

DRUG BENEFIT NEWS

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

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Senators, FTC Aim to Stop Deals Delaying Generics; Practice Costs Plans Billions

Some Capitol Hill observers say the odds are good that Congress will pass legislation this session that would prohibit brand drug manufacturers from paying generic drug firms to delay the entry of generic products. Health plans and PBMs say the practice is costing them billions of dollars in unnecessary drug spending. A bipartisan group of senators introduced a bill last month that would prohibit the brand-generic agreements.

The Federal Trade Commission (FTC), which threw its support behind the legislation, issued a Jan. 17 report that says there has been a substantial increase recently in the number of settlements involving a payment to the generic drug maker and a restriction on generic entry. Implications of these deals for consumers, and for others who pay for prescription drugs, are serious, FTC Commissioner Jon Leibowitz told a Senate Judiciary Committee hearing on the topic Jan. 17.

"The increased costs resulting from anticompetitive agreements that delay generic competition harm all those who pay for prescription drugs," he said.

The issue centers on pharmaceutical patent settlements involving "exclusion payments," also known as "reverse payments," in which a brand manufacturer pays its potential generic competitor to abandon a patent challenge and delay entering the market, Leibowitz explained. Such agreements have become more common following two appellate court decisions in 2005 that took an "extremely lenient view of exclusion payment settlement," he added.

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Boom in Walk-In Clinics Raises Questions About New Rx Spending, Pharmacy Records

As walk-in health clinics in retail stores proliferate, some health plans and others are raising questions about their potential to drive prescription drug spending. But clinic operators and industry observers say the clinics' numbers are still too small to have an effect on pharmaceutical payers' bottom lines. One health plan, in fact, says patients at the clinics are actually receiving fewer Rx drugs than had been expected.

Still, the full picture remains in flux as these clinics expand nationwide. The number of retail-store walk-in clinics — which generally are staffed by nurse practitioners who treat a limited number of disorders, such as colds, allergies, strep throat and skin conditions — are expected to grow from about 300 clinics now to between 600 and 900 by the end of the year, says Tine Hansen-Turton, executive director of Convenient Care Association (CCA), a new trade group that represents such clinics.

Among recent developments, Walgreen Co. said it plans to boost its number of in-store clinics to 250 by August — up from the 50 clinics it opened last year. CareClinic, Inc. said it will open 20 clinics in Meijer, Inc. stores in Indiana and Michigan. RediClinic LLC said it will launch nine new sites in Richmond, Va., and intends to have 500 clinics opened nationwide by 2009. And Pennsylvania Gov. Edward Rendell

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(D) unveiled a health care reform plan that, among other things, calls for increased access to nurse practitioners, a move that could encourage use of walk-in clinics.

These clinics provide new avenues for patients to receive drugs, Hansen-Turton says, noting this could generate more prescriptions. "The opportunity is that you now have more prescribers. It's not just the primary care provider," she adds.

Clinics Have Potential to Drive Prescribing

The growing number of clinics, and their effects on prescribing, has been on the mind of BlueCross BlueShield of Tennessee (BCBSTN), which recently contracted with MinuteClinic, the largest provider of retail-based clinics. More and more of these clinics are opening in Tennessee, says Ken Patric, M.D., chief medical officer at BCBSTN.

Patric acknowledges that he has wondered how they might affect drug sales. "One might think, 'Gee, if

these clinics are in a pharmacy, they might write more prescriptions,'" he says. "That actually isn't what we've seen. We've tended to see, at least thus far — it's only been six months so far — less prescriptions. This is making us think there is more use of over-the-counter [OTC] medications in a number of cases."

He says this makes sense logically. "When you delve into it, you find the margin is higher on the OTC drugs than it is on the prescription drugs for the pharmacists," Patric says.

Blue Cross and Blue Shield of Michigan (BCBSMI) also is monitoring the trend. If a walk-in clinic meets the insurer's basic credentialing requirements, BCBSMI will allow it in as a network provider. "If they have prescribing privileges, they can effectively write scripts," says Kevin Seitz, executive vice president of health care value enhancement at BCBSMI. At this point, however, the insurer has not modified its pharmacy benefit in light of the clinics' growing numbers, he adds.

