

# DRUG BENEFIT NEWS

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

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## CVS CEO Is Overpaid Compared to Peers At Rival PBM Companies, Analyst Says

For the second year in a row, CVS Caremark Corp.'s President and CEO Thomas Ryan earned double the amount of the firm's two closest PBM competitors — a figure that is three times larger than what Ryan should have made, one analyst says.

According to *DBN's* annual compensation rankings for the highest-paid executives at five publicly traded PBMs, Ryan received \$30.4 million in 2009 total annual pay — a 27% increase from the year before (see table, p. 7). Medco Health Solutions, Inc. Chairman and CEO David Snow took home \$13.4 million in total annual compensation, while Express Scripts, Inc. Chairman, President and CEO George Paz came away with \$10.6 million, according to a review of PBMs' proxy statements filed with the Securities and Exchange Commission (SEC).

But a study of executive compensation at 271 companies commissioned by *Bloomberg News* found that Ryan should have been paid only \$10.26 million last year based on its shareholders' 13.2% return on total equity. The study's "fair pay" model calculated aggregate CEO compensation, according to a formula based two-thirds on a

*continued on p. 6*

## Medco, CVS Caremark Gear Up to Expand Genetic Testing Management Services

Trying to "raise the bar on understanding" around pharmacogenomics, Medco Health Solutions, Inc. and CVS Caremark Corp. are both expanding their genetic testing services this summer with new programs aimed at helping payers make well-informed coverage decisions.

As of now, more than 2,000 different molecular and genetic diagnostic tests are available in the marketplace — making coverage choices an arduous process for plans. That's especially so since more than 46% of large plans that now cover pharmacogenomic testing still lack comprehensive programs and policies to administer them (*DBN* 12/4/09, p. 1).

"Several different health plans have said they are needing help to understand what they're spending in this area of genetic and molecular testing, because it's very nonspecific in terms of coding," Jane Barlow, vice president of Medco's Precision Health Solutions unit, tells *DBN*. "They're looking to us to help them get a handle on what they should be covering and how to manage that with their providers." Precision Health Solutions houses the new suite of services being offered by the PBM starting in July.

Currently, Medco estimates that 20% of genetic tests are ordered and used inappropriately. Therefore starting in July, it will expand its clinical testing program to include anticlotting drug Plavix (clopidogrel) and HIV drugs Selzentry (maraviroc) and Ziagen (abacavir). And in September, the PBM will begin using a test that monitors patients being treated for chronic myelogenous leukemia with Gleevec (imatinib mesylate).

Medco is choosing to cover these specific tests because "there is enough scientific information to support a program in these areas, and we think it will make an impact

on safety and clinical outcomes related to the condition," Barlow says.

The program also will include "decision support tools" to help patients, employers and health plans understand when it would benefit them to use a genetic test, Barlow says. This will include web-based tools that will connect patients and physicians to live counselors who can provide "reliable information around these kinds of tests by walking them through indications of a test and helping them to understand the results," she explains.

For plans and employers, Medco will offer coverage management to help them determine reimbursement policies and appropriate coverage criteria, while ensuring that the tests are properly used. It will also provide policy and benefit consultation to advise plans on how to best structure their genetic test benefit and help plans choose available tests, including lab work.

This lab component has drawn some criticism. Because expensive lab tests are usually covered under the medical benefit by insurers, some are concerned that Medco could eventually start competing with its health plan clients in the genetic testing arena.

Barlow contends that its broader lab testing will offer an additional service for health plans, not compete with them.

"By and large our health plan clients haven't taken a stance on pharmacogenomic testing, so they don't currently do a lot of this testing in their plans or manage it," she explains. "So it's not really a competition with the health plan clients; it's making sure clients have access to testing that can help them around their pharmacy benefit."

Starting next year, she adds, Medco will continue to expand its services for payers with a broader set of utilization management tools for genetic testing that will include integrated offerings from DNA Direct, Inc., which it acquired in February (*DBN 2/5/10, p. 4*).

Medco now has 220 clients, representing more than 10 million members, enrolled in its personalized medicine program and provides clinical testing for patients using the blood thinner warfarin and breast cancer drug tamoxifen.

