

# DRUG BENEFIT NEWS

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

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## Plans, PBMs Are Taking Control of Oncology Pharmaceutical Management From MDs

With roughly 400 cancer drugs in the pipeline, and prices of existing therapies topping tens of thousands of dollars, pharmaceutical payers are exploring new strategies to ensure that cancer patients receive the most appropriate therapies at the best price. Recent initiatives include the formation of Web-based oncology pharmaceutical auctions and movement by health plans to wrest control of oncology Rx management from physicians.

Treating employees with cancer takes a significant financial toll on plan sponsors, especially smaller employers, said Rebecca Shanahan, president of Shanahan Capital Ventures LLC and former president of Oncology Therapeutics Network Specialty Services. If an employee of a police department with 90 people gets cancer, for example, and the treatment regimen costs \$46,000 or \$50,000, those 90 employees have to pick up the tab, she said at a June 18 session of the Biotechnology Industry Organization (BIO) international convention in San Diego.

*continued on p. 7*

## Demand Grows for Value-Based Rx Plans; As Insurers Expand Offerings, ROI Is Elusive

Pharmaceutical payers are expressing increased interest in adopting value-based insurance designs, according to health plans and other stakeholders involved in the VBID concept. As insurers roll out new VBID offerings to meet the growing demand, some pharmacy executives acknowledge that hard data demonstrating a return on investment (ROI) remain elusive.

So far, however, that hasn't dampened interest in VBID — a concept in which financial barriers to "high-value" drugs are lowered in hopes of raising Rx compliance and avoiding more expensive medical costs later on.

Among the recent developments, Humana Inc. last month launched "RxPlus" to its administrative services only (ASO) customers. The program has three components: (1) lower copays for diabetes and asthma medications; (2) opportunities to add services, such as nurse-based clinical management of the two conditions; and (3) incentives and rewards, such as gift cards, for individuals who meet specific behavioral targets and guidelines.

It's still too early in the selling season to know how many clients will sign on to the new program, says Troy Koch, Pharm.D., director of pharmacy sales at Humana. But many clients are inquiring about this and other VBID programs, he tells *DBN*. "Many groups are in the learning mode as to what is the potential impact, what are the savings versus the costs," he explains.

On these issues, Koch says that VBID, first of all, improves drug adherence. "And adherence will lead eventually to a level of improvement on the medical side," he adds. Humana expects soon to have more data on the ROI question based on several ongoing RxPlus pilot programs with its ASO customers, he says.

*continued*

Meanwhile, Aetna Inc., which offers two separate VBID programs, is seeing a “groundswell of interest” in the concept from its customers, says Mark Rubino, chief pharmacy officer at the insurer. Much of the interest comes from large national accounts, but those interested also include the midsized market of 1,000 to 2,000 covered lives, he tells *DBN*.

Under Aetna’s VBID programs, plan sponsors can reduce copays to whatever levels they choose, says Rubino, who couldn’t say exactly how many sponsors have signed up for the programs. He notes that Aetna also is trying to get a clearer view of the programs’ ROI. As such, it is conducting a multi-year prospective study that looks at a group of heart attack patients who have zero copays on their cardiac drugs versus a control group that has normal copays. The study, which has several years to go, will examine copay effects on such things as compliance and the incidence of second heart attacks, he says.

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Most recently, Independence Blue Cross on June 19 said it would waive copays and coinsurance on 75 generic drugs used to treat common chronic conditions. Among other things, the program aims to improve Rx adherence (see brief, p. 8).

Some questions about the financial value of VBID also could be answered in a study soon to wrap up at the University of Michigan (UM) in Ann Arbor.

The university in June will conclude its “focus on diabetes” program, a two-year research study that examines the link between lower drug copays and increased adherence and compliance among diabetic patients, says Keith Bruhnsen, who manages the university’s prescription drug program.

UM has about 2,500 diabetics in its health insurance plans, he tells *DBN*. UM selected a half dozen “essential medications” for lower copays: Generics had 100% copay relief, preferred brand drugs had a 50% copay reduction, and non-preferred brands had a 25% reduction. The program costs UM roughly half a million dollars annually in lost copays, Bruhnsen says. Members with diabetes from Blue Care Network of Michigan — the parent of which acquired the UM health plan in January 2008 — served as the control group.

