

DRUG BENEFIT NEWS

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

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OptumRx Faces Daunting Challenges as It Jockeys for Position in New PBM Wars

Does OptumRx have what it takes to be a serious competitor in what will arguably be a new PBM landscape in the wake of Express Scripts, Inc.'s proposed acquisition of Medco Health Solutions, Inc.?

Are the IT systems of the UnitedHealth Group company scalable? Does it need to build or acquire more mail-order facilities? How is its pricing? Does it have a robust enough specialty pharmacy unit?

While industry insiders have mixed responses to those questions, what they all seem to agree on is that OptumRx has some weak areas that it needs to address, including IT systems and mail order, before it is ready to take on a potential behemoth.

Until recently, UnitedHealth was Medco's biggest client, representing 17% of its 2010 revenue. But the same day the Express Scripts/Medco deal was unveiled, Medco said it would not renew the UnitedHealth contract when it expires at the end of 2012 (*DBN 7/22/11, p. 1*). Industry analysts speculate that UnitedHealth is planning to take its PBM business in-house. A UnitedHealth spokesperson declines to comment for this article.

"OptumRx processed 350 million adjusted prescriptions in 2010. This will increase to a bit over 500 million when the Medco business is integrated in 2013. That would make it about one-third as large as a combined Medco/Express Scripts and

continued on p. 7

Step Therapy, Generics, Smart Technology Are Among Top 2012 Benefit Design Tactics

Don't be fooled by the hot August weather — open-enrollment season is right around the summer, and employers are finalizing their 2012 pharmacy benefit design and planning communications strategies.

According to some top-tier PBMs and benefits consultants, step therapy, a larger copayment spread, prior authorization and narrow pharmacy networks are just a few of the options that employers are embracing for 2012 benefits.

"We are seeing more and more plan sponsors looking for ways to improve outcomes and manage out waste without creating dissatisfaction among their members," Thomas Gross, Express Scripts, Inc. spokesperson, tells *DBN*.

At Express Scripts, customers are moving toward step therapy in greater numbers next year.

Gross says a five-year Express Scripts study of behavior has paid off. "We now know that the gap isn't between what plans want and what members want, but between what members want and what members do — the 'intent-behavior' gap."

For 2012, Gross reports that more Express Scripts clients are moving to the "Select Solutions" suite of programs, particularly Select Step Therapy (*DBN 4/15/11, p. 1*), which uses a zero-dollar copayment incentive to promote participation. Gross

says that in terms of the number of members in step therapy, the company has seen about a 25% increase because of the introduction of Select Step Therapy.

"Mandatory step therapies are much more common now than they have ever been. That's because we have more choices that are very inexpensive that are great drugs," Michael Jacobs, national clinical practice leader at Buck Consultants, tells *DBN*.

At CVS Caremark Corp., executives continue to see plan sponsors taking more aggressive steps to control costs. "In fact, we are seeing more employers adopting plan designs to promote the cost savings of generics," Asif Ally, vice president, marketing, tells *DBN*.

"Our health plan clients are typically more focused on trend control and reducing total health care costs to maintain health care premium competitiveness compared to their national peers or other benchmarks," Ally says.

Ally reports that the top 90th percentile of CVS Caremark's book of business is approaching an 80% generic dispensing rate (GDR) in 2011. Both employers and health plans are even more focused at the therapeutic class level to promote generics without losing clinical efficacy, he reports. Specific classes include ARBs/ACE inhibitors to treat hypertension, non-benzodiazepine sleep aids, triptans for migraine, nasal steroids, statins for high cholesterol, proton-pump inhibitors for acid reflux and bisphosphonates

for osteoporosis. These therapies can represent up to a quarter of a client's drug spend.

"Plan sponsors realize they can save not only on pharmacy cost, but they can reduce the cost of preventive care by getting patients to start on generic therapy," Ally says.

According to Ally, a recent study conducted by CVS Caremark, Harvard University and Brigham and Women's Hospital, and published in the July issue of *Health Affairs*, found that using generic medications can significantly lower the cost of preventive care for chronic disease.

