Volume 9, Number 4 *February 15, 2008*

DRUG BENEFIT NEWS

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

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Generic Rx Copays Are Steady or Dropping; Wal-Mart's $4 Generics Seen as Factor

Despite ever-increasing financial pressures to shift more pharmacy costs to consumers, health plan sponsors in 2008 generally are keeping their generic drug copayments low, while lifting copays on preferred and non-preferred brand drugs, say PBMs and health plans surveyed by *DBN*. The next big trend, in fact, could be "zero-dollar copays" on generics, say pharmacy executives who attribute the interest in reducing members' financial barriers in part to Wal-Mart Stores, Inc.'s $4 generics program.

While zero-dollar copay models are still mostly in the discussion stage, Rx payers in 2008 have widened the copay gap between formulary tiers as they try to push members to generics, according to executives on the front lines. Whether the lower copays will boost Rx compliance — another often-stated goal of the model — is a more complicated question, some add.

"I see that employers are looking to possibly lower generic [copays] but increase differentials between preferred and non-preferred [brands], to really incentivize employees to look at generics first," says Tom Tran, Pharm.D., senior director of pharmacy at Health Care Service Corporation (HCSC), which operates Blue Cross and Blue Shield plans in Illinois, New Mexico, Oklahoma and Texas.

Average copays offered by HCSC plan sponsors range from $10 to $15 for generics, $25 to $40 for preferred brands and $40 to $100 for non-preferred brands, he explains. HCSC has heard "a lot of conversation around zero copays for generics," but no sponsor yet has implemented such a plan, he adds.

Sponsors want to know if picking up the full costs of the drug would translate into a return on investment, with employees using more generics, as well as better medical outcomes, Tran says. The answer lies in how many beneficiaries a sponsor can switch to generics from brands, he explains. "If you're talking current generic utilizers, and you're giving those drugs away for free but you're not switching any of the brand utilizers to generic, you're really not seeing any return on investment," he says.

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Plans Are Urged to Use New RFP Process To Extract Improved PBM Rx Pricing Terms

Pharmaceutical payers consistently fail to get the best deal possible when negotiating new PBM contracts, one consultant contends. Corporate, union and government health plans, in fact, could reduce their pharmacy benefit spending by 10% to 30% if they were to use the leverage of the request-for-proposal (RFP) bidding process to extract better and binding contract terms from competing PBMs, says Linda Cahn, president of Pharmacy Benefit Consultants.

Because of today's flawed process, the promises and pricing projections of a winning PBM almost never materialize in the final contract, Cahn says in series of free informational videos posted this month on the Internet and in an interview with *DBN*.

continued

Published by Atlantic Information Services, Inc., Washington, DC • 800-521-4323 • www.AISHealth.com
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Among other things, Cahn contends that consulting firms — which are hired by health plans and other Rx payers to evaluate competing PBM bids — fail to use the RFP process to draft, negotiate and execute airtight PBM contracts. Consultants contacted by *DBN* agree that the RFP process could be improved upon, but some take issue with Cahn's assertions, including that many consulting firms:

◆ ***Have "terrible undisclosed conflicts of interest" with PBMs.*** "Unbeknownst to the health plans, many consulting firms are collecting large amounts of money from certain PBMs," Cahn says in the video.

◆ ***Fail to seek information from PBMs that can be verified.*** "For example, most questioners ask, what is your PBM accuracy rate? Not surprisingly, every PBM contestant in virtually every RFP, knowing the answer can't possibly be verified, answers 99.9999%," she says.

◆ ***Never require any PBM to bind itself to provide the projected drug prices in the final contract;*** and

◆ ***Select the winner before the actual PBM contract has been negotiated.*** "In fact, most consulting firms don't even discuss a single contract term with any PBM contestant during the RFP," she contends.

The videos urge health plans to "radically change their method of conducting RFPs." First, plans should require that consultants disclose any conflicts of interest, says Cahn, an attorney who in the late 1990s sued some of the largest PBMs over their business practices. Plans should also select consulting firms that have attorneys who are familiar with PBM contracting, she adds. These consultants should draft a contract — with blank lines in it — and send it to each PBM contestant.

The PBMs then fill in the blanks with binding contract prices and guarantees, and return them to the consultant. The process is repeated with each round of negotiations, extracting better contract terms and prices for clients, Cahn explains. When the RFP reaches the final step, the plan can announce a PBM winner and sign a finalized contract on the same day, she says.