Results of the study are expected by October, Bruhnsen says. “We’re on a timeline to make a decision about whether we’re going to adopt this as a standard benefit here at the university, or whether the evidence does not show there is an improvement in adherence and compliance or utilization,” he says. “In that case, we’d make some decision about modifying or ending that program.” He declined to discuss any preliminary findings.

Bruhnsen says the industry’s challenge is to develop research and data supporting the concept that lowering copays for essential services actually removes barriers to their use. “Personally, I believe the reasons people take prescription medications are quite complex,” he says. “There are a lot of motivations and issues in that, and copays may not, in and of themselves, be enough to change adherence and compliance.”

### Demand for VBID Said to Remain Strong

Still, VBID continues to remain a popular insurance concept, finds a survey of pharmacy benefit stakeholders.

According to a Pharmacy Benefit Management Institute (PBMI) survey of Rx benefit payers, consultants, PBMs, pharmaceutical companies and others, “many multinational corporations are embracing value-based benefit design to meet business objectives while working to improve the health of the workforce.” The challenges of VBID include quantifying clinical and economic ROI, as well as implementing the program, gathering data and measuring outcomes, according to PBMI.

Tim Watson, Pharm.D., principal of consulting firm Pharmaceutical Strategies Group, says employers continue to invest in health and wellness initiatives, but in a fragmented fashion that makes measurement of outcomes difficult, if not impossible, to achieve. "The main interest in VBID is to try to use benefit design tools that will result in improvements in pharmaceutical care, that will extrapolate to all other areas of health care," he tells *DBN*.

Watson says employers are looking for a broader outcomes measurement approach than strictly measuring improvements in medical outcomes.

Cyndy Nayer, president of the Center for Health Value Innovation (CHVI), says her organization, formed in 2007, helps employers develop "business-based evidence" that can demonstrate the value of VBID. She says both large and midsized employers are "incredibly interested" in the concept.

"They want to jump in," Nayer tells *DBN*. "They need to be able to see an early ROI, what we define as somewhere around 15 to 18 months. We've got to help them get that information."

To this end, CHVI has developed ways to document the "business ROI," including reductions in excess drug utilization, rescue treatments and disability days. Nayer acknowledges that costs and utilization of drugs under a VBID program go up. "That's the investment," she says. "The return on the investment is more workdays, more work production, less rescue treatments. Those are the reductions in costs, and those take time."

Contact Nayer at [cyndyn@vbhealth.org](mailto:cyndyn@vbhealth.org), Watson at [twatson@psgconsults.com](mailto:twatson@psgconsults.com) and Koch through Doug Bennett at (502) 580-3625. ♦

## Biotech, Pharma Firms Eye New Payment Models Based on Value

Health plans and other pharmaceutical payers are intensifying their focus on comparative effectiveness and "overall value" of pharmaceuticals when making coverage decisions, according to drug manufacturers eyeing efforts to tame the ever-increasing Rx costs. Drug makers say they are responding by considering new ways to ensure that their products reach patients and are reimbursed.

Emerging reimbursement models include manufacturer and Rx payer financial risk-sharing agreements, and single, up-front payments for therapies based on overall value of therapy rather than per-dosage price.

Manufacturers face a payer environment in which resources are becoming increasingly constrained and the rate of medical inflation is increasing, said Mahesh Krishnan, M.D., medical director at Amgen Inc. The industry is "rapidly reaching a state" in which payers are making

decisions about what types of evidence are needed before they will pay for the therapies, he told a June 19 session of the Biotechnology Industry Organization's (BIO) 2008 international conference in San Diego.

As such, the U.S. is starting to resemble Europe, he said. European regulatory agencies ascribe a value to the cost of therapies, and some countries, such as the United Kingdom, refuse to pay for products if their prices exceed some government-established "quality ceiling," Krishnan explained.

"If we don't have the right data to actually show payers, if we don't have the right data to show [regulatory authorities], it is going to be very difficult for them to reimburse our products," Krishnan said of the expected situation in the U.S. As evidence, he pointed to the increasingly tough reimbursement hurdles established by CMS.

"We used to think that if we feed the right data to the health care agencies, [i.e., the FDA or the European Medicines Agency] and those products are granted approval, then *de facto* they will get reimbursement and we'll set that reimbursement to where we want it to be. And that's increasingly no longer the case," Krishnan said.

To adjust to the new reality, he said Amgen is "increasingly trying to incorporate" value and quality data around products in its pipeline. This will ensure that the right outcomes data are available to people making reimbursement decisions when the products hit the market, he added.

