

# DRUG BENEFIT NEWS

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

## Contents

- 3** Payers Should Look to Pharmacists to Improve Medication Adherence
- 3** *Table: Average Third-Tier Copay Dips After a Decade Of Increases*
- 5** Plans Pushing for Rx Carve In Face Resistance From States
- 6** PBMs, Payers Need More Focus on Curbing Spike in Rx Pain Med Abuse
- 8** *News Briefs*

## CVS Caremark's Blockbuster Client Win Could Boost Customer Confidence in PBM

Previously spooked investors and clients are likely to regain confidence in CVS Caremark Corp.'s PBM business after the company proudly unveiled its new relationship with Aetna Inc. The blockbuster client win couldn't have come at a better time for the PBM, but investors and analysts are expressing concern over what this could mean for Aetna — one of the few remaining health plans with its own pharmacy benefit unit.

CVS Caremark delighted investors this month after announcing that it has entered into a 12-year contract with Aetna to provide PBM services for the plan's roughly 9.7 million members. Under the deal, CVS Caremark will administer approximately \$9.5 billion in annual drug spend as well as manage purchasing, inventory management and prescription fulfillment for Aetna's mail-order and specialty pharmacy. Financial terms of the agreement were not disclosed.

As part of the arrangement, Aetna will retain its PBM and manage clinical programs, protocols and oversight of its pharmacy benefits business. In addition, the plan will transfer approximately 800 of its PBM employees to CVS Caremark and retain about 1,000.

During a second-quarter earnings call with investors July 28, CVS Caremark CEO Thomas Ryan said the company "couldn't be happier with this new agreement." That's not surprising, since Aetna will become CVS Caremark's biggest customer.

*continued on p. 7*

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

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

"We're just seeing the tip of the iceberg" for MTM programs geared at commercial populations, says Lauri Amirpoor, staff vice president of clinical program policy at WellPoint, Inc.

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

One of the challenges holding plans back from moving into the commercial space is simply convincing members to be more involved in their health, says Barry Malinowski, medical director for Anthem Blue Cross and Blue Shield Ohio. Plans also must get physicians and pharmacists on board. "Sometimes it's like pulling teeth to

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get people involved," he tells *DBN*. "We have to get the doctors to participate fairly early so that they're behind the program and not feeling threatened or feeling like it's competing with what they're trying to do."

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

The Academy of Managed Care Pharmacy (AMCP) recently conducted a survey of its members to get an update on current MTM programs being offered by payers. Out of 57 respondents — which included 43 health plans, six PBMs, five integrated delivery systems and three other organizations — only six reported using MTM pro-

grams for their commercial populations alone. Another 17 said they use MTM programs for both Medicare and commercial populations.

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

The Regence Group, for example, "has done MTM-type programs since 2004" for its commercial population, says Ruth Linard, manager of clinical pharmacy at Regence. "We have multiple types of programs — some are condition-specific and some are adherence-type programs," she tells *DBN*.

But others argue that up until recently, plans have been doing only the bare minimum in administering MTM outside of Medicare Part D. "People weren't putting a lot of effort in MTM and weren't building strong programs," Patty Kumbera, chief operating officer of Outcomes Pharmaceutical Health Care, a provider of MTM services, tells *DBN*. "Some plans just have letter campaigns and call that MTM, but that's really apathy."

According to Kumbera, many health plans that were forced into doing MTM because CMS mandated it for Part D are now truly recognizing the value of it. "And they are saying this is a good business decision to spread into their other commercial, fully insured lives," she adds.

### Plan Saved Thousands in ER, Hospital Visits

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

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

Under its current MTM program, eligible HealthPartners members receive private one-on-one, in-person

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consultations with a qualified pharmacist and multiple annual pharmacist visits, Rehrauer says. For members who do not have a close MTM provider or who have mobility issues, the plan offers telephonic MTM visits.

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

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

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

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

The ultimate goal, Amirpoor says, "is for patients to be more engaged with their disease state and improve their overall health."

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## Payers Should Look to Pharmacists To Improve Medication Adherence

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

"The pharmacist is an under-utilized resource today," George Van Antwerp, vice president of the Solu-

tions Strategy Group at Silverlink Communications, tells *DBN*. "They go to school to work with patients and often end up simply filling bottles." But with more programs that encourage pharmacist participation, that could soon change.

