Volume 13, Number 16 August 24, 2012

DRUG BENEFIT NEWS

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

Contents

3 Southwire Tests the Line to Rx Savings With 'Custom' Network

4 Walmart Exec Offers Shopping Guide to Custom Networks

6 Coventry Buy Boosts Business for Aetna and PBM Partner CVS Caremark

7 *AIS Survey Data:* No Limits In Sight on Brand-Name Ingredient Costs

8 *News Briefs*

As Plans Await EHB Formulary Guidance, Patient Groups Put the Pressure on HHS

The clock is ticking for insurers to begin designing their individual and small-group benefit plans sold on health insurance exchanges, but health plans — and some states — are still holding out for one crucial piece of guidance: a proposed or interim final rule on essential health benefits (EHB) that carriers must include in their plan designs, including prescription drug coverage.

At press time, HHS had not yet issued a regulation, and various stakeholders continued to debate potential formulary requirements such as a one-drug-per-class minimum that was mentioned in a December 2011 bulletin released by CMS's Center for Consumer Information and Insurance Oversight (CCIIO) *(DBN 2/10/12, p. 1)*. Insiders now say HHS is reconsidering the use of a two-drug-per-class mandate and protected drug class requirement borrowed from Medicare Part D — which were rejected in the original bulletin — or something else altogether.

At issue is whether requiring a certain number of antidepressants, ACE inhibitors, cholesterol-lowering statins or drugs in other classes will ensure adequate coverage for people with chronic conditions while still allowing health plans to have the flexibility needed to negotiate discounts with drug manufacturers.

"It's a question of patient access to covered therapies versus cost, and I think that's a big issue that HHS is struggling with and that states are also going to be struggling with," observes Lisa Murphy, senior manager in the health reform practice at Washing-

continued on p. 5

Health Insurers Weigh Benefits, Cost Against Risk for New Anti-Obesity Agents

With more than one-third of U.S. adults considered obese, insurers have chosen to tackle the obesity epidemic with health risk assessments and wellness programs to encourage healthier lifestyles. But what if they had safe, effective drugs in their toolkits? For the first time in 13 years, the FDA recently granted approval to not one but two weight-loss drugs as adjunct therapies to reduced-calorie diets and exercise. But they may be a tough sell to health plans, several of which tell *DBN* they believe the risks of such agents still outweigh the benefits.

According to the Centers for Disease Control and Prevention (CDC), 35.7% of adults in the U.S. are obese (defined as people with a body mass index (BMI) of 30 or more). By 2030, obesity rates could reach 42%, with severe obesity (defined as having a BMI of 40 or more) rising to 11%, compared with nearly 5% in 2010, according to an analysis of CDC and state health department data that was published in the June 2012 issue of the *American Journal of Preventive Medicine.* That study forecasts a 33% increase in the prevalence of obesity over the next two decades, which could contribute to half a trillion dollars in medical expenditures.

Yet even with the new approvals of Belviq (lorcaserin HCl), marketed by Eisai Inc. and manufactured by Arena Pharmaceuticals, Inc., and Vivus Inc.'s Qsymia (phentermine and topiramate extended-release), some health plans are taking a "wait and see"

approach when considering these drugs for formulary coverage. Qsymia is expected to hit the market first — possibly in the fourth quarter of this year — while Belviq awaits classification from the U.S. Drug Enforcement Administration and may not be available until early 2013.

"The problem that we've had with anti-obesity drugs in the past has always been the cardiovascular risks," says Robert Giles, Pharm.D., manager of formularies at BlueCross BlueShield of Tennessee, which does not plan to cover Belviq and Qsymia right away. "Frankly, I think the jury may still be out on these two new products. Perhaps post-marketing studies will tell us that either they may be risky or they may be safe, as the companies are alleging that they are. Obviously, we hope for the latter," he tells *DBN*.