Concerns About Ties With Pharmacies, PBMs

Seitz says walk-in clinics have the potential to be like physician-owned ancillary services, which cover such things as radiology and laboratory work. The tendency is for physicians to over-order lab work because the lab could generate money, he explains. The same tendencies could hold true if clinics are located in pharmacies and there is joint ownership, Seitz contends.

Atheer Kaddis, director of pharmacy services at BCBSMI, says that based on his conversations with pharmacy chains and PBMs, there is "a lot of interest in these walk-in clinics being in retail pharmacies." He points to changing dynamics in the market, including CVS Corp.'s proposal to acquire Caremark Rx, Inc. "Other PBMs are looking at some sort of ways to get into this market," Kaddis says. "We have to be somewhat concerned about whether there is going to be over-prescribing or some increase in utilization because of this co-ownership."

But Richard Datz, senior vice president of business development at CareClinic, says walk-in clinics would not necessarily increase drug sales. "We don't see this as incremental," he says of clinics' entrance in the health care market. "We just see this as a different distribution of the same type of care that's being delivered in a different setting, in a more convenient setting. Those patients... would have gotten [a prescription] anyway, but somebody else is writing that prescription." CareClinic does not have special financial arrangements with the pharmacies in the retail establishments in which its facilities are located, Datz adds.

Marissa Schlaifer, director of pharmacy affairs at the Academy of Managed Care Pharmacy, agrees that most clinic patients would likely have pursued care some-

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where, regardless of the setting. Where these clinics may drive drug spending is for something cosmetic, or an allergy or something else that is bothering the patient who decides to drop in one of the clinics while on an errand. "For people who are busy, they might get care they otherwise might not have," she says. "It might drive pharmaceutical costs in that area."

The clinics also will likely drive utilization of tried-and-true, inexpensive generics, says Joseph Paduda, principal of consulting firm Health Strategy Associates. The ingredient costs of these drugs will likely be next to nothing, he adds. "People who are going to these [clinics] are going to be lower in the socioeconomic scale, and may not have supplemental coverage for drugs. They're going to be looking for the \$4 generic drug plans from Wal-Mart."

Walk-in clinics now do not drive pharmaceutical spending, says Mary Kate Scott, a consultant who wrote a report last year about retail clinics for the California HealthCare Foundation. "In the long run, they could," she adds. "We predict that in five years, we should see between 3,000 to 4,000 clinics." To be financially viable, clinics need to see 18 to 23 patients per day, she says.

Retail pharmacy chains, in fact, stand to gain the most from the growth of these clinics. For every patient who gets a prescription at a retail clinic, roughly 98% of them fill that prescription at the location of the clinic, Scott says.

Providing a Complete Pharmacy Record

The procedures for Rx payments and providing pharmacy records at walk-in clinics generally mirror those of the primary care provider. The copayment structure for BCBSTN members who use the MinuteClinic, for example, is exactly the same as it would be in any other urgent-care clinic, Patric says.

For its part, CareClinic provides patients with a printout of the examination, including any drugs that were prescribed, which can be taken to the primary care physician. The record can also be delivered electronically.

Most walk-in clinics use proprietary software systems and electronic health records, according to a report by CCA. Nurse practitioners write prescriptions if needed, and transmit them electronically to the store pharmacy or any pharmacy that accepts electronic scripts, the report adds.

Clinic operators that are members of CCA follow the same policies and procedures as any other contractor with an insurance company, says Hansen-Turton. "They're consistent with the procedures, even if they do not have insurance. There is a protocol, there is a record, they go to the pharmacy. They have a pharmacy record."

Walk-in clinics in "big box" stores such as Wal-Mart can provide that kind of Rx record information very

easily, says Paduda. "These are folks that make their living out of being efficient," he says. "They're going to have to be able to document what happened, provide the patient with a record of that, and provide that information upstream. They don't have time to be answering the phone tracking down this piece of paper...did they get this script? They're going to be very efficient."

But whether the walk-in clinics will ultimately be cost effective remains to be seen. "We don't know yet," BCBSTN's Patric says. "That's obviously the big question. Will this end up serving people who otherwise wouldn't have accessed the system?...Or is this a less expensive alternative to going to the emergency room? The jury is still out."