Eliminating 'Phony' Pass-through Pricing

In an interview, Cahn tells *DBN* that health plans and other payers should insist on a contract that "breaks the mold by eliminating traditional PBM loopholes." Among other things, she says plans should require all PBM contracts to contain true "pass-through pricing, not the phony pass-through pricing that exists in most PBM/client contracts."

"PBMs claim they are providing pass-through pricing, but their contracts at best require only pass-through pricing for retail-dispensed drugs. [The contracts] allow PBMs to obtain huge markups on mail-order and specialty drugs," Cahn asserts. An airtight pass-through pricing contract, by contrast, must require pass-through pricing for all three drug channels: retail, mail and specialty, Cahn says. It also must eliminate all other hidden profit centers that exist in almost all PBM contracts, such as PBMs' retention of drug manufacturer rebates and discounts, she adds.

Cahn says her firm writes contracts that require PBMs to get their profits from one source only, a flat administrative fee. "As PBMs compete for health plans' business, health plans can force PBMs to reduce their administrative fees, or lose the RFP," she adds.

Alliance Coal, LLC, a self-insured mining company with roughly 7,500 covered lives, used Cahn's RFP approach last spring. The process resulted in the company switching from Express Scripts, Inc. to a much smaller PBM, Envision Pharmaceutical Services, Inc. That contract started Nov. 1, 2007. Alliance already is seeing

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.

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significant savings on its drug spend, says Paul Mackey, Alliance's general manager of human resources benefits.

"We're well on track to get some of our projections," he says. "It's safe to say it is going to be more than 10%, and that's very conservative."

Some consultants contend that selecting the winning PBM requires more than just focusing on contract terms.

Sean Brandle, national pharmacy leader at The Segal Co., says that his consulting firm not only sends out a bid document to contestants, but also requests that each PBM send in a signature-ready copy of a contract that the client could sign. After an analysis of the bids and the contracts, Segal will say to its client, "The best contract really came from XYZ [company]. It gives you the most benefits," he explains.

Brandle also stresses that there are certain things a client must do to have a successful relationship with a PBM. "And I don't think that you can really achieve that in the long run by just mandating," he says, adding that plans have to work closely with PBMs in such areas as formulary management and customer service. These are "a lot of hard core things that can cause real problems for clients," he says.

On the question of conflicts of interest, Brandle says that Segal does not receive payments from PBMs. "We know that some of our competitors do have arrangements," he adds. For example, some consulting firms charge a bidders' fee that the winning PBM pays to the consultant. "It's important that those types of payment arrangements be disclosed," Brandle says.

Bids and Contracts Are Evaluated

Consulting firm Pharmacy Outcomes Specialists (POS) focuses both on the PBM contract and a financial analysis of PBMs' rates for such things as maximum allowable cost (MAC) pricing, mail-order pharmacy and retail pharmacy rebates.

As part of its RFP process, POS reprices one year's worth of PBM claims under the "exact rates" that will be part of the contract, says Susan Hayes, president of the consulting firm. So, for example, if a PBM contracts at various rates with the chains in its retail network, "they must send us each and every rate. They must send us a MAC list; they must send us rebate rates. We sign confidentiality agreements to get this information," she adds.

"If the PBM does not send us this information, they are not considered contenders," Hayes explains. Her firm also no longer sends out questionnaires where PBMs insert boilerplate language. "We send out a contract of terms and if the PBM agrees to the terms, they are considered finalists together with the financial evaluation," she says. "There are few consulting firms that do what we do."

New Movement in PBM Contracting?

Jack McClurg, CEO of the PBM HealthTrans, LLC, says that PBMs have a "love/hate relationship" with RFPs. "I understand that the RFP process is supposed to be a more objective approach for the brokers and consultants to get bids, but it does take up a lot of time, effort and expense [so it] does seem like there would be an easier way," he says.

Still, McClurg says the process is about as good as one can expect for right now. "One of my goals in life as CEO is [to] develop a product that is simpler to understand, so that the non-PBM-professional benefits person can make a decision about price and service and quality. Then we can simply go to that sort of pricing model," he tells *DBN*.

Cahn says the PBM industry could change rapidly if larger groups start demanding airtight contracts.

"Imagine what would happen if a few Blues, with a few million members each, used RFPs to say, 'This is the airtight contract we want, and you're losing our business if you don't give it to us,'" Cahn says. "The larger PBMs would have no choice but to change their business models, and the entire marketplace would enjoy far lower costs."

