

DRUG BENEFIT NEWS

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

Contents

- 3** *Chart:* Most Frequent Changes Made When Tightening Formularies
- 4** More Chains, PBMs Offer Cheap Generics; Rx Payers Ponder Impact
- 5** LIS Beneficiaries Could Prompt Big Shifts in Part D Membership
- 6** *In Their Own Words:* Regence Rx Chief Seeks Evidence-Based Meds
- 8** *News Briefs*

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UM Tweaks Value-Based Rx Drug Benefit Offerings Based on 'Validating' Research

The University of Michigan (UM) will maintain — but slightly restrict — its value-based insurance design program (VBID) for diabetic employees in 2009. The decision was based on preliminary UM research that appears to validate the VBID premise of removing financial barriers to high-value drug therapies as a means of improving overall health, UM's chief health officer tells *DBN*.

The unpublished study data, revealed to *DBN* on Dec. 8, finds "significantly" more diabetics in a two-year UM pilot project with reduced or zero copayments started on medications than did patients in a control group who had full copays, says Robert Winfield, M.D. Pilot members also had higher levels of adherence to certain medications examined in the study, he adds.

"Our conclusion was that there was sufficient evidence for us to continue the benefit and review it in three years," says Winfield.

The UM study evaluated the adherence and uptake rates of a half-dozen "essential medications" taken by employees in UM's "focus on diabetes" program, which offered zero or reduced copayments. The four therapeutic categories in the study were: (1) hypoglycemics, with the indicator drug being the glucose-controller metformin; (2) antihypertensives, with the indicator drugs being angiotensin receptor blockers (ARBs) and ACE inhibitors; (3) hypolipidemics, with the indicator drugs being cholesterol-lowering statins; and (4) antidepressants, with the indicator drugs being selective serotonin reuptake inhibitors (SSRIs).

continued on p. 7

PBMs Tout Their 'Transparency,' but Model Doesn't Always Lower Clients' Drug Costs

The PBM industry claims to embrace the concept of "transparency." In today's business environment, few, if any, PBMs would dare prohibit clients from examining at least a good measure of their contract arrangements. But as more and more PBMs tout their commitment to financial disclosure, some acknowledge that transparency alone doesn't always lower Rx payers' costs. And at least one consultant claims the industry still has a long way to go on demonstrating "real" transparency.

Nevertheless, PBMs are attempting to shed greater light on their business practices. Among recent developments, the HR Policy Association (HRPA) this fall certified three new PBMs and recertified 12 PBMs that agreed to do business in a "fully transparent manner" under HRPA's pharmaceutical coalition standards known as the "Transparency in Pharmaceutical Purchasing Solutions" (TIPPS) standards (*DBN 10/3/08, p. 8*).

The standards include: providing employers the acquisition cost of brand and generic drugs dispensed at retail and mail-order pharmacies; disclosing and passing through all revenue from drug manufacturers that relates to utilization under an employer's contract; providing acquisition cost and pricing transparency for specialty pharmacy drugs; and allowing rigorous audit rights.

continued

The TIPPS standards are changing the relationship between employers and PBMs, says Marisa Milton, director of health care policy at HRPA.

For one thing, HRPA coalition members are much more likely to ask their PBMs about transparent arrangements than are other employers, she tells *DBN*. The coalition is made up of roughly 60 large employers. "More importantly, employers are asking for transparency on their terms, as opposed to having PBMs define transparency for them," she adds.

Because of this, Milton says, employers in the TIPPS program report savings of 3% to 10% off total program costs, compared with their former contracts. But that doesn't mean there aren't areas that could still benefit from greater transparency, she adds.

"Going forward, we would like to explore ways in which employers can hold retailers to the same standards as we currently hold our certified PBMs," Milton explains.

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"And we would like to have more information on how PBMs calculate savings estimates for their clinical management programs."

Other groups also have sought to ensure greater PBM transparency. Standards body URAC addressed transparency in its PBM accreditation standards, released in October 2006 (*DBN* 10/20/06, p. 1). The URAC standard for customer service, communication and disclosure requires that PBMs clearly and adequately disclose the business relationships between contracting parties to health care purchasers. Under this provision, PBMs also should allow their clients the right to audit to adequately determine that contract terms are clearly followed.

