

DRUG BENEFIT NEWS

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

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CVS Caremark's 29-State Legal Settlement Curtails 'Drug Switching,' Leaves Questions

The \$41 million settlement that CVS Caremark Corp. agreed to pay to resolve a 29-state lawsuit alleging deceptive business practices in a drug-switching program will force Caremark to be "more transparent" in its communications with clients, physicians and patients, according to state attorneys general (AGs). The PBM denied any wrongdoing and said its business practices would not be significantly changed by terms of the Feb. 14 settlement.

One industry consultant tells *DBN* that the settlement does a good job of stopping certain drug-switching practices, but leaves a host of other problems on the table, including not passing through payments by manufacturers to PBMs for claims data.

The new CVS Caremark deal — which follows a similar 2004 settlement by Medco Health Solutions, Inc. — involves the alleged activities of Caremark Rx, LLC and two of its subsidiaries: Caremark, LLC and CaremarkPCS, LLC, formerly Advance PCS. CVS acquired Caremark in March 2007 (*DBN* 4/6/07, p. 3).

According to the settlement, the states contend that Caremark engaged in deceptive business practices by encouraging doctors to switch patients to different prescription brand drugs, on the representation that patients and/or the health plans would save money. However, Caremark did not clearly disclose to its clients that rebates

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As Rx Costs Rise, Some PBMs, Health Plans Seek to Improve Interactions With Doctors

With prescription drug spending expected to rise steeply again after a period of modest Rx price growth, some health plans and PBMs are stressing the need to work closely with a key health care stakeholder: physicians.

PBM and plan pharmacy executives contacted by *DBN* say developing a collaborative relationship with doctors is crucial to maximizing their members' pharmacy benefit, which can improve clinical outcomes and rein in costs. Pharmacy executives contend that their goal is to make drug management tools, such as prior authorization and step therapies, as seamless as possible with doctors. Some plans and PBMs also are taking a proactive approach with doctors, discussing therapeutic alternatives with high prescribers and adopting pay-for-performance (P4P) incentives around the Rx benefit.

Doctors say they have long grown accustomed to working with PBMs and health plans to resolve drug formulary issues. But a community pharmacist, who interacts with both physicians and PBMs, contends that the number of prior authorizations (PAs) has soared in recent years, causing increased headaches for both pharmacists and doctors' offices.

Meanwhile, drug spending is expected to accelerate in the coming years, reaching almost \$515.7 billion in 2017, more than double the \$231.3 billion projected for 2007, according to a study published Feb. 26 in the journal *Health Affairs*.

continued

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One PBM executive acknowledges his industry's relationship with physicians has had challenges.

"Historically doctors would probably love nothing more than to take a patient and give a prescription and have the patient go to the pharmacy, and that would be the end of it," says Brian Solow, M.D., medical director for clinical programs at Prescription Solutions, a PBM division of UnitedHealth Group.

"Physicians in the past have seen PBMs as maybe interfering with the practice, but now they understand that [PBMs are] here and here to stay," he tells *DBN*. "We're trying to get the word out that the PBM is there to maximize the patients' benefit, which hopefully in turn will make the physician's life easier by helping the patient control their disease and get the proper medications. The trick is how to do that and get that word out."

Solow, a practicing physician for 20 years who recently joined Prescription Solutions, says anything that

makes the physician's life harder is seen as a negative, including delays in adjudicating a PA. At Prescription Solutions, he says, the process takes a matter of minutes. "Other PBMs have a mandatory fax, which you will not hear [back from] for 24 to 36 hours. But ours is adjudicated very quickly," he asserts. "My goal is to make us the most physician-friendly PBM. We're reaching out doctor to doctor."

Jasmine Moghissi, M.D., who runs a family medical practice in Fairfax, Va., says dealing with PAs is time consuming. The process, she adds, differs among the dozen health plans and PBMs that cover her patients. "Sometimes you have a form to fill out, other times you have to call," Moghissi says, adding that a telephone call is not always the most efficient method. "Calling is always potentially problematic, because it depends on how long you're on hold," she says.

Moghissi notes that drug representatives and, less frequently, health plans will visit to discuss certain drugs and where they fall on a formulary. "In primary care, I deal with so many drugs and so many insurance companies, that [it] doesn't do me any good to have them come in," she says. "You just sort of pick [a drug], hope it flies, and if it doesn't, somebody has to deal with it."