Other pharmaceutical manufacturers also are feeling the effects of increased scrutiny on value. Susan Slaton, director of reimbursement policy and coverage strategy

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at Bayer HealthCare Pharmaceuticals, Inc., said she welcomes efforts to improve quality.

“But it does present a challenge to pharma companies. How do we show quality?” she added. This challenge does not just involve the price of a product, Slaton said, but rather demonstrating how a medication may benefit a person well into the future, including by avoiding major medical events such as heart attacks.

Employers also are asking similar questions. “They want to know, ‘How does the use of this product help my employees? Will they have less sick days? Will they have better performance at work?’ Those are some of the things that have to go into the development of an innovative therapy.”

One likely outcome of this trend in the U.S. will be the introduction of “risk-sharing agreements” that are increasingly common in Europe, Slaton said. This concept involves manufacturers offering financial guarantees around certain drugs, and reimbursing the payers if products fail to perform as indicated.

“When we start getting to the point where pricing starts to prohibit coverage, we’ll see a growth in these risk-share agreements,” Slaton said. “We’ll have to look at what is the outcome...and how much is the manufacturer at risk for making sure the patient has the outcome,” she said.

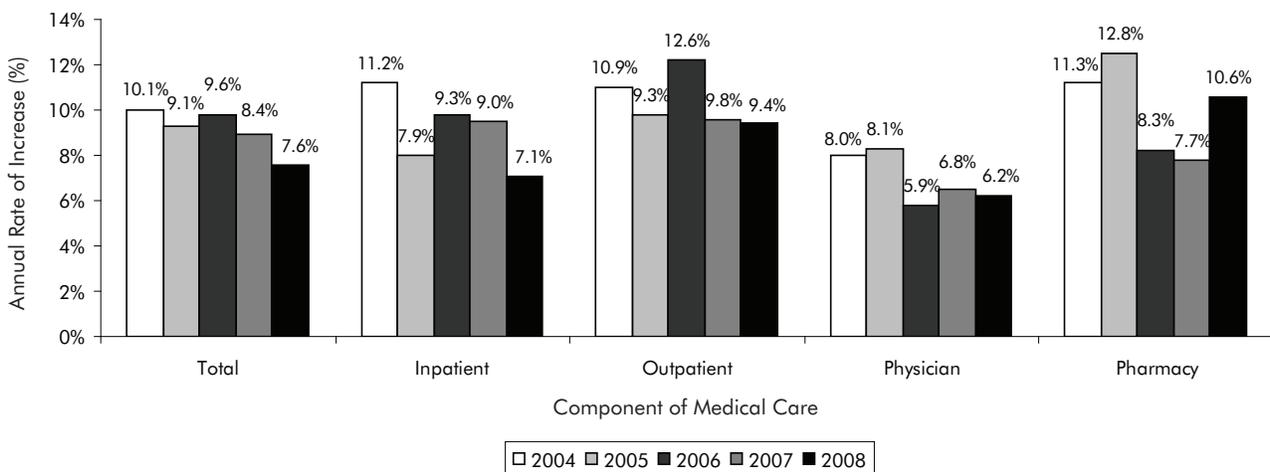
Some U.S. health plans, including CIGNA Corp., already are eyeing risk-sharing agreements with brand manufacturers in drug categories where there is significant generic competition (*DBN 8/3/07, p. 1*). This is one way for brands to demonstrate their value above generics, a CIGNA pharmacy executive told *DBN*.

Drug manufacturers may be interested in such a risk-sharing model if the response is tied to compliance, said Tomas Philipson, Ph.D., professor of health economics at the University of Chicago and former economic advisor to CMS under the Bush administration. “If you don’t comply with the treatment, we don’t offer the guarantee,” he told the conference session.

The approach is appealing to manufacturers because it may actually boost compliance, Philipson said. “And if you induce more compliance, you might raise sales that way to offset the fact that you’re offering assurances of costs. It is something that is worth considering. It is a goodwill gesture, but nevertheless you may raise profits by having people more compliant.”

Philipson said there are other ways of addressing questions of what is the long-run value of therapies, and how to set reimbursement levels. One way is to determine the “total value of being on the regimen,” and getting away from calculating pricing on a per-dose basis. That calculation for employers, for instance, could include such factors as not having to train new employ-

### 2008 Milliman Medical Index Annual Rate of Increase in Costs by Component of Medical Care



SOURCE: 2008 Milliman Medical Index (MMI), May 2008 ([www.milliman.com](http://www.milliman.com)).

