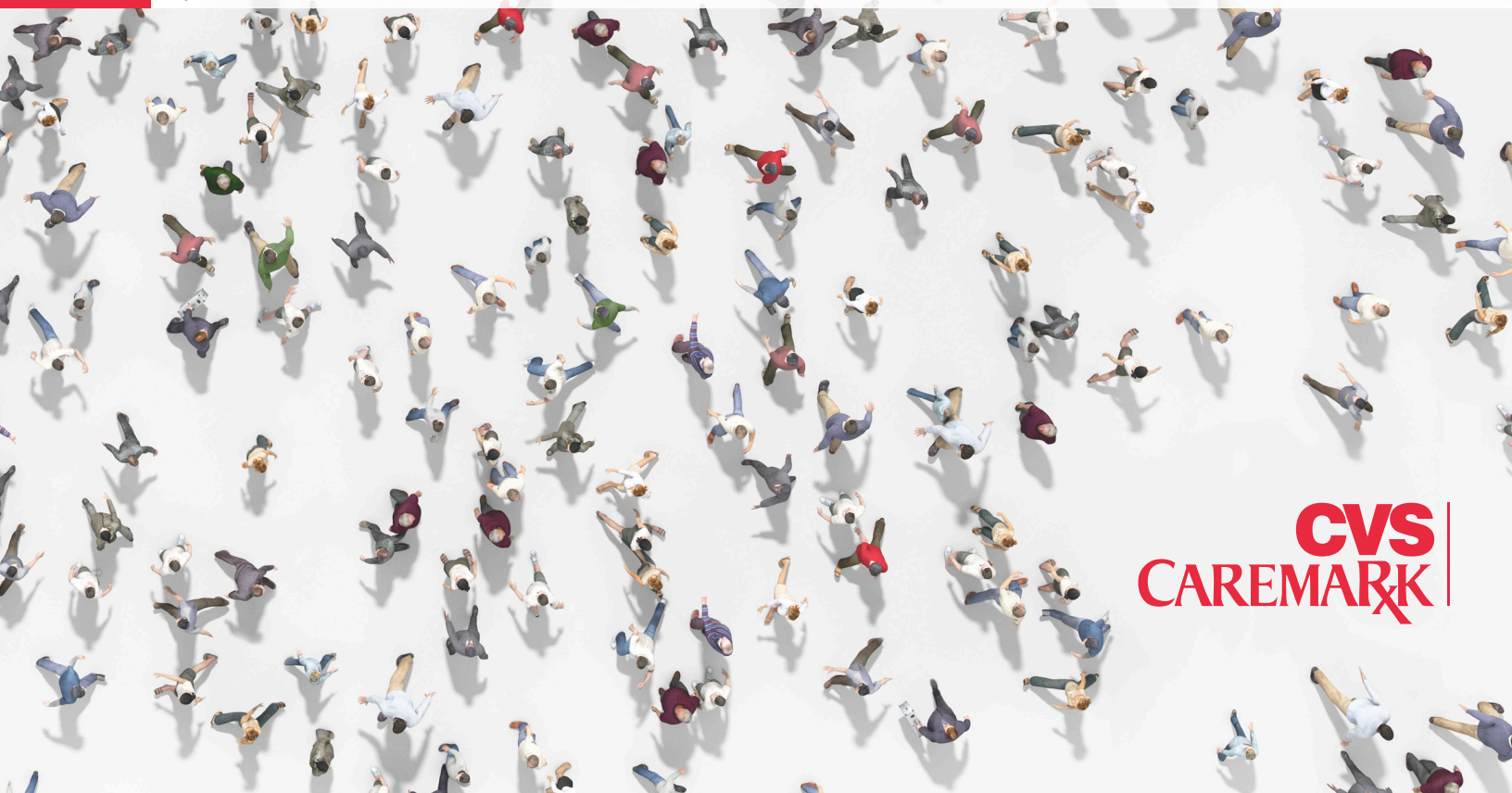
INSIGHTS

ADVANCING THE SCIENCE OF PHARMACY CARE

2013 focus:

