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DRUG BENEFIT NEWS

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

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House Passes Part D Rx Negotiations Bill; Senate Goes Slow in Face of Opposition

As expected, the full House passed legislation last week that gives HHS the authority to negotiate prescription drug prices under the Medicare Part D benefit. The initiative, however, is expected to face a much tougher time in the Senate, where some Democrats already have expressed skepticism about the government's ability to drive prices lower than what can be achieved by private health plans and PBMs.

Meanwhile, CMS issued a report from its independent actuaries that concluded mandated government negotiations "would not produce any savings." And President Bush has vowed to veto any bill that includes the government negotiations provision.

Nevertheless, the House voted 255 to 170 — including 24 Republican votes — on Jan. 12 to approve H.R. 4, a bill that removes the "non-interference clause" in the 2003 Medicare reform law that has prevented the government from negotiating prices. According to the legislation, the HHS secretary "shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged" to Medicare Prescription Drug Plan (PDP) sponsors and Medicare Advantage prescription drug plans (MA-PDs).

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Humana Launches Generic Copay Waiver; BCBSMN's Zero Copay Lifts Generic Rx Usage

In an effort to raise awareness about the value of generic drugs, Humana Inc. is waiving the first copayment on generics in a half-dozen therapeutic classes. The program, unveiled last month, will be available in 2007 to all of Humana's fully insured commercial members on tiered copay Rx drug plans. The initiative comes as other health plans and PBMs are renewing efforts to promote the low-cost therapies, including through the use of copay waiver programs, which rocketed generic utilization to more than 70% at one Blues plan.

Under Humana's "Waive Generic Copayment" program, members get their first prescription free when they elect to switch to generic alternatives in one of six targeted classes: proton pump inhibitors, Cox-2 inhibitors, hypertension, cholesterol, depression and diabetes oral medications. The program is Humana's first step at waiving generic copays, say company executives.

continued

"It's an added value to the consumer," says Steve Hyde, manager of clinical operations and pharmacy and therapeutics at Humana. "It saves the consumer money [and] saves the payer some money."

Humana selected the six drug classes initially for the program because they treat chronic diseases for which medication compliance is important, says Hyde. The company will consider expanding the program based on its effectiveness in these classes, he adds. Hyde also says that Humana has not set a target percentage for generic utilization. "We feel it can definitely go higher," he says. "We'd like to see it go higher. There is really no ceiling as to what number is appropriate."

Blue Cross and Blue Shield of Minnesota (BCBSMN), meanwhile, has seen generic utilization soar to more than 70% under its year-old copay waiver program. The program more than pays for itself, says Al Heaton, Pharm.D., director of pharmacy at BCBSMN, which first offered the program to self-insured clients in January 2006, and extended it to fully insured clients in July 2006. In total, about 35% of BCBSMN's 2.7 million members are not charged for generics, Heaton explains.

After a year on the program, self-insured clients have seen major shifts toward generics, he says. "They went from an aggregate of 54% to 55% of all prescriptions filled generically now to 72% to 73% of all prescriptions filled," Heaton says. Most self-insured clients reach a break-even point when their generic utilization rate rises between five and 10 percentage points. At this point, the money spent on absorbing the full cost of the covered population's generic drugs is fully offset by the money not being spent on brand drugs, according to BCBSMN.

Small Copay Shifts Make Big Impact

"The net result is they are paying a lot less money for their members for a [per member per month] basis than they did almost two years ago," Heaton says. Fully insured clients are on the same track, he adds. "Within four months time, we have had an improvement of nearly four percentage points on generic use, from about 56% to 60% of all prescriptions generic," Heaton says. Cost savings for these clients have been estimated at about $17 million already, he adds.

Heaton also explains that even a small shift of $2 to $3 in copays can make a difference in utilization patterns. "When you go from $10 to zero dollars, as you would on a typical generic, you do see quite a bit of difference," he says.

BCBSMN does financial modeling for employers to demonstrate savings under the waiver. "If you want to hedge your bets a little bit, and say 'I want to drop my generic copays to zero, but I'll up my non-formulary brand copayment to some amount,' we model that out as well," he says. "This provides additional incentive to move to generics. They can move right away to zero and feel that they're still whole, that they're not losing something. This way, if the behavior does take place, then they gain the benefits of that as well."