### CVS Caremark Develops Genetic Network

Rival CVS Caremark also is rolling out a new pharmacogenomics pilot program in July. The company, which partnered with Generation Health, Inc. last November (*DBN 11/13/09, p. 8*), will have a team of counselors, pharmacists and physicians available to educate its plan clients and physicians about testing opportunities. It aims to help patients and physicians interpret genetic test results, according to CVS Caremark spokesperson Christine Cramer.

In addition, Generation Health is working to credential a "Best Test" genetics network that employers and health plans can access through CVS Caremark. Today, the program incorporates "the latest genetic guidelines for more than 12 specialty drugs," Cramer tells *DBN*. Through the pilot, the PBM will introduce additional genetic testing interventions for six medications generally dispensed through retail and mail pharmacies. However, she declines to mention which ones.

Per G.H. Lofberg, president of CVS Caremark's PBM business and past president and CEO of Generation Health, previously told *DBN* that the company is conducting the pilot "to give payers a chance to experiment with this approach and gather the data to allow them to measure the cost benefits of these services for their organization."

Contact Cramer at (401) 770-3317 and Ann Smith for Barlow at [ann\\_smith@medco.com](mailto:ann_smith@medco.com). ♦

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## UHC Replaces Generics Coverage With Lower-Cost Brand Drugs

While most payers are spending their dollars to promote utilization of low-cost generic and over-the-counter drugs under the pharmacy benefit, one plan is offering up a new idea: Why not put more money towards helping patients afford expensive brand medications instead?

UnitedHealthcare (UHC) just rolled out a new pharmacy benefit design, called BrandsPlus Rx, which aims to “bridge potential coverage gaps” by making higher-cost brand and specialty drugs more affordable to small businesses. This will be accomplished by letting patients absorb the costs of their own lower-priced generics and over-the-counter medications.

“Covering things that people can already afford isn’t necessarily what insurance is for,” Tim Heady, CEO of UnitedHealth Pharmaceutical Solutions, tells *DBN*. “This benefit is really positioned for that part of the market where there may not be a benefit at all.”

While the new plan design will lend a helping hand to members in need of more expensive medications, Heady says the program will still encourage patients to use lower-cost options when available. “But the reality is that there aren’t always generic or other low-cost alternatives and some drugs just aren’t affordable,” Heady explains. “And we can either say that’s too bad, or we could have a better-aligned benefit in those situation, to provide some meaningful coverage for those drugs.”

Under the new program, for example, a patient would pay only \$60, and the plan would cover the remaining \$90 in a therapeutic category where there are no generics available and the brands are averaging \$150. “In a generic-only benefit, the patient would be out of luck and would have to pay the full \$150,” Heady says.

According to UHC, the program will cost employers about half as much in premiums as the plan’s traditional pharmacy benefit packages and is “price-competitive with other generic-only plans available in the market.”

It will provide coverage for medications to treat chronic conditions — such as asthma, diabetes, HIV, hepatitis C and multiple sclerosis — that do not have many effective generic equivalents. These drugs will be placed on a four-tier copayment structure that should steer patients to more cost-effective medications, Heady says, adding that the lowest-value drugs will be placed on the fourth tier.

“If there are very good tier-two or tier-three options, rather than excluding other drugs, we’re going to throw those into the fourth tier,” Heady explains. “While there won’t be a lot of drugs in that space, it will allow us to acknowledge that there are very different value propositions amongst the brand choices.”

BrandPlus Rx is currently available to small groups in Arizona, Arkansas, North Carolina, South Carolina, Tennessee and Wisconsin. Heady says UHC will roll out the program nationally once it gains more experience in these states.

Contact Heady through Lynne High at [lynne\\_m\\_high@uhc.com](mailto:lynne_m_high@uhc.com). ✧

## How to Integrate FDA Risk Evaluation and Mitigation Strategy Requirements Into Formulary Management

- How can plans ensure that members have appropriate access to limited-distribution drugs under REMS programs?
- What steps should health plans and specialty pharmacies take to integrate REMS programs into their utilization management programs?
- How can the various stakeholders make sure they comply with patient privacy laws that could be compromised under REMS programs?
- What approach is needed when the FDA requires a REMS program for a drug that is already on the market?
- How can specialty pharmacies and PBMs leverage outcomes data from REMS efforts?