For example, using branded statins for lowering low-density lipoprotein (LDL, or "bad") cholesterol cost \$83,327 per quality-adjusted life year (QALY), a financial measure that evaluates the impact of improving the quality of life for patients with chronic diseases, according to the study.

"Today, recalculating for the same treatment using generic alternatives would cost \$17,084 per QALY, or 20% of the original estimate," Ally says.

Ally adds that plan sponsors are adopting a combination of strategies to capitalize on the generic wave, such as increasing the copay spread, typically by lowering the generic copay, coupled with a "generic first" plan design. According to a CVS Caremark 2011 benefit planning survey, a generic first plan design applies clinical edits that require the physician to prescribe a generic as first-line therapy before a more expensive brand is covered in the same drug class. Approximately 30% of employer plans have these designs in place, with another 45% saying they are considering adopting in 2012 or beyond.

90-Day Plan Design Is Popular

"CVS Caremark supports these clients with a comprehensive member and physician communication campaign to help patients get started on generics," Ally says. CVS Caremark sends personalized, actionable written communication to members who should be transitioned to first-line therapy based on historical claims data. In addition, prescribers are made aware of the coverage change via personalized patient chart inserts and face-to-face visits from clinical consultants. A designated call center supports physicians to help facilitate a new prescription when appropriate for that member.

Another trend Ally points to is innovative network strategies to lower costs for maintenance medications.

"We are experiencing more clients asking for 90-day plan designs at retail with the same savings as mail order. Traditionally, the member disruption from mandatory mail has deterred some clients, but now with

Drug Benefit News (ISSN: 1530-3438) is published 24 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

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the Maintenance Choice model, we are able to provide the same benefits plus the added convenience and improved adherence for those taking chronic medications," Ally says. Under Maintenance Choice, members can get a 90-day prescription at the same cost whether it's filled by mail or at a CVS/pharmacy retail store.

Ally adds that health plans see new opportunity to help manage the looming increase in specialty spend, including implementing a preferred drug plan design for key biologic classes and exploring new ways to manage oncology drugs paid under the medical benefit.

continued

AIS Survey Data

New Specialty Generics Impact Drug Trend

The average ingredient cost per prescription increased by an alarming 48% over the past year for generics. The average ingredient cost per generic Rx is now \$52.12, compared with \$35.14 a year ago, according to AIS's second-quarter 2011 survey results. The rapid rise was instigated by new generic products available for distribution by specialty pharmacies and oncology pharmacies. However, there are only a small number of products driving that trend, and the prices typically decline over time. For instance, one specialty pharmacy executive reports that generic Lovenox, approved last year, is still priced almost as high as the brand version, while generic ribavirin has continued to decline in sale price since its 2004 approval.

PBM's Average Costs per Rx, as of Second-Quarter 2001-2011

	Average Ingredient Cost Per Rx		Average Amount Paid Per Rx		Average Dispensing Fee	
	Brand	Generic	Brand	Generic	Brand	Generic
2Q2001	\$54.90	\$11.05	\$51.66	\$11.21	\$2.29	\$2.58
2Q2002	\$64.26	\$13.61	\$55.43	\$12.08	\$2.18	\$2.34
2Q2003	\$72.50	\$17.29	\$62.44	\$13.91	\$2.01	\$2.16
2Q2004	\$83.35	\$19.68	\$72.22	\$16.27	\$2.10	\$2.23
2Q2005	\$89.67	\$20.29	\$74.86	\$16.21	\$2.21	\$2.43
2Q2006	\$93.33	\$19.51	\$78.07	\$16.38	\$1.04	\$1.18
2Q2007	\$115.77	\$22.60	\$109.03	\$19.71	\$1.22	\$1.31
2Q2008	\$128.53	\$21.25	\$123.42	\$19.35	\$1.20	\$1.30
2Q2009	\$153.15	\$23.07	\$143.04	\$20.48	\$1.69	\$1.88
2Q2010	\$282.87	\$35.14	\$286.82	\$36.24	\$1.91	\$2.03
2Q2011	\$307.73	\$52.12	\$244.43	\$39.64	\$1.93	\$2.07