Another benefit of the zero-dollar copay appears to be improvement in Rx persistency, Heaton explains. "If you get on the right drug, and it doesn't cost you anything, you have a tendency to stay on the drug," he says, pointing out this could have a beneficial financial effect for payers. "There may be some downstream cost savings on the medical side from doing this practice," says Heaton. He adds that BCBSMN is examining the data to find such a correlation.

Like other insurers, Aetna, Inc. aims to increase generic usage. It has been successful in boosting generic rates in recent years as several large therapeutic classes

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have gone generic, says Michael Brodeur, head of formulary development and pharmacy clinical policies at Aetna. The major class to go generic in 2006 was the statins, with both Merck & Co.'s Zocor (simvastatin) and Bristol-Myers Squibb's Pravachol (pravastatin) going generic in the second half of the year, he says.

"In the last several years, we have had major drug classes every year: Antidepressants went generic two years ago, and now the cholesterol-lowering drugs in '06," Brodeur says. "Going into '07, there is not really a large class of drugs. But in '08, there will be another big class of drugs: The [proton pump inhibitors] will have their second big entrant of a generic. We probably would see a lot more shifting. The goal is always to keep increasing the generic utilization."

Plans, PBMs Continue Pushing Generics

Aetna plans to continue using a number of tools to encourage generic usage in the coming year, including a coupon program that allows members to skip a copay while still reimbursing the pharmacy. "We usually roll it out in targeted areas first," Brodeur says. Aetna identifies areas with the lowest generic utilization rates, and uses the coupons to try and boost generic utilization among prescribers, he says.

Medco Health Solutions, Inc. also will continue its efforts around generics in 2007. These initiatives include sending out client communications about the generic pipeline and patient-specific physician communications asking for a "dispense as written" waiver so that the generic can be substituted.

The PBM also will continue using its "Off-Patent Migration Program" that focuses on blockbuster drugs losing patent protection, says Medco spokeswoman Jennifer Luddy. The program communicates to members, physicians and retail pharmacists about the arrival of the generic. Elements include:

◆ ***A $15 copay waiver to encourage members to move their brand prescription to Medco's mail-order pharmacy prior to drugs going off patent*** (this is to capitalize on the generic substitution quicker once the patent expiration takes place, Luddy says);

◆ ***A faxed notification that the generic version of a particular brand drug is coming*** (90 days prior to patent expiration), and a faxed notification that the generic is now available; and

◆ ***Point-of-sale messaging.*** Through Medco's integrated data systems, the PBM sends a message to retail pharmacies if a generic equivalent is available.

Contact Doug Bennett for Hyde at (502) 580-3625, Kate Prout for Michael Brodeur at (215) 775-6264 and Luddy at (201) 269-6402. ✧

Rx Copay Waivers Could Help Save Lives of Heart Attack Victims

Covering the full cost of cardiology drugs taken by patients who have suffered a heart attack could prevent repeat attacks and strokes, saving 4,736 lives and $2.5 billion in annual health costs, according to a new study that finds waiving medication copayments would greatly increase compliance rates.

The study, published in the January-February 2007 issue of the journal *Health Affairs*, estimated that health insurers would spend an additional $644 per patient to waive out-of-pocket expenses for drugs such as beta-blockers, ACE inhibitors and statins. But the researchers found that an increase in medication compliance would save $5,974 per patient.

In practice, however, such condition-specific copayment programs are not common among health insurers, and carry some operational challenges, say managed care executives.

The return on investment from so-called secondary prevention programs — aimed at patients who already have suffered a primary heart attack or other event — "is pretty strong," says Robert Epstein, M.D., chief medical officer at Medco Health Solutions, Inc. "We have had a lot of plans that have experimented with different plan designs for secondary prevention," he says. The tactic allows health plans to direct additional resources to patients at significantly higher risk of a second attack, rather than to the "worried well," he says.

Overcoming Operational Challenges

But, Epstein adds, in one case, "chaos ensued at the member level" since different employees paid different copays for the same drug. Ultimately, these programs were phased out. "I'm not opposed to the concept," he says. "The reality is how it plays out in the member level."

Blue Cross and Blue Shield of Michigan subsidiary Blue Care Network offers reduced copays for certain conditions. But the insurer avoids restricting the programs to patients with specific diagnoses because of operational challenges, says Kim Tonkavich, director of pharmacy health centers at Blue Care Network.

