

DRUG BENEFIT NEWS

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

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Rx Sleep-Aid Spending Continues to Surge, Express Scripts Says; Ambien Goes Generic

Spending on prescription sleep aids grew an "astonishing" 36.9% last year, according to Express Scripts, Inc.'s annual drug trend report. The number of people using hypnotic sleep aids grew by 16.5% in 2006, adds the report, which was released April 25. Insomniacs and Rx payers, however, should be able to rest somewhat easier knowing that the top-selling sleep agent, Ambien, went generic late last month — a development that is expected to save Rx payers millions of dollars annually.

Still, Express Scripts, along with other PBMs and health plans, are scrutinizing the entire hypnotic drug class, and applying programs that aim to ensure appropriate utilization, including through quantity limits and patient coaching programs that help address underlying causes of insomnia.

Hypnotics saw "explosive growth," primarily due to the increased use of three relatively new products, Express Scripts said. These drugs are sanofi-aventis' Ambien CR (zolpidem tartrate extended release), Sepracor Inc.'s Lunesta (eszopiclone), and Takeda Pharmaceutical Co.'s Rozerem (ramelteon). Drug manufacturers, meanwhile, invested \$498 million in direct-to-consumer (DTC) advertising on sleep aids last year — the highest promotional spending for any class of pharmaceuticals.

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Seven States Oppose First DataBank Deal; Wholesaler Rx Survey Eyed to Replace AWP

Seven states have told a federal judge they "strongly oppose" a proposed class-action lawsuit settlement under which First DataBank Inc. would reduce Average Wholesale Prices on thousands of pharmaceuticals and eventually discontinue publishing its controversial AWP benchmark. Some industry observers say the states' opposition could scuttle the deal, which plaintiffs had said would save Rx payers roughly \$4 billion in the year following the settlement.

The proposed deal is now before Judge Patti Saris of the U.S. District Court in Massachusetts. In November 2006, Saris issued an order stating that on a "preliminary basis" the settlement appears "fair" (*DBN 12/1/06, p. 3*). Among other things, First DataBank agreed in October 2006 to roll back its AWP benchmark by roughly 4%, and discontinue the widely used AWP benchmark two years after the settlement is finalized (*DBN 10/20/06, p. 1*).

The judge's decision on whether to accept the agreement is not expected until midyear.

The proposed settlement stems from a class-action suit that alleges First DataBank conspired with drug wholesaler McKesson Corp. to arbitrarily increase the "spread" between the lower prices that pharmacies pay wholesalers for drugs using the wholesale acquisition cost (WAC) benchmark and the higher prices they charge health plans and insurers for the same drugs with AWP. First DataBank has denied any wrongdoing, but McKesson, which is also a defendant in the case, has vowed to fight the suit.

continued

It's anybody's guess as to how Saris will rule on the settlement, says Alex Sugerma-Brozan, project director of the Prescription Access Litigation Project, which supports the litigation and the settlement. If she rejects it, the case could start back up again "at whatever point we left off at, which was somewhere in discovery," Sugerma-Brozan tells *DBN*.

Opposition to the settlement has come from seven state attorney general (AG) offices, which describe the deal as "being an inappropriate and inadequate remedy."

"The settlement agreement appears to sanction the publishing of a fictitious price whether or not that price is identified as average wholesale price, a wholesale acquisition cost, 'suggested wholesale price,' or some other name," according to a January letter, filed last month with the court, by AG offices in Wisconsin, Illinois, Idaho, Kentucky, Alaska, Iowa and Minnesota.

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"Any published price should be an authentic representation of what it is labeled, and should purport to be consistent with the plain meaning of its name."

These states also oppose a provision that allows First DataBank to terminate the settlement agreement if more than one state AG declines to provide written assurances that it won't pursue claims based on the underlying allegations in the complaint. "That certainly is not a standard," says Kevin St. John, spokesman for the Wisconsin Department of Justice. "We think it is inappropriate to tie up a settlement agreement upon a non-party — such as a state — making a declaration as to the status of investigations that may or may not be ongoing."