Contact Cahn at (973) 975-0900, McClurg through Mary Ann McCauley at mam@catalystcomm.net, Brandle at sbrandle@segalco.com and Hayes at susan.hayes@pharmout.com. To view the video, visit www.youtube.com/watch?v=H-4LJeyjR6E. ✧

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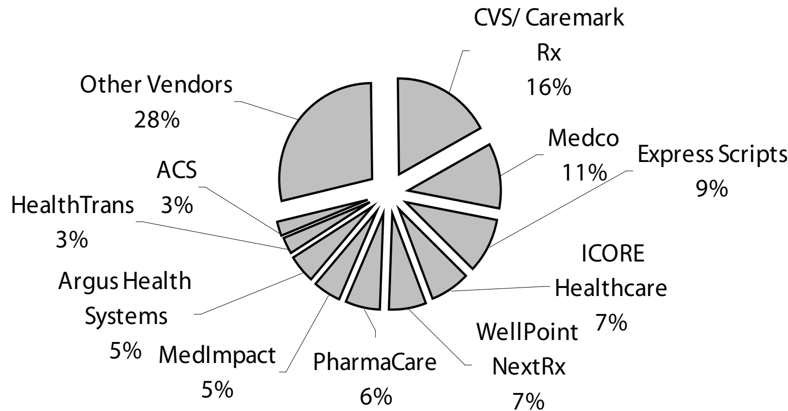
PBM Membership Is Growing, Concentrated in 10 Largest Firms

Total membership among PBMs has increased by 22% over the past five years. There are now about 550 million lives covered by PBMs and related types of vendors. While the AIS database, designed specifically for DBN, *is tracking 177 companies, the 10 largest firms represent 72% of all PBM business by membership, and the top three represent 37% of the total market.*

PBM Market Share by Covered Lives, 4Q2007



SOURCE: AIS's quarterly survey of PBMs and related companies, conducted exclusively for *DBN*.

Top 25 PBMs as Measured by Membership in 4Q2007 Compared With 4Q2002 Membership

PBM	Covered Lives		% Change	PBM	Covered Lives		% Change
	4Q2007	4Q2002			4Q2007	4Q2002	
CVS/Caremark Rx	95,000,000	24,566,484	286.71%	Health Information Designs	11,000,000	5,000,000	120.00%
Medco Health Solutions	60,000,000	65,000,000	-7.69%	Prescription Solutions	10,822,182	5,500,000	96.77%
Express Scripts/CuraScript	50,000,000	50,000,000	0.00%	Aetna Pharmacy Management	10,700,000	8,200,000	30.49%
ICORE Healthcare	38,000,000	NA	NA	First Health Services Corp.	10,000,000	12,500,000	-20.00%
WellPoint NextRx	36,000,000	32,259,618	11.59%	CIGNA Pharmacy Management	9,200,000	8,400,000	9.52%
PharmaCare Management Services	31,000,000	14,000,000	121.43%	NMHC	8,900,000	2,500,000	256.00%
MedImpact Healthcare Systems	27,000,000	24,000,000	12.50%	RxAmerica	7,965,730	4,700,000	69.48%
Argus Health Systems	25,000,000	24,000,000	4.17%	Walgreens Health Services	6,100,000	2,100,000	190.48%
HealthTrans	15,100,000	NA	NA	Catalyst Rx	5,000,000	276,168	1710.49%
ACS	14,000,000	10,000,000	40.00%	Sanovia Corporation	5,000,000	NA	NA
Prime Therapeutics	12,500,000	4,120,624	203.35%	BioScrip	4,656,614	9,000,000	-48.26%
RxStrategies, Inc.	12,000,000	NA	NA	RESTAT	3,300,000	2,000,000	65.00%
ScriptSave	12,000,000	NA	NA				

NA = Not applicable; company was not in existence or not participating in the survey in 4Q2002.
SOURCE: AIS's quarterly survey of PBMs and related companies, conducted exclusively for *DBN*.
METHODOLOGY: Latest available total covered-lives count, as reported by companies to AIS researchers during the quarter(s) indicated. Excludes companies that did not respond to this survey question (total number of covered lives is vastly greater than the U.S. population because members may be served by multiple vendors for various functions of the pharmacy benefit).
NOTE: AIS's PBM survey has been conducted by *DBN* every quarter since 2000. Additional data points address claims volume, mail order, specialty pharmacy, ingredient costs, costs by therapeutic category, copay levels, and claims per tier. A complete set of survey data (book plus CD) is now being sold on the AIS Web site at www.aishealth.com/Products/dru.html, or call customer service at (800) 521-4323.