Average Ingredient Costs, Amount Paid, Dispensing Fee per Rx, Percentage Change From Year Ago and From 2000

	Ingredient Cost		Amount Paid		Dispensing Fee	
	Brand	Generic	Brand	Generic	Brand	Generic
% Change from beginning (2000 to 2011)	482.58%	361.40%	375.14%	268.01%	1.77%	-1.89%
% Change Past Year (2010-2011)	8.79%	48.35%	-14.78%	9.37%	0.98%	1.58%

METHODOLOGY: Companies were asked for their average ingredient cost, amount paid and dispensing fee per Rx for brand and generic drugs across their entire books of business over the most recent 12-month period. Responses were then averaged by AIS. Averages are among all respondents answering the question, including specialty pharmacies, PBMs, PBAs, etc. The jump in ingredient cost and amount paid per Rx from 2009 to 2010 reflects new participation in this question from several SPPs and oncology management firms, as more high-cost drugs become managed under the pharmacy benefit instead of the medical benefit. Averages calculated by AIS are not weighted by volume. Survey respondents are promised confidentiality in answering this set of questions.

SOURCE: AIS's quarterly pharmacy benefit survey conducted for *DBN*. AIS's *Pharmacy Benefit Survey Results* can be downloaded from our subscriber-only website at <http://aishealth.com/newsletters/drugbenefitnews/quarterly-survey-results>. 2Q2011 results are now available.

Many PBMs continue to see their customers focus on plan design basics, such as lowering out-of-pocket costs for members who choose mail over retail pharmacy distribution.

"We also see, with regard to generics, lower-cost options when members choose generics — and for plans that have preferred drug lists, lower out-of-pocket costs when plans choose preferred drugs," Glen Stettin, M.D., chief medical officer and senior vice president for medical affairs for Medco Health Solutions, Inc., tells *DBN*.

For 2012, Stettin predicts increased usage of broader cost-sharing differentials between mail order and retail, and broader differentials to provide incentives for generic and preferred drugs. In addition, he says, step therapy remains as popular if not more popular than ever, as well as prior authorization for very expensive specialty medications.

Regarding copays, Stettin says that it's too early to say what changes will be adopted because many plans won't finalize their designs for 2012 until mid-October.

Stettin says that at Medco, it's not only about plan decisions but also about the availability of tools.

"Our customers continue to see the value of getting people engaged and registered to the plan's website — because through the website we're able to develop and deliver consumer tools such as Medco's MyRx Choices, which helps consumers understand their options for their therapy and how to save money out of pocket within the plan design," Stettin says.

Smartphone Apps Are Growing Popular

Stettin adds that Medco also is seeing increased take-up of applications for smartphones such as BlackBerrys and iPhones. "That helps the consumer have a specialist pharmacist right on their hips so that in the doctor's office they can get information about medication safety, as well as cost and different medication options, and have more informed discussions with their physician," Stettin says.

On the topic of narrowing pharmacy networks, Stettin says, "It is in the plan's interest to narrow their network as it relates to getting [a] discount. The magnitude of the discount really depends on where the plan is starting from and what regions of the country their population is located in. But in general, by concentrating the network, a plan could get better discounts."

Stettin says that cost is important, but the quality of care and the appropriate use of drugs to avoid medical costs are also increasingly important to customers. "Something else we've seen increase as an option is in plans having our specialist pharmacists communicate

or engage members about adherence and omission gaps in care," Stettin says.

A prescription drug benefit survey conducted by Buck Consultants in late 2010, looking at 2011 benefit designs, revealed that as employer pharmacy plan costs have increased over the past decade to 15% or more of total benefit costs, employers have made significant changes in their employee cost-sharing approaches. Two key trends that emerged from the survey include a shift from two-tier to three-tier cost sharing and a shift from flat-dollar copays to coinsurance.