The Member

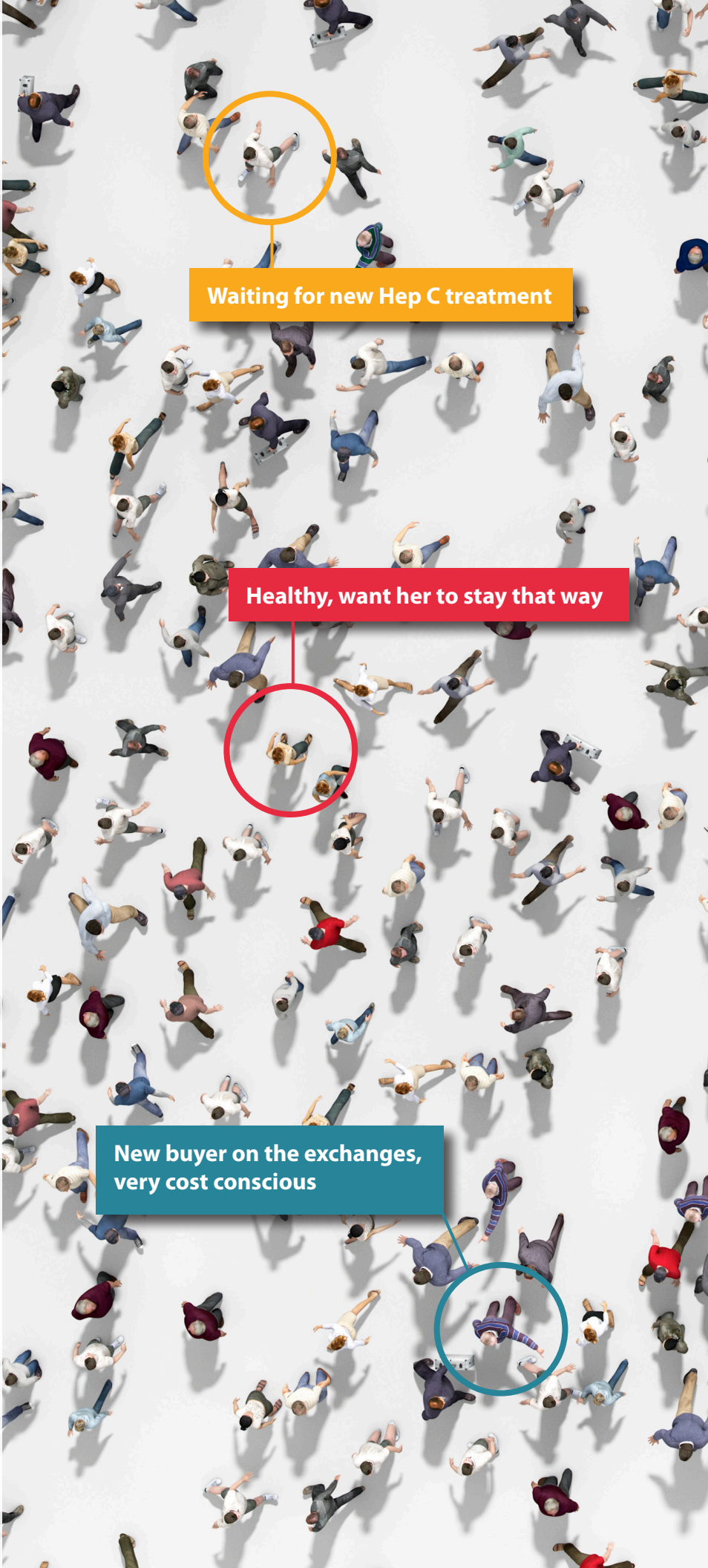


CVS CAREMARK

The U.S. health care system serves over

300 million Americans.