Employers are responding to the industry's efforts. Employers that say they are "extremely satisfied" with the financial transparency of their PBM relationship gave their PBMs an average overall service performance rating of 9.1 on a scale of one to 10, according to the Pharmacy Benefit Management Institute's annual PBM Customer Satisfaction Report, released Dec. 8. By comparison, employers that are "extremely dissatisfied" with the transparency arrangement rated their PBMs' performance an average of 4.7, the report said.

PBMs See Value in HRPA Stamp of Approval

PBMs that have received the TIPPS or URAC accreditation naturally are touting their commitment to transparent financial disclosures. But one large health plan-owned PBM says that savings to PBM clients stem from more than just transparency. There are many factors involved when looking at pharmacy costs, and savings are not always guaranteed or achieved through the TIPPS transparency model, says Rob Galle, chief operating officer at Aetna Pharmacy Management (APM).

Galle says clients of PBMs must still carefully review the value proposition in the PBM offering, such as the quality of the services that they will receive. Clients also should have an "inherently strong relationship with their PBM partner to ensure maximum value," he tells *DBN*.

To comply with the TIPPS standards, APM had to modify "minor components" of its business, explains Galle. "However, TIPPS certification has primarily been just a confirmation of the standards we already set for ourselves." APM also received URAC's PBM and drug therapy management accreditation. "These accreditations provide a broad spectrum of checks and balances as it relates to transparency," Galle says.

Tim Heady, CEO of UnitedHealth Pharmaceutical Solutions, says UHPS has long believed in being transparent and has practiced these principles for many years. The principles may be holding sway over other PBMs as well. "The industry overall has clearly moved to a more transparent model due to market demands and increasing

pressures from employers on full financial disclosure," he tells *DBN*.

But Galle also cautions employers about drawing the wrong conclusion regarding PBMs that are not part of standards promoting transparency. "One certification is not the sole indicator of the effectiveness or ineffectiveness of the programs that a company offers," he says.

Transparency Is Said to Be Still Lacking

Meanwhile, some PBM observers contend the industry still fails to provide real transparency.

"The new buzzword in the industry is 'transparency,' but very few PBMs are actually providing transparency, and most PBM clients need assistance if they are to achieve it," says Linda Cahn, president of Pharmacy Benefit Consultants.

If real transparency is to be provided, she tells *DBN*, a PBM must contractually agree to three things:

- ◆ **First, the PBM must agree to invoice its client for every drug dispensed (whether by retail, mail or specialty pharmacy) using the actual price the PBM paid for the drug;**

- ◆ **Second, the PBM must pass through to its client all "financial benefits" that the PBM receives from all third parties, including all rebates, discounts, credits, and administrative and other fees, because all such "financial benefits" decrease drug costs; and**

- ◆ **Third, the PBM must agree to provide the documents and data necessary for its client to verify that the previously described contract terms are being satisfied.**

"Almost no PBMs will execute contracts that contain such terms, and very few consulting firms are insisting they do so," says Cahn, an attorney who has reviewed hundreds of PBM/client contracts and litigated against PBMs (*DBN* 9/5/08, p. 1).

PBMs claiming to be transparent typically agree in their contracts to invoice clients for retail drugs based on the PBMs' reimbursements to retail pharmacies, she says. Those PBMs also agree to disclose data showing they have done so, she adds. "But tellingly, those same PBMs make sure their contracts do not contain pass-through pricing for mail and specialty costs. And they make sure that they will have no obligation to disclose their actual costs for mail and specialty drugs."

As a result, whatever savings a client may achieve from transparency related to retail drugs is "taken back by those PBMs when the PBMs increase their profit spreads on mail and specialty drugs," Cahn contends.