According to Jacobs, three-tier pharmacy benefit design represents about 69% to 70% of all pharmacy benefit designs. "We are not observing anything unusual that has changed dramatically from a couple of years ago to now. We are actually starting to talk to more clients about taking a look at coinsurance types of cost sharing if they hit an 80% generic fill rate. We would have a minimum copay on the brand-name drugs but no tiers. We have a couple of clients in that area."

Jacobs says he's seeing an increase in employee copays for brand drugs in retail and mail pharmacies — sometimes more than \$100 for brand-name preferred medications.

"We're seeing the formula for mail-order cost sharing going from two-to-one, double what your retail [cost sharing] would have been, to two-and-a-half to even three times what your retail cost sharing is. So some plans that have a mandatory mail are saying, 'Why share any of the savings with the member?'" Jacobs tells *DBN*.

Contact Gross at (314) 684-6321, Ally via Christine Cramer at (401) 770-3317, Stettin via Jennifer Luddy at (201) 269-6402 or Jacobs at (770) 916-6018. ♦

Leading Insurance Trade Group Criticizes Preventive Coverage

The head of a health insurance trade organization said new federal guidelines for women's preventive care will result in unnecessary physician office visits and increased cost for patients.

One controversial component of the new regulations involves contraceptives. While many health plans already include contraceptives in their coverage, most of them share the costs with members.

Under the new federal regulations, insurers will be prohibited from cost sharing, resulting in potentially higher prices that would be passed on to members for items such as prescription birth control pills and contraceptive devices.

Karen Ignagni, president and CEO of America's Health Insurance Plans (AHIP), in a prepared statement contended that the newly mandated preventive services go "beyond existing evidence-based guidelines, suspend current cost-sharing arrangements for certain services, and encourage consumers to obtain a prescription for routine supplies that are currently purchased over-the-counter." In addition, the decision "sets a troubling precedent" for future decisions such as requirements for "essential health benefits" due out later this year.

An Aug. 1 amended interim final regulation issued by HHS, IRS and the Labor Department's Employee Benefits Security Administration outlined eight women's health services that insurers must cover without cost sharing:

- ◆ *Well-woman visits;*
- ◆ *Screening for gestational diabetes;*
- ◆ *Human papilloma virus (HPV) DNA testing for women 30 years and older;*
- ◆ *Sexually transmitted infection counseling;*
- ◆ *Human immunodeficiency virus (HIV) screening and counseling;*
- ◆ *FDA-approved contraception methods and contraceptive counseling;*
- ◆ *Breastfeeding support, supplies and counseling;* and

◆ *Domestic violence screening and counseling.*

The eight services were proposed on July 20 by the Institute of Medicine, which HHS had asked to develop recommendations for women's preventive care. The requirements took effect Aug. 1.

Many health plans already cover similar preventive services for women, including contraceptives, although they typically require cost sharing.

At BlueCross BlueShield of Tennessee (BCBST), plan members get coverage for oral contraceptives through the prescription drug benefit, subject to member cost sharing. "This benefit is purchased by the vast majority of our groups. Implantable and injectable contraceptives and barrier methods are covered in our base medical plan, subject to member cost share. Over-the-counter contraceptives are not covered under any of our current plans," Kelly Paulk, product manager, BCBST, tells *DBN*.

Paulk says that most other preventive services are covered subject to member cost sharing, with the exception of equipment to promote breastfeeding. "Our members already have coverage for one annual wellness/preventive visit per year, at no cost share. Breast pumps to promote breastfeeding are not covered under any plan; however, they are provided free of charge to mothers of NICU [i.e., neonatal intensive care unit] babies as part of our Care Management program. This

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benefit is outside the coverage under the EOC [i.e., Evidence of Coverage document],” Paulk says.

When asked how the new regulations regarding contraceptives and other preventive services would impact BCBST financially, Paulk responds, “at this time we do not have any specific numbers on the financial

impact this would have on our company or on health plan costs for our members.”