In an effort to improve medication compliance, the HMO subsidiary in March 2006 said it would reduce copays for certain brand-name asthma control medications to the generic copay level. The goal is to increase compliance with control drugs, improving asthma control, reducing dependence on rescue medications and eliminating some hospitalizations. Under the most popular benefit structure, that accounts for almost $400 per patient per year in additional spending by the insurer, Tonkavich says. The brand-name copay is $40,

versus a $10 generic copay, and such prescriptions typically are refilled monthly.

"By helping to lower the consumer share of out-of-pocket expenses, there is a direct correlation to an increase in compliance," Tonkavich says. So far, the insurer has noted a 20% to 25% increase in controller medication utilization, although the company still is conducting analysis to compare its experience to local and national trends, he says. The company also is still examining the effect of compliance on costs. The Michigan Blues plan is considering expanding the program to other disease states, including both diabetes and cardiovascular conditions.

"We opted to put the reduced copay at the drug level, irrespective of the disease identifier," Tonkavich says. "We didn't load it only to specific patients — we loaded it globally." As a result, the health plan is "pretty confident" that members with other airway conditions such as chronic obstructive pulmonary disease also are benefiting from the program. Blue Care Network was concerned that if the program was restricted to certain conditions, new patients and those for whom the plan has incomplete medical data would not benefit, he explains.

Call *Health Affairs* spokesperson Caroline Broder at (301) 652-1558 or Michigan Blues spokesperson Jon Ogar at (517) 336-5648. ✧

Medco, Mayo Ink Genetic Testing Deal, but Some Questions Remain

Medco Health Solutions, Inc. last month entered into a strategic alliance with Mayo Collaborative Services, Inc. to evaluate the potential of genetic testing — a move that some say is another sign that genetic testing continues to gain mainstream health care acceptance. But one industry insider asks whether PBMs' role in genetic testing will prove to be a boon or distraction to that burgeoning area of health care.

The initial focus of the partnership is a "comprehensive, community-based analysis" of patients taking the anticoagulant warfarin, also known as the brand-name drug Coumadin. Slated to start in the first quarter of 2007, the study will enroll patients and their physicians in order to look at real-world experiences on the drug. The two companies plan to evaluate genetic test results of more than 1,000 patients.

Medco says that about 2 million people begin warfarin therapy annually in the United States, and about 200,000 of those patients are in Medco's prescription drug database. Patients metabolize the drug differently, and improper doses can cause clotting or overbleeding. Genetic testing can help physicians determine the rate at which patients will metabolize the drug.

Robert Epstein, M.D., chief medical officer at Medco Health Solutions, Inc., says that the long-term goals of the collaboration are focused on "taking a broader approach" to genetic testing, specifically "what is the value proposition of genetic testing, of personalized medicine, for the payer?" Although he declines to elaborate on any other areas that the new alliance may look into, Epstein does tell *DBN* that "specialty drugs is a particularly interesting area" and that the "value proposition is even better" for genetic testing within these drugs.

With the agreement, Medco becomes the second big PBM to form an arrangement with a company focused on genetic testing. In September, PharmaCare Management Services, Inc. and a division of diagnostic services company Clinical Data, Inc. said they had formed a collaborative agreement to incorporate genetic testing into specific treatments, including a warfarin test *(DBN 11/17/06, p. 6).*

Reaching a Tipping Point

Epstein says that Medco had actually begun looking at personalized medicine about five years ago, but a lack of industry interest led to the PBM's shelving the idea — at least for a while. So what's changed since then?

"I feel like we are close to a tipping point," says Epstein, pointing to "an alignment of policy, economics, consumer demand and interest.…The community has run the gamut of benefit design changes, and they are looking for something different. The timing is better now," he contends.

Self-insured employer payers are expressing stronger interest than are health plans, says Epstein. "Health plans are concerned about return on investment [ROI]. They need to make a policy decision," he says, adding that "this is not an inexpensive test."