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Member Education Seen as Vital For Specialty Rx Compliance, Costs

With a wave of new biologic drugs expected soon to hit the market, some health plans and pharmaceutical payers are seeking ways to ensure that members know exactly how to take these expensive therapies — and not waste millions of dollars on unused product or avoidable emergency-room visits. Patient training is a crucial component in compliance with specialty drugs, which can cost hundreds of thousands of dollars annually, executives tell *DBN*.

The need for effective training is compounded by the fact that infusible and injectable specialty drugs no longer are just for life-threatening or rare illnesses, says one vendor. Many of the new biologics in the pipeline are designed to treat chronic conditions, such as arthritis and allergies. These will require monthly or weekly applications for a lifetime, according to ActiveCare Network LLC, which operates a national network of clinics for biologic services.

By 2010, "chronic biologics" are expected to comprise half of all drug approvals and dramatically affect mainstream populations, notes ActiveCare Network. An effective training program up front can lessen the risks that patients either won't start on the medication or won't understand the importance of compliance, says Judi Grupp, president and CEO of ActiveCare Network.

"A lot of these people are taking injections for the first time other than the shots they got as a kid," Grupp tells *DBN* of patients starting on biologics. "It is very, very intimidating for these patients, and it's important to get patients started right the first time."

The financial stakes of noncompliance with biologics are significantly higher than with traditional oral

Level of Part D 'Dual-Eligible' Plan Switching Draws Scrutiny

Of the roughly 3.1 million Medicare Part D beneficiaries — or 12% of enrollees — who changed plans this year, approximately two-thirds were low-income individuals who were automatically reassigned so as not to have to pay a premium, according to CMS. One Medicare observer describes the level of switching among the "dual-eligible" Medicare-Medicaid population as "very high," but adds that the overall Part D enrollment figures show just how loyal most beneficiaries are, especially given that the largest Part D sponsors significantly raised premiums in 2008.

Roughly 2.1 million low-income subsidy (LIS) beneficiaries switched to new Part D plans in 2008 because their existing plans submitted bids that exceeded CMS's benchmark for determining which plans get assigned LIS beneficiaries. About 6% of all non-LIS beneficiaries also switched Part D plans in 2008, "a level that is consistent with changes made during health coverage open enrollment periods in the private sector," CMS said.

Dan Mendelson, president of consulting firm Avalere Health LLC, describes the LIS member switching as "stunning and unprecedented." "It is going to be very important for CMS to monitor the health effects associated with this to make sure there is good continuity of care for the beneficiaries that have been forced to switch," he tells *DBN*.

For its part, CMS already is considering mechanisms to prevent that level of switching in the future, Mendelson says. Lawmakers also are taking notice. "There is sufficient concern in the Congress that they would push [CMS] along to prevent that level of switching if they thought that was possible," according to Mendelson.

CMS on Jan. 7 issued a proposed rule that aims to reduce the number of LIS beneficiaries who must be randomly reassigned by allowing stand-alone Medicare Prescription Drug Plans to offer a reduced premium amount for LIS-eligible individuals starting in 2009 *(DBN 1/18/08, p. 4)*.

On the flip side, Part D sponsors that raised premiums have not appeared to lose other beneficiaries, Mendelson adds. "The three largest plans raised their prices by 27% this year," he explains. "They made a practicable calculation that increasing the premiums by a significant percentage would not result in an outflow of beneficiaries, and they were right. There is a remarkable stickiness to this population."

Among CMS's other findings for 2008: About 90% of the 44 million Medicare beneficiaries have drug coverage from Medicare or another source. Roughly 25.4 million are enrolled in Part D, and 6.6 million retirees are enrolled in employer or union-sponsored retiree drug coverage that qualifies for the Retiree Drug Subsidy.

For information on 2008 Part D enrollment, visit www.cms.hhs.gov/PrescriptionDrugCovGenIn/01_Overview.asp. Contact Mendelson at dmendelson@avalerehealth.net.

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medications. Biologics used to treat chronic conditions, for example, can cost up to $400,000 per patient per year, according to ActiveCare Network.

