Medicare Prescription Drug Plans Jockey For Top Positions in Volatile 2012 Market

Acutely aware that Medicare beneficiaries will be shopping for the best bargain, Part D plans are gearing up for aggressive marketing campaigns as competition in the market intensifies. And with an earlier enrollment period, plans won’t have as much time to make their case to customers.

An analysis by Avalere Health, LLC shows average premiums across all prescription drug plans (PDPs) will decrease by almost 4% in 2012. However, six of the top 10 plans will actually increase premiums. CMS has not confirmed those figures.

“I think that there is going to be aggressive marketing from the numbers three through five companies. I think that they are going to go at it this year,” Dan Mendelson, CEO of Avalere Health, tells DBN. According to the Avalere analysis, UnitedHealthcare, Inc. is the largest Part D plan, followed by CVS Caremark Corp., Humana Inc., Coventry Health Care, Inc. and Wellcare Health Plans, Inc.

“There are some pretty dramatic changes for 2012. The changes are mostly a matter of commercial positioning of plans one against the other,” Mendelson says. Avalere predicts United will hike PDP premiums by 14%. “You have the market leader, UHC [i.e., UnitedHealthcare], raising its prices to the point where they are going to be ceding the right to care for 535,000 dual eligibles,” Mendelson tells DBN.

continued on p. 7

Online Prior Authorization Offerings Loom Large in Health Plan and PBM Strategies

Whether it’s done internally or outsourced, more health plans and PBMs are using technology, including online capabilities, to get the most out of their prior authorization (PA) systems. These payers report that there are several strategies involved in optimizing PA systems, such as emphasizing evidence-based medicine standards and moving the process as close to real time as possible.

At OptumRx, a new, internally developed online PA service is just what the doctor ordered. “We’ve really turned [around] the process of requesting a prior authorization, and given the physicians and their office a self-serve type option where they can log [in] online, provide a user name and password, and tap into our prior authorization system,” Richard Skinner, Pharm.D., director of prior authorization services at the UnitedHealth Group subsidiary, tells DBN.

With the Web-based capabilities, Skinner says, physicians can speak online, identify themselves and their patient, and list which drugs they’re requesting. Pharmacists will walk them through the PA review process, and in some cases they will receive approval instantaneously if criteria are met.

“You take that claim and prior authorization system, and they can talk to each other. This way, 24/7 you can enter in online and get instantaneous answers in some cases, or within the next 48 [to] 72 hours. The medical community likes this,” Brian Solow, M.D., chief medical officer for OptumRx, tells DBN.

continued
"Physicians never enjoy doing prior authorizations. Most doctors feel that they should be able to write whatever drug they want and have it filled without any questions asked. We try to make it as painless as possible," Solow says.

At RxEOB, a company that provides software and services to health plans, an online PA system is now part of its service set, says CEO Robert Oscar. He asserts that online PA is the kind of functionality that is critical to physician adoption. "Our next version calls for a more complete integration with e-prescribing systems," Oscar tells DBN.

Among the benefits of online PA is "having all of the appropriate people and having all of the information in one spot so the best decision can be made in the shortest amount of time," says William Reay, Pharm.D., chief pharmacy officer and senior director at Physicians Plus Insurance Corp., an insurer that now is installing RxEOB’s PA system. Physicians Plus previously had used an internal, home-grown system.

Reay says that the RxEOB system allows Physicians Plus to capture a lot of data and attach notes as well as produce hard copy letters for members and providers. "We desire at some point in the future to do that electronically, [but] we’re not there yet," he says.

Another weakness of the Physicians Plus home-grown system is that it operates outside of the insurer’s claims processing system. "One of our goals is to somehow integrate the two," says Reay.

OptumRx handles its prior authorizations in-house — a system that Skinner says helps maintain quality. "My department will create the guidelines and then can pass those on to our prior authorization operational pharmacists to go ahead and produce those. And they are the ones out there speaking with the docs and back office to the pharmacies," says Solow.

By processing PA authorizations internally, Solow says it allows OptumRx to negotiate fees with clients on an event basis as opposed to per member per month (PMPM). "So they’re charged in the initial contract with the pharmacy benefit unit a fee for prior authorization," says Solow.

