

# DRUG BENEFIT NEWS

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

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## Final Part D Sales Regs Hit on Eve of '09 Selling Season; New Entrants Face Hurdles

Medicare Part D sponsors may continue using direct mail to entice potential enrollees, but will be prohibited from making unsolicited follow-up calls, according to CMS's new Part D marketing regulations that aim to crack down on deceptive and high-pressure sales tactics. Part D plans now are scrambling to implement the rules by the start of the Oct. 1 selling season. And some industry observers assert that the regulations could make it harder for new entrants into the market to attract members.

The final marketing rule, released Sept. 15, generally mirrors provisions in the Medicare law enacted in July and CMS's proposed rule issued in May, Part D stakeholders say. But there are some notable exceptions, particularly around how plans pay commissions to agents and brokers.

While the rule doesn't contain any major surprises, its arrival in mid-September leaves Part D plans with little time to prepare for the Oct. 1 start of the selling season, says one industry observer.

"It's a lot of specific information for plans to digest and make operational in a short period of time," says Bonnie Washington, vice president in the Medicare practice at Washington, D.C.-based consulting firm Avalere Health LLC. "But it's not a surprise, because that is what was required by the law," she tells *DBN* of the marketing provisions in the Medicare Improvements for Patients and Providers Act (MIPPA) enacted July 15 (*DBN* 7/18/08, p. 1).

Under the final rule, stand-alone Part D Prescription Drug Plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) are prohibited from making cold calls, selling plans in doctors' offices and providing meals to potential beneficiaries. Plans also are banned from cross-selling non-health care-related products during any sales or marketing effort for an MA plan or PDP. A separate rule eliminates incentives

*continued on p. 7*

## Payers Seek Control of Drug Management; Rx Benefit Vendors Tout Innovative Efforts

Employers are getting "much more active" in managing their employees' prescription drug benefits, and are looking for new strategies to control pharmaceutical costs, according to a consultant who studies employer trends in pharmacy spending. Aiming to take advantage of this trend, some midsized PBMs and other pharmacy benefit vendors are rolling out what they say are "innovative" and "game-changing" pharmacy plans that promise to lower Rx spending and improve employees' overall health.

New pharmacy offerings unveiled in recent weeks include a program that provides employer executives with pharmacy data that establish health risks of employees and that allow for better management of overall health care. Another new program incentivizes employees to choose healthier foods when picking up their medications in the supermarket.

*continued*

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"There are a lot of creative things going on all over the country," says Michael Jacobs, a principal at human resources and consulting firm Buck Consultants, LLC, which recently released its annual survey identifying strategies that employers are using to manage prescription drug costs (see chart, p. 3).

Some of the pharmacy benefit innovation is being driven by the increasing number of health, nutrition and wellness coaching programs, as well as the emergence of very low-cost generic drug initiatives offered by Wal-Mart Stores, Inc. and other large retailers, Jacobs tells *DBN*.

For some pharmacy vendors, he says, the emerging programs go against traditional business models.

But others seek to drive change. One new pharmacy-based program aims to help employers manage their employees' health care in the same way they manage other aspects of their businesses.

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The program, "Point to Point Healthcare," was recently unveiled by software firm Healthcare Interactive and employee health-benefit administrator WellNet Healthcare. Company leaders say this administrative tool will eliminate "rampant waste and excessive medical-benefit costs" in part by simplifying health benefits and giving employers control over their data.

"Medical benefits are not that complicated," says Keith Lemer, president of WellNet. "But outsiders want it to appear this way," he asserts. "They make benefits seem difficult so employers won't stand up and question the annual double-digit cost increases they face. These choices do not expose the real issue: Without data, employers can't manage or measure their employees' health care benefits."

Point to Point addresses this issue by giving employers rapid access to pharmacy claims data that have been analyzed by predictive modeling software. With this tool, employers can quickly understand and track the financial risks they face regarding their employees' health care costs, Lemer tells *DBN*.