According to CVS Caremark Corp., pharmacist interventions consistently rank as highly effective compared with those from other providers. And pharmacists inter-

### Average Third-Tier Copay Dips After a Decade of Increases

After 10 years of steady increases, average copay levels appear to be stabilizing, and third-tier copay levels may actually be decreasing. The average member cost share per Rx for products at the third tier is \$36.93 as of second quarter 2010 — 0.69% lower than a year ago. First- and second-tier copays continued to increase but at a slower rate. Member copay amounts (and differentials between tiers) are designated to incentivize members to work with their doctors and pharmacists to pursue lower-tier, more cost-effective products, yet too-high levels may discourage members from taking necessary medicines. Second- and third-tier copay amounts have increased dramatically in recent years and have been effective in pushing utilization to lower tiers (*DBN* 7/31/09, p. 4). A future issue of *DBN* will examine the correlation between copay levels and utilization per tier.

**Average Rx Copay Amount Per Tier, as of 2nd Quarter 2000-2010**

	Average Copay Amount			Average Differential	
	1st Tier	2nd Tier	3rd Tier	1st-2nd Tier	2nd-3rd Tier
2000	\$7.90	\$14.03	\$26.14	\$6.13	\$12.11
2001	\$7.75	\$16.15	\$27.90	\$8.39	\$11.76
2002	\$7.60	\$16.97	\$29.41	\$9.37	\$12.44
2003	\$7.81	\$17.86	\$30.93	\$10.05	\$13.08
2004	\$7.87	\$18.66	\$31.06	\$10.79	\$12.40
2005	\$8.36	\$20.03	\$31.56	\$11.67	\$11.54
2006	\$8.41	\$20.36	\$31.96	\$11.95	\$11.60
2007	\$9.01	\$19.68	\$33.44	\$10.67	\$13.76
2008	\$9.10	\$20.22	\$34.32	\$11.12	\$14.10
2009	\$9.89	\$22.05	\$37.19	\$12.16	\$15.14
2010	\$9.98	\$23.69	\$36.93	\$13.71	\$13.24
% change since beginning (2Q2000)	26.40%	68.94%	41.31%	123.78%	9.32%
% change past year	0.91%	7.44%	-0.69%	12.75%	-12.54%
% change past 5 years	19.45%	18.32%	17.02%	17.51%	14.76%

SOURCE: AIS's *Pharmacy Benefit Survey Results*, available by download for \$150 at [www.aishealth.com/Products/gdq.html](http://www.aishealth.com/Products/gdq.html). 2Q2010 results now available.

METHODOLOGY: PBMs were asked their latest available average copay per Rx, per tier, among all plans and groups in their books of business in the quarters indicated. Responses were averaged by AIS. Tier designations for specific products/dosages vary by plan.

vening at the pharmacy are typically the most effective, followed by those in hospitals and clinical settings.

"There's a real opportunity for payers to leverage the role of the pharmacists," Len Greer, CVS Caremark's senior vice president of marketing for the PBM unit, tells *DBN*. "We feel that the pharmacists can play a very helpful role in patient care. And this sentiment is growing."

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

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

Realizing the benefits of pharmacist interventions, CVS Caremark plans to roll out a new program called

Pharmacy Advisor next January. This program will provide one-on-one pharmacist counseling for patients with chronic conditions, with the aim of improving member adherence and closing gaps in care. While the program will initially focus on managing diabetes patients, it will eventually expand to patients with cardiovascular disease and other chronic conditions.

### Pharmacist Counseling Can Save \$600 PMPY

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

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

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

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

In the case of CVS Caremark, the PBM is picking up the bill at no extra cost to its clients. Why it would do this is simply "because it is good business," Van Antwerp says. "This takes them out of the claims-processing and

### Hot New Products From AIS

- ✓ **The AIS Guide to Blue Cross and Blue Shield Plans: 2010**, with info on Blues plans' products, market strategies, acquisitions and alliances — including financial projections and data on revenues, earnings, enrollment and medical loss ratios. Not affiliated with the Blue Cross Blue Shield Association or its member companies.
- ✓ **AIS's Health Reform Week**, a new weekly newsletter designed to help savvy business leaders in health care understand what the enormous changes *mean* to them ... and what they can *do* about it.
- ✓ **Managed Medicare & Medicaid Factbook: 2010**, a book packed with rates, benefit designs, trends, directories and strategies on Medicare Part D, Medicare Advantage and managed Medicaid.
- ✓ **Complying With the Mental Health Parity and Addiction Equity Act** provides hands-on guidance for making complicated benefit design decisions that comply with the parity requirements. The book is written by experienced health benefits attorneys John R. Hickman, Esq., and Laurie Kirkwood, Esq., of the law firm of Alston & Bird, LLP.