An attorney for the plaintiffs that negotiated the settlement sought to allay the states' concerns. In an April 13 letter to the state AG offices, Thomas Sobol, a partner with Hagens Berman Sobol Shapiro LLP, said the settlement involves a putative class case on behalf of private third-party payers, and not on behalf of any public payer. The proposed settlement "does not affect state claims," Sobol said in the letter.

He also noted, "The settlement does not sanction, condone, or otherwise approve any future conduct of First DataBank and therefore it cannot pre-approve any future conduct." Indeed, Sobol continued, requirements under the settlement "move things forward toward a published price that would be an authentic representation of what it is labeled to be."

St. John declined to comment on Sobol's letter. "Our attorneys are reviewing it," he says.

Some analysts, however, say the states' opposition could kill the settlement. "It doesn't seem like that is going anywhere, given that seven states have opposed the [settlement]," says, for instance, Lisa Zeitel, principal and national leader of the Managed Pharmacy Group at consulting firm Mercer Inc.

The case against McKesson, meanwhile, is proceeding, with a class certification hearing set for May 22, Sugerma-Brozan notes.

Expert Suggests Using Wholesaler Price Survey

PBM executives and consultants agree the long reign of AWP as a benchmark for pharmaceutical reimbursements and contract negotiations is coming to an end. While most stakeholders are still grappling with what should replace AWP, one expert suggests collecting pricing data directly from the country's largest pharmaceutical wholesalers.

"The logical thing would be to do a wholesaler survey of prices to retailers," says James Boyd, principal of consulting firm James Boyd & Associates, Ltd. "You have three national wholesalers that cover 75% of transactions in the country," he told the Pharmacy Benefit

Management Institute's (PBMI) annual Prescription Drug Utilization Management Conference in Phoenix Feb. 23. "The data is readily available electronically. It's just a matter of collecting and data-mining the data that they all have."

The three largest wholesalers are McKesson, AmerisourceBergen Corp. and Cardinal Health Inc.

A drug-price survey would require federal intervention, Boyd added. "Wholesalers and retailers aren't going to disclose that data without a mandate," he says. Bringing all of the right parties to the table also would require a Federal Trade Commission exemption from antitrust implications, according to Boyd. "The idea is not to set prices but to set methodology for determining reference pricing," he said.

Implementation of a new benchmark methodology "will be absolute chaos," Boyd said. Changes will have to be made to retail claims, claims editing and claims processing, among others, he said. In addition, all third-party contracts will have to be renegotiated, he maintained. "Somebody is going to go to court to say, 'Stop. We can't accommodate the change this fast.' It will be delayed," Boyd said.

But one PBM executive told the PBMI conference that it may not really matter what form the benchmark ultimately takes. "AWP was good; it was national, it was auditable," said Robert Craig, Pharm.D., executive director of strategic benefit services at Medco Health Solutions, Inc.

"At the end of the day, no one is going to win big, and no one is going to lose big," he said of AWP's demise. "We will have some substitute for AWP that will be published, available, auditable and will do essentially what AWP did before we realized how arbitrary it was from one drug to another."

Contact Boyd at (817) 423-9855 and Craig through Jennifer Luddy at Jennifer_Luddy@medco.com. ✧

Value-Based Plans Said to Pay For Themselves, Pass Legal Muster

Health plans that implement value-based insurance designs — which may reduce or eliminate copayments on targeted "high-value" prescription drugs — can offset the reduced copay revenue by boosting members' cost sharing on lower-valued services, according to experts. At the same time, value-based plans do not create adverse member selection, nor do they raise legal red flags, say those involved in developing and implementing the concept.

From the beginning of health benefits, there have always been benefit packages that have done more for certain people, whether it's based on demographic, gen-

der or clinical diagnosis, says Mark Fendrick, M.D., director of the University of Michigan's Center for Value-Based Insurance Design.

"There is certainly precedence to do other things such as copay relief," Fendrick told an April 24 AIS audioconference on value-based design strategies for health plans. This point was echoed in the conference by Lonny Reisman, M.D., CEO of ActiveHealth Management, Inc., a health management and data analytics subsidiary of Aetna, Inc.

Under a value-based insurance design, which Fendrick describes as both "fiscally responsible and clinically sensitive," cost sharing is not set on price, but rather on the value of the services. High-value services would have low or zero copays.

