers Watson’s North America pharmacy practice leader. “Before an employer considers automatically adding another tier to their benefit structure, the client should consider what they’re trying to accomplish and determine if there is a simpler design that promotes consumerism and will not adversely impact adherence.”

This is especially concerning for patients on specialty medications where high coinsurance — without a maximum or cap — could prevent someone from filling and taking their medications regularly, she says.

“As the drug pipeline has evolved and employers think about ways to manage their benefit more aggressively, plans have begun distinguishing between therapies that are ‘life saving’ versus ‘life enhancing,’” Rosier explains. “Some have also evaluated and distinguished therapy classes that have either generic or OTC alternatives available — these are common medications that have been placed in higher tiers within the benefit.”

Rosier says her company has been engaging its clients to “re-evaluate their overall health care benefit philosophy and their cost-mitigation strategies.” This has caused some employers to unravel their traditional three-tier design in favor of other approaches.

She maintains that managing inappropriate utilization is the best way to control long-term trend without increasing cost-sharing for employees. “Implementing a variety of clinical programs such as prior authorization and step therapies can ensure appropriate use aligned with evidence-based guidelines, and help employers manage their drug spend over the short and long term,” Rosier advises.

Allegra Goes Over the Counter, Off the Formulary for Most Pharmacy Benefit Plans

Allegra (fexofenadine), the popular allergy-relieving antihistamine, may become even more popular now that it has the FDA’s green light for over-the-counter sales. Sanofi-Aventis racked up $452 million in sales in 2010, according to IMS Health. Available since March 2011 without a physician’s say-so, Allegra and its generic versions could rake in that much and
more in years to come, although with Sanofi and its competitors slashing prices down to below $20 per 30-day fill from amounts several times that just in 2010, makers will have to move a lot more units.

And they will have to do it without drug benefit plans — which rarely cover OTC drugs without a prescription — picking up the tab for Allegra or its generic equivalents. Ever since the drug gained OTC status, health plans and PBMs have been busily notifying enrollees that they will have to pay for the anti-allergy medication out of pocket.

OTCs take more out of pocket than ever, thanks to the Patient Protection and Affordable Care Act. Effective Jan. 1, 2011, a PPACA mandate stipulated that consumers could no longer use their flexible spending accounts (FSAs) or health reimbursement arrangements (HRAs) to cover the cost of OTCs unless prescribed by a physician.

CareFirst BlueCross BlueShield waited for the sky-high pollen counts of spring before informing enrollees in a mass mailing it would no longer cover the medication. An April 7, 2011, letter signed by Winston Wong, Pharm. D., associate vice president of pharmacy management, told members their “prescription drug plan will no longer pay for” Allegra or generic versions of fexofenadine. As an anesthetic to make the transition a little less painful, Sanofi ponied up a $5 coupon toward the members’ first over-the-counter purchase of the drug.

Milwaukee-based PBM Restat Inc. got a jump on the transition by informing plan sponsors in February 2011 of the impending change in Allegra’s status and recommending that they eliminate coverage of it and other legend and OTC antihistamines, accentuating the attractive bottom line. “Depending on the plan, clients could realize yearly savings of 1% to 5%” off their overall drug spend, the letter read.

Prior to their OTC approval, Dohmen subsidiary Restat tiered generic forms of Allegra and Allegra-D (fexofenadine-pseudoephedrine), a version with a decongestant, with other generics on its formulary. When Sanofi announced the new OTC status for Allegra and stopped shipping the legend version to pharmacies, Restat removed both generic forms from its formulary for those clients who did not cover OTC medications. Restat informed clients of the changes in February 2011 and suggested several solutions.

“Restat recommends that clients require a prescription from a physician for an OTC product, which will help ensure the member is receiving regular follow-up with their physician and require the OTC product to undergo a drug utilization review to identify potential interactions with other prescription medications,” Scott Draeger, Pharm.D., director of clinical services for Restat, told AIS in April 2011.

But Restat will help clients design a benefit plan that covers OTC items, if so desired. “Typically, Restat will conduct a financial analysis for interested clients to determine if it makes sense to offer coverage for certain OTC medications,” Draeger says. “Proton pump inhibitors and antihistamines are the most commonly covered OTCs in the Restat book of business.”

**Plans Can Require Prescriptions for OTCs**

In some cases, Restat clients require the trial and failure of OTC medications before legend alternatives are allowed. Then, if OTC drugs are allowed, Restat recommends that clients still require a prescription. “In cases where the OTC alternative offers the best value — equal or
superior efficacy at a lower cost — then it makes sense to offer coverage for these products,”
Draeger says.

Larger health plans may offer less flexibility for drugs that have gone over the counter. As a general rule, CIGNA Corp., which has a captive health plan, covers only FDA-approved prescription medications in its standard pharmacy benefit plans.

“Only covering those medications that require a physician’s prescription and oversight can be part of an overall cost management strategy,” CIGNA spokesperson Lindsay Shearer told AIS. “Adding OTC drugs to the pharmacy benefit package would dramatically increase the cost of that coverage.”

“Think about how you purchase OTC medications — aspirin, cough medicine, cold or flu medications, antacids, topical antibiotic ointments or liquids — and the list goes on. Now just imagine multiplying that by all the families buying these same medications. The impact on the cost of pharmacy benefits would be enormous. This country, which is seeking ways to decrease the cost of health care benefits, simply cannot afford that additional cost added on to existing pharmacy or medical benefits,” Shearer says.

Now that the brand and generic versions of fexo-fenadine have won OTC approval, competition isn’t just heating up, it’s going global.

Besides a generic equivalent manufactured by U.S. drug maker Barr Pharmaceuticals, Inc., Israel-based Teva Pharmaceutical Industries Ltd. and Dr. Reddy’s Laboratories Ltd., headquartered in Hyderabad, India, have received FDA clearance to sell generic fexofenadine in the United States.

But Sanofi is likely to hold its own against these upstarts, as its preparations to sell the unscripted Allegra have long been underway. At the end of 2009, when the French drug titan announced it was buying Chattem Inc., a Chattanooga, Tenn.-based maker of health and beauty products, for $1.9 billion, many industry watchers construed a shrewd move to tap native expertise for moving low-priced products in the U.S. market. So far, Chattem has not disappointed, launching OTC Allegra in 25,000 retail stores and posting coupons on the proprietary Allegra.com website. ♦
Generics Utilization

2010 Generic Entrants to Offer Savings in Hypertension, Depression, Other Classes

As health plans finalize 2010 pharmacy benefit designs, one key consideration is how they’ll maximize the opportunity from likely new generic drug entrants for hypertension, depression, Alzheimer’s disease and other conditions. Most payers’ pharmacy benefit designs already include automatic generic switches for equivalent drugs, so little strategy is required to benefit from those savings. But PBM executives say payers also should take advantage of savings stemming from switching patients to new generic alternatives that aren’t chemically identical but are the same class.

Brand-name drugs that generated $8.8 billion in 2008 retail and mail-order sales will lose patent protection in 2010, said Andrew Behm, Pharm.D., senior director of Express Scripts, Inc.’s office of clinical evaluation and policy, in September 2009.

Looking at the potential for cost savings associated with greater use of generics, “typically, about 2% to 3% of the opportunity to use generics is about equivalents, and 97% of the opportunity is about alternatives,” says Colleen Manley, senior director of channel and generic client engagement at Medco Health Solutions, Inc.

“The opportunity is really in the scenario around the market share and mix of medications within a given generic category where you can promote and encourage optimization of generic alternatives,” agrees David Lassen, chief clinical officer at Prime Therapeutics, LLC, a PBM owned by several Blue Cross and Blue Shield plans. After all, “for every 1% increase in the overall generic utilization rate across the population, we would anticipate a 1% to 2% decrease in expenditures for pharmacy costs,” he said in September 2009.

<table>
<thead>
<tr>
<th>Likely Generic Drug Entrants for 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand name (generic name), manufacturer</td>
</tr>
<tr>
<td>Mirapex (pramipexole), Boehringer Ingelheim</td>
</tr>
<tr>
<td>Aldara (imiquimod topical cream), Graceway</td>
</tr>
<tr>
<td>Astelin (azelastine nasal spray), Meda</td>
</tr>
<tr>
<td>Cozaar (losartan), Merck</td>
</tr>
<tr>
<td>Hyzaar (losartan/hydrochlorothiazide), Merck</td>
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<tr>
<td>Flomax (tamsulosin),* Boehringer Ingelheim</td>
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<tr>
<td>Effexor XR (venlafaxine extended-release), Wyeth</td>
</tr>
<tr>
<td>Arimidex (anastrozole), AstraZeneca</td>
</tr>
<tr>
<td>Rapamune (sirolimus), Wyeth</td>
</tr>
<tr>
<td>Differin (adapalene topical),* Galderma</td>
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</tbody>
</table>

* Possible patent expiration assumes a pediatric extension.

Note: Availability dates for first-time generics are subject to significant change as a result of multiple patent protections, patent litigation, pediatric or other exclusivities, at-risk launches, and delays between patent expiration and launch of first-time generics.

Sleep aids offer an example of how payers can maximize switches to generic equivalents and generic alternatives, Manley says. When zolpidem, the generic version of the sleep aid Ambien, became available in 2008, most patients on Ambien were automatically moved to zolpidem. But at that time, Medco also recommended that its health plan clients move some patients who were taking Lunesta, another sleep aid, to zolpidem. Despite the fact that Lunesta has no generic and is not chemically equivalent to zolpidem, the two drugs are similar enough that many patients can take zolpidem as a generic alternative to Lunesta.

But switching to a generic alternative, as opposed to the generic equivalent, can’t be done automatically. Instead, patients must get their physician to write a new prescription for the generic. As a result, physician-targeted communications are a common tactic used by PBMs to encourage use of generic alternatives.

The PBM operated by United Drugs, Inc., a Phoenix-based cooperative of more than 1,000 pharmacies, launches physician-targeted communications programs in situations where many members are on a brand-name drug that’s about to go generic, says Darla Russell, director of clinical services. Until now, it has been rare for United Drugs to send member-directed communications about a particular drug, she adds. But “in 2010, because there are so many more generics [becoming available], we will be doing more member and physician communications.”

Here’s a look at two key brand-name drugs likely to face generic competition in 2010:

1. **Merck’s hypertension drugs Cozaar and Hyzaar.** Cozaar is an angiotensin receptor blocker (ARB), which is used to treat high blood pressure, reduce the chance of stroke in patients with hypertension and left ventricular hypertrophy, and slow the effect of diabetic kidney disease. Hyzaar combines an ARB with a diuretic. The two drugs, which had a combined $1.3 billion in 2008 sales, “are going to be first-in-class generics,” Behm says. “Therapeutic conversion opportunities become fairly significant once you start talking about categories that haven’t had generics.”

“The other common treatment for hypertension is ACE inhibitors,” Manley explains, “so there have been generics available to treat high blood pressure...but these [ARBs] are a different type of high blood pressure drug” for patients who can’t use ACE inhibitors.

**Some PBMs Promote Brand Before Switch**

Express Scripts, Inc. likely will encourage utilization of Cozaar and Hyzaar while they still have patent protection, says Juyalyna Meyer, vice president of strategic relations and clinical sales support. For example, the PBM might leave those drugs on the second tier, with a lower copayment than other ARBs, so that more patients starting antihypertensives will be likely to take those drugs and will be positioned to transition to the generic once it becomes available. At that time, Express Scripts may move Cozaar and Hyzaar to a higher tier, Meyer said in September 2009.

At Prime Therapeutics, “our clinical strategy has been to really utilize ACE inhibitors,” Lassen says. “That particular class of medications has gone completely generic,” so plans have been encouraging use of ACE inhibitors before moving patients to brand-name ARBs. Once prices for generic ACE inhibitors and ARBs are equivalent, “we would recommend that basically either the generic ACE or generic ARB is appropriate,” he says.
At United Drugs, “Cozaar and Hyzaar are on most of our formularies already,” says Russell. “We would most likely institute a physician-targeted program” to try to move patients on other ARBs to Cozaar and Hyzaar once there are generic equivalents.

**2) Wyeth’s antidepressant Effexor XR.** That drug, which had 2008 retail sales of $2.8 billion, “has a tremendous opportunity from a client’s perspective of just going generic” and allowing for automatic switches from the brand-name version, Manley says. Effexor XR (extended release) is one of a subclass of antidepressants called serotonin-norepinephrine reuptake inhibitors (SNRIs). The generic version of Effexor, venlafaxine, already is available.

Typically, PBMs would encourage utilization of the generic drug rather than a brand-name extended-release formulation that offers more convenience, but no significant clinical benefit. But the original version of Effexor increased blood pressure in many patients, Behm explains, while Effexor XR does not have that effect. “It’s one example where the extended release had a material, not just a theoretical, advantage,” he says.

He adds that Express Scripts doesn’t promote switches in the antidepressant class for patients who are stabilized and having success on one drug. “That’s an exception to the rule, because there are many categories where the products are relatively interchangeable.”

Lassen predicts that a generic equivalent to Effexor XR will become available around July 2010, but as the first generic entrant, that medication likely will have a six-month exclusivity period. Because of that, he says, “the real opportunity probably is in 2011.”

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**Plans Should Focus on Generics As Feds Try to Rein in Prices**

Several reports concerning significant price hikes in prescription brand drugs have recently garnered a lot of media attention and even led to a government investigation into drug manufacturers’ pricing practices. But while many health plans have expressed concern over price increases and their ability to provide the same level of pharmacy benefit coverage over the next few years, some consultants contend that the reports are misleading and maintain that increased utilization of generic drugs will offset the increasing cost of brand drugs.

According to an AARP study, wholesale prices of the most widely used brand-name drugs have shot up about 9% since September 2008 despite the economic downturn. At the same time, average generic prices have decreased, leading to an overall increase in drug prices of 5.4%. Separately, a study by investment bank Credit Suisse found that prices for all drugs from the eight largest U.S. drug companies have risen, on average, at the highest rate in at least five years. Some of the biggest price increases over the past year include more than 85% jumps in prices of both antibacterial drug Bacim and blood thinner Fragmin, according to Destination-Rx, a Web-based drug-price comparison company. Among more well-known brands, the price of muscle relaxant Amrix and blood pressure medication Verelan both increased by 21% since 2008.

Recent news reports have indicated that the drug industry may be artificially raising prices for certain pharmaceuticals in anticipation of new price-containment measures in health care reform, as both the House and Senate health care bills include provisions that could put a dent
in drug manufacturers’ profits. As a result, in August 2009 five lawmakers asked the Government Accountability Office (GAO) to conduct an investigation of drug industry pricing and submit a proposal to continuously monitor prescription drug prices.

**Studies Are ‘Misleading’**

While not denying that drug prices have spiked, drug manufacturers contend the increases have nothing to do with the pending health reform legislation, which may authorize the government to negotiate drug prices directly with drug makers and force the industry to provide bigger discounts for beneficiaries dually eligible for Medicaid and Medicare. And some Democrats are trying to get a provision into the Senate bill that could open the door to lower-priced prescription drugs from other countries. Ken Johnson, senior vice president of the Pharmaceutical Research and Manufacturers of America, says the move to involve the GAO is uncalled for, as it is based on “the misleading use of statistics and sensationalized media reports.” He adds that AARP’s conclusions also are based on incomplete information because they do not take into account discounts and rebates negotiated between drug makers and payers that can significantly reduce the cost of drugs. Pointing to an IMS Health study that shows drug spending growth falling to 1.3% in 2008, he adds that “AARP ignores the historic slowdown in prescription drug spending.”

Adam Fein, Ph.D., president of Pembroke Consulting, agrees that the study is “incredibly misleading” because the list prices are not always a good benchmark for what payers’ costs are, including rebates and other discounts. In either case, health plans shouldn’t worry, he says. “Brand drugs are only about 30% of the market right now, and they’ll be less than 20% of the market by 2013, according to my estimates,” Fein told AIS in September 2009. “So this is a relatively small part of the market.” In addition, roughly $90 billion of branded drug revenues will be available in generic form over the next four to five years, he says. “So those price increases are in some sense going to be mitigated by generic substitution very quickly.”

Still, most insurers say they’ve noticed the prices of drugs going up substantially over the past year. For example, WellPoint, Inc.’s wholesale acquisition cost of branded drugs increased by 10.6% from 2008, spokesperson Lori McLaughlin told AIS in September 2009.

In fact, more than half of plans have said that they are “extremely or very concerned” about price hikes and their ability to provide the same level of pharmacy benefit coverage over the next two to three years, according to a recent survey by Medco Health Solutions, Inc. Consequently, nearly 70% of plan sponsors say they definitely or probably will boost member cost sharing over the next two years — a sharp increase from 46% in 2008. The remainder plan to reduce their members’ share of increasing prices in order to encourage the use of lowest-cost drugs and mail order.

According to Steve Miller, M.D., chief medical officer at Express Scripts, Inc., there are several reasons beyond health reform for why brand drug makers are raising their prices, including a shrinking pipeline and products reaching the end of their life cycles. “A lot of people are speculating about why manufacturers have drastically increased their prices at this point in time, and we just know the end effect of it,” he says.

Now more than ever, Miller said in September 2009, health plans should be taking advantage of generic drugs. He adds that many health plans that have historically avoided generics are now enthusiastically embracing them and, in turn, helping to moderate large increases in
branded drug prices. “For our clients, the price increases are significantly lower than the na-
tional increase because of our use of generics, and we still have clients whose trends year over
year are relatively flat,” he tells AIS. “And if all Americans were to use generics to the maxi-
mum appropriate level, we believe about $8.2 billion in drug costs could be saved.”

Miller adds that federal negotiation of drug prices will not lower costs, unless there is a
tight formulary with very few products, allowing them to negotiate for a best price. “If the
government really wanted to impact the drug price, they’d have to have best commercial
practice, which is what PBMs do by having a clinically developed formulary that narrows the
number of products so we can get better prices than what’s typically available in the mar-
ketplace.” Pointing to the success of Medicare Part D programs, Miller says the government
should follow the lead of PBMs. “Medicare Part D has been successful in holding down its
costs mainly because it’s a federally funded program run by private organizations like Express
Scripts and others that are able to manage those funds very effectively.” ♦

**Generic, Brand Cost Differential Plays Larger Role in
Tough Economy**

While getting patients to switch from using brand-name medications to low-cost generics
involves more than just financial motivation, a number of new studies are raising questions
around the importance of patients’ price sensitivity and are asking whether most payers’ ben-
efit designs have sufficient cost-sharing differentials to improve brand-to-generic conversion
rates.

One study published in the February 2010 issue of the *American Journal of Pharmacy Benefits*
found that patients most resistant to using generics would need to save an average of $25.50
per month in order to choose a generic alternative over a brand drug. However, at present,
the average difference between copayments that patients pay for generic and preferred brand
drugs is about $13.

“Evidence is pretty solid that if you increase the differential to the appropriate amount,
patients will move towards lower-cost generics,” Emily Cox, Ph.D., senior director of research
at Express Scripts, Inc., told AIS in March 2010. Express Scripts’ formularies have about a $20
differential, which is consistent with most of the large PBMs that AIS interviewed. Internal
studies conducted by Medco Health Solutions, Inc. — which tracked actual behavior for more
than half a million drug users — turned up similar results, according to Ken Malley, vice presi-
dent of channel and generic strategy. Medco’s findings showed that few patients would choose
the generic equivalent of a brand when the copay differential is less than $10 per month. “In
fact, we found that 95% of all the movement occurs with a differential of $22 per month,” Mal-
ley tells AIS.

On average, Medco’s copay differential is $24 between generics and brands. This is
achieved by both increasing copay amounts for brands and decreasing them for generics.
“Copays have been rising generally, but there has been a focus on the large number of generics
available to make sure they’re affordable to patients,” Malley says.

However, Cox warns that payers should be sensitive to pricing of brand drugs if they’re
trying to attain a high cost differential. “We recommend an upper limit,” Cox tells AIS. “You
can’t go to a $30 or $45 price differential, because then you’re just increasing the brand copay. We found that at a particular point — when you do have a very high differential — members using branded drugs just stop taking their medications and are not shifting to generics.”

HealthTrans, LLC, is one such PBM that chooses to set a smaller copay differential spread out of concern that patients will become nonadherent with higher out-of-pocket costs. For its clients with three-tier benefit designs, the differential is approximately $16, while the differential on a two-tier benefit design is about $11.

**High Differential Could Lead to Nonadherence**

“High cost differentials among various tier levels of a prescription benefit design may cause a greater shift towards the lower-cost or preferred agents due to the increased out-of-pocket expenses for a patient,” Andy Szczotka, senior vice president of corporate clinical services at HealthTrans, told AIS in March 2010. At the same time, “there is concern that greater out-of-pocket expenditures may be a contributing factor towards patient nonadherence or noncompliance with their prescribed drug regimen.”

Brian Solow, M.D., vice president and senior medical director at UnitedHealth Group unit Prescription Solutions, says that all payers would “love to know what the ideal copay amount is.” However, he adds, financial incentives are not enough to drive members to generics — even with sufficient cost-sharing differentials. Prescription Solutions, which hasn’t changed its $15-to-$20 copay differential for several years, was the PBM with the highest generic penetration rate in 2009, according to Solow.

“We feel that there are several other aspects that go into driving our 70% generic penetration rate that are playing a role along with that differential,” Solow tells AIS. For example, Prescription Solutions has a physician outreach program to educate doctors on benefit designs.

For Medco, a preferred drug step-therapy benefit design has been one of the PBM’s most successful programs for driving patients to generics. According to Malley, 60% of Medco’s covered lives use this program, and enrollment is growing significantly.

“The wild thing about the program is that it’s not uncommon for it to achieve a 95% share shift to the generic alternative, or the nonpreferred brand to preferred, making it a very significant source of savings for payers — and there has been virtually no patient noise,” he says. “Clients are anxious before they use this program, but they always come to us and say that was much easier than they expected and the savings were unprecedented.”

According to Solow, one of the major contributing factors that prevents patients from switching to generics is lack of education about their safety and efficacy. Studies by Prescription Solutions have revealed that nearly one-third of patients don’t know or believe that generics have the same active ingredients and effectiveness as brand drugs, and two-thirds are unaware of the cost differences. At the same time, 71% of patients remain concerned about drug costs — with more than 27% having either delayed filling or not filled their prescription in order to save money.