OptumRx outsources very few functions, Solow says, especially in areas where it is difficult to control the quality. "We’ve looked at the possibility of purchasing guidelines externally, but we believe that with our factually based literature, we have much better control in the clinical sense," he tells DBN.

Solow adds that recently there have been fewer PAs in certain classes because of generics. "But I think the advent has really been toward the specialty arena with all the new biologics coming out and some of these new treatments."

When it comes to PA volume, Skinner says it can vary based on clients and their needs, such as what type of plans they have and whether the enrollment is under or over age 65.

**PBM**s Double-Check PA Accuracy

OptumRx’s Solow says it performs PA audits to make sure that they are serving their purpose. "There are two parts to that. One is that safety mechanism, and that is hard to measure because you’re talking about providing the right drug and having it be the safest drug for that member because of some safety concerns and monitoring," says Solow. "Of course, we’re saving those costs for clients and possible complications of adverse drug reactions and hospitalizations." OptumRx also does algorithms on various functions to make sure that they are prior authorizing the correct drugs.

OptumRx clients have the option to not select the recommendations of the clinical teams regarding which drugs should have prior authorization required.

Solow says the overarching goals of the PA process are still the same. "What I make sure from a clinical sense is that we are able to justify the prior authorization need and process — really the guideline itself — to the doctor. The last thing you want to do is not have the patient get the right medication that’s going to help..."
his or her particular disease process and slow down recovery or that treatment process," Solow explains.

He acknowledges that there is increasing pressure to ensure that PA is based on evidence-based medicine rather than just pure cost factors.

Skinner says PA systems have evolved in two ways. "It’s becoming much more of a literature-based, scientific actual guideline, rather than pure cost driven as it was many years ago. The solution for prior authorization is keeping up with technology such as online prior authorization."

“We see a greater interest in enforcing evidence-based medical practice standards. Prior authorization is part of that, and I think where you are going to find the greatest role for prior authorization is around specialty pharmacy,” RxEOB’s Oscar tells DBN. “Our clients will be helping patients find the best distribution and clinical review and management of a complex disease with very expensive treatments.”

At RegenceRx, which also handles PA internally, the resulting savings are often dependent upon two factors: “The experience of the internal or external vendor in customizing and automating and/or handling criteria that may be complex, and/or aggressive utilization management criteria,” Lynn Nishida, director of pharmacy services for RegenceRx, tells DBN. RegenceRx is the PBM unit of The Regence Group, which operates Blue Cross and Blue Shield plans in Idaho, Oregon, Utah and Washington.

Regarding billing, Nishida says it depends on the complexity of review for a prior authorization, and it varies based on the level of complexity and review that may be required by medical health professionals.

Contact Solow and Skinner via David Himmel at (714) 226-3772, Oscar at (804) 648-0988, Reay at (608) 417-4660 or Nishida via Samantha Meese at (503) 225-4871.

**Insurers Push for Guidance on OTC Rx Coverage in Prevention Reg**

More than a year after health reform law-mandated preventive care regulations initially were published, managed care pharmacists are demanding guidance on how to cover over-the-counter (OTC) drugs related to these services.

The issue, according to the Academy of Managed Care Pharmacy (AMCP), is that it’s unclear whether the interim final rule requires plans to cover OTC drugs such as aspirin and folic acid in conjunction with required preventive services, or to cover only the preventive care counseling itself. AMCP initially outlined its concerns in a July 2010 letter sent to HHS and the Labor and Treasury departments, and then reiterated the issues in a second letter sent this summer.

A spokesperson for CMS’s Center for Consumer Information and Insurance Oversight (CCIIO) tells DBN that it received AMCP’s letter and is working on a response.


In its initial letter to CCIIO, AMCP requested guidance and clarification for recommendations in four areas: aspirin to prevent cardiovascular disease in men age 45 to 55, aspirin to prevent CVD in women age 55 to 79, folic acid supplements for women and iron supplements for children age six to 12 months.

