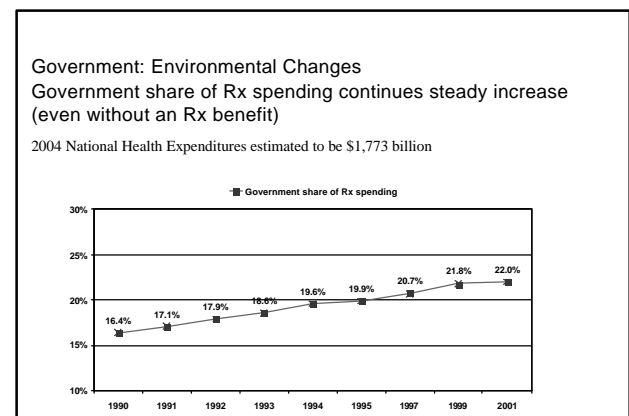


- ## EMPLOYER STRATEGIES
- Coinsurance with caps to avoid catastrophic out-of-pocket costs
 - Web site that include:
 - Drug pricing and lower cost treatments
 - Drug prices and effectiveness data
 - Step therapy
 - Mandatory mail
 - Offer plan designs ranging from low to high relative value
 - Waive every third co-pay or lower co-pay for generic drugs when claims indicate members are compliant
 - Use coinsurance for brands
- JPG 06/12/04

- ### Pitney Bowes 2001 Revised Plan Design*
- Tiered Reimbursement
 - Tier 1 – Most Generics
 - **All medications for: Diabetes, Asthma and Hypertension**
 - Tier 2 – Most Preferred
 - Tier 3 – Non-preferred Name Brand Drugs
 - No mandatory mail order or generic drugs
 - No step therapy
 - **Market share rewards program to better performing providers with Quality Incentive Program (QIP)**
 - Limited Prior Authorization
- *Jack Mahoney, Corporate Medical Director
- JPG 06/12/04

- ## American Standard
- Consumerism
 - Appropriate cost sharing
 - Tools and information
 - Defined contribution
 - Direct provision of health care (company doctors, company pharmacies)
 - **Health and disease management**
 - **Promotion of evidence-based medicine**
- “There is no one silver bullet, we will leverage all”
- JPG 06/12/04



GOVERNMENT STRATEGIES

- Negotiation of prescription supplemental rebates and price caps
- Buying coalitions of federal and state payers
- Increased co-pays
- Influence access to drugs through preferred drug lists (Negative/Positive Lists)

13 JPG 06/12/04

Implications for Pharmacy

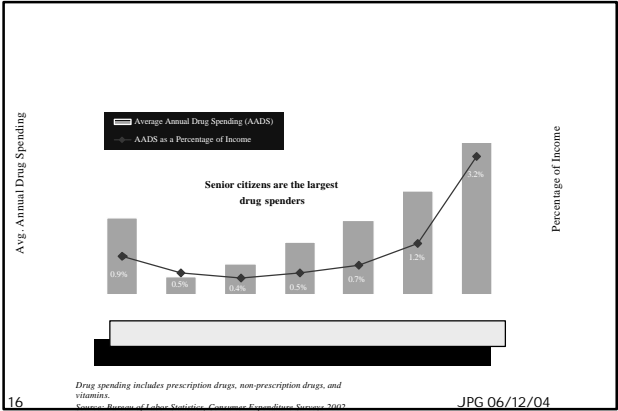
- Changes coming in US healthcare model
 - ⚡ **Buyers play an increasingly bigger role in shaping the healthcare system**
 - ⚡ **Growing importance of patient as an active consumer**
 - ⚡ **Competition will be on value creation**
- A continuing challenge through 2006 will be to offer specialized pharmaceutical services that improve patient outcomes.