He points, for example, to the potential benefits of a value-based plan design for patients taking cholesterol-lowering statin drugs.

"The data are irrefutable that if you give statin therapy on a regular basis to a patient who has known coronary disease or has had a heart attack, you have to treat about 50 patients over a year to prevent one adverse cardiovascular event," Fendrick explained. By contrast, for the majority of people who take cholesterol-lowering agents in the U.S. — who may have elevated cholesterol levels but have not been diagnosed with coronary disease — you have to treat roughly 500 individuals to prevent a heart attack or stroke, or other cardiovascular event, he added.

"The clinical research would suggest to us that we would provide certain incentives for certain services for one patient group over another," Fendrick said. "Thus, the patient who has had a heart attack should have a lower copayment for his or her statin than the primary prevention patient."

Potential Impact on the Bottom Line

Potential long-term savings on the bottom line in this and other categories include fewer hospitalizations and a reduction in premature mortality, as well as improvements in employee productivity, he said. In the short term, Fendrick suggested, plans could subsidize copay reductions through higher cost sharing in services of lower value.

"Given that the number of services that we would push for high level of copay reduction are relatively few, most of our studies have shown to fund these interventions the amount of money you would have to raise copays [for] in everything else... would be very, very small," he said.

One listener to the audioconference asked whether by reducing copays, health plans would create an adverse selection and attract significant numbers of mem-

bers who have chronic illnesses. Both Fendrick and Reisman sought to allay that concern.

"For large employers who seem interested in this, their focus is on the fact that they've already got these people, and those people are driving 60% [to] 70% of their costs," Reisman said. "The real orientation is that, 'We've got to take better care of these people.'" Sick people generally stay with their employer, if for no other reason than to keep the medical benefit, he added.

"These self-funded employers and plans we're talking to don't expect to have these people exit, and to the extent they're bearing the risk for them, they're frankly desperately looking for strategies that will improve their well-being," Reisman said.

Fendrick said that adverse selection has not been a concern with a value-based plan at the University of Michigan (UM) that reduces copays on diabetes treatments.

"We've had a number of legal people look over the concept of value-based insurance design, not only approaching the issue of adverse selection, but also discrimination and other factors," Fendrick said. "You can imagine the UM approving this process in the pilot phases, and expanding it to other conditions — it has certainly passed muster from a legal perspective, and we have no data to suggest that we're attracting a large

number of diabetics who want to work here just to get their drugs for free."

While many stakeholders like the idea of value-based insurance design, Fendrick acknowledges it has been a challenge to move the concept forward. Many employers and plans are looking for evidence that value-based insurance designs provide a return on investment (ROI), Fendrick and Reisman say.

Looking for evidence of financial return is one objective of a major forthcoming study on the value-based insurance design plan at the Marriott Corp.

The Marriott plan design, implemented by ActiveHealth, provides zero-dollar copays for generics and 50% copay reductions for brand drugs in five highly used drug categories: statins, ACE inhibitors, diabetic drugs, beta blockers and inhaled steroids.

Reisman says of the initial results, "It appears that adherence has increased for the Marriott group as compared to the control groups, so the hypothesis that people will take more of their drugs when presented with a lower copay is true."

He also notes that the "big part of the analysis" relates to how increased adherence to these essential therapies for members did or did not translate into lower rates of hospitalizations, and an offset in the increased pharmaceutical costs by a decrease in the overall medical costs. "The results of that final analysis will be forthcoming," Reisman said.

Contact Fendrick at amfen@med.umich.edu and Reisman at lreisman@activehealth.net. ♦

To purchase a CD of AIS's April 24 audioconference Value-Based Insurance Design Strategies for Health Plans, please visit www.AISHealth.com or call (800) 521-4323.

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Aetna: Consumer-Directed Plans Don't Diminish Rx Compliance

While some health industry observers fear that consumer-directed health (CDH) plans force patients to forgo medicines in an attempt to save money, one health-plan pharmacy executive contends that doesn't have to be the outcome. With proper incentives and education, members of CDH plans offered by Aetna, Inc. have maintained high levels of Rx compliance, said Tracy Shobert, vice president of business development at Aetna Pharmacy Management.