Many businesses use predictive modeling to determine health risks, Lemer says, but the modeling typically uses medical data that are gathered at the end of the program year. "When people get that [medical] data, it's too late to do anything, because people have already veered off the track," Lemer says.

### Rx Claims Data Highlight Risks

"Because of the nature of pharmacy data, which comes same day/next day, they hit immediately and you can see the risk in the plan," he says.

Using these de-identified pharmacy data, a company can then adopt appropriate strategies to manage care, Lemer says. WellNet can suggest solutions and reach out to high- and moderate-risk employees and customize disease care management programs to address their unique conditions, he adds.

Henry Cha, president of Healthcare Interactive, says large companies shy away from predictive modeling because they get too many false positives, and they do not want to be intrusive in the lives of their employees. Relying on pharmacy data, however, avoids this problem, he tells *DBN*. Pharmacy data are "outcomes" that provide a fairly clear picture of what's going on with the patient, he adds. "You're not going to get a script for diabetes [medicine] unless you have diabetes," he says as an example.

Lemer says that taking control of such data can save employers up to 10% on their health care expenses, in part by proactively getting their employees healthy. "They know that they have risk going on in their plan, and if they don't do something about it, the cost down

the road to the medical plan is going to be astronomical," he says.

Point to Point also includes an online health care social network that links members to physicians, pharmacists and insurance benefit managers.

### Discounts on Mangos Along With Medicines

Another pharmacy program that appears to go beyond the traditional offerings comes from 4D Pharmacy Management Systems, Inc. and the Great Atlantic & Pacific Tea Company, Inc. (A&P) supermarket chain.

The Live Better! Wellness Program, announced this month, offers discounts on various generic drugs and over-the-counter drugs in A&P stores, as well as discounts on various grocery products, including fruits, vegetables and other foods that promote a healthful diet, the companies say.

"It's really less about filling prescriptions and more about improving overall health," says Jeff Polter, vice president of business development at 4D Pharmacy. "You're going to be healthier because of this card," he tells *DBN* of the program, adding that foods offered under the program are sold at roughly a 25% discount. The pharmacy portion of the program works with all of 4D Pharmacy's network pharmacies, and is not restricted to A&P stores, Polter adds.

The placement of Live Better! Wellness in grocery stores — which are visited by people on a regular basis — distinguishes it from other wellness programs, Polter says. It's often difficult to know whether some wellness programs actually are resulting in improved health outcomes, such as avoided heart attacks, he asserts.

"What's certain is that if people eat healthier, they will be healthier," he says. "What I'm trying to do is simplify the whole idea of health and wellness, and help people financially with making the right decisions."