The regulation requires health insurers to cover the preventive services themselves at 100%, with no member cost sharing. But managed care pharmacists working for health plans assert that they need clarification so they can determine the proper cost-sharing requirements for the OTC drugs. For example, does the recommendation mean that health insurers must cover the physician office visit for counseling to recommend that patients take aspirin, or the aspirin itself?

Marissa Schlaifer, director of pharmacy affairs for AMCP, says that while there was no specific clarification on how these four areas should be handled, there was specific guidance in other areas such as cholesterol testing.

**Plans Differ on Interpretation**

“Some plans have lawyers telling them that they have to cover aspirin, folic acid and iron. Other plans have lawyers that are telling them that they don’t have to cover aspirin, folic acid and iron,” Schlaifer tells DBN. “We have health plans doing what they think the agency intended by not covering it, but they’re concerned that the agency is going to come back on any given day and tell them that they have to cover it. And that would have a significant premium change.”

Schlaifer says that most plans are interpreting this to mean they don’t have to cover the actual cost of the drug. “But they are very uncomfortable with whether or not they are in compliance with the law. What we indicated in our letter is that we think that because these are available OTC, that it does not appear that...
the regulation requires coverage of the medication itself. But we need clarification," Schlaifer says.

AMCP has been getting repeated calls from pharmacy directors for major health insurers asking if any clarification has been issued by CCIIO.

Schlaifer says the regulation applies to all non-grandfathered health plans with plan years beginning after Sept. 23, 2010. “We will have to be in compliance with this…when we don’t know exactly what it says.” AMCP has been in communication with CCIIO staff for the past year, she adds. “Part of the challenge is this regulation was not just issued by HHS. It’s issued in partnership between the Department of Labor and the Department of the Treasury, and this decision

| Study: Generic Fosamax Has Better Outcomes, Lower Cost |

In comparing bisphosphonates, a class of drugs used to treat osteoporosis, WellPoint, Inc.’s Anthem unit found that members had fewer fractures, better compliance and lower total costs with an older generic drug compared to a newer brand-name agent.

“After a careful review of the literature, we found that the older medication Fosamax [alendronate] was much stronger and showed stronger evidence for reducing fractures compared to the newer drug Boniva [ibandronate sodium]. This is a case where newer is not necessarily better. Older will result in better health for our members,” Jeff White, director of drug evaluation and clinical analytics at WellPoint, Inc., tells DBN.

In addition, White says, Anthem reviewed its own data regarding fracture rate reduction and didn’t find that Boniva had lower fractures compared with Fosamax. In fact, Boniva had a slightly higher fracture rate than Fosamax.

“We encourage the use of Fosamax and Actonel [risedronate], another brand drug, as our preferred medications on our drug list for reducing fractures, improving health and lowering total cost of care,” White says.

The study began in early 2011 and used data from WellPoint’s 14 Blue Cross and Blue Shield plans. It is expected to be published in October.

In addition, according to a separate analysis Anthem conducted of members in its affiliated health plans, enrollees with both medical and pharmacy benefits managed by Anthem have medical costs that are $8 to $16 lower per employee per month compared with those without Anthem’s pharmacy program.

For example, in some health plans, a specialty drug may be used off-label for a condition different from what was approved, even though there is no evidence to prove that it is clinically effective for that condition. White says alignment of medical and pharmacy benefits helps encourage appropriate use of medications that may be paid for through either channel, resulting in appropriate care and improved health for members.

The integrated care analysis included 524,360 members in Anthem’s affiliated health plans that had Anthem’s medical and pharmacy benefits, as well as members who had Anthem medical benefits only. The study included both self-insured and fully insured commercial members in national accounts and local groups representing 14 states from July 1, 2009, to June 30, 2010.

Anthem reports that the lower medical cost savings that were associated with integration and coordination of its medical and pharmacy programs were confirmed in Anthem’s general membership, as well as among those enrollees who have common drug-dependent disease states that drive overall costs, including diabetes, coronary artery disease, congestive heart failure, hypertension, stroke and chronic kidney disease.

In reaction to Anthem’s analysis, George Van Antwerp, general manager, pharmacy solutions at Silverlink Communications, Inc., says, “it would create a strong case for carve-in, which is interesting given Anthem (WellPoint’s) carve-out to Express Scripts.”