Contact Paduda at (203) 314-2632, Patric through Scott Wilson at scott_wilson@BCBST.com, Hansen-Turton at (215) 731-7140, and Seitz and Kaddis through Jon Ogar at (517) 336-5648. ✦

Pharmacy Benefit Resources From AIS

- ✓ *Medicare Part D Compliance News*, monthly news and strategies on marketing, enrollment, formularies, rebates, claims pricing, and fraud, waste and abuse.
- ✓ *Specialty Pharmacy News*, monthly news and strategic information on managing high-cost biotech and injectable products.
- ✓ *Understanding the Medicare Part D Drug Benefit*, a 62-page basic guide that summarizes the major rules, guidelines, deadlines and market dynamics needed to comprehend the new drug benefit; perfect for training your workforce.
- ✓ *Specialty Pharmacy Stakeholders, Strategies and Markets 2007*, a softbound book on vendors and products in the specialty pharmacy marketplace and health plan strategies for managing high-cost biotech, injectable and infusible products.
- ✓ *A Guide to the Medicare Drug Benefit*, a comprehensive looseleaf (updated quarterly) that weaves together guidance from thousands of pages of statutory language, regulations and preambles, and CMS guidance on Part D, PDPs, the Medicare formulary and more; includes specially designed Web site.
- ✓ *Health Plan Strategies for Pharmacy Benefits*, a 486-page compendium of information on cost trends and cost containment strategies for the prescription drug benefit.

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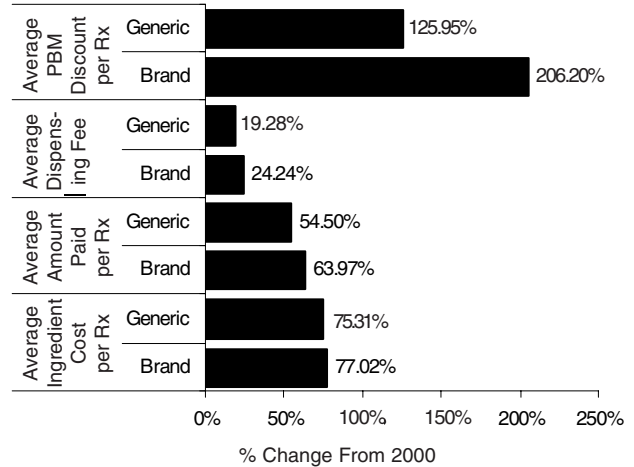
Rx Ingredient Costs Rise Much Faster Than Pharmacy Dispensing Fees

PBMs were paying an average of \$82.36 for brand-name prescriptions and \$16.81 for generic drugs at the end of 2006, according to *DBN's* exclusive quarterly survey of PBMs and related companies. Ingredient costs have risen significantly faster than have pharmacy dispensing fees, and the actual amount paid per prescription has risen more slowly than ingredient costs due to increased volume discounts and other factors negotiated by PBMs, the survey found.

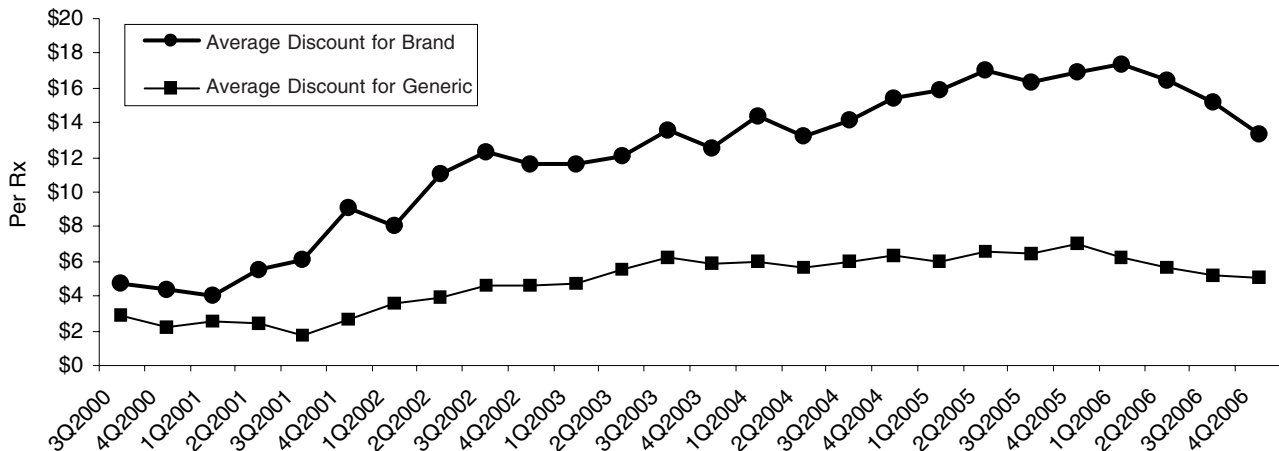
Average Costs per Rx for PBMs, Fourth Quarter 2000-2006