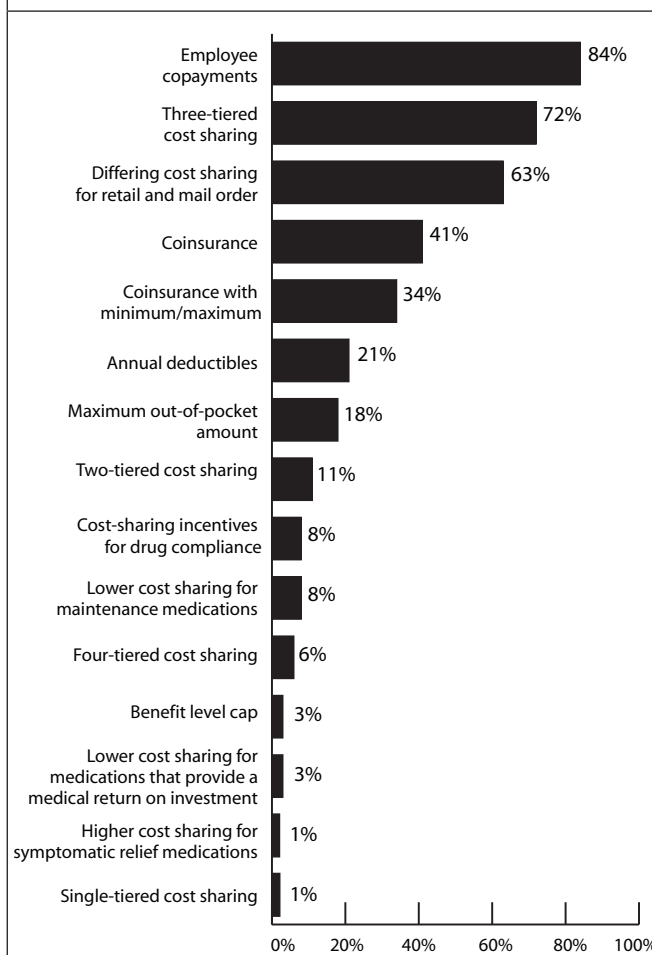
Other features of the program include health screenings, patient counseling and information services in A&P stores. Carol J. DiNicolantonio, senior director of pharmacy at A&P, says the partnership with 4D Pharmacy provides more advanced, comprehensive services than those traditionally provided by PBMs. "Being in the supermarket environment, we are able to interact with our customers even when they are not filling a prescription," she said in a prepared statement.

Chris Nee, Pharm.D., principal of consulting firm PharMedQuest, says the concept of integrating better diet and medication to improve health sounds good, but it is very hard to measure clinical and cost outcomes. "Since the whole topic of foods and medicine has not been well defined, making any claim may be premature," he tells *DBN*.

Likewise, the partnership that uses pharmacy data to give employers more power to manage their employees' health "is another twist on an old theme: that more information leads to better health," Nee asserts. This program also raises issues about its ability to demonstrate a positive effect on patients, employers or society at large, he adds. "This is because giving information to lay people may not lead to the best outcome," Nee says, pointing to the adage, "A little knowledge could be very dangerous."

Contact Jacobs through Carol Verble at carol.verble@buckconsultants.com, Lemer and Cha through Neil Adler at neil.adler@dmngood.com, Polter at jeff@4dpharmacy.com and Nee at chris@pharmedquest.com. ♦

### Employee Cost-Sharing Program Characteristics on Drug Benefits\*



\* Participants were allowed to select more than one answer.

SOURCE: Buck Consultants, LLC "Understanding Your Strategies for Coping with the Changing Pharmacy Benefit Landscape, Survey Results," August 2008

METHODOLOGY: Survey of more than 150 organizations representing a broad range of industries and employer sizes, conducted in the first quarter of 2008.

## Part D Negotiations, Rx Reimports Have Support From Obama, McCain

Presidential candidates Sens. John McCain (R-Ariz.) and Barack Obama (D-Ill.) disagree on many things. But they find common ground on two key pharmacy cost-control policies: giving HHS the authority to negotiate drug prices under Medicare Part D and legalizing the reimportation of lower-cost drugs from abroad.

These controversial proposals also have the broad support of Democrats, who are widely expected to maintain or increase their majorities in Congress following the November election. But that doesn't mean a presidential signature on bills allowing for Rx reimportation or direct Part D negotiations is a sure thing, nor are they necessarily good ideas, industry observers and health plan pharmacy executives tell *DBN*.

The safety issue involving reimported drugs is still a major concern, say health plans, which note this could ultimately dampen enthusiasm for importation. And the Part D program now covers millions of seniors who previously paid cash for their medications, a fact that has eased some of the intense pressure to rein in drug costs.

Nevertheless, lowering drug costs, including those for Part D, remains a perennial target for politicians. Both McCain and Obama favor allowing HHS to negotiate prices directly with drug manufacturers under Part D. Obama has said that repealing the ban that now prevents the government from negotiating prices could result in savings of as much as \$30 billion. He did not specify over what time period the savings would occur.