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mail-fulfillment business and puts them in the critical path of improving health outcomes." In addition, the use of their retail assets and large pharmacist base "is a strategic opportunity for them to differentiate themselves and continues to validate the combined entity."

Contact Greer through Emily Hyman (617) 520-7094 and Van Antwerp at (314) 517-8915. ✧

## Plans Pushing for Rx Carve In Face Resistance From States

Medicaid managed care organizations in the Midwest that have been dealing with prescription drug "carve outs" are starting to see some disruptions in care and damage to their bottom lines. As a result, they're pushing to reintegrate pharmacy benefits within their states' Medicaid systems, but are being faced with some resistance because the biggest argument in favor of carving out pharmacy benefits — that better rebates help states balance tight budgets — "remains in full force," one analyst says.

"It's going to be a bit of a battle to carve back in," HealthLeaders-InterStudy analyst Rick Byrne tells *DBN*. This is because states such as Kentucky, Indiana and Ohio are facing tough budgets, "and they're going to want to keep that rebate money for themselves," he argues.

The issue started before health reform passed — when Medicaid managed care organizations were not eligible to receive rebates provided by pharmaceutical manufacturers for drugs prescribed to Medicaid enrollees. Consequently, states began to "carve out" the pharmacy component from managed care plans in order to receive the full rebates for their members.

The Drug Rebate Equalization Act of 2009 (DRE), which was included in the health reform bill signed into law in March, now allows for states to collect prescription drug rebates on medications prescribed to enrollees in Medicaid managed care plans. The law also bumps up the amount drug companies must give states in rebates for Medicaid enrollees from 15.1% to 23.1% for brand-name drugs and from 11% to 13% for generics.

Industry analysts interviewed by *DBN* expected this would bring an end to the practice of carving out pharmacy benefits and allow plans to regain control of formularies and utilization management (*DBN* 4/16/10, p. 1).

According to Byrne, that hasn't been the case in the Midwest. "There's a little bit of inertia that goes on here because the federal government is going to capture a portion of the money that comes out of the rebates," he explains. That's because the DRE mandates that 100% of the increased rebates drug companies are required to

pay for Medicaid enrollees' prescriptions must go to the federal government. This has created a reason for states to be upset about the changes because they won't see the additional savings.

"There is a significant amount that comes in under that floor of 23% for drugs, so it's not as big of a bargain as it might have been for the states that would like to see prescription drugs carved back in," Byrne maintains.

Health plans, on the other hand, have an incentive to carve pharmacy back in. According to Byrne, managed care organizations can take a higher reimbursement from states on their capitation fee to cover their management expenses — "and they can put their markup on that." He adds that for publicly traded plans, "this goes to their bottom line — their revenues and their earnings."

Health plans now are making a huge push to carve back in, "but they might not face receptive state governments," Byrne maintains.

### Rebates Aren't All That Matter

Mesfin Tegenu, CEO of PerformRx, a Philadelphia-based PBM unit of AmeriHealth Mercy that serves Medicaid programs in several states, argues that managing pharmacy "is more than just collecting government-mandated rebates." And any state that bases its pharmacy management decision solely on rebates "will very likely experience higher overall health care expenses."

This is in part because drug companies pay rebates to maximize use of single-source brand products. And the average cost for a single-source pharmaceutical product is about five times more than that of an equivalent generic product, Tegenu explains.

In addition, managing pharmacy involves providing drug therapy management "to enhance appropriate utilization, which improves quality and minimizes resource need," he tells *DBN*. "As very well documented, such an approach is better accomplished in an integrated health delivery system."