14 JPG 06/12/04

OBJECTIVES

- Describe Rx Drug Management Strategies
- *Discuss MMA Provisions*

15 JPG 06/12/04



PAST MEDICARE DRUG COVERAGE

- Inpatient - Reasonable and Necessary Drugs During Hospital Stay
- Outpatient -
 - ⚡ Drugs provided in physician's office or outpatient clinic that are not usually self-administered (e.g., injectables)
 - ⚡ Other narrowly-defined categories of drugs (e.g., oral anti-cancer drugs, certain vaccines, blood clotting factors)

17 JPG 06/12/04

KEY FEATURES OF MMA

- Patient Enrollment
- Private Insurance
- Immediate assistance through Rx drug card
- Drug Benefit
 - ⚡ Low-income assistance
 - ⚡ Catastrophic coverage

18 JPG 06/12/04

TRANSITIONAL ASSISTANCE CARD

- Essential goals
 - ⌘ Discounts on Rx drugs
 - ⌘ \$600/yr debit card for below 135% Federal Poverty Level (FPL) beneficiaries
 - ⌘ Educate Beneficiaries
 - ⌘ Initiate education campaign on drug benefit concepts, such as formularies before Part D takes effect
- 37+ Applicants approved national cards, 21 regional or specialty cards
- HHS estimates 15 – 25% savings per prescription;

¹⁹ Harvard Study 17.4% JPG 06/12/04

TRANSITIONAL ASSISTANCE CARD

- Time Line
 - ⌘ Outreach started in May
 - ⌘ Program started 06/01/04, ends 12/31/05
 - ⌘ Transition period starts 01/01/06 through the end of open enrollment for Part D in early 2006
- Community pharmacies, PBMs, MCOs, others to offer Medicare (CMS) endorsed drug discount cards to Medicare beneficiaries for most drugs (can use formularies)
- Up to \$30 fee (being waived)
- Sponsors negotiate discounts and rebates with manufacturers and/or pharmacies; programs required to pass along "some" discounts
- Price comparison web site for drugs available

20 JPG 06/12/04

BASIC STRUCTURE PART D

- Medicare Part D Rx drug benefit begins Jan. 1, 2006
 - ⌘ Risk-bearing stand-alone drug plans contract with Secretary of HHS in designated regions
 - ⌘ Estimates are 15 regions will be designated by Secretary of HHS

21 JPG 06/12/04

ENROLLMENT

- Voluntary, can choose either:
 - ⌘ Stand-alone plans sponsored by Prescription Drug Plans (PDPs) (PBMs will not take risk, instead will join with an insurer to offer benefit)
 - ⌘ PPO/HMO plans (Medicare Advantage)
 - ⌘ No plan, pay no premium
- Annual open-season
- Late sign-up penalties = 1% per month, or as HHS Secretary determines
- Open enrollment begins November 2005

22 JPG 06/12/04

DRUGS COVERED

- Covered Drugs (subject to plan formulary)
 - ⌘ Drugs and biologicals
 - ⌘ Insulin and medical supplies associated with insulin injection
 - ⌘ Smoking cessation
- Not covered
 - ⌘ OTCs, benzos, barbs, weight loss, fertility, vitamins
- **USP determines categories and classes**

23 JPG 06/12/04

SUMMARY FEATURES OF STANDARD DESIGN

- \$250 deductible; 75% coverage from \$251 to \$2,250
- "Doughnut Hole" in coverage between \$2,250 and \$5,100 (\$3,600 out-of-pocket)
- 5% co-pay above \$5,100
- Premium \$35 per month, or \$420 annually
- Actuarial value is \$1,400 (the cost of providing the benefits, net value \$1,150 after premium)
- Full coverage with no premiums for low-income beneficiaries

24 JPG 06/12/04

IMPACT OF MMA ON BENEFICIARIES ABOVE FEDERAL POVERTY LEVEL*

Beneficiary's annual drug cost	\$2,250&	\$3,160#	\$5,100@
Deductible:	250	250	250
Premium:	420	420	420
Co-insurance: (25%)\$250 - \$2,250	500	500	500
Gap in coverage		910	2,850
Co-pay greater of \$2 generics/\$5 brand co-pays or 5% coinsurance above stop loss of \$5,100			
Total cost to beneficiary:	\$1,170	\$2,080	\$4,020
Net savings (loss)	\$1,080	\$1,080	\$1,080
Percent Saved	48%	34.2%	21.2%