Insurers are understandably wary, given that anti-obesity treatments don't have the best track record. In 2004, "fen-phen" (fenfluramine/phentermine) was withdrawn from the market after fenfluramine was shown to cause potentially fatal pulmonary hypertension and heart valve problems. Phentermine, which is an active ingredient in Qsymia, was not found to produce harmful effects. In 2010, Abbott Laboratories took Meridia (sibutramine) off the U.S. market after a clinical trial showed that patients using it had an increased risk of cardiovascular events such as heart attack and stroke.

The drug makers of Belviq and Qsymia must conduct post-marketing studies, which will include evaluating the effects of long-term treatment on the incidence of major adverse cardiovascular events in overweight and obese patients with cardiovascular disease or multiple cardiovascular risk factors.

As a result of safety concerns, the Tennessee Blues plan will place the two new anti-obesity agents on a "menu of potential exclusions" for clients. Some insurers refer to these as lifestyle drugs, which typically include dermatologic products, smoking cessation therapies and erectile dysfunction agents. "I think the problem with anti-obesity medications — as well as with the smoking cessation products — is that their success rates have just never been very good, so plans feel that the results don't always justify the expense of the products," asserts Giles. "I don't know that our coverage policy will change, but we will be watching the potential post-marketing studies on any cardiovascular problems."

Both drugs are approved for use in adult patients with an initial BMI of 30 or greater or overweight adults with a BMI of 27 or greater who also suffer from at least one weight-related comorbid condition such as high blood pressure, high cholesterol or type 2 diabetes. The average weight loss for patients taking Belviq ranged from 3% to 3.7% over those taking a placebo, while Qsymia trials demonstrated an average weight loss of 6.7% when using the recommended daily dose and 8.9% with the highest dose.

Plans Put PA Restrictions on New Drugs

Xenical (orlistat), which is sold over the counter (OTC) in a lower dose as Alli, is the only other prescription drug approved for long-term treatment of obesity. Giles says Tennessee Blues clients who have chosen to exclude Xenical from their formularies justify that decision because there is an OTC version available.

HealthPlus of Michigan, meanwhile, says it has always covered weight-loss therapies and does not consider them lifestyle drugs. That being said, the insurer requires prior authorization based on FDA indications for those treatments. "We're actually going to put those new weight-loss drugs in that same category, so they'll be subject to that same criteria," Jennifer Szumowicz, director of pharmacy operations, tells *DBN*. "We don't have a lifestyle rider that those would fall into. I think a lot of plans will because I think they're going to be expensive, and I don't know that the cost-benefit ratio to them is going to pan out to be a whole heck of a lot, because the percentage weight loss that you get on those isn't huge."

According to drugstore.com, the suggested retail price for a 40-day supply of Alli is $69.99, or a $1.75 a day. While no pricing data has been officially released for the new treatments, analysts estimate Belviq could cost any-

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

Editor, Lauren Flynn Kelly; Managing Editor, Angela Maas; Executive Editor, Jill Brown; Director, Databases and Directories, Susan Namovicz-Peat; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Coordinator, Darren Jensen.

Subscriptions to *DBN* include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *DBN* content, archives of past issues and AIS's Pharmacy Benefit Survey Results (available for download).

To order an annual subscription to **Drug Benefit News** ($557 bill me; $532 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

where from $3 to $4 a day, while its competitor could sell for about $3.50 a day, says *The Wall Street Journal.*

WellPoint, Inc. says it plans to group the new agents with the "least preferred" drugs on its third tier, assigning them the highest copay for non-specialty drugs. And, if deemed necessary by its pharmacy and therapeutics committee, the insurer may tighten prior-authorization criteria beyond FDA indications.

"While most benefits offered by our affiliated health plans generally follow our drug formulary, weight-loss drugs are not included in our standard plans and generally are not reimbursed through most of our customers' benefits," explains Colleen Haines, vice president of clinical pharmacy services at WellPoint. "Historically, we have found that weight-loss drugs in general show modest weight loss along with high-risk side effects."

Haines points out that Qsymia also comes with a warning for pregnant patients, who may face an increased risk of birth defects such as cleft palates in infants exposed to Qsymia during the first trimester of pregnancy. Females are strongly advised to prevent pregnancy or discontinue using Qsymia immediately if they become pregnant.