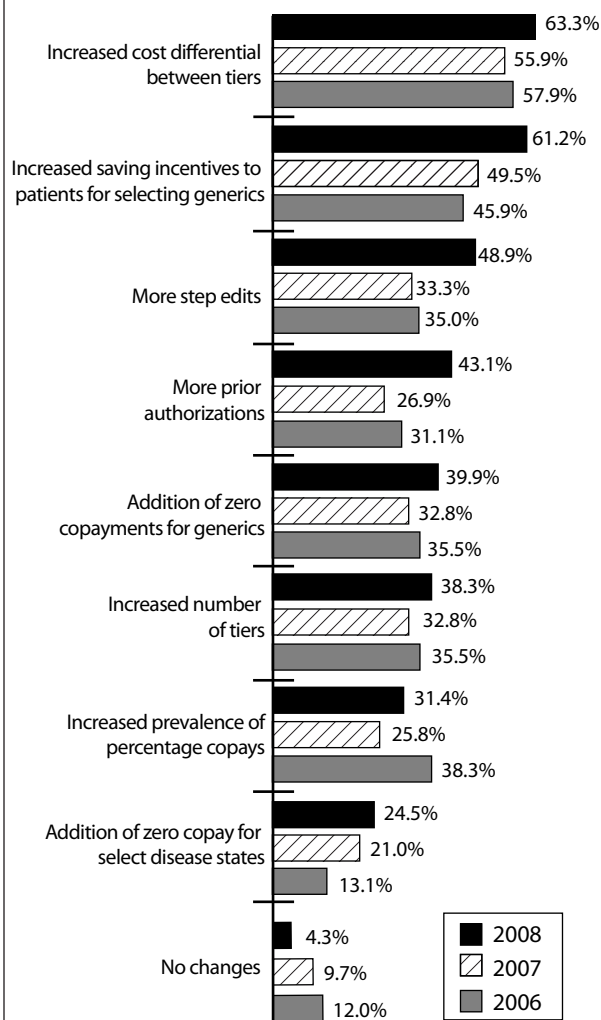
Cahn also asserts that most PBMs write contracts that ensure they will not have to disclose information about third-party payments and discounts, such as the fees paid to PBMs by drug manufacturers or the discounts provided to PBMs by wholesalers. "The test of transpar-

ency is whether a PBM is willing to sign a truly transparent contract, not whether a PBM claims it will provide transparency," says Cahn. "Almost no PBMs are willing to sign such contracts."

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Increased Cost Differential Tops List Of Most Frequent Changes Made When Tightening Rx Formularies, Survey Finds

(percentage of respondents citing each change used)



SOURCE: Foundation for Managed Care Pharmacy's 3rd Annual Emerging Trends Research With Managed Care Pharmacy Experts, October 2008

METHODOLOGY: Survey of 188 managed care pharmacy stakeholders, of whom 139 in 2008 responded to the question: "In the last year, what significant changes have you seen in the way multiple-tiered formulary options are being used to more tightly manage pharmacy spend?"

More Chains, PBMs Offer Cheap Generics; Rx Payers Ponder Impact

More and more health plans, PBMs and retailers are launching or expanding discount generic drug programs in response to the sinking economy and soaring unemployment levels. Meanwhile, some large employers — looking for new ways to reduce their drug spending — are encouraging employees to access retail-based Rx discount programs in addition to their covered pharmacy benefits.

The proliferation of deeply discounted generics programs has underscored the value of these therapies, and created new levels of Rx pricing transparency, stakeholders say. But one drugstore coalition executive also asserts that the programs are creating “turmoil” in the pharmacy benefit marketplace.

Wal-Mart Stores, Inc. launched the concept with its \$4 generics program in September 2006, and other retailers followed suit with their own plans (*DBN 9/22/06, p. 8*).

Most recently, Blue Cross and Blue Shield of North Carolina (BCBSNC) on Dec. 8 said that it would help its customers “fight the recession” by waiving copayments on generics for selected chronic conditions from Jan. 1 through June 30, 2009. The program applies to roughly 1 million BCBSNC customers. Express Scripts, Inc. on Dec. 2 said it would offer 180-day supplies of more than 150 generics for \$20 through its mail-order discount program for low-income individuals known as “Rx Outreach.”