* (Source: MMA December 8, 2003)
 & Maximum discount below \$5,100, beginning of "doughnut hole"
 # "Average Sinner" will have an annual Rx drug bill of \$3,160 in 2006
 @ End of "doughnut hole"

25 JPG 06/12/04

- ### Importation/Foreign Markets
- HHS Secretary is authorized to set up importation system.
 - Secretary must complete a 12-month study of problems relating to implementation of re-importation law.
 - Secretary is authorized to promulgate rules to permit Canadian imports.
 - Law also directs Secretary to conduct a study of drug pricing practices overseas.
- 26 JPG 06/12/04

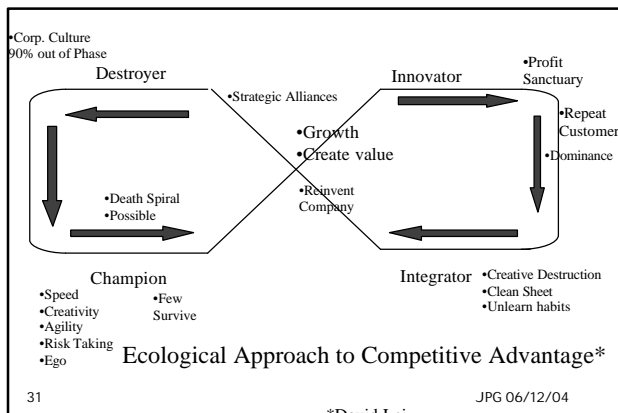
- ### ELECTRONIC PRESCRIBING
- Provides for real-time, interactive electronic transmittal of messaging between MDs and RPhs related to prescribing drugs, e.g., drug information (formulary), drug history, cost and generic drugs
 - Program is voluntary, i.e., MDs can use paper prescriptions
 - HHS will promulgate ePrescribing standards
 - Time Line for Standards
 - ⌘ Initial standards 9/1/05
 - ⌘ Evaluation and report to Congress on pilot 4/1/07
 - ⌘ Final rules on standards 1/1/08
 - Starting in 2007 matching grants (50% of cost) available to hospitals and MDs for new hardware/devices for ePrescribing technology
- 27 JPG 06/12/04

- ### DRUG HEALTH OUTCOMES RESEARCH
- Agency for Health Research and Quality authorized \$50 million to improve the quality, effectiveness and efficiency of health care by:
 - ⌘ Conducting research on the outcomes, comparative clinical effectiveness and appropriateness of Rx drugs
 - ⌘ Support by grants or other means activities including the provision of technical assistance, scientific expertise or other methodological assistance
 - Time Line
 - ⌘ Priorities developed no later than 6 months after December 8, 2003
 - ⌘ Establish an initial list of priorities for research, complete evaluation and syntheses in 18 months
 - ⌘ Report to Congress no later than October 1, 2005 on the results of directed studies
- 28 JPG 06/12/04

- ### MEDICATION TREATMENT MANAGEMENT
- Prescription Drug Plan (PDP) required to have Medication Treatment Management (MTM) programs for targeted beneficiaries
 - ⌘ Multiple diseases, taking multiple drugs, high drug spend
 - ⌘ Payment: PDP plan shall consider the resources used and time required to implement the MTM program
 - May be furnished by a pharmacist
 - Must be developed in cooperation with licensed physicians and pharmacists
 - MTM Elements:
 - ⌘ Beneficiary education and counseling
 - ⌘ Increase adherence through refill reminders, special packaging and compliance
 - ⌘ Detect ADRs, overuse and misuse
- 29 JPG 06/12/04

WHAT WILL HAPPEN TO COMMUNITY PHARMACY?