"Overall, these drugs have demonstrated modest weight loss and significant risk," concludes Haines. "The FDA has acknowledged safety concerns with these drugs in both adult and pediatric populations in its requirement for post-marketing studies."

Contact Giles via Kelly Allen at Kelly_Allen@bcbst.com, Haines via Lori McLaughlin at Lori.McLaughlin2@anthem.com and Szumowicz via Shawn Boeneman at sboenema@healthplus.org. ✧

Southwire Tests the Line to Rx Savings With 'Custom' Network

Narrow, limited, restricted, preferred, alternative — call them what you will, but these revamped pharmacy networks are here to stay. *DBN* has covered ongoing discussions around the feasibility of narrow pharmacy panels, but what about the employers who've already implemented such networks? In a case study presented at the 6th Annual Pharmacy Benefits Academy in Chicago, one such employer identified employee outreach, a flexible PBM partnership and a tiered approach as the keys to successfully implementing what it refers to as a "custom" network.

Through a unique approach involving its own onsite pharmacy and a preferred partnership with Wal-Mart Stores, Inc., Southwire Company was able to implement a custom pharmacy network with little member disruption and save 7% on pharmacy benefit expenditures last year, Lisa Evans, director of healthcare, told attendees on July 31 at the conference, which was sponsored by Pharmacy Outcomes Specialists and the Midwest Business Group on Health.

Southwire, a major manufacturer of cable and wire with more than 3,800 employees, had already achieved a high generic dispensing rate (GDR) in the mid 80s at its onsite pharmacy in Carrollton, Ga. But outside of its headquarters, there are 19 plants and 12 customer service centers across North America. "We knew we could not have a pharmacy at every one of our locations — it just was not going to work — so we tried to do a similar strategy by looking at different networks and how we could manage that," she explained.

Evans first performed a geographic access analysis to see how a narrow network would impact employees, and was pleasantly surprised with the results.

"As you can imagine, when you make wire and cable, you do not do that in the great places of the world — you do it in places that most people haven't heard of. So we did the analysis and found that 91% of our employees have a store within 20 miles. And those that didn't, they didn't have anything within 20 miles, so we were just sending them to civilization as they normally went. So that wasn't a big deal for most," she explained. The employer also found that 20% of its employees were already going to Walmart.

Southwire negotiated prices directly with Walmart, with their PBM operating in the background mainly as a claims adjudicator. The employer has gone through several PBM shifts due to consolidation in the industry and is now with Catamaran Corp., but was using former Anthem/WellPoint, Inc. PBM NextRx at the time of negotiations with Walmart. "They were very flexible in helping us set up the pricing structure and confidentiality agreements that are needed for this type of contract," Evans tells *DBN* in a follow-up interview. The employer did talk to other chains, but "we just didn't have enough

people for them to justify being able to look at a secondary network on top of that."

In mid-2009, the company put in place a tiered network that incentivized patients outside of the Carrollton area to obtain their medications from a Walmart pharmacy by instituting 40% coinsurance with a $35 maximum, compared with 60% coinsurance with a $50 maximum for using a pharmacy other than Walmart. Coinsurance percentages apply to all traditional medications, while the company has a fixed copay of $100 for specialty agents. Southwire does not have a formulary.

In 2011, the in-network cost per prescription to the employer was $45, as opposed to $54 per script filled by a non-network pharmacy. That translated to $211,000 in savings to the employer and $70,000 in savings to members. Their GDR across the board in 2011 was 81%, up from 77% in 2010 and 71% in 2009. Evans points out that the increase was partly due to the expansion of generic medications and the advantage of having a clinic on the same site as its Carrollton pharmacy.

The savings figures are based on utilization from July 2009 — when the network went into effect — through July 2010, but the company received the 7% savings in 2011 as part of the reconciliation process that was set up with Walmart after the first year as market share was established, explains Evans. "This was a one-time savings only, although I would argue that [the arrangement] has kept our costs from rising as fast as other employers using PBMs," she tells *DBN*. While there's the potential for additional savings by driving more employees to the preferred Walmart pharmacies, Evans says she doesn't expect to see much more movement.