### Direct-Negotiations Fight Is Likely

Giving the federal government greater negotiating authority under Part D is expected to be a big issue for the next Congress and administration, says Bill Hermlin, director of government affairs and general counsel at the Academy of Managed Care Pharmacy (AMCP). "If they had to choose one or the other, I think they will put more of their political heavies at work on Part D than on [drug] importation," he tells *DBN*, adding that this is going to be an area where AMCP, which opposes such negotiations, will "place a lot of its emphasis with the new Congress."

The issue is still fresh in the minds of many lawmakers. The full House in early January 2007 passed a bill giving the federal government authority to negotiate Part D drug prices (*DBN* 1/19/07, p. 1). The bill, however, died in the Senate in April 2007 after supporters were unable to muster a two-thirds, filibuster-proof majority (*DBN* 4/20/07, p. 8).

The presidential candidates' positions on these issues so far have not been entirely clear, says Dan Mendelson,

president of Washington, D.C.-based health consulting firm Avalere Health LLC. "In order to really understand what would happen, you have to have more details," he says.

"What McCain has said is very general rhetoric," Mendelson tells *DBN*. "McCain has historically supported smaller government. I would be really hard pressed to see him support a full government price control on drugs. With Obama, we don't really know how far he would go. Would it be a strict price control? Or would it be something you would navigate and modulate?"

### Rx Reimportation Faces Obstacles

Similarly, the candidates' support for drug reimportation appeals to the notion of doing something about expensive drugs. "This is better rhetoric than it is policy," says Mendelson. "It's a very popular and populist policy," he adds. "It's one that people like the sound of: getting cheaper drugs." Brand drugs in the U.S., for example, often cost twice as much as they do in Canada or the European Union. Supporters of earlier reimportation efforts say that allowing drug imports to the U.S. could save consumers \$50 billion over 10 years.

McCain's chief economic advisor, Douglas Holtz-Eakin, told *The Wall Street Journal* Sept. 6 that a McCain White House could focus first on areas of health care where the two parties agree, including allowing the reimportation of drugs from Canada and expanding the use of generic drugs.

But Mendelson asserts that reimportation proposals from McCain or Obama would undoubtedly contain a provision that requires the HHS Secretary to certify that any drugs coming into the country would "pose no additional risks to the public's health and safety," and would significantly reduce costs for consumers. This so-called "poison pill" provision is in current law that allows for reimportation, and no HHS Secretary has yet granted that certification.

"Then the question is, would you get an HHS Secretary who would certify it?" Mendelson asks. "In all likelihood, if they were thinking carefully, they wouldn't certify it. The fact is, the U.S. distribution system is the only one that we can fully trust."

Health plans also raise the safety issue about reimportation. Lynn Nishida, director of pharmacy services at The Regence Group, which operates Blue Cross and Blue Shield plans in the Northwest, says Rx importation continues to be a topic of debate for health plans as a mechanism to obtain lower costs. "However, there also continues to be the unknown certainty of the quality and safety of these medication products," she tells *DBN*.

Regence does not encourage its members to seek foreign sources for medication products, Nishida says.

If Rx reimportation were to become law, Nishida says, the potential consequences on health plans include:

- ◆ **Practical challenges of reimbursing drugs and claims adjudication with network pharmacies versus foreign pharmacies.** This includes being able to assure dispensing pharmacies are following contractual obligations in dispensing; and
- ◆ **Practical administration of tools that help assure safety and prevent unnecessary use of medications, such as automated edits and prior authorization.**

Keith Bruhnsen, manager of the University of Michigan's prescription drug program, says the UM plan, as a standard practice, discourages members from trying to lower their out-of-pocket costs by purchasing prescriptions from other countries, including nearby Canada. "It could result in their claims being denied, unless it's preapproved," he tells *DBN*. Part of the reason is that processing paper claims from drugs purchased abroad is much more expensive than is processing electronic claims from domestic network pharmacies, he explains.