“We recognize that more and more it is a social mission that the country needs us to do right now,” says Ed Weisbart, M.D., chief medical officer of medical affairs at Express Scripts. “These are dire economic times, and we are looking at what we can do to help people who are really struggling,” he tells *DBN*.

Likewise, CVS Caremark Corp. launched a program in November that includes 90-day supplies on more than 400 generic drugs for \$9.99, a program that also aims to help the uninsured during the weak economy (*DBN 11/14/08, p. 6*).

J.B. Hunt Eyes Discount Rx Programs

J.B. Hunt Transport, Inc. is looking at ways to take advantage of these Rx discount plans, according to Samantha Bradshaw, senior benefits manager at the trucking giant.

The company is “very focused on talking about these retailer discounts and encouraging employees to use those, but at the same time ensuring they’re utilizing their prescription drug card,” she told a Nov. 21 audioconference sponsored by the Pharmacy Benefit Management Institute (PBMI). The goal here is to “maintain the detail and the information that supports our experience in [drug] trend data,” she added.

Difficulty in obtaining employees’ Rx utilization data, in fact, remains one of the drawbacks of these programs,

she explained. “If they’re not using the [PBM’s] drug card at the retailer, you’re not going to have the data that supports and supplies your managed care programs, [such as] disease management and lifestyle programs focused on wellness targeting specific conditions.”

J.B. Hunt is working with its PBM to find alternative ways to capture necessary Rx utilization data, including through medical systems integration and working directly with providers and pharmacies, she said.

‘Turmoil’ in the Marketplace?

Meanwhile, the programs appear to be shifting consumers’ prescription purchasing patterns, according to the head of an independent pharmacy Rx buying cooperative.

“We believe there [is] a tremendous amount of prescriptions that were formerly filled on a prescription card that are [now] merely a cash transaction,” said Bruce Semingson, CEO of United Drugs, a pharmacy cooperative that has more than 1,000 independent pharmacy members.

Many independent pharmacies, as well as PBMs and health plans with mail-order pharmacies, are grappling with how to respond to these programs, Semingson told the PBMI audioconference.

The discount programs have shed light on generic pricing, he said. But they also have brought a “tremendous amount of turmoil in the marketplace as it relates to all of the players,” he asserted, pointing out that generics are the most profitable piece of the prescription business — for both retail and mail-order pharmacy — and that deeply discounted generics undercut the bottom line.

Commercial health plans, for example, pay on average \$22.50 to \$25 to retail pharmacies for a 30-day supply of generics, with member copayments totaling between \$10 and \$15, Semingson said. The actual generic, however, may cost just pennies per pill. “Right there you see, ‘Wow, the \$4 program,’” he said. “There is an opportunity at retail to have a better cash price for that patient, versus the managed price.”

Aside from cutting into profit margins, cheap generics have other unintended consequences, Semingson added. For one, it creates a new floor for contracted prices paid by health plans and PBMs, he explained. The cash price — in this case a \$4 generic drug — becomes the “usual and customary” (U&C) price, which is paid by the Rx payer, he explained. “If the regular price is calculated to be \$20, and I have a \$4 generic price program for that same drug, then \$4 becomes the price,” he said of the contract price. As such, retail and mail-order pharmacies receive lower reimbursements.

Fierce pricing battles, brought on in part by the ultra-cheap generics programs, have helped drive down overall U.S. generic spending, according to Rx data firm IMS Health. Sales of generics declined 2.7% in dollar terms in

the 12 months ending in September, while at the same time generic volume increased 5.4% from the previous year's period, IMS said in a Dec. 10 report. As a result, U.S. generic sales dropped \$1 billion to \$33 billion during this time from \$34 billion in the previous 12-month period, it added.

Some PBMs, however, are taking a wait-and-see view of the potential consequences posed by retail-based generic programs.

Most understand that these low-cost options are regarded as drivers of foot traffic for the retailers, says Daniel Coady, director of pharmacy benefit administration strategies at HealthTrans LLC, a nationwide PBM. Still, anecdotal evidence suggests that 1% to 2% of scripts have shifted to retailers with such programs, he tells *DBN*.