The results of another study released in March 2010 reinforce the idea that consumers have become more price sensitive toward prescription drugs, especially brand medications. According to an analysis conducted by Wolters Kluwer Pharma Solutions, Inc., there were 2.6 billion prescriptions filled for generics in 2009 and only 1.3 billion for brands.
Benefit Managers Alter Plans to Reap Savings Stemming From 2012 Generics

With the patents of an unprecedented number of blockbuster brand drugs expiring in 2012, drug benefit managers are modifying their plan designs to take advantage of the savings offered by generic competitors. Foremost among the challenges they face is getting plan members to shift from brand to generic drugs. Accordingly, benefit managers are incorporating a host of tools and tactics into their plan designs to increase generic utilization.

Pharmacy managers harbor little doubt that the plethora of patent expirations on major brand drugs will make 2012 a watershed year. “Everyone characterizes this as a landmark event in our industry, and I think it’s real,” Robert Galle, COO of pharmacy benefit management for Aetna Inc. told AIS in March 2011. “The number of drugs coming off patent will create an unprecedented amount of activity. It affects almost 20% of our total drug spend.”

Among the brand drugs facing patent expiration in 2012 are some of the most popular moneymakers in the history of the pharmaceutical business. Patents are scheduled to run out on the blood clot inhibitor Plavix (clopidogrel); the asthma drug Singulair (montelukast); Concerta (methylphenidate), a drug for attention-deficit hyperactivity disorder; and the antipsychotics Seroquel (quetiapine) and Zyprexa (olanzapine), to name just a few.

Interestingly, a disproportionate number of the patent expirations are for drugs used to treat schizophrenia and other mental disorders. “Antipsychotic use in our book of business has increased 5%,” David Lassen, chief clinical officer for Prime Therapeutics, LLC, tells AIS. Among the robust antipsychotics trade, Lassen adds, “the opportunity for savings generic Zyprexa offers is meaningful.”

“Changes in plan design to take advantage of this opportunity are being seriously evaluated due to the expiration of key blockbuster brand drugs,” Nadina Rosier, North American pharmacy practice leader for Towers Watson, tells AIS.

“Despite the fact that generics use has long been mainstream, a recent survey we conducted found nearly one-third of Americans still do not know or believe that generics have the same active ingredients and effectiveness as brand name drugs,” Brian Solow, M.D., senior medical director for clinical services at Prescription Solutions, the PBM subsidiary of UnitedHealth Group, told AIS in March 2011.

For the record, Solow clarifies that a generic drug is by definition bioequivalent to its brand-name counterpart in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

One of the best-known means plan sponsors have at their disposal to sway

<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic</th>
<th>Patent Expiration</th>
<th>Sales (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plavix</td>
<td>clopidogrel</td>
<td>05/17/2012</td>
<td>$6,130</td>
</tr>
<tr>
<td>Seroquel/XR</td>
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<td>Singular</td>
<td>montelukast</td>
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<td>Actos</td>
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<td>Detrol/LA</td>
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SOURCE: Express Scripts, Inc.
their members to switch from brands to generics is by reinforcing the price differential. “We are advocating an increase in the differential between generic and brand name copays,” Prime’s Lassen says. “Right now the average differential between Tier 1 generics and Tier 2 preferred brands is about $15. We think this difference should be bigger. We’ve seen research suggesting consumers need to save an average of $25 in order to select a generic over a brand name drug.”

**Plans, Sponsors Jigger the Tiers**

Michael Jacobs, national clinical practice leader for Buck Consultants, cites a growing interest among plan sponsors in lowering member cost sharing for generics to encourage utilization and increasing cost sharing for brands.

But why not take it a step further, he speculates: Move to a full-blown, coinsurance environment for both brand and generic medications, with minimums and/or maximums for out-of-pocket spending. “This increased transparency in the true cost of medications will hopefully improve consumerism and drive costs to a more appropriate level for all involved,” Jacobs tells AIS.

Another mechanism is jiggering formulary tiers. Rosier says plan sponsors have been considering “up-tiering” specific classes of drugs that have viable generic or over-the-counter alternatives.

And Prime Therapeutics is developing a “Two-Tier Generic” program to wring additional savings from generics by subdividing them into preferred and nonpreferred classes. “New generics often enter the market at higher prices,” explains Lassen. “A two-tier generic design might use this cost difference to lower prices or create savings for members.”

Another approach to encouraging generic utilization is giving enrollees the power of choice. Using research from the behavioral sciences, St. Louis-based PBM Express Scripts, Inc. has developed a suite of products and services it has branded under the label Select Solutions. The program involves contacting members directly and soliciting whether or not they wish to participate in particular plan features, such as home delivery or plan therapy. The idea is to offer plan sponsors programs with the effectiveness of mandatory plan features and the high member acceptance of voluntary features.

In a Feb. 17, 2011, conference call to discuss the company’s fourth-quarter and year-end financials, Express Scripts’ Chairman and CEO George Paz called Select Solutions “a family of choice-based products that nudge members to positive behaviors in a radically new way.”

“Research tells us consumer inattention and inaction get in the way of making the right decisions,” Brian Seiz, Pharm.D., vice president of clinical services at Express Scripts, tells AIS. “What these programs try to do is activate the good intentions while preserving the member’s choice.” ☪
Mail-Order Strategies

Some Payers Work to Promote Mail Order, But Others Simply Make Use Mandatory

Some health plans and PBMs are working to develop new ways to promote mail-order fulfillment, responding to slowing growth in mail-order penetration, one PBM consultant said in late summer 2009. They’re experimenting with new ways of reaching out to members, both when they first join and after they receive the first bill. Other plan sponsors have skipped such efforts, however, either instituting mandatory mail-order use for maintenance medications or not promoting mail order at all because enrollees prefer retail fulfillment.

The recession has slowed down the traditionally steady growth PBMs have seen in mail-order penetration, says George Van Antwerp, vice president of the Solutions Strategy Group at Burlington, Mass.-based consulting firm Silverlink Communications. As the economy has worsened, some patients have stopped taking medications as frequently because of affordability issues.

At the same time, some mail-order customers have returned to retail pharmacies, wooed by 90-day retail fulfillment offers and $4 generic-drug programs like the one launched by Wal-Mart Stores, Inc. The result for PBMs is that “all of a sudden, they’ve seen mail-order rates be more challenging,” Van Antwerp says.

Depending on the payer, mail-order customer retention rates vary from 75% to 95%, according to Van Antwerp. “Very few people left because of service issues,” he explains. “The majority left because of refill issues. They got to the point where they forgot to refill an important medication and couldn’t get it within a 24-hour time period…or it was up for renewal and they needed to get the next prescription written.”

To address that, some PBMs are working to develop better refill-reminder programs, including moving some customers to auto-refill, Van Antwerp says. “When you look at refill patterns, some people chronically refill too early so they hit that ‘refill too soon’ reject [code],” he explains. “Others chronically refill too late.”

“Secondarily, we look at the channel that they’re using to fill,” he adds. “Some people still mail in their refill via ‘snail mail.’ Others use IVR [i.e., an interactive voice-response system].” His firm is working with some PBMs to help them understand each enrollee’s historical behavior, and then customize a response that helps improve mail-order retention while moving the member to the lowest-cost channel for ordering refills — either IVR or the member portal, Van Antwerp says.

Prescription Solutions, the PBM subsidiary of UnitedHealth Group, sends out a welcome package to new members to let them know about the mail service. Along with a “letter from our CEO and tchotchkes” such as magnets with contact information, the PBM also sends material outlining the benefits of mail order, says Randell Correia, Pharm.D., the firm’s senior vice president of mail service and specialty operations.

Prescription Solutions serves as the PBM for the largest Medicare Part D plan, offered by UnitedHealth subsidiary Ovations. As a result, the PBM has developed special strategies...
for seniors, such as making a personal outbound call to each member. “Seniors respond very well” to that approach, Correia says. “They’re available, and the outbound calls really make a difference in promoting mail and promoting refills and promoting generics inclusively.”

He contends that “once people try mail, they really enjoy it.” As a result, “we actually have a 95% script retention rate” for the mail-order facility. Prescription Solutions does not disclose its mail-order penetration rate. For the 5% who leave mail order, “we do a certain amount of surveying and focus groups to see why people may have left or changed location,” Correia says. In some cases, the member prefers a retail pharmacy in the community or finds it more convenient to use one attached to the grocery store, he explains.

But the $4 generic offers from Wal-Mart and other big-box retailers have not drawn Prescription Solutions members away from mail order, he says. “Our copay amounts have been competitive with those for a long time.”

**Hawaii State Workers Protest Mail Requirement**

One approach Prescription Solutions does not recommend is mandatory mail order, and the PBM says few of its customers use that. “What they prefer is a preferred mail system,” in which members pay lower copays if they use the mail-order pharmacy, Correia says. “The candidates for this kind of thing [i.e., mandatory mail order] will be the public sector...since their budgets are so constrained.”

One public-sector health plan that has instituted mandatory mail order is the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). Administrator James Williams concedes that both some members and local pharmacies have protested the change, which took effect July 1, 2009.

Under the program, active members and non-Medicare-eligible retirees can get three 30-day supplies or one 90-day supply of a maintenance medication at retail before having to switch to mail order, Williams says. “The mandatory feature actually hasn’t kicked in yet,” he adds, “because the three months would be July, August and September. But it’s already more than doubled the mail-order utilization rate.”

Some members have protested the change, simply because “for one reason or another [they] think it’s less convenient to use mail order,” Williams says. In addition, “the local independent pharmacies are upset about it because they feel that it’s taking business away from them.” But, he says, “only about 15% of our claims go through local independent pharmacies,” with the remainder dispensed by chain drug stores.

“The projected savings [from the change] are about $10 million per year, and that’s pretty significant for us,” he says. “Overall, I think the board is pretty well determined to stick with it.”

**Some Payers Don’t Promote Mail Order**

Although many PBMs and employee benefits consultants say plan sponsors should promote mail order both for convenience and potential savings, not all plan sponsors agree. The University of Michigan (UM) does not promote mail order for its employees, says Keith Bruhnsen, assistant director of the university’s benefits office and manager of its prescription drug plan.
“UM began offering mail-order pharmacy [fulfillment] in 2003 when we adopted a carve-out/consolidated drug plan,” Bruhnsen said in September 2009. But despite using three different mail-order vendors, “our experience has been less than satisfactory. In our last customer satisfaction survey, mail order scored significantly lower than retail pharmacy services.”

“The problems with mail pharmacy have been mostly inadequate communication with members on the status of their orders; handling any exceptions (like larger supplies for travel); and delays due to prior authorizations, refill [requests submitted] too soon, etc.,” he explains. “It’s mostly the front-end ordering operations, not the fulfillment facility.”

UM gets retail discounts of average wholesale price minus 16% to 18%, while mail service is usually 22% to 24% off AWP, Bruhnsen concedes. “The higher mail pharmacy drug discounts we receive are split between the plan and our members by reducing their cost by one copay.”

Despite those savings, “about 7% to 8% of our claims process at mail, we do not actively promote mail, and the volume has not grown,” Bruhnsen says. The fulfillment channel getting the most growth among UM members is 90-day-at-retail programs. UM began allowing that benefit in 2004 “after a customer satisfaction survey showed members preferred to pay three copays at retail in order to get 90-day supplies over the current two copays for 90-day [supplies] at a mail-order pharmacy,” he says.

More Plans Implement Mandatory Mail, Yielding Greater Savings, Adherence Rates

While mandatory mail-order programs have been proven to save patients, plans and employers a lot of money, few sponsors actually use them because of the potential backlash expected from enrollees. However, a growing number of successful mandatory mail-order programs using innovative communication techniques are springing up across the public and private sectors — leading to 8% to 10% savings for some plans and higher medication adherence rates.

The shift towards more plans offering mandatory mail programs “is definitely growing,” according to Ken Malley, vice president of channel and generic strategy for Medco Health Solutions, Inc. Given the tough economy, “more payers and employers are focusing on ways to save money, and implementing programs such as mandatory mail is one way to do that,” he told AIS in February 2010. Enrollment across all sectors — including public payers, health plans, and large and small employers — is on the rise, he adds. Out of Medco’s more than 60 million covered lives, 11 million patients were enrolled in mandatory mail programs as of the fourth quarter of 2009.

The 1199SEIU Benefit Fund is one public payer that has successfully implemented a nationally recognized mandatory mail pharmacy program, which Medco administers. Through the program, called the 90 Day Rx Solution, members can receive 90-day prescriptions for maintenance drugs by mail at no cost or have them delivered to a Rite Aid pharmacy store for pickup. If members choose to fill 30-day prescriptions at other retail pharmacies, they must pay out of pocket.
By offering patients two options — instead of forcing them to use a traditional mail-order program — “members felt empowered,” Mitra Behroozi, the Fund’s executive director, told AIS in February 2010. “Early polling found that a vast majority was satisfied with their choices.” And follow-up polling a year later yielded even higher satisfaction levels, she adds.

The program is “a win-win situation for everyone,” Behroozi says. “Members were pleased with the convenience, and they participated in containing costs to preserve their prescription benefits.” As for the Fund, she estimates that $50 million has been saved since the program started in 2005. In addition, Rite Aid has benefited from getting more traffic flowing in and out of its stores.

The challenge for health plans considering implementing such programs, however, rests in the fact that “there isn’t great awareness of how to use mail service or what the experience is going to be like,” Malley says. “So that anxiousness is what many clients are worried about when they’re contemplating offering mandatory mail.”

In the past, some plans have faced major opposition when trying to implement mandatory mail programs. The Hawaii Employer-Union Health Benefits Trust Fund (EUTF), for example, got a lot of backlash from members and local pharmacies that protested the change, which took effect in summer 2009. Some of the plan’s members insisted that it was less convenient for them to use mail order, while the local independent pharmacies were angry that it would take away their business. At the time, the plan said it was expecting to save about $10 million per year through the program and seemed determined to stick with it. Hawaii EUTF could not be reached for comment.

Sean Brandle, national pharmacy practice leader at consulting firm The Segal Co., says that requiring mail order can be viewed as intrusive by patients. “Members may feel that the loss of some face-to-face rapport with their pharmacist is a major factor,” he told AIS in February 2010.

Good Communication Can Ease Anxiety

In order to introduce mandatory mail without being disruptive, plans and employers need to effectively communicate with their members, according to George Van Antwerp, vice president of the Solutions Strategy Group at Silverlink Communications. “People who understand change are less likely to get upset,” he told AIS in February 2010. On a blog posting, Antwerp maintains that plans that don’t put money into strong communications efforts when implementing mandatory mail because they see it as unnecessary are “old school.”

To address this issue, some payers have strong initial communications and comprehensive refill-reminder programs. When CIGNA Corp., for example, brought a large client on board its mandatory mail program in 2009, “we did some custom communication in advance of enrollment, co-branding the program with the client,” Claire Marie Burchill, CIGNA’s vice president of product, strategy and marketing, tells AIS. “We outlined the benefits of home-delivery pharmacy and we didn’t even use the word ‘mandatory’ — we called it the ‘pharmacy of choice.’”

For another client, CIGNA embedded a coupon in the initial communication sent with the first generic drug dispensed by the home delivery pharmacy. “The client was thrilled and thought that would go a long way, because the customers can appreciate the benefit at the get-go.”
CIGNA gives its clients the option to use its mandatory home delivery program for all drugs on its formulary, including specialty medications. Burchill says the plan added several large accounts to its portfolio in 2009, making it the biggest mandatory mail enrollment year they’ve had. However, she would not disclose the specific amount.

As part of its program, CIGNA tells new members about the mandatory mail service right after they go to the pharmacy to fill their first prescription. Members automatically get a letter in the mail that tells them they can have only two more refills at the retail pharmacy before they have to switch to mail, and then it gives them the option of calling CIGNA if they want to order their new prescription through mail right away. The plan is currently building the capability to do a second fill reminder as well.

The fact is that once members start using mail pharmacy, the overwhelming majority of them like it, “but the challenge is more the inertia of getting them started,” Van Antwerp says. “They need a good boarding experience at mail around first fill, and then it becomes more automatic.” Depending on the payer, mail-order customer retention rates vary from 75% to 95%.

He adds that if more plans start implementing mandatory programs, “initially you’re going to get some disruption, because people push back against change.” However, once patients realize that they can receive 24/7 support and save money, “most people will be pretty happy,” Van Antwerp says.

Malley backs up this claim by touting Medco’s 96% customer satisfaction rate with its mail-service programs.

**CIGNA Sees 5% Savings from Mail**

Mandatory mail programs also provide several benefits for payers, Burchill says. Along with increased savings, which have been approximately 5% per year for CIGNA, mandatory mail boosts patients’ adherence with their medications. People who use home delivery at CIGNA have an 11% higher rate of medication adherence than those who use retail alone, she says. “That’s because we do refill reminders by leaving voicemails at home, or sending text or e-mail messages. We even will call your doctor and move a prescription for you.”

According to Malley, Medco’s clients typically see 8% to 10% savings on the cost of a prescription from retail to mail. In addition, “Medco mail-service pharmacy has achieved a 13% greater generic substitution rate as compared to retail,” he says. And as far as adherence goes, Malley says that 78% of patients using its mail pharmacy were adherent with their diabetes medications, compared with 57% for retail. “And because of the implications of better adherence leading to lower overall medical costs, that’s a very important element.”

**PBM, Pharmacy Groups Propose Solutions to Overhaul of USPS**

Plummeting mail volume and a bleak financial outlook have led the U.S. Postal Service (USPS) to consider implementing major reforms — including the discontinuation of Saturday delivery — which could impact mail-order drug delivery for health plans, PBMs and pharmacies.
While a PBM trade group says cutting out weekend delivery is unlikely, a community pharmacy association sees opportunities to work with USPS to bring all postal service capabilities inside more pharmacies and increase the volume of prescriptions processed at retail.

A projected $238 billion shortfall over the next decade prompted USPS in March 2010 to propose a 10-year plan that aims to cut costs and increase productivity. Included in the business plan is a proposal that would eliminate Saturday mail delivery. If implemented, “this could have a huge impact on mail-order pharmacies run by PBMs and the patients they serve,” says John Coster, senior vice president of government affairs for the National Community Pharmacist Association’s (NCPA), whose members compete with PBMs for mail-service customers.

“It’s possible that because of the one day less delivery, you’ll have more patients potentially going without their medications,” Coster told AIS in March 2010.

“We don’t want Saturday delivery to be a reason for us to go out and knock people getting their drugs. We’d like people to go to the pharmacy whether there’s seven-day delivery or five-day delivery,” he says.

Cutting out Saturday delivery also could lead some PBMs to turn to private carriers such as UPS or FedEx, which charge premiums for weekend delivery, according to NCPA. And Coster thinks it’s possible that these charges would be passed down to patients in the form of increased copayments.

But many PBMs already use alternate delivery methods, especially for patients who take medications to treat chronic conditions that can require special handling. “Sometimes prescriptions need to be changed, sometimes doctors prescribe new medicines, and sometimes people lose their medications and can’t just wait four extra days over the course of a weekend to get them,” says Mark Merritt, president of the Pharmaceutical Care Management Association (PCMA).

He contends it’s unlikely that USPS will completely cut out Saturday delivery. “Many chronic care patients who can’t make it to the pharmacy really count on Saturday delivery,” he told AIS in March 2010. “There are a lot of different ways to reform the postal system,...and I don’t think stopping Saturday delivery is the best way to go about it.” He adds that there are several different reform proposals on the table that could be more beneficial.

**NCPA Wants to Up Rx Processed at Retail**

Merritt says the organization has been talking with the agency to make sure “the kinds of reforms that are made don’t hurt patients.” However, he would not disclose PCMA’s specific proposals.

“Those are things we’d rather keep in discussion with them and work with them privately on,” he explains. “At some point we know there will have to be a real strategic shift in USPS’s business. It’s just not ripe yet for the full set of reforms that are being proposed,” he says.

NCPA hasn’t missed its chance to work with USPS, either. In March 2010, the organization met with USPS to learn more about its plans and explore opportunities for community pharmacies to partner with the agency. “We suggested helping the postal service by mapping out where independent pharmacies are around the country in rural areas, where they are looking at downsizing, and whether there is an opportunity for that pharmacy to take over all or part
of the postal service capabilities in those areas,” Coster explains. “We wanted to make sure that we are on the map and let them know that we are interested and willing partners, so that when they do turn to this restructuring, they think of independent pharmacies.”

NCPA seems to be stepping in at the right time, as one USPS proposal would expand the availability of mail services through pharmacies and other community businesses. According to the proposal, USPS would close post offices in rural areas that are not open full-time and instead partner with local businesses such as grocery stores, pharmacies and retail centers to provide the same services.

“There is definite interest in working with the postal service to make sure that if there are any closures of post offices or consolidations, that consumers have access to all the services that the post office currently offers,” Coster says. “This could be done by bringing the post office’s capabilities inside pharmacies in those rural areas.” He adds that a few retail pharmacies already serve as contract postal units, which are “basically full-service post offices that are right inside some retail pharmacies.”
Initiatives for Over-the-Counter Drugs

Covering OTC Prescription Drugs Could Bring Next Big Wave of Savings for Payers

Like the generic prescription-drug revolution of the last decade, over-the-counter (OTC) drugs in the form of generic and store-brand prescriptions are expected to save payers billions of dollars in the next few years. While an increasing number of payers have added OTC drugs to their formularies, there are still many health plans that haven’t realized the benefits of covering these products, such as improved drug tracking and better adherence, say some industry executives. However, implementing an OTC program can be tricky, and many payers aren’t sure how to build OTC drugs into their plan design structure.

OTC products are “one of the most high-value classes of drugs that have largely been missed from the pharmacy value dialog,” says Mark Fendrick, M.D., co-director of the University of Michigan’s Center for Value-Based Insurance Design and a consultant to OTC manufacturer and marketer Perrigo Co. Store-brand or “off-brand” OTC drugs exist in most categories where there are brand-name OTCs — ranging from pain relievers to heartburn remedies.

More than $12 billion in annual sales of the most popular brand prescription drugs will become available as OTC generics — and subsequently as even lower-cost store-brand OTC drugs — within the next five years, Fendrick explained in March 2010. “But only innovative employers and payers that see the value proposition have been very aggressive to place drugs that are available over the counter in a situation for coverage,” by placing them on a formulary, he tells AIS. OTC drugs are usually placed on tier one and have similar copayments as generics.