WellPoint sold its in-house PBM, NextRx, to Express Scripts, Inc. two years ago. Express Scripts processes claims, maintains relationships with pharmacy providers, manages mail-order services and contracts with pharmaceutical companies for WellPoint.

“An $8-$16 per employee per month savings is fairly significant. Maybe employers with higher health care costs are more likely to carve-out pharmacy benefits,” Matt Coffina, equity analyst for Morningstar, Inc., tells DBN. “This kind of evidence could help Anthem convince clients to use its own pharmacy program.”

Contact White via Lori McLaughlin at Lori.McLaughlin2@anthem.com, Van Antwerp at (314) 517-8915 or Coffina at (312) 696-6864.

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has to be made by what they refer to as a tri-agency workgroup. So HHS can’t clarify this by themselves,” Schlaifer says.

Dan Mendelson, CEO of Washington, D.C.-based consulting firm Avalere Health LLC, asserts that in this particular case the details matter. “And the details have not been forthcoming from the agency. Everyone agrees that prevention is a good thing; everyone agrees that it should be covered. The premise is clear — but the details are murky,” Mendelson tells DBN.

In order to predict future medical costs, write policies, perform underwriting and develop marketing materials, insurers have to know what costs are mandated under the law, he says. “As the plans start to specify premiums as well as benefit design, they need to know. And they need to know before the deadline for actually complying….That’s why this issue is coming to a boiling point.”

What is likely to happen? Mendelson says that at some point, he thinks CCIIO will issue clarifying guidance, but he added that there are a lot of issues still to resolve. “You can only enforce what you have specified. Or if you don’t specify, you can’t enforce it — and they will want to able to enforce it because that’s their job.”


Mobile Phone Apps Are Gaining Momentum Among PBMs, Insurers

Positive feedback from members and a surge in smartphone usage are driving PBMs and insurers to adopt mobile applications as a way to provide members with easy access to pharmacy information. Payers say it’s critical to get member feedback in order to guide future development and implementation of mobile pharmacy apps.

So far this year, several leading health insurers and PBMs, including Independence Blue Cross (IBC), Catalyst Rx and Medco Health Solutions, Inc., launched mobile phone applications (DBN 5/27/11, p. 1).

“We are listening for feedback and plan to adapt the application as we proceed. When possible, we will engage member feedback via surveys and user groups,” Mike Yetter, director of IBC’s eBusiness Development, tells DBN.

IBC became the latest health insurer to roll out a smartphone application that allows members to manage and navigate through their health plan.

Yetter says IBC hopes to avoid some of the pitfalls that are common when a large enterprise is entering into a new technology channel. To address that, he says, IBC has partnered with Usablenet, Inc., which he calls “a very experienced and reputable technology vendor….Their technology and hosting allowed us to enter the market more quickly and without investments in infrastructure.”

Yetter adds that the primary lesson that IBC learned as it prepared to launch IBX Mobile is to allow more time for implementation than initially planned. “New technology for an enterprise results in new questions and business decisions that can extend the timeline.”

Research on smartphone adoption conducted by IBC reveals that while smartphone use is increasing among older people, including those who are Medicare-eligible, 18- to 35-year-olds represent the lion’s share of smartphone end users. “There’s definitely a demand across the age demographics, but there is a particularly strong comfort with technology and familiarity with smartphones and adoption of smartphones in the younger demographics,” says Yetter.

Taking Advantage of Popular Platforms

End users can download IBX Mobile to their smartphones using Apple’s App Store or Android Market. Yetter says upfront research showed that app utilization was the greatest on Apple’s App Store and Android Market platforms. IBC did not choose the BlackBerry platform because data showed that BlackBerry users didn’t download apps as frequently.

In addition to allowing end users to view personal health records and find a health care provider, IBX Mobile’s pharmacy benefit tool enables them to:

◆ View the prescription plan summary of benefits (including the ability to look up copayment amounts),
◆ View employer reimbursement account balances for consumer-directed high-deductible plans,
◆ Search for a drug by brand or generic name, and
◆ Compare prescription prices across local pharmacies and via mail order.