According to Tegenu, as part of the health reform law, rebates will be collected based on appropriate utilization. And the rebate collection process can be enhanced under appropriate health plan management. States that have a tendency to "operate in silos" seem to believe rebates are all that matter, he explains. "They see rebate collection independent of total pharmacy cost and overall health care expenditure."

Byrne says the other reason these Midwestern states want to keep pharmacy benefits carved out is because they prefer working with only one common formulary and a single set of utilization management restrictions. "The states really like the idea of having just one contractor to deal with," he adds.

*continued*

But Tegenu contends that different formularies are one way to maximize competition that the free market strives for. "The idea of using a single formulary...state-wide as suggested by Ohio, Kentucky and Indiana is counter intuitive," he says.

Before the reform law was passed, Tegenu adds, many states viewed rebates as a source of additional income and attempted to carve pharmacy out. "Now states [that] already have carved pharmacy out, if they simply look at [the] pros and cons of doing it in light of the new legislation, I have no doubt they will choose to reverse course," he maintains.

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## PBMs, Payers Need More Focus on Curbing Spike in Rx Pain Med Abuse

As new statistics paint a grim picture of how prescription pain medication abuse has spiraled out of control, some PBMs are urging payers to help curb this increasing trend by improving monitoring systems and visibility of pharmacy claims.

Substance abuse treatment admissions for patients on prescription drugs ballooned by 400% over the last 10 years, according to a new study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The study shows that the number of emergency room admissions for misuse of painkillers alone rose from some 40,000 in 1994 to more than 300,000 in 2008. The finding also revealed a more than tripling of pain reliever abuse among patients who needed treatment for opioid dependence.

The nonmedical use of prescription pain relievers is now the second-most prevalent form of illicit drug use in the U.S., "and its tragic consequences are seen in substance abuse treatment centers and hospital emergency departments throughout" the country, says SAMHSA Administrator Pamela Hyde. Researchers found that this abuse spans every age, gender, race, ethnicity, education, employment level and region.

While these findings may come as no surprise to many health plans and PBMs that have comprehensive systems to catch prescription drug abuse, the problem shows a lack of effective monitoring across all health care stakeholders — not just physicians and pharmacies, says David Hunt, vice president of pharmacy for Envision Pharmaceuticals Services, Inc.

Hunt argues that payers and PBMs have a large role to play in curbing this trend. "We have a responsibility to our clients to protect them from being exposed to this," Hunt tells *DBN*. "With programs like drug management,

we want to assist them and identify folks that may have these drug-seeking behaviors."

During the past year, Envision looked at more than 1,000 people and referred about 50 to 60 on to plans for further investigation, according to Hunt. "But that's barely the tip of the iceberg for the number of cases that there are," he adds.

To catch even that number, Envision uses a combination of "custom-designed reports and good old-fashioned claims review" to look for anomalies in prescribing practices or drug purchases. "We sample populations of people and then review reports for suspicious behavior," Hunt explains. The PBM will then have conversations with physicians and pharmacists to alert them of a potential problem. Envision's refill-too-soon policies also help raise red flags.

Medco Health Solutions, Inc. is another PBM with a few utilization and patient safety programs in place to help monitor drug risk and safety. These programs detect about 7 cases of drug abuse per 1,000 covered lives — 70% of which have successful interventions. In cases where signals of abuse or high utilization are detected, the programs also help coordinate care with prescribers.

However, "more can be done by all in the health care system to help curb abuse," says David Muzina, M.D., national practice leader for Medco's neuroscience therapeutic resource center.

He calls on payers to improve in the following ways:

- ◆ *Have more frequent monitoring* of patients using controlled prescription medications;
- ◆ *Provide specific, evidence-based* guidelines to treat pain;
- ◆ *Improve visibility of pharmacy claims* for these drugs to all prescribers and make claims part of the electronic medical record; and
- ◆ *Develop additional education and awareness* programs for the public, especially high-risk groups.

### PBMs Take Part in FDA REMS Debate

Meanwhile, even the FDA is considering using PBMs' resources and databases to increase safe prescribing of some pain medications. According to *The Pink Sheet*, a possible partnership with the FDA would involve assessing whether PBM distribution of safety information to physicians would change prescribing practices.