Yet this could soon change. Several of SXC Health Solutions Corp.’s clients, for example, are already covering OTC drugs, and many more are considering it for their 2011 formulary list, according to Jerry Shipkin, vice president of clinical services and chief clinical officer at the Lisle, Ill.-based parent of PBM informedRx. The holdup has been that many payers “aren’t sure of how they should go about doing it,” he told AIS in March 2010.

As with generics, one thing that has slowed the adoption of OTC drugs is the false perception that they may not be as effective as their brand counterparts. “The way you’re going to get members to go to the OTC is to first of all make sure that it doesn’t cost them more than what it would cost them to just go to a generic or a brand,… and then educate them on their equivalence,” Shipkin says.

Another roadblock for OTC adoption has been that plan sponsors are unsure of how to build an OTC option into their established plan design structure. While OTC drugs will invariably save patients money, “you have to make sure that the pricing works for the payer as well, because in some cases, by pushing people to an OTC, you may have an impact on your rebates,” Shipkin explains.

“The key to being successful depends on what strategy you use in covering OTC drugs,” he adds. “The most important thing is to keep it inside your drug benefit — that way you’ll have the ability to track the drugs as part of your members’ overall patient record.”
Some of SXC’s clients with successful OTC coverage programs have taken a reference-based pricing approach, “where payers take the OTC as the reference product and price point in a specific class of drugs,” Shipkin explains.

Others have established an entirely separate tier for OTC drugs — called tier zero — that sits one level below tier-one generics. In this situation, he says, payers are “trying to place the OTC in a better position for the member than the generic.” For example, if the generic copayment is $10 for a 30-day supply, the OTC drug on tier zero could be $7.50 for a 30-day supply.

**Payers See High OTC Retention Rates**

“The pricing has to be advantageous so both the payer comes out with a lower cost by having an OTC strategy, and the member doesn’t have an increase in their out-of-pocket cost,” Shipkin maintains. While this approach has proven successful, most payers still choose to place OTC drugs on tier one alongside generics.

Blue Cross & Blue Shield of Rhode Island (BCBSRI) is one payer that has experimented with covering select OTC drugs. In 2009, it concluded an “OTC Options” pilot program that offered members OTC allergy drugs at no charge. Under the test program, more than 4,600 members received OTC allergy drugs omeprazole (generic Prilosec) and loratadine (generic Claritin) at a zero copayment for up to one year.

Covering OTC omeprazole saved the plan and patients combined more than $500,000, while loratadine coverage saved them more than $750,000 for the program year, according to Tara Higgins, R.Ph., a clinical pharmacist with BCBSRI. In addition, the plan found that once its members switch or start on OTC drugs, “they tend to stay on OTCs,” she says. For example, “we looked at OTC omeprazole use and found that over 85% of members did not have a prescription medication filled for that same class of medications within one year” of starting the OTC drug.

“We continuously look at what OTCs are available or becoming available,” Higgins tells AIS. However, “to make it of value for consideration for coverage, it needs to be a class of medications that is large in volume and expensive.” This is one reason why BCBSRI chose to cover omeprazole and loratadine. In addition, because the market availability of OTCs can change rapidly, “it makes sense to have a program for a specific time frame,” she adds.

Currently, the most popular classes of drugs for OTC coverage include proton-pump inhibitors (PPIs) and antihistamines. Prescriptions for PPI drugs climbed 4.7% in 2008 to 110 million and are expected to keep growing, according to Fendrick.

But because of the multitude of OTC products available, many plans no longer cover PPIs or non-sedating antihistamines, according to Laura Wesolowicz, director of pharmacy services at Blue Cross Blue Shield of Michigan. “And there may be opportunities to expand OTC coverage for some of the more costly branded prescription, non-sedating antihistamines that may move from prescription-only to OTC status in the near future,” she told AIS in March 2010.

Shipkin says other categories of drugs that are expected to have some OTC drug entrants include sleeping aids, digestive aids, pain relievers and drugs to ease urinary incontinence and erectile dysfunction.

When looking at what drugs to cover, Fendrick advises, plans should be paying the most attention to generic or store-brand OTC medications. As with prescription drugs, OTC gener-
ics are less costly than the branded OTCs. “As people see the branded drugs go OTC, it’s the savvier PBM who is noticing the store-brand version of the branded drug OTC, where basically the same chemical entity is at an even lower ingredient cost.”

For example, non-sedating antihistamine Zyrtec — a branded OTC — retails for about 72 cents per dose, while a generic or store-brand OTC costs only about 53 cents per dose. “The substantial drop off in ingredient costs for all agents as they go OTC makes them ripe candidates for a value-based pharmacy move,” Fendrick says. Key examples include loratadine, cetirizine (generic Zytrec) and polyethylene glycol 3350 (generic MiraLAX).

**Including OTC Rx on Formularies Helps Track Patient Behavior, Utilization**

Beyond significant cost savings, payers should consider adding over-the-counter (OTC) drugs to their formularies because of the care management information it can provide, experts say.

Patient monitoring and drug utilization tracking is one of the biggest reasons for considering coverage of OTC drugs, according to Mark Fendrick, M.D., co-director of the University of Michigan’s Center for Value-Based Insurance Design and a consultant to OTC manufacturer and marketer Perrigo Co.

“If you allow doctors to write prescriptions and let the patient go through the motions that they were accustomed to for a drug that used to be [prescription] that is now OTC, it allows positive outcomes for the patients to get their medications at lower costs and allows our system to work the way it should to know what our patients are doing and, more importantly, not doing,” he told AIS in March 2010.

Jerry Shipkin, vice president of clinical services and chief clinical officer at SXC Health Solutions Corp., agrees that one of the reasons to keep OTC drugs inside the pharmacy benefit “is to make sure that compliance and adherence with taking the medication is observed.” This way, payers can have “visibility that a member is taking a certain medicine, [and] we can apply our insurance program to encourage patients to stay compliant.”

SXC was able to track the brand-to-OTC conversion rate for one of its clients that started covering an OTC proton-pump inhibitor in 2009. “In a six-month period, we’ve already seen a 34% switch to the OTC from the brand,” Shipkin said in March 2010. “This was obviously a pretty significant savings for them.”

Aspirin, for example, is one OTC drug that Fendrick has been urging payers to cover because “it’s one of the most important drugs in terms of assessing the quality of care in Americans,” he says. “And until we figure out a way to get aspirin therapy and use of aspirin for heart attack prevention into the system,…we’ll never really know in a rigorous way whether patients are doing what we want them to do.”

Shipkin says he doesn’t see the benefit of covering aspirin, only because it is so inexpensive. “It would almost be 100% copay,” he explains. “And other than knowing the patient is taking it, there’s no financial driver there that I can see.”
Blue Cross & Blue Shield of Rhode Island, on the other hand, is currently evaluating coverage of aspirin “since it would be inexpensive to cover, and would assist physicians and BCBSRI in tracking the use of aspirin and assist in the promotion of preventive medicine,” contends Tara Higgins, R.Ph., a clinical pharmacist with BCBSRI.

**Careful Implementation Can Guarantee Savings on OTC Program**

While many payers recognize the value of covering over-the-counter (OTC) medications under the pharmacy benefit, many have yet to implement coverage programs primarily because of uncertainties around cost savings. But one innovative health plan successfully integrated OTC drugs into its formulary and is preparing for the slew of new entrants into the marketplace.

“The biggest issue is that the economic impact of an [OTC] program is not predictable,” Mark Fendrick, M.D., a professor at the University of Michigan and codirector of its Center for Value-Based Insurance Design, said during a May 18, 2010, AIS webinar on OTCs. “There also is this theoretical concern that if you cover a drug that had not previously been covered, that a larger number of people would come and buy that and incur that to the payer at a lower cost to the beneficiary.” But that is simply not the case, he maintains.

Blue Cross & Blue Shield of Rhode Island (BCBSRI) is one plan that has tested and successfully established a comprehensive OTC options program. In fact, the plan is set to expand the program in July 2010.

“This is all part of our focus on preventative health,” Tara Higgins, a clinical pharmacist with BCBSRI, said during the webinar. “We now encourage providers to write an OTC first at the point of diagnosis.”

**BCBSRI Saved $280,000 With OTC Pilot**

After evaluating its OTC Options pilot program, the plan realized savings of about $280,000 in one year. Spend also decreased over the past two years with the implementation of another OTC pilot. In addition, BCBSRI’s members experienced minimal disruptions when switching to an OTC drug.

“A lot of the switches were generated by the pharmacy intervening on the patients’ behalf,” Higgins explained. “They would offer to call the physician and ask if it was OK for them to switch.”

As part of the new program, certain OTCs will be covered at no charge, including aspirin, calcium drugs, vitamin D, folic acid and children’s multivitamins. “And with that coverage, we’re going to be focusing on generic options,” Higgins added. The plan also is considering implementing a tier zero, reserved specifically for OTCs. “It’s easier from an administrative standpoint to have a tier zero...when you delineate and speak to providers or members.”

Michael Cartier, Pharm.D., executive vice president of Envision Pharmaceutical Services, Inc., said that many plans and members are adopting OTC programs and are interested in learning more. More than 15% of Envision’s clients have adopted an OTC benefit design.
“However, success is determined on how it’s implemented,” he said during the webinar. “If you do a sloppy implementation with poor communication to physicians, members and providers, that’s where you run the risk.”

Cartier recommended that plans considering an OTC program should take the following steps:

Identify potential OTC classes for review,

- **Assess** the prescription drug endorsement language,
- **Perform** a cost savings analysis,
- **Determine** a benefit enhancement approach,
- **Set** implementation timelines,
- **Prepare** the communications materials, and
- **Measure** the results.

When deciding which OTC medications to cover, Higgins said, the plan took three things into consideration: competition, marketability and reputation.

Participating in an OTC program is valuable only when there is generic competition in the OTC marketplace and many people take the drugs, she explained. “There are many options available that will drive the cost down and make it affordable for the plan to cover,” she added. “If a category of utilization is minimal, the amount of marketing resources may be disproportionate to the volume of membership that will benefit from the program.”

The drug also must be reputable, “because if physicians aren’t comfortable prescribing a certain medication, they’re not going to do it,” Higgins asserted.

Drugs that currently have OTC alternatives include proton pump inhibitors, nonsedating antihistamines, H-2 antagonists, ophthalmic allergy medications and NSAIDs.

Once the drugs are chosen, Cartier warned, obtaining pricing information can be very difficult. While the price can be obtained at retail pharmacies most of the time, pricing may vary by pharmacy and by chain.

“You have to make an assessment of what the pricing may be to make your savings assessment,” he maintained.

When it comes time to create the pharmacy benefit, Cartier said there are three approaches plans can take:

1. **Enhance the existing benefit** with select OTCs at a $0 or very low copayment,
2. **Include utilization controls**, such as step therapy, to maximize savings, and
3. **Combine the first two strategies** by grandfathering existing usage, but require step therapy on new starts. Then gradually phase out grandfathering.

The mix of existing strategies, in which a plan grandfathers existing patients or members and moves the new starts to the OTC product with step therapy, “seems to be the path of least resistance and most likely the ones employers and plans will implement,” Cartier said.

But before any of this is complete, plans should run various scenarios of either copay or utilization controls to come up with an estimate of what actual savings will be, he added. ✩
PBM, Plan Sponsors Weigh Implications of OTC Changes

As the deadline for coverage changes to over-the-counter (OTC) medications quickly approaches — due to an obscure provision in the health reform law — many employers and health plans are raising concerns about the implications the change will have on members. But other industry insiders say that requiring prescriptions for such medications is a step in the right direction.

Starting Jan. 1, 2011, patients will not be able to use their health savings accounts (HSAs), flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) to pay for most OTC medications unless they have a doctor’s prescription.

If a patient has a medical necessity note or a prescription from their doctor for an OTC product, they must pay for the OTC at the point of service and submit a manual claim for reimbursement. If HRA members try to pay for OTCs with their account, they could face an IRS audit and a 20% excise tax penalty.

Under the provision, products no longer eligible for reimbursement under the new law will include cough medicines, pain relievers, acid controllers, allergy drugs, anti-diarrheal treatments, cold sore remedies, sleep aids and sinus medications, to name a few.

For plans that don’t already have an OTC benefit built into their plan design, “this is going to be a huge pain,” Rachel Wright, a spokesperson for Employee Health Insurance Management, Inc., told AIS in August 2010. “These plans are going to have to look to their PBM to enhance their program.”

For one thing, health benefit cards that currently have automated adjudication procedures for OTC expenses will need to be adjusted and manual claims processes will have to be implemented for such expenses. For example, plan sponsors will have to incorporate physician approval into the process.

Steven Wojcik, vice president of public policy at the National Business Group on Health, says cutting OTC coverage in tax-advantaged accounts was “driven by a need to come up with dollars to pay for the health reform legislation.” While it’s only $10 million over the next 10 years, “the government needed to get money from lots of places, and that was one,” he said Aug. 18, 2010, at the 4th Annual Pharmacy Benefits Academy conference in Chicago.

The other reason was that there are members of Congress “who are philosophically opposed” to such tax-advantaged accounts. “And the general tax subsidization of health care encourages wasteful spending.” The health reform bill will reduce the amount of money that can be set aside in FSAs for medical care from $5,000 to $2,500 in 2011.

“People do rely on these tax breaks as health care cost go up to pay for other things,” Wojcik maintains. “It’s going to hurt people that rely on those payments for their maintenance medications and for people who used over-the-counter drugs.”

Other industry insiders project the change will have little effect on employees with FSAs because most don’t take advantage of them when they’re offered and few use them to purchase OTCs.
According to a recent report by Hewitt Associates Inc., just one in five employees contributed to an FSA in 2010, and 75% of the account expenses were for medical treatments and prescription drugs.

Judy Hearn, health and welfare manager of packaging product company Pactiv Corp., expects that the majority of patients are going to stop buying OTCs altogether because physicians aren’t going to write them prescriptions for such products. “Unfortunately, we’ll still have to change our plan designs,” she said during the conference.

In addition, Wojcik thinks employers and plans will have to pick up some of the tab, which will eventually increase pharmacy costs. “For doctors that don’t provide prescriptions, employers will be paying a lot more for their employees’ OTC medicines,” he said.

But Wright argued that the new law will help produce better health outcomes in the form of improved patient compliance. “By mandating a prescription for OTC products, physicians can get a better sense of what drugs patient are taking and be able to see if there are any potential drug interactions,” she explained. “It’s hard to treat patients without knowing what else they’re taking….And while it may be an inconvenience for people, it will ultimate allow for better health.”
Restrictive Networks

CVS’s Maintenance Choice Program Leads Way for More ‘Restrictive Networks’

An innovative savings program developed by CVS Caremark Corp. that blurs the line between retail and mail prescription fulfillment is proving to be successful and may be leading a growing trend of burgeoning “restrictive pharmacy” networks. And at a time when many of the same tools and services are offered by most PBMs, new programs such as this one are essential for PBMs to remain competitive, some experts say.

Launched in 2009, Maintenance Choice allows consumers to buy 90-day supplies of drugs for chronic conditions at CVS pharmacies for the same price as mail order. While employers are typically slow to adopt new PBM offerings, CVS Caremark says its clients were quick to accept the deal — making the program the fastest growing of its new services.

CVS Caremark executives gave investors an update on Maintenance Choice during a Feb. 8, 2010, conference call to discuss fourth-quarter 2009 earnings. According to CVS CEO Thomas Ryan, 412 of the PBM’s clients, representing 5.1 million lives, are using Maintenance Choice — up from 130 clients at the beginning of 2009. “We expect that number to grow even more” by an additional 70 clients with more than 400,000 lives in the next year, Ryan told investors. What’s more, he added, 10% of those Maintenance Choice clients are new to CVS Caremark.

According to Adam J. Fein, Ph.D., president of Pembroke Consulting, Inc., and author of the DrugChannels.net blog, Maintenance Choice is an example of a restrictive pharmacy network, in which consumers can choose the channel to purchase their drugs, but are limited to using either a CVS retail pharmacy or a Caremark mail-order pharmacy — a model that he maintains is a growing trend.

“We’re moving away from preferred networks to more restrictive models, where the consumer has to use a specific designated pharmacy,” Fein told AIS in February 2010. “This is now only common in specialty pharmacy, but not for retail outpatient drugs.” While the specific design of Maintenance Choice would be hard to replicate, “a PBM could and will, in the future, establish more limited pharmacy networks,” he says.

He adds that many plan sponsors have been reluctant to use such restrictive programs in the past because organizations don’t want to upset their enrollees. “But the fact that Maintenance Choice is growing shows that payers are more willing to accept this more restrictive network,” Fein explains. Similar programs include Walgreen Co. and Wal-Mart Stores Inc.’s deal with Caterpillar, which offers a limited range of services, such as retail dispensing, in order to increase traffic in Walgreens’ and Wal-Mart’s stores. “They have established a restricted network, which gives the payer the greater degree of control,” Fein says. However, the Walgreens’ program “is not a new concept and it doesn’t match mail pharmacy pricing,” CVS Caremark spokesperson Christine Cramer told AIS in February 2010.
Does the Program Give CVS an Advantage?

At the end of the day, the multibillion-dollar question, Fein says, is if Maintenance Choice “is sufficiently innovative or cost effective to drive market share to Caremark.” He doesn’t expect the program to give CVS Caremark an overwhelming advantage over other PBMs.

Sanford C. Bernstein & Co. analyst Helene Wolk, on the other hand, argues that the program is groundbreaking and even capable of changing the PBM industry. By blurring the lines between mail and retail prescription fulfillment, she explains, the program allows members to choose mail or retail while reaping the cost savings typically reserved for mail. And given that many plans are focused on medication therapy management, Maintenance Choice “may enable face-to-face interaction with consumers to counsel medication adherence and compliance — assuming face to face garners better results versus telephonic contact,” she told AIS in February 2010.

Wolk maintains that most PBM services — such as formulary management, step therapy and prior authorization — are fairly standardized across the industry, making it harder to distinguish among companies. “CVS is attempting to differentiate on the unique merits of its integrated PBM/retail model, embodied by Maintenance Choice,” she says.

While other retail pharmacies with PBMs, such as Walgreens, could offer services similar to Maintenance Choice, Wolk says they’re “not a meaningful threat in the large PBM segment.” The program could also be replicated by joint-venture arrangements between a large retailer and PBM, but the economics would not be as favorable as they are for CVS Caremark, she adds.

While the program is unique to CVS Caremark, it’s “not a game changer” for the industry, says Kemp Dolliver, a managing director at Avondale Partners, LLC. “I think that Maintenance Choice has interested employers who want to encourage mail use without using a mandatory plan design,” he tells AIS. “At the same time, all are well aware that it can help CVS’s stores too.”

He points to two other innovative programs that are attracting significant interest: Medco Health Solutions Inc.’s Therapeutic Resource Centers, which appeal to plan sponsors by focusing on managing patients with chronic illnesses; and Express Scripts, Inc.’s focus on analyzing consumer behavior. Dolliver says it’s “too early in their development to call [it] a game changer, but [they are] very well received in the market.”

Maintenance Choice Boosts CVS’s Revenue

Even if CVS Caremark’s program isn’t changing the face of the PBM industry, there is no question that Maintenance Choice is helping boost CVS Caremark’s pharmacy revenue. Up by 7.3%, the retail giant’s pharmacy sales were ahead of rival Walgreens’ because of the benefit of the Maintenance Choice program, according to Morningstar, Inc. analyst Matthew Coffina. CVS Caremark maintains that for every patient who switches to Maintenance Choice, the company could get as much as $1,500 in additional revenue. In the fourth quarter of 2009, 22% of prescription revenue at CVS pharmacies came from Caremark, up from 16.2% in the fourth quarter of 2008.

The PBM, on the other hand, isn’t performing as well in the market. “As expected, results in the PBM were unimpressive,” Coffina says. CVS Caremark’s PBM operating income grew
just 3% in the fourth quarter and 4% for the year. And in 2010 the company expects the PBM to experience a 10% to 12% decline in operating profits.

Meanwhile, some were struggling to find the benefit of Maintenance Choice for employers or health plans. During the fourth-quarter earnings call, Mark Wiltamuth, an analyst with Morgan Stanley, asked if the program was providing more benefits to members than plans. “Pharmacist counseling and front-end discounts, those things all are aimed at the individual consumer, but are viewed as more neutral to the employer,” he said in February 2010.

Ryan responded that the program does produce savings for the payer in the form of increased mail-order prescriptions. In addition, “we’re having better compliance [and] better performance around generic dispensing, so they get the mail pricing plus the generic dispensing,” he said. “Clients switching from voluntary mail to Maintenance Choice see a significant increase in 90-day utilization.”

This reason is precisely why the trend toward restrictive networks is becoming more popular, Fein says. Such programs “provide a way for a payer to get lower cost and greater control over the distribution and dispensing cost in their pharmacy benefit — ultimately, it’s a way to save money.” Mandatory mail programs, for example, are used by one in six private employers and are a form of a restrictive network. However, Fein adds, they are not very popular because they limit choice.

“[2010] will be a year of testing and evaluation,” he contends. “If the deals like Caterpillar/Wal-Mart and Maintenance Choice are successful, we’ll see more and more of these network models being replicated in 2011 and 2012.” The outcome, he adds, “will be more rapid consolidation, especially as these programs increase market share for the ‘preferred’ providers of pharmacy services.”

**Retail Giant Ups Momentum for Limited Pharmacy Networks, Guarantees Savings**

Stepping up to the plate, Wal-Mart Stores Inc. is the most recent retail giant to tout the cost-saving potential of restricted pharmacy networks — a controversial model that has seen slow adoption. Although limited networks don’t have long-term proof of success, some industry analysts said in summer 2010 that it’s “just a matter of time” before they become common in the pharmacy benefit industry and predict that the network design could bring the next big wave of cost-saving strategies for payers.

In a new white paper, Wal-Mart makes a case for the cost-saving capabilities of an access-based network design, which limits pharmacy networks to “minimize cost while achieving predetermined access standards.” According to Michael Struhs, director of business development for Wal-Mart’s Health and Wellness business unit and author of the white paper, the program doesn’t just slow increases in costs — “it actually creates a break in the cost curve and slows future cost increases by applying downward pressure on cost drivers.”

While some industry analysts see Wal-Mart’s model as a “compelling rationale” for narrower pharmacy networks, other observers say the program is merely a ploy by the retail giant to gain market share, since it also has pharmacies in many of its stores and could serve as a
restricted network. Nationwide pharmacy chains Walgreen Co. and CVS Caremark Corp. have introduced similar business models.