In addition, when a generic is available, the tool automatically shows the price of both brand and generic drugs for comparison. It also can display drug history via the mobile personal health record, including the drug name, correct dosage and the date last dispensed.

According to the results of a survey of 2,251 adults conducted in January 2011 by the Pew Research Center’s Internet & American Life Project and the Project for Excellence in Journalism, 84% of American adults own a smartphone application that allows members to manage and navigate through their health plan.
mobile device (including cellphones and tablet computers), and two-thirds of them use texting, emailing, Web browsing and other features. The half-million members now logged on to IBC’s portal are the ones who would be most interested in using mobile apps, says Yetter. IBC covers 3 million members.

IBC is working with its PBM, FutureScripts, LLC, which IBC sold in August 2010 to Catalyst Rx, a subsidiary of Rockville, Md.-based Catalyst Health Solutions, Inc. “The MyFutureScripts website has the set of site features that we’re leveraging in order to provide the information to members around the drug pricing,” Yetter says.

IBC also is looking to partner with Catalyst Rx, which introduced its own mobile platform Catalyst Rx Mobile, in May. “One of the conversations I’m engaging in with Catalyst is what can we leverage for our members going forward. We are definitely looking for ways to leverage their capabilities down the road,” Yetter says.

IBC officials contend that they view mobile apps as part of a long-term multichannel strategy. “It’s easy to get caught up in the buzz of mobile apps and bringing things into the mobile space. It’s really about member convenience. It’s about having info in your hand in a situation when you need it,” Yetter says.

While it’s too soon for most companies who launched mobile apps to calculate return on investment (ROI), some are confident that their investment will ultimately pay off.

“In the initial roll-out, our main goal was to provide customers and clients with a capability that could make life simpler, help them manage their medications and provide us with user feedback that could help us to evolve the capabilities,” says David Whitehouse, M.D., chief medical officer at Catalyst Rx.

So far, Catalyst Rx’s focus with mobile apps has been on acceptability, usefulness and uptake. “Going forward, the focus is to leverage the unique possibilities that this approach affords — to link with predictive modeling capabilities, identification of opportunities and targeted implementation strategies to create measurable ROI,” says Whitehouse. “We should begin to have data by the end of the year.”

Looking toward the future, Whitehouse says, “As data, information and knowledge about their medications become more personal and relevant, the smartphone is likely to become the device of choice to manage and understand medication use, buying, refilling and effectiveness.”

Industry analysts view smartphone apps as a great way to increase member involvement, but for now, they aren’t key to success.

“Smartphone apps are a low-cost way to increase consumer engagement. For example, they might help a health plan deliver wellness messages, encourage adoption of mail-order pharmacy or make it easier for members to find in-network providers,” Matt Coffina, equity analyst for Morningstar, Inc., tells DBN.

Medco, Express Scripts Dominate PBM Market

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SOURCE/METHODOLOGY: AIS’s quarterly pharmacy benefit survey conducted for DBN. Total drug spend for all PBMs reporting as of second quarter in the year indicated. Market share calculated as percentage of total drug spend reported as of 2Q2011. Survey includes companies that describe themselves as PBMs, pharmacy benefit administrators, specialty pharmacy providers and others providing pharmacy benefit services. Definition of drug spend may vary among respondents and business models. 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.

Web addresses cited in this issue are live links in the PDF version, which is accessible at DBN’s subscriber-only page at http://aishealth.com/newsletters/drugbenefitnews.
But Coffina says he does not consider mobile apps
central to anyone’s business strategy, nor a source of
competitive advantage, given how easy it is for com-
petitors to imitate the technology.

“PBM’s and insurers are definitely investing in
mobile applications for the long term by integrating
them into their platforms, and see them as an oppor-
tunity to push real-time messaging to the consumer
at the point of prescribing,” George Van Antwerp,
general manager, pharmacy solutions at Silverlink
Communications, Inc., tells DBN.

Although Van Antwerp agrees that mobile apps
aren’t a “critical path” from a competitive perspective,
he says that almost everyone has some type of mobile
application or mobile Web solution. “I expect they
will continue to get more sophisticated and interesting
as consumers download them and, more importantly,
begin to use them regularly.”