Average per Rx	Ingredient Cost		Amount Paid		Dispensing Fee	
	Brand	Generic	Brand	Generic	Brand	Generic
4Q2000	\$52.86	\$11.10	\$50.23	\$10.88	\$1.74	\$2.02
4Q2001	\$57.80	\$12.52	\$50.52	\$11.87	\$1.81	\$2.05
4Q2002	\$66.91	\$15.55	\$57.28	\$13.19	\$2.03	\$2.19
4Q2003	\$79.67	\$19.30	\$69.35	\$15.82	\$2.20	\$2.33
4Q2004	\$88.48	\$20.23	\$75.18	\$16.22	\$2.16	\$2.33
4Q2005	\$92.97	\$21.09	\$78.15	\$16.46	\$2.13	\$2.39
4Q2006	\$93.56	\$19.45	\$82.36	\$16.81	\$2.16	\$2.41

Average Costs per Rx for PBMs, Percentage Change From 2000 to 2006



Average Discount* per Rx for Prescriptions Processed by PBMs



*Discount is calculated roughly by AIS as (Ingredient Cost + Dispensing Fee) – (Amount Paid). In actuality, there may be additional factors involved in calculating costs and discounts, and these factors may vary by each PBM contract.

SOURCE: AIS's quarterly survey of PBMs and related companies, conducted exclusively for *DBN*.

METHODOLOGY: Survey includes companies that describe themselves as PBMs, pharmacy benefit administrators (PBAs), specialty pharmacy providers (SPPs) and other related types of companies. Data are per prescription. Averages in all three charts are calculated on the basis of average for each company's entire book of business, divided by the number of companies responding in each quarter; averages calculated by AIS are not weighted by volume. The survey does not specify definitions for terms, nor does it dictate how individual companies should calculate the averages provided in the survey.

MA-PDs Attract Many New Members; Most Part D Beneficiaries Stay Put

Enrollment in Medicare Part D drug plans grew at a moderate pace during the just-completed open-enrollment period, according to new CMS figures. The percentage growth was greater for Medicare Advantage prescription drug plans (MA-PDs) than for stand-alone Prescription Drug Plans (PDPs) — 10% versus 5.9%. But only 7% of beneficiaries chose to switch plans during open-enrollment season, a figure that one industry observer says shows the “stickiness” of the marketplace.

The number of enrollees in PDPs as of Jan. 16 was 10.98 million, up from 10.37 million in June 2006, when CMS last released enrollment data, Acting CMS Administrator Leslie Norwalk said in a Jan. 30 news conference. MA-PD enrollment, according to Norwalk, advanced to 6.65 million from 6.04 million over the same period, while Medicare-Medicaid dual-eligible enrollment increased to 6.27 million from 6.07 million.

Newly eligible Medicare beneficiaries accounted for 580,000 of the 1.4 million overall increase in Part D enrollment since last June, she said.

Beneficiaries Are Satisfied With Plans

About 2.4 million or 10% of eligible beneficiaries changed plans in the open-enrollment period for 2007 that ended last month, except for MA enrollment, which continues through March 31. Excluding the low-income-subsidy beneficiaries who were moved by CMS so that they would not have to pay higher premiums, about 7% of beneficiaries switched Part D plans during open enrollment, Norwalk said.