To explain the Wal-Mart model, Struhs points to three basic principles:

- **If payers can leverage supply and demand** to create competition among pharmacies, they can reap the benefits of lower drug costs.
- **A network should be based on the number** of pharmacies a payer needs, rather than the number of pharmacies available.
- **Payers can offset any disruptions or inconveniences** caused by a limited network by providing financial incentives to plan members.

Struhs argues that the pharmacy network model most payers currently use encourages all pharmacies to offer a rate that doesn’t get them kicked out of the network — not necessarily the most competitive one. It also doesn’t encourage patients to pick one pharmacy over another. And because there are over 60,000 pharmacies in the U.S., the supply of vendors is larger than the demand.

This is where PBMs and payers “are missing the boat,” Struhs says. “The large supply of pharmacies is not being leveraged to drive down costs.”

To illustrate, Struhs says many Medicare Part D vendors have been able to survive with a national network of less than 20,000 retail pharmacies. With that number, about 90% of Medicare beneficiaries who live in an urban area have access to a network pharmacy within 2 miles of their residence. And for 70% of beneficiaries living in rural areas, a network pharmacy is available within 15 miles of where they live.

All payers need to do, Struhs maintains, is determine what access standards should be required in their network (i.e. 90% of employees must live within six miles of a network pharmacy), and then force pharmacies to compete against each other to be allowed in this network.

**Critics: Wal-Mart Can’t Deliver Savings**

Despite Struhs’ rationale, some critics just aren’t buying it. “Wal-Mart’s strategic plan here is an attempt to see how they can get more people in their stores,” Mike Winkelman, CEO of Winkelman Pharmacy Consulting, tells AIS. “Unless Wal-Mart is clever enough to find some way to acquire drugs cheaper…they cannot control the cost of the major brand name pharmaceuticals. And they certainly can’t control costs of specialty medicines, the fastest-growing segment of pharmacy benefit costs.”

Although a fan of restricted pharmacy networks, Adam Fein, president of Pembroke Consulting Inc., says Wal-Mart’s model for such networks is difficult to implement. He adds that there is hardly any data on actual bottom-line savings, and payers “may perceive bigger savings opportunities in other areas that have less potential beneficiary disruption.”

But Wal-Mart says the program — compared with actual spending data from self-insured employers — has led to cost savings of about 8% to 12% for its clients that use an access-based network of no more than 20,000 pharmacies nationwide.

In addition, a number of PBMs “have embraced this approach to network design,” and are actively promoting it with some of their members, Wal-Mart spokesperson Kate Axt tells AIS. While she declines to mention specific clients, she contends that there are now a number of
companies and health plans that are implementing access-based networks or making plans to start one soon.

**Direct-to-Consumer Deals Pose Threat to PBMs**

While payers may be slow to adopt this particular model, similar limited network designs and direct-to-employer deals have been gaining traction over the past year. Restat, for example, has been promoting its cost-plus, fee-for-service PBM pricing model that is geared toward self-insured employers willing to use a preferred pharmacy network.

Launched at the end of 2009, the design actually sprung out of a one-year pilot program with Wal-Mart and Caterpillar Inc., the guinea pig for the direct-to-employer model.

Caterpillar, which also contracts with Walgreen Co., is already touting double-digit savings with this model. Walgreens is also rumored to be working out a similar deal with Delta Airlines Inc.

In a June 12, 2010, research note, Collins Stewart securities analyst Brian Wright said the direct-to-employer model poses long-term risks to the PBM industry.

“We believe industry margins are likely to be higher for direct-to-employer customers as health plans implement a renewed focus on costs, given heightened regulatory pressures,” he wrote. “Further, we believe competitive pressures will likely mount with additional formidable competition in the high margin direct-to-employer PBM market in 2013.”

Winkelman disagrees that direct-to-employer deals or limited networks pose a threat. “At the end of the day, most health plans are going to want or need relatively broad networks,” he says. “If you’re the benefit manager for a health plan, your idea of nirvana is the phone never ringing. And access to care is a major issue.”

Moreover, cost savings data are still unclear, says Jim Fields, chief financial officer of ApproRx. He argues that Wal-Mart’s deal with Caterpillar, for example, cut costs only for the employee — not the employer — which reduced the noise.

“Wal-Mart is comparing its savings numbers to what existed,” he told AIS. “If you come in and say, ‘we’re going to leave everything as is and reduce the copay to your employees,’ that sounds like a winning system. And they say they’re saving because of the volume increase, but that’s simply not true.”

He adds that the system is bound to fail because it focuses only on cutting cost. “You’re not giving any quality, you’re just pushing the price down to a certain level but then it ends there,” he maintains. “And everybody pays the same price for drugs. There is a very narrow range and there is only so much you can do there.”

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**Humana Becomes ‘Price Leader’ in Part D By Inking Preferred Rx Deal With Walmart**

Humana Inc. and retail giant Wal-Mart Stores Inc. have partnered to offer what they say is an “innovative” Medicare Part D prescription drug plan that will save beneficiaries hundreds of dollars and beat the national monthly premium price of every other plan by using a preferred pharmacy network. While the new plan could significantly benefit both the two compa-
nies and beneficiaries who sign up for it, some are concerned over the impact it will have on other retail and mail-order pharmacies, and others have raised questions about the legality of its marketing campaign.

The Humana-Walmart-Preferred Rx Plan offers a $14.80 monthly premium — the lowest national plan premium in 2011 for a stand-alone Part D plan, according to CMS — and very low copayments when members use a “preferred” pharmacy like Walmart and its subsidiaries Neighborhood Market and Sam’s Club. By enrolling in this basic plan, the new business partners estimate that Medicare beneficiaries could save more than $450 annually on their monthly plan premiums and prescription drug copays and cost shares.

William Fleming, Pharm.D., vice president of Humana Pharmacy Solutions, says the company chose to go with a preferred plan design so that more of its members could get access to lower-cost drugs. Simply put, “the basics of the preferred network — tight formulary and a low premium — offer an affordable value proposition for patients,” he told AIS in fall 2010.

The move is a “strategic play” for both Humana and Walmart, says Troy Filipek, an actuary at consulting firm Milliman Inc. “All of a sudden, Humana has regained its status as a ‘price leader’ and it can say that it has a plan out there that’s less than $15 in every region — that’s a strategic thing to say,” he tells AIS. In addition, the plan’s low cost allows Humana to be one of the only payers offering three plans — “which is what a lot of payers would have liked to do.”

For Walmart, “it makes sense for them to be able to bring a lot of volume into their stores and create some publicity around having a plan design like this,” he adds.

However, the relationship may not benefit many other stakeholders. Through the partnership, Walmart is “challenging the conventional wisdom about profitability and market share with a lower cost, consumer-driven plan design,” says Adam Fein, Ph.D., president of Pymee Consulting, Inc. and author of the DrugChannels.net blog. However, the company’s “incentivized preferred network design” has a major “disruptive potential for retail and mail-order pharmacies,” he adds.

Fein maintains that Walmart’s discount retail prescription drug pricing will influence pharmacy choice “while simultaneously undermining the economic model of the Big Three PBMs” — CVS Caremark Corp., Express Scripts, Inc. and Medco Health Solutions, Inc.

Independent pharmacies are especially concerned, as evidenced by the National Community Pharmacists Association’s (NCPA) negative reaction to news of the deal. “This is simply Walmart’s latest ‘loss leader,’ intended to bring more people through its doors at the expense of patient care and quality customer service,” NCPA President Joseph H. Harmison says in a statement. “Patients taking a brand-name drug or who can’t or don’t want to take a therapeutic substitute for the drug their doctor prescribed may see little, if any, savings.”

He adds that Walmart stores make up less than 7% of all of the retail pharmacies in the U.S. and points out that many patients gave its pharmacies “very poor marks” in the most recent J.D. Power and Associates 2010 National Pharmacy Study. “The negative views patients have toward Walmart pharmacy persist despite high profile, multi-million dollar campaigns, such as promoting $4 generic drugs,” Harmison maintains. “In fact, many independent community pharmacists saw patients return to their pharmacies once they experienced the wait times and assembly-line service first-hand.”
The co-branded plan is also raising concerns about the two companies’ marketing campaign. According to CMS, pharmacies are not allowed to endorse any particular plan. But Fleming says that Humana and Walmart’s “entire marketing plan is aligned...and we plan on doing a lot of media advertising.” In addition to online and television advertisements, Humana will set up informational kiosks in approximately 3,000 Walmart stores across the country.

Despite these issues, Fein contends, a preferred pharmacy network is an effective way to realize major cost savings by still giving consumers a choice of providers, while providing financial incentives to use certain pharmacies “that offer lower costs to the payer.” In Humana’s network for this plan, there are 4,200 preferred pharmacies and 58,000 nonpreferred pharmacies.

Under the plan, members shopping at one of the preferred pharmacies (i.e., Walmart, Sam’s Club and Neighborhood Market) pay $2 for tier-one preferred generics and $5 for tier-two generics. After that, members have a 20% coinsurance for tier-three preferred brands and nonpreferred generics, and 35% coinsurance for nonpreferred brands. The only difference for mail-order drugs, which are handled through Humana’s mail-order pharmacy, is a zero copay for tier-one and tier-two drugs.

For members choosing to get their drugs at one of the nonpreferred pharmacies, the cost is $10 for tier-one and tier-two generics, 37% coinsurance for tier-three nonpreferred products and 50% coinsurance for the highest-tier drugs.

With this formulary, “we tried to put together a plan design that encourages members to use one of the Walmart pharmacies,” Fleming says. “But if they don’t choose a preferred pharmacy, they still have access to affordable prices — we are still competitive.”

The partnership also raised questions over whether the new plan is part of Walmart’s access-based network design, which promises 7% to 12% savings by limiting the number of pharmacies that payers contract with. The company has been promoting this design over the past few months.

John Agwunobi, M.D., president of Walmart’s health and wellness division, maintains that the plan is not part of the access-based network. “While we have been promoting preferred networks with employers and through PBMs, this is different,” he told AIS in fall 2010. “This is fundamentally different because its structure and design is dictated by Part D plan guidelines. We didn’t design this in Walmart, it’s a Part D plan like any other.”

He adds that the plan is an “exclusive arrangement” with Humana and Walmart has “no intention to reach out to anyone else.”

However, if Humana ends up winning significant market share in the Part D network, Filipek expects other payers will start to consider the preferred pharmacy network model for themselves. But even if enrollement numbers aren’t extraordinary, “this is the biggest news in Part D [in 2010],” he maintains. “And you’re going to see a lot of carriers trying to piggyback on this idea or similar type of ideas.”

Currently, only 8,400 of Humana’s 1.8 million Part D members are in a basic plan. Fleming says the plan is expected to generate a 5% operating margin, which is the average of all its Part D plans.

As for Walmart, Fein predicts the move will win the company significant market share in the areas where it has a lot of stores. ✤
Coupon Programs

Payers Counteract Some Rx Coupon Programs, Partner on Others

Drug manufacturers’ copayment subsidy coupons target a range of medications, from blockbuster statins such as Pfizer Inc.’s Lipitor to very expensive specialty drugs like Abbott Laboratories’ rheumatoid arthritis medication Humira. And the response of health plans to these promotional programs should vary just as much, advised two pharmacy experts who spoke at a Nov. 5, 2009, audioconference sponsored by AIS.

There are several strategies health plans can adopt to lessen the effect of such promotions on utilization of high-cost, high-volume blockbuster medications, said Michael Cartier, executive vice president of Envision Pharmaceutical Services, Inc., a PBM, and George Van Antwerp, general manager of pharmacy solutions at Silverlink Communications, Inc. But for certain specialty drugs, health plans may take the opposite approach, partnering with drug companies to promote copay subsidy coupons that help members pay for costly treatments.

Copay subsidy programs likely are here to stay, Cartier says. “Since every [drug manufacturer with a product] in a competitive class has these copay subsidy programs, it’s almost a requirement that they continue,” he asserts. And from the drug company’s perspective, adds Van Antwerp, the coupons serve as “virtual” samples — only less expensive to produce and with the added benefit of gathering patient clinical and demographic data.

Although the programs may improve adherence by reducing patients’ financial burdens, the downsides for payers go beyond the increased costs from higher utilization of brand-name drugs. For example, if the coupon is for a large enough amount that the drug claim is not submitted, PBMs and insurers cannot perform cost- and clinical-management services such as checks for adherence and drug-drug interactions.

Among strategies health plans can adopt to counteract coupons targeted at oral solids:

- **Increase the difference** in cost sharing between generics and non-formulary drugs;
- **Make the consumer pay** the majority of the drug cost even with the coupon, such as by closing the formulary or implementing step therapy;
- **Ban coupon use** — particularly in tightly controlled retail networks or in mail-order pharmacies;
- **Push manufacturers** to adopt contracts that tie usage to adherence; and
- **Offer adherence rewards** to consumers.

Specialty medications, however, aren’t the target of aggressive formulary management since most drugs have no competitors or generic versions, Van Antwerp says. In addition, many drugs are targeted to relatively rare conditions and often are quite costly. As a result, he contends, health plans should use different tactics in responding to coupons for these medications:

- **Continue to drive consumers** to a limited specialty network;
♦ **Partner with manufacturers** to allow coupons where it would be clinically appropriate and would help lower costs; or

♦ **Refuse to accept coupons** not provided by the specialty pharmacy directly.

Van Antwerp adds that “health plans should embrace specialty coupons that support cost-effective therapies, reduce copay burden and potentially impact adherence.” Humira is one drug that “plans may choose to endorse,” Cartier adds.

### Payers in Massachusetts Fight to Keep Ban on Drug Copay Coupons, Discounts

Massachusetts is the only state that doesn’t allow consumers to use drug coupons or copayment waivers offered by drug manufacturers — and many would like to keep it that way. As legislation to overturn the ban on prescription drug coupons gains support among pharmacies and patient groups, one payer group in the state contends that Massachusetts’ system works and that it has helped payers deliver the highest generic utilization rates in the country, saving patients and plan sponsors money.

Many health plans and PBMs in several other states have said they’re growing increasingly alarmed by copay subsidy coupons and are even adjusting copays for different tiers to deal with the growing number of coupons offered. While coupons are more common for specialty pharmaceuticals, they are used increasingly often for brand-name drugs. For example, enrollees using AstraZeneca’s statin drug Crestor (rosuvastatin calcium) can get a coupon that limits out-of-pocket costs to no more than $25 per month.

Massachusetts is now hearing some noise from local pharmacy associations and patient advocacy groups that say the law is preventing patients from saving a significant amount of money on their medications. They are pushing for passage of H. 4320, An Act Relative to Manufacturers’ Coupons and Rebates, which re-emerged in the state’s House of Representatives earlier in April 2010. If passed, the bill would overturn a ban on prescription discount programs offered by drug makers by allowing patients to use discounts, rebates or other reductions in price on prescription drugs.

Advocates for the bill say that allowing drug coupons and discounts could save some patients up to 75% of their copay for certain drugs — especially patients on specialty medications, according to Todd Brown, executive director for the Massachusetts Independent Pharmacists Association (MIPA). “As independent pharmacists, we see the struggle that patients have in affording their medications,” he told AIS in spring 2010. “And it would benefit patients tremendously if these coupons were allowed in Massachusetts — not only with affordability, but compliance as well.”

Brown also is concerned about how the current law is affecting independent pharmacists. “Because pharmacies in the state cannot accept the drug coupons, patients travel out of state to nearby Rhode Island or Connecticut to get their prescriptions filled with the discount,” he explains.

Previous efforts to pass similar legislation were blocked by payer groups that claimed such discounts are ultimately a bad deal for consumers and payers, which end up covering the bulk
of health insurance costs. The Massachusetts Association of Health Plans (MAHP), for example, argues that easing up on discount restrictions would incentivize patients to choose more expensive brand drugs.

“Our concern with the bill is that on its face, coupons would seem to benefit consumers and lower their costs, but ultimately they’ll pay higher costs,” Eric Linzer, MAHP spokesperson, told AIS in spring 2010. “While coupons may provide a one-time savings, the savings are only temporary for the consumer.” Once the initial supply of the drug is exhausted, he explains, the consumer has to repurchase the drug at the higher copay — increasing out-of-pocket costs for consumers and the cost of coverage for payers. “Only the big drug companies benefit from coupons,” he adds. “Everyone else ends up paying more.”

Pharmacists Say Brand Use Won’t Rise

Brown contends that due to the state’s generic substitution law, consumers will be unable to purchase the brand drug in lieu of the generic and that concerns about the impact on health care costs are unfounded. “We don’t buy the argument that it would drive patients to higher-priced drugs,” he maintains. “We see that patients seek these coupons after they are already prescribed these brand medications. And by not allowing Massachusetts residents to do it, they can’t take advantage of these huge discounts that are available and end up paying more.”

However, Massachusetts’ generic substitution law requires that pharmacists fill prescriptions using generic drugs unless the prescription states that they are brand name only or should be dispensed as written. Therefore, Linzer argues, “there is nothing to prevent physicians from prescribing brand-name drugs when requested to do so by a patient, especially if the patient has a coupon.” In addition, the bill would allow the use of coupons or rebates for a nonpreferred brand drug rather than a less expensive preferred brand drug, “leading to increases in prescription drug costs and higher health insurance premiums,” he explains.

The Massachusetts law banning drug coupons is just another example of where the state “has gone its own way on health care,” Dolores Mitchell, executive director of the state’s Group Insurance Commission, tells AIS in spring 2010. When asked why the state took this route, she says, “It’s simple. If coupons were available for manufacturers’ total book of business products, then we might feel differently, but that tells you something.” She adds that it’s not just a matter of getting people to switch from using high-cost drugs to generics. “It’s also that we, the purchasers, have to pay three-fourths of the cost of these drugs where coupons are made available.”

In addition, because H. 4320 would make it optional for plans to choose whether they want to honor the coupons, allowing them would become a logistical headache for plan sponsors. “I don’t see why I should have to deal with four or five different PBMs on this issue,” Mitchell says. “It’s harder for payers because the point of sale isn’t in their offices; it’s at thousands of different pharmaceutical outlets across the country, and you can’t always count on it easily being adjudicated at the point of service.”

Matthew Connell, vice president of pharmacy and contracted health services for Blue Cross Blue Shield of Massachusetts, says the ban, along with its pharmacy benefit strategy and the generic substitution law, has “helped health plans in the state deliver the highest generic utilization rates in the country,” which has significantly lowered the cost of care for employers and state residents.
Amid Rampant Coupon Use, FDA Plans Study to Evaluate Impact

As pharmaceutical manufacturers continue to bombard the general public with discount drug coupons, the FDA is launching a major investigation into the impact of such promotional offers on consumer behavior.

The federal agency plans to conduct a sweeping survey to discover if rebates and other offers in direct-to-consumer print advertisements influence perceptions of a drug’s value and performance.


At issue is whether such coupons offer consumers genuine savings or merely steer them toward more expensive drugs of questionable efficacy and away from cost-effective generic equivalents. Some maintain coupons can wipe out copays and yield huge savings for consumers, while others warn that coupon users can be misled into perceiving greater benefits in a particular prescription drug than there exists.

“Anything that helps decrease the overall cost of medications and health care is valuable,” says Helen Sherman, chief pharmacy officer for Portland, Ore.-based PBM RegenceRx, a subsidiary of The Regence Group. “What’s unknown is whether coupons decrease, increase or are neutral on overall costs,” she tells AIS.

At issue, Sherman says, is that coupons may entice a consumer into trying a brand-name medication without understanding:

♦ Their various treatment options, including alternative drugs,
♦ The value and pros and cons of each option, and
♦ Their insurance plan’s requirements for coverage of each option.

Although RegenceRx does not have a policy specific to prescription drug coupons, utilization management policies such as requiring prior authorization and step-by-step prerequisites can deter a plan member’s gravitation toward pricey, brand-name drugs just because a coupon is available, according to Sherman.

Kathryn Aikin, a senior social science analyst in the FDA’s Division of Drug Marketing who is involved in the coupon study, says the goal is to discover what effects various direct-to-consumer promotional offers in advertisements have on:

♦ Consumers’ perceptions of product risks and benefits,
♦ Comprehension of product risks and benefits, and
♦ Strongly held beliefs that may act as potential moderators.

A secondary focus of the study is to “explore ways in which additional contextual information can be used to enhance processing of information in the advertisement,” Aikin tells AIS. For example, incorporating specific information about a drug’s efficacy from its label into ad copy might actually improve the way consumers process the ad.
Based on 20-minute interviews with some 10,000 respondents, the FDA study will seek to
gauge the effect of such DTC promotions as free trial offers, buy-one-get-one-free offers and
money-back guarantees.

As coupon-based offers flourish, the time seems ripe for such a study of their effects. One
recent Bloomberg report cited pharmacy-sales data indicating that coupon use has escalated
more than 250% over the past four years.

One place coupon use hasn’t flourished is Massachusetts, which remains the only state in
the union that enforces a total ban on drug coupons. While some critics decry the measure as
a draconian moratorium that deprives consumers of significant savings, the state also boasts
some and the highest generic utilization rates in the country. Earlier in 2010 coupon advocates
came close to overturning the ban with a narrowly defeated bill in the state legislature. ♦

As Competitors Encroach, Pfizer Seizes a Few More Glory
Days With Lipitor Promo

Google “Lipitor” and “discount,” and you’ll see free-for-all Internet capitalism at work. Of
course, not all of the 3.18 million hits lead to a legitimate manufacturer’s discount for Pfizer’s
wonder drug, but thousands do. And the vast majority of those simply are tapping the im-
mensely popular Lipitor (atorvastatin) to redirect traffic through their own websites, trying
to waylay visitors on their way to Lipitor.com, Pfizer’s proprietary site for the cholesterol-
lowering drug. There, visitors find the wellspring of a drug promotion gone viral, the now-
ubiquitous $4 copayment card. Just fill out the online form, wait for your card in the mail, and
receive every 30-day prescription fill of Lipitor for just $4, up to $600 in savings per year. Pfizer
picks up the rest.

If only it were that simple. Faced with generic competition in November 2010, Pfizer is try-
ing to corner as much market share as it can for its hugely successful drug, which lowers low-
density lipoproteins (LDL) and triglycerides. Pfizer’s $4 copay program is a case study on how
far drug makers are willing to go to gin up sales and brand loyalty when their patent expiries
are imminent. But too-good-to-be-true promotions generally are, critics charge. Tempted by
free or near-free medications, consumers go on buying sprees, leaving third-party payers and,
ultimately, plan sponsors to pick up the tab.