When asked about its current women’s preventive services, a spokesperson for CIGNA Corp. told *DBN* that standard plans typically cover most contraceptives as well as some of the services addressed by the new

NEW STUDIES

◆ **Prescription drug spending grew 3.5% in 2010, down from 5.3% in 2009, to \$258.6 billion, with continued slow growth in the use of drugs and an increasing share of prescriptions being filled with generic drugs**, according to a study conducted by CMS’s Office of the Actuary and published on the *Health Affairs* website July 28. The study authors attributed the deceleration in spending to “continued slow growth in the use of drugs and the ongoing change in the mix of drugs purchased. Through tiered copays and other mechanisms, health plans have continued to shift medication use toward less-costly generic drugs,” leading to an increase in the generic dispensing rate from 66% in 2009 to 69% in 2010. But the study authors added that the drug trend should increase during the 2011-2013 period to 5.7%. Visit www.healthaffairs.org.

◆ **Implementation of the Medicare Part D program led to lower nondrug spending, increased drug utilization, lower out-of-pocket costs and better medication adherence**, according to a study published in the July 27 *Journal of the American Medical Association* (JAMA). The study tracked spending among beneficiaries who previously had limited prior drug coverage. The study found that total nondrug medical spending fell by \$306 per member per quarter among beneficiaries with previously limited drug coverage compared with those with generous prior drug coverage. “This differential reduction was explained mostly by differential changes in spending on inpatient and skilled nursing facility care,” the authors wrote. Visit <http://jama.ama-assn.org>.

◆ **Doctors who aren’t psychiatrists increasingly are prescribing antidepressants to patients**, according to a study in the August issue of *Health Affairs*, which noted that these medications now are the third most commonly prescribed in the United States. Researchers evaluated a 12-year period from 1996 to 2007 and found that the percentage of visits in which antidepressants were prescribed by physi-

cians who didn’t record a specific psychiatric disorder rose from 59.5% to 72.7% during that period. The researchers reported that “although antidepressants are clinically effective for major depressive disorder, chronic depression, and some anxiety disorders,...the growing use of antidepressants by nonpsychiatrists for broader conditions raises worrisome questions about whether they are being inappropriately prescribed.” The study’s lead author, Ramin Mojtabai, an associate professor in the Department of Mental Health at the Johns Hopkins Bloomberg School of Public Health, said, “We don’t know if those patients who are receiving antidepressants without a psychiatric diagnosis really are benefiting as much as those who do have a diagnosis.” The authors’ recommendations included reform of insurers’ drug formularies as a way to rein in inappropriate antidepressant prescribing practices. Visit www.healthaffairs.org.

◆ **Mail-order use among new patients on statins was positively associated with control of low-density lipoprotein cholesterol (LDL-C)**, according to the results of a study published in the July 2011 issue of the *Journal of General Internal Medicine*. The study authors concluded that “future research should continue to explore the relationship between mail order pharmacy use and outcomes, and address how to appropriately target mail order services to patients most likely to benefit without compromising patient choice, care, and safety.” The study looked at 100,298 adult Kaiser Permanente Northern California members who started on statins between Jan. 1, 2005, and Dec. 31, 2007, to compare the impact of mail-order versus retail pharmacy use on LDL-C levels. The study found that 85.0% of patients who used the mail-order pharmacy to deliver statins at any time achieved target LDL-C levels compared with 74.2% of patients who used only the local Kaiser pharmacy. For more information, visit the *Journal of General Internal Medicine* at www.springer.com/medicine/internal/journal/11606.

preventive services regulations such as well-woman visits, counseling for prevention of sexually transmitted diseases, and counseling and screening for the prevention of HIV. The spokesperson said the company would continue to evaluate the regulations to determine the impact to customers, clients and CIGNA.

In an amendment to the new regulations, the Obama administration said it would allow religious institutions that offer insurance to their employees the option of not covering contraceptive services.