CMS data also show that about 88.5% of all beneficiaries enrolling in a Part D plan for 2007 chose one that offers coverage other than the standard benefit. These include plans offering no deductible or coverage in the “donut hole” gap between \$2,400 in drug spending and \$3,850 in out-of-pocket drug expenses.

Norwalk said that about 4.13 million out of the 43.2 million Medicare beneficiaries now don't have drug coverage, a percentage that is about the same as last June after allowing for a rise in Medicare membership since then. The number of beneficiaries covered by the retiree drug subsidy edged up to 6.94 million from 6.9 million during that period, indicating that very few employers opted to stop taking the subsidy and let Medicare provide some or all of the benefit.

Commenting on the enrollment figures, Dan Mendelson, president of health consulting firm Avalere Health, said it is remarkable how few beneficiaries actually switched plans.

Beneficiaries stayed put even in the face of premiums that went up this year by a weighted average of

12% (and in some cases by 30% to 60%), he says. In addition, most plans' four-tier formularies are offering fewer brand drugs while offering more generics, he adds. “But the relative absence of switching shows how seniors like to buy insurance, which is that once they buy it, they like to hold on and leave it,” Mendelson explains. If a senior is satisfied with a plan, “even if the premium goes up significantly, they're going to be resistant to change. It shows the stickiness of the marketplace.”

“Both the upside and downside for this is there is more stability here than not,” Mendelson says.

CMS did not have enrollment figures for individual companies, and few Part D sponsors have released their own 2007 figures. Mendelson says that some smaller companies are doing very well, and some larger companies aren't doing so well. Sponsors' success depends in part on their ability to maintain strong relationships with their brokers, Mendelson adds. “It's the brokers that are selling this product, on a ones and twos basis,” he says.

For more information, visit www.cms.hhs.gov. Contact Mendelson at (202) 207-1310. ✧

Appeals Court Finds Caremark Rx Did Not Breach Fiduciary Duties

Caremark Rx, Inc. did not breach its fiduciary duties when negotiating drug prices and managing the formulary for a multi-employer health fund because it was not acting as a fiduciary, a federal appeals court ruled last month. The PBM industry hailed the opinion, saying it sets a precedent for other lawsuits and state initiatives that claim PBMs have fiduciary responsibilities.

In a Jan. 19 ruling (No. 05-3476), the U.S. Court of Appeals for the Seventh Circuit upheld a lower court ruling that found Caremark was not an Employee Retirement Income Securities Act (ERISA) fiduciary for the Chicago District Council of Carpenters Welfare Fund (Carpenters). The fund had sued Caremark, claiming it breached fiduciary duties under three multiyear contracts to provide Rx benefits to union members.

The parties disagree about the nature of Caremark's obligations under the contracts, according to the ruling.

Carpenters portrays Caremark as its fiduciary, responsible for, among other things, negotiating prices with retail pharmacies and drug manufacturers on behalf of Carpenters. Caremark claims only to have agreed to provide the stated benefits at prices determined via “arm's-length negotiations between Caremark and Carpenters,” the ruling says.

In fact, each contract provided that Caremark “was not a fiduciary as that term is defined by ERISA, and that Carpenters possessed the sole authority to control and administer the plan,” according to the ruling.

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"Nonetheless, Carpenters alleges that, under the three contracts, Caremark has discretionary authority over the management and administration of Carpenters' drug benefit plan and also exercises discretion and control over Carpenters' assets," according to the appeals court. The fund contends this "discretionary authority" gives rise to fiduciary duties under ERISA, the ruling adds.

Specifically, the union alleges Caremark has discretion (and therefore fiduciary duties) in four specific areas: (1) negotiations with drug retailers over drug prices; (2) negotiations with drug manufacturers over rebates and other discounts; (3) the management of the formulary program; and (4) the management of the drug switching program.

Among other things, Carpenters contends that Caremark breached its fiduciary duties by charging the fund a higher price than Caremark negotiated with retail pharmacies, and by choosing drugs for the formulary that were more expensive so that Caremark could pocket extra rebates it obtained from drug makers, according to the ruling. The district court, however, found nothing in the contracts that required Caremark to pass through cost savings to Carpenters, according to the appeals court.