Reaching Out to MDs, Implementing P4P

BlueCross BlueShield of Tennessee (BCBSTN) says it works closely with physicians in its network to lower Rx spending. The plan has six clinical pharmacists across the state that visit between 35 and 40 doctors each month to discuss prescribing alternatives.

"We're taking a play from drug companies," Terry Shea, Pharm.D., director of pharmacy management at BCBSTN, says in an interview. "These pharmacists go out and visit our high-writing prescribers, and bring to them copies of our preferred drug lists [and] information about their patients who are Blue Cross members. We can show them a member who is on a brand when generics have just been released. So the physicians know when these things are happening."

Shea doesn't rule out the possibility of a P4P indicator around the pharmacy benefit in the future. There are some Healthcare Effectiveness Data and Information Set (HEDIS) measures for prescription drugs, including the use of angiotensin-converting enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs) in diabetics with kidney dysfunction, and the use of beta blockers, aspirin and cholesterol-lowering drugs after a heart attack, he says.

A P4P program around such Rx measures would present unique challenges, Shea acknowledges. "Physicians will say, 'I don't know why you can stratify me on that drug. I wrote the prescription, [but the patient] just

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never went and got it filled,'" he says, adding there would have to be some "give and take" around this measure.

The implementation of a P4P program around pharmacy, in fact, would be another good reason for doctors to move toward electronic prescribing, Shea says. "We could measure whether [the doctor] wrote that prescription and [the patient] did not get it filled," he explains. "We can intervene and talk to [the patient] and say, 'You know, your doctor wrote that prescription and you didn't get it filled. Is there a reason why not?'"

On the other hand, Shea says that BCBSTN wants to stay clear of controversial P4P programs that offer doctors a cash payout for prescribing certain drugs. *The Wall Street Journal* in January reported that some health plans are drawing scrutiny for paying doctors \$100 each time they switch a patient from Pfizer Inc.'s cholesterol-lowering drug Lipitor (atorvastatin) to a generic alternative. The P4P initiative BCBSTN is proposing "looks at adding a factor to their fee schedule, so it is across the board, and not just every time they write a generic they get a \$5 check or something like that," Shea says.

Pharmacist Sees Spike in PAs

Meanwhile, one pharmacist contends PBMs' administrative regulations are getting more onerous. "The prior-authorization process was kind of rare a few years ago, with a few drug classes," says David Shirley, Pharm. D., pharmacy manager of an independent pharmacy in Charleston, S.C. "It now is becoming a complete bottleneck in community pharmacy and the physicians' offices," he tells *DBN*.

Shirley asserts that even some very inexpensive generics are now facing PA. "I know certain, more expensive drugs are covered, and cheap generics aren't," he said, declining to name the PBM in those restrictions. "The only explanation I can come up with is there's got to be some kind of back-door deal making going on." He argues that PBMs should become more transparent in their pricing, and offer an explanation as to why certain low-cost drugs are facing PA.

Furthermore, resolving a PA can take days, Shirley adds. But not all PBMs provoke Shirley's wrath. "A few have done a good job," he says. "I called a company on behalf of a patient [for a] prior authorization. The physician needed to be contacted to switch a patient," he recalls. "The PBM said, 'We'll call the physician and patient for you, and we'll call you back when it's done. My chin fell to the floor. That was the first time in hundreds of calls that that happened.'"

Contact Shea through Scott Wilson at scott_wilson@BCBSTN.com and Solow through Brenna Harrington at brennaharrington@bellsouth.net. ♦

FTC Clears Kaiser's Rx Model in Proposed Fee-for-Service Plan

The Federal Trade Commission (FTC) has cleared the way for Kaiser Foundation Health Plan, Inc. to use its not-for-profit status to purchase discounted pharmaceuticals as part of a proposed fee-for-service health benefit for self-insured employers. According to a Feb. 13 advisory opinion from the FTC Bureau of Competition, the use of discounted drugs in this program would not violate federal rules prohibiting anticompetitive pricing.