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## Medco Says Kids Are Contributing To Greater Portion of Spending

Medco Health Solutions, Inc. is focusing its attention on the growing prevalence of “adult” diseases in children and adolescents, as child obesity rates soar and more enrollees under 18 are being prescribed drugs to treat chronic conditions. For plan sponsors, the complications associated with the rise in such chronic and complex diseases “may foreshadow new spending patterns” in coming years, the PBM says.

For the second year in a row, spending on drugs for children has exceeded that for all other age groups, according to Medco’s 2010 *Drug Trend Report*. As a result, several new indications to existing medications that traditionally treat “adult diseases” made their way into the marketplace last year. To keep pace, some manufacturers even had to file patent extensions for pediatric indications, Medco says.

Such new drugs include Atacand (candesartan cilexetil) to treat hypertension in children aged 1 to 17, Axert (almotriptan malate) for acute treatment of pediatric migraine and Seroquel (quetiapine) for schizophrenia in children aged 13 to 17.

One factor substantially contributing to increases in childhood chronic conditions, Medco says, is the growing obesity epidemic. In 2008, approximately 32% of adolescent and school-age children were overweight, while about 17% were obese.

“We’re just looking at the tip of the iceberg here, and we need to get our arms around some very fast lifestyle

modifications, or we’re going to have some real problems,” Robert Epstein, M.D., Medco’s chief medical officer, said during a recent conference call.

“Having these adult illnesses show up in children will change their life expectancy if they’re going to be sick from a young age,” he said.

The No. 1 condition affecting children is diabetes, Epstein said. While children and young adults are most commonly diagnosed with Type 1 diabetes (previously known as juvenile diabetes), Medco saw a 150% increase in cases of Type 2 diabetes last year — three times higher than the rate for adults. “We are really creating a diabetes bubble here,” Epstein maintained.

Spending for drugs used to treat attention-deficit hyperactivity disorder (ADHD) in children also surged last year by 13.2% for plan sponsors. ADHD therapies that contributed the most to per-member-per-month plan costs in 2009 included Concerta and Adderall XR. The latest estimates from the CDC show that 5 million kids aged 3 to 17 are currently diagnosed with ADHD.

Despite these numbers, Medco says, plan sponsors are still spending more dollars for a larger variety of medications in older patients, whereas plan spending is concentrated among a few categories in children. Yet the PBM maintains that in the next few years, it will be critical for plans to develop disease prevention programs and adjust benefit strategies to “effectively manage chronic and complex conditions in ever-younger populations.”

Contact Medco spokesperson Jennifer Luddy at (201) 269-6402. ✧

### Medco Keeps Drug Trend Low, Sees Major Mail-Order Savings

Medco Health Solutions, Inc. managed to keep its drug trend at a low 3.7% last year — outperforming its competitor Express Scripts, Inc., whose spending swelled 6.4% during the same time period (*DBN* 4/30/10, p. 1). Specialty spend, however, continued to climb, reaching 14.7% by the end of 2009, according to Medco’s 2010 *Drug Trend Report*.

Utilization also grew last year by 1.3% from a negative 1.1% in 2008. Medco says oral antivirals and drugs to treat diabetes and respiratory conditions were the largest percent contributors to this trend — exceeding 11% last year.

The PBM did see significant savings with its average generic dispensing rate, which was 67.5%, up from 64.1% in 2008, and boasted that its specialty trend is one of the lowest in the industry.

Medco also highlighted its mail-order pharmacy business, which experienced virtually no trend increase (0.1%) for its clients with more than 50% mail penetration. Clients with less than 50% mail-order penetration, on the other hand, had a markedly higher spending increase of 5.3%.

Over the next few years, Medco estimates that drug trend will continue to grow between 3% and 6% annually, driven by increases in utilization, high price inflation for single-source brands and new expensive specialty drugs. However, spending increases could be offset by a new wave of generics, as approximately \$46 billion in brand drug sales are scheduled to go generic by 2012.

Contact Medco spokesperson Jennifer Luddy at (201) 269-6402.

## FDA Could Increase Scrutiny Of Unapproved Genetic Tests

The FDA and Congress are taking a closer look at how direct-to-consumer (DTC) genetic tests should be regulated after retail pharmacy giants Walgreen Co. and CVS Caremark Corp. attempted to sell personal saliva collection kits in their stores. The FDA's sudden move to investigate the kits has prompted concerns that the agency may also step up its regulation of laboratory-developed tests (LDT), which are more widely available and increasingly being used by the two largest PBMs.