Ruling Seen as Setting Precedent

Stephanie Kanwit, special counsel at PBM trade group Pharmaceutical Care Management Association (PCMA), described the appeals court decision as an "important ruling" that will set a precedent for other cases. "There are a number of other lawsuits out there that are trying to say that PBMs are fiduciaries, as well as legislation," she says.

PBM fiduciary laws have been enacted only in Maine and the District of Columbia. The 2003 Maine law hasn't had much impact so far, Kanwit says. It was narrowed by the courts, and because the law was applied prospectively, it didn't apply to existing contracts, she explains. The D.C. law has been blocked from taking effect by the U.S. District Court, and litigation is still ongoing, Kanwit notes.

Other PBM fiduciary legislation appears to have stalled. At least 20 states rejected PBM fiduciary and/or disclosure bills in the first half of last year, according to PCMA (*DBN 7/21/06, p. 8*). The latest appeals court ruling makes clear from one of the most economically sophisticated courts in the country that these are matters of contracts, Kanwit contends. "It doesn't do any good and, in fact, harms the interest of customers like this union to start claiming breach of fiduciary duty. That's a red herring."

Kanwit says PBM customers generally don't want their PBMs to be fiduciaries. "Customers want the PBM to do what the Carpenters did here, enter into a contract," she says. "You do not want them to be in charge of what this court calls 'discretion.' There is no discretion about it. In a contract, here it is, here is the price. It's spelled out."

Others say the ruling on the federal ERISA law will have a limited effect on state efforts to impose PBM fiduciary duties. Some states have adopted or are considering legislation that says fiduciary duties exist between a PBM and any company or health plan that hires a PBM to negotiate rebates and other discounts from a drug company, says Sharon Treat, executive director of the National Legislative Association on Prescription Drug Prices, which has worked with states to develop PBM fiduciary laws.

"That legislation really isn't affected by a decision that interprets ERISA, because these laws aren't intended to interpret ERISA," she says. The legislation, rather, defines the relationship between contracting parties as a "fiduciary relationship under state law," Treat says, adding that states have had the right to regulate contracts since time immemorial. "How courts rule on ERISA is, in some cases, beside the point," she adds.

The appeals court ruling is available at www.ca7.uscourts.gov/fdocs/docs.fwx. Visit PCMA at www.pcmanet.org. ♦

UHC Finds 'Less Is More' With Specialty Pharmacy Contracting

When the UnitedHealthcare (UHC) unit of UnitedHealth Group analyzed its network of specialty pharmacy providers (SPPs) in early 2005, the plan found that for some therapeutic conditions, it had literally dozens of providers. UHC began performing a rigorous assessment of the SPPs' capabilities. In the process, the plan realized the wisdom behind the adage "less is more."

UHC first developed a "good set of metrics" that would allow it to evaluate Provider A versus Provider B, says Randy Falkenrath, vice president of specialty pharmacy at UHC. Among the issues it examined were differences in costs or outcomes. UHC followed three steps to get the information it needed:

(1) *Exploratory discussions with companies:* Providers would come to UHC and talk about their companies and backgrounds.

(2) *A "pretty intensive RFP [request-for-proposal] process":* UHC asked companies for examples of their management approaches, partnerships and similar programs.

(3) *Reviewing, questioning and challenging the RFP:* UHC had companies submit data to back up their claims. Among UHC's questions: What metrics do they use to define success? What programs are their robust ones? How do they integrate with payers and provide care coordination and disease management?

As a result, UHC narrowed down its network to two SPPs for each of six therapeutic categories: rheumatoid arthritis, multiple sclerosis, anemia and neutropenia,

growth hormone, infertility and hepatitis C. Cirrhosis and thrombocytopenia are included as well because they are "conjunctive with the other categories," says Falkenrath. UHC chose these categories because most were in its top 10 for pharmacy benefit spending.