The issue centers on whether Kaiser's proposed plan falls within the Non-Profit Institutions Act (NPIA) exemption to the Robinson-Patman Act, according to FTC. The Robinson-Patman Act prohibits price discrimination in the purchase and sale of certain commodities — including pharmaceuticals — where the effect could lessen competition or create a monopoly, the FTC explained. Under NPIA, eligible nonprofit entities (i.e., schools, churches and hospitals) may purchase supplies at reduced prices for the nonprofit institutions' "own use" without running afoul of the Robinson-Patman Act's prohibitions, FTC said.

Kaiser, a not-for-profit organization that provides health coverage to roughly 8.5 million members mainly through an HMO, has been found to be an eligible entity under NPIA, according to FTC. Kaiser members can purchase drugs at discounted rates at Kaiser hospitals or at non-hospital pharmacies operated by Kaiser affiliates, FTC added.

"To meet what it sees as changing needs in the markets...Kaiser proposes to offer the same set of services it offers to its HMO members to persons covered under

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self-insured health benefits plans offered by employers," the FTC letter stated.

Kaiser says the opinion simply clarifies an outstanding issue affecting its efforts to respond to employers' requests to provide quotes for self-funded financing of benefits. "Many employers in the market have demonstrated a significant preference for self-funding of health care expenses rather than purchasing coverage on a fully insured basis, as we have offered exclusively in the past," Mitch Goodstein, senior vice president of health plan pricing and provider contracting at Kaiser, tells *DBN*.

Under the proposed program, FTC said, Kaiser would bill self-funded employers for pharmaceuticals at "market-rate prices," and not at the NPIA-discounted prices. "The difference between what Kaiser pays for the NPIA-discounted pharmaceuticals and what it takes in by being reimbursed for the drugs from the self-funded plans at market prices will be kept by Kaiser and used to lower its overall operating expenses, thereby potentially benefiting all Kaiser members and enrollees," FTC said.

Markus Meier, assistant director of the Health Care Services and Products Division of the FTC's Bureau of Competition, said in the advisory opinion letter that Kaiser's proposed program would fall within the NPIA. That is because:

(1) Kaiser previously had been held to be an "eligible entity" under the NPIA;

(2) Its drug purchases under the proposed program appear to be for Kaiser's "own use" in that they will further Kaiser's intended institutional function; and

(3) All the savings earned through the use of the NPIA-discounted pharmaceuticals will accrue only to Kaiser, and not to the self-insuring employers.

But Meier also said Kaiser's proposed plan raised some concerns.

"If for-profit employers, or other customers that themselves were not eligible entities under the NPIA, were to contract with Kaiser under the proposed program and be charged only the NPIA-discounted costs of pharmaceuticals provided to their employees under the program, in our opinion, this would disqualify the ar-

SXC Health Agrees to Acquire NMHC for \$143 Million

PBM SXC Health Solutions Corp. said it agreed to acquire National Medical Health Card Systems, Inc. (NMHC) in a cash and stock deal worth roughly \$143 million. The acquisition is expected to close in the second quarter of 2008, and is subject to various closing conditions and regulatory approvals, the companies said in a Feb. 26 joint statement.

NMHC has 300 clients and 2.3 million lives under management, SXC said. A securities analyst tells *DBN* that NMHC will account for the majority of covered lives under the combined company. After closing, SXC said, the company's competitive position will center on an "innovative mix of market expertise, information technology, clinical capability, scale of operations and mail order and specialty pharmacy offerings." SXC also said it expects annual cost savings of between \$12 million and \$14 million beginning in the second year after the deal closes.

NMHC has been struggling in recent years. On Feb. 7, NMHC 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 (*DBN* 2/15/08, p. 8). Revenue decreased 15.3% to \$168.9 million from \$199.3 million. NMHC attributed the revenue decline to a 20% reduction in prescriptions related to a 25.7% decrease in the number of covered lives.

Tom Erickson, chairman and interim CEO of NMHC, says in a prepared statement that the combination with SXC enhances NMHC's capabilities with "advanced technology, new clinical programs, an expanded customer service organization, and increased financial flexibility."

Paul Steep, a securities analyst at Scotia Capital Inc., says SXC's purchase of NMHC represents a move to significantly expand SXC's PBM offerings. Most significantly, it adds "scale to the firm's PBM initiatives with acquired capabilities around mail order and pharmaceutical services (e.g., clinical management and specialty services)," he writes in a Feb. 27 research note.