Contact Golden at (212) 895-8621, Yetter via Karen
Burnham at (215) 241-3106, Coffina at (312) 696-6864
or Van Antwerp at (314) 517-8915.

Part D Plans Gear Up for 2012
continued from p. 1

Avalere predicts that UnitedHealthcare will lose
those members this year because in several regions it
bid above the benchmark CMS uses to determine which
plans qualify to serve beneficiaries receiving the Low-
Income Subsidy.

“Then you have CIGNA and Coventry and
Humana, all gunning for that higher-end product in the
top 10,” he says. Those three insurers are expected to
decrease premiums by about 10%, Avalere reports.

“United is going to position itself as having a high-
quality, high-end plan, and I think that a lot of the other
plans are going to come in and say, ‘We’re trustworthy,
reliable and less expensive,’” says Mendelson.

UnitedHealthcare spokesman Matt Burns
says that of those plans included in Avalere’s study,
UnitedHealthcare’s was the only national basic plan
with a zero deductible. “UnitedHealthcare has a more
robust formulary and covers more branded drugs than
many of our competitors’ plans,” Burns tells DBN.

Burns says UnitedHealthcare dropped its premiums
last year by about $5 (12%) on its preferred plan. “On
average, our premiums for 2012 are slightly lower than
2010 levels. Some of our competitors increased premi-
ums over the last several years,” he adds.

Avalere’s Mendelson expects to see aggressive mar-
keting pitches to seniors. “Seniors are very price con-
scious when they are shopping for these benefits.”

Industry analysts assert that engaging with mem-
ers and potential members will be very important
for Medicare Part D plans in order to differentiate
themselves during the marketing period.

“It will be important that they communicate
not only premium pricing, but also plan designs
associated with medication coverage as well as
any additional programs that may be available to the
member,” says Jan Berger, M.D., chief medical officer
for Silverlink Communications, Inc. and former chief
clinical officer at CVS Caremark. “Members will need
to understand the value that a plan can bring to them,
and members will need to feel the love and an affinity
to a plan,” Berger tells DBN.

Creative Marketing Is Vital

This year, Berger says, members have a shorter
time frame to make decisions regarding Medicare cov-
erage. “The plans will need to utilize creative methods
to communicate with the members.” The 2012 open-
rollment period runs from Oct. 15 through Dec. 7,
compared with Nov. 15 through Dec. 31 in previous
years.

Thomas Carroll, a securities analyst at Stifel
Nicolaus, also anticipates aggressive marketing among
the plans. “Given the nature of this product, it’s a new
game every year, similar to Medicare Advantage,” he
tells DBN. “I think that Humana Walmart [Preferred
Rx Plan] product was a game changer. It provided the
first standard product available nationwide for the
same bargain basement price. This product will likely
see competition in 2012,” Carroll says.

In Avalere’s analysis of Medicare PDPs by enroll-
ment and premiums for 2012, the Humana Wal-mart
Preferred Rx Plan offered the lowest premium, $15.10.
CVS Caremark’s Community CCRx Basic premium
will be $30.84, an increase of 4%, while CVS Caremark
Value and CIGNA Medicare Rx Plan One also had
premiums in the low $30’s — $30.49 and $31.19 respec-
tively, according to Avalere.

Contact Mendelson via Erica Garland at (202) 745-
5119, Burns at (952) 931-6242, Berger via Marit Fratelli
at (781) 425-5886 and Carroll at (443) 224-1310。

New from the editors of
AIS’s Directory of Health Plans
AIS’s Database and Report on
2010 Medical Loss Ratios
Go to www.AISHealth.com/marketplace/gmlr

Subscribers who have not yet signed up for Web access — with searchable newsletter archives, Hot Topics, Recent Stories and more — should click the blue “Login” button at www.AISHealth.com, then follow the “Forgot your password?” link to receive further instructions.
NEWS BRIEFS

◆ Express Scripts, Inc. accused Walgreen Co. of using false advertising to urge Medicare patients to abandon Express Scripts. In a Sept. 7 complaint filed in the U.S. District Court for the Northern District of Illinois, Express Scripts charged Walgreens with violating a contract that is set to expire on Dec. 31, 2011. Walgreens said in June 2011 that it no longer would participate in Express Scripts’ pharmacy network, citing a breakdown in negotiations on the $5 billion contract (DBN 6/24/11, p. 1). A Walgreens website stated that Medicare patients who stay with Express Scripts wouldn’t be able to have their prescriptions filled after Dec. 31. Express Scripts fired back, accusing Walgreens of failing to negotiate in good faith. Contact Express Scripts’ Brian Henry at (314) 684-6438 and Walgreens’ Michael Polzin at (847) 914-2920.