30 JPG 06/12/04



OBJECTIVES

- Describe Rx Drug Management Strategies
- Discuss MMA Provisions
- *Speculate on Opportunities*

32

JPG 06/12/04

Patient Viewpoints

- Patients report community pharmacies are **weak at communicating to patients full range of services or clinical capabilities**
- Patients predict community pharmacies will evolve into centers where consumers can receive **basic clinical services and clinical support from RPhs**

33

JPG 06/12/04

Pharmacy Practice Shift

- *Role of Pharmacist must change from distributor of drugs to clinical manager*
- *Medication Treatment Management (MTM) offers opportunity to create value*
- *Pilot programs are underway*

34

JPG 06/12/04

IMMUNIZATIONS

- Pharmacists Immunizing
 - ≈ Approximately 12,000
- Doses Administered
 - ≈ Flu 1,000,000
 - ≈ Travel vaccines – Hep. A, Tetanus, other
- New Jersey asked days after collaborative agreement signed to set up program to administer vaccines

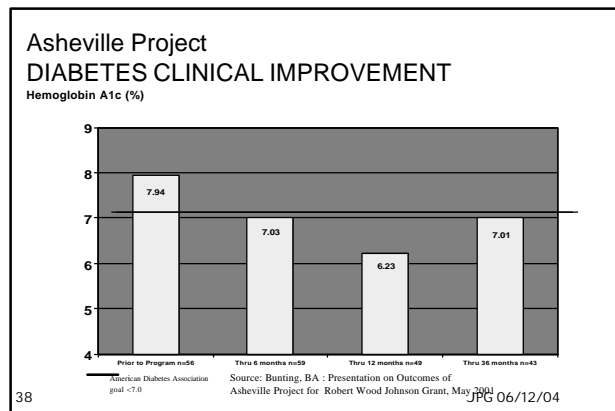
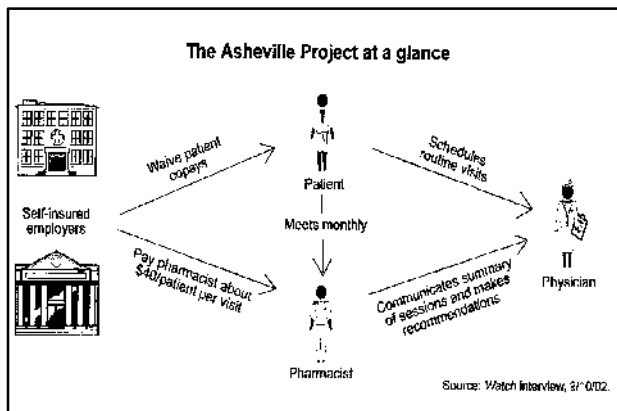
35

JPG 06/12/04

ASHEVILLE PROJECT

36

JPG 06/12/04



Asheville Project: Analysis of Changes in Health Care Costs

Cost Item	Baseline Year	Year Two	% Change
Inpatient Medical	\$88,569	\$19,059	-78%
Outpatient Medical	95,118	66,845	-30%
Prescription Medication	34,043	55,155	+62%
Patient Education	0	14,831	NA
Total Costs	\$217,730	\$155,890	-28%

Base on data from Cranor, C.W. Outcomes of Community Pharmacy-based Pharmaceutical Care Services for Patients with Diabetes. Preliminary Results of doctoral dissertation, July 2000, p. 20.

- Patient Self Management Project: Diabetes (PSM) (Aventis/APhA)**
- Program Goals
 - ≈ Improved clinical outcomes
 - ≈ Improved medication persistence and compliance (adherence) with therapy
 - ≈ Decreased emergency room visits/hospitalizations
 - ≈ Increased worker productivity
 - ≈ Improved economic outcomes for all stakeholders

FIXING COMPETITION IN US HEALTH CARE*

- **Healthcare competition today works on the wrong level**, players (plans, payers and providers engage in zero-sum competition (dividing value rather than creating it)
- **They transfer costs onto one another**, limit access to care, hoard information and stifle innovation
- **Competition should occur at the level of preventing, identifying and treating** patients' conditions and disease

FIXING COMPETITION IN US HEALTH CARE*

- **Call for collecting and disseminating information about the outcome of medical procedures** so patients can make intelligent choices
- **Recommend transparency** in billing and pricing to reduce cost shifting, discrimination and other inefficiencies
- **Increased specialization** by health care providers resulting in centers of excellence, who does best job at prostrate surgery with least complications and best recovery
- **Government's role would to block network restrictions, hospital consolidations**