To minimize disruption, Southwire took an "honest and upfront" approach when communicating the benefit change to members. "We didn't try to make it anything other than what it was," said Evans. "This was huge for Southwire, telling people outside of the Carrollton area, 'You're going to be going to a new place unless you want to pay more.' We told our members that in remote locations, we are filling 60,000 prescriptions and it's costing us $4 million a year. And our people are going, 'What?!' They didn't get that, because the most they see is a $35 copay. So we pretty much said, 'Hey, we've negotiated with [Walmart] directly. We're going to pay less, so you're going to pay less. It's up to you what you want to do.'"

While there was some pushback from members, it was mainly in the form of questions. And when people asked why they couldn't go to their regular pharmacy, Evans simply had to say, "I cannot share something with you we do not have," referring to the discounts on drug prices that Walmart was willing to provide, although there was some reduction in dispensing fees as well. "Some people just aren't Walmart people," she added.

Walmart Exec Offers Shopping Guide to Custom Networks

Custom networks can take on multiple forms, according to Art Sorg, divisional sales manager at Wal-Mart Stores, Inc., which has narrow network arrangements with Humana Inc.'s PBM subsidiary, Humana Pharmacy Solutions, and several other PBMs, as well as direct contracts with employers. Speaking at the 6th Annual Pharmacy Benefits Academy in Chicago on July 31, Sorg outlined the following three benefit designs for payers to consider:

(1) Direct contracts with one or more "preferred" pharmacies. Options in this category include a single contract with a retail chain where the employer encourages the use of the preferred retailer through copay waivers (and subsequently copay penalties for going outside the preferred network), or a tiered arrangement with varying copay levels based on the pharmacies and the discounts they're providing. This allows employers to negotiate deeper discounts and better prices while still giving employees access to the rest of the pharmacy network and letting the PBM process claims and operate "behind the scenes," explained Sorg. "Basically, you really have a lot of options on how you want to design the network."

(2) Specific network designed by your PBM. "We've worked with a number of PBMs to help incent them to customize networks," said Sorg. "A few years back when we initially got into this type of a program, we did a geo-access test based on the Medicare standards put out by CMS and we found that we needed a little less than 18,000 pharmacies to meet those access standards. Do we need 64,000 pharmacies? Probably not. We've had that discussion in the past and I'm sure it will continue, because obviously when you reduce the size of your network there is going to be some disruption."

(3) Exclusive arrangement with a retailer. "This is probably the most difficult to pull off, but in certain circumstances it will work. Obviously you have more concerns about access standards there, but it's not really rocket science. Basically, the retailer is willing to trade you price for volume."

When evaluating retail networks to identify the right provider for a limited network, Art Sorg, divisional sales manager at Walmart, pointed out that lower reimbursement rates should not be the only factor. Speaking on the panel with Evans, Sorg recommended considering the following performance metrics:

◆ ***What is the pharmacy chain's overall average generic dispensing rate?*** Ideal rates would be in the ballpark of 80% to 85%.

◆ ***What percentage of those claims is that provider paying at usual and customary rates?*** "The reason that's important is because they'd be paying below the negotiated plan price, delivering additional savings beyond what your 'negotiated' rate is," he said.

◆ ***How successful are they are at brand-to-generic substitution after patent expirations?***

"We've seen narrow networks grow exponentially, and they're not necessarily all in large clients," added Sorg. "We're finding that employers are certainly more interested."

Contact Lisa Evans at Southwire at (770) 832-4303. ✧

Stakeholders Debate Access in EHB

continued from p. 1

ton, D.C., consulting group Avalere Health LLC. "How do you ensure that patients have lots of choices in terms of coverage while making sure that the coverage is affordable and keeping premiums low?"