Compliance is always an issue around consumerism in health care, she told an April 23 session of the World Health Care Congress in Washington, D.C. Consumer perceptions of pharmaceutical costs still linger from the days of \$3 to \$5 copays, Shobert added. "When you get a copayment for 30% of the cost of the drug, it's a real

wake-up call," she said. "It is really hitting them in the pocketbook, and they need to think about what choices can they make...and are there other options."

For its part, Aetna has found that members who have health savings accounts (HSAs) and health reimbursement arrangements (HRA) have maintained compliance rates similar to those of patients in more traditional plans, Shobert said.

Aetna conducted a multi-year evaluation of more than 152,000 members. Among CDH plan members, 13% of patients with asthma received at least one prescription for an inhaled steroid in 2005, Shobert explained. "This is statistically higher than the 7% of other members in a control group in the standard [preferred provider organization] program with a copayment," she added. "You can see the benefit of the consumer-driven plan, and the concerns around compliance in this study group were alleviated."

Study: High Deductibles Are Barrier

But doubts persist. A new study by Express Scripts, Inc. found that some CDH enrollees did indeed stop taking their medications to save money (*DBN 4/20/07, p. 8*). Express Scripts examined nine months of drug claims from two unidentified national financial firms that have offered an optional high-deductible HSA-based plan since January 2006.

While compliance with medications varied by condition among chronically ill enrollees, it was lower among CDH members when compared to the control group, according to the study released April 17. The compliance rate among asthma patients, for example, was 54% among the control group, but 45% among the CDH enrollees, it found. Likewise, patients with high blood pressure in the control group had a compliance rate of 85%, compared with 80% among the CDH enrollees.

"The study reveals that there is a need to connect CDH participants with education and engagement," says Glen Moller, vice president of product development for Express Scripts. CDH plans "do not automatically produce more cost-effective behavior." As members are exposed to a high deductible for the first time, they need significant help and outreach to make sure they are spending money as wisely as possible, he tells *DBN* sister publication *Inside Consumer-Directed Care*.

Meanwhile, Shobert noted that health plans may use other consumer-based strategies to boost members' Rx compliance, including non-monetary incentives.

"The majority know that a lot of times, rewards work better than poking and prodding," she said. "We have a plan sponsor — very successful — with an iPod campaign, where compliance rates are up, they're filling

out their questionnaires, and they're sending out health care podcasts to those folks who are now compliant and doing things they're supposed to do."

Elizabeth Bewley, vice president of strategic planning at Johnson & Johnson Health Care Systems, Inc., says consumers would make better Rx choices if they had better information on drugs' efficacy and risks.

She points to the example of an unidentified drug that claims to reduce the risk of stroke by one-third. Does that mean "out of 100 people, 100 people would get a stroke if they don't take this drug, but with this drug only 67 people will have a stroke"? Bewley asked. "Or does this mean that three people out of 100 will have a stroke, and with this drug only 2 people out of 100 will have a stroke? Both of those numbers are a one-third reduction of risks."

"I'm not sure doctors have that information today. I'm pretty sure patients don't have that information," she continued. "For a patient to make an informed decision about what risks they want to assume and what risks they want to protect themselves against, I think they need to have a better understanding of what the real risk is."

Contact Moller at gdmoller@express-scripts.com and Bewley at ebewley@hcsus.jnj.com. ✧

Sleep-Aid Spending Keeps Soaring

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Sleep aids in 2006 were the 19th largest therapeutic class in Express Scripts' drug trend, up from 23rd largest in 2005. The class, however, was No. 1 in terms of total percentage change in both price and utilization of common drugs from 2005 to 2006 (see story, p. 6).

"The trend for sleep [aids] has been over 30% for two years in a row, but it is still a small category," says Steve Miller, M.D., chief medical officer of Express Scripts. "This is really being fueled by direct-to-consumer advertising," he tells *DBN*. "A bad night's sleep is now considered a treatable problem in this country. We are very excited to support our clients with appropriate use of sleep agents — but there is a lot of question about if this trend of 30% each year is really treating the appropriate patients."

Like other PBMs and health plans, Express Scripts offers utilization programs, including prior authorization and step therapies, which clients can use to control this drug category. The programs allow clients to monitor for appropriate use, Miller says, "but when use is appropriate, you're going to have a great generic opportunity," he adds of Ambien's generic entry.