Whether they're healthy or in the hospital, with or without insurance, the system serves them all. And it's never been more clear that what individuals do—how they behave in regard to their health—materially impacts not just their outcomes but the welfare of the system as a whole. This year, in INSIGHTS 2013, we look at how we at CVS Caremark interact with the members and consumers we serve to improve health and cost outcomes for them and for our pharmacy benefit clients.




Sub-optimally adherent to diabetes therapy
High risk of hospitalization
Has 4 different doctors, 17 prescriptions
Believes he's indestructible
Eligible for subsidies?

2013 focus: The Member

INSIGHTS

Across CVS Caremark, we understand the challenges consumers face in the health care system. Cost, complex regimens, and lack of information can be obstacles to a patient's compliance with prescribed treatment. To help our PBM clients improve their cost and health outcomes, we develop solutions that help members overcome these obstacles, adopt healthier behavior patterns and make cost-effective choices. Our model—PBM services, retail pharmacy and retail clinic—provides unique advantages and opportunities to support effective member outreach.

How people choose to handle their health makes a difference to more than their outcomes.

Knowledge and insights. We interact with millions of members and consumers every day. These interactions provide a depth of data and insights on health behaviors, communication preferences, and effective interventions. In addition, CVS Caremark actively partners with leading academics in health care and behavioral economics to develop and test innovative ways to change member behavior. Testing helps validate and optimize our programs before they are launched.

Advanced analytics. Our expertise in this area helps us build models that will predict a member's likelihood to be adherent and to respond to various types of interventions. These models are built on past behavior, attitudinal data, and disease state. By assigning a probability to each person, we can target more accurately and deliver tailored, relevant messages. We also group "like" members into cohorts with similar characteristics like chronic condition, attitudes, lifestyles, and behaviors. Then we develop specific strategies to drive desired outcomes.

Technology and touchpoints. We've invested in technology that enables synchronized delivery of targeted, actionable, personalized messages across our unmatched range of channels. A single member may talk face to face with her CVS pharmacist about a new prescription; identify savings opportunities on caremark.com; get text refill reminders on her cell phone; and receive outbound calls from our Pharmacy Advisor counseling team to help her manage her condition.

Our knowledge base, analytic and modeling capabilities, technology and multi-channel model allow us to identify and implement the most effective member outreach. That can mean using behaviorally-based wording in a letter. Or it may mean making personal concierge-like calls to members to help them transfer prescriptions to mail, enroll in automatic refills, or register on caremark.com. Below are three ways we're working on improving the member experience while helping our clients achieve even better outcomes from both a health and a savings perspective.

1. Helping to reduce costs. In 2012, 53 percent of prescriptions were transmitted electronically.[1] E-prescribing has some clear advantages over the handwritten prescription: fewer prescribing errors, direct transmission to the pharmacy, greater convenience for the patient. It also enables **better benefit management** by moving some cost decisions from the pharmacy counter to the physician's office.

E-prescribing technology allows us to provide information on formularies and benefit designs at the time of prescribing. Prescribers can evaluate and discuss coverage or utilization management processes with the patient before the prescription is written, avoiding potential frustration at the pharmacy. Automated approvals make the process easier; the physician and pharmacy don't need to trade faxes and phone calls; the member visits the pharmacy once. CVS Caremark was the first to introduce electronic prior authorization and continues to lead the industry in using technology to minimize disruption and maximize savings.

2. Providing better access. One in three patients prescribed a specialty medication tries to fill the prescription at a traditional retail pharmacy.[2] Twenty five percent are turned away without adequate guidance on where or how to fill the prescription.[3] This can be very confusing for patients and can lead to delays in starting therapy.

For a better patient experience, we are creating a model, now in pilot, that will allow us to holistically **manage the specialty patient using all our access points, channels and resources.** When this program is rolled out starting in 2014, a patient will be able to drop off the prescription at any CVS/pharmacy. The medication can be delivered to their location of choice or picked up at the pharmacy. Every CVS Caremark specialty patient will receive consistent industry-leading clinical service and expertise from a dedicated CareTeam, regardless of the channel through which they enter.