Coupons, cards and other discount promotions fall into a gray area for many PBMs and
health plans. “We have two different perspectives on coupons, depending on how they are
used,” Everett Neville, chief trade relations officer for Express Scripts, Inc., told AIS in early
2011. “One, they can be used to subvert the formulary and cause the patient to not adhere to
the formulary. That’s bad for the whole industry. However, if it’s being used to alleviate the
financial difficulties of acquiring a drug, it’s not necessarily a problem.” Which category a
particular coupon deal comes under, though, can be ambiguous because the use of a coupon
or copay card by a consumer circumvents the normal PBM transaction, making research and
record-keeping difficult.

Coupons and rebates used to be among the most alluring drug promotions targeted at
consumers, but manufacturers have adopted more sophisticated means of driving utilization.
Neville says that in his experience, print coupons are the least common discount. Nowadays
copayment cards are much more prevalent. Hence the $4 Lipitor offer currently blanketing
cyberspace.

“Copay-assistance programs seem to be the most popular type of discount for patients,” Ric Gross, a market analyst at Nashville-based health care information company HealthLeaders-InterStudy, tells AIS. “These tend to cover all out-of-pocket patient expenses for the drug except for some small amount.”

A New Level of Competition

Unsurprisingly, pharma companies don’t offer plan sponsors the same financial assistance, and some experts submit that deep copay discounts woo consumers at the expense of other players in the health care system. “Payers are concerned that copay cards incent consumers to use higher-cost drugs,” George Van Antwerp, general manager of pharmacy solutions for Silverlink Communications, tells AIS. “The consumer no longer sees the penalty of using a more expensive drug.”

Up until its patent expired and a licensed generic appeared on the horizon, Lipitor had followed a by-now-familiar life-cycle for successful drugs. “Pharma companies tend to promote a drug heavily when it’s first introduced to the market,” Gross says. “That means more reps going to talk with docs. As time goes by, the docs become more familiar with the drug, and the drug’s efficacy becomes more apparent. At that point, focus shifts more to health plans regarding things like formulary placement and rebates.”

Pfizer, who declined to comment for this article, has given some indication that it will continue the $4 copay card only until November 2010, when a generic version hits the market, but Van Antwerp says he’d be surprised if the company did not extend the offer. “Back when Zocor went generic, Merck actually made the brand drug cheaper than the generic drug,” Van Antwerp recalls. “United and a few other payers ended up putting brand name Zocor into the generic tier on their formulary.”

When a brand drug goes up against generic competition, Express Script’s Neville says, to be competitive, manufacturers may lower the price of the brand anywhere from 10% to 70%, “depending on the dynamics of the particular drug.” Since an established drug like Lipitor has earned the costs of getting to market many times over, there is little obstacle to Pfizer dropping its price to compete with generics, setting up a whole new level of competition. ◊
Medication Therapy Management

MTM Spreads Into Commercial Space as Pilots Reveal Big Savings, Better Outcomes

Medication therapy management programs are picking up speed in the commercial space, as more health plans recognize that MTM need not be defined by only Medicare Part D guidelines and several pilot programs have revealed real dollar savings for plans and their members. However, member engagement and coordination of physicians and community pharmacists could pose challenges.

“We’re just seeing the tip of the iceberg” for MTM programs geared at commercial populations, said Lauri Amirpoor, staff vice president of clinical program policy at WellPoint, Inc., in July 2010.

WellPoint has been experimenting with MTM programs in the commercial space for the past few years. In fact, the plan just completed a successful “Pharmacy Coaching” pilot in Cincinnati for patients with diabetes and hypertension, and is planning to launch a similar program in California later in 2010. While Amirpoor cannot disclose the final results of the study, she says the plan did see improved outcomes for patients and a return on investment (ROI) for the plan.

One of the challenges holding plans back from moving into the commercial space is simply convincing members to be more involved in their health, says Barry Malinowski, medical director for Anthem Blue Cross and Blue Shield Ohio. Plans also must get physicians and pharmacists on board. “Sometimes it’s like pulling teeth to get people involved,” he told AIS in July 2010. “We have to get the doctors to participate fairly early so that they’re behind the program and not feeling threatened or feeling like it’s competing with what they’re trying to do.”

In addition, MTM has traditionally been targeted at seniors, since it evolved out of the Medicare Part D program. “The percent of the pool that would benefit from MTM is certainly smaller in a commercial population,” says Dan Rehrauer, Pharm.D., clinical pharmacy program manager at HealthPartners. This is because patients in the commercial space generally have very different lifestyles from those of Medicare beneficiaries. For example, Medicare patients “generally don’t have to deal with the burden of taking time off of work for appointments,” he explains.

The Academy of Managed Care Pharmacy (AMCP) recently conducted a survey of its members to get an update on current MTM programs being offered by payers. Out of 57 respondents — which included 43 health plans, six PBMs, five integrated delivery systems and three other organizations — only six reported using MTM programs for their commercial populations alone. Another 17 said they use MTM programs for both Medicare and commercial populations.

Marissa Schlaifer, AMCP’s director of pharmacy affairs, says plans have been implementing different components of MTM, such as adherence programs and drug utilization reviews, for several years. “Plans may not be doing MTM as a packaged program, but they’re doing
pieces and parts,” she told AIS in July 2010. “They’re doing all the components and all the things we want to accomplish with MTM.”

The Regence Group, for example, “has done MTM-type programs since 2004” for its commercial population, says Ruth Linard, manager of clinical pharmacy at Regence. “We have multiple types of programs — some are condition-specific and some are adherence-type programs,” she told AIS in July 2010.

But others argue that up until recently, plans have been doing only the bare minimum in administering MTM outside of Medicare Part D. “People weren’t putting a lot of effort in MTM and weren’t building strong programs,” Patty Kumbera, chief operating officer of Outcomes Pharmaceutical Health Care, a provider of MTM services, tells in July 2010.

**Plan Saved Thousands in ER, Hospital Visits**

HealthPartners is one plan that expanded its Medicare Part D MTM program to its fully insured commercial clients and self-insured commercial groups. The program’s expansion started off as a pilot program for Minnesota state employees with diabetes. To be eligible, patients had to be taking five or more medications and incurring more than $1,000 in pharmacy costs within three months.

One pilot revealed a $41,288 reduction in emergency room costs and a $196,266 reduction in hospital costs compared with a control group, according to Rehrauer. Patients also had a 44% increase in blood pressure control, an 18% jump in cholesterol control and a 15% rise in diabetes A1C control. MTM pharmacists also identified several drug-related problems. On average, three drug-related problems were identified per patient, including low dosage, adverse drug reactions and the need for additional drug therapy.

Under its current MTM program, eligible HealthPartners members receive private one-on-one, in-person consultations with a qualified pharmacist and multiple annual pharmacist visits, Rehrauer says. For members who do not have a close MTM provider or who have mobility issues, the plan offers telephonic MTM visits.

For now, the plan’s MTM services are available to its fully insured commercial patients taking multiple medications. However, within the next quarter, HealthPartners will expand its fully insured MTM program to diabetics and patients with heart disease. And for the self-insured populations, MTM is offered as an optional service that employers can purchase.

According to Rehrauer, the keys to an effective MTM program include face-to-face visits, simple administration for the pharmacists providing care, effective patient marketing materials, an ample provider network and established relationships between pharmacists and physicians in the community.

Kumbera maintains that by applying comprehensive MTM programs, health plans can eliminate vast amounts of medication waste that occur from patient noncompliance, ineffective drugs, inappropriate medical treatment due to side effects and the use of a high-cost drug when an effective cheaper alternative is available.

And as evidenced by HealthPartners’ program, plans’ ROI can be calculated by assessing improved quality of care, drug product costs, number of physical visits, hospital admissions and emergency room visits, among other things. Outcomes’ clients, for example, usually experience an annual ROI of $4.73 for every $1 spent, according to Kumbera.
As CMS Toughens MTM Regs, Plans Demand More ROI Data

Complying with the growing number of CMS requirements for medication therapy management (MTM) programs is becoming tougher as the number of Medicare Part D beneficiaries eligible to enroll in such programs also expands. While the agency is convinced of MTM’s effectiveness, some payers — including an increasing number considering MTM programs for their commercial populations — are demanding more specifics on such programs’ return on investment (ROI), according to several pharmacy benefit experts who participated in a Sept. 28, 2010, webinar sponsored by AIS.

At the beginning of 2010, CMS estimated that 25% of Part D beneficiaries were eligible for MTM services, compared with 10% to 12% in previous years. At the same time, CMS began requiring Part D plans to expand their current MTM programs to include an annual comprehensive review of medications, a process to assess the medication use of individuals who are at risk, and automatic enrollment of targeted beneficiaries who qualify on a quarterly basis.

As a result of increased reporting requirements, many plans have had to invest more money and hire additional staff to meet CMS standards, according to Marissa Schlaifer, the Academy of Managed Care Pharmacy’s (AMCP) director of pharmacy affairs. “Previously, all Part D plans were required to report the number of beneficiaries eligible for their MTM program and the number who opted out,” she said during the webinar. “Beginning [in 2010], plans had to report at the beneficiary level the receipt of a comprehensive medication review, the number of targeted medication reviews, the number of prescriber interventions and changes in therapy from MTM requirements.”

In interviews with several plans to see how they are complying with the 2010 requirements, Schlaifer found that one plan had to hire more staff and provide additional training for its internal call center staff. Other plans either contracted with an outside call center or an MTM pharmacy network to provide person-to-person comprehensive medication reviews and other services.

What they all had in common was “the need for updated and improved information technology systems to provide integrated data and reporting capabilities,” Schlaifer said. “Some of that was to provide MTM services, but to a greater extent it was to comply with increased reporting requirements.”

Taking note of the increased work and investment necessary on behalf of plans, many payers often question how these MTM providers determine ROI. The problem is that “it’s very hard to isolate ROI with your MTM program,” Schlaifer maintained. “Pretty much any plan that is offering MTM services is also offering other services — whether it’s the standard PBM utilization management or disease management programs — and it’s very hard to isolate ROI and just quantify it as being due to MTM services.”

MTM Company Estimates $4.73 ROI

However, some providers say they can provide solid numbers. Over the past two years, “we’ve seen a lot of expansion of MTM programs to non-Medicare Part D populations,” Brand Newland, vice president of MTM services provider Outcomes Pharmaceutical Health Care, said during the webinar. “And many other plans are considering doing such.”
According to Newland, this is because plans are seeing an ROI of $4.73 for every $1 spent for overall estimated cost avoidance. “And when we just looked at drug product costs, we were seeing $1.87 to $1 for our entire book of business — a number that has increased over the past year,” he added.

ROI can be calculated by assessing improved quality of care, drug product costs, number of physician visits, hospital admissions and emergency room visits, among other things.

WellPoint, Inc. is one health plan that has been experimenting with MTM programs in the commercial space for the past couple of years. “There just hasn’t been a lot of education for patients about medication compliance,” Laurie Amirpoor, staff vice president of clinical program policy at WellPoint, Inc., said during the webinar.

As a result, WellPoint rolled out an “innovative” employer-based MTM program in Cincinnati aimed at improving diabetic and hypertensive members’ knowledge of their disease, medication adherence, self-management behavior and clinical outcomes. This “Pharmacy Coaching” program encouraged eligible patients to go to large pharmacy chains to get one-on-one consultations with a pharmacist.

While it’s too early to disclose the final results of the study, Amirpoor revealed that WellPoint did see improved outcomes for patients in the form of lower hemoglobin A1c, blood pressure and lipid levels, and a significant ROI for the plan. WellPoint is planning to launch a similar program in California later in 2010.

**Plans, PBMs Increasingly Integrate MTM Into Benefit Plan Designs**

As plan sponsors, PBMs and consultants ponder the factors impacting the drug benefit plans of the near future — such as the increase in use and costs of specialty drugs, including the future introduction of biosimilars, and the generic wave — another component entering the mix is medication therapy management (MTM). While MTM services have been mandated for several years in Medicare Part D and will be increased by 2013 per health reform, MTM has only gradually been making inroads into the private sector, acquiring buzzword cachet and arousing the curiosity of plan sponsors ever on the lookout for innovations to cut cost and improve outcomes.

Prime Therapeutics LLC, for one, is blazing MTM trails. “Prime is expanding existing MTM capabilities into the commercial space for 2012,” David Lassen, chief clinical officer for Prime, told AIS in March 2011. Acknowledging that Prime’s MTM program was developed to serve the Medicare Part D market, Lassen believes those capabilities will form a good baseline to expand on in the commercial market. Prime is owned by the 17 Blues plans it provides PBM services to.

Bringing MTM to the commercial market is especially liberating, Lassen says, “because there are no mandated features or requirements.” Minus the strictures CMS imposes on Part D MTM services, benefit plan designers have more freedom to experiment and innovate.

Lassen concedes that any given benefit plan is a partnership between the third-party payer and the plan sponsor. Prime marries its pharmacy expertise and understanding of the pharma-
ceutical industry to the perspective, broader health management programs and medical expertise of its client. The resultant program adopts a more holistic view of the members’ health.

“We are collaborating with our owner-clients on solutions for their unique markets and membership needs,” Lassen says. “As a result, our commercial program will exhibit a greater amount of flexibility and be more open to customization than competitive offerings.”

United Health Group unit Prescription Solutions boasts a commercial MTM program that relies heavily on interaction with physicians. “For MTM programs to work well, they must include physician involvement and education,” Brian Solow, senior medical director for clinical service at Prescription Solutions, told AIS in March 2011. “Physicians must remain the focal point of the coordination of member care.”

Prescription Solutions targets physician-prescribers on medication-related issues via direct mail or fax. The PBM solicits feedback from providers to help design programs that meet current patient needs and anticipate future issues. “Our clinical program criteria and materials are reviewed by physician-led groups, and we streamlined our provider materials based on the feedback from these groups,” Solow says.

For example, the comprehensive medication review (CMR — mandatory under the CMS-mandated MTM services for Part D plans) provides members with a telephone consultation with pharmacists. Those pharmacists may also contact physicians by phone for any urgent issue that comes up in the CMR.

Recognizing the role MTM programs play in improving members’ health, Prescription Solutions continually seeks ways to educate and engage members, Solow says. For example, any drug-related issues are compiled in a personalized medication action plan for members, along with a personal medication record of their drug history. These same documents are faxed to providers to promote better coordination of care.

At the informal end of the spectrum is Aetna, Inc. “We don’t use the term ‘medication therapy management,’” Robert Galle, chief operating officer of Aetna’s PBM, tells AIS. Eschewing the formal rubric of “MTM” for the much broader definition of “pharmacotherapy,” Aetna has pursued an array of initiatives and practices, some of which look like offerings in MTM programs:

◆ **Case reviews performed by pharmacists** to check for improved clinical outcomes;

◆ **Generic step therapy programs**, in which a generic is used first and a switch is authorized only when patient fails to achieve a desired outcome;

◆ **Save a Co-Pay Program**, in which copayments for generics are eliminated for several months in an effort to motivate members to switch; and

◆ **Pharmacy Advisor program** — which is managed through a contract with CVS Caremark Corp. — an award-winning new program in which pharmacists help manage drug therapy for patients with diabetes.

With the big policy push and some studies indicating cost savings and positive outcomes, MTM is getting a lot of play these days and plan sponsors are getting curious. Galle points out that 50% of Aetna’s business is with self insured plan sponsors, so they have a lot of motivation to align their strategies.
E-Prescribing

As the Number of E-Prescriptions Soars, Payers See Higher Formulary, Generic Use

Successful payer initiatives and new government regulations have been key drivers in the accelerating growth of e-prescribing, leading to better formulary compliance and generic utilization. While most payers have jumped on the e-prescribing bandwagon, late-adopter prescribing physicians and start-up costs remain obstacles to making e-prescribing standard practice.

The number of e-prescriptions nearly tripled in 2009 to 191 million, representing approximately 12% of all prescriptions filled, according to Surescripts LLC, which holds the largest electronic prescribing network in the U.S. Electronic requests for prescription benefit information also grew by a staggering 284% in 2009, as access to prescription benefit and history information became available for more than 65% of patients in the U.S.

And these numbers will continue to grow, Surescripts says, as nearly one in five prescriptions was filed electronically in the first three months of 2010.

Over the past couple of years, a nationwide push by payers and the government has significantly contributed to accelerating growth of e-prescribing. In 2009, for example, the American Recovery and Reinvestment Act put $19 billion toward the adoption of health information technology. At the same time, CMS released proposed regulations for “meaningful use” of electronic medical records while Medicare launched an e-prescribing initiative that pays physicians a bonus for e-prescribing. Under this initiative, those who haven’t adopted the electronic system by 2012 will be penalized.

Most recently, the Drug Enforcement Administration released a final rule that will allow physicians to use e-prescribing for controlled medications such as narcotics and antidepressants, which were previously allowed only paper prescriptions. The new rule, effective June 1, 2010, is expected to contribute to an even greater uptick in e-prescriptions in 2010.

All this has been good news for payers, which have been pushing e-prescribing initiatives since the beginning. CVS Caremark Corp. — the first national chain pharmacy to have all of its stores e-enabled — has been encouraging adoption of e-prescribing through all parts of the enterprise, according to Timothy Kurth, vice president of CVS Caremark’s e-business. He says the efforts have proven successful, as the PBM received 43.38 million electronic prescriptions from physicians in 2009 — reflecting an approximately 126% increase from the prior year.

E-Prescribing Ups Formulary, Generic Utilization

By now, most payers acknowledge that “the benefits of e-prescribing to both the health plan and the patient are aligned — to get information to doctors so they can make the best choice,” Jeff Taylor, clinical pharmacy manager at Aetna Inc., told AIS in April 2010. E-prescribing has been proven to reduce serious dosing and drug combination errors and increase adherence to medications, he explains. A study published in February 2010’s Journal of General
E-prescribing also has led to increased formulary compliance and generic utilization, Taylor says. “By using an e-prescription device that informs the physician while they’re making a drug choice about where that drug falls on the formulary, health plans and patients are helped to reduce their overall cost,” he adds. But the industry still has a long way to go, Taylor maintains, as many organizations and physicians have resisted adapting to change.

According to Surescripts, only 25% of all office-based physicians currently have the technology necessary to e-prescribe. This is because start-up costs for e-prescribing software are obstacles for physicians. According to the Wall Street Journal, the cost of e-prescribing software and training can range from about $1,000 to $1,750 per physician.

“The costs associated with converting a doctor’s office to an electronic office — not just for e-prescribing, because it’s typically done as part of the move to electronic medical records — can be prohibitive for small practices,” says John Jones, senior vice president for professional practice and pharmacy policy at UnitedHealth Group subsidiary Prescription Solutions. Plans also have to pay to implement and maintain the process with Surescripts and pay fees every time a members’ information is accessed, he adds. In addition, many physicians “aren’t technically savvy and aren’t willing to change to a system which demands the application of technology to their practices,” Taylor says.

However, he maintains, “once it’s done, it’s well worth it.” Aetna hopes that new technological advancements “will make it much easier for physicians to accept change and adapt to the system,” he says. He adds that the maturation of the e-prescribing industry and the increase in availability of stable connectivity tools such as wireless internet and smartphones will allow e-prescribing to become more accessible for prescribers.

In an effort to reform the system, some plans are requiring physicians to use e-prescribing. Blue Cross Blue Shield of Massachusetts, for example, will require all physicians in its incentive program to begin prescribing electronically starting Jan. 1, 2011. As of now, almost all primary care doctors and almost three-quarters of specialists in the plan’s network participate in its incentive programs.


Aided by federal and local incentives for utilization as well as encouragement from forward-thinking payers and provider networks, the leading states on the e-prescribing front afford numerous lessons for how other jurisdictions can get themselves connected. These states have moved beyond the start-up costs of implementing e-prescribing systems and are now reaping rewards in the form of cost effectiveness, treatment efficacy and greater patient safety.

Massachusetts and Michigan were No. 1 and 2 respectively in e-prescribing activity for 2009, according to 2010’s Safe-Rx Award rankings issued by health IT vendor Surescripts. Here’s how they did it.
In 2010 Massachusetts physicians routed more than 11 million prescriptions electronically, which accounted for one in three prescriptions overall. The state also fielded more than 12 million electronically submitted requests for information on prescription benefits and responded to nearly 3 million requests for medical history information, also submitted electronically.

The open secret of the state’s success in e-prescription adoption is a predisposition toward high-tech and a spirit of collaboration among plans, payers and providers. “Many of our physicians are part of large integrated delivery systems and physicians’ groups, and these are groups that are much more likely to implement e-prescribing systems early on,” Karen Bell, M.D. chairwoman of the Certification Commission for Health Information Technology (CCHIT) and a former director of health IT adoption at HHS, told AIS in November 2010.

Massachusetts’ growing adoption rate for e-prescribing reflects an enthusiastic embrace of health IT in general and goes hand-in-hand with higher utilization of electronic health records (EHRs) in the state. “States that have high rates of e-prescription are often states that have a high rate of electronic health record adoption, and that is certainly the case here in Massachusetts,” Bell says. Accordingly, more than half of Massachusetts’s e-prescriptions in 2009 were made via EHRs. Two of the state’s largest health systems were instrumental in making that happen. Partners HealthCare and CareGroup Healthcare System combined their own proprietary electronic medical record systems into a single infrastructure dubbed MassShare.

There are other examples. From the earliest days of the push for HIT, significant players throughout the state have been on the same page. “Massachusetts is a super, super collaborative market where payers and providers work very closely and effectively together,” Kate Berry, Surescripts’ senior vice president of strategy and innovation, tells AIS.

Three of the state’s largest payers — Blue Cross Blue Shield of Massachusetts, Tufts Health Plan and Neighborhood Health Plan — were among the very first to board the e-prescribing bandwagon. The partners focused on picking a common vendor and pooled all their data on

### Surescripts’ Top 10 States for eRx Use

Surescripts’ Safe-Rx Awards went to 10 states with the most electronic prescribing activity. The audit used to produce the rankings looked at several factors, including the number using an e-prescribing system.