Contact Ignagni via Robert Zirkelback at (202) 778-8493 or Paulk via Kelly Allen at Kelly_Allen@bcbst.com. ✧

OptumRx Stays in the Game

continued from p. 1

about one-half as big as CVS Caremark [Corp.],” Matt Coffina, equity analyst for Morningstar, Inc, tells *DBN*.

Coffina says that while the relative lack of scale would leave OptumRx at a competitive disadvantage, he asserts that it is possible for a PBM to do well even at a smaller size.

Another concern facing OptumRx, says David Balto, former policy director for the Federal Trade Commission, is that it is going to have significantly fewer covered lives than Medco had, and that’s going to impact its ability to secure the kinds of discounts and lower drug prices that Medco offers.

“United is a well-run company and has lots of money, but it faces challenges. There are significant economies of scale and significant buying power that the major PBMs have that it does not have,” says Balto, now a senior fellow at the left-leaning think tank Center for American Progress.

“Express Scripts was at a size disadvantage to peers before the NextRx acquisition [purchased from WellPoint, Inc. in December 2009], and Catalyst [Health Solutions, Inc.] has done very well despite being much smaller. One advantage that [UnitedHealth] does have is its ability to cross-sell into the health benefits book of customers. It will likely be much harder to win third-party business, particularly from competitor MCOs,” Coffina says.

It is very difficult to determine whether United would have competitive prescription pricing, Coffina says. “However, earnings before interest, taxes, depreciation and amortization (EBITDA) per script was about \$1.76 last year, which would make OptumRx much less profitable than peers. If UnitedHealth really wants to catch up to a combined Medco/ Express Scripts, its best bet would be trying to acquire Caremark from CVS,” Coffina says. By comparison,

in 2010, EBITDA per script for Medco was \$3.11, for Express Scripts \$3.19 and for CVS Caremark \$3.96.

Coffina adds that there is a long-shot possibility that OptumRx could try to outbid Express Scripts for Medco.

Adam Fein, president of Pembroke Consulting, Inc. and author of the Drug Channels blog, says OptumRx needs to prove that it can successfully take over UnitedHealth’s commercial business from Medco in 2013. “Even if that happens, OptumRx may find it hard to credibly sell its services to health plans that compete with United,” Fein tells *DBN*.

Systems Capabilities May Be Tested

Among the key questions being asked regarding OptumRx’s strengths and weaknesses: Has OptumRx stressed-tested its capabilities in mail order and at the claims level?

“I would be loath to speculate on whether they have or haven’t, but it’s one of the questions I would have. Stress-testing that system or those systems’ capabilities are critical for them to convince the marketplace and the current UHC/Medco clients that they’re worthy of the business come Jan. 1, 2013,” Brian Bullock, president and CEO of Burchfield Group, tells *DBN*.

Bullock says OptumRx’s IT systems capabilities may need some work because they are not as mature in some areas as are other players’ in the industry.

“It would be difficult for me to speak to what they are going to do internally in the next year to overcome that. I think that their claims processing system is as good as other PBMs’. I think if they are weaker, it’s probably in the analytics area where they need to beef up their capabilities,” Bullock says.

“That’s one of the key things that they have to do to get from where they are today and where they will be,” Bullock added.

Despite obstacles, OptumRx (formerly Prescription Solutions) is already a player in the PBM market, ranked 14th with 12,691,733 covered lives and a 1.79% market share, according to *AIS’s Pharmacy Benefit Survey Results: 2nd Quarter 2011*.

Coffina adds that UnitedHealth believes it already has the infrastructure in place, such as IT systems and mail-order capacity, to be able to handle the Medco scripts.

Some Clients May Be Wary of United

Are plan sponsors wary of using one health insurer for medical coverage and a different health insurer — such as UnitedHealth’s OptumRx — as a carved-out PBM vendor? “I would say the market has been cool to that concept,” says Bullock.

continued

"WellPoint's [NextRx] benefit operation, I don't think, ever had an awful lot of uptake in the independent PBM sales arena. You look at Aetna and CIGNA in history — none of them have been real hard players as a carve-out PBM provider," Bullock says.

"Plans value tremendously having an independent PBM," adds Balto.