*Porter M, Olmsted Teisberg, E., June 2004

SPECIALTY PHARMACIES

- *Focuses on injectable, high technology drugs for chronic diseases, such as rheumatoid arthritis*
- *Focus on patients with rare chronic diseases, such as hemophilia*
- *Provide clinical technician staff, nurses, compliance specialists and drug information pharmacists*
- *Includes comprehensive follow-up programs* that include telephone calls to new patients and monthly checkups to ensure patients are compliant
- Create value for patients and buyers

43

JPG 06/12/04

SPECIALTY PHARMACIES

- Demand for specialty drugs outpacing normal drug use
 - Approximately \$27 billion in 2002
- Drugs carry a high expense with retail prices as high as \$1,200 per month
- Negotiate with pharmaceutical firms for reduced pricing
- Stock products too expensive or too complex for traditional pharmacies
- Will include the dispensing of many biotechnology drugs which make up 24% of what is in the Pharma pipeline

44

JPG 06/12/04

SPECIALTY PHARMACIES

- *HealthPartners* carves out Specialty Pharmacy Benefits
 - Wanted more control over cost inflation for specialty drugs
 - Will pay more in professional fees to Doctors
- *Rite Aid* starting a specialty pharmaceutical program via a partnership with McKesson
 - Opening its 3,400 doors to this market
- *AdvancePCS and Caremark* merging specialty pharmacy operations after merger

45

JPG 06/12/04

SPECIALTY PHARMACIES

- Walgreens approach
 - Health Initiatives (WHI) (formulary utilization, drug effectiveness and patient safety, measurement and quality improvement)
 - Serves employer groups, MCOs, Government entities, TPAs
 - Learn how merged medical-pharmacy claims can be used for retrospective DUR
 - Learn how merged medical-pharmacy claims can be used for DM

46

JPG 06/12/04

OBJECTIVES

- Describe Rx Drug Management Strategies
- Discuss MMA Provisions
- Speculate on Opportunities
- *Present Action Steps*

47

JPG 06/12/04

Critical Time For Pharmacy

Your Leadership is Crucial

48

JPG 06/12/04

PHARMACY GROUP MEETING WITH MARK MCLELLAN

- Must follow Congressional requirements
- But can provide incentives for pharmacists to deliver MTM in rules and regulations
- What are the quality indicators that can be used to measure performance?

49

JPG 06/12/04

Action Steps

- RPhs must keep abreast of what is happening with specialty pharmacy activities
- As Pharmacy Administration teachers you must know what is going on in the marketplace, e.g., Walgreens Health Initiatives
- RPhs must think about retraining and obtaining new clinical skills
- *Pharmacy Administration teachers must teach how to construct and use comparative clinical information and how to analyze, evaluate and interpret evidence base medicine reports*

50

JPG 06/12/04

Action Steps

- Monitor CMS and its regulation process and how the regulations affect pharmacy; establish a contact at the agency
- Do the same with your state Medicaid Department and local employers
- Work with state legislators and their staffs
- Work with Medicare beneficiary groups to educate them on Medicare changes
- Work to change pharmacy laws to accommodate changes
- Examine possibility of pharmacist prescribing

51

JPG 06/12/04

Hurdles*

- Most venerable can prove to be the most vulnerable
- Strong culture can blind leaders to events that do not fit their mental framework
- Leaders must contend with trappings of "Legacy Assets", e.g., old sales and distribution systems

* "Blown to Bits", Evans and Wurster

52

JPG 06/12/04

At this Critical Juncture Strategy Really Matters!

- Must rethink the way drug distribution system currently works, look at what is evolving, e.g. case management and specialty pharmacies which use service components as businesses in their own right

53

JPG 06/12/04

HOW WILL YOUR TEACHING AND RESEARCH BETTER PHARMACY'S FUTURE?

54

JPG 06/12/04

WHO WILL CAPTURE THE ECONOMIC BENEFITS OF FUTURE CHANGES?

55

JPG 06/12/04

SUMMARY

- Described Rx Drug Management Strategies
- Discussed MMA Provisions
- Speculated on Opportunities
- Presented Action Steps

56

JPG 06/12/04

REACTION & DISCUSSION



57

JPG 06/12/04

Contact Information



Jean Paul Gagnon

jean.gagnon@aventis.com 800-648-9499 Ext 6379
Aventis Pharmaceuticals Inc.