◆ Prime Therapeutics, LLC selected Corticon Technologies, Inc. to develop software for its GuidedHealth clinical platform that is set to launch in 2012. GuidedHealth modules will assist physicians, members and health plans in identifying prospects for better management of pharmacy utilization, gaps in care, safety and costs. Corticon’s technology will help Prime “be able to quickly search its data for patients in need of follow up and establish automated processes for ongoing review,” said Bob Schoettle, Corticon’s chief marketing officer. Contact Prime’s Sheila Thelemann at (612) 777-4252 and Corticon’s Samira Abrari at (650) 212-2424, ext. 247.

◆ Health insurer CalOptima has selected PerformRx LLC as its PBM, effective Jan. 1, 2012. Under the terms of a four-year contract, PerformRx, a unit of the AmeriHealth Mercy Family of Companies, will provide PBM services to 416,220 CalOptima members in MediCal, Healthy Families and OneCare. Contact CalOptima’s Margaret Tatar at (714) 246-8796 and Perform Rx’s Paul Coppola at (215) 937-8478.

◆ Although the pharmaceutical supply chain in the U.S. is secure, new strategies could help to make it even safer and less vulnerable to theft, the National Community Pharmacists Association (NCPA) told the U.S. Senate Health, Education, Labor and Pensions Committee. Among NCPA’s recommendations: a track and trace system for controlled substances and counterfeited products, and new authority for community pharmacists to confirm prescription medications in larger batches. Contact NCPA’s John Norton at (703) 600-1174.

◆ Pharmacy customers have much higher expectations regarding waiting times, and they expect more from their pharmacist and the pharmacy staff, according to a J.D. Power and Associates 2011 U.S. National Pharmacy Study. Data from the study revealed that for customers of chain drug stores who wait less than three minutes to submit their prescription information to a pharmacy staffer, “satisfaction averages 836 on a 1,000-point scale.” Lower satisfaction in the prescription ordering and prescription delivery process contributed to a decline in overall satisfaction with mail-order pharmacies. Contact J.D. Power’s Jeff Perlman at (818) 598-1115.

◆ Capital District Physicians’ Health Plan, Inc. has selected Mirixa Corp.’s care services and medication therapy management (MTM) services for CDPHP’s Medicare Part D members. Lisa Passino, R.Ph., medication therapy management service leader for CDPHP, said, “Our community of consultant pharmacists suggested that we consider the Mirixa platform for MTM service documentation because they found it to be easy to use and organized in a way similar to how pharmacists work and think.” Contact CDPHP’s Julie Tracy at (518) 641-5126 or Mirixa’s Anne Marie Heil at (703) 865-2035.

◆ The U.S. House of Representatives Committee on the Judiciary Subcommittee on Intellectual Property, Competition, and the Internet held a hearing Sept. 20 that explored the potential ramifications of Express Scripts’ planned purchase of Medco. Among those testifying was independent pharmacist and NCPA member Joseph Lech, who contended that “the merger of these two PBMs would create a ‘mega PBM,’ specialty pharmacy provider and mail-order pharmacy with overwhelming power in markets that are critical to controlling health care costs.” Rebutting Lech’s testimony, George Paz, chairman and CEO of Express Scripts, said the merger “will help make prescription drugs more affordable for seniors, people with disabilities and working families.” View the hearing at http://judiciary.house.gov/hearings/hear_09202011.html.

◆ PEOPLE ON THE MOVE: Navitus Health Solutions President Terry Seligman was promoted to the additional role of CEO. Apothecary by Design, an independently owned pharmacy, named Mary Jean Darby, R.N., vice president of business development. Darby was a vice president at Express Scripts, Inc.
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