Indeed, the availability of generic Ambien is expected to eventually decrease costs of the drug by 50% to

70%, according to *Consumer Reports*. FDA on April 27 approved 15 manufacturers to make zolpidem in 5- and 10-mg doses. Thirty tablets of brand Ambien 5 mg at CVS.com sells for \$134.12.

Ambien had U.S. brand sales of \$2.2 billion last year — more than half of all sales in the \$4 billion sedative/hypnotic categories, according to Medco Health Solutions, Inc., which also points out that sleep drugs have become one of the fastest-growing categories of drug spending in recent years.

The use of Rx sleep drugs by children under age 19 surged 45% between 2001 and 2006, and 52% among adults aged 20 and above, Medco said in an April 30 news release.

The PBM projects a savings of \$150 million annually from switching patients to generic Ambien. But Medco also points out safety concerns with the class. The FDA in March asked all makers of sedative-hypnotic drugs to include stronger language in the labeling regarding po-

tential risks such as severe allergic reactions and complex sleep-related behaviors, which may include sleep-driving, Medco noted.

"The good thing is that people with sleep problems are getting treated," says Lon Castle, M.D., director of medical policies and clinical quality at Medco. "The question is, do these people all need to be treated with medication, or could some of them benefit from sleep intervention programs or techniques."

Medco offers clients various tools to manage sleep-aid utilization, including clinical programs in which Medco clinicians talk to physicians to make sure patients require long-term use of sleep aids. "We'll contact physicians and have discussions, but in the end, it's the responsibility of the physicians. What we can do is try and help our clients keep their costs to a minimum," Castle says.

To lower costs, Medco encourages patients to switch to generic Ambien, including by means of copay waivers, formulary placement and by directing members to

Biotech Drugs Continue Spending Surge; Non-Specialty Remain Steady

Mirroring trends of recent years, biotech drug spending surged in 2006 — including a jump in spending on growth hormones for adult patients — while non-specialty drug spending increases slowed to record lows, according to Express Scripts, Inc.'s 2006 drug trend report.

Non-specialty drug spending grew only 5.9% last year, down from 7.9% in 2005, said the report, which was released April 25. The report attributed the decline in non-specialty drugs in part to a mild flu season, as well as the introduction of new generic drugs.

On the other hand, biotech drug spending increased 21% last year, a figure that reflects growing demand for the high-cost products that once were prescribed only to treat rare genetic diseases, says Steve Miller, M.D., chief medical officer of Express Scripts. The PBM projects spending on specialty drugs will grow by between 20% and 25% in total through the end of the decade, "because the pipeline is just so strong for the biopharmaceuticals," Miller tells *DBN*.

While the biotech growth figure was not unexpected, one surprise in this year's data was the significant increase in spending on growth hormones, Miller says. Spending in this category grew by 22.8% last year, according to the report. Spending on cancer biologics, by contrast, increased by 39.5%.

"More of a surprise was seeing the amount of growth hormone that was being used by people over the age of 20," Miller says. "There are adult indications for growth hormone, like AIDS wasting syndrome, but our clients are mostly commercially insured. The population with AIDS wasting syndrome in a commercial insurance product is probably pretty low. The fact that 25% of the scripts are in people over the age of 20 [means] there is probably a high likelihood that that's inappropriate use for weight reduction and anti-aging."

Programs to bring down specialty drug spending include greater use of prior authorizations (50% of Express Scripts' PAs are for specialty drugs) and implementation of quantity limits. "Our most aggressive clients are actually seeing double-digit decreases in their specialty," Miller says. But without the availability of generic biologics, it will be hard to get spending down to the non-specialty levels, he asserts.

In fact, generic drugs now represent 60% for Express Scripts' national book of business. Miller says there is room to drive even more generic usage. "The Express Scripts employees themselves are at 75%," he notes.

Contact Miller through Rita Holmes-Bobo at rholmesbobo@express-scripts.com. Read the 2006 Drug Trend Report at www.express-scripts.com/ourcompany/news. Click on Industry Reports.