The FDA believes using PBMs to track prescriptions and educate physicians about risks associated with long-acting and sustained-release opioids and long-acting beta agonists would help promote safe use.

The FDA has determined that all extended-release and long-acting opioids will be subject to risk evaluation and mitigation strategies (REMS) intended to ensure that

the benefits of the medicines outweigh their risks for legitimate patients, according to Eric Carter, M.D., chief science officer of King Pharmaceuticals. Manufacturers of a number of recently approved extended-release opioids have implemented interim REMS while they await the FDA's decision on a standard approach to be applied to all medicines within this class.

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## **CVS Expects Strong Selling Season**

*continued from p. 1*

Morningstar, Inc. securities analyst Matthew Coffina tells *DBN* that CVS Caremark "needed a big win to show that their model isn't falling apart" in the wake of last month's brief but highly public dispute with rival pharmacy giant Walgreen Co. Though the fight was resolved after only two weeks, industry insiders expected the spat to spook some of CVS Caremark's existing and potential new clients (*DBN* 6/25/10, p. 5).

However, Ryan assured investors that the impact was minimal. "While some clients were concerned, they understood the resolution was quick," he said. "We lost a few small clients in the midst, [but] it did not impact our PBM selling season."

CVS Caremark's other recently announced deal with Trustmark Co. — a large life and health insurance company — serves as further proof that the PBM's selling season is going well. Under the arrangement, CVS Caremark will administer pharmacy benefits to the insurer's small-group, large-group and association fully insured and self-funded clients.

### **CVS Caremark Sees Profit Drop**

Meanwhile, CVS Caremark also reported a 7.3% drop in second-quarter earnings and cut its 2010 outlook. However, it attributed this to the Aetna implementation, greater-than-expected legal expenses and "softness" in the overall retail environment. The company's second-quarter net income fell to \$821 million, or 60 cents per share, from \$886 million, or 60 cents per share, a year earlier. Quarterly revenue in its pharmacy business was down 9% to \$11.8 billion, and total net revenue was down 3.5% to \$24.01 billion.

As for Aetna, Coffina maintains that the plan "saw an opportunity to lock in some favorable pricing for a long time period" with the deal. "It must have looked like a good option after they apparently tried to sell their PBM and didn't get any offers they considered acceptable," he adds.

Coffina is referring to Aetna's rumored interest in selling its PBM last year. As the fifth-largest in its industry — and handling about 125 million prescriptions per year — Aetna's PBM was estimated to be worth about \$2 billion at the time, according to a Sanford Bernstein report.

Antitrust issues might have prevented an outright sale to one of the "Big Three" PBMs, says Kemp Dolliver, managing director of equity research at Avondale Partners, LLC. But because Aetna made a point of emphasizing continued control over several critical functions, such as rebates and clinical programs, he argues, "they wanted more ability to differentiate their pharmacy offerings relative to a complete carve out."

Many investors and analysts, though, seem wary of the deal for Aetna. Some were expecting the plan to sell off its PBM business like rival WellPoint, Inc. did when it sold NextRx to Express Scripts Inc. for \$4.7 billion in return for a 10-year contract and access to better drug pricing. Citigroup analyst Carl McDonald thinks WellPoint "got the better deal on its PBM transaction."

McDonald expects the market will react negatively to the agreement with CVS Caremark "unless Aetna can explicitly quantify meaningful near-term synergies from this transaction, which could be hard given our understanding that Aetna's unit cost on drugs is relatively competitive," he explains in a research note.

But Aetna President Mark Bertolini defended the decision. During the plan's second-quarter earnings call with investors on July 28, Bertolini said the company "looked at a full, comprehensive range of all conceivable options," and the deal with CVS Caremark "stood out as a superior opportunity." The company expects the partnership to improve its value proposition and "provide substantial differentiation among the major players," he added.

Besides UnitedHealth Group — which still has the largest captive PBM in addition to its relationship with Medco Health Solutions, Inc. — CIGNA Corp. is now the only remaining health plan with a "pure" pharmacy benefit unit, according to Coffina.

### **Rival Medco Also Touts Client Wins**

Although it didn't garner as much attention as the CVS Caremark/Aetna deal, Medco also landed a blockbuster new client — retail giant Wal-Mart Stores Inc. Dow Jones Newswire reported on July 26 that Medco will serve as the PBM for Wal-Mart's employees starting Jan. 1, 2011.