METHODOLOGY: The 2008 MMI measures average medical spending for a typical American family of four covered by an employer-sponsored preferred provider organization program. MMI is based on analysis of claims for millions of members in different locations nationwide.

ees to replace those who died of cancer, he said as an example. "It doesn't have to include just the health effect; it might include productivity," Philipson said.

Pricing based on total value could take the form of an up-front fee to get started on therapy, he explained. "It lowers the cost of compliance," he said. "The up-front fee should be something related to the overall value of being on the therapy. We're moving in that direction: charge for curing disease as opposed to charging for pills."

Contact Philipson at t-philipson@uchicago.edu. ✧

## Plans, Employers Urged to Focus On PBM Contracting Definitions

Health plans and employers are leaving lots of money on the pharmacy benefit table by not nailing down the definitions in their PBM contracts, according to a pharmacy benefits consultant. One PBM executive also advises Rx payers to be on the lookout for "games" that can be played during the PBM contracting process.

Contract definitions are critically important because they define the terms of the agreement, Linda Cahn, president of Pharmacy Benefit Consultants, told a June 12 AIS audioconference on PBM contracting. Pharmaceutical payers often mistakenly think their PBM contracts contain definitions that everybody understands, she said (*DBN 5/16/08, p. 1*).

"But in fact, the PBM is very likely to interpret them one way, and you're going to interpret them another way, which means the contract is ambiguous, and the PBM can do whatever it wants," said Cahn, an attorney who has reviewed hundreds of PBM contracts and has litigated against PBMs. Some of the common terms with ambiguous interpretations, she said, include:

◆ **Claim:** "That seems like an absolutely obvious term that anyone would interpret the same way, [but] that's just not the case," Cahn said.

About 20% of all claims that go through a PBM are never dispensed, she said. These fall into a category of "reversed claims, rejected claims," she added. "The question is, when you write the word 'claim' — and you don't define in the definition what happens to reversed or rejected claims — are you going to be billed for them or aren't you?" Cahn asked. "The answer is that PBMs are billing clients for reversed and rejected and other such claims. It never got dispensed to your members; the PBM didn't do anything at all to reverse or reject them."

◆ **Average Wholesale Price (AWP):** One of the problems with this definition centers on bulk purchasing, she said. PBMs and retail pharmacies buy prescriptions in vats of 500, 1,000 or 5,000 pills, and typically they get a bulk-purchase discount, she said. "PBMs universally are all

writing AWP definitions that say you are going to be invoiced at the 30-pill or 90-pill or 100-pill size," Cahn said. "You are losing all of the bulk-purchase discounts that you ought to be getting."

◆ **Maximum Allowable Cost (MAC) guarantees:** PBMs will say that the average discount for all generic drugs on their MAC list will be AWP minus "blank," Cahn said. "And they will fill in the blank with whatever great number they can invent: 60%, 62% or up to 64%," she said. "You're going to get induced into this and be focused on the discount, and they're going to tell you they're sweating blood because you've taken out of them such a high discount — they used to only pay 55%, and now you're getting from them 62% or 64%," she said.

But, Cahn added, PBMs write MAC definitions that let them change the MAC whenever they want, and include only a small percentage of the total number of generics on the list. "They can charge you whatever they want for those other drugs, including above brand pricing," she said of the other non-MAC generics.

### Avoiding 'Games' in PBM Contracting

Dan Coady, director of pharmacy benefit administration strategies at HealthTrans LLC, says plans and employers should be on the lookout for certain "games" that PBMs may play during the contracting process.

One of these is pharmacy access limitations, he said. "Most PBMs have about 60,000 pharmacies in their networks," Coady explained. "You might see pricing that's based on 50,000 pharmacies, which means they're carving somebody out — one or multiple chains — and they're realizing better pricing by leveraging the retail community. You need to make sure you're getting the benefit of that if, in fact, they're doing that. Everything needs to be above board."

During the request for proposal (RFP) process with PBMs, Coady suggests that Rx payers:

◆ **Provide claims data to all prospective PBMs, and have them do a reprice;**

◆ **Ask how many pharmacies are offered;**

◆ **Focus on a minimum average generic discount that covers both MAC and non-MAC generics; and**

◆ **Pay attention to specialty drugs, which are typically less than 1% of all claims but result in up to 20% or more on total spend.**

Coady also urged payers to double check that the agreed-upon contract provisions are actually set up in the system. For example, he said he has heard from payers who think they have a mandatory-generics plan. But when someone goes into the pharmacy and buys a brand with a generic alternative, nobody has stopped them to

say "you have mandatory generics, and you need to buy the generic alternative," Coady said.

