Proposed Highmark-IBC Merger Prompts Competition Concerns Over Drug Benefits

The proposed merger of Highmark Inc. and Independence Blue Cross (IBC) in Pennsylvania could hinder competition in the state’s pharmacy benefit market, asserts one Pennsylvania-based PBM. But for their part, Highmark and IBC say their merger would not harm competitors, and contend that the combined company would generate $285 million in pharmacy-cost savings for customers over six years.

Stakeholders for and against the proposed merger squared off at three public hearings July 8, 10 and 15 held by the Pennsylvania Insurance Department.

The state’s two largest health plans, which unveiled their intention to merge in March 2007, claim that because they offer health coverage in different regions of Pennsylvania, the combined entity would not stymie competition. Highmark operates in the western and central parts of the state, including Pittsburgh, while IBC operates in the southeast part of the state, which includes Philadelphia.

The firms say the merger would result in cost-saving efficiencies of roughly $1 billion. The combined firm also has pledged to hold its administrative fees flat for two years, as well as to better manage prescription drug costs. The expected $285 million savings on pharmaceuticals would be part of the $1 billion.

continued on p. 6
“Those costs will not be charged in premiums for customers if the consolidation is approved,” Michael Weinstein, spokesman for Highmark, tells DBN.

But a stand-alone PBM contends that the merger could put his company out of business in Pennsylvania, and eventually lead to fewer choices for customers. The issue centers on whether the combined health plan will require the “bundling” of pharmacy and medical benefits, says Harry Kovar, CEO of Southampton, Pa.-based WellNet Healthcare, which offers PBM and disease management programs.

IBC now allows its customers to carve out PBM services, while Highmark does not, he says. The different policies have had a direct impact on WellNet’s business, Kovar says.

“WellNet has about 40 clients in southeast Pennsylvania [where IBC operates],” Kovar tells DBN. “Why? Because Independence Blue Cross allows the carve-out of pharmacy benefits. Do you know how many clients we have in Pittsburgh [where Highmark operates]? We have zero.” If bundling were to be adopted by the merged company, it would drive WellNet out of business in the state, he asserts.

Weinstein confirms that Highmark will not sell medical and pharmacy coverage separately to its fully insured customers. But he declines to say what the company’s policy on bundling would be if the two firms are allowed to merge. “Going forward, we don’t know,” Weinstein says. “We’re only speaking as to why we have that position now.”

Advantages to Combining Rx and Medical

One of the reasons for this position, he says, is that Highmark assumes all of the financial risks. “The medical component and pharmacy component are so intertwined and interconnected that in order to assume that financial risk, we feel it is much easier to manage the costs by having the medical and pharmacy combined.”

Another reason is that Highmark’s customers ask for it, he says. “Our group customers have often expressed that preference — that they would prefer to have them integrated. One, because it is simpler administration, which is an important issue. And two, because their carrier then is able to handle disease management.”

He notes, for example, that medications are essential for treating patients with heart conditions or asthma. “It makes logical sense to have those two components [i.e., pharmacy and medical] integrated in order to most effectively manage care, most effectively work with their employees to ensure compliance with treatment protocols,” Weinstein says.

This point is echoed by IBC spokeswoman Karen W. Burnham. While IBC does not require customers to buy both medical and pharmacy, many customers request both, she tells DBN.

“The purpose of integrating medical and pharmacy benefits is to enable the insurer to have full access to data needed to respond to customers’ desires to reduce long-term health care costs,” Burnham says. “By analyzing medical and pharmacy data, a health insurer can recommend wellness programs, case management or other approaches to lower the number of medical claims without restricting access to care or reducing the quality of care.”

Burnham says that once the merger transaction is closed, “the senior management team of the combined company will have to make decisions as to how business practices like this will be managed moving forward.”

But Kovar disagrees that bundling is a prerequisite to furnish adequate member care. He says that by using pharmacy data alone, WellNet can analyze the health of its clients’ employees and design effective and personal-
ized disease-management programs. Its clients include the Pew Charitable Trusts and the City of Evanston, Ill.

“The pharmacy data will tell us the health of the employee population, who is subjected to catastrophic events, who has potential diseases,” he says. “The client can see what the health of its population is, and put individuals through comprehensive designing of disease management programs, concentrating on the individuals who are specific to those diseases. And we even rate those diseases by high, medium or low points of risk.”