Two patient advocacy groups, the National Health Council (NHC) and the National Alliance on Mental Illness, recently issued position statements calling for ample drug coverage in state-operated and federally facilitated exchanges, arguing that a one-drug-per-class or even two-drug-per-class mandate would not be sufficient for patients. And on July 12, 28 House Democrats issued a letter to CMS urging the agency to adopt an EHB approach that reflects Part D's policy designating certain protected drug classes. In Part D, there are six protected classes in which plans need to cover "all or substantially all" of the drugs in that class.

NHC, which is comprised mainly of patient advocacy organizations but also includes pharmaceutical manufacturers, large insurers and other stakeholders, on Aug. 10 called for a "patient-centered" EHB formulary, with a "robust selection of covered drugs as well as a set of well-defined patient protections…[including] a protected-class policy modeled after Medicare Part D." WellPoint, Inc. and UnitedHealth Group are members of NHC, but both declined to comment for this story.

"From our perspective, the timing was to continually keep the pressure on," explains NHC Executive Vice President and Chief Operating Officer Marc Boutin of the organization's decision to issue the statement. "We've had ongoing meetings with CCIIO and ASPE [the HHS Assistant Secretary for Planning Evaluation] and while they've not given us any indication of what they're going to do, they have indicated that they're going to address oversight and protection. And they've also indicated that the one drug per class was meant to be an example of what they could do but is not what they are necessarily intending to do. And from our conversations, we're under the strong impression that will not be the case; they're going to do something else."

NHC: Benchmarks Could Define Formularies

The CCIIO bulletin also proposed four types of "benchmark" plans that states can use to define essential benefits. The bulletin explained that if certain benefits — such as prescription drugs — are missing from the selected benchmark plan, benefits in that category would be based on coverage in one of the other benchmark plans. Preliminary guidance requires states to submit their selected set of EHBs by no later than Sept. 30. Some states are further along than others in selecting their EHBs, according to Murphy.

NHC recommends that in lieu of mandating a specific number of drugs per class, HHS should require plan formularies to "meet the same depth and breadth of the state-selected benchmark formulary."

"I actually think the benchmark process is workable…with certain protections and oversight," asserts Boutin. "What we're saying is whatever benchmark a state picks should also govern the formulary. And the rationale for that is even if you look at a small-group employer benchmark, they typically have seven drugs per class. And some of them have more, so the point being if you're going to use a benchmark for everything, why would you take the drugs out and then limit it to one drug per class? That just makes no sense and, in fact, for many people that would be deadly."

Meanwhile, trade groups like the Pharmaceutical Care Management Association and the Academy of Managed Care Pharmacy (AMCP) have argued that the potential imposition of protected drug classes would raise premiums and eliminate drug manufacturers' incentives to offer discounts. Boutin says NHC is in support of protected drug classes, but only as a part of "several layers of protection."

Agreeing with HHS's initial proposal not to include protected classes, AMCP CEO Edith Rosato wrote in a Jan. 31 letter, "This coverage requirement has made it difficult, if not impossible, for plan sponsors to negotiate favorable rates for the drugs in these classes, as pharma-

ceutical manufacturers know that the plans are required to cover their products regardless of cost."

If the process is anything like the Part D benefit, "plans would finalize their formularies in April 2013, submit their bids in June, and then begin marketing in the fall, for the plan to start on Jan. 1, 2014. So plans may need to start their negotiations with manufacturers as soon as this fall," suggests Murphy.

Since states are required to select their benchmarks by the third quarter, Murphy says it is possible that HHS could issue the rule between now and the end of September, although there are no guarantees. After a comment period, the final rule is likely to come out by the end of the year.

Contact Boutin via Nancy Hughes at nhughes@nhcouncil.org and Murphy at lmurphy@avalerehealth.net. ✧

Coventry Buy Boosts Business for Aetna and PBM Partner CVS Caremark

While Aetna Inc.'s Aug. 20 agreement to acquire Coventry Health Care, Inc. for $7.3 billion may bolster the national insurer's Medicare Part D business, analysts predict the real winner will be CVS Caremark Corp., which could walk away with another $3 billion in revenue in 2016, thanks to its long-term PBM pact with Aetna.