Still, Epstein says, some of these tests do have an ROI. He cites a November 2006 American Enterprise Institute-Brookings Joint Center for Regulatory Studies report on the case for genetic testing involving warfarin to realize health care savings, and says its results seem to be similar to Medco's findings after an internal analysis of new starts on Coumadin. "We estimate that formally integrating genetic testing into routine warfarin therapy could allow American warfarin users to avoid 85,000 serious bleeding events and 17,000 strokes annually," finds the study. "We estimate the reduced health care spending from integrating genetic testing into warfarin therapy to be $1.1 billion annually, with a range of about $100 million to $2 billion."

"Dabbling into genetic testing with a sense to see who is at risk is not a real new idea conceptually," says Al Heaton, Pharm.D., director of pharmacy at Blue Cross Blue Shield of Minnesota. "Will it safeguard some drug therapy? Yes. The tricky problem is do you test the entire

population," or do you wait until someone is diagnosed with a condition and needs to begin medication, which has a more urgent need.

According to Heaton, the PBM deals are coming at a time when "there is public uncertainty surrounding genetic testing, and there is public uncertainty surrounding PBMs." He asks whether people will wonder whether such deals are self-serving for PBMs. "To have PBMs out in the forefront of the issue, it's hard to know how well this will be received."

Heaton also notes that there are two big factors in the current environment that will impact genetic testing: The government wants to promote the idea, but there are corresponding privacy concerns *a la* HIPAA. The issue is highlighting the collision of the public-health perspective and the private-life perspective, he says. Still, Heaton stresses that "we're all interested in seeing genetic testing done" on a larger scale.

Contact Heaton at al_heaton@bluecrossmn.com and Jennifer Luddy for Epstein at (201) 269-6402. View the AEI/Brookings study at www.aei-brookings.org/admin/authorpdfs/page.php?id=1337. ✧

Senate Mulls Direct Rx Negotiations

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The bill, however, does not authorize HHS to establish, or require, a particular formulary. The legislation also does not prevent a Part D sponsor from obtaining a discount or reduction of price for a covered Part D drug below the price negotiated by the government.

While some health plans have said direct negotiations could level the playing field among Part D sponsors — and lower costs for all participants — most industry stakeholders have roundly opposed the idea. Many critics of government negotiations point out that Part D already is providing drugs at costs that are well below initial expectations.

"We are very supportive of the competitive model on which Medicare Part D is structured," says Judith Cahill, executive director of the Academy of Managed Care Pharmacy (AMCP). Repealing the non-interference provision would introduce factors that are incompatible with a competitive model in the way it is structured and being administered today, she tells *DBN*. "The reason we're opposed to that change is because the program is working," Cahill says.

Recent satisfaction surveys find that in excess of 70% to 80% of beneficiaries are realizing Rx cost savings and improved access to the medications they need, she notes. In addition, premium levels in the first year and 2007 came in under budget, Cahill says.

Such arguments will now be taken up by the Senate, where Rx negotiations legislation is expected to face more obstacles, if not be killed outright through a promised filibuster. Sen. Max Baucus (D-Mont.), chairman of the Senate Finance Committee, which has jurisdiction over Medicare, held a hearing Jan. 11 on the issue. Baucus, who has opposed earlier Rx price negotiation measures, said he was open to the idea.

"The non-interference clause in the original Medicare Modernization Act is prohibiting us from pursuing constructive efforts to make the benefit work better for seniors," he said in a prepared statement. "The total prohibition on negotiation should be eliminated."

But Baucus also said the Part D program is working well for most beneficiaries. "I see nothing that warrants heavy-handed intervention in this market," he said. "We should proceed cautiously with any legislation. But we should proceed nonetheless." Among other things, Baucus said, "price controls and national formularies are clearly not the answer."

Leading Senate Bill Has Narrower Focus

Sens. Ron Wyden (D-Ore.) and Olympia Snowe (R-Maine) on Jan. 9 unveiled what will likely be the leading legislation on the issue. The bill, S.250, allows for government price negotiations, but also calls for some limitations. Under the legislation, the HHS secretary would be required to negotiate if:

- ***A pharmaceutical is a single-source drug, which means there is only one brand name of the drug available;***
- ***A drug was created with substantial taxpayer funding for its research and development; and***
- ***A private insurance plan requests help.***

The legislation also says there can be no "price-setting or uniform formularies." The Wyden-Snowe bill is a revised version of last year's legislation that received

54 votes in the Senate. Any measure, they acknowledge, would need 60 votes to overcome a filibuster. Indeed, Sen. Chuck Grassley (R-Iowa), ranking minority member of the Senate Finance Committee, has said he would join other senators to filibuster the legislation.