Meanwhile, more and more of these products are being taken in the home. Roughly 70% of the new specialty drugs in the pipeline require "clinical oversight," while the other 30% are labeled for self-injection, says Grupp. "Of the drugs that require clinical oversight, you're still going to get some of that administered in the home, either with a care partner or by themselves," she says.

Quality of Training Varies in Industry

Because many payers today do not reimburse for training patients, physicians now generally forward specialty prescriptions directly to specialty pharmacies. The training component can get lost in the translation, Grupp says.

Many biologics manufacturers have stepped in to address the need by hiring home-care agencies — or companies such as ActiveCare Network that have clinics — to train patients who are starting on the drugs, she says. ActiveCare Network's training includes providing additional information about the therapy and the condition itself, how to properly handle and store the product, and how to self-administer the drug, Grupp says.

This training is provided at no cost to the patient, and is generally paid for by the manufacturer, she adds.

There is, however, a lack of consistency in how vendors provide training, she contends. While home-care agencies are sending nurses into homes, the nurses themselves may not be familiar with the new drug or device, Grupp explains. "They are learning together. That is not very comforting." By contrast, ActiveCare, which has more than 2,000 national clinics, ensures that every nurse who sees a patient is trained on the particular drug or device.

Others say the increased workload in most doctors' offices is squeezing the time that physicians and nurses traditionally used for training patients. At the same time, specialty pharmacies are facing cost pressures from payers, says Tom Solberg, associate vice president for specialty pharmacy at PBM Prime Therapeutics LLC, which is owned by 10 Blue Cross and Blue Shield plans across the country.

"One of the ways that specialty pharmacies take costs out of the system is to cut [down] on support services," he says in an interview with *DBN*. "We don't like to see that trend because we believe that will ultimately drive costs up, not down."

Solberg also agrees that the quality of patient training varies across the industry. "Most specialty pharmacies have some support component, but there is clearly a difference between the really good ones and the less aggressive or sophisticated ones," he says.

Prime's specialty Rx division is preparing the "next generation" of its specialty program in mid-2008 that will feature a "significantly enhanced" clinical support and education component. Among other things, the program also will use a "dynamic support model," which would vary the level of clinical support depending on the drug and condition. "You want to make sure you provide an appropriate amount of support, but that you don't over-support where there is no value," Solberg adds.

Contact Grupp through Kenneth Li at kli@chempetitive.com and Solberg through Jenna Elving at jelving@primetherapeutics.com. ✧

More Smoking-Cessation Rxs Hit Market; Plan Coverage Is Growing

About this time of year, thousands of cigarette smokers who made New Year's resolutions to kick the habit are realizing that willpower alone is not enough to do the job. Recognizing the limits of human nature — and eyeing a market opportunity — pharmaceutical firms are set to introduce a batch of new prescription smoking-cessation therapies. Health plans and PBMs tell *DBN* they increasingly are offering coverage of smoking-cessation therapies, whereas they did not just a few years ago.

The smoking-cessation market is still dominated by over-the-counter therapies, according to a new market report on the products. Nicotine-replacement gums and patches had sales of more than $2 billion in 2006 in major global markets, says a Jan. 25 report by market research firm Datamonitor. The market for Rx smoking treatments, however, is growing exponentially, the report states.

Prescription nicotine-dependence drugs generated sales of just $213 million in 2006, Datamonitor says. The market is expected to grow at a compounded annual rate of 16% to $4.6 billion by 2016, it adds. Two drugs today dominate the Rx tobacco-cessation market, the report says: GlaxoSmithKline's Zyban (bupropion) and Pfizer Inc.'s Chantix (varenicline).

Approved by the FDA in May 2006, Chantix had U.S. sales of $202 million in the fourth quarter of 2007, up from $68 million in the same quarter the previous year, Pfizer said in a Jan. 23 earnings report. But future sales growth could be dampened by the FDA's Jan. 31 warning that it is "increasingly likely" Chantix may be linked to serious psychiatric symptoms, such as suicidal thinking.

Meanwhile, other smoking-cessation treatments are set to hit the market soon. Datamonitor said it expects the launch of two promising nicotine vaccines in 2010 and 2012, respectively: Nabi Biopharmaceuticals' NicVAX and Novartis' NIC-002.