"We believe that NMHC's financial results for the past two years reflect a series of operational challenges resulting from the 2005 acquisition of Pharmaceutical Care Network (PCN)," Steep writes. "Over the past several years, NMHC has experienced the loss of two major clients (i.e., Mohawk Valley Physicians Plan and CalOptima) along with the fall-off of a number of unprofitable high volume transaction contracts that PCN had signed prior to the acquisition by NMHC," he says.

Contact Jeff Park, SXC's chief financial officer, at investors@sx.com; Stuart Diamond, NMHC's CFO, at sdiamond@nmhc.com; and Steep at paul_steep@scotiacapital.com.

rangement from eligibility for the statutory exemption," he stated in the letter.

"In that case, the savings from the discounted purchases would directly benefit entities not eligible for the NPIA-authorized discounts, and the purchases more properly would be characterized as for the employers', rather than Kaiser's, 'own use,'" Meier said.

But Meier also noted that Kaiser has stated that drugs provided to enrollees under the proposed program will be billed to the self-funded employers at market prices.

Carl McDonald, a securities analyst at Oppenheimer & Co., says he doesn't view Kaiser's move into the self-funded market as a significant threat to the existing plans. The drug angle is interesting from a marketing perspective, he adds. "But the issue here is that drug costs only account for 15% of total medical costs," McDonald tells *DBN*. "So even if Kaiser were able to achieve a 10% discount, this translates into a relatively modest impact on overall costs. Keep in mind, too, that Kaiser has fewer than 10 million lives, so its negotiating power probably isn't as great as [UnitedHealth Group, WellPoint], or any of the stand-alone PBMs."

Contact the FTC public affairs office at (202) 326-2180 and McDonald at carl.mcdonald@opco.com. To read the FTC's advisory opinion, visit www.ftc.gov/opa/2008/02/npia.shtm. ↔

More PBMs Tout 'Drug Mix' as One Rx Consultant Urges Scrutiny

More and more PBMs are touting their ability to improve a client's "drug mix" as a means of lowering pharmaceutical spending. Some pharmacy-benefit executives, for example, say that generic drugs should account for at least 70% of an employer's or health plan's drug mix, which measures the overall utilization of generics, brand drugs and lower-cost brands. But some experts also urge pharmaceutical payers to scrutinize the fees that PBMs may want to charge as part of their pitch to guarantee a better mix.

The generic fill rate (GFR) is the most important performance metric in drug mix, according to Jake Cedergreen, senior director of market intelligence at Express Scripts, Inc. GFR measures the percentage of total drug claims filled with generic prescriptions, he told a Feb. 13 AIS audioconference on the topic. "The higher it is, the lower the overall drug spend," he said.

Just how high can GFR go? Most plans today that have a 60% GFR could go as high as 75%, Cedergreen contended. Some Medicaid plans can go as high as 80%, he noted.

"But for the most part, on average, 75% is a realistic achievement while maintaining clinical quality without

cost shifting," Cedergreen said. "Every 1% [increase] in generic fill rate means about a 1% decrease in cost. Plans have an enormous opportunity to reduce their prescription drug costs by 15% or more."

How PBMs Influence Drug Mix

PBMs that can influence patients to take advantage of generics have a lot of value to offer, Cedergreen said. There is a variety of ways to do this, including through aggressive Rx management. "Some programs like step therapy, while very impactful, may not be right for every employer," he said. "The good PBMs are working on ways of moving that market share toward generics without putting harsh programs in place. We're talking mostly of patient education programs."

But such education programs aren't free. "It takes a lot of administrative costs to go into generic promotions," Cedergreen said. "Generic promotional activities are not funded by pharma. These are purely and completely funded by the PBM. The value that can be had by the client far exceeds the value that can be received by the PBM."

For example, he said, PBM A may charge a \$2 "claim administration fee" and provide a rebate guarantee of \$3.38 per prescription, while also guaranteeing a generic fill rate of 60%. The total cost per prescription under this pricing methodology comes to \$70.55, he said. On the other hand, PBM B may charge a higher \$3 claim administrative fee and offer a lower rebate guarantee of \$3.06 on prescriptions, while guaranteeing a generic fill rate of 63%, he said. "The result of this is an expected cost per script of \$66.72, which is significantly lower than the competition," said Cedergreen, who adds that "it is critically important to incorporate these things in the pricing."