In addition to providing Medicaid managed care plans, Medicare Advantage (MA) products and commercial health insurance, Coventry is a major Medicare Part D player, and the new deal would add 1.5 million Prescription Drug Plan (PDP) enrollees to Aetna's membership. On the Medicare side, Aetna mainly offers group MA plans.

"Strategically, the acquisition increases the scope of Aetna's MA business while adding a leading Medicare Part D platform," observed Michael Wiederhorn, an equity analyst at Oppenheimer Inc., in a research note issued the same day as the announcement.

Part D consolidation is nothing new, as CVS Caremark earlier this year acquired Health Net, Inc.'s stand-alone PDP for $160 million, following last year's purchase of Universal American Corp.'s Part D business, and Cigna Corp. in January completed its acquisition of HealthSpring, Inc. for $3.8 billion to boost its own Medicare business *(DBN 1/27/12, p. 1)*.

Coventry operates three PDPs under the First Health brand, and its First Health Part D Premier plan was the sixth-largest PDP as of February 2012, with nearly 1 million enrollees, according to an Avalere Health LLC analysis of CMS enrollment data.

One question that remains, however, is how this will impact Aetna's 12-year PBM outsourcing deal with CVS Caremark, which began in January 2011. Meanwhile, Coventry recently renewed both its Part D and commercial contracts with Medco Health Solutions, Inc. (now part of Express Scripts Holding Co.), and those contracts are set to expire in 2015 and 2016, respectively.

Analysts at ISI Group LLC's Healthcare Tech and Distribution sector anticipate that CVS Caremark will become the PBM post-expiration. "Aetna is CVS Caremark's largest customer and on a combined basis would represent [approximately] $15 billion in spend," ISI Senior Managing Director & Partner Ross Muken explains to *DBN*. "It is unlikely that Aetna wouldn't use their size/scale advantage pro forma for Coventry to get excellent pricing from their key partner."

In an Aug. 20 research note, the firm estimated that the Part D portion of Coventry's pact with Medco is worth between $2 billion and $2.5 billion, while the commercial contract is valued at $500 million to $1 billion. That means an additional $2.5 billion to $3.5 billion of new Aetna business, assuming that CVS Caremark gets the Coventry contract later on.

When asked about PBM synergies on an Aug. 20 conference call to discuss the acquisition, Aetna Senior Vice President and Chief Financial Officer Joe Zubretsky said that in the near term, there would be no synergies. "Currently, both companies have very, very good PBM contracts. We expect to run those contracts to term and when the opportunity presents itself, the combined organization will have $15 billion of pharmacy spend and we'll make sure we get the best pricing available on the market," he told investors.

"One other fact to consider: Express Scripts did recently benefit from WellPoint's purchase of Amerigroup (CVS customer), which we estimate should add $1-2 billion of incremental revenues over time (contract starts in 2014)," added ISI. WellPoint, Inc. last month unveiled plans to buy managed Medicaid provider Amerigroup Corp. for $4.9 billion.

Subject to approvals from stockholders and regulators, the Aetna/Coventry deal is expected to close in mid-2013.

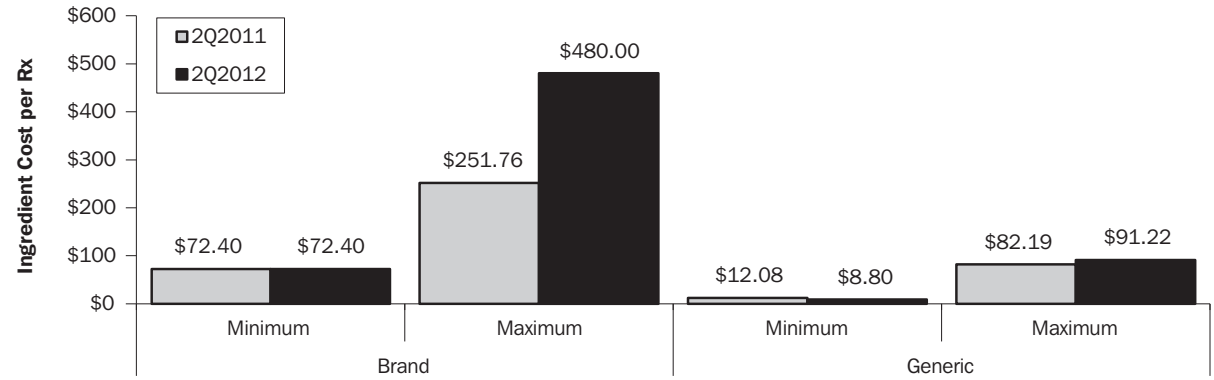
Contact Tom Cowhey, Aetna's vice president of investor relations, at cowheyt@aetna.com.