As a result, competing retailers are offering "loyalty programs and other discounts" that could result in lower out-of-pocket costs than the standard U&C rate. This may result in "devaluing PBM contracts as well as diminishing the perceived value of employer/payer benefit plans," Coady asserts. "Many plans have opted to mitigate these issues by offering copay incentives for low-cost generics," he says.

Express Scripts' Weisbart doesn't see any marketplace turmoil caused by \$4 generics cutting into profit margins of mail-order pharmacies. "We've looked into that; it's a reasonable question. But we haven't seen much of that at all."

In fact, Weisbart praises the programs for having placed a spotlight on the value of generics. "It has helped moved people past some of their concerns they have had about: 'Are generic drugs the same as brand drugs?'" he says. "We haven't heard anywhere near the discussions around that sort of question as we used to a few years ago."

Contact Coady through Mary Ann McCauley at mam@catalystcomm.net and Weisbart through Steve Littlejohn at SLittlejohn@express-scripts.com. ✦

LIS Beneficiaries Could Prompt Big Shifts in Part D Membership

Premium shifts and product changes among stand-alone Medicare Part D Prescription Drug Plan offerings in 2009 may prompt many of the 17 million people now covered by PDPs to shop for new plans, according to an analysis released Dec. 2 by Mark Farrah Associates (MFA), a health insurance analytics firm. Competition for these beneficiaries is further intensified by the fact that fewer companies will offer PDPs next year, says MFA, which describes the angling for members in the ongoing 2009 open-enrollment season as "tumultuous."

Other Part D watchers say the biggest shifts in enrollment next year will occur where Part D plans exited the market for Medicare-Medicaid dual-eligible beneficiaries.

Avalere Health LLC, for example, says that dual eligibles will have "significantly fewer plans" with zero premiums from which to choose in 2009 than in 2008.

While large shifts in low-income subsidy (LIS) beneficiaries could change the ranking of the 10 largest PDPs in 2009, some insurance brokers interviewed by *DBN* say they are seeing a fairly stable environment during the open-enrollment season for Part D plans that runs from Nov. 15 to Dec. 31.

"We're finding most of the plans in the marketplace are staying very steady," says, for instance, Sam Bennett, a broker in Columbia, Mo. "None of them are withdrawing. None are making dramatic changes."

Some of the changes that are taking place, he notes, include broader coverage options, such as covering generic drugs in the "doughnut hole" gap, which in 2009 starts when total drug spending reaches \$2,700 and ends when out-of-pocket expenses reach \$4,350. "There is just a lot available in the marketplace," Bennett says.

Beneficiaries Have Ample Choice

According to Avalere Health, most states will have between 45 and 49 different PDP options, with some states offering up to 60 PDPs. "So while we're seeing a downward trend in this area, there is still an ample choice by anyone's definition," Bonnie Washington, vice president in the Medicare practice at Avalere Health, told a Dec. 5 audioconference sponsored by her consulting firm.

The stability of the marketplace also is reflected in the fact that only one new company, Bella Vista PharmaCare, entered the PDP market nationwide in 2009, says MFA, citing CMS's recently released "Landscape Files," which provides information on PDPs nationwide. Sixty companies are vying for PDP membership in 2009, down from 66 in 2008, it added. The vast majority of contracts with CMS

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in 2009 were carried over from 2008, MFA said. New York was the only state that did not get new contracts with CMS for 2009, it noted.

At the same time, plan designs will stay fairly steady in 2009. Slightly less than 20% of plans changed the type of coverage offered in the gap between 2008 and 2009, with the majority changing from offering "all drugs covered in the gap" to "many drugs covered in the gap," according to MFA. PDP monthly consolidated premiums in 2009 will vary widely, from \$1 for Pharmacy Insurance Corporation's basic plan in Puerto Rico to \$136.80 for Aetna Inc.'s enhanced plan in New York.

The nationwide average monthly premium for a basic plan with a \$295 deductible and no gap coverage increased \$4.19 a month, or 14%, to \$34.06, MFA notes. The average premium for an enhanced plan with a zero deductible and at least some extra coverage in the gap is \$76.07 for 2009, a 19%, or \$12.48, increase from 2008.