58

JPG 06/12/04

BOOKS TO READ

- “Creating and Dominating New Markets,” Peter Meyer, AMACOM, 1601 Broadway, New York, NY10019
- “Will and Vision,” Gerard J. Tellis and Peter N. Golder, McGraw-Hill Companies, Inc.
- “Good to Great,” Jim Collins, HarperBusiness, 10 E. 53rd Street, New York, N.Y.
- “Fixing Competition in Health Care”, Michael Porter and Elizabeth Olmsted Teisberg, HBR Research Report, June 2004

59

JPG 06/12/04

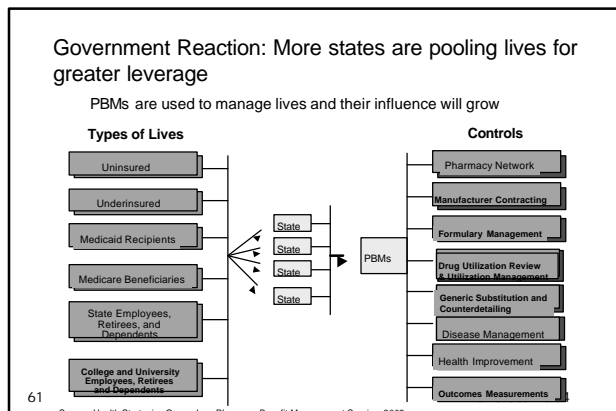
Employers Evolving into Role of Information Providers

Future Health Benefits - Aventis Employer Research Key Findings

- 1) **Employees are forcing employers to:**
 - 1) Offer benefit designs with more choice
 - 2) Demand a broader range of clinical services from their healthcare vendors
- 2) **Employer role will evolve to that of information provider. Within three to five years, employers will:**
 - 1) Develop healthcare education programs
 - 2) Evaluate health outcomes data
 - 3) Benchmark healthcare vendors
- 3) **Employers will still assert significant power by:**
 - 1) Determining which vendors are included in cafeteria plans
 - 2) Organizing healthcare education opportunities for employees
 - 3) Benchmarking the quality of care provided by vendors, and
 - 4) Implementing their own health management programs

60

JPG 06/12/04



Top Issues

- **Cost**
 - ⌘ Demographics and innovation (in both pharmaceuticals and benefit design) are combining to increase both real cost and visibility of prescription drug expenditures.
- **Value**
 - ⌘ While executives believe there is usually a strong value proposition for the use of prescription drugs, hard evidence is scarce. Segments also challenge one another's value in relation to cost.
- **Consumerism**
 - ⌘ Executives in all segments recognize the informed, empowered consumer as a major "wave."

62

JPG 06/12/04

Top Issues

- **Information Technology**
 - ⌘ While prescription drug programs are currently the model for automation in the health industry, executives recognize large untapped opportunities to further apply technology.
- **Government Involvement**
 - ⌘ Uncertainty how government will address Medicare, Medicaid and the uninsured has "frozen" strategies.
 - ⌘ Influence of this large payer will be felt.

63

JPG 06/12/04

SPECIALTY PHARMACIES

- **Changes in Specialty Pharmacy market place***
 - ⌘ **Point of care Customization of Medications**
 - ⌘ Future specialty medications will require reconstitution or other modifications to meet individual specific needs
 - ⌘ Delivery of specialty drugs time sensitive
 - ⌘ **Provider Demand**
 - ⌘ Future practices that are certified disease treatment specialists in defined therapeutic areas
 - ⌘ **Improvements in Inventory Management Processes**
 - ⌘ Advanced services offered by wholesalers and manufacturers will allow local providers to reduce their inventory carrying costs, national/regional distribution (Caremark, Chronimed, CVS ProCare, Optioncare versus mail order delivery strategies)

*Tim Watson, Pharm.D., MBA

64

JPG 06/12/04

PSM: Diabetes

Conditions for Implementation

- Employer/Payer that will invest in incentives for patients and providers to improve health and lower costs
- Local physician and hospital support for community-based collaborative care
- Local networks of pharmacists that have the motivation, training and time to help patients manage their care