Last month, Walgreens inked a deal with genetic test manufacturer Pathway Genomics to begin selling Insight, a saliva collection kit, in its stores starting in mid-May. But shortly after publicly announcing the deal, the FDA informed Pathway that the product "appears to meet the definition of a device," and therefore must be cleared and approved for marketing by the agency, according to a May 10 letter sent to the manufacturer.

As a result, Walgreens quickly reversed its decision to offer the product, which can be used to determine predisposition for chronic diseases and response to common drugs like Plavix (clopidogrel), Tamoxifen (soltamox) and Coumadin (warfarin). Following Walgreens' lead, CVS Caremark also shelved its plans to sell the kit in its stores.

### Congress Questions Test Makers

The incident even grabbed the attention of Congress. Shortly after the FDA announced it would be investigating, the House Committee on Energy and Commerce sent letters to Pathway and two other prominent DTC genetic testing companies, 23andMe and Navigenics, requesting more information about their tests.

The committee says it is addressing concerns "from the scientific community regarding the accuracy of test results," and would like to know how the companies analyze test results to determine consumers' risk for any conditions and drug responses.

While this particular move by the FDA drew a lot of attention, "in the long run, it will be viewed as not much more than a footnote to a conversation that's been going on much longer about the appropriateness of DTC genetic tests," Dan Vorhaus, an attorney at Robinson, Bradshaw & Hinson and editor of the Genomics Law Report blog, tells *DBN*.

He adds that the FDA might have chosen this as a "test case" for evolving regulations concerning other types of genetic testing.

According to Vorhaus, genetic tests are divided into two categories: the kits, which are developed by test manufacturers, and LDTs, which are made and marketed by

laboratories. LDTs are what PBMs such as Medco Health Solutions, Inc. and CVS Caremark typically use.

While the FDA usually regulates kits as medical devices (meaning they have to go through an extensive premarket approval process), it uses its "enforcement discretion" to regulate LDTs. This means that the "FDA says it has the ability to regulate these tests, but it is choosing not to — it's just keeping an eye on them," Vorhaus explains.

The FDA proposed stricter regulations of LDTs back in 2007, but backed off shortly after because of harsh criticism it received from the industry. However, "this whole DTC thing might be a warning sign that there is more on the horizon," Vorhaus says. "It's possible that this will be part of their plan for reviving some of this LDT regulation."

If this scenario ends up playing out, it would mean more barriers to market for LDTs and would pose a huge challenge for smaller labs, which don't have the resources to go through the FDA approval process, Vorhaus explains. For Medco or CVS, "it might be an added expense, but it's not going to be something that insurmountable for them," he adds.

Several home sample collection kits, like Pathway's, are already on the market, including diagnostics for HIV and diabetes Hb1Ac. And although personal genetic kits are typically sold online, Pathway Genomics would not be the first DTC genetic testing firm to sell its products through a retail chain. In 2007, Sorensen Genomics made a deal with Rite Aid stores and other pharmacies across the West Coast to sell the company's Identigene DNA paternity test kit.

Vorhaus maintains that the agency's response to the Walgreens incident "strongly suggests that the FDA is focusing its regulatory attention on Pathway's actual genetic test and its subsequent interpretation of the test results." If that's the case, he argues, "it's difficult to see other DTC genetic testing companies escaping increased regulatory scrutiny."

Contact Vorhaus at (704) 377-8111 and Walgreens spokesperson Jim Cohn at jim.cohn@walgreens.com. ✦

## CMS Guidance Clarifies Payers' Concerns on Part D Discounts

CMS's final guidance, issued May 24, requiring Medicare Part D plan sponsors to administer the 50% discount on brand-name drugs in the "doughnut hole" coverage gap clarifies who is considered an applicable beneficiary, allows for retroactive changes to the discounts and says there is no distinction between multiple-source drugs and authorized generics.

On April 30, CMS released draft guidance that detailed the logistics of how payers will administer drug

manufacturers' contribution to close the Medicare Part D doughnut hole, which was required by the recently enacted health care reform law. Beginning in 2011, the law calls for drug makers to provide the 50% discount on brand-name drugs and authorized generics used by beneficiaries while they are in the coverage gap (*DBN 5/14/10, p. 1*).

