MIDATLANTIC BUSINESS GROUP ON HEALTH
RXBENEFIT *NEWSFLASH*

August 1, 2011

➔ Benefit Design Considerations in Managing Chronic Disease

What:

A 2003 World Health Organization report concluded that "poor adherence to treatment of chronic diseases is a worldwide problem of striking magnitude. Adherence to long-term therapy for chronic illnesses in developed countries (ie USA) averages 50%. Poor adherence to long-term therapies severely compromises the effectiveness of treatment making this a critical issue in population health both from the perspective of quality of life and of health economics."

A research report published July 2011 in Health Affairs journal demonstrates that prevention, with the use of generic medications, is far more cost-effective than previously documented and may save on costs. An earlier study estimated that reducing blood pressure to widely established clinical guidelines in nondiabetic patients cost an estimated $7,753 per quality-adjusted life-year at generic medication prices versus $52,983 if a brand-name drug was used.

A 2009 RAND report on medication adherence concluded: "Evidence is clear that higher copayments contribute to lower adherence to medication. Cost-sharing could thus be reduced as a barrier when the appropriate use of a particular medication has health or financial benefits, such as avoiding future complications, functional decline, or more-expensive future treatments."

Why Important:

MABGH pharmacy advisors believe that it is cost-effective to encourage patient adherence with generic medication therapy of chronic diseases. We recommend that coalition members consider revisions of pharmacy benefit designs to lower cost share for select maintenance medications, and consider using approved contracted PBM adherence programs. Please contact us for documentation or to discuss your options further.

➔ Express Scripts (ESRX) to Acquire Medco Health

What:

Analysts at BB&T Capital Markets estimate that the top 4 PBMs (Medco, Express Scripts, CVS Caremark, Optum/Prescription Solutions) processed ~61% of all US prescriptions, with Medco at 13-16%, ESRX at ~19%, CVS at ~18%, and Optum/Prescription Solutions at ~11% market share.

Assuming FTC approval, the combined ESRX/Medco would hold ~32-35% market share.

Why Important:

Express Scripts is the current MABGH contracted PBM, currently serving our Coalition members. MABGH pharmacy advisors will monitor merger-related activity to ensure that it does not adversely effect Coalition members' contracted level of service, but does improve contract performance for our members.

Published by Institute for Integrated Healthcare (IIH), Randy Vogenberg, RPh, PhD and Elan Rubinstein, PharmD, MPH. randy@iihonline.net or elan@iihonline.net | Confidential

➔ United Healthcare Enters Drug Benefit Business While Walgreens/ESRX Continue Contract Discussions

What:

UnitedHealth Group has announced that its OptumRx/Prescription Solutions PBM subsidiary will move aggressively into the pharmacy benefits marketplace. OptumRx CEO Jacqueline Kosecoff said in a recent interview the company is "very interested in the employer market and are getting very aggressive on bidding some very large accounts."

Walgreens has informed Express Scripts of its decision to leave the PBM's provider network, due to low reimbursement. Walgreens has reached out to benefits consultants to recommend that self-insured employers should consider selecting a different PBM which includes Walgreens stores, or make arrangements directly with Walgreens for patient access to Walgreens stores.

Why Important:

MABGH pharmacy advisors continue to monitor the provider network, which in this case may limit access for Coalition member beneficiaries. We continue to explore alternatives, including new and different PBM or specialty pharmacy alternatives that may offer enhanced service performance for our members. Please contact MABGH pharmacy advisors to discuss any issues or concerns.

➔ A New Branded Proton Pump Inhibitor on US Market Will Increase Benefit Cost

What:

The proton pump inhibitor drug class represents one of the highest spend classes on a per member per month basis for Coalition members. Dexilant, a branded PPI, was launched in the US market January 2009. According to IMS, which tracks prescription drug dispensing trends, Dexilant is the fastest growing branded PPI with more than 4 million prescriptions dispensed. Impax, a generic manufacturer, has challenged Takeda's patent on Dexilant, which expires in June 2020. However it is not known if the challenge will be successful.

Why Important:

The PPI drug class includes several generics, yet branded PPIs costing several hundred dollars per 90 day supply are frequently dispensed. MABGH pharmacy advisors suggest that members work with Express Scripts and with us to develop and implement solutions for this problem.

Concerned about your pharmacy benefit or specialty pharmacy cost? Learn about the biologics/specialty pharmacy initiative, national survey results, and an employer tool kit based on this employer driven project at the MABGH morning program on October 6, 2011 at the BWI-Westin Hotel.

For more information, contact John Miller at MABGH.

➔ Controlling Fast-Growing Cancer Treatment Cost

What:

According to a recent paper published in the New England Journal of Medicine by two highly respected oncologists, "annual direct costs for cancer care are projected to rise — from $104 billion in 20061 to over $173 billion in 2020 and

beyond.2 This increase has been driven by a dramatic rise in both the cost of therapy3 and the extent of care in the United States, the sales of anticancer drugs are now second only to those of drugs for heart disease, and 70% of these sales come from products introduced in the past 10 years. Most new molecules are priced at $5,000 per month or more, and in many cases the cost-effectiveness ratios far exceed commonly accepted thresholds. This trend is not sustainable."

Authors suggest several changes in oncologists' behavior to change this situation:

1. "Target surveillance testing or imaging to situations in which a benefit has been shown.
2. Limit second-line and third-line treatment for metastatic cancer to sequential monotherapies for most solid tumors.
3. Limit chemotherapy to patients with good performance status, with an exception for highly responsive disease.
4. Replace the routine use of white-cell–stimulating factors with a reduction in the chemotherapy dose in metastatic solid cancers.
5. For patients who are not responding to three consecutive regimens, limit further chemotherapy to clinical trials."

Furthermore, authors recommend several changes in oncologists' attitudes and practice:

1. "Oncologists need to recognize that the costs of care are driven by what we do and what we do not do.
2. Both doctors and patients need to have more realistic expectations.
3. Realign compensation to value cognitive services, rather than chemotherapy more highly.
4. Better integrate palliative care into usual oncology care (concurrent care).
5. The need for cost-effectiveness analysis and for some limits on care must be accepted."

<u>Why Important</u>:

Only those oncology therapeutics and supportive care agents that are managed through the pharmacy benefit are visible to Coalition members in PBM data and reports. Much of this utilization and spend is paid through the medical benefit, where it is typically hidden from view. MABGH pharmacy advisors recommend that while PBM and specialty pharmacy centered efforts will be helpful to better manage cancer-related spend, a holistic approach across the medical and pharmacy benefit would more effectively address this problem.