<table>
<thead>
<tr>
<th>State</th>
<th>Prescription Benefit Requests</th>
<th>Total Prescriptions Routed Electronically</th>
<th>Total Estimated Responses to Medication History Requests</th>
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*New to the top 10

prescription benefits, formularies and medication histories. “Basically, they created a single infrastructure they all could use,” Berry says.

Berry and Bell both credit payers in the state with expediting e-prescription implementation. “They make e-prescribing free to high-prescribing providers in their system and provide financial incentives to physicians,” Berry says. Some plans dole out free e-prescription tools and instructions on their use. An early investment in e-prescription by Blue Cross Blue Shield of Massachusetts to the tune of $50 million also didn’t hurt.

Michigan physicians processed the second-largest number of prescriptions among states in 2010. From 2008 to 2009, Michigan’s e-prescribing volume increased 230%, jumping from 4.9 million to 11.3 million. Patients in the state submitted more than 20 million electronic requests for information about their prescription drug benefits and made another 3.5 million electronic requests about their medical histories.

Timothy Antonelli, a clinical program manager at Blue Cross Blue Shield of Michigan (BCBSM), has been involved in a number of e-prescribing initiatives in the state and credits a couple of key programs with increasing Michigan’s e-prescribing rate.

Perhaps the best known of these is the Southeast Michigan E-prescribing Initiative (SEMI), in which BCBSM banded together with Medco Health Solutions, Inc., CVS Caremark Corp. and several health plans of the state’s automakers in a coalition to promote e-prescription in seven targeted counties. SEMI launched in August 2005 and today boasts 5,500 participating physicians.

“The benefit of drug-drug interaction alerts and having access to patients’ medication history enables our practice to keep patient safe by reducing adverse drug events,” says Mark Kelley, M.D., CEO of the Henry Ford Medical Group, in a statement from SEMI.

BCBSM’s Antonelli is also quick to recount the achievements of his own organization on the e-Rx front. Through its online portal for physicians, dubbed Web Denis, Blue Cross Blue Shield of Michigan hosts an e-prescribing program for 1,000 e-prescribers. For these 1,000 early adopters, BCBSM provides interconnectivity and e-prescribing hardwire from Dr. First, a health IT vendor. BCBSM also sponsors an incentive program that awards doctors up to $2,000 paid out over two years for adopting e-prescribing. Antonelli believes that having tools and information right on the website was a boon to helping physicians adopt e-prescribing.

Antonelli says about a third of Michigan doctors now use e-prescription.

“I think we’re going to see the biggest cost savings around medication adherence and helping patients move towards the most cost-effective therapies, such as generics,” he says. But e-prescribing has a value above and beyond the bottom line, Antonelli believes, by improving patient safety and enforcing more effective treatment. Actuaries may be able to put a price tag on the medical errors avoided by the safety checks of the e-prescribing process — drug interactions, duplicate therapy checking and dose checking — since the sum is greater than the whole.

Although federal policy makers may have lagged behind these states in implementing their own HIT goals, e-prescription boosters in both Massachusetts and Michigan credit Uncle Sam with paving the way for them to lead the pack. HHS and CMS continue to sweeten the incentive pot.
The Recovery Act earmarked $19 billion in funding for HIT implementation, and CMS offers a 2% incentive on Medicare payments to physicians who e-prescribe, a lagniappe that gradually will invert to a 2% penalty by 2012. More significantly, CMS finalized its “meaningful use” rule in June 2010. Under the auspices of the program, physicians who make liberal use of health IT will be eligible to receive up to $44,000 in incentives from Medicare and $63,750 from Medicaid.

HIT advocates credit the feds with removing a long-standing roadblock earlier in 2010. In June 2010, the Drug Enforcement & Administration signed off on a rule that gives a green light to the e-prescribing of controlled substances. In exchange for the protections once afforded by paper prescriptions, e-prescribers may now have to implement such special safeguards as biometrics (fingerprint readers and retinal scanners) and crypto-keys, devices that a provider plugs into a computer’s USB port for purposes of authorization and accountability.

Still, numerous impediments to universal electronic prescriptions remain in the form of cost, technophobia, workflow disruption, administrative hassles and general resistance to change, among others. After years of pushing for higher rates of e-prescribing, few advocates harbor any delusion about the uphill battle they face. “Until we have a really widespread health information exchanges there will be some reluctance to jump into the full HIT arena and of course that’s going to be dependent on privacy, security, governance and a number of other issues,” says CCHIT’s Bell. ♦
Employer Strategies

‘Creative’ Employers Are Raising Copays, Using Mandatory Mail, Generics Programs

To offset anticipated cost increases resulting from health reform, many large employers are planning to raise copayments for retail and mail-order prescription drugs in 2011, according to a major survey. At the same time, a growing number of employers have already revised their pharmacy benefit designs to include more mandatory mail and generics programs — a “cutting edge” move that puts employers ahead of health plans.

In a survey of 72 large self-insured employers, the National Business Group on Health (NBGH) found that 25% of respondents plan to raise copays for drugs filled at retail pharmacies, while another 21% plan to increase employees’ copay for mail-order.

Although shifting increasing costs to consumers is inevitable, “health reform has put more emphasis on getting value out of pharmacy benefits,” said Steve Wojcik, NBGH vice president of public policy, in August 2010. Employers have been using “strong incentives” to drive better performance and many of the top benefit design changes have been in the pharmacy area, he maintains. In addition, many employers have been using several innovative techniques to manage their pharmacy benefits and rein in rising costs.

According to the survey, 47% of employers are now using mandatory mail order for maintenance medications to manage their pharmacy spending. And another 37% have implemented mandatory generic substitution.

NBGH President Helen Darling says the widespread use of these methods shows that employers “are more creative” and “more cutting edge on making changes” than health plans.

She explains that health plans typically assume that employers are not willing to make sweeping changes to their benefits. “On the contrary, many employers are aligned with plans’ strategies,” she tells AIS. “I think employers are much more likely to go to something like mandatory mail order or even mandatory generics — or even step therapy and increased cost sharing.”

Darling adds that such programs have not created much noise from employees, mostly because the term “mandatory” is misleading. When most employers implement mandatory mail order, employees still have the option of receiving their medications through retail — they just have to pay the full difference in cost, she explains.

The three other most prevalent techniques employers use to manage their pharmacy costs are prior authorization (73%), step therapy (63%) and three-tier design (63%). Several employers also use dose optimization, four-tier design, mandatory formularies and separate deductibles for pharmacy benefits, according to the survey.

An even larger number of techniques is being used by employers to control spending on specialty pharmaceuticals. According to the survey, prior authorization was the most used method to control specialty pharmacy costs, followed by utilization management, step therapy and preferred networks.
“If you go back just a few years, you would see that not all employers were taking advantage of every tool to manage their pharmacy benefits, but increasingly they are out of necessity,” Darling says. “There has been an increase in all the things we would expect employers to be doing.”

Darling adds that there is “more encouragement” for coverage of preventive medications, especially in consumer-directed health plans (CDHP). According to the survey, 18% of CDHPs and 7% of non-CDHPs cover preventive medications at 100%. The majority of employers cover preventive medications outside of the deductible, but subject to a regular copay.

**Reform Law Alters Retiree Subsidy**

Changes to prescription drug programs are also playing a large role in retiree benefits, which is a particular area of concern for employers, according to Wojcik. “As large employers, they are more likely to have retiree benefits and have lots of them,” he says. “Some of our members even have more lives covered in the retiree plans than in their active plans.”

He adds that prescription drugs are “the only exception where health reform has changed the way employers will do things and caused them to evaluate what they’re doing as far as retiree benefits.”

By taxing the federal subsidy on Medicare Part D prescription drugs that Congress originally created as an incentive to encourage employers to continue offering retiree benefits, the reform law basically made it more expensive for employers to continue offering retiree benefits. As a result, many employers are considering providing only secondary coverage or setting up a Medicare Advantage waiver plan. According to the survey, 5% of employers plan to drop retiree health coverage in 2011, while another 60% are considering it.

In addition, the closing of the Part D doughnut hole is making private retiree health coverage “even more unattractive for employers,” Wojcik says. “So we’re making it more costly for private retiree drug coverage and at the same time, it’s more tempting for those people to jump ship.”

Such changes are going to have “huge implications” on the pharmacy benefit market because Medicare will end up paying for the bulk of prescription drugs, Wojcik maintains. “And then for the active workforce, there could be an increase in the potential for cost-shifting in trying to make up for some of the shortfalls in Medicare payments for prescription drugs through private coverage for active employees,” he adds.

**‘Innovative’ Firms Move Away From Value-Based Design, Embrace Consumerism**

In September 2010, as employers finalize 2011 benefit designs, it’s clear that most are becoming “more active” in managing their employees’ prescription drug benefits. But the strategies they choose to control pharmacy spending are diverging into two different camps, according to several pharmacy benefit consultants. Some employers are sticking with the tried and true value-based insurance design, while the more “innovative” employers are promoting consumerism by implementing reference-based pricing models.
The basic premise of value-based insurance design is to remove barriers (i.e., cost) to essential, high-value drugs to promote better overall health outcomes. Employers that continue to use value-based benefit designs are “aiming to promote therapy adherence,” and are focused on selected medications to treat conditions such as cardiovascular disease and high blood pressure, says Nadina Rosier, Towers Watson’s North America pharmacy practice leader.

Meanwhile, a few employers are experimenting with an approach “that is aggressively moving the market-place towards consumerism in an innovative way,” Rosier tells AIS. These employers are implementing “reference-based pricing models for therapy categories that have viable generic equivalents or alternatives,” such as proton-pump inhibitors or drugs to treat multiple sclerosis, she explains. “These models cap the company benefit on a therapeutic category basis, which primarily impacts the expensive, brand-name drugs in the class.”

The method’s downside is that it could increase cost sharing with employees. This is because most of the tactics used in pharmacy management — such as mandatory generics and step therapy — “can only result in limited or one-time savings,” Chris Nee, president of health care consulting company PharMedQuest, tells AIS. However, because drug costs keep rising, “the remaining option to provide cost savings is to increase cost sharing with patients.”

Such strategies employed through this model include removing prescription drugs that have over-the-counter equivalents from the formulary, increasing the use of step-therapy and prior-authorization requirements, and implementing four-tier formularies.

According to Michael Jacobs, national clinical practice leader at Buck Consultants, these innovative employers are betting that consumers are becoming more engaged in managing their health. “People are going to ask the question about what alternatives are,” he argues. “And this idea that anyone would ask those questions and start doing some research gets into a philosophy that many employers are including in their benefit about consumer engagement.”

Value-based insurance design, on the other hand, “aims to make everything as carefree as possible for the employee,” Jacobs contends. “If you make things too easy, people will take certain medications just for the sake of it because it doesn’t cost them anything.” This, in turn, can increase costs for employers by unnecessarily paying more for expensive therapies, he adds.

Cost can be used as an incentive to move people to better-value drugs, Jacobs argues. The only problem is that “some employers have removed the barriers, but they haven’t taught people how to use the resources,” he adds. “If you’re the employer, give your employee resources and access to a professional.”

Narrow Pharmacy Networks Gain Interest

Restricted pharmacy networks are another pharmacy benefit design trend that has been gaining momentum. “A lot of employers are focusing more on a personal, face-to-face approach and are considering the value of 90-day fills at retail — especially with all the things coming down the pike with health care reform that will mandate a lot of services that could be provided at the retail pharmacy level, such as preventive services,” Sean Brandle, national pharmacy practice leader at consulting firm The Segal Co., tells AIS. Programs such as CVS Caremark Corp.’s Maintenance Choice are already demonstrating increased adherence rates, he adds, and “are really appealing to employers because they can provided ancillary counseling services.”
Other types of narrow networks simply require limiting the number of pharmacies an employer contracts with. “We have more than 60,000 drug stores in America, 38,000 grocery stores, and about 13,000 McDonalds,” Jacobs points out. “How difficult is it for someone to find a McDonalds hamburger if they want one? …Not hard. So why do we need 64,000 drug stores within our network?”

Limited networks “offer a tremendous amount of opportunity for employers who are aggressive in the way they delivery their prescription drug benefits to their employees,” he maintains.

According to a recent Wal-Mart Stores Inc. study, employers can save 7% to 10% on drug costs by narrowing their pharmacy network.

According to Rosier, an increasing number of employers also are relying on predictive modeling, rather than pharmacy data, to analyze their pharmacy spend and come up with new options for their benefit design.

“While some PBMs are offering predictive modeling tools to primarily identify gaps in care and prevent adverse events, not all have this level of sophistication and capability,” she explains. “Capability is only half the battle — what is critically important is not only the presence of predictive modeling but what the clinicians, health plans and PBMs armed with that information” do with it.

Nee argues that “predictive modeling is based on historical pharmacy data,” so they go hand in hand. Predictive modeling “is really another version of actuarial analysis,” he adds, and is mainly used to assist in analyzing historical data. “As such, it is quicker than a full-fledge actuarial review.”

**Employer Reveals First Positive Results of Maintenance Choice**

Skeptics that previously questioned the benefits of CVS Caremark Corp.’s Maintenance Choice program can now review positive results from one of the PBM’s largest employer clients — US Airways Group Inc. — which reported an almost 20% jump in adherence rates among its employees.

US Airways on Sept. 15, 2010, reported that its employees and dependents enrolled in Maintenance Choice in the past year were 18% more consistent in refilling their prescriptions than they were the year before. According to Pam Weier, the company’s director of benefits, the PBM measures adherence by using a medication possession ratio of greater than or equal to 80%. She says the program yields the same prescription drug savings as mandatory mail, but “improves adherence by influencing behavior change” among the company’s 60,000 members.

Launched in 2009, Maintenance Choice allows consumers to buy 90-day supplies of drugs for chronic conditions at CVS pharmacies for the same price as mail order. While employers are typically slow to adopt new PBM offerings, CVS Caremark says its clients have been quick to accept the program — making it the fastest growing of the PBM’s new services. Some indus-
try insiders have predicted that the program’s success will lead the way for greater adoption of restricted networks.

However, Weier says the company does not view Maintenance Choice as a restricted network. She explains that this is because prior to implementing the program, US Airways had mandatory mail in place for its plans, which required all maintenance drugs to be filled through 90-day scripts at mail and did not allow for retail fills after the first two or three 30-day fills (depending on the plan).

“By implementing Maintenance Choice, our participants now have a choice of using mail order or also filling their 90-day maintenance scripts at a CVS pharmacy, thus expanding their access,” Weier tells AIS. “Participants still have the option of filling their nonmaintenance medications or their first two or three fills of maintenance medications at any one of the pharmacies in the CVS Caremark network.”

Whichever way it’s viewed, Maintenance Choice “is a very appealing product,” maintains Greg Madsen, principal at pharmacy benefits consulting firm Innovative Rx Strategies, LLC. “Having the ability to pick up prescriptions at a local store, as opposed to mailing it, is a huge convenience for employers and their employees….It just makes a lot of sense,” he tells AIS.

Other companies, such as Walgreen Co., have been trying to keep up by coming up with similar products, Madsen says. “But Walgreens is on a much different scale because it has a smaller PBM, and it’s really focused on self-insured employers.”

According to Morningstar, Inc. analyst Matthew Coffina, Maintenance Choice has already put the retail giant’s pharmacy sales ahead of rival Walgreens. And CVS Caremark has said that for every patient who switches to Maintenance Choice, the company could get as much as $1,500 in additional revenue.

Madsen says the news of US Airways’ success with Maintenance Choice will likely boost interest in the program.

However, while the results of the US Airways pilot are impressive, “most plan sponsors and consultants look at these as best case in evaluating them for their employees,” contends Kemp Dolliver, a managing director at Avondale Partners, LLC. “It probably starts some discussions, [but] not all will work out.”

Maintenance Choice “is very important to CVS Caremark,” he adds. “It’s at the heart of their model, so they’ll keep promoting it.”

### New Pricing, Contract Wins Bode Well for Wisconsin Cooperative

WisconsinRx is having a good year already. First, the Madison-based member-owned coalition for buying pharmacy benefit services signed a deal effective Jan. 1, 2011, for improved drug pricing with its PBM, CVS Caremark Corp. Then National CooperativeRx, the national division of WisconsinRx, landed a contract with the Midwestern Higher Education Council (MHEC), an organization representing higher education institutions in 12 states, to help its schools save on prescription drug costs. Depending on how many schools it creates programs...
for, National CooperativeRx could gain any number of MHEC’s more than 700,000 students, faculty and employees as enrollees.

These are ambitious moves for a small local cooperative launched by two employer groups and an insurer seven years ago to control drug expenses. WisconsinRx was the brainchild of WEA Trust, a not-for-profit insurance company, and The Alliance and the Fond du Lac Area Businesses on Health, small local business groups dedicated to combating escalating health care costs. Today, the co-op represents 450 self-insured employers with 260,000 enrollees, split evenly between the state-based and nationwide units.

Greg Horstman, for one, is taking the co-op’s recent successes as good omens. And the CEO of Wisconsin/National CooperativeRx says more good news is around the corner. Though Horstman declines to name names, National CooperativeRx expected to sign “a major insurance company” based in Georgia as a partner in April 2011.

Horstman is equally quick to extol the cooperative’s success in its primary mission of controlling pharmaceutical expenses for its member organizations and their beneficiaries. “All our members have seen at least 10-plus percentage points just on drug savings,” Horstman told AIS in February 2011. “We’ve been able to keep our aggregate drug spend and trend over the past five years at pretty much a flat level.” That achievement alone, during a period in which drug trend was 10% to 12% nationwide, might warrant bragging rights.

One program that has aided WisconsinRx in flattening its drug spend is its promotion of generics. Horstman says the cooperative has pushed its generic utilization rate from 50% to 70% over the years. Aside from negotiating for lower drug prices, WisconsinRx uses benefit design features such as prior authorization, a new fourth formulary tier, and safety and waste control programs.

The co-op started with three staff members and has grown to a dozen. It funds its operations with a per-member-per-month fee that can literally be measured in cents. Because WisconsinRx is member-owned, the cooperative doles out dividends to its members whenever income exceeds expenses, as it did in 2010.

**Wielding Collective Clout**

Other coalitions have formed to wield their collective clout to purchase drug benefits, such as the MidAtlantic Business Health Group’s Pharmacy Collaborative, but WisconsinRx is the sole member-owned cooperative of its kind known to those interviewed for this article. That it formed in a state that has long been a hotbed of cooperatives, beginning with dairy farmers in the mid-19th century, seems only natural. “There are many similar purchasing coalitions around the country that have been in operation for many years,” Kemp Dolliver, managing director at Avondale Partners LLC, tells AIS. “Their cooperative model differs from others, but that looks like the biggest distinction.”

Whether through a cooperative or some other form of group purchasing organization, pharmacy purchasers benefit from strength in numbers.

“While health care decisions are personal and localized, the procurement process and vendor selection process lends itself to cooperative and coalition models like WisconsinRx,” George Van Antwerp, general manager of pharmacy solutions at Silverlink Communications, tells AIS. “By aggregating lives, they should be able to negotiate better pricing, and the
employers and unions should have a representative focusing on managing their spend and partnering with their PBM.”

Avondale’s Dolliver agrees: “In general, the more that the coalition’s members can act in a unified fashion — for example, through a single formulary or a single plan design — the more effective it will be.”

**Meddling at Mittal: CVS Pilot Improves Outcomes for Steelworkers**

A bunch of overeducated professionals intervening in the affairs of steelworkers might sound like a recipe for mayhem, but in this case, the workers took their medicine and liked it. For six months beginning in the fall of 2009, 13,000 of the 80,000 U.S. workers of ArcelorMittal, the world’s largest steel company, were human guinea pigs in a pilot for the Pharmacy Advisor program, created by CVS Caremark Corp. to improve the pharmacy care of beneficiaries with diabetes. The pilot was such a success, improving medication adherence and closing gaps in care, that by the time the program was finished, CVS Caremark had begun rolling out Pharmacy Advisor as part of its regular core offerings for 10 million of its members.

The company estimates that the program could save employers about $600 per year on each member with diabetes. For a firm with 50,000 employees with an average prevalence of diabetes, that translates into savings of between $3.3 million and $6 million, according to CVS Caremark. By reviewing claims data, the program identifies enrollees with diabetes who are receiving less-than-optimal pharmacy care. Evidence-based protocols are applied to identify gaps in care or problems with medication adherence. Pharmacists are then prompted to discuss the issues with members either via the phone or face-to-face in a CVS pharmacy. By the end of the six-month pilot, gaps in care were closed at rates bettering a control group by 59% for phone counseling and 91% for face-to-face intervention.

**Engaging Patients and Pharmacists**

Pharmacy Advisor drew accolades from ArcelorMittal, which has gone full-scale with the initiative for its drug benefit program since the pilot ended. “We learned that employees are happy to receive information and support that can help them manage their disease and lower their costs,” Mary Hendrickson, employee benefits manager for ArcelorMittal, told AIS in March 2011. “We also realized that some employees did not have all of the facts about how to treat this disease. Now that they do, they can potentially add years to their life and avoid some of the catastrophic events that can accompany out-of-control diabetes.” The pilot garnered a 2011 Rx Benefit Innovation Award from the Pharmacy Benefit Management Institute in February 2011.

CVS Caremark executives hatched the idea for the program when they realized they served millions of members with diabetes, but “we didn’t have an enterprise approach to how we managed their care,” Doug Ghertner, senior vice president for CVS Caremark’s pharmacy business, told AIS in March 2011. For the pilot, the company sought an employer with a significant concentration of its employees in a given market so it could administer the program in a handful of stores and assess the impact of face-to-face engagement. Not least of all, CVS
Caremark needed to land a pilot client that was receptive to the aims of Pharmacy Advisor. “We wanted to find a client who saw that connection between adherence, gaps in care, the impact the pharmacy side of things can have on one’s total health care costs,” Ghertner says. ArcelorMittal, which had a 13.7% prevalence rate of diabetes among its workers, expressed interest in bettering outcomes for its employees.

Though approached gingerly, the pharmacist interventions that were a key element of Pharmacy Advisor were surprisingly well-received. Fearing employees would find the phone calls intrusive, ArcelorMittal officials requested that CVS Caremark build an opt-out feature into the plan. But Ghertner cited “countless examples” of incidents in which pharmacists would phone the home of a member with diabetes only to be asked to talk to other family members with the same condition.