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## Medco's Snow: Rx Compliance Is Part of Plan to Reduce Health Care Costs

The United States spends twice as much per capita on health care as do most other developed nations but achieves no better do clinical outcomes, says David Snow Jr., chairman and CEO of Medco Health Solutions, Inc. The U.S. could reduce its expense by as much as \$1 trillion — and bring spending in line with other industrialized countries — through measures such as ensuring better medication compliance, he asserts.

"Our system is broken," Snow told a Sept. 9 news conference at the National Press Club in Washington, D.C. The situation has "reached a tipping point where people are prepared to deal with what we need to do around health care reform," he adds. But first, he says, policymakers must understand "the root-cause problems."

Snow unveiled a five-step program, apparently the first of its kind from a major PBM CEO, that addresses what he identifies as these problems. The program, implemented over time, would cut U.S. spending on health care by roughly half, or \$800 billion to \$1 trillion annually, he says. The steps are:

- ◆ **"Wiring" health care (\$162 billion savings).** This is a fundamental building block that will eliminate all sorts of administrative waste, Snow says. "At Medco alone, when I get a digitized prescription through an e-prescribing tool versus a paper prescription in mail, I save \$3 per prescription. Medco manages over 700 million prescriptions," he says as an example. E-health also would drive accountability standards in pay-for-performance initiatives. "You can't measure performance because you don't have the data to know what people are doing," Snow says.
- ◆ **Eliminating medical liability through protocol-driven medicine (\$200 billion savings).** Electronic data would provide information that allows physicians to "treat medicine as a science, not an art," he says.

When physicians are practicing to an established protocol, "they should be held harmless of medical liability," Snow contends. "If you can measure it and monitor it, you can absolve physicians from the worries of medical malpractice," he contends. This would allow physicians to get away "from the waste of defensive medicine that goes on in this country today," he adds.

- ◆ **Reducing waste in Medicare (\$130 billion savings).** Roughly 30% of Medicare spending today relates to costs incurred by patients in the last year of life, often when there is no hope for recovery or improvement in quality of life, Snow says. Government needs to set policy and establish rational rules for the level of care for these patients based on medical science.
- ◆ **Increasing medication compliance while reducing errors (\$177 billion savings).** "Patients are sometimes not given enough time by their doctors," Snow says. "They walk out of the office being told they're a diabetic with four prescriptions in their hand, and they really don't understand what they're taking and why." This confusion leads to non-compliance, he adds.
- ◆ **Promoting healthy lifestyles (\$300 billion savings).** More than 10% of the overall medical spending — \$275 billion — is related to self-inflicted conditions linked to obesity and smoking, he says. Another \$38 billion is associated with drug and alcohol abuse.

Snow says he hopes his five-step plan will help change the discussion in Washington. "When the debate centers around, 'Should the employer be responsible, the individual, the government be responsible,' that is simply pushing the shells around," he says. "It is not getting at root cause, which is the U.S. has to come down into the zone of other countries that have the same outcomes, such as Switzerland or Canada."

For more information, contact Lowell Weiner at [Lowell\\_weiner@medco.com](mailto:Lowell_weiner@medco.com).

Hypothetically, if the next president signs an Rx reimportation bill with an HHS certification of safety, UM might consider developing networks with overseas pharmacies, Bruhnson says. But reimporting drugs from other countries would make sense only if the prices on drugs are lower than UM's current discounted rates, he adds.

Government-controlled pricing in Canada is good for lowering brand drug prices, but generics are not necessarily any cheaper, he adds. "We're now at 70% of our products being dispensed as generics," Bruhnson says.

Meanwhile, Rx reimportation is not the "burning white hot issue it was prior to Part D," says James Yocum, executive vice president of DestinationRx, a drug price comparison Web site. "Part D has reduced the total volume of drugs being reimported by seniors," he says of the population that consumes the most drugs.