Despite his concerns over bundling and several other competitive issues of the proposed merger, Kovar says he is not opposed to Highmark and IBC linking up. He simply wants the Pennsylvania Insurance Department to require that the proposed entity unbundle medical and pharmacy benefits. “This is an opportunity for the state to allow competition to thrive throughout the state,” he says.

But some other health care executives in the state assert that the merger would limit choices for consumers. A study commissioned by Harrisburg, Pa.-based competitor Capital BlueCross and released July 8 finds the merged company would control 72% of the state’s insurance market, rather than the roughly 52% that had been frequently cited.

The Pennsylvania Insurance Department is expected to make a decision on the proposed merger in the first quarter of 2009.

For more information on the proposed merger, visit www.ins.state.pa.us and click on Highmark/IBC. Contact Weinstein at michael.weinstein@highmark.com, Burnham at Karen.Burnham@ibx.com and Kovar through Neil Adler at neil.adler@dmngood.com. ✷

Study Finds Follow-on Biologics Law Could Save $25 Billion Over 10 Years

Congressional efforts to establish an abbreviated approval pathway for follow-on biologics got a shot in the arm following the June 25 release of a Congressional Budget Office (CBO) study that finds FOBs could reduce U.S. spending on biologics by $25 billion over 10 years. While the eventual savings would be welcomed, some health plan executives tell DBN that they aren’t expecting biosimilars to deliver the kind of “dramatic savings” that they have enjoyed with traditional generic drugs.

“One thing we don’t know is what the cost is likely to be,” says Tom Solberg, assistant vice president of specialty pharmacy at Prime Therapeutics, LLC, a PBM owned by 10 Blue Cross and Blue Shield plans.

“The speculation is that [the arrival of FOBs] is unlikely to have the same cost impact as we see in the non-specialty space,” he tells DBN. “It’s unlikely that biogenerics will have the 80% to 90% cost reduction [seen with non-specialty generic drugs]. If you’re talking about more of a 10%, 20% or 30% cost reduction, how is that likely to impact how we choose to manage that process?”

Because of their complexity and a limited patient base, there is not likely to be a “slew of generic manufacturers going after some of these products,” Solberg says. But he quickly adds that given the costs of these drugs, a 10% to 30% cost decrease is “still an awful lot of dollars.” Some likely strategies around biosimilars will include utilization and formulary management programs seen with non-specialty drugs, he says.

CBO Eyes 2012 for First FOBs

The CBO report scores the financial impact of the bipartisan Senate bill S. 1695, a leading candidate for biosimilar legislation. The bill cleared the Senate Committee on Health, Education, Labor, and Pensions in June 2007, but has languished since then. Key provisions of the bill, CBO said, include:

◆ Establishing standards for FDA approval of FOBs, including requiring the conduct of certain clinical trials. The bill would grant FDA the discretion to waive trials;

◆ Permitting FDA to determine that an FOB is interchangeable with an innovator biological product, subject to the FOB applicant providing certain types of clinical evidence; and

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According to CBO, if S. 1695 is enacted, the first FOBs could enter the market near the middle of 2012, and roughly $70 billion worth of biologics would face competition by FOBs in 2018. The effects of enacting S. 1695, CBO said, include:

◆ A $200 million reduction of total U.S. expenditures on biologics for the 2009-2013 period, and a $25 billion reduction for the 2009-2018 period; and

Head of Sandoz’s Biologics Unit Sees Up to 35% FOB Price Cut Over Time

While U.S. lawmakers and biopharmaceutical industry executives grapple with how to bring follow-on biologics (FOB) to market (see story, p. 3), Sandoz, the generic drug unit of brand Rx giant Novartis, AG, has been marketing its follow-on human-growth hormone Omnitrope in the U.S. since last year. Omnitrope (somatropin [rDNA origin]) is a follow-on version of Pfizer’s Genotropin. It received FDA approval in June 2006 under Section 505(b)(2) of the Food, Drug, and Cosmetic Act, which permits applicants to rely on information from published scientific literature or on the fact that the FDA has already found a similar drug to be safe and effective. In approving Omnitrope, the FDA emphasized that the drug is not a generic biologic, and that its approval does not establish an abbreviated marketing pathway for other biologics.

In an exclusive interview with DBN, Friedrich Nachtmann, Ph.D., head of biotech cooperations at Austria-based Sandoz, shared his thoughts on the potential of FOBs.

DBN: Once a regulatory and legislative pathway is approved in the U.S., how soon will follow-on biologics come to market?