ArcelorMittal employees weren’t the only ones motivated by the Pharmacy Advisor program. The pharmacists themselves often found it inspiring and invigorating. “A lot of them said it got back to the heart of why they went to pharmacy school,” Ghertner says. Pharmacists in stores and in call centers receive training on the condition and the motivational psychology and consumer behavior that goes into patient engagement. But much of what makes the program successful can’t be programmed, Ghertner says. “While we provide talk tracks for both pharmacists in the call center and in the stores, you can’t really script it entirely just because it’s a more sophisticated communication than ‘Let me take down your phone number and address,’” he says.

While the Pharmacy Advisor program may be novel, the notion of pharmacist intervention improving patient adherence isn’t. “There’s a lot of data out there that backs up the idea that when the pharmacist is involved, we get better results in terms of engagement, adherence and persistence,” Cyndy Nayer, president and CEO of the St. Louis-based Center for Health Value Innovation, told AIS in March 2011.

The decision to focus on diabetes, a disease affecting 25 million Americans by CDC estimates, is also a logical one, Nayer believes. “Diabetes has a very defined treatment path, so we can follow whether people are getting the appropriate care,” she says. But CVS Caremark has no intention of confining the improved clinical outcomes obtainable though Pharmacy Advisor to only one disease or condition. Ghertner says the PBM hopes to introduce a Pharmacy Advisor program for a vascular cluster that includes coronary artery disease, congestive heart failure, hyperlipidemia and hypertension sometime in 2012.

Consultant Helps 84 Lumber Cut High Rx Costs Down to Size

In an era when employers have grown all too accustomed to watching drug benefit costs soar skyward, 84 Lumber has brought them down to earth. The well-known building supplier, based in the eponymous town of Eighty Four, Pa., near Pittsburgh, held its drug trend to essentially nil in 2009. While 84 Lumber has earned something of a reputation for generous employee benefits, the company gives much of the credit for containing drug costs to pharmacy benefit consultant ARMSRx.
“ARMSRx provides independent analysis and marketplace advice we can’t get from a PBM,” Jeweleen Hartzfeld, benefit manager for 84 Lumber, told AIS in March 2011. Two-and-a-half years ago, Windermere, Fla.-based ARMSRx designed a benefit plan and a shepherded a request-for-proposal process that helped 84 Lumber flatten drug inflation in 2010. The plan covers 3,700 employees at 281 locations around the country.

“They said, ‘We want you to reduce costs with as little employee disruption as possible,’” Jennifer Kingsley-Wilson, founder and CEO of ARMSRx, told AIS in March 2011. One of the first steps ARMSRx took was to ensure that the plan design drove generics over brands. The result: an 8.7% increase in generic utilization in 2010 over 2009. Over time, as employees get even more used to the idea of generics, the plan could shave off an additional $350,000, according to Stephanie Cormier, vice president of account management for ARMSRx.

In another classic cost-savings measure, ARMSRx pushed mail order, which, accordingly, improved 83.4%. All in all, ARMSRx helped 84 Lumber cut plan costs in 2010 by 13% over the previous year, while leveling drug trend to a mere 0.1%.

Much of the savings ARMSRx carved out for 84 Lumber came by piggybacking the company on a group contract to the New Jersey Hospital Association (NJHA), on which ARMSRx also consulted. NJHA had tasked ARMSRx with custom-building a PBM just for it. All parties were bowled over when Express Scripts, Inc. responded to an RFP with terms equal to those the homegrown, custom-built PBM was able to provide. And because NJHA in 2005 had opened its network to a wide variety of non-hospital members, e.g., school districts, 84 Lumber was able to harness the bargain-basement terms of the association.

As much credit as she gives to plan-design wizardry of ARMSRx, Hartzfeld sings equally loud praises for 84 Lumber employees. “We are blessed with the associates we have,” she says. “Overall, the culture and mentality is to be conscious of spending and saving money.” Still, she insists, “we focus on ways to both save money…while making sure that we are offering above-the-national-average medical plans.”

84 Lumber achieved its cost containment results despite cutting against the grain in some areas. For instance, while automatic or mandatory enrollment in low-cost, high-value programs is almost de rigueur these days, 84 Lumber adamantly opposes imposing such dictatorial measures on its employees.

“We do not want to take away choices or quality in the medical arena for our folks,” Hartzfeld says. “Therefore, offering a non-mandatory home delivery program was a seemingly win-win situation.” She adds, “a combination of clinical and administrative programs” also helps 84 Lumber curb costs and ensure quality care.

ARMSRx Leverages Association Plan

Tracy Clayton, director of client services at AIA Benefits Resource Group, a human resources and employee benefits consulting company in Harrisburg, Pa., has worked with ARMSRx for about five years. “We use ARMSRx as an extension of our consulting services,” Clayton tells AIS. “We’ll look to them for their expertise in assessing our clients’ current situations and analyzing the market.”
AIA depends on ARMSRx to help out with its large, self-funded clients. “We use them to continually audit the contract against the claims and make sure everything is processed and paid as it was negotiated in the contract,” Clayton says.

Clayton describes how ARMSRx has built on the hospital association plan it had extended to 84 Lumber. ARMSRx took it a step further, leveraging the NJHA plan and charging a fee to pretty much any employer that wanted to join it.

“It is one of the most aggressive pharmacy contracts in the marketplace,” Clayton marvels. “It was genius, actually.” ♦
Walgreens’ Diabetes Management Program Sparks Plans’ Interest

Walgreen Co., the nation’s largest drug store chain, thinks it may have a solution to the growing number of patients diagnosed with diabetes who are not complying with treatment plans. While one expert is skeptical of patients’ willingness to participate in the program because they might have to pay for it, several health plans and employers are considering offering it to enrollees.

The CDC estimates that diabetes, one of the largest drivers of higher health care spending, costs more than $130 billion per year in direct and indirect expenses. And for PBMs and health plans, diabetes was one of the few disease categories that increased as a percentage of total drug spend from the fourth quarter of 2008 to the fourth quarter of 2009, according to AIS’s quarterly survey of PBMs.

According to Walgreens, part of the problem is patient non-compliance, lack of education and insufficient patient monitoring. Therefore, as part of its new program, Walgreens will hire and train pharmacists and nurse practitioners to work as “health coaches” who will consult with and educate diabetic patients during face-to-face meetings on how to manage their disease, Sharon Dunn, Walgreens’ senior director of corporate innovation, told AIS in January 2010.

The Optimal Wellness program will begin by targeting patients with type 2 diabetes and eventually will expand into other chronic diseases. Walgreens officially launched its pilot programs and began enrolling patients in January 2010 at select drug stores in Indianapolis, Phoenix, Oklahoma City and Albuquerque, N.M.

As the pilot programs roll out, Walgreens hopes to wrap up negotiations with several large health plans and FORTUNE 500 employers to enroll more patients in the program within the next month, according to Dunn. She adds that many other companies have been showing “tremendous interest” in the program, although she would not disclose which ones. The company is offering health plans the option of using Optimal Wellness as an addition to their existing chronic management and compliance programs. “Many health plans have shared their existing programs with us and said that their telephonic systems are perfectly suited for certain segments of their population, but that Optimal Wellness is better suited for those that are newly diagnosed or out of control,” Dunn says.

While this may be true, Al Lewis, executive director of the Disease Management Purchasing Consortium and Advisory Council, contends that a lot of patients just won’t go for it — mostly because some of them will have to pay for the program. He maintains that despite the apparent size of the program, Walgreens will have trouble enrolling members. “There is no way that they are going to get more than 5% of the relevant universe into a program that requires patients to show up and pay,” he told AIS in January 2010.

According to Dunn, cost will vary depending on how much a health plan or employer decides to cover. While health plans would be expected to pay for most of the services, there
could be some “modest” out-of-pocket expenses for patients in the form of copayments or coinsurance. “But that’s really predictive of what kinds of features each and every plan will be selecting,” she adds.

**Patient Participation May Pose Challenges**

While consults always work better in person rather than over the phone, Lewis argues that “most payers and diabetes management vendors find them too expensive,” adding that the idea of “modest contributions” has never been successful before. He says that only a few other face-to-face interactive programs currently exist, including MedAssurant, Inc.’s CCS Advantage program and Matrix Healthcare Management Solutions’ care management program for its Medicare members.

But Walgreens doesn’t seem to think patient participation will be a problem. Pointing to the successful results of a small-scale program conducted in Asheville, N.C., on which Walgreens’ program is based, Dunn says the outcomes speak for themselves. For this case study, two employers participated in two initiatives targeting asthma and diabetes, and assessed both clinical and economic outcomes for up to five years for 194 employees.

The study found that the mean insurance cost per patient per year decreased by $2,704 in the first year to a decrease of $6,502 by the fifth year, and the mean hemoglobin A1c (HbA1c) levels decreased (improved) at every follow-up visit. However, the strong results experienced by Asheville were partly the result of the city’s incentive program, in which diabetic patients had up to 100% of expenses for diabetes drugs covered in exchange for entering a disease management program.

Because people will opt into the program, it’s bound to have good results, says Lewis, so “it will be very difficult to determine whether the fabulous results are due to self-selection or to the program itself.” However, this might not stop health plans from testing it out.

**Medco Keeps Drug Trend Low, Sees Major Mail-Order Savings**

Medco Health Solutions, Inc. managed to keep its drug trend at a low 3.7% in 2009 — outperforming its competitor Express Scripts, Inc., whose spending swelled 6.4% during the same time period. Specialty spend, however, continued to climb, reaching 14.7% by the end of 2009, according to Medco’s 2010 Drug Trend Report.

Utilization also grew in 2009 by 1.3% from a negative 1.1% in 2008. Medco says oral antivirals and drugs to treat diabetes and respiratory conditions were the largest percent contributors to this trend — exceeding 11% in 2009.

The PBM did see significant savings with its average generic dispensing rate, which was 67.5%, up from 64.1% in 2008, and boasted that its specialty trend is one of the lowest in the industry.

Medco also highlighted its mail-order pharmacy business, which experienced virtually no trend increase (0.1%) for its clients with more than 50% mail penetration. Clients with less than
50% mail-order penetration, on the other hand, had a markedly higher spending increase of 5.3%.

Over the next few years, Medco estimates that drug trend will continue to grow between 3% and 6% annually, driven by increases in utilization, high price inflation for single-source brands and new expensive specialty drugs. However, spending increases could be offset by a new wave of generics, as approximately $46 billion in brand drug sales are scheduled to go generic by 2012.

**UHC Replaces Generics Coverage With Lower-Cost Brand Drugs**

While most payers are spending their dollars to promote utilization of low-cost generic and over-the-counter drugs under the pharmacy benefit, one plan is offering up a new idea: Why not put more money towards helping patients afford expensive brand medications instead?

UnitedHealthcare (UHC) just rolled out a new pharmacy benefit design, called BrandsPlus Rx, which aims to “bridge potential coverage gaps” by making higher-cost brand and specialty drugs more affordable to small businesses. This will be accomplished by letting patients absorb the costs of their own lower-priced generics and over-the-counter medications.

“Covering things that people can already afford isn’t necessarily what insurance is for,” Tim Heady, CEO of UnitedHealth Pharmaceutical Solutions, told AIS in May 2010. “This benefit is really positioned for that part of the market where there may not be a benefit at all.”

While the new plan design will lend a helping hand to members in need of more expensive medications, Heady says the program will still encourage patients to use lower-cost options when available. “But the reality is that there aren’t always generic or other low-cost alternatives and some drugs just aren’t affordable,” Heady explains. “And we can either say that’s too bad, or we could have a better-aligned benefit in those situation, to provide some meaningful coverage for those drugs.”

Under the new program, for example, a patient would pay only $60, and the plan would cover the remaining $90 in a therapeutic category where there are no generics available and the brands are averaging $150. “In a generic-only benefit, the patient would be out of luck and would have to pay the full $150,” Heady says.

According to UHC, the program will cost employers about half as much in premiums as the plan’s traditional pharmacy benefit packages and is “price-competitive with other generic-only plans available in the market.”

It will provide coverage for medications to treat chronic conditions — such as asthma, diabetes, HIV, hepatitis C and multiple sclerosis — that do not have many effective generic equivalents. These drugs will be placed on a four-tier copayment structure that should steer patients to more cost-effective medications, Heady says, adding that the lowest-value drugs will be placed on the fourth tier.

“If there are very good tier-two or tier-three options, rather than excluding other drugs, we’re going to throw those into the fourth tier,” Heady explains. “While there won’t be a lot of
drugs in that space, it will allow us to acknowledge that there are very different value propositions amongst the brand choices.”

BrandPlus Rx is currently available to small groups in Arizona, Arkansas, North Carolina, South Carolina, Tennessee and Wisconsin. Heady says UHC will roll out the program nationally once it gains more experience in these states.

Prime Scores Lowest Drug Trend Among Top PBM Competitors

Boasting one of the lowest trends in the industry, pharmacy spending for Prime Therapeutics, LLC increased just 3.4% in 2009 — outperforming the company’s top PBM competitors that Prime says reported 4.5% average spending increases.

According to its 2010 Drug Trend Insights report, this is the seventh year that Prime — a PBM owned and used by 12 Blue Cross and Blue Shield plans — has seen below-industry-average drug spending increases across all drug classes. By comparison, Medco Health Solutions, Inc. reported a 3.7% trend in 2009, while Express Scripts, Inc.’s spending swelled to 6.4% during the same time period. CVS Caremark’s overall trend was 3.4%.

Prime’s spending on traditional drugs increased just 1.8% in 2009, while specialty medications rose 13%. Meanwhile, the average member’s share of pharmacy costs remained steady at 26.4%.

“We have a different framework than our competitors that we use around total health spend management,” Steve Blumenfield, Prime’s chief marketing officer, told AIS in summer 2010. “It’s all about moving people towards generics or lower-cost alternatives while ensuring adherence.” The company accomplishes this by establishing a generics-focused formulary with a $20 or more cost differential between tiers to drive members to lower-cost drugs. It also offered several incentives for 90-day prescriptions to drive adherence.

These tactics helped Prime’s generic fill rate increase to 67%, reflecting a 4% uptick in generic utilization in 2009. The PBM also managed to cut the average cost of generics by more than $1 per script in 2009. Prime says it expects the generic rate to exceed 70% for its commercial population by the end of 2010 because of the pipeline of new generic drugs.

Blumenfield touts the PBM’s 95% member satisfaction rate with Prime’s mail-service pharmacy. He attributes this to a 99% fill accuracy rate and the fact that its members get prescription refills a day faster than members of its competitors. “That data is what tells the story for satisfaction,” he says. “Members want convenience — they want it to be accurate and fast. So we made some significant investments in our training of our call center.”

Consistent with the other major PBMs, spending on diabetes medications contributed most significantly to the increase in drug trend in 2009, followed by multiple sclerosis and arthritis.

Overall, specialty drugs made up 12% of drug spending, but accounted for less than one-half of a percent of all prescriptions dispensed.

However, drugs that did not meet the “technical definition of specialty” were not included in 2010’s report. This is because specialty drugs, such as HIV medications and immunosuppressants, were previously defined “in the broadest possible sense,” says David Lassen,
Pharm.D., chief clinical officer at Prime. This includes all drugs that might be recommended for a specialty benefit, as well as other relatively low-unit-cost products that are delivered via an injection. “This year, to be more aligned with the typical average unit cost/Rx data presented for specialty drugs in the industry, we made the decision to remove several of these categories that may not be considered specialty within the industry,” he told AIS in August 2010.

Lassen says specialty trend for 2010, as of the second quarter, is at 11.9%, “which would suggest a slight flattening of the specialty trend for 2010.”

**Amid Skepticism, Express Scripts Claims It Can Better Predict Rx Nonadherence**

Express Scripts, Inc. thinks it may have found the “holy grail” of health care solutions with a new predictive model that could reduce medication nonadherence before it starts. With this program, the PBM says it’s redefining the way predictive modeling is done and used. But while several other PBMs and health plans strive to solve the adherence issue with similar models, one competitor says such programs lead to insignificant results.

Express Scripts claims its new model, unveiled last month, is able to accurately predict up to a year in advance which patients are most at risk of falling off their prescription drug regimen. It then uses this information to “intervene in customized ways” before those patients actually stop taking their medications.

“People have been talking about predictive models in healthcare forever, and insurance companies try to predict who the high-risk patients are,” Steve Miller, M.D., chief medical officer at Express Scripts, told AIS in October 2010. “However, after looking at all the literature, we determined that our model is significantly better at discerning who will take their medication and who won’t.”

According to Miller, the technology has proven 85% accurate in predicting the top 10% of people who are least likely to be adherent.

The model builds on Express Scripts’ entire behavioral economics and consumerology platform, which touts the benefits of personalized health care. Miller says the program is “a truly personalized model” that takes into consideration past patient behavior and demographics, and characteristics of the particular medical condition and prescription drug, among several other factors.

But Express Scripts isn’t alone in this endeavor. The PBM’s new model is one of a growing number of programs to predict and prevent medication nonadherence.

Competitor CVS Caremark Corp., for example, is also developing a program that predicts nonadherence, which it plans to start using in 2011. Company spokesperson Christine Cramer declines to give further details on the program, as the results of one study are being published in a few months.

“Everybody’s trying similar efforts in terms of how to predict adherence,” George Van Antwerp, general manager of pharmacy solutions at Silverlink Communications, tells AIS. “But there hasn’t been a model that has proven itself as being a good predictor. Maybe Express
Scripts has cracked the code....I would assume that if you can accurately predict who is going to be adherent, that will be a good tool.”

Medco Health Solutions, Inc., though, disagrees. The PBM deployed predictive modeling technology back in 1992, and while it was effective, it was “difficult and expensive to execute long term,” spokesperson Jennifer Luddy tells AIS. “And we realized that it only goes so far.”

Medco’s research shows that approximately 50% of patients do not remain compliant with their chronic medication within the first six months of therapy, and two out of every three patients dealing with chronic conditions will experience a gap in care. “We don’t need a tool to tell us that,” Luddy contends. “It’s more effective to have immediate intervention with a patient upon seeing an issue.”

That is where Medco’s Therapeutic Resource Centers and specialist pharmacists come into play, she adds. These services “have been proactively reaching out to patients to close gaps in care such as refill/adherence issues, missing a vital medication in their therapy profile based on national clinically recognized guidelines, or potential drug-drug interaction or duplicative therapy.”

The company also recently launched a new web-based tool that provides “real-time interventions” by messaging each member directly “to close that gap in care, or contact a specialist pharmacist with a question instantly 24/7.”

Express Scripts Takes Proactive Approach

But Miller argues that it’s more effective to catch bad behavior before it starts. “Everyone else is driving forward looking through the rearview mirror,” he says. “They’re watching behavior over a six-month period and in retrospect determining that patients are nonadherent. And by that point, they’ve already developed horrible habits.”

There is no one “silver bullet” for why people don’t adhere, Miller explains. “There’s a small group of patients that care about cost. For others it’s about forgetfulness, and for some it’s convenience. So we can now reach out to each of these patients as individuals and customize solutions for them.”

Therefore, a predictive model could determine if a patient needs to enroll in a copayment-assistance program if there is a cost issue, a mail-order program if there is a convenience issue and refill reminders if the person struggles with forgetfulness. “For everyone it would have to be a customized solution,” Miller maintains. “And because you can target them more effectively, you can afford to do that.”

Other interventions to improve adherence include consultations with a pharmacist and auto refills and renewal assistance.

However, attempting to change behavior in the top 10% of patients likely to be nonadherent will be tough, Van Antwerp contends. “The industry is still waiting for that proof,” he maintains. “If we can predict that patients are adherent but can’t change behavior, then the model doesn’t do us much good.”

Instead, he suggests focusing on the people who are likely to be adherent and developing ways to enable them to be more adherent. ✗
Mont. Governor’s Drug Problem — High Prices in Big Sky Country

Montana Gov. Brian Schweitzer (D) grabbed headlines Nov. 16, 2010, with his bid to ease high prescription drug prices by seeking a waiver from CMS to extend discount Medicaid drug prices to all Montanans. Piggybacking on Medicaid rebates is not a novel tactic for expanding drug discounts to more residents, one analyst tells AIS, and it may win CMS approval.

Dubbed “Medicaid Part D” by its creators, the scheme would grant all citizens access to the same pharmaceutical price breaks afforded those enrolled in the state’s Medicaid plan — a savings the state reckons to be 55% off retail prices.

“This is a way to save money on prescription drugs,” Schweitzer said in a statement. “No one should be forced to make decisions about whether or not to buy medicine.”

If it clears CMS, the proposed research and demonstration waiver will allow Montana to provide the discounts the Medicaid program receives on medications to all Montanans, including those that receive their drugs through Medicare and private insurance, Jessica Rhoades, health and family policy advisor to the governor, told AIS in November 2010. The health reform law increased the amount drug companies must give states in rebates for Medicaid enrollees from 15.1% to 23.1% for brand-name drugs and from 11% to 13% for generics.

What at first glance may look like the brazen tactic of a maverick governor turns out to be rich in precedents. “He or they are not reinventing the wheel,” says Richard Cauchi, program director for health at the National Conference of State Legislatures. Cauchi, who tracks numerous state initiatives to gain access to lower drug prices, specifically cites programs in Hawaii, Maine and Vermont that leveraged Medicaid pricing and structure to pass along deep discounts to citizens. The programs were among the first of a wave of “pharmacy plus” plans that originated in the states and were largely squeezed out by the Medicare Part D prescription drug program in 2006. “My sense is that someone in Montana was aware of some of this history,” Cauchi tells AIS.

Cauchi says the Montana plan may stand a greater chance of success by going the waiver route. “The waiver process is a negotiation — not just a yes-no,” he says. Unlike legislation, a waiver is unlikely to be killed outright in its infancy and more likely to be subject to a deliberative and dialogic give-and-take process. “Something like the Montana plan could be reworked not so much in legal process, but in discussions and negotiations, and some version of it might in fact get approved.”

Schweitzer’s initiative finds a staunch ally in state Rep. Sharon Treat (D), a Maine lawmaker who backed something of a precursor to the Montana program in her own state. Treat and now-U.S. Congresswoman Chellie Pingree (D-Maine) in 2000 co-sponsored the Maine Rx program (now Maine Rx Plus), which made Medicaid discount drug prices available to Maine residents with incomes up to 350% of the federal poverty level. Maine Rx faced legal challenges from the pharmaceutical industry all the way to the U.S. Supreme Court, which mostly upheld the program.
States Revolt on Drug Prices

“Drug prices have continued to rise, often bearing no relationship to actual costs of production or development,” Treat tells AIS. “As soon as the federal Affordable Care Act was enacted, drug makers hiked the prices for many commonly prescribed prescription drugs. The ACA did little to rein in drug prices, while opening new markets and the opportunity for additional profits to the drug industry as more consumers will be insured.”