"For a lot of the health plans that would have seen it as a way to reduce their own costs, or to improve adherence and compliance for their own members, they now have a Part D program and mechanisms in place to manage their drug costs," Yocum tells *DBN*.

### Pharmacy Benefit Resources From AIS

✓ **2000-2007 Survey Results: Pharmacy Benefit Trends & Data**, a book and CD resource featuring the complete results of AIS's quarterly survey of PBM companies — with information on costs, benefit design, utilization and PBM market share.

✓ **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.

✓ **Specialty Pharmacy Stakeholders, Strategies and Markets**, 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.

✓ **Oncology Drug Management: A White Paper on Marketplace Challenges, Opportunities and Strategies**, a 72-page white paper with data, illustrations and case studies that clearly explain the industry's history and current climate.

Visit the AIS MarketPlace at  
[www.AISHealth.com](http://www.AISHealth.com)

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## Prime Therapeutics' Drug Trend Echoes Other Low PBM Drug Trends

The increasing availability and acceptance of generic drugs helped Blues plan-owned PBM Prime Therapeutics LLC post a drug trend last year of just 2.3% — the company's lowest annual rate of increase in drug spending since it started tracking Rx trend and less than half of what it recorded in 2006. Meanwhile, drug spending growth industrywide is expected to remain relatively flat through 2009, according to The Segal Company's annual survey of major health plans.

Prime Therapeutics' drug trend report, released last month, follows those of other major PBMs that reported similarly low drug trends for last year. Medco Health Solutions, Inc., for example, said that its 2007 drug trend showed only a 2% average price hike from the previous year, and Express Scripts, Inc. reported a drug trend of 4.7% last year, compared with a growth rate of 5.9% in 2006 and a high of 15.9% in 2000 and 2001.

A low drug trend translates into greater affordability and compliance for members, says David Lassen, Pharm. D., chief clinical officer at Prime Therapeutics, which is owned collectively by 10 Blue Cross and Blue Shield plans. These factors, in turn, "really do improve outcomes and quality of care," he tells *DBN*.

While dropping drug trends are good news, that doesn't mean the battle to control rising pharmaceutical costs has been won, Lassen asserts. He notes that Prime Therapeutics is taking the savings it achieves on generics to offset more expensive pharmacy costs.

"You can look at it as the ability to...subsidize where we see some increasing trends in some of the biotech or specialty drug categories," he explains. "We're looking out into the future, and we're expecting some double-digit trends going there," he adds of the specialty drug trend.

Indeed, "specialty biotech drugs are really driving the trends now," says Sean Brandle, national pharmacy practice leader at Segal.

According to the Segal Health Plan Cost Trend Survey, released last month, the 2009 specialty drug trend is forecast to be 18.1%, down more than two percentage points from last year's projection of 20.5%, but roughly double that of traditional drugs. Specialty drugs make up roughly 13% of total drug trend, and utilization is expected to rise, the Segal survey said.

Specialty drugs are receiving new indications, and are now being advertised directly to consumers — two factors that can drive up spending, Brandle tells *DBN*.

But even specialty pharmacy spending has moderated from its rocketing pace set just a few years back. Prime Therapeutics' specialty drug trend was 8.9% in 2007, down from 10.5% in 2006 and significantly lower than its peak of 17.5% in 2005. Similarly, Medco this summer reported that specialty Rx spending grew 12.3% in 2007, compared with a 16.1% growth rate in 2006. And Express Scripts said its specialty Rx trend was 14% in 2007, down from 20.9% growth in 2006 (*DBN 6/13/08, p. 1*).

Lassen attributes the 2007 specialty drug trend decline in part to a 13% decrease from 2006 in utilization of the once rapidly growing class of anemia erythropoiesis-stimulating agents (ESAs), such as Epogen.

With the rate of drug spending expected to continue decelerating, plan sponsors that see double-digit spending increases in 2008 should examine their options, advises Brandle.