HHS Doesn't Want the Authority

That would likely satisfy HHS just fine. Private competition, the department says, has driven down prices below initial expectations. According to CMS actuaries, Part D budget estimates show that payments to Part D plans are projected to be $113 billion lower than expected over the next 10 years, HHS said Jan. 8. Of the $113 billion reduction, $96 billion is a direct result of competition and significantly lower Part D plan bids, the department asserted.

CMS also said the average monthly premiums for the basic benefit will be roughly $22, down from $23 in 2006. The original estimate for 2007 premiums was $38, it added. Government negotiations couldn't drive prices lower, CMS contends. Independent actuaries at CMS that reviewed H.R. 4 concluded government negotiations would "have no effect on lower drug prices," CMS said.

The "inability to drive market share via the establishment of a formulary or development of a preferred tier significantly undermines the effectiveness of this negotiation," said Paul Spitalnic, a director in CMS's Office of the Actuary. "Manufacturers would have little to gain by offering rebates that aren't linked to a preferred position of their products, and we assume that they will be unwilling to do so," he said in a Jan. 11 prepared statement.

AMCP's Cahill asserts the push for direct negotiations reflects a lack of appreciation for the complexities involved in the purchase of medications. Formulary decisions involve a combination of looking at clinical attributes and value that medications offer to covered populations, she says.

The reason a health plan is able to negotiate a low price for a drug is because the manufacturer believes

VA's Prices for Top 20 Drugs Prescribed to Seniors vs. Prices Offered by Top Part D Insurers, November 2006

				Part D Plans		Percentage Difference	
Drug Name	Strength	Dose Form	Lowest VA Price per Year	Lowest Price per Year	Highest Price per Year	Lowest VA Price and Lowest Plan Price	Lowest VA Price and Highest Plan Price
Actonel	35 mg	tab	$372.24	$763.56	$902.64	105%	142%
Aricept	10 mg	tab	$1,058.69	$1,561.44	$1,795.56	47%	70%
Celebrex	200 mg	cap	$632.09	$946.44	$1,107.36	50%	75%
Fosamax	70 mg	tab	$250.32	$763.56	$902.64	205%	261%
furosemide	40 mg	tab	$7.81	$15.24	$54.96	95%	604%
Lipitor	10 mg	tab	$520.49	$785.40	$946.92	51%	82%
Lipitor	20 mg	tab	$782.44	$1,120.32	$1,340.52	43%	71%
metoprolol tartrate	50 mg	cap	$10.84	$16.20	$78.36	50%	623%
Nexium	40 mg	cap	$848.45	$1,433.16	$1,652.04	69%	95%
Norvasc	5 mg	tab	$315.84	$486.48	$592.56	54%	88%
Norvasc	10 mg	tab	$448.88	$667.56	$795.24	49%	77%
Plavix	75 mg	tab	$989.36	$1,323.24	$1,529.16	34%	55%
Prevacid	30 mg	cap DR	$332.71	$1,444.32	$1,647.00	334%	395%
Protonix	40 mg	tab	$214.52	$1,148.40	$1,333.20	435%	521%
Toprol XL	50 mg	tab	$167.22	$263.16	$342.60	57%	105%
Toprol XL	100 mg	tab	$250.06	$395.52	$490.56	58%	96%
Xalaton	0.005%	sol	$427.08	$582.96	$700.56	36%	64%
Zocor	20 mg	tab	$127.44	$1,485.96	$1,693.92	1,066%	1,229%
Zocor	40 mg	tab	$191.16	$1,485.96	$1,693.92	677%	786%
Zoloft	50 mg	tab	$465.91	$819.96	$1,254.24	76%	169%
Median Percentage Difference						**58%**	**101%**

Note: Annual prices are calculated based on the price posted by the Part D plans and the VA in November 2006. Not all drugs in the chart are on the VA formulary, but they are available to VA members at the price listed.
SOURCE AND METHODOLOGY: *No Bargain: Medicare Drug Plans Deliver Higher Prices*, January 2007, Families USA Report
VA prices are from the VA PBM and the VA's list of national contracts. These prices were collected online through www.pbm.va.gov during the last week of November 2006. For each drug, the VA price shown is the lowest price for that drug on any one of several price schedules negotiated and maintained by the VA. Part D plan prices are from the Medicare Prescription Drug Plan Finder located online at www.medicare.gov, accessed the weeks of Nov. 20 and 27, 2006. Prices shown are the prices reported by the largest Part D insurers in Region 5, and include both mail-order and retail prices. The drugs are the 20 drugs most frequently prescribed to seniors in the Pennsylvania PACE program in 2004.