3. Making health care easier. The changes underway in health care mean that consumers will be taking on a more active role in making decisions and managing their health care. Our **enterprise digital strategy** is intended to help make that easier. We are building one seamless digital experience that will provide:

- Centralized prescription information and easy refills
- Ready access to drug and family health information
- Personalized messaging in the member's channel of choice
- Access to a pharmacist, live or online, to answer questions
- Personalized promotions and incentives

Our purpose:

Helping people on their path to better health

INSIGHTS

Spend and Trend

While the recession has officially ended, growth in health care spending remains low. The Centers for Medicare and Medicaid Services projected that, on average, spending would grow at 4 percent from 2011 through 2013. This is only slightly higher than the historically low growth rate of 3.8 percent in 2009. National health spending as a share of GDP has remained stable at 17.9 percent since 2009.[4] The only areas of growth in 2011 (latest national data available) were in prescription drugs and physician and clinical services; and that growth was attributed to increasing prices, not increases in utilization. In fact, analysts expected a bigger post-recession bounce in health care utilization than has been seen.[5]

Book of Business gross prescription drug trend: 0.1%

Various reasons for low utilization have been cited. Lingering effects of the economic downturn are a likely contributor, but the recession is officially over. Fewer people are unemployed and more people have insurance, factors which usually lead to increases in utilization.

One persistent explanation for lower health care utilization is that higher cost share is deterring consumers from getting care. Incomes have not kept pace with increases in health care costs. From 2002 to 2012, for workers with employer-sponsored insurance, premiums almost doubled while wages increased just 33 percent.[6] One study found that 40 percent of consumers reported postponing care in 2012 because of costs.[7]

Member cost share has been increasing as plans work to mitigate the effects of unsustainable cost growth, increase member accountability and curb unnecessary spending. High deductible plans are now the primary benefit offering for 13 percent of U.S. employers, up from three percent in 2006.[8] Some studies have shown that enrollees in such plans cut back on preventive care.[9] These results underscore the importance of careful plan design, rigorous member education and ongoing support to help consumers make the right care decisions.

2012 CVS CAREMARK BOB DRUG TREND

Figure 1

OVERALL TREND PMPM				SPECIALTY TREND PMPM			NON-SPECIALTY TREND PMPM		
Gross	**Net**	**Util.**	**Segment**	**Gross**	**Net**	**Util.**	**Gross**	**Net**	**Util**
0.8%	2.3%	-0.2%	Employer	18.8%	19.1%	4.3%	-3.2%	-2.2%	-0.3%
-0.8%	1.1%	-1.4%	Health Plan	15.9%	16.6%	0.1%	-4.7%	-3.8%	-1.5%
0.3%	1.9%	-0.5%	Emp+HP	18.1%	18.4%	3.2%	-3.6%	-2.6%	-0.6%
2.9%	4.9%	1.1%	TPA	22.5%	22.8%	6.1%	-0.7%	0.8%	1.0%
5.7%	5.7%	2.8%	Medicaid	20.6%	20.6%	9.3%	1.8%	1.9%	2.7%
-2.8%	-1.2%	-1.2%	Medicare D	24.5%	24.6%	7.8%	-6.1%	-4.9%	-0.8%
0.1%	**1.7%**	**-0.5%**	**Total**	**18.3%**	**18.6%**	**3.6%**	**-3.8%**	**-2.7%**	**-0.5%**

Plans have been making other changes to slow cost growth, such as implementing tighter care management and narrower networks and formularies. Plans and providers are aligning to support better coordination of care and pay-for-performance measures. Accountable care organizations (ACOs) are expanding across the country. There were more than 400 in January 2013. ACOs sponsored by physician groups and hospital systems saw the fastest growth.[10]

With all these forces in play, consumer behavior is changing. People aren't accessing care as readily as they have in the past, and they are more willing to question their doctor's recommendations—whether a particular treatment is needed, or is needed at the time it is first recommended. In general, however, most consumers don't understand why their costs are rising or what they can do to slow the increase. Most tend to equate health care cost increases with increases in the cost of insurance, not the cost of care. In one study, requesting generic drugs was one of the few ways (outside of lifestyle changes) consumers could identify as an action to lower health care costs.[11]

Consumers are right. Expanding use of generics has helped to curb prescription spending and is a major factor in lowering prescription drug trend. In the CVS Caremark Book of Business (BOB), drug mix, along with low utilization, lowered trend to 0.1 percent in 2012. Forty-six percent of all clients in our trend cohort had a trend lower than 1.0 percent.

Generic dispensing rates in 2012 were well above 75 percent. As a component of trend, drug mix, which looks at the proportion of brand and generic drugs being dispensed, came in at a negative 4.5 percent. CVS Caremark BOB utilization figures—measuring the intensity of drug use—were largely flat, except for the Medicaid population. Price continued to be the major trend driver, accounting for 5.3 percent as a component of trend.

The true driver of trend in 2012 was specialty pharmacy. Without specialty, BOB gross trend was a negative 3.8 percent. BOB specialty utilization trend was 3.6 percent, compared to a negative 0.5 percent for non-specialty drugs. Specialty price trend for the BOB measured 15.8 percent, compared to 6.8 percent overall. As a percentage of client drug spend, specialty grew three percentage points in one year, from 16.9 to 19.9 percent. Growth in specialty spend is not expected to slow; by 2016, specialty drugs are projected to account for more than 30 percent of drug spend.[12]

BOB Trend Components

Util: -0.5%

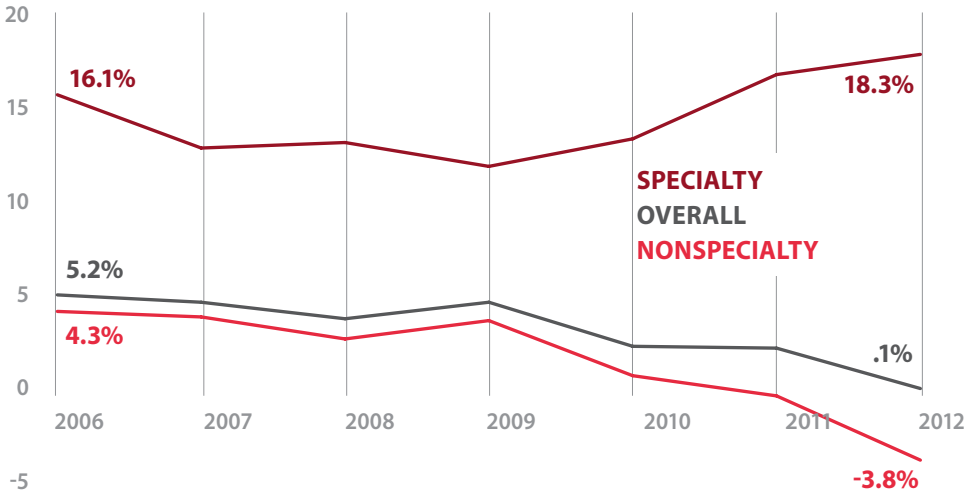
Price: 5.3%

Mix: -4.5%

More than 46% of clients had a gross trend <1.0%

Figure 2

CVS CAREMARK BOB TREND COMPARISON



Specialty spend is the single greatest trend driver. In the 2012 Book of Business, specialty spend accounted for just under 20 percent of client drug spend.

Specialty trend is driven by the same forces—utilization, price, and mix—as trend for more traditional pharmaceuticals. In either pharmaceutical segment, new drugs and new indications drive utilization. For several years, the specialty drug pipeline has been far more robust than that for non-specialty drugs. Specialty products account for more than half the drugs in late-stage development and three quarters of applications for supplemental indications. For the last two years, FDA approvals of specialty pharmaceuticals have outnumbered those for traditional drugs.

New specialty drugs may offer life-altering therapeutic benefits or the first effective treatment for conditions. For example, drugs for orphan diseases are second only to oncology in the pipeline. Orphan diseases affect fewer than 200,000 patients; 80 percent affect fewer than 6,000 patients. These conditions have few, if any, effective treatments. To spur development, potential therapies may qualify for fast track review and receive tax credits, grants and fee waivers from the FDA. At least ten of the newly approved drugs in 2012 had fast track status. Drugs for orphan diseases have annual average therapy cost of $150,000.[13]

Many specialty products face little market competition and target a small patient population, driving price inflation. Because many of these drugs are infused or administered in medical facilities, site of care and source of the drug also figure into price as a trend driver. Close to half of specialty pipeline drugs, and about a third of those approved in 2012, are provider-administered formulations.

There are few generics among specialty drugs. The 2010 Affordable Care Act did authorize a pathway for sponsors seeking approval of products deemed "biosimilar" or "interchangeable" with an FDA-approved product. The FDA provided additional guidance in 2012, but questions remain. With this uncertainty and the high cost of drug development, testing and approval, it's difficult to predict when biosimilars will be a significant market force in the U.S. Overall, the expectation is that savings will be much lower than the 70 to 80 percent cost reductions typical of more traditional generics. Some analysts suggest that increased cost consciousness among payors and providers will help accelerate development, approval, and market entry of biosimilars.

Continued on page 9

HCV Infection

Estimated **3.2M** Americans have hepatitis C[14]

75% of those infected are undiagnosed[15]

3% of baby boomers test positive[16]

75%-85% of those infected develop chronic hepatitis C[17]

Leading cause of liver transplants

2012 HEPATITIS C TREND	GROSS TREND	UTIL TREND
Commercial (HP, EMP)	48.0%	40.5%
Medicare	76.7%	43.2%
Medicaid	58.7%	31.8%

Figure 3

Hepatitis C is the most common blood-borne viral infection in the United States. Most of those infected develop a chronic infection, but symptoms may not be evident for 20 to 30 years, leading to low rates of early diagnosis and treatment. While patients are asymptomatic, the virus can cause serious liver damage, leading to cirrhosis, liver failure and liver cancer.

Today, the virus is most commonly spread by IV drug users sharing needles. Before the advent of widespread screening of the blood supply, it was also spread through transfusions and organ transplants. The Centers for Disease Control (CDC) estimate that two million of those infected with hepatitis C are baby boomers and have recommended that everyone born between 1945 and 1965 have a blood test for the virus. As baby boomers age into Medicare, that high rate of infection, combined with new specialty therapies, has driven trend to over 70 percent.

In 2011, two new orally-administered specialty drugs—Incivek and Victrelis—dramatically changed the treatment of the disease. When used with pegylated interferon and ribavarin, the "triple therapies" have the potential to significantly improve outcomes.

Seven additional orals are expected to be approved for hepatitis C in 2014. New launches may enable an all-oral therapy with much better tolerability. With this potential in mind, physicians have been "warehousing" patients, delaying treatment in hope of achieving better results with the new regimens.

Trend in the category rose rapidly with the introduction of the new treatments in 2011. As patients were held back in anticipation of the expected launches, trend receded somewhat. Utilization and trend may rise dramatically again in 2014 with the approval of the new therapies.

Role of Pharmacy Care: While an all-oral regimen promises greater convenience, treatment is still complicated and side effects can be grueling. Lifestyle issues and co-infection can further complicate therapy and jeopardize its completion. Adherence is crucial. In the past, many patients abandoned therapy early, potentially increasing viral resistance to treatment—another significant factor in the decision to "warehouse" patients.

Our CareTeams provide careful monitoring and support. Genetic testing helps to determine which therapy is appropriate for a patient. Monitoring of viral levels is important; if the patient doesn't respond within a specific timeframe, likelihood of response decreases and therapy may be terminated.

An all-oral hepatitis C regimen may be on the horizon.

Multiple Sclerosis

Affects **400,000** people in the U.S.[18]

Lifetime cost of treating one member: **$3.4M**[19]

Projected average annual drug cost: **$50,000**[20]

80% of MS patients are unemployed within 15 years of diagnosis[21]

2012 MULTIPLE SCLEROSIS TREND	GROSS TREND	UTIL TREND
Commercial (HP, EMP)	17.8%	0.2%
Medicare	22.6%	6.2%
Medicaid	18.0%	1.9%

Figure 4

Promising new therapies drive trend in multiple sclerosis.

Multiple sclerosis is a chronic inflammatory disorder of the central nervous system, which can progress to cause physical and cognitive disability. Symptoms vary widely and usually appear during "relapses," periods of acute worsening of the disease. The disease is not curable, and the goal of treatment is to reduce relapses, prevent the progression of disability, manage symptoms, and improve the quality of life.

Twenty years ago, there were virtually no effective therapies. Now there are several specialty pharmaceuticals indicated for MS, many administered by injection. For some patients, the new drugs changed the course of the disease, but side effects can be very difficult. In an effort to find the most tolerable and effective therapy, many multiple sclerosis patients try a succession of therapies over time.

The first oral medications for multiple sclerosis were launched in the last few years—Gilenya in 2010 and Aubagio in 2012—both with once-a-day dosing. In clinical trials, both reduced the frequency of relapses.

A third oral, Tecfidera, was approved early in 2013 and is believed to have blockbuster potential. In studies it reduced relapse rates by about 50 percent, significantly reduced the frequency of new brain lesions, and slowed the progression of the disease. Moreover, side effects appeared tolerable in trials.

Role of Pharmacy Care: Early initiation of treatment helps to slow progression of the disease and can reduce the number of relapses, but severe side effects can cause some patients to stop therapy. Limited efficacy and difficult administration also discourage patients. Our specialty pharmacy CareTeams support patient adherence and compliance, monitor therapy outcomes, and facilitate communication between the patient, physician and plan. Early identification of suboptimal response is particularly important. A patient who is not responding to current therapy may improve results by moving to an alternate regimen with a different mechanism of action.

Having multiple treatment options can also make the condition more manageable for clients. Preferred drug plan design and therapeutic interchanges become viable additions to previously existing utilization management strategies such as prior authorization.

Our BOB annual generic dispensing rate (GDR) reached 77.4 percent in 2012. If we look at just the last quarter, GDR hit 79.1 percent. 2012 marked a high point in the flood of generic launches. Long-time blockbuster statin Lipitor lost its patent late in 2011, followed in 2012 with patent expirations for Plavix, Singulair and Lexapro, among others. Estimated market value of brands that lost their patents in 2012 exceeded $35 billion. While patents for additional high-profile brands will expire over the next few years, the rush of new alternatives seen in 2012 will not be repeated.

Among the projected major expected new launches in 2013 are generic versions of Cymbalta, currently the top antidepressant by spend in the CVS Caremark BOB, and the anti-ulcer drug Aciphex. Another top anti-ulcer drug, Nexium, is expected to lose its patent in 2014, along with Nasonex, a nasal corticosteroid used for relief of asthma and allergy symptoms.

The trend impact of new generics varies due to the circumstances of the launch. Stakes for brand manufacturers are high, and they employ a variety of means to maintain their market share and revenue for as long as possible. Atorvastatin, the generic for Lipitor, launched with two generics, one an authorized version with six months of exclusivity. Lipitor lost about 10 percent of its market share the first month. By mid 2012, atorvastatin was available from multiple suppliers, and Lipitor sales were down 70 percent.[22]