Falkenrath declines to identify the companies, but he says there are a total of six SPPs for all of the categories. They comprise a mix of "large, multi-class companies and a couple of niche providers" that are "not necessarily independent but specialize in one or two categories." The pharmacies also offer a mix of mail and retail pharmaceutical availability, he says.

In addition, UHC has created a benchmark based on historical data that it uses to evaluate the companies' performance per product mix vs. the "ideal" mix. "Some are much more effective in influencing providers and members," Falkenrath says. Over the next three quarters, the company will review the data. The SPPs are on 18- to 24-month contract timelines, says Falkenrath, so that UHC can evaluate a 12-to-16 month data set.

Seventy-five percent of the covered lives in UHC's network started in the program in June 2006. Fifteen percent of self-funded lives have implemented this program. UHC has seen a 5% reduction in pharmacy costs since last June in those categories, Falkenrath says.

UHC is in the process of rolling out the second wave of the initiative, which includes HIV, oral oncology and transplant drugs.

Contact Lynne High for Falkenrath at (952) 992 5708. ✦

Bill Would Remove Barrier to Generics

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In 2006, for example, 14 of the 28 final settlement agreements between brand and generic companies included both an agreement to defer generic entry and some form of payment from the brand firm to the generic challenger, Leibowitz said.

In 2007 and 2008, drugs expected to go generic include the \$1 billion blockbusters Prevacid (heartburn), Imitrex (migraine headaches), Zyrtec (allergies) and Effexor (depression), Michael Wroblewski, project director of consumer education and outreach at advocacy group Consumers Union, told the hearing.

Leibowitz contended that under the appeals courts' rulings, the parties in drug patent challenges have "the strong economic incentive...to enter into anticompetitive settlements that deprive consumers of the benefit of low-cost, non-infringing generic drugs."

In an attempt prevent such an outcome, Sen. Herb Kohl (D-Wis.) on Jan. 17 introduced the "Preserve Access to Affordable Generics Act" (S. 316), which would explicitly prohibit brand firms from using "pay-off agree-

ments to keep cheaper generic equivalents off the market." The bill, which was first introduced last session, has four co-sponsors, including Sen. Chuck Grassley (R-Iowa).

Prescription drug and generic drug issues in general will be very high on the congressional agenda, according to a health care industry source who asked not to be identified. "As part of that discussion, the Kohl bill will be high on the radar screen," the source tells *DBN*. While the measure would likely pass the House and Senate on a clean up or down vote, "things are rarely that simple," the source adds.

It's not clear what, if anything, the measure will be attached to, and it's not clear where the White House stands on the issue, the source adds.

Meanwhile, both the brand and generic industries argue that a blanket prohibition on patent agreements could have the opposite effect of further delaying generic entry.

Kathleen Jaeger, president and CEO of the Generic Pharmaceutical Association, said that many of the settlements discussed at the Jan. 17 committee hearing actually contained provisions that guaranteed early market entry, and were pro-competitive and pro-consumer. "It is critical that as we continue this discussion we do not inadvertently sweep good settlements in with the bad ones," she said in a prepared statement. "A case-by-case approach protects consumers by evaluating the market implications of a particular settlement." Jaeger did not participate in the hearing on the bill.

Plans, PBMs Want Generics Sooner

For their part, PBMs and health plans want to see the issue addressed. "We have had continual problems with...how patent laws have been manipulated over time by manufacturers to really keep the market from operating," says Kevin Seitz, executive vice president of health care value enhancement at Blue Cross and Blue Shield of Michigan (BCBSMI).

Atheer Kaddis, director of pharmacy services at BCBSMI, says some of the brand drugs cited as examples of agreements delaying generics in the FTC report should have come to market as generics years ago.

But he also cautions about passing "do-or-die" legislation that doesn't allow for some exceptions.

"That is why you don't see all of the health plans and payers out there clambering to support this proposed legislation at this point," Kaddis says. "What everyone would be happy with is if there is some flexibility in the legislation based on looking at each case on a case-by-case basis."

Seitz adds that the devil's in the details. "But generally our inclination is that we want the free market to

operate," he says. "We do not feel it is appropriate in general for companies to receive money to effectively impede the competitive market. Those are tendencies that are good within the legislation, but we need to do a more thorough analysis to better understand all of the issues that are surrounding all of the details of the bill."