In its new final guidance, CMS states that the reason the agency cannot collect the discount payments directly from manufacturers is because the statute does not allow it. Further, it adds that it did not believe "requiring manufacturers to pay the invoiced discount amounts directly to Part D sponsors would be overly burdensome."

The agency also clarifies that enrollees in employer group waiver plans (EGWPs) are considered "applicable beneficiaries" and included in the discount program. In the draft guidance, CMS raised questions about the level of the discount that would apply to EGWP claims. Now, it says that it will allow EGWPs to participate in the program in 2011 if they can attest or otherwise demonstrate that their beneficiaries have cost sharing between the plan initial coverage limit and the catastrophic threshold and that they will apply any supplemental benefits before determining the applicable discount that will be reported on prescription drug events.

### Retroactive Discount Changes Allowed

The guidance also allows for retroactive changes to applicable discounts when retroactive changes are made to claims or beneficiary eligibility. The agency says it was "concerned that allowing retroactive changes would complicate the application of the discount." Now, it says it was convinced by comments that "such adjustments can be accurately applied." It does warn sponsors that they should limit retroactive adjustments to pharmacies with claims in which pharmacy reimbursements change and not to distribution of sponsor, manufacturer and beneficiary liabilities.

One area that caused concern in the industry was whether multiple-source products and authorized generics would be covered under the discount program. CMS clarifies in the final guidance that there is no distinction between multiple-source drugs and authorized generics approved under new drug applications versus any other applicable drug. The agency defines "applicable drugs" as including all drugs approved under new drug applications, and all such drugs would be subject to the discount if covered under a manufacturer discount agreement.

CMS did remove a reference to authorized generics from the definition of "applicable drug," however. The agency says that while most authorized generics are approved under new drug applications, others may be approved under abbreviated new drug applications. Only those authorized generics licensed by sponsors of new

drug applications are applicable drugs subject to the discount, it says.

CMS released a separate draft drug manufacturer agreement on May 21 providing a model they must agree to if they want their drugs covered under Part D. In it, the agency clarifies its position on allowing discounts on Part D drugs not covered under manufacturers' agreements. A potential loophole in CMS's earlier draft guidance on the discounts raised concerns that some drug makers will not have to pay the discount at all.

Now, however, CMS says in the draft model deal that it expects all manufacturers of applicable drugs to sign agreements. Therefore, it does not intend to allow coverage of drugs not covered under deals, even if they are essential to the health of beneficiaries for 2010. The agency also clarifies that that it may require all manufacturers to sign agreements in the future if it determines that access to applicable Part D drugs is being restricted.

Go to [www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount\\_Revised%20Guidance%20052110.pdf](http://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_Revised%20Guidance%20052110.pdf) to view CMS's memo. ✧

*This story was excerpted from DBN's sister publication Medicare Part D News. Check out AIS's Health Reform Week, which helps savvy business leaders in health care understand what the enormous changes mean to them...and what they can do about it. Go to [www.aishealth.com/Products/NewsREF.html](http://www.aishealth.com/Products/NewsREF.html).*

### CVS Caremark CEO Gets Top Pay

*continued from p. 1*

company's stock performance and one-third on company revenues. Graef Crystal, a compensation analyst that created the study, says that Ryan earned 297% more than he should have — making him the 18th most overpaid CEO.

Snow, on the other hand, was underpaid by almost \$2 million, while Paz should have been paid about \$5 million more, according to Crystal.

CVS Caremark says in its SEC filing that Ryan was "instrumental in guiding the integration of pharmacy services and retail segment products and services." This includes the success of its new Maintenance Choice program that lets consumers buy 90-day supplies of drugs for chronic conditions at CVS pharmacies for the same price as mail order (*DBN 2/19/10, p. 1*). The company also says that its performance in 2009, compared with its peer group, demonstrates that it "navigated through a challenging economic environment and effectively managed expenses" — taking the top ranking in revenue growth, operating income and shareholder return.

Since CVS Caremark owns a large retail pharmacy chain in addition to its PBM operations, it uses different benchmarks in setting compensation levels. CVS Caremark says in its SEC filing that it compares itself to

retail giants such as Home Depot, Inc., Target Corp. and Walgreen Co., as well as health care firms like Medco, McKesson Corp., WellPoint, Inc. and Aetna Inc. By contrast, Medco and Express Scripts include in their peer groups large health insurers, PBMs and drug companies.