that by giving the health plan this price, the plan will support the use of that product, and therefore more product will be sold by the manufacturer, Cahill explains. "So there is leverage that comes with the volume of business that the manufacturer assumes they are going to be doing on behalf of that covered population for that particular health plan," she adds. "If I'm the federal government, what do I have to offer? I don't offer a prescription drug benefit. Where is my leverage?"

Still, some proponents of direct negotiations argue that Medicare Part D could have at least the same leverage as the Department of Veterans Affairs (VA). Prices under the VA's drug plan are 58% lower than those under the Medicare drug plans, says health advocacy group Families USA.

According to a Jan. 9 Families USA report, prices charged by the five largest Part D sponsors are 50% to 75% higher than the VA price for Celebrex, 51% to 82% higher for Lipitor (10 mg), 69% to 95% higher for Nexium, and 205% to 261% higher for Fosamax (see table, p. 6).

Families USA believes that access to drugs under the VA system and access to drugs under Part D are quite comparable, says Marc Steinberg, deputy director of health policy at Families USA. Both systems have an exception process for drugs not on the formulary, for example.

The price difference on the VA program provides a sense of the bargaining power that the government has, Steinberg says. "No one is saying that you'd want to import the VA system wholesale into Medicare Part D," he says. "But to get a sense of the magnitude of the savings that are left on the table by Part D, it is a very helpful comparison."

But Cahill counters that the price comparison between VA and Part D drug plans is "really looking at apples and oranges."

Substantial differences between the two systems include the fact that VA maintains its own formulary and uses a comparatively limited network of VA pharmacies, Cahill says. VA both purchases and distributes prescription drugs, she adds. By contrast, the Medicare program serves as an insurer that pays for care that is delivered to covered beneficiaries at a myriad number of sites by professions operating without a centralized system's oversight and guidance, according to AMCP.

Regardless of the technical arguments, some observers contend that the direct-negotiations initiative is much more about politics than pharmaceutical procurement.

Direct negotiations "is politically an easy win," says John Graham, director of health care studies at free-market think tank Pacific Research Institute. Graham, who opposes the idea, expects a bill will eventually pass both chambers. "I would anticipate a bill that is quite sloppily written just to go up to [President Bush] to veto, to make him [and other Republicans] look bad in '08," he says.

For more information on the Wyden-Snowe proposal, visit http://wyden.senate.gov. Contact Graham at (415) 955-6104 and Cahill at (703) 683-8416. ✧

NEWS BRIEFS

◆ **CVS Corp. on Jan. 16 boosted its offer to acquire Caremark Rx, Inc. by $2 a share to be paid in the form of a one-time dividend to Caremark shareholders.** CVS also said it would retire 150 million outstanding shares in the new company, representing roughly 10% of the combined firm's shares. The share retirement is expected to significantly increase the combined company's return on equity in 2008, CVS said. The sweetened deal came hours after rival suitor Express Scripts, Inc. said it would offer Caremark stockholders $29.25 in cash and 0.426 of a share of Express Scripts stock for each share of Caremark. The offer gives Caremark stockholders a 7% premium over the value of CVS's proposal as of Jan. 16, Express Scripts said. The bidding war follows on the heels of Caremark's Jan. 8 rejection of Express Scripts' $26 billion offer in December 2006 to acquire the company *(DBN 1/8/07, p. 1)*. That offer, in turn, followed a November 2006 CVS offer of $21.1 billion to acquire Caremark *(DBN 11/3/06, p.4)*. CVS and Caremark said Jan. 16 that the combined company is expected to achieve between $800 million and $1 billion in "incremental revenues" in 2008, revenues that would be driven by sales of new offerings that only a drugstore/PBM combination can provide. But Express Scripts responded that this is the third set of synergy estimates from CVS and Caremark in as many weeks. "This time, CVS and Caremark have discovered alleged revenue synergies with unknown, if any, profitability," Express Scripts said. The fate of a Caremark-CVS merger could rest on a shareholder vote expected in mid-March.