Medco's online Rx price comparison tool, MyRxChoices. Generic Ambien is on Medco's least expensive tier, which has an average copay of \$10. Brand sleep aids are generally on Medco's preferred tier, which has an average copay of \$25, Castle says. To encourage greater use of generic Ambien, Medco's clients may consider moving these brands to the most expensive non-preferred tier, which has an average copay of \$40, Castle says.

The Regence Group, which includes Blue Cross and Blue Shield plans in the Northwest, says the widespread, continuous nightly use of prescription sleep aids is one of the top growth areas for pharmaceuticals, and is "of significant concern" for the health plan.

"The newer sleep aids, such as zolpidem (Ambien), Ambien CR, Lunesta, Rozerem and Sonata, are intended

for the short-term treatment of insomnia," says Helen Sherman, Pharm.D., director of pharmacy services at Regence's PBM, RegenceRx. "There's no reliable scientific evidence that these agents are effective or safe for long-term, continuous nightly use." As such, Regence applies quantity limits of 14 tablets/capsules to Ambien, Ambien CR, Lunesta, Rozerem, and Sonata. "This means that up to 14 tablets/capsules are covered each month without restrictions," Sherman says, adding that additional quantities may be covered for certain medical conditions with prior authorization. Because of the prescribing limits, "Regence has not experienced the large growth in use of sleep aids compared to the overall market," she says. In 2006, there was essentially no growth in the number of prescriptions of newer sleep aids across the overall Regence membership.

continued

Utilization of Common Drugs for the Top 25 Non-Specialty Therapy Classes, 2005 to 2006 (Ranked by Total Percentage Change)

	Therapy Class	Rxs PMPY*		% Change		
		2005	2006	Prevalence (new users)	Intensity (frequency of use)	Total
1.	Hypnotics	0.14	0.16	10.6%	5.3%	16.5%
2.	Diagnostic Products	0.08	0.09	9.8%	0.2%	10.0%
3.	Anticonvulsants	0.23	0.25	9.2%	-1.2%	7.9%
4.	Stimulants/Anti-Obesity	0.14	0.15	6.1%	0.6%	6.7%
5.	Misc. GI Agents	0.06	0.06	9.3%	-2.3%	6.7%
6.	Antidiabetics	0.57	0.60	5.4%	0.7%	6.2%
7.	Decongestants	0.18	0.19	7.0%	-1.2%	5.7%
8.	Antidepressants	0.86	0.90	4.2%	1.3%	5.5%
9.	Antihyperlipidemics	0.99	1.04	3.9%	1.3%	5.3%
10.	Narcotic Analgesics	0.56	0.59	4.7%	0.6%	5.3%
11.	Migraine Products	0.07	0.07	4.9%	0.1%	5.0%
12.	Gastrointestinals	0.55	0.58	2.8%	2.1%	4.9%
13.	Antivirals	0.08	0.09	-0.1%	4.2%	4.1%
14.	Antiasthmatics	0.45	0.46	0.7%	1.6%	2.2%
15.	Antihypertensives	1.10	1.12	2.7%	-0.6%	2.1%
16.	Antihistamines	0.28	0.29	1.3%	0.8%	2.1%
17.	Beta Blockers	0.57	0.58	1.4%	0.4%	1.8%
18.	Contraceptives	0.48	0.49	1.9%	-0.9%	1.1%
19.	Misc. Hematologicals	0.10	0.10	-0.8%	1.9%	1.1%
20.	Ophthalmic Products	0.18	0.18	4.1%	-4.0%	-0.1%
21.	Antipsychotics	0.08	0.08	1.0%	-1.8%	-0.9%
22.	Dermatologicals	0.31	0.30	1.4%	-2.6%	-1.3%
23.	NSAIDs	0.33	0.32	0.3%	-2.6%	-2.4%
24.	Misc. Endocrines	0.22	0.21	-3.0%	-2.8%	-5.7%
25.	Calcium Blockers	0.34	0.31	-7.1%	-0.3%	-7.4%
	Top 25	8.92	9.20	-0.1%	3.2%	3.1%
	Other	4.14	4.15	-0.8%	1.2%	0.3%
	Total	13.06	13.34	1.0%	1.2%	2.2%

*PMPY=per member per year

SOURCE: Express Scripts 2006 Drug Trend Report

Members who request quantities in excess of 14 tablets or capsules per month are referred to Regence's Health Coaching Program. "Our health coaches provide information and support to the member to work on the underlying causes of insomnia and help them get a better night's sleep without becoming dependent upon medications," says Rod Hart, manager of safety and wellness at Regence.