Yet because of the tough economic environment, the company delayed increasing the base salaries for its executive officers in 2009. However, Ryan was paid a variety of perquisites, including \$55,620 for personal use of the company aircraft, \$2,186 for use of a company car, \$13,734 for financial planning services and \$15,132 for home security.

Despite his generous compensation package, Ryan announced his retirement from the company earlier this month (*DBN 5/14/10, p. 8*). CVS Caremark's board of directors has appointed Larry J. Merlo, executive vice president for CVS/pharmacy operations, to take his place.

Part of the reason for Ryan's inflated compensation could have to do with his pension package. Crystal points out that CVS Caremark does not have a qualified defined benefit plan, which is an IRS-approved plan that may not discriminate in favor of higher-paid employees, and offers, typically, some percentage of the final three-year average pay before retirement (e.g., 2% of final three-year average

salary for each year of service up to 30 years). Under CVS Caremark's plan, Ryan received \$14,197,821 in change in pension value and nonqualified deferred compensation earnings. This increase reflects a one-time adjustment of approximately \$7.6 million to implement a provision of the 2005 retention agreement between him and the company, provided he remained employed through the end of 2009.

In assessing Snow's performance, Medco took into consideration the influence he had on the company's brand and reputation. According to its SEC filing, Snow was named the No. 1 CEO in the health care technology and distribution industries by *Institutional Investor* magazine and was ranked 27 on the *Harvard Business Review's* list of "Top 100 Best Performing CEOs in the World." In addition, Medco applauded Snow's contribution to the company's strong overall performance, including a 22.5% increase in earnings per share, record total net revenue and an increased generic dispensing rate. While Medco did not reach its target for mail prescription volume, it did not attribute this to Snow's performance.

Like CVS Caremark, tough economic conditions also prevented Medco from handing out salary increases. Richard Rubino, Medco's senior vice president and chief

### Compensation for Highest-Paid PBM Executives in Selected Large Publicly Traded Firms, 2008-2009\*

	2009 Salary	Stock Awards	Option Awards	Non-Equity Incentive Plan Compensation	All Other Compensation**	2009 Total Compensation	2008 Total Compensation
<b>Medco Health Solutions, Inc.</b>							
David Snow, Chairman and CEO	\$1,300,000	\$1,805,810	\$7,173,000	\$3,000,000	\$45,681	\$13,372,037	\$14,382,068
Kenneth Keppler, President and COO	\$810,872	\$1,061,776	\$1,923,751	\$1,200,000	\$12,251	\$5,037,128	\$5,329,303
Richard Rubino, Senior VP and CFO <sup>1</sup>	\$548,560	\$620,468	\$1,124,018	\$800,000	\$11,732	\$3,126,228	\$2,352,078
<b>CVS Caremark Corp.</b>							
Thomas Ryan, President and CEO	\$1,400,000	\$6,425,007	\$4,625,000	\$3,512,526	\$14,466,580	\$30,429,113	\$23,916,260
Dave Rickard, Executive VP and CFO <sup>2</sup>	\$775,000	\$950,022	\$1,350,004	\$1,223,759	\$2,335,056	\$6,633,841	\$5,395,778
Troyen Brennan, Executive VP and CMO <sup>3</sup>	\$575,000	\$812,509	\$1,012,504	\$505,000	\$13,964	\$2,918,977	N/A
<b>Express Scripts, Inc.</b>							
George Paz, President and CEO	\$971,692	\$4,146,000	\$2,764,000	\$2,528,500	\$217,582	\$10,627,774	\$10,287,756
Jeffrey Hall, Executive VP and CFO	\$507,846	\$885,000	\$885,000	\$714,000	\$80,521	\$3,072,367	3,678,577
Patrick McNamee, COO	\$490,412	\$745,000	\$745,000	\$687,120	\$80,840	\$2,748,372	\$2,638,588

\* The table includes the top three highest-paid executives at each company on the basis of total annual compensation.

\*\* May include a change in pension value and nonqualified deferred compensation earnings

N/A = not applicable

<sup>1</sup> Rubino's position became effective March 15, 2008. Prior to that, Rubino served as the senior vice president and controller.

<sup>2</sup> Rickard retired effective Dec. 31, 2009.

<sup>3</sup> Brennan joined the company in November 2008.