65

JPG 06/12/04

SITES

- VF Corporation / 4 North Carolina Sites
- Mohawk Carpet, Dublin, Georgia
- Ohio State University, Columbus, Ohio
- Kroger, Columbus, Ohio
- Lakeshore Business Coalition / Manitowoc, Wisconsin

66

JPG 06/12/04

Action Steps

- Understand Forces Shaping the Future*
 - ⌘ Consumer-driven Health Care Models
 - ⌘ Customized Design
 - ⌘ Catastrophic/Health Reimbursement Arrangement (HRA) Designs
 - ⌘ Mapping costs and quality; professional incentive programs

*Hewitt Associates

67 JPG 06/12/04

Action Steps

- RPhs must get involved in Case Management
 - ⌘ Establish collaborative agreements with physicians
 - ⌘ Work with local employers/Medicaid to develop programs that provide patients with services, waive co-pays and provides RPh service compensation
 - ⌘ Reorganize pharmacies to provide diabetes, asthma, hypertension, smoking and other case management services
- If allowable in their states RPhs should establish immunization programs and look to expand it to other injectable-type programs

68 JPG 06/12/04

AT-HOME PHARMACY SERVICE

- Katz in Toronto launched PharmAssist Service
 - ⌘ Provides Toronto-area consumers at-home Rx consultation, full medicine cabinet audits, disease state and lifestyle counseling and other services by appointment
 - ⌘ Seniors with multiple disease states using multiple medications would be targets
 - ⌘ Patients call toll-free number to access service
- RPhs will do home-visiting

69 JPG 06/12/04

PHARMACISTS AS PRESCRIBERS

- Eight pharmacies in Seattle will prescribe contraceptives in a one-year feasibility study
 - ⌘ Univ. of Washington School of Pharmacy/Dept. of Obstetrics and Gynecology will evaluate the experiences of 300 healthy, non-smoking women taking contraceptives
 - ⌘ Patients will complete a medical and contraceptive history questionnaire and RPhs will conduct a screening process and will prescribe the appropriate drug following a protocol

70 JPG 06/12/04

PART D – SUBSIDIES FOR MEDICARE BENEFICIARIES

- Elderly with income -
 - ⌘ Below 135% of poverty and low assets receive full premium subsidy
 - ⌘ Between 135% and 150% of poverty and low assets receive partial premium subsidy
- Reduction or elimination of deductible varies based on income level
- Cost-sharing varies based on income level -
 - ⌘ Co-pays of \$1 for generics and \$3 brand name for “dual eligibles” below 100% of poverty
 - ⌘ Co-pays of \$2 for generics and \$5 brand name for beneficiaries with incomes below 150% of poverty

71 JPG 06/12/04

EMPLOYERS SUBSIDY

- Approximately 33% of beneficiaries currently have Rx drug coverage through former employers
- Feds to subsidize 28% of Rx costs between \$250 - \$5,100 in 2006 for firms offering program actuarially equivalent to Medicare benefit (\$1,400)
- Total amount available over 10 years is \$71 billion which is not taxable; equates to \$81 billion
- Employers provided maximum flexibility in administering benefit

72 JPG 06/12/04

MMA IMPACT ON MEDICAID

- Medicare becomes primary payer for Rx drugs for dual eligibles who account for 25% of Medicaid spending
- Secretary to establish process to transfer duals to Medicare
- Children, adults below 65, and blind & disabled left
- Medicaid can provide drugs, but at their own cost
- Pharmacy has option to waive Rx co-pays
- No Federal matching funds available after January 1, 2006 for states for Medicare covered drugs or co-pays
- Federal government “claws back” state savings resulting from shift of dual eligibles, phasing from 90% in 2006 to 75% in 2014

73

JPG 06/12/04

COMMUNITY PHARMACY ISSUES

- Endorsed Discount Cards
- Transparency and Accountability
- Negotiated Prices
- Conversion of Medicaid to Medicare
- Modifications to State Rx Assistance Program
- Importation
- Electronic Prescribing
- Comparative Clinical Effectiveness
- Medication Therapy Management

74

JPG 06/12/04