“States need to continue to take the lead and press the federal government for action,” she contends. Treat is also executive director of the National Legislative Association on Prescription Drug Prices, a nonprofit that works with state legislators to lower drug costs.

Schweitzer hatched his waiver plan when a staff member obtained a confidential list of Medicaid drug prices. Comparing the prices of 20 drugs commonly prescribed to seniors, he noted Medicaid prices were substantially lower than Medicare. Schweitzer estimates adoption of his plan would save the federal government $96 million.

The Montana governor has compiled a lengthy track record of challenging what he calls “the drug cartel.” In 2000, Schweitzer made prescription drug prices a key issue in an unsuccessful race to unseat Sen. Conrad Burns (R-Mont.). During his tenure as governor, he has chartered convoys of buses to shuttle Montana seniors across the border to Canada for significant pharmaceutical discounts. And as recently as September 2010, Schweitzer announced plans to dun pharmaceutical companies that he says evade paying their fair share of taxes in Montana and in the country.

CIGNA-Merck Outcomes Contract Hailed as ‘First Step,’ But Some Want More Data

Since CIGNA Corp. and Merck & Co., Inc. first publicly disclosed results from an outcomes-based contract on oral diabetes drugs in fall 2010, many medical innovation boosters have heralded the program as the Next Big Thing. And although more skeptical observers concede the first nationwide agreement of its kind between a PBM and a drug manufacturer appears to be groundbreaking, they caution that if such initiatives are to chart a course for a widespread movement, more clinical data and greater transparency in reporting are needed.

Under the terms of the partnership, launched in April 2009, Merck lowered the price for its brand drugs Januvia (sitagliptin) and Janumet (sitagliptin/metformin) and offered an initial discount, via rebates, to CIGNA when its members with type 2 diabetes reached benchmarks for medication adherence and lowered blood sugar, regardless of what drug they were taking. The pharma company offered a second round of rebates when patients taking the drugs lowered their blood sugar even further.

And the results — at least those CIGNA is willing to make public — are in. In a population of 165,000 members taking the two oral diabetes drugs, blood sugar levels improved by more than 5% on average. Participants also registered a 4.5% increase in blood sugar lab testing during this period. Finally, medical adherence improved across the board, rising to 87% for those taking Januvia and Janumet. Diabetes was one of the leading drivers of drug trend, growing
faster over the past three years in its percentage of health care plan spending than any other therapeutic category, according to Medco’s 2010 Drug Trend Report.

Sometimes cited as a variety of pay-for-performance pact and often linked with comparative effectiveness research (CER), such outcomes-based contracting has been commended for aligning the incentives of health plans, payers, providers and patients alike. And in this particular case, the largely positive results of the CIGNA-Merck collaboration have left many proponents of such arrangements impressed.

“The Merck-CIGNA contract is the game-changer,” Cyndy Nayer, executive director of the Center for Healthcare Innovation, told AIS in December 2010, “because in it Merck moved beyond its own drugs and said, ‘We will reimburse no matter how people get better.’”

Dan Haron, president of CIGNA Pharmacy Management, admits that lowering the price for a product as its performance improves may trigger bouts of cognitive dissonance. “The idea of paying less for medications if they are successful is really kind of counterintuitive,” he tells AIS. “This outcomes-based contract aligns the incentives of the pharmaceutical company and the health services company behind the health of the individual. That’s really what we should all be aspiring to do.”

CIGNA: Care Tools Drove Adherence

Unsurprisingly, the incentive Merck is geared toward is selling more drugs. CIGNA leveraged the drugmaker’s self-interest by deploying some of its other programs, such as Coach Rx, a Web-based notification tool, to drive adherence in the diabetes program. “What’s key here is we’re creating a compelling environment in which Merck gets the opportunity to demonstrate the effectiveness of their product,” says Haron. “If medication adherence is improved, more of their product is utilized.

“This is a template we hope we’ll be utilizing for products in the future, particularly in the specialty drug class,” Haron says. Among drug therapies under consideration for such programs are those for oncology, multiple sclerosis and rheumatoid arthritis.

Continuing to build momentum as a national movement in health care, CER got a presidential imprimatur in 2009 when President Obama allocated $1.1 billion in the economic stimulus law to bolster CER studies. Evidence-based research got a second boost in 2010’s health reform law, which provided for the creation of a Patient-Centered Outcomes Research Institute. But the heart of CER is precisely the sort of real-world application embodied by the CIGNA-Merck diabetes venture.

“It is a good first step, as others have indicated,” F. Randy Vogenberg, principal of the Institute for Integrated Healthcare, told AIS in December 2010. “Aligning multistakeholders is not easy, and just having this first step represents an advance among those business partners, along with employers who use CIGNA as their ASO [i.e., administrative services only] or benefit plan.”

But, he says, “market skepticism will remain in play until hard results are shared. Since most employers view quality as a financial performance characteristic, there remains a need for proof of actual performance from such an arrangement.”

Barbara Bartman, M.D., medical officer at the Agency for Healthcare Research and Quality’s Center for Outcomes and Evidence, agrees, adding that in such a case as the CIGNA-Mer-
ck diabetes initiative, she would like to see more detailed reporting on the clinical side. She also says she would like to see the outcomes of such programs corroborated in more formal, scientific settings with rigorous clinical research.

“The numbers aren’t complete enough,” she tells AIS. “We need to see the total number of participants, [and] median and mean percentages of blood sugar improvement.” That said, her prognosis is an optimistic one. “A program like this certainly has the feasibility to improve adherence. It’s encouraging to see two entities collaborating like this.”

Some Demand More Financial Details

“I think that this is definitely moving in the right direction, which effectively is forcing employers as well as PBMs to look at pharmacy management a little more bluntly,” says Nadina Rosier, North America pharmacy practice leader for Towers Watson & Co. “I see this as merely a first step.” Foremost among the next steps Rosier says she would like to see taken is more complete and transparent reporting. “You want to make sure the numbers are real. The buzzword in the industry is ‘transparency.’ This is just one vehicle to make that transparency is a reality.”

Rosier’s concerns, however, revolve around not so much clinical data as financial transparency. “In the CIGNA-Merck deal, how are employers getting paid?” she asks. “They claim there are increased rebates that will flow back to the client in the form of a credit or discount that will be completely transparent to them.

“Rebate arrangements, while transparent for a number of employers, depending on their PBM contract, are still a little bit of a black box. This is another way of providing a rebate that is tied to clinical outcomes. If you’re getting rebates anyway, why not get more favorable money if your health plan or PBM is driving positive outcomes?” Rosier says.

“My challenge is really around the reporting and how those monies exactly flow through to employers,” Rosier tells AIS. “Some employers collect rebates based on the utilization of their population; others don’t — do they therefore get lower administrative fees with it? Is it prospective, meaning they look back at your baseline adherence and we see this much improvement? OK, do they just cut you a check? Do they provide an invoice credit?” CIGNA responds that the undisclosed financial and clinical details of the program are proprietary.

Like other observers, Rosier says she would like a fuller accounting of the clinical outcomes, too. “It’s important for any health plan, any disease management vendor, to prove the value of what they’re delivering. You need to make a strong argument that if we do X, the result is Y% improvement,” she contends.

“I’m one of those folks that says, ‘I trust you, but can I please see the reporting?’ Validate that what you’re saying is correct,” she says. ✦
UnitedHealthcare Ventures Further Into Value-Based Rx Territory

UnitedHealthcare is extending some tough love to its plan members who persist in making higher-cost medication choices. The health plan is expanding to 44 states and 32 drugs a program that forces consumers using expensive prescription drugs to switch to lower-cost alternatives or less-expensive distribution channels or both.

Prompted by surveys that showed as many as 70% of respondents were unaware of lower-cost medication options, UHC’s “Select Designated Pharmacy” program for commercial clients requires plan beneficiaries filling prescriptions for high-cost, tier-three drugs at a retail pharmacy to switch to mail order to continue receiving the same drug, yielding a savings of $8 for members and $2 for their plan sponsor.

“The difference between this program and so-called mandatory mail programs is that we’re not saying to the individual you have to go to mail. What we’re saying is if you have to choose a tier-one or tier-two option, to stay in retail,” Tim Heady, CEO of UnitedHealthcare Pharmacy, told AIS in December 2010. The health plan has estimated the program has the potential to save consumers $32 million in out-of-pocket expenses with nearly $60 million in savings rendered to plan sponsors.

The program marks a further foray into value-based benefit design for pharmacy management. Having pushed such mechanisms as mail order, generic utilization and preferred pricing to the saturation point, plans increasingly are deploying every means at their disposal. In cases such as Select Designated Pharmacy, drug managers are proactively conscripting members to participate, much like retiree benefits managers in recent years who automatically enrolled beneficiaries in 401(k) programs.

Even though most plan participants will recognize the benevolence of such interventions, health plans and drug managers should exercise caution lest they spark a beneficiary revolt. “Education is the best tool to avoid a backlash,” says Marissa Schlaifer, director of pharmacy affairs for the Academy of Managed Care Pharmacy. “Once patients understand that the decisions stem from evidence-based, clinical considerations — and are not based solely on financial calculations — they will realize their best interests are being served. Transparency and forthright information are the best tools to avoid a backlash.”

Kemp Dolliver, managing director at Avondale Partners, LLC, calls the UHC program “an interesting ‘softening’ of the mandatory mail plan design.” He predicts the continued evolution of such plan design as already evidenced by such programs as CVS Caremark Corp.’s Maintenance Choice and Express Scripts Inc.’s Select Home Delivery.

Select Designated Pharmacy also informs enrollees of lower-cost tier-one and tier-two alternatives. For example, plan members who have $50 copay and choose both mail-order and lower tier options can save as much as $42 a month. The program targets 32 high-cost brand-name drugs: Lyrica, Symbicort, Avodart, Uroxatral, Lexapro, Ascensia, Breeze, Contour, Freestyle, Glucometer diabetes testing strips, Precision, Novolog, Novolog Mix, Novolin N, Novolin R, Novolin Mix, Atacand, Atacand HCT, Avapro, Avalide, Asacol, Asacol HD, Axert, Frova, Maxalt, Maxalt MLT, Zomig, Zomig ZMT, Toviaz, Detrol, Zenpep and Pancreaze. All
drugs in the program occupy UHC’s third tier, the highest copayment position, in therapeutic categories that have equivalent, lower-cost tier-one or tier-two options.

“The drugs that we put into this program are drugs that have good therapeutic alternatives that cost less,” Heady says. “The only other consideration as to whether or not we put them in this program is, are they in therapeutic categories where we want people to get larger script sizes? The drug needs to justify 90-day script sizes.”

However, switching to the lower tier options isn’t feasible for everyone. “Some patients will still require the innovator product due to product formulation characteristics — fillers, additives, excipients, etc. — or personal genetics in reaction to a particular medication,” F. Randy Vogenberg, CEO of the Institute of Integrated Healthcare, told AIS in December 2010. “The latter will continue to evolve in importance through the increased availability of biologic products for chronic diseases, not just rare diseases.”

When pharmacists fill a UHC, enrollee’s prescription for one of the targeted drugs, an automated message on the pharmacy’s computer system informs them that the prescription can be filled only two more times at retail, after which the consumer will have to switch to mail order. The message also tells the pharmacist of the tier-one and tier-two alternatives available to an individual who wishes to continue filling the prescription in a retail setting. Similarly, a letter is generated informing consumers of two grace refills for the drug in a retail setting, after which a move to mail order is mandatory.

“It immediately helps the consumer recognize they have an opportunity to lower their out-of-pocket costs,” says Heady. “And it reinforces for the pharmacist they have an opportunity to encourage the individual to stay in the retail setting, but at a lower cost.”

The critical question remains how structured or driven around medication price an approach needs to be, Vogenberg says. “United has chosen only a select group of medications where the opportunities are greatest for all parties. We have seen similar swings to more mandatory actions, such as mail order, evolve over time, so it is possible that more aggressive initiatives would evolve from this initial effort.”

Choice, Opt-Outs Drive Increased Patient Engagement in Innovative Program Design

Concurrently with the release of its 2010 Drug Trend Report, Express Scripts, Inc. touted its Select Solutions programs at an April 7, 2010, meeting in Washington, D.C. Based on “Consumerology,” Express Scripts’ label for its extensive research into the behavioral economics behind consumer decision making, Select Solutions purport to motivate plan members to make the shrewdest choices in their pharmaceutical care.

With the introduction of two new offerings in January 2011, the St. Louis-based PBM now has four Select Solutions programs: Select Home Delivery mail-order service; Select Specialty for specialty drugs; Select Network, employing limited pharmacy networks; and Select Step Therapy, which uses a zero-dollar copayment incentive to promote participation. The programs employ such tools as patient telephone calls and snail-mailed reminder letters to prompt patients to make the most clinically sound, cost-effective decisions regarding their drug benefits.
“Select Solutions is the only set of programs in the industry designed to yield results on par with mandatory programs, yet preserve member satisfaction,” Kit Sundararaman, Ph.D., director of Consumerology for Express Scripts, tells AIS. “These programs do this by activating the intent that members already have and align that with the interests of plan sponsors — moving [members] to generics, utilizing the optimal Rx channel, and improving therapy adherence.”

Some employer groups are optimistic about the cost-saving potential of programs that combine the effectiveness of mandatory features with the member buy-in of voluntary programs. “Select Solutions and initiatives like this that harness what is really driving people’s pharmacy choices and drug adherence could powerfully impact employee health in a positive way,” Steve Wojcik, vice president of public policy for the National Business Group on Health, tells AIS. “At the same time it could save employer plans too.”

Wojcik concedes that Express Scripts’ extensive research into the psychology behind consumer inertia and motivation may represent a key to curtailing pharmacy spend. “Their individualized approach to understanding the obstacles to adherence, the source of the greatest waste in pharmacy spend, sounds promising,” he says.

“Express Scripts has continued to focus on leveraging consumer insights into the creation of unique plan design offerings that take advantage of the behavioral economics research com-

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### Breakdown by State of $403B in Behavior-Related Rx Waste, 2010

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Colors reflect per-capita waste by state; dollar amounts represent total waste for each state in billions.

- States in lowest 33.3% for waste per capita
- States in middle 33.3% for waste per capita
- States in highest 33.3% for waste per capita

ing out from them and others,” George Van Antwerp, general manager for pharmacy solutions at Silverlink Communications, tells AIS. “If inertia is a key issue for change, the concept of active choice — nudging — that the Select Solutions are based upon should show meaningful results.” (Van Antwerp is a former senior director for Express Scripts.)

In designing Select Solutions, Express Scripts cribbed lessons from the retirement industry, according to Sundararaman. David Laibson, a Harvard University economist and a member of Express Scripts’ Consumerology Advisory Board, studied for years how to increase enrollment in 401(k) retirement programs. Interminable efforts at educating members on the value of 401(k)s had barely budged low enrollment.

Eventually, he realized he was tackling the wrong problem. Even though people were largely bought into 401(k)s as a value proposition, they failed to act. Laibson had to figure out how to turn that intent into behavior. He accomplished this by incorporating two features into plan design: active choice, halting the process and asking the individual what they want to do, and opt-outs, which defaulted members into 401(k)s but still allowed them to opt out if they chose. Participation in 401(k) programs increased dramatically. “We’ve used these same active-choice and opt-out principles when designing Select Solutions,” Sundararaman says.

**Mail-Order Program Allows Opt-Out**

Using the lessons learned from research in retirement planning, Express Scripts introduced Select Home Delivery, a mail-order service that enrolled members automatically but allowed them repeated opportunities to opt out, in May 2010. After pilot programs with large plan sponsors such as home improvement retailer Lowe’s Companies, Inc. resulted in millions in savings, Express Scripts went to work designing other Select Solutions offerings.

“Based on the success of Select Home Delivery, we knew we were onto something big,” Sundararaman says. “Since then, we’ve been working on deploying these learnings to help achieve other clients’ goals.” Select Specialty, applying the same principles as Select Home Delivery to the use of CuraScript, Express Scripts’ specialty pharmacy, soon followed. Then the PBM rolled out Select Network and Select Step Therapy Jan. 1, 2011.

Express Scripts calculates that the United States loses an estimated $403 billion annually, due to unnecessary costs exacted by failure to choose the most cost-effective medication available, to employ the most cost-effective delivery channel and to adhere to the therapy as prescribed. Express Scripts factored into the $403 billion loss figure:

- **Nonadherence waste**, such as increased doctors’ visits, duplicated medications and superfluous or replicated lab tests, estimated to be $258.3 billion;
- **Channel waste**, amounting to $88.3 billion that could be recouped if members used the most cost-effective channels, such as mail-order for maintenance medication and specialty pharmacies for specialty drugs; and
- **Drug mix waste**, or the differential between using brands when generic versions are available and the maximum possible generic utilization, which tallied at another $56.7 billion.

Express Scripts estimates that its Select Services programs can save plan sponsors $13 to $30 per member per year, depending on the program. Express Scripts would not disclose specific costs to plan sponsors for Select Solutions programs but says that two of the programs incur nominal fees while the rest are available with no additional cost.
Ironically, Express Scripts has found an old-fashioned mode of communication the most effective one for ensuring patients participate in its newfangled plan offerings.

While the Information Age puts more communications channels than ever for contacting members at Express Scripts’ disposal — telephone, e-mail, text messaging, etc. — the PBM has found direct mail still the most effective. “Although we have capabilities to connect with members using all these channels, we’ve largely used snail mail to communicate to members about Select Solutions,” Sundararaman says. “We’ve found that it is still the most reliable way of ensuring the member receives the message and that the contact details are correct.”

MedImpact, Premier Partner to Forge New PBM Aimed at Hospital Employee Plans

Talk about a tough sell. It’s hard to imagine any class of health care consumers warier or savvier than health care providers. That’s exactly the market that a partnership hawking a new PBM program is targeting: hospital-based employee benefit plans. But one consultant warns that the program has its work cut out for it and may lack the kind of contacts, relationships and top-tier PBM that its member might expect.

The Premier Inc. health care alliance, a group purchasing organization, on April 7, 2011, said it was teaming up with San Diego-based PBM MedImpact Healthcare Systems Inc. to offer pharmacy management services to the self-funded plans of hospitals and health systems. The program, dubbed Premier’s Pharmacy Benefit Management, will have a captive audience to market to: Premier’s coalition of 2,500 hospitals and 73,000 other care facilities. With 35 million lives covered, MedImpact calls itself the nation’s largest privately held PBM.

Jennifer Kingsley-Wilson, founder and CEO of pharmacy benefit consultant ARMSRx, considers it normal for Premier to use its collective clout to sell PBM services to its members. But even with the captive audience of its membership rolls to market to, she told AIS in April 2011 that Premier might find its hot leads turning into cold calls.

“While no two hospitals are identical, many have similar challenges in managing the complexities and rising costs of their employee pharmacy benefit program,” Durral Gilbert, vice president of supply-chain operations for Premier, tells AIS. “Hospitals and health systems have unique opportunities, unlike most other employer groups, to bend the cost curve.”

Among the benefits Premier is touting for the new PBM are:

- **Full transparency and pass-through pricing**, manufacturer rebates and fees;
- **Strategies to optimize generic utilization**, in-house fulfillment and pricing for group purchasing and 340B federal entitlement programs;
- **Flexibility in benefit and formulary design to lower costs**;
- **Best practices** leveraged through collaborative, knowledge-sharing initiatives; and
- **Data analytics and benchmarking**.

Health care providers as plan sponsors have their own specialized set of strengths and needs. One advantage hospitals and health care systems often have over other plan sponsors is having their own in-house pharmacies to realize savings. In one example of how it hopes
to leverage this resource, Premier plans to link member pharmacies together in a mail-order network so all members benefit from the cost efficiencies.

Premier also intends to harness its supply-chain expertise to help its member hospitals procure pharmaceutical inventory more effectively and streamline distribution. “For example, we can help our hospitals align their inpatient and outpatient formularies and benefit design to gain efficiencies,” Gilbert says. Although a member organization, Premier is a for-profit entity, and stands to turn a healthy profit if its PBM enterprise takes off.

Hospital employees and physicians tend to be higher utilizers of health care, including prescription drugs, than the general population. And hospitals must provide attractive benefits packages in order to recruit and retain highly qualified employees.

The Charlotte, N.C.-based coalition assembled a member-based task force of executives with respective expertise in human resources, pharmacy, supply-chain management and finance. “We tailored this solution to help hospitals and their health plans better manage the cost and quality of their prescription drug benefit programs by organizing the purchasing power and collaborative strength of the alliance,” Gilbert says.

**Hospital PBM Must Meet High Expectations**

“Our PBM model is based on transparency and driving use toward the lowest net cost drug that is medically appropriate for each patient,” Gilbert says. “Hospitals can benefit significantly from this aggressively negotiated offering, as well as from better utilization of their pharmacy assets.” The cost to employers is a per-claim processing fee, similar in structure to many other pass-through PBM models on the market.

“Through this model and working with MedImpact, we saw our employee prescription spend decrease by almost 18 percent in 2009,” said Robert Carta, assistant vice president of pharmacy services at Carolinas HealthCare System in Charlotte, in a statement. “This dramatic savings in year one is linked to ‘own-use’ pharmacy strategies and plan design changes. In 2010, we saved another 3.2 percent in light of the average 4 to 8 percent trend increase being experienced by others.”

Kingsley-Wilson anticipates the new PBM will be hampered by not contracting with one of the top three vendors. “The type of clients that Premier has under its umbrella is going to be looking for a top-tier PBM,” she says.

Many of the prospective clients in Premier’s captive audience will be smaller, fully insured health care facilities. To contract with the new PBM plan, such smaller work forces will have to be combined under the self-funded plan of a larger health system.

More importantly, Kingsley-Wilson says, Premier is unlikely to gain immediate access to those who call the shots on benefits. Their first contacts more likely will be purchasing and procurement agents, not human resources personnel, and HR is unlikely to know what the purchasing agents are buying.

“It’s about relationships,” she says. “Insurance brokers ‘own’ the relationships with HR personnel in hospitals. Premier’s PBM is going to approach human resources and human resources is going to say, ‘Hey, talk to my broker.’ There’s going to be a few more hoops to jump through.”