AIS Survey Data

No Limits In Sight on Brand-Name Ingredient Costs

New and high-cost specialty drugs continue to drive alarming increases in pharmacy benefit costs. The total industrywide average ingredient cost of brand-name drugs jumped another 53% in just the past year, driven by specialty products with $2,000+ price tags. In the retail PBM sector (excluding stand-alone specialty pharmacy providers), the maximum average brand-name cost reported by a PBM jumped to $480/Rx compared to $252/Rx just a year ago. In AIS's database, this recent spike in reported raw ingredient costs mimics a similar increase during 2009; ingredient costs have risen 266% over the past five years, compared with only 140% over the preceding eight-year period.

Range of PBMs' Average Ingredient Cost per Rx, Brand and Generic, 2011 vs. 2012



PBMs' Average Costs per Rx, as of Second-Quarter 2002-2012

	Average Ingredient Cost Per Rx		Average Amount Paid Per Rx		Average Dispensing Fee	
	Brand	Generic	Brand	Generic	Brand	Generic
2Q2002	$64.26	$13.61	$55.43	$12.08	$2.18	$2.34
2Q2003	$72.50	$17.29	$62.44	$13.91	$2.01	$2.16
2Q2004	$83.35	$19.68	$72.22	$16.27	$2.10	$2.23
2Q2005	$89.67	$20.29	$74.86	$16.21	$2.21	$2.43
2Q2006	$93.33	$19.51	$78.07	$16.38	$1.04	$1.18
2Q2007	$115.77	$22.60	$109.03	$19.71	$1.22	$1.31
2Q2008	$128.53	$21.25	$123.42	$19.35	$1.20	$1.30
2Q2009	$153.15	$23.07	$143.04	$20.48	$1.69	$1.88
2Q2010	$282.87	$35.14	$286.82	$36.24	$1.91	$2.03
2Q2011	$307.73	$52.12	$244.43	$39.64	$1.93	$2.07
2Q2012	$469.61	$60.47	$407.07	$45.32	$2.03	$2.20

Average Ingredient Costs, Amount Paid, Dispensing Fee per Rx, Percentage Change From Year Ago and From 2002

	Ingredient Cost		Amount Paid		Dispensing Fee	
	Brand	Generic	Brand	Generic	Brand	Generic
% Change from 2002 to 2012	630.86%	344.25%	634.38%	275.23%	-6.54%	-6.28%
% Change Past Year (2011-2012)	52.60%	16.01%	66.54%	14.34%	5.45%	6.26%

METHODOLOGY: Companies were asked for their average ingredient cost, amount paid and dispensing fee per Rx for brand and generic drugs across their entire books of business over the most recent 12-month period. Responses were then averaged by AIS. Averages are among all respondents answering the question, including specialty pharmacies, PBMs, PBAs, etc. Averages calculated by AIS are not weighted by volume. Survey respondents are promised confidentiality in answering this set of questions.

SOURCE: AIS's quarterly pharmacy benefit survey conducted for *DBN*. *AIS's Pharmacy Benefit Survey Results* can be downloaded from our subscriber-only website at http://aishealth.com/newsletters/drugbenefitnews/quarterly-survey-results. 2Q2012 results available.