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Achieving reimbursement for a new smoking-cessation drug is unlikely to be difficult, the report concludes. "Health care payers…should be willing to approve such drugs owing to the long-term savings accrued from reducing the incidence of smoking-related illnesses," Datamonitor says.

More Plans Pay for Smoking Cessation

Indeed, although payers once considered them lifestyle drugs that were not covered by insurance, health plans increasingly are paying for anti-smoking treatments.

Coverage of any tobacco dependence treatment increased from 25% of health plans in 1997 to 88% of plans in 2003, according to the most recent survey by America's Health Insurance Plans (AHIP) trade group, which polled 160 HMO plans representing more than 60 million members. "Given the survey date, we expect that there is widespread coverage for smoking-cessation therapies driven by the best available medical evidence on therapies that work," says AHIP spokesman Mohit Ghose.

Blue Cross and Blue Shield of Florida (BCBSF), for one, covers prescription smoking-cessation products through a rider, says Beckie Fenrick, Pharm.D., director of clinical pharmacy programs at the plan.

"Smoking-cessation coverage has evolved over time as have the prescription drugs available," she tells *DBN*. "Some older products have a lower smoking-cessation success rate with a less durable response. Newer products such as Chantix produce a response in more, but still not all patients." Some insurers cover Rx smoking-cessation products either as standard coverage or through a rider, Fenrick says. Others treat smoking cessation as a standard exclusion. The cost of BCBSF's smoking-cessation rider, which is proprietary, is actuarially determined based on factors such as the employer group's size, makeup and likely use of the program, according to the insurer.

Aetna, Inc. also covers smoking-cessation products for plan sponsors that purchase the smoking-cessation rider, says Ed Pezalla, M.D., national medical director for Aetna Pharmacy Management. Using these products produces varied success rates, compared with simply a motivated person who has chosen to quit smoking, he says.

"Success increases when a patient behavioral support program is part of the solution," he says. "Aetna offers a support program called Quit Tobacco, and plan sponsors that want coverage of smoking-cessation products are encouraged to include the patient behavioral support program," Pezalla adds.

AHIP says that clinical interventions to reduce smoking provide a positive return on investment within two to three years for plans and immediate savings for employers.

Contact Fenrick through Valerie Rubin at (904) 905-5315 and Pezalla through Katie Vukas at vukask@aetna.com. ✧

More Plans Start Zero-Copay Efforts

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Tran also cautions about simply giving drugs away for free. "The value of that drug will be diminished, because anything free in the long run will have little value," he says. Copay-waiver incentives, in fact, should be a short-term solution for encouraging utilization, Tran says, adding that plans need to do a better job of educating members on the value of Rx compliance.

"If the member feels that the medication they are taking is essential, you could raise [copays] $4, $10, and they'll still see the benefit of taking my drug. I'd rather pay $10 a month than to have my diabetes worsen and I lose my vision and I lose my feelings in my legs and my big toe amputated," Trans says as an example. "If they don't see the value of why they're taking their drugs or disease states, they're going to see a dollar increase in copays as a burden and not take them."

Still, several plans have rolled out zero copays recently as part of an effort to lower financial barriers and boost compliance. Blue Cross and Blue Shield of North Carolina offered a program starting Jan. 1 that waived copays on all generic drugs that treat congestive heart failure, high blood pressure, high cholesterol and diabetes *(DBN 1/4/08, p. 1)*. And Prescription Solutions, a PBM division of UnitedHealth Group, instituted a zero-dollar copay program starting in 2008 for generics purchased by mail under the Medicare Part D plan.

Lower consumer costs, Prescription Solutions says, will help shift member usage toward generic dugs, and will delay or help avoid members falling into the Part D coverage gap, which in 2008 begins when total drug spending reaches $2,510 and ends when out-of-pocket expenses reach $4,050. Brian Solow, M.D., medical director for clinical programs at Prescription Solutions, says the evidence shows copays are a barrier to some members. "There is no doubt that with lower costs there is gong to be better adherence," he says.

The Effect of Wal-Mart's $4 Generics

Another health plan-owned PBM doesn't recommend zero copays, but does suggest keeping generic copays at $10 or under. Prime Therapeutics, LLC recommends implementing a differential of $20 between the first and second tiers as a way to drive utilization of generics, says Christine Solberg, Pharm.D., assistant vice president of clinical products and benefit strategy at the PBM, which is owned by 10 Blues plans. Prime recommends that copays for the third tier range from $50 to $100, she says.