"The problem with using [UnitedHealth] is people are going to be uncomfortable about how OptumRx is going to work with their insurer should their insurer not be [UnitedHealthcare's insurance unit]," Balto explains.

Bullock maintains that in order to expand, OptumRx is going to be looking hard at its capabilities and capacity.

"At this stage it's a question mark, but [UnitedHealth] has a lot of resources at its disposal, and I think that they already have a trajectory that they are on to close the gap."

But can OptumRx compete? Bullock thinks that it can. "I think that as an integrated solution through [UnitedHealthcare], they will be a very viable competitor. Whether they are a carve-out competitor or not to the rest of the industry remains to be seen."

Other industry insiders aren't quite as confident that OptumRx will have an easy time competing in a new PBM universe. "It's a leap of faith to believe that UnitedHealthcare can go and step into the shoes of Medco," says Balto.

Still, Balto says, "They will stay in the game. It will take them being able to steal major customers from Express Scripts. That's daunting." He adds, "Express Scripts doesn't lose much business in the first place. It's going to lose even less business now that Medco is off the table."

Contact Coffina at (312) 696-6864, Fein at (215) 523-5700, ext. 15, Bullock via Ihor Andruch at (201) 641-1911, ext. 50 or Balto via Maggie Aker at (202) 789-5424. ♦

NEWS BRIEFS

◆ **In a deal worth \$77 million, SXC Health Solutions Corp. has agreed to acquire PTRX, Inc., a full-service PBM, and its mail-order pharmacy provider, Save-DirectRx, Inc.** SXC Chairman and CEO Mark Thierer said, "this transaction is in keeping with our strategy to acquire assets that currently utilize SXC's technology platform and can be easily integrated," partly since PTRX has been a client and partner since 2006. The deal is expected to close in the fourth quarter of 2011. PTRX and SaveDirectRx together manage about \$90 million in annual drug spend and are expected to generate approximately \$10 million in earnings before interest, tax, depreciation and amortization in 2011. Thierer added that the deal will drive growth for SXC by leveraging "our existing partnership, the PTRX book-of-business, the SaveDirectRx mail volume, and the combined entity's ability to drive mail penetration." Contact SXC's Tony Perkins at (630) 577-4871.

◆ **CalOptima has awarded a four-year contract to PerformRx, LLC to provide PBM services.** The deal takes effect Jan. 1, 2012. The contract calls for PerformRx to supply provider network, quality, cost, account and rebate management services; claims adjudication; clinical services; fraud, waste and abuse prevention; and auditing. CalOptima, an Orange County, Calif.-based health system, provides publicly funded health coverage programs for 416,000 low-income enrollees and individuals with disabilities. Contact Tom Bell at (215) 837-9385.

◆ **Blue Cross and Blue Shield of North Carolina (BCBSNC) said Aug. 3 it is in negotiations to change its PBM vendor from Medco Health Solutions, Inc. to Prime Therapeutics LLC.** Pending successful negotiations and regulatory approval, BCBSNC would own part of Prime, along with nine other Blues organizations representing 12 plans. BCBSNC President and CEO Brad Wilson said that having more "hands-on" contact with a PBM would help "lower costs.... We also will be able to work with other non-profit Blues on formulary designs, improved information and communications to customers, and programs that integrate pharmacy and disease management programs to improve health." Contact BCBSNC's Lew Borman at (919) 765-3005 or Prime's Sheila Thelemann at (612) 777-5508.

◆ **Pharmaceutical firms were the second most active sector in terms of mergers and acquisitions among health industry players during the second quarter of 2011,** according to a report by Irving Levin Associates. A total of \$73.5 billion was spent to finance 243 mergers and acquisitions in the health care industry, up 44% from the \$51.1 billion spent in the first quarter of this year, and up 61% from the \$45.7 billion spent in the second quarter of 2010. Pharmaceutical firms accounted for \$27.4 billion in the most recent period, second only to medical device firms, at \$33.2 billion. Contact Sanford Steever at (800) 248-1668.

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