Nachtmann: With or without a regulatory pathway for follow-on biologics in the U.S., patents for biologic products worth approximately $80 billion are set to expire between 2010 and 2015. This market will continue to grow considering that more than one-third of all medicines currently under development are biotech drugs, and it is expected that by the year 2010, over half of all approved drugs will be biotechnological products.

DBN: What are the key barriers holding up a U.S. pathway for biologics?

Nachtmann: While there is growing support for a pathway to approve follow-on biologics in the U.S., the debate remains focused on several issues, including data exclusivity, patent protection and ways to challenge patent resolution procedures, and the scope of discretionary authority to be granted to the FDA, particularly to make interchangeability determinations in the judicial system....The goal for policymakers, regulators and the industry is to constructively develop a science-based pathway that is fair and reasonable, ensures that patients continue to have greater access to safe and effective medicines, and promotes competition while continuing to encourage innovation by respecting legitimate intellectual property rights.

DBN: How much can health plans and other pharmaceutical payers expect to save on follow-on biologics, compared with their branded versions?

Nachtmann: As an increasing number of biologic drugs come off patent, savings from follow-on biologics could be billions of dollars over 10 years. According to a recent Insmed Inc. assessment, if a follow-on biologic pathway is approved in 2008 and products already off-patent could be approved by 2010, there would be a price discount of 25 to 35% over 10 to 20 years. This translates into a savings between $67 billion and $108 billion over the first 10 years, and $236 billion to $378 billion over 20 years. These estimates are in line with what we experienced with the 2007 U.S. launch of our follow-on biologic Omnitrope that was priced at a 32% reduction from comparable branded drugs.

DBN: Do Rx payers have any misperceptions about follow-on biologics (e.g., price, safety, availability, etc.), and what should they know about these products?

Nachtmann: Biologics represent more complex products than classic synthetic drugs, and therefore some skepticism has been expressed about quality and comparability of follow-on biologics to originator products. However, the science has improved dramatically over the last 20 years, so that it is now possible to use updated processes to develop and manufacture these products cost effectively using the same high-quality standards that apply to originator products. Even the FDA agrees that the science behind follow-on biologics is not in question. In August 2004, while the FDA was considering our Omnitrope application, they said publicly that they found no deficiencies with the application. With our European approvals of Omnitrope and Binocrit and U.S. approval of Omnitrope, we have demonstrated that we can make biosimilars to the same high standards that are used for innovator products.
A 20% to 25% sales-weighted market average discount on FOBs relative to innovator drugs during the first year of competition, and roughly a 40% discount by the fourth year.

Competition would not begin for most products until the second half of the 2009-2018 period, according to CBO. Certain types of more complex biologics, such as monoclonal antibodies, may obtain marketing approval near the end of the 2009-2018 period, CBO added. It also said that several factors — including FDA approval requirements, scientific and technical barriers, and patent challenges — would mean that savings over the next five years “would be relatively small.”

Still, advocates of developing an approval pathway quickly jumped on CBO’s findings. Jim Greenwood, CEO of the Biotechnology Industry Organization (BIO), said the CBO report underscores the urgency of approving legislation this session.

“The report finds that most of the savings will be obtained several years after a follow-on pathway is established, reinforcing the need for Congress to develop and pass a reasonable pathway this year that protects patient safety and preserves innovation,” Greenwood said in a June 25 prepared statement. “We are essentially leaving money on the table the longer we wait to implement a pathway.”

Details Could Delay Legislation

While it’s feasible that biogenerics legislation could pass in 2008, most Washington observers say the issue will likely be dealt with by the next Congress and president. Both leading presidential candidates, Sens. John McCain (R-Ariz.) and Barack Obama (D-Ill.), have expressed support for biosimilars.

Debbie Stern, vice president of managed care consulting firm Rxperts, Inc., says that the threat of a Democrat winning the presidency, as well as more Democrats in Congress next year, may be prompting BIO to push legislation this year as a way to protect the industry.

BIO, for example, seeks legislation that provides a 14-year marketing exclusivity period. “Data exclusivity is absolutely necessary to preserve incentives for innovation,” BIO’s Greenwood wrote in a May 9 letter supporting H.R. 5629, which would provide 12 years of exclusivity plus the option for two more years for brand biopharmaceuticals.

By contrast, conventional brand drugs have five years of data exclusivity before they face generic competition. Some biosimilar proposals supported by House Democrats contain provisions with similar data exclusivity periods for brand biologics.