Like HCSC, Prime also is getting a lot of questions about zero copays, but only a handful of sponsors are

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moving on it in 2008, Solberg says. Meanwhile, the PBM also continues to field queries about the pricing effects of Wal-Mart's $4 generic program, which the retail giant implemented with much fanfare in September 2006 *(DBN 9/22/06, p. 8)*. "That is part of our thinking in keeping that generic copay $10 or less," she adds.

Wal-Mart last fall expanded its program to include 361 generics. Other retailers have matched the program.

Louis Brunetti, M.D., medical director of PBM MedImpact Healthcare Systems, Inc., says Wal-Mart's program has slowed the movement to increase consumers' costs on generics. "The impact is that it has had a moderating effect on the costs of generics, and in some cases has pushed some of our clients to keep the generics low or lower them even more," he says.

Brunetti says MedImpact's clients are keeping generic copays stable, while boosting preferred and non-preferred brands. But just as lower copays can incentivize patients to start or remain on therapy, higher copays can have the opposite effect, he says. MedImpact released a study in 2007 that found a $10 increase in copays reduced compliance by roughly 10%.

Still, he adds, other non-financial factors also affect compliance. "We found that an individual who is already poorly compliant was more affected by increased copays," Brunetti says. "Individuals who had good compliance were less affected, and were willing to suck up the copay increase and stay on their medications."

Contact Solberg through Jenna Elving at jelving@primetherapeutics.com and Brunetti through Gayle Griffithe at gayle@iacunato-mclane.com. ✧

NEWS BRIEFS

◆ **PBM National Medical Health Card Systems, Inc. (NMHC) on Feb. 7 reported net income of $759,000 in the 2008 fiscal second quarter, which ended Dec. 31, 2007, down from $1.5 million in the previous year's period.** The company said profits declined in its PBM segment but rose in its specialty segment. Revenue decreased 15.3% to $168.9 million from $199.3 million. The revenue drop is primarily the result of a 20% reduction in prescriptions related to a 25.7% decrease in the number of covered lives, the company said. This figure was partially offset by an increase in the gross revenue per prescription. Contact Stuart Diamond at sdiamond@nmhc.com.

◆ **Medco Health Solutions, Inc. on Feb. 12 said that it had launched a pilot program to help physicians of Medicare Part D patients switch from handwritten to electronically generated prescriptions.** The pilot includes 500 physicians now treating enrollees in the Medco Medicare Prescription Plan, the company said. Working with RxNT, a vendor of e-prescribing technology, Medco will provide participating physicians with free RxNT e-prescribing software and training. Over a six-month period, the physicians' rate of generic drug dispensing, formulary compliance and generated safety alerts will be compared with a control group of 500 doctors who did not receive e-prescribing software or training, Medco said. Ultimately, 2,000 doctors will participate in the e-prescribing program, it added. Contact Jennifer Luddy at Jennifer_Luddy@medco.com.

◆ **HealthTrans LLC on Jan. 30 said that it had won a new PBM contract with Colorado Springs Utilities (CSU).** The three-year contract covers roughly 5,000 beneficiaries, who account for about $3 million in annual drug spending. Other contract terms were not disclosed. The Colorado firm had been receiving its PBM services from Walgreens Health Services. HealthTrans CEO Jack McClurg says CSU was "looking for a lot higher level of service, a lot higher touch for its employees." Among other things, he adds, HealthTrans is participating in CSU's benefit fairs, quarterly meetings and member education seminars. Contact McClurg through Mary Ann McCauley at mam@catalystcomm.net.

◆ **CVS Caremark Corp. and Universal American Corp. said on Feb. 13 that they would end their Medicare Part D strategic alliance on Dec. 31, 2008, subject to regulatory approvals.** Since 2006, Universal American has offered Medicare Part D services through its Prescription Pathway stand-alone Prescription Drug Plan (PDP) in conjunction with Caremark Pharmacy Services, a subsidiary of CVS Caremark. SilverScript Insurance Co., which is CVS Caremark's PDP, and Universal American will divide Prescription Pathway's roughly 550,000 members equally, the companies said. "As we approach the end of the initial 3-year term of our joint venture, and in light of CVS' merger with Caremark, we decided to consolidate our Part D business under our SilverScript PDP," Tom Ryan, chairman, president and CEO of CVS Caremark, said in a prepared statement. Contact Eileen Howard Dunn of CVS at (401) 770-4561.

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