Fewer PDPs Compete for LIS Members

Meanwhile, more than 2 million LIS recipient Medicare beneficiaries may face a disruption to their Rx drug coverage in January, according to a report released in late November by the National Senior Citizens Law Center (NSCLC).

The LIS program now provides premium assistance to more than 9 million low-income seniors and individuals with disabilities, according to the group. PDPs are eligible for LIS beneficiaries if they offer premiums below a certain benchmark set each year by CMS. But fewer PDPs are competing for these beneficiaries. Between 2008 and 2009, the number of LIS offerings decreased in all but one state, and the number of LIS plans offered across all states decreased by nearly 40%, said NSCLC.

Roughly 25% of LIS recipients are now enrolled in fully subsidized plans that will not be subsidy-eligible in 2009, according to NSCLC.

CMS in October said that roughly 1.3 million low-income seniors (14% of the total) would have to change plans next year because their current vendor submitted a bid that exceeded the benchmark (*DBN 10/3/08, p. 1*). This is down from 2008, when 1.6 million low-income seniors (17% of the total) had to leave their plan, according to CMS.

Shifts in LIS beneficiaries can significantly change plans' membership totals, explains Washington. "We'll probably have a different top 10 after everything has settled down early next year when everyone has moved," she tells *DBN* of the largest PDPs.

Carl McDonald, a financial analyst with Oppenheimer & Co., this fall noted that several large PDP players in 2008 are expected to lose significant low-income PDP membership as a result of their 2009 bids (*DBN 10/3/08, p. 1*). These include WellCare Health Plans, Inc., which is expected to

lose almost 450,000 dual and low-income PDP lives in 2009, or roughly 45% of its membership, and Humana Inc. which has said it will lose roughly 308,000 dual eligibles as the results of 2009 bids.

Contact Washington at bwashington@avalerehealth.net. To read the NSCLC report, access <http://www.nsclc.org/areas/medicare-part-d>. ♦

In Their Own Words: Regence Rx Chief Seeks Evidence-Based Meds

The following interview is part of an occasional DBN series that examines hot-button pharmacy benefit issues through the words of the industry's thought leaders. To suggest a topic and commentator, contact Neal Learner at nlearner@aispub.com.

Helen Sherman, Pharm.D., is senior director of pharmacy services and chief pharmacy officer at The Regence Group, which operates Blue Cross and Blue Shield plans in the Northwest. She also is a leading advocate for the use of evidence-based medicine in designing formularies and other utilization tools for prescription drugs. *DBN* caught up with Sherman recently to get her thoughts about evidence-based medicine and how the concept is being applied in managed care pharmacy today.

DBN: *What is evidence-based medicine, and how well are PBMs and health plans today applying the concept?*

Sherman: Evidence-based medicine is applying scientific information in the course of making health care decisions. Evidence-based medicine means different things within the health care industry. Some health care professionals consider evidence-based medicine to mean that the information is published in an established, well-known scientific journal, and the results/author's conclusions are relied upon for health care decisions. There are cautions and risks with this approach because oftentimes the results/author's conclusions are not substantiated within the published information, even in the best medical/pharmaceutical journals. Unsubstantiated information can be misleading and result in unintended health care consequences.

The highest standards in evidence-based medicine include:

◆ *A complete search of all worldwide scientific information, as well as authoritative evidence-based reviews [i.e., the Cochrane Reviews, BMJ Publishing Group's Clinical Evidence, and the U.K.'s National Institute for Clinical Excellence, or NICE].*

◆ *An audit of each study to determine if the information is valid and reliable. In order for data to be reliable, the study must remove bias and confounding, and be designed to prove cause and effect. The necessary components of a reliable study can be found at www.consortstatement.org.*

◆ *The results of only reliable studies are used to draw conclusions for the chances of benefit, harm and value.*

Unfortunately, we find that only 15% to 20% of pharmaceutical studies are reliable. Our findings are not unusual. For example, Pitkin, R. et al (*JAMA*. 1999; 281:1110-11) found that 18% to 68% of abstracts in six top-tier medical journals contained information not verifiable in the body of the article. To assure Regence doesn't disregard valid studies, we request full study information from pharmaceutical manufacturers in addition to reviewing published information. Unfortunately, it's rare for manufacturers to provide information beyond what's in the published study.