The problem with biosimilar legislation lies in the details, says Bill Sullivan, president of Specialty Pharmacy Solutions LLC.

He contrasts the legislative effort around biosimilars to the 2003 Medicare law that established Part D. “There is a big difference between administering an entitlement program and drawing hard lines for an industry with hundreds of millions of dollars at stake and mountains of cash at hand ready to be unleashed to protect their property rights,” he tells DBN.

Still, many manufacturers are gearing up for the eventual pathway, Sullivan notes. There already is significant investment in research and development around the world, from China to Croatia, he adds.

The CBO report is online at http://cbo.gov/ftpdocs/94xx/doc9496/s1695.pdf. Contact Sullivan at wsullivan@specialtyRxSolutions.com and Solberg through Sheila Thelemann at SThelemann@primetherapeutics.com.

Specialty Rx Management Focuses On ‘Value’ and Better Outcomes

The nation’s health care system will not be able to sustain unrestricted access to high-cost biotechnology agents, according to a specialty-pharmacy consultant who urges health plans and other pharmaceutical payers to implement management strategies that reduce waste and promote appropriate utilization of specialty drugs. This effort will require a greater emphasis on proving the clinical and economic value of these drugs, particularly as specialty pharmacy costs are expected to almost double to roughly $100 billion by the end of the decade.

Health plans must get a handle on managing high-cost specialty drugs, which now comprise the majority of therapies under development, said Debbie Stern, vice president of managed care consulting firm Rxperts, Inc.

As recently as two or three years ago, Rx payers were implementing very few management tactics, she told a July 9 AIS audioconference on specialty pharmacy management strategies. In fact, some therapeutic categories, such as oncology, HIV/AIDS and genetic disorders, were viewed as totally off limits, Stern noted.

But that is changing as more biologics come to market to treat either common diseases or for use as chronic therapies, she said. Payers are moving aggressively to implement clinical and utilization-management strategies, Stern said. “No drug categories will be considered off limits if there is a sufficient utilization in those categories [or] concern about their value and appropriate use,” she said of the focus on management.

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Common strategies already include the creation of more copay tiers on drug formularies, such as a fourth and fifth tier for “preferred specialty” and “non-preferred specialty.” There also has been a “slight shift” in moving products from the medical benefit to the pharmacy benefit, and vice versa. “The idea being to put them all under the same management strategies, cost share and utilization management overall,” she said.

In addition, Stern said, payers increasingly are requiring that patients and physicians obtain specialty Rx products through a specialty pharmacy. This is a positive development, she added, noting that it results in “increased attention that is given to the patients managing their drugs.”

Management strategies proving most effective include the use of prior authorizations, contracting with specialty pharmacies, implementing step edits and mandating the use of specialty pharmacy by patients, Stern said. “These are the strategies that seem to have some effect on managing the trend and costs, and ensuring the appropriate use of the products,” she added.

As specialty Rx costs increase, payers are intensifying scrutiny of the value of these products, Stern said. Determining value requires better outcomes data, she said. Payers for oncology drugs, for example, are frustrated by the lack of survival-benefit data and published guidelines on utilization, she added. “Now that treatments are becoming more chronic, that’s leading to a concern about are these products actually improving life expectancy and quality of life for patients.”

One health plan is showing that its specialty pharmacy program can improve patient outcomes and demonstrate value. Edmund Pezalla, M.D., national medical director at Aetna Pharmacy Management, said a plan’s specialty pharmacy benefit should focus on value.

Value can be measured according to the outcomes of survival, disease-free survival, and improved quality of life, Pezalla told the AIS audioconference. When determining value, payers should take into account direct and indirect medical costs, as well as productivity, he added.

“Many folks will be able to continue to work and go back to work after a disease episode if it is successfully treated,” he said as an example of the productivity measurement. “Their ability to work, to achieve other things in society will be an important outcome that we’ll be looking for. That will impact the indirect costs, [such as] lost wages and other things that are important to the individual.”

Aetna takes a holistic approach to its management of specialty pharmacy, Pezalla said. Among other things, the plan screens its specialty Rx members for depression and stress. Specialty pharmacy members who test positive for depression are referred to Aetna’s Medical/Psychiatric High Risk Case Management Program (Med./Psych).

The Med./Psych program has resulted in a 17% reduction in emergency room visits, a 64% reduction in the length of inpatient stays, as well as an increase of total pharmacy costs as patients receive more antidepressants and other drugs, he said. The overall net medical cost reduction is 12%, Pezalla added.