NEWS BRIEFS

◆ **Prime Therapeutics LLC was chosen as the exclusive PBM and third-party administrator for the HR Policy Association's Pharmaceutical Coalition,** which represents chief human resource officers at more than 330 large corporations. Through the fully transparent arrangement, the cost of drugs and all financial benefits will be passed on to employers, according to Prime. The program will be available to coalition employers starting on Jan. 1, 2013. Prime was one of the first PBMs to participate in the coalition's Transparency in Pharmaceutical Purchasing Solutions certification program, which began in 2006. Contact Sheila Thelemann at sthelemann@primetherapeutics.com.

◆ **The use of automatic copay offset programs is on the rise in the category of diabetes medications, with four out of 24 (16.6%) copay coupons being processed in that category through RelayHealth's eVoucherRx program,** observes The Zitter Group's new *Co-Pay Offset Monitor.* Related studies conducted by The Zitter Group suggest that automatic copay offset programs, also referred to as e-Programs, are favorable to pharmacists because they are relatively easier to process than traditional coupons and cards. On the flip side, the use of such automated programs may result in "reduced impact on positive clinical outcomes, such as persistency," stemming from a lack of patient interaction inherent to e-Programs, suggests the business intelligence firm. According to The Zitter Group's most recent study of copay offset programs, 131 manufacturers sponsor 419 of these discount programs, which vary in benefit design and amount, distribution mechanism and apparent objectives. Contact Chris Wheeler at cwheeler@zitter.com.

◆ **Pending CMS approval, member pharmacies of RxAlly would make up the preferred network for Smart Insurance Company Holdings' new Medicare Part D Prescription Drug Plan.** RxAlly's 22,000 member pharmacies nationwide include independent stores, retail chains such as Kerr Drug, Thrifty White Pharmacy and Bartell Drugs, and national retailer Walgreen Co. Contact Susan Weingram of 5W Public Relations at (212) 584-4271.

◆ **The Academy of Managed Care Pharmacy (AMCP), along with 10 other national pharmacy organizations, is seeking to preserve funding for research on drug-related patient outcomes and a medication therapy management (MTM) grant program.** The House Appropriations Committee's draft fiscal year 2013 Labor, Health and Human Services funding bill, introduced on July 17, proposes to eliminate funding for the Agency for Healthcare Research and Quality. That agency sponsors outcomes research through the Centers for Education and Research on Therapeutics and was authorized in the health reform law to directly fund an MTM grant program that supports MTM pilot programs nationwide. AMCP and the other organizations sent a joint letter on Aug. 9 to committee chairman Harold Rogers (R-Ky.) and Ranking Member Norman Dicks (D-Wash.) urging the committee to reconsider and at least match the $364 million in funding for the agency that was approved by the Senate. The groups argued that the budget cut may save money in the short term, but would ultimately "sacrifice quality and savings" associated with MTM programs. To view the letter, visit the Letters, Statements and Analysis page at www.amcp.org/2012.

◆ **Catamaran Corp. says it plans to relocate its corporate headquarters from Lisle to Schaumburg, Ill., by spring 2013.** The company will integrate operations of its current headquarters and a facility in Bannockburn once renovation on an 11-story, 300,000-square-foot facility in Schaumburg is complete. In addition to maintaining an existing call center in Lisle, Catamaran will open an Innovation Center in Chicago for health care industry leaders, clients and prospects to convene and learn about new ideas in pharmacy benefits management. Catamaran's predecessor company, SXC Health Solutions Corp., moved its base of operations from Ontario to Illinois in 2007. Contact Angela Masciarelli of Zeno Group at Angela.Masciarelli@zenogroup.com.

◆ **PEOPLE ON THE MOVE: Ren Elder** was appointed head of pharmacy at Aetna Inc., where he will be responsible for Aetna's pharmacy businesses, in addition to managing Aetna's strategic agreement with CVS Caremark Corp. Elder previously served as president of NextRx, the former PBM unit of WellPoint, Inc....AMCP has selected **Robert A. Fulcher** to serve as vice president of external relations. Fulcher has more than 30 years of experience in health care association management, including his most recent post as director of publications at the American Society for Bone and Mineral Research.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at **www.AISHealth.com** and click on "Newsletters."

3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)