Tim Watson, Pharm.D., principal of Pharmaceutical Strategies Group, said that "payers are 100% on board that this drug-mix thing is real." What they're looking for is "a balanced approach between how the strategy is to be driven, and who is to execute what portions of the intervention approaches to achieve the desired results," he told the AIS audioconference.

A "shared-savings platform" is one approach that PBMs increasingly are pitching, Watson said. "PBMs want to be rewarded for programs that can increase generic use, because it is expensive to develop interventions," he explained.

"On the other hand — at least for those [PBMs] that own their own mail-order facility — every generic that goes through there they're already earning additional margins on," Watson said. "I don't feel like you should have to double-dip if the [generic] migration is going already, and you're earning more margins."

continued

The question payers should ask is where the natural generic migration is going versus what a PBM can offer, Watson explained. If the PBM is developing a specialized communications platform that will demonstrate some additional value, then it's fair for the PBM to ask for compensation. Watson said that he prefers this to be on a fee-for-service basis, and not a shared-savings or shared-reward type basis.

The value of establishing an effective drug mix with high generic utilization was echoed by Helen Sherman, Pharm.D., director of pharmacy services at RegenceRx, the PBM of The Regence Group, which operates Blue Cross and Blue Shield plans in the Northwest.

She laid out a real-life example of a 500,000-member plan that used 4.5 million prescriptions per year. A ge-

neric cost \$18.50, while a brand cost \$134.75, including all discounts and rebates, she told the AIS audioconference. The total annual cost of a 60% generic utilization rate was \$292.5 million, while a 65% generic rate was \$266.3 million, and a 70% generic rate was \$240.2 million. The savings between a 60% and 70% generic utilization rate is \$52.3 million. "Each 5% increase is a significant difference in lower total annual costs," Sherman said.

Contact Cedergreen through Rita Holmes-Bobo at rholmesbobo@express-scripts.com; Watson at twatson@psgconsults.com; and Sherman through Samantha Meese at sxmeese@regence.com. ✧

To purchase a CD of AIS's Feb. 13 audioconference on drug mix, please call (800) 521-4323 or visit www.AISHealth.com.

Medicare Part D Stand-alone Prescription Drug Plan (PDP) Enrollment, January 2008 vs. November 2007*

PDP Sponsor	November 2007 Pre-Open Enrollment	January 2008 Post-Open Enrollment	Change	January PDP Market Share
UnitedHealth Group, Inc.	4,696,799	4,107,622	-589,177	23.6%
Humana Inc.	3,458,903	3,167,297	-291,606	18.2%
Universal American Corporation	1,643,593	1,848,277	204,684	10.6%
WellPoint, Inc.	1,229,432	1,373,337	143,905	7.9%
WellCare Health Plans, Inc.	982,559	1,006,493	23,934	5.8%
Coventry Health Care, Inc.	722,046	850,018	127,972	4.9%
CVS Caremark Corporation	361,484	533,636	172,152	3.1%
Health Net, Inc.	368,121	529,140	161,019	3.0%
Longs Drug Stores Corporation	249,433	441,181	191,748	2.5%
Medco Health Solutions, Inc.	314,833	415,259	100,426	2.4%
Aetna, Inc.	309,893	362,335	52,442	2.1%
CIGNA Corp.	320,021	335,704	15,683	1.9%
Health Care Service Corporation	321,506	324,679	3,173	1.9%
Blue Cross and Blue Shield of Minnesota	343,339	322,334	-21,005	1.9%
HealthSpring, Inc.	139,212	254,810	115,598	1.5%
Torchmark Corporation	166,451	151,968	-14,483	0.9%
Bravo Health, Inc.	53,739	134,396	80,657	0.8%
Highmark Inc.	131,223	105,526	-25,697	0.6%
Emblem Health Inc.	115,150	95,209	-19,941	0.5%
Blue Cross and Blue Shield of Florida	69,114	69,125	11	0.4%
Top 10 PDP sponsors	14,027,203	14,272,260	245,057	82.0%
Top 20 PDP sponsors	15,996,851	16,428,346	431,495	94.4%
All Other PDP sponsors	1,242,257	981,628	-260,629	5.6%
Total Enrollment in PDPs	17,239,108	17,409,974	170,866	100.0%

*Includes beneficiaries enrolled in employer/union only group plans. Does not include lives in plans with less than 10 enrollees.
SOURCE: Avalere Health LLC analysis, released February 2008, of CMS data from November 2007 and January 2008.