Delays in accessing generic drugs cost BCBSMI tens of millions of dollars a year, Seitz says.

For more information, contact Seitz and Kaddis though Jon Ogar at (517) 336-5648. To read S. 316, visit <http://thomas.loc.gov>. Type the bill number into the search engine. ✧

NEWS BRIEFS

◆ **Anthem National Accounts, which serves members of Anthem Blue Cross and Blue Shield in 11 states, said on Jan. 22 that it had launched an electronic prescribing pilot with General Motors Corp.** The e-prescribing pilot, which will involve 100 physicians, will be available to thousands of patients in two Ohio communities regardless of their health plan affiliation. The program will equip participating physicians in Dayton and Warren/Youngstown, Ohio with computer hardware and software that provides instant access to current health plan formularies and patient medication history available through claims data, Anthem says. This will allow physicians to send prescriptions electronically to both retail and mail-order pharmacies. Visit Anthem at <http://www.anthem.com>.

◆ **AmerisourceBergen Corp. and Kindred Healthcare, Inc. said Jan. 22 that Gregory Weishar would become CEO of the firms' new combined institutional pharmacy business, PharMerica Corp.** Weishar is now CEO and president of PharmaCare Management Services, Inc., the PBM subsidiary of CVS Corp. PharMerica will become an independent and publicly traded company. It will be the second largest in the institutional pharmacy services market, with revenues of roughly \$1.9 billion and a customer base of approximately 330,000 licensed beds in 41 states. The transaction is expected to be completed by the end of March 2007, the two firms said. The deal still requires clearance by the Securities and Exchange Commission. Contact AmerisourceBergen's Michael Kilpatric at (610) 727-7118 and Kindred Healthcare's Susan Moss at (502) 596-7269.

◆ **American adults in 2004 spent \$32 billion on cardiovascular drugs, putting the therapies at the top of the five costliest classes of drugs prescribed for people age 18 and over,** according to a new report from the Agency for Healthcare Research and Quality (AHRQ). The five costliest classes of drugs combined accounted for two-thirds — \$119 billion —

of the \$181 billion in total expenditures on outpatient drugs by U.S. adults in 2004. Hormones were the second-costliest drug class (\$25 billion); followed by central nervous system drugs (\$24 billion), which can be used to treat pain and control seizures; cholesterol-lowering medications (\$22 billion); and anti-depressants and other psychotherapeutic drugs (\$18 billion), AHRQ says. To read the report, Statistical Brief 154, visit www.meps.ahrq.gov/mepsweb. Click on "What's New."

◆ **Caremark Rx, Inc. on Jan. 30 sent a letter to its shareholders describing why the Caremark board believes the pending merger with CVS Corp. is the best course for Caremark shareholders.** In the letter, Mac Crawford, chairman, CEO and president of Caremark, reiterated the board's belief that, given its "compelling strategic and financial benefits and high certainty of completion," the proposed CVS merger will create significant shareholder value (*DBN 11/3/06, p. 4*). Crawford said the merger is expected to generate annual cost savings "conservatively estimated to exceed \$500 million." Meanwhile, Express Scripts, Inc., which is also bidding for Caremark, said in an earlier letter to Caremark shareholders that Caremark and CVS have overstated the savings from the proposed merger (*DBN 1/8/07, p. 1*). Caremark shareholders are scheduled to meet Feb. 20 to consider the CVS deal, and CVS shareholders will meet Feb. 23. Contact Caremark's Craig Hartman at (615) 743-6653 and Express Scripts' Steve Littlejohn at (314) 702-7556.

◆ **PEOPLE ON THE MOVE:** Pharmaceutical Strategies Group (PSG), a pharmacy benefits consulting firm, has added five new members: **John Hines, Marybeth Ochoa, Jennifer Athmann, Pharm.D., Pamela Knox** and **Sondra Ferrill**. Hines is director of tools and client automation; Ochoa is manager of client support services; Athmann is director of strategic account services; and Ferrill and Knox are account managers... Tuality Healthcare promoted **Lori Syed, Pharm.D.**, to director of pharmacy services.

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