Interviewing specialty pharmacy members on what motivates them also has proven effective in improving adherence, he explained. “We have a compliance rate overall of approximately 94% versus 53% for similar members who received their drugs in a retail setting,” he said.


New Law Raises Formulary Concerns

continued from p. 1

“There are a lot of Democrats that want to see that shift occur — where the government takes a much more aggressive role in setting out criteria, standards, operating requirements, etc.,” he tells DBN. While the legislation had wide support of Democrats, many Republicans also voted for it and to override the veto. The House voted 383 to 41 to override the veto. The Senate followed with a 70 to 26 vote.

One Part D shift that has drawn fire in recent weeks is a provision (Sec. 176) that gives HHS authority to
require the inclusion on formularies of drugs that meet certain criteria. CMS already requires Part D sponsors to include “all or substantially all” drugs in six categories: HIV/AIDS drugs, antipsychotics, antidepressants, anti-convulsants, cancer chemotherapy drugs, and immunosuppressants for transplants.

Under the new provision, the HHS secretary has authority to identify categories and classes of drugs that meet two criteria:

- **Restricted access to drugs in the category or class would have major or life-threatening clinical consequences for individuals treated by the drugs.**
- **There is a significant clinical need for individuals to have access to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs.**

All drugs in the identified classes or categories that meet the criteria would be covered by Part D sponsors, according to the provision. The HHS secretary could make exceptions that permit sponsors to exclude a drug from its formulary based on scientific evidence and medical standards. In addition, the secretary can authorize an exception for plans that limit access to such a drug, including through prior authorization or utilization management. The exceptions would be subjected to a rulemaking process, according to the provision.

**Opening the Door to Lobbying?**

Opponents contend that this provision opens up the Part D formulary development process to pressure from drug manufacturers and patient groups to add drugs to the list. Lobbying groups could use children and elderly patients to press their cause, the opponents say. Counteracting this pressure will be difficult, says Marissa Schlaifer, AMCP’s pharmacy affairs director.

“Once CMS identifies a drug class, who will argue that every drug in that class shouldn’t be added?” she asks as an example. Schlaifer acknowledges that every drug has its merits. “There are good arguments to have any drug on formulary or not on formulary,” she says. “That decision needs to be made by the physicians and pharmacists that operate that plan.”

Sponsors of the legislation say there are sufficient safeguards to prevent undue lobbying. An aide to Senate Finance Committee Chairman Max Baucus (D-Mont.) said the provision requires the administration to justify any expansion of protected drugs through a formal rule-making process, according to a July 14 article in Congressional Quarterly.

And another Medicare observer says complaints about the provision focus more on the government’s increasing regulation of Part D. This provision puts an existing sub-regulatory guidance into statute, Bonnie Washington, vice president of health care consulting firm Avalere Health, LLC, tells DBN.

“If you look at the provision itself, it basically does what the [HHS] secretary has been doing for the last several years,” she says. “It allows him — or her in the future — to designate protected classes and require plans to cover all drugs in those classes, subject to exceptions that they establish. That is what we have today, and have had for the past several years with the six ‘classes of concern.’”

**MA Payment Cuts May Benefit PDPs**

Washington points out that the law contains few provisions that directly affect Part D. The ones other than the formulary requirements garnered mixed receptions.

“One of the most important things that will come out of this bill will be electronic prescribing, which we should have had in 2003,” William Novelli, CEO of AARP, told a July 10 AIS conference on health care reform. The full Senate on July 9 passed H.R. 6331. “Now we’re going to get electronic prescribing…and that is going to make a huge difference in many different ways.” This provision also was widely supported by PBMs, drug manufacturers and health plans.

Billy Tauzin, president and CEO of the Pharmaceutical Research and Manufacturers of America, told the AIS conference that PhRMA was “very pleased [the bill] includes a provision” that liberalizes the access of low-income seniors into Part D.

“In the last three years, we’ve saved $450 billion [through Part D]…It’s time to liberalize those access provisions for subsidies to make sure that no one is left out of the system,” said Tauzin, a former congressman from Louisiana who was the chief architect of the 2003 Medicare law. “There are 2.5 million seniors that we know about who are eligible for the low-income subsidy, and getting them enrolled is very important.”