SOURCE AND METHODOLOGY: Compiled by Atlantic Information Services, Inc. from company proxy statements, May 2010.

financial officer (CFO), was the only top executive to receive a salary increase in 2009 because he was promoted and his salary was no longer competitive compared to his peers. He also played a large hand in more than doubling Medco's cash balances from \$938 million at the end of 2008 to more than \$2.5 billion in 2009, the company says. As a result, Rubino landed an award by *Institutional Investor* magazine as the No. 1 CFO in health care, technology and distribution.

Express Scripts says its compensation for executive officers is not overly weighted toward short-term incentives. For instance, Paz's target annual bonus plan award in 2009 was approximately 14% of his total target compensation. Moreover, the award is limited to 200% of his base salary.

Compensation levels at the three large PBMs dwarfed pay at two smaller companies, Catalyst Health Solutions, Inc. and SXC Health Solutions Corp., where the chief executives each received a little more than \$2 million in total compensation.

In its SEC filing, Catalyst explains that it benchmarks compensation levels against a peer group that include smaller health services companies, such as AMERIGROUP Corp., Magellan Health Services, Inc. and Molina

Healthcare, Inc. Catalyst also reviews compensation practices at Express Scripts and Medco, but it notes that although both companies are "direct competitors of ours, [they] have significantly greater revenues, scale of operations and number of employees." Overall, the base salaries of its executive officers were 79% and 71% of the peer 25th percentile and median, respectively, the company says.

SXC says it evaluated its executives' role and contribution to internal goals — such as sales growth, margin, operating expenses and customer satisfaction — to determine the amount and types of compensation it awards executives. It adds that the CEO "bears primary responsibility" for increasing the value of shareholders' investments.

Exceeding a target bonus of \$425,000 based on the company's overall performance, Mark Thierer, SXC's President and CEO, received a \$740,779 bonus, which represented 174% of his base pay, for "achieving individual and financial threshold performance factors." He also earned \$400,000 for successfully exceeding cost integration targets related to the acquisition of the National Medical Health Card Systems, Inc.

Contact Crystal at graefc@bloomberg.net. ✦

## NEWS BRIEFS

◆ **U.S. price increases for brand-name prescription drugs rose 9.7% in the 12 months ending March 2010**, according to a study by AARP. The analysis found that prices for drugs most commonly used by Medicare Part D enrollees were the highest since 2002. Specialty drug prices rose by 9.2% over the period, while the prices of generics fell 9.7%, the group adds. This means the average annual cost of therapy for someone taking three generics decreased by \$51 during the year, while the cost for people taking three brand drugs rose by about \$706. View the report at [www.aarp.org/research/ppi/healthcare/medicare/articles/rxwatchdog.html](http://www.aarp.org/research/ppi/healthcare/medicare/articles/rxwatchdog.html).

◆ **Plans with an integrated medical and pharmacy benefit could save \$1.60 per member per month**, according to an analysis by CIGNA Corp. This is because closing "gaps in care" — defined in terms of noncompliance and not getting appropriate tests — is 3% higher when the same company provides combined benefits. Improvements in obtaining necessary care were 14% higher for asthma patients and 7.6% higher for people with hypertension. Contact CIGNA spokesperson Lindsay Shearer at (603) 268-7721.

◆ **WellPoint Inc. is making its comparative effectiveness research (CER) guidelines public** to help drug makers provide useful data to health plans. By placing its guidelines in the public domain, WellPoint hopes to provide "some guidance to pharmaceutical companies looking to offer meaningful information to health benefits companies that are evaluating pharmaceutical products on behalf of its members," the company says. WellPoint has tested its new guidelines retroactively on two CER studies. For one, it determined that the research comparing osteoporosis drugs was not useful. Contact Lori McLaughlin at [lori.mclaughlin2@wellpoint.com](mailto:lori.mclaughlin2@wellpoint.com).

◆ **Medco Health Solutions, Inc. and CVS Caremark Corp. spent a combined \$2.96 million lobbying Congress** in the first quarter of 2010. CVS Caremark spent the majority of that (\$1.98 million) pushing its interest in changes to Medicare and Medicaid as well as reimbursement rates for generic drugs. Medco, on the other hand, held discussions on biotechnology drugs, chronic care management and health information technology. Contact Jennifer Luddy for Medco at (202) 269-6402 and Christine Cramer for CVS Caremark at [ckcramer@cvs.com](mailto:ckcramer@cvs.com).

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