continued

NEWS BRIEFS (continued)

◆ **WellPoint NextRx said Jan. 9 that it had won a three-year contract with the Missouri Department of Transportation (MoDOT) and Missouri Highway Patrol Medical and Life Insurance Plan.** Under the contract, which took effect Jan. 1, WellPoint NextRx provides pharmacy benefit management to an estimated 27,500 covered lives. The PBM services include claims processing, network management mail services, specialty drug services, formulary management and prior-authorization services. WellPoint NextRx will also support MoDOT's clinical programs and drug utilization review. Contact Leslie Porras at (805) 557-6745.

◆ **OptionCare said Jan. 11 that it has signed a two-year agreement with New York-based Excellus BlueCross BlueShield and Univera Healthcare to provide specialty pharmacy services to more than 1.4 million members.** Under the agreement, OptionCare will provide specialty therapies and medication management programs to members of FLRx, the pharmacy benefit management entity for these companies. These services will be coordinated through OptionCare's Specialty Pharmacy Center located in Ann Arbor, Mich. Contact Raj Rai, president and CEO of OptionCare, at (847) 229-7724.

◆ **HealthExtras, Inc. said the state of Louisiana has informed the company that it intends to award a new contract to Catalyst Rx, the company's PBM subsidiary.** The award is subject to final contract execution and is expected to be effective July 1, 2007. The contract would cover more than 225,000 beneficiaries. HealthExtras said it will provide an update on this and other corporate developments in its quarterly conference call, scheduled for Feb. 27. Contact Michael Donovan at (301) 548-2900.

◆ **Roughly 4,200 people submitted applications on the first day of enrollment Jan. 2 for CoverRx, the state of Tennessee's prescription-drug program for the uninsured, or for people who have insurance that doesn't cover drugs**. The program is open to people ages 19 to 64 who earn no more than 2.5 times the federal poverty rate, which is $24,500 for an individual and $50,000 for a family of four. CoverRx is part of the state's multipronged health initiative dubbed Cover Tennessee, according to the *Tennessean*. CoverRx is expected to cost the state $45 million over three years if an anticipated 25,000 to 50,000 people sign up. About 250 drugs are available through CoverRx. Copayments, which vary depending on income, will be required of all enrollees. Individuals earning as much as $24,500 can expect to pay no more than $10 for a generic drug, according to the newspaper. Poorer people will pay as little as $3 for generics.

◆ **Prescription drug spending grew 5.8% in 2005, compared with 8.6% in 2004 and a peak of 18.2% in 1999,** according to a Jan. 9 article in the journal *Health Affairs*. Overall U.S. health care spending slowed to 6.9% in 2005, down from 7.2% growth in 2004 and 8.1% in 2003. The slowdown in drug spending is a result of increasing generic drug use, a proliferation of tiered-copayment benefit plans (which slowed the use of brand-name drugs), a drop in the number of new drug introductions, and a "dramatic decrease in Medicaid prescription drug spending," the article said. Total drug spending in 2005 was $200.7 billion, compared with $189.7 billion in 2004, it added. Drug prices increased 3.5% in 2005, about the same rate as in 2004, according to the article. The average manufacturer price increase for brand drugs in 2005 was 6.0%. "However, this strong price growth was offset by a continued shift to generic drugs that cost, on average, 30%-80% less than brand-name drugs," the report said. Contact Caroline Broder for *Health Affairs* at (301) 652-1558.

◆ **PEOPLE ON THE MOVE: Edmund J. Pezalla, M.D.**, vice president and medical director at Prescription Solutions, has been named to the board of trustees of the Pharmacy & Therapeutics Society, a nonprofit association, for a two-year term.…CIGNA HealthCare said **Eric Elliott** will rejoin CIGNA on Jan. 17 to become president of CIGNA Pharmacy Management. Among his duties, Elliott will oversee CIGNA Tel-Drug, the company's home-delivery and specialty pharmacy. Most recently Elliott held senior executive positions at Aetna, Inc., leading its pharmacy and limited benefit/voluntary businesses. Prior to that, he ran product, sales and e-business for CIGNA Pharmacy Management while leading CIGNA's Tel-Drug business.

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