One option is to request a trend cap or some kind of guarantee from their PBM, Brandle says. "We're having some success in getting some of the PBMs to do those types of arrangements," he adds. But in exchange, sponsors must be prepared for some member complaints if programs are implemented that drive down trend, such as step-therapy programs that require generics before more expensive brands. "If you let [PBMs] implement some programs, they can control trend," he says.

Contact Lassen through Sheila Thelemann at [SThelemann@primetherapeutics.com](mailto:SThelemann@primetherapeutics.com), and Brandle at [sbrandle@segalco.com](mailto:sbrandle@segalco.com). ✧

## Part D Plans Eye Final Sales Regs

*continued from p. 1*

in the commission structure for agents to switch beneficiaries from plan to plan each year.

Whether the new marketing rules will change the competitive landscape, or affect sales, renewals or general churn of customers, remains to be seen, according to Washington. "Everyone is operating on this new, even playing field," she says. Still, she adds, the final rules emphasize previous relationships and name recognition. "It may make it difficult for a lesser known entity to come into the market and get market share."

The rules incorporate the related MIPPA provisions, which superseded CMS's proposed rule issued in May in areas where they overlapped (*DBN 5/16/08, p. 1*), Washington says.

In some cases, the MIPPA provisions are a bit tougher or more specific than the proposed rule, she adds.

One example involves the location where Part D plans can have marketing discussions in health care facilities, Washington explains. "In areas where CMS may have left a little bit more discretion for the plan, the legislative language was quite specific in the requirements, so CMS repeated those legislative requirements in the final rule."

Washington asserts that Part D plans were not caught off guard by the final rule. "They were expecting it because of MIPPA and because of the proposed rule," she says. "You can look at it as the proposed rule was the first notice, and MIPPA was pretty clear that this was going to happen, and [that the rules] were going to be effective for the plan year that starts this January."

### Some Marketing Changes Are Significant

But other Part D observers note that the final rule does contain some big changes from the proposed rule.

The biggest change involves the agent commission structure, says Jean LeMasurier, director of the employer group practice at Gorman Health Group, LLC, a Washington, D.C.-based Medicare consulting firm. "That was a sea change from what was included in the proposed rule," she tells *DBN*. But this change is one that was recommended by the industry, LeMasurier adds.

"It's very similar to the compensation arrangement used in the Medigap arrangement today that has been tried and tested for many years," she says. "It gets at some of the same issues."

CMS's final rule on the commission structure aims to reduce financial incentives to churn members to new plans, CMS says. Among other things, the final rule creates a six-year compensation cycle.

"This means that in the first year, the compensation paid can be no more than 200 percent of the compensation paid in the second year or any individual subsequent renewal year, up to a total of 5 renewal years," according to the final rule.

The rule "eliminates the incentive for agents to move their clients from plan to plan since the compensation that agents receive for a replacement plan will be nearly the same as if the client had stayed in the original plan," CMS says.

The final rule also goes further than the proposed rule in clarifying what's acceptable for other marketing tactics, LeMasurier explains. Regarding unsolicited contacts, for example, the rule allows for direct mail but prohibits follow-ups unless the beneficiary gives permission, she points out.

"There is a very narrow definition of how this permission may be used, and there must be a clear request, not just a telephone number," she says. "Plans cannot call former members."

*continued*

Overall, the changes are pretty consistent with the proposed rule and MIPPA, LeMasurier says. But plans must still push hard to implement them before the Oct. 1 start date, she adds. Contracts already in place with agents will have to be modified, and some sales events for October that were planned under the old rules may have to be canceled, she explains.

“Those are things that will create some problems for plans in the short term,” LeMasurier says. “But Congress and CMS are very resolute in their determination to make this marketing be effective and beneficiary friendly.”