On the other hand, PBM trade group Pharmaceutical Care Management Association (PCMA) slammed a provision that requires both MA prescription drug plans (MA-PDs) and PDPs to pay pharmacies within 14 days for electronically submitted clean claims and 30 days for clean claims submitted by mail. “PCMA continues to oppose other special interest provisions which would pay independent pharmacists twice as fast as all other Medicare providers,” the group said in a prepared statement after the Senate passed the legislation.

Meanwhile, payment reductions to the MA program could stoke competition between MA-PDs and PDPs for the 2.3 million beneficiaries.

Avalere’s Washington notes that many MA plan sponsors also offer stand-alone PDPs. “It is likely that
those companies will try to keep their customers and redirect them to their PDPs,” she says. “There will be a lot of transition in the market with PDP plan competition for the beneficiaries whose MA plan stopped doing business as a result of the legislation.”

Looking ahead, AMCI’s Hermelin says the win will likely embolden Democrats to make further changes to the Medicare program, including removal of the “non-interference” clause that prevents the government from negotiating prices directly with drug manufacturers.

Contact Hermelin and Schlaifer through Carolyn Stables at cstables@amcp.org and Washington through Lindsey Spindle at lspindle@avalerehealth.net.

**NEWS BRIEFS**

- **SXC Health Solutions Corp.**, a PBM and vendor of health care technology services, on June 30 said it had won a five-and-a-half year contract to provide PBM services to The University of Toledo (UT). SXC said it would begin providing its services through its informedRx suite of tools for more than 6,000 members of UT’s employee prescription benefit program on July 1, and would expand its coverage to more than 13,000 covered lives on Jan. 1, 2009. Terms of the agreement were not disclosed. Terms of that agreement also were not released. Contact SXC Chief Financial Officer Jeff Park at investors@sxc.com.

- **Express Scripts, Inc.** on June 27 said it had won a consolidated contract to provide PBM services to more than 9 million Department of Defense (DOD) beneficiaries. The contract includes the option for five years of mail-order and retail-pharmacy dispensing services, the company said. If all options are exercised, the total value of the contract is roughly $2.8 billion, excluding the cost of pharmaceuticals, DOD said on June 26. Express Scripts said it has been providing home delivery and pharmacy network services to the Defense Department since 2003 and 2004, respectively. Under the new contract, mail-order services are scheduled to begin Sept. 1, 2009, and retail services to begin Dec. 1, 2009, DOD said. Express Scripts is expected to process more than 78 million prescriptions during the first year of operation, DOD said. Contact Steve Littlejohn at slittlejohn@express-scripts.com.

- **InnovationRx**, a division of Innovation Group, on July 14 launched a medication adherence service that it says “educates and empowers patients to take more control over their medications and health.” The service, jointly developed through a research grant with Northeastern University School of Pharmacy, targets all demographic segments, age groups and disease states, and includes a combination of education, self-assessments, customized intervention plans, reminders and private access to live pharmacists, the company said. Patients can choose among several monthly subscription plans, which start at $7.99 per month. For more information, visit www.innovationrx.com. Contact Madeline Shedno for InnovationRx at (781) 684-0770.

- **CVS Caremark Corp. and Microsoft Corp.** on June 26 said they would collaborate to offer consumer health care tools to help people manage their health and wellness, and control their health information. Using Microsoft HealthVault, consumers will be able to download a comprehensive list of prescriptions filled at CVS/pharmacy or through CVS Caremark by mail. Consumers also will be able to save copies of their health records — including laboratory tests from visits to MinuteClinic, CVS Caremark’s retail-based health clinic — into their individual HealthVault record. These services are expected to be available to consumers beginning in fall 2008, the companies said. Contact Carolyn Castel at CCastel@cv.com.

- **PEOPLE ON THE MOVE**: Walgreens Co. named Hal F. Rosenbluth corporate senior vice president. He was president of Walgreens Health and Wellness division, and co-founder and chairman of Take Care Health Systems, a wholly owned subsidiary of convenient care clinics acquired by Walgreens in 2007. Walgreens also promoted Michael Nameth and Mark A. Wattley to corporate divisional vice presidents. Nameth was executive vice president for pharmacy benefit management and specialty pharmacy at the Walgreens Health Services division. Wattley was vice president and legal counsel of human resources in the same division....WellNet Healthcare, a health-management company and PBM, named George Pantos senior adviser for strategic planning, communications advice and outreach on issues including employer-sponsored benefit programs. Pantos was vice president at consulting firm Kinder & Associates, where he served as principal lobbyist in Washington, D.C., for the self-insurance industry.
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