The sleep-aid story is similar at Blue Cross and Blue Shield of Michigan (BCBSMI), according to Atheer Kaddis, director of clinical pharmacy services at the Blues plan. "The rapid growth is a concern to us as we have seen growing dependency on these medications, potential drug interactions, as well as doses being prescribed at levels much higher than recommended by the

FDA," he tells *DBN*. "There is not only a cost concern with these medications but a safety concern."

BCBSMI has quantity edits available for these drugs, as well as drug-use evaluation initiatives to address potential overprescribing or abuse of these medications. Atheer says he believes the availability of generic Ambien will cause brand drug manufacturers to increase their detailing efforts and sampling of brand-name competitor products, "which may lead to greater use of the brand-name products."

Contact Miller through Rita Holmes-Bobo at rholmesbobo@express-scripts.com, Castle through Jennifer Luddy at (201) 269-6402, Sherman through Samantha Meese at (503) 225-5332 and Kaddis through Jon Ogar at (517) 336-5648. ✧

NEWS BRIEFS

◆ **Medco Health Solutions, Inc. on May 1 reported record first-quarter net income of \$274.8 million and diluted earnings per share of 94 cents, up from first quarter 2006 net income of \$144.7 million and diluted EPS of 47 cents, excluding the \$99.9 million or 32 cents per diluted share legal settlements charge in the 2006 period.**

Medco also reported first-quarter net revenues of nearly \$11.2 billion, an increase of 5.6% from first-quarter 2006 and up 2.1% from fourth quarter 2006. In addition, Medco had a record generic dispensing rate of 58.2%, up 4.5 percentage points from first quarter 2006. Mail order grew across the company's book of business, with more than 9 million members now enrolled in the firm's Retail Refill Allowance programs, an increase of more than 1 million members since the last quarter of 2006, the firm said. Contact Jeffrey Simek at (201) 269-6400.

◆ **Express Scripts, Inc. on April 23 reported strong 2007 first-quarter earnings, posting net income of \$133.7 million, or 97 cents per diluted share. Excluding non-recurring items, earnings per diluted share were \$1.04, up from \$104.7 million, or 70 cents per diluted share, for the same quarter last year.** Generic utilization reached a record 60.3%, compared with 56.3% for the 2006 period. Adjusted gross profit for the first quarter increased 21% to \$417.1 million from \$344.6 million in the year-ago period, according to Express Scripts. The increase reflects higher generic utilization and lower retail and home delivery drug purchasing costs, the company said. Operating income

for the Specialty and Ancillary Services segment decreased \$3.7 million sequentially from \$20.1 million in the 2006 fourth quarter to \$16.4 million in the 2007 first quarter. Most of this decrease resulted from migration of members in patient assistance programs to Medicare Part D and other discount programs, the firm said. Contact David Myers at (314) 702-7173.

◆ **CMS last month released the annual adjustments for the Part D standard benefit in 2008.**

The standard deductible increases from \$265 in 2007 to \$275 in 2008. The initial coverage limit, before the "donut-hole" coverage gap, rises from \$2,400 in 2007 to \$2,510 in 2008, and the out-of-pocket threshold, before catastrophic coverage starts, increases from \$3,850 in 2007 to \$4,050 in 2008. The minimum cost sharing in the catastrophic-coverage portion of the benefit increases from \$2.15 for generics in 2007 to \$2.25 in 2008 and from \$5.35 for other drugs in 2007 to \$5.60 in 2008. These amounts apply only to beneficiaries who are enrolled in plans with standard benefits. Plans offering something other than the standard benefit design must have equal or greater actuarial value compared to the standard benefit. To view a copy of CMS's release on 2008 Part D rates, go to www.cms.hhs.gov and click on "Newsroom."

◆ **PERSON ON THE MOVE:** Prime Therapeutics promoted **Kim Mageau** to chief operating officer. Mageau formerly served as Prime's chief financial officer.

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