Most health plans and PBMs want to apply evidence-based medicine. However, applying the highest evidence-based medicine standards entails having a champion to lead the endeavor, an investment in training, and ongoing validation that the approach produces reliable, meaningful conclusions. It's about being a private investigator, digging deeply and using a microscope on the data. Generally, the highest standards are not applied across the health care industry.

DBN: *What are the biggest obstacles facing evidence-based medicine, and how much more could Rx payers save if these obstacles were removed?*

Sherman: [They need] an understanding of what scientific evidence is and isn't reliable. At Regence, we've invested heavily to understand this. We've studied the worldwide standards and brought in evidence-based thought leaders to assist, critique and validate our approach. We've worked the most extensively with The Delfini Group (www.delfini.org).

Regence has documented over \$530 million in cost avoidance for our 3 million health plan members with our evidence-based approach. This approach has been foundational to helping members and doctors navigate to the best medication values, as well as helping to avoid safety risks.

DBN: *What trends do you see in the private sector to improve evidence-based medicine? Likewise, what can or should the government do to address this issue?*

Sherman: I am encouraged that more large health plans are investing and adopting high standards in evidence-based medicine. There's evidence of this publicly. A standardized, central source of credible evidence-based information in the United States would be ideal. However, large governmental systems who have attempted this so far have not been able to keep up with constantly emerging science in a timely manner.

DBN: *What is the reaction of providers and patients to restrictions on drugs due to evidence-based medicine reviews?*

Sherman: When restrictions are placed as a result of applying high evidence-based standards, the conclusion translated into consumer-friendly information often speaks for itself. For example, letting a patient know there's a one in 50 chance of getting better with treatment, but a one in 25 chance of a life-threatening adverse effect not only provides factual information for his or her own decision, but sheds light and understanding about restrictions.

DBN: *How many new drugs demonstrate a "proven value" when evidence-based techniques are applied?*

Sherman: Since 2004, less than 20% of new pharmaceuticals have proven value in terms of effectiveness, safety, persistence and/or cost. Most new pharmaceuticals have been targeted to improve convenience, but that has not been translated into proven better clinical performance. The pharmaceutical pipeline contains very few innovations that are breakthroughs to address unmet needs, or provide substantial improvement over existing options. ✧

UM Modifies VBID Rx Diabetes Plan

continued from p. 1

"What happened is that the uptake was significantly increased for all four categories, and the adherence was significantly increased for the ACE/ARBs and borderline for the statins," Winfield explains.

UM health insurance plans cover more than 85,000 employees, retirees and dependents. Of these, roughly 3,500 participated in the "focus on diabetes" reduced copay program during all or part of the pilot project.

Winfield acknowledges that the university was prepared to end the program if the data didn't support its aims. UM is a leading champion of the VBID concept, and in 2005 established the Center for Value-Based Insurance Design to "develop, evaluate, and promote value-based insurance initiatives." Expert opinion varies on the VBID concept because of the substantial costs associated with implementing the programs, Winfield explains.

Keith Bruhnsen, manager of prescription drug programs at UM, told *DBN* in June that the VBID program costs the university roughly half a million dollars annually in lost copays (*DBN* 6/27/08, p. 1).

VBID is based on "a complex balance between quality of life, life years saved and the moral value placed on doing the right thing," Winfield says. "The research, in my opinion, validated the value of value-based insurance design," he asserts. "There still remains some discussion about how powerful this effect is, and where and when it should be applied."

In 2009, UM will again apply the value-based design to its focus on the diabetes program, with some modifications. Next year, the program will offer reduced or waived

copays on hypoglycemic, antihypertensive and hypolipidemic drugs for diabetes patients.