"Sometimes PBMs don't even turn on the edits they promise." To avoid this outcome, payers should send through some test claims to ensure that everyone is on the same page.

Ambiguities in PBM contracting definitions and pricing games will end as soon as the marketplace demands it, Cahn and Coady agreed.

"As soon as a large number of plans...get on the wagon and say, 'We are not signing on to your boilerplate contracts anymore. We're going to write our own contracts and insist that you give us our contract terms,' that's when change will come," Cahn said. "When the PBM industry sees that they are losing market share to the smaller PBMs that are willing to give these kinds of terms — and there are PBMs that are willing to do so — then the large PBMs will stop playing the games."

She acknowledged that the largest PBMs now are responsive to such demands only from big clients, but added that she's been able to get meaningful concessions from accounts with 5,000 or more covered lives from medium- and small-sized PBMs.

Contact Cahn at (973) 975-0900 and Coady at [dcoady@healthtrans.com](mailto:dcoady@healthtrans.com). ✦

To purchase a CD of the June 12 AIS audioconference on PBM contracting, please call (800) 521-4323 or visit [www.AISHealth.com](http://www.AISHealth.com).

## Michigan's Hospital-Owned UPHP Cuts Rx Costs, Boosts Generics

The following case study is part of an occasional DBN series that profiles innovative approaches used by pharmacy benefit programs to lower pharmacy costs.

In 2003, the Upper Peninsula Health Plan (UPHP) had one of the highest per-member per-month (PMPM) pharmaceutical drug spending rates of any Medicaid managed care plan in Michigan. Recognizing the problem, representatives of UPHP and the Upper Peninsula Health Care Network (UPHCN) — which is owned collectively by the region's 15 hospitals — gathered to see what could be done to lower the drug spending growth.

The high Rx spending stemmed in part from the fact that each UPHCN hospital had a different drug formulary, says Sheryl Waudby, pharmacy director of UPHP.

"The idea was hatched to look at all of the hospitals across the Upper Peninsula," she tells *DBN*. "The network is owned by the hospitals. UPHP is owned by the hospitals. So the ideas for an Upper Peninsula-wide formulary that made decisions based on evidence and looked at costs came into being."

The initiative led to the formation in December 2004 of the Upper Peninsula Pharmacy and Therapeutics (P&T) Committee, which is comprised of physicians and pharmacists from each member hospital and the plan.

### Harnessing Hospitals' Buying Power

At the same time, the hospitals took steps to harness their Rx buying power, she explains. "We said to the manufacturers, 'We have this much buying power and utilization. What kind of price would you be willing to give us if you had the major market share in all of the facilities?'" Waudby says as an example.

*The results:* Since 2003, UPHP's PMPM drug spending decreased 21%, and its generic drug utilization rate has increased to roughly 75% from 60%, Waudby says. In three therapeutic categories alone — fluoroquinolone antibiotics, proton pump inhibitors, and hematopoietics — the hospitals in 2007 saved an estimated \$381,000, she says. By contrast, the average PMPM Rx drug cost for other Michigan Medicaid plans rose by 2% during this period, she adds.

For its effort, UPHP and UPHCN earned the Pharmacy Benefit Management Institute's (PBMI's) "2008 Rx Benefit Innovation Award" for a community-based initiative to manage prescribing cost and quality.

Waudby says the P&T committee follows the evidence-based "STEPS" philosophy — examining safety, tolerability, efficacy, price and simplicity — when reviewing new drugs. "Everything else has to be equal before we look at pricing," she adds. "That way you have the credibility with your providers that you are not making a decision based just on cost."

In fact, Waudby stresses the importance of seeking physician buy-in when making formulary decisions. "We're doing this in a vacuum otherwise," she says. "The biggest step is to improve our dissemination of this information to the providers," she says. To this end, the P&T committee has a Web site, and is looking to develop an e-mail system to notify doctors of decisions after meetings.

Contact Waudby at [sdwaudby@uphp.com](mailto:sdwaudby@uphp.com). ✦

If you know of a pharmacy benefit program that is providing particularly impressive financial savings, and can furnish full details, please contact DBN Managing Editor Neal Learner at [nlearner@aispub.com](mailto:nlearner@aispub.com).