PBM Settlement Forces Transparency

continued from p. 1

earned from the drug-switching process would be retained by Caremark and not passed directly to the client plan, the settlement states.

"Caremark was operating against their clients' interest by retaining rebates and discounts that they were obligated to pass onto their clients," Pennsylvania AG Tom Corbett (R) said in a prepared statement. "This agreement stops the deceptive business practices and takes the necessary steps to protect health plans and patients."

The states' complaint also contends that Caremark restocked and reshipped previously dispensed drugs that had been returned to its mail-order pharmacies as undeliverable.

For its part, CVS Caremark on Feb. 14 noted the investigation began in 2004 and is similar to multistate consumer-protection investigations of other major PBM companies.

In entering the settlement, CVS Caremark's subsidiaries "have expressly denied any and all allegations, and there has been no finding of wrongdoing or inappropriate business conduct on their part," the company said in a prepared statement. "The mutually agreed consent order requires AdvancePCS and Caremark to maintain certain PBM business practices and will not result in significant changes to current business practices," it added.

CVS Caremark also said the amounts to be paid "were previously accrued for by legacy Caremark in prior fiscal periods, so the settlement will not affect the 2008 financial results of the company." CVS declined *DBN's* request to comment on details of the settlement.

Among other things, the settlement prohibits Caremark from soliciting drug switches when:

- ◆ *The net drug cost of the proposed drug exceeds the net drug cost of the originally prescribed drug;*
- ◆ *The cost to the patient will be greater than the cost of the originally prescribed drug;*
- ◆ *The originally prescribed drug has a generic equivalent, and the proposed drug does not; or*
- ◆ *The originally prescribed drug's patent is expected to expire within six months.*

The settlement also requires Caremark to:

- ◆ *Inform patients and prescribers what effect a drug switch will have on a patient's copayment;*
- ◆ *Inform prescribers of Caremark's financial incentives for certain drug switches;*
- ◆ *Refrain from making any claims of savings for a drug switch to patients or prescribers unless Caremark can substantiate the claim; and*

- ◆ *Refrain from restocking and reshipping returned drugs unless permitted by applicable law.*

The deal is the latest in a series of large PBM settlements, including Medco's \$29.3 million deal in April 2004 with 20 states to settle complaints of drug switching. Similar to the CVS Caremark settlement, Medco was prohibited from switching to more expensive drugs, and was required to disclose to prescribers and patients Medco's financial incentives for certain drug switches. In October 2006, Medco also paid \$155 million to resolve federal fraud and kickback charges, as well as drug-switching allegations (*DBN 11/3/06, p. 1*).

Medco says its 2004 settlement was described by two AGs as establishing a new "gold standard" for business practices in the PBM industry.

"Our success in winning new business and retaining existing business reflects the market's comfort with our business practices, which we believe are at the forefront of transparency," Medco spokeswoman Jennifer Luddy tells *DBN*. She also says Medco does not restock and re-ship returned drugs from its mail-order facilities.

Consultant Says Other Issues Left Unaddressed

Linda Cahn, president of Pharmacy Benefit Consultants, says the consent decree for CVS Caremark is "more sophisticated" than the Medco one and addresses the drug-switching problem very well. "But it left a host of other problems on the table to be addressed, and they need to be addressed either by CVS Caremark's clients or the government," she tells *DBN*.

The consent decree mentions some of these issues in passing, Cahn says. Among other things, the CVS Caremark consent agreement notes that PBMs may: receive revenue for selling claims data to manufacturers (and not passing the revenue through to clients); "average" the average wholesale prices rather than invoicing clients at actual AWP; and allow retail pharmacies to collect copayments that are in excess of the cost of the drug if it was purchased without PBM coverage.

"The settlement agreement allows Caremark to continue all of these practices, as long as Caremark discloses the practices and is therefore 'transparent' about them," she says.