Along with the new rule, CMS said it was ramping up its oversight of Part D marketing. Among other things, the agency says it will triple the number of “secret

shoppers” — Medicare officials who pose as prospective enrollees — and will increase the penalty for violations to as much as \$25,000 per beneficiary who is affected. The final rule also lays out other sanctions for violations, such as restricting a plan from marketing during the marketing season or from accepting new enrollments for a period of time.

“This is an area where there is very low tolerance [for bad behavior], given the population,” says Washington.

To read the final rule, visit [www.cms.hhs.gov/center/press.asp](http://www.cms.hhs.gov/center/press.asp) and click on “CMS Enforces Marketing Requirements.” Contact Washington at [bwashington@avalerehealth.net](mailto:bwashington@avalerehealth.net) and LeMasurier at [jlemasurier@gormanhealthgroup.com](mailto:jlemasurier@gormanhealthgroup.com). ✧

## NEWS BRIEFS

◆ **Specialty pharmacy provider BioScrip, Inc. said Sept. 11 that UnitedHealthcare was terminating its contract with BioScrip and would take over services for HIV/AIDS and solid organ transplant drugs for United members effective Jan. 31, 2009, and March 31, 2009, respectively.** This contract termination will have no impact on BioScrip’s 2008 operating results, the company said. For 2009, BioScrip said it expects a loss of \$100 million in revenue and \$2 million in operating income associated with this contract. Contact Craig Allison at [callison@BioScrip.com](mailto:callison@BioScrip.com).

◆ **PBM HealthExtras, Inc. said Sept. 16 that it will change its name to Catalyst Health Solutions, Inc. effective Oct. 1.** The name change gained unanimous approval from the company’s board of directors on Sept. 10. The company’s stock will trade under the ticker symbol CHSI. “As our largest operating subsidiary, Catalyst Rx has significant brand recognition among our clients,” said David T. Blair, CEO of Catalyst Health Solutions. Contact Hai Tran at [htran@HealthExtras.com](mailto:htran@HealthExtras.com)

◆ **PBM and health care IT firm SXC Health Solutions Corp. on Sept. 12 said it had won two contracts for its HealthCare Information Technology (HCIT) Group with the state of South Dakota.** Under the first agreement, worth roughly \$10 million, SXC will provide software licenses and implementation services to the South Dakota Department of Social Services for two years during the deployment of the state’s new Medicaid Management Information System, followed by one year of software maintenance services. Under the second three-year contract, SXC will provide South Dakota with state maximum allowable cost (SMAC)

list design, development and management to support the state’s Medicaid pharmacy program. Terms of the second contract were not disclosed. Contact Susan Noonan at [susan@sanoonan.com](mailto:susan@sanoonan.com).

◆ **HealthPass, a New York City-based nonprofit organization that works to improve health coverage for small employers and sole proprietors, said Sept. 9 that it had formed a partnership with PBM SUNRx, Inc. to offer a free prescription drug discount card program.** Under the agreement, HealthPass members, as well as individuals who don’t have any health insurance, will have access to the SUNRx Discount card that will provide savings in the range of 15% on brand drugs and 70% on generic drugs, HealthPass said. Terms of the agreement were not disclosed. Contact Ed Emerman for HealthPass at [eemergen@eaglepr.com](mailto:eemergen@eaglepr.com).

◆ **The Medical Society of the State of New York (MSSNY) on Sept. 2 released a survey that finds health insurers often force New York state physicians to alter the way they treat patients.** Among the findings, 93% of physicians complained that health insurers required them to change Rx drugs. Physicians overwhelmingly (95%) agreed with the statement: “Decisions on what medications are right for a patient should be made by the patient’s own doctor and not by the health plan or the insurance carrier.” As a result, 91% of the physicians surveyed said that there should be enforceable legislation to regulate the restrictions that insurance carriers put on physicians regarding treatments they prescribe for patients. The complete survey results are available on MSSNY’s Web site at [www.mssny.org](http://www.mssny.org). Contact Liz Dears at [ldears@mssny.org](mailto:ldears@mssny.org).

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