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## Plans Seek Control of Oncology Rx

*continued from p. 1*

"That is what plan sponsors are very focused on," she said of these costs. "What employers tell plans and PBMs is that 'if I'm going to spend \$46,000, I want to make sure I [couldn't] have spent \$32,000 to get the same results. And I want to be sure that the [expected clinical outcome] actually happens and that I get a patient who comes out of it and can return to work.'"

The health plan in turn "is going to push the providers and those businesses that can deliver that kind of value," Shanahan added.

One result of such pressure has been the introduction of Web-based auctions around oncology drugs, Shanahan explained. The concept allows physicians to stop dedicating staff members' time to the drug purchasing process, while using technology to drive efficiencies and pricing transparency, she said.

A Web-based auction allows "distributors and ultimately manufacturers to say, 'OK, the doctors are willing to pay X, I'll provide it at X plus 1%,'" she noted, adding that such a model matches "the interests of the doctors and the interests of the manufacturers." The process allows for transparency around pricing and makes it a more efficient model, she added.

### Oncology Provider Model Gains Momentum

Another promising approach, she said, is through the movement by which health plans are adopting more oncology pharmacy management through their specialty pharmacies. Oncology pharmacy management addresses the situation that exists today in which oncologists derive 50% to 60% of their income from buying drugs at wholesale and selling them at retail under a system known as "buy and bill."

Oncologists pick drugs — when they're therapeutically appropriate — based on the biggest margins that are returned to the physician's office, Shanahan said. Instead of selecting the lower margin for a drug that costs \$13,000, they're going to pick the higher margin for a drug that costs \$27,000, she said.

"Doctors are not out to make these decisions just based on the economics, but if all the clinical information is the same, then today, the way the system is set up, they should make that choice," she said. An oncology specialty pharmacy, by contrast, understands the therapeutic substitution opportunities and what regimens could be therapeutically equivalent, Shanahan said.

"Because they're doing that on a much larger scale, they're aggregating the activities of multiple doctors," she said. "They now can not only provide efficiencies and a lower cost of production, but they can also really be proactive in working with the plans when a doctor's

already given up 'buy and bill,'" she said. "Here's the way for us to do bio-management in a way that makes sense. This is a way for real savings to [go to] the health plans," she said.

Burt Zweigenhaft, CEO and managing partner of BioPharma Partners LLC, said the evolution of oncology management will be an adjustment for cancer drug manufacturers. They know the physicians and the GPOs, but now control is being wrested away by the health plans, he said.

Still, it will be difficult for health plans to bring some of these drugs back under management, he asserted. "That horse is out of the barn," Zweigenhaft told the conference session. "But if it's a new drug, I'm going to put it through my specialty pharmacy program," he added as an example. "New drugs are going to have a lot harder road to sow, and it's going to be more difficult."

### Rx Manufacturers Will Adjust

The big purchasers who had control in the past were doctors. "In the new model, it's going to be the health plans," he told the audience of mainly biopharmaceutical manufacturers. "You've got to be more prepared to go to market for a new customer."

Among the things manufacturers must consider, Zweigenhaft said, are new evidence-based guidelines that will compare therapies for formulary placement. If the drug is not more effective than what's out there, it will probably be a tier two, he said. On the other hand, if it performs better, you could deserve a premium, he added.

"Health systems are looking at this not just from the drug price, but the whole episode of care costs and what [is] the contribution to the health care system," he said. "Any modeling you can put together around that, and not just pharmacoeconomics but the modeling of the disease, is essential and is going to be important in developing the standard of care."

Aetna Inc. has launched its own initiative to understand how it can better manage the proliferation of cancer drugs, says Mark Rubino, chief pharmacy officer at Aetna. "It's very important to not disrupt the relationship between the physician and the patient in this disease state," he tells *DBN* in an interview.

Rubino acknowledges the challenges of taking the typical buy-and-bill process and creating a new process in which doctors would have to buy the drug from Aetna's specialty pharmacy or from some other infusion company. "It's an area that we feel that we need to look at a little more closely, because of what's in the pipeline — pretty much everything in the drug pipeline is drugs for oncology," he says.