Cahn also notes that the consent decree requires CVS Caremark to notify patients and prescribers that they may be reimbursed for out-of-pocket expenses resulting from a drug switch, such as extra visits to the doctor. But the agreement does not require CVS Caremark to notify the health plan or self-funded employers of the extra costs. "They are left to fend for themselves," she says.

"What it says to me is how alert health plans have to be," Cahn adds. "They should be aware of this issue and writing into their contracts their own protection. You're

not allowed to engage in drug-switching programs unless there are no extra costs. Or if there are extra costs, we have to be notified of what they might be."

"Health plans and employers have to rewrite their PBM contracts, and the Caremark settlement goes a long way in illuminating the contract changes that must be made," Cahn continues. "For example, PBMs should be contractually required to pay for all extra costs that result from their drug switches, or be precluded from switching drugs if they will not do so. Moreover, contracts should require PBMs to pass through all claims data revenues; should eliminate "averaging" of AWP; and should re-

quire retail pharmacies to collect the lower of the copay or a drug's ingredient cost."

The following states divided the settlement money: Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Vermont, Virginia and Washington state.

Contact Eileen Howard Dunn for CVS at (401) 770-4561 and Cahn at (973) 975-0900. For more information, access www.atg.wa.gov/pressrelease.aspx?id=19122. ♦

NEWS BRIEFS

◆ **Express Scripts, Inc. on Feb. 21 reported fourth quarter 2007 net income of \$138.5 million, or 54 cents a diluted share, down from \$147.2 million, or 54 cents a diluted share, in the 2006 period.**

The company reported a net loss from discontinued operations of \$27.6 million, or 11 cents per diluted share, in the fourth quarter of 2007. Revenue increased 4% to \$4.7 billion in the fourth quarter from \$4.5 billion in the same 2006 period. Generic utilization grew to a record 63.7% in the quarter from 59.7% in the year-ago period. Contact David Myers at investor.relations@express-scripts.com.

◆ **Medco Health Solutions, Inc. on Feb. 19 reported that fourth-quarter 2007 net income declined 9.3% to \$207.6 million, or 38 cents per share, from \$228.8 million, or 39 cents per share, in the 2006 period.** The company said earnings were hurt by rising costs associated with acquisitions and business expansion. Medco said net revenues increased 4.1% to nearly \$11.4 billion in the quarter from the 2006 period. Net revenues rose as a result of higher mail-order volume associated with new clients and "price inflation" by pharmaceutical manufacturers on brand-name drugs, the company said. This was partially offset by a greater representation in its product mix of lower-cost generic drugs, Medco added. The company posted an overall generic dispensing rate of 61.4%, up from 57.3% in the fourth quarter of 2006. Contact Lowell Weiner at (201) 269-6986.

◆ **HealthExtras, Inc.'s PBM unit Catalyst Rx on Feb. 19 launched its "Generic Advantage Plan,"** which the company said offers the lowest generic drug prices through mail, and eliminates significant markups that traditional PBMs add to their client mail

pricing. The company said clients can reduce total mail-service drug costs by 15% using the tool. Contact Michael Donovan at mdonovan@healthextras.com.

◆ **Prime Therapeutics, LLC on Feb. 26 released its "Efficiency Program," which the PBM said provides a "targeted approach to value-based pharmacy management"** and helps employers understand how to spend money in ways that are most beneficial to their employees' health. The program uses "predictive modeling logic" and medical claims information to identify members at high risk for an adverse health event within a population. Pharmacy claims are then used to determine which members have been prescribed a drug and which have not. Using this information, clients may choose to implement clinical programs or value-based benefit designs — which may provide financial incentives to use certain "high value" drugs. Contact Jenna Elving at jelving@primetherapeutics.com.

◆ **PEOPLE ON THE MOVE:** PBM FutureScripts LLC promoted **Paul N. Urick** to senior vice president, overseeing operations of the company. Urick had served as vice president of pharmacy services at FutureScripts.... HealthTrans LLC named **Brent McKenzie** vice president of regional sales for the southeastern states. McKenzie was regional sales manager at Coalition America, Inc., which specializes in preferred provider network management for managed care organizations.... Zynchros, Inc., a vendor of pharmacy quality management tools, named **Jim Tinney** chief technology officer. Tinney had held a similar job at Tailored Mail, which furnishes online communications tools.

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