Copays under the VBID program will be zero for generic drugs, \$7.50 for preferred brand drugs on tier 2 and \$22.50 for non-preferred brand drugs on tier 3 of the Rx formulary. By contrast, normal copays in 2009 will be \$5 for generics, \$15 for tier 2 and \$30 for tier 3.

The program, however, will not offer copay reductions on antidepressants, as it had in the pilot project. "We decided to take what we felt were the highest-value, highest-impact drugs," Winfield explains about the decision.

Diabetics who are "diet controlled" will not be able to access the VBID benefit. Diet-controlled members are those who were able to control their blood sugar exclusively with diet and were not on insulin or oral meds for blood sugar, according to UM. These individuals could opt in during the pilot phase, but in 2009 will no longer have that option.

And UM retirees will remain ineligible, because "their adherence and uptake are excellent already," Winfield says. "If they're already doing well, the university felt that the additional gain was not sufficient to justify the change in benefit," he explains. These measures will reduce spending on the program.

Winfield says that further study of the impact of copay reductions on health care costs is needed over the long term. "We were pleased to see the positive results," he says of the preliminary findings. "However, we want to keep an eye on the consequences of this benefit design in further research that will be coming out. So we intend to review the data again in three years." In the meantime, UM is already considering VBID programs for other health purposes, including smoking cessation.

For more information, contact Winfield through Dave Reid at dtreid@umich.edu. ♦

NEWS BRIEFS

◆ **Hannaford Supermarkets and HealthTrans LLC on Dec. 1 launched a pharmacy benefits plan for other employers in Maine, New Hampshire, Vermont, Massachusetts and New York.** Among other things, the companies said, the plan features a non-restrictive network, cost incentives to fill prescriptions at Hannaford pharmacies, and a value-based formulary design with options that reward employees who make cost-effective choices. Hannaford will market the program, while HealthTrans will provide back-office support, according to HealthTrans. The supermarket chain operates 167 stores in the Northeast and provides pharmacy service at 128 locations. Contact Mary Ann McCauley for HealthTrans at mam@catalystcomm.net.

◆ **Attorneys representing consumers and third-party Rx payers on Nov. 21 said they reached a proposed \$350 million settlement with McKesson Corp. to settle allegations it conspired with drug information firm First DataBank (FDB) to fraudulently inflate the average wholesale price (AWP) Rx pricing benchmark.** Health plans, retailers and others use AWP to calculate the price of drugs. The suit alleged that McKesson and FDB increased the AWP spread between wholesale acquisition costs (WAC) and AWP from 20% to 25% beginning in 2001, allowing retail clients to reap larger profits at the expense of consumers and third-party payers, according to plaintiffs' law firm Hagens Berman Sobol Shapiro LLP. The plaintiffs propose that \$288.7 million of the \$350 million settle-

ment go to insurers and other entities that paid for drugs from Aug. 1, 2001, to March 15, 2005, according to the law firm. A settlement approval hearing has not yet been set, it added. For more information, visit http://www.hbsslaw.com/McKesson_classaction.htm. Contact Mark Firmani at Mark@firmani.com.

◆ **Prime Therapeutics LLC on Dec. 2 said it entered an agreement with Rochester, N.Y.-based Excellus BlueCross BlueShield to provide pharmacy mail service to roughly 1.2 million health plan members through PrimeMail, Prime's mail-service pharmacy.** The arrangement begins Jan. 1, 2009. PrimeMail expects to process roughly 500,000 mail scripts for Excellus Blues members in 2009, Prime said. In another development, Blue Cross and Blue Shield of Montana selected Prime to provide PBM services under a three-year contract that begins Jan. 1, Prime said Dec. 10. The company said it will provide services to more than 175,000 Montana Blues members. Contact Sheila Thelemann at ssthelemann@primetherapeutics.com.

◆ **PEOPLE ON THE MOVE: Thomas Boudreau**, general counsel and executive vice president of law and strategy at Express Scripts, Inc., said he plans to retire effective April 1, 2009, according to a filing with the Securities and Exchange Commission. Boudreau will remain executive vice president of law and strategy until his retirement. **Keith Ebling** was named executive vice president and general counsel for the company, effective immediately.

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