Contact Rubino through Katie Vukas at [vukask@aetna.com](mailto:vukask@aetna.com). ♦

## NEWS BRIEFS

◆ **The House voted 355-59 on June 24 to approve the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331)**, which includes provisions for “prompt payments” of Medicare Part D claims, new Part D formulary requirements, electronic prescribing initiatives and a delay until Sept. 29, 2009, of the start of using the Average Manufacturer Price (AMP) benchmark for generic drugs under Medicaid. The Senate was expected at *DBN* deadline to soon take up companion legislation, S. 3101 (*DBN* 6/13/08, p. 4). The fate of the bill in the Senate is less clear than it was in the House. One potential sticking point in the Senate is the House provision to cut \$14 billion from Medicare Advantage (MA) plans over five years, according to *The Washington Post*. President Bush, who supports the current MA structure, has threatened a veto, and Senate leaders reportedly have made concessions to the White House in an effort to avoid that. Lawmakers are under pressure to pass a bill by June 30 to block a scheduled Medicare physician pay cut set to take effect July 1. To read the legislation, visit <http://thomas.loc.gov> and type the bill numbers in the search.

◆ **CMS on June 19 filed a settlement agreement in a class-action lawsuit to streamline how it administers Medicare Part D benefits for low-income Medicare-Medicaid “dual eligible” beneficiaries**, according to the National Senior Citizens Law Center (NSCLC). Under the agreement, CMS would process files received from states identifying new dual eligibles within one business day after receiving the files. The agreement also requires Part D plans and CMS regional offices to provide additional assistance to beneficiaries whose names are inadvertently missing from pharmacy or plan computer systems. NSCLC and the Center for Medicare Advocacy filed the suit against HHS Sec. Michael Leavitt in April 2006. A copy of the settlement is at [www.medicareadvocacy.org](http://www.medicareadvocacy.org). Contact Severn Williams for NSCLC at [sev@sevwilliams.com](mailto:sev@sevwilliams.com).

◆ **Medco Health Solutions, Inc. said June 23 that it has won a multi-year PBM contract with Coventry Health Care, Inc. starting Jan. 1, 2009.** Medco said it will provide mail-order, retail and specialty pharmacy services for all of Coventry’s Medicare programs, covering roughly 1 million members with total annual drug spending of more than \$2 billion. Other terms of the agreement were not disclosed. CVS Caremark Corp. now has the business. Medco’s

Therapeutic Resource Centers were viewed as an “important advantage for its members,” Medco Chairman and CEO David B. Snow Jr., said in a prepared statement about the Coventry contract. Contact Jennifer Luddy at [jennifer\\_luddy@medco.com](mailto:jennifer_luddy@medco.com).

◆ **Express Scripts, Inc. on June 13 said that it agreed to acquire the workers’ compensation PBM business of Medical Services Company (MSC) for an undisclosed price.** Express Scripts is buying the business from Monitor Clipper Partners, a private-equity firm, it added. The transaction is expected to be neutral to earnings in 2008 and slightly accretive in 2009, Express Scripts said. Contact Steve Littlejohn at [slittlejohn@express-scripts.com](mailto:slittlejohn@express-scripts.com).

◆ **Independence Blue Cross (IBC) will waive co-payments and coinsurance on 75 generic drugs used to treat common chronic conditions, such as high blood pressure, high cholesterol, diabetes, depression, acid reflux, heart failure and heart disease**, the insurer said June 19. The program, Rx for Better Health, begins on July 1 and ends Dec. 31. The program is administered by IBC’s PBM, FutureScripts. Among other things, the program hopes to improve Rx adherence, the company said. Contact Liz Williams at (215) 241-2220.

◆ **Aetna Inc. on June 12 released results of an internal study that found a 70% reduction in Rx duplications for members enrolled in its therapeutic duplication (TD) program.** TD can occur when two doctors are prescribing drugs for the same patient, Aetna said as an example. Launched in January 2007, the TD program is available to fully insured members taking cholesterol-lowering statins. Aetna said it expanded the program to include selective serotonin reuptake inhibitors (SSRIs) for depression, proton-pump inhibitors for ulcers, and “triptan” drugs for migraine headaches. Contact Katie Vukas at [vukask@aetna.com](mailto:vukask@aetna.com).

◆ **PEOPLE ON THE MOVE:** SXC Health Solutions Corp. said that **Gordon S. Glenn**, chairman and CEO, will retire as CEO effective June 30, and that **Mark Thierer**, president and chief operating officer, will be appointed president and CEO. Both will continue to serve as members of the board of directors of the PBM, with Glenn remaining chairman until Dec. 31.

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