While no details about the contract were released, media reports say that some 1.2 million people currently receive health benefits through Wal-Mart. The retailer has been using Express Scripts subsidiary NextRx as its PBM.

*continued*

During its second-quarter earnings call July 22, Medco CEO David Snow told analysts that its business benefited from the Walgreens/CVS Caremark quarrel in the form of conversations with a few potential new clients.

As for its second-quarter earnings results, Medco received mixed reactions from investors, as its profit rose 14% in the second quarter, but its shares plunged to their lowest levels in more than a year. In early trading, the stock dropped more than 10% to an annual low of \$47.76 per share because investors were concerned about how much money the company is making on prescriptions, according to Bloomberg News.

The PBM made \$2.97 per prescription in the second quarter, which is less than it made a year ago. At the same time, Medco said new clients and higher drug prices helped boost its net income to \$356.9 million, or 77 cents

per share, from \$312.1 million, or 64 cents per share, a year ago.

Overall revenue rose 10% to \$16.41 billion from \$14.93 billion a year ago, exceeding average analyst estimates. This was due, in part, to \$5 billion it received in revenue from its new clients. Medco said it already has \$1 billion in new contracts for 2011 and is about halfway done with signing clients for next year.

Meanwhile, Express Script's second-quarter earnings surpassed analysts' estimates, climbing 51%. The PBM reported a net income of \$307.3 million, or 56 cents per share, compared with \$192.3 million, or 37 cents per share, a year ago. The company says it has now successfully integrated more than 50% of NextRx's membership.

Contact Coffina at matthew.coffina@morningstar.com. ♦

## NEWS BRIEFS

◆ **House lawmakers have introduced a bill that would allow Medicare Part D to cover prescriptions used for off-label indications.** According to H.R. 5732, the Prescription Parity Act, off-label uses must be supported by peer-reviewed medical literature. With the exception of medications to treat cancer, Medicare currently will not cover drugs used for off-label indications if they are not listed in statutorily identified compendia. Supporters of the bill say it would give Part D plans "the same flexibility allowed under other parts of the Medicare program and in the commercial insurance market." Visit [house.gov](http://house.gov).

◆ **Fox Insurance Company has agreed to wire \$13.6 million in overdue payments for Medicare Part D prescription drug claims from Feb. 16 to March 1 to its administrator, ProCare Pharmacy Benefit Management, Inc.** According to the National Community Pharmacists Association (NCPA), Fox still owes tens of millions of dollars in unpaid claims from March, and is promising to clarify a few lingering issues to fulfill its remaining obligations. CMS terminated Fox's contract in March as a result of "significant deficiencies" in its operations (*DBN 3/19/10, p. 1*). Contact NCPA spokesperson John Norton at (703) 600-1174.

◆ **Medco Health Solutions, Inc. is sponsoring a head-to-head study of drugs to treat coronary artery disease.** The study will examine the impact that the PPI Prevacid (lansoprazole) has on the effect

of two different anti-platelet agents, Effient (prasugrel) and a double-dose of Plavix (clopidogrel), which is the third top-selling drug in the U.S. PPIs are often prescribed with anti-platelet agents to prevent gastrointestinal bleeding. However, some studies show they can blunt the clinical benefit of clopidogrel and raise the risk of major adverse cardiovascular events. Contact Medco spokesperson Jennifer Luddy at (201) 269-6402.

◆ **Generic medications have saved the U.S. health care system more than \$824 billion over the last decade,** according to a study by the Generic Pharmaceutical Association (GPhA). The study found that in 2009 alone, generics saved about \$382 million every day. And savings generated by new generics will continue to increase, as \$89 billion in branded drug sales will lose patent protection over the next five years. Contact GPhA spokesperson Lorrie McHugh at (202) 249-7100.

◆ **CVS Caremark Corp. has launched an iPhone application that will allow users to manage their prescriptions.** According to the company, any iPhone user can download the application and use the "Drug Information" function, which connects them to a database where they can research particular prescriptions, get information about how to take them, learn about available generic alternatives and research side effects and precautions. Members can also refill a prescription and check drug cost. Contact Christine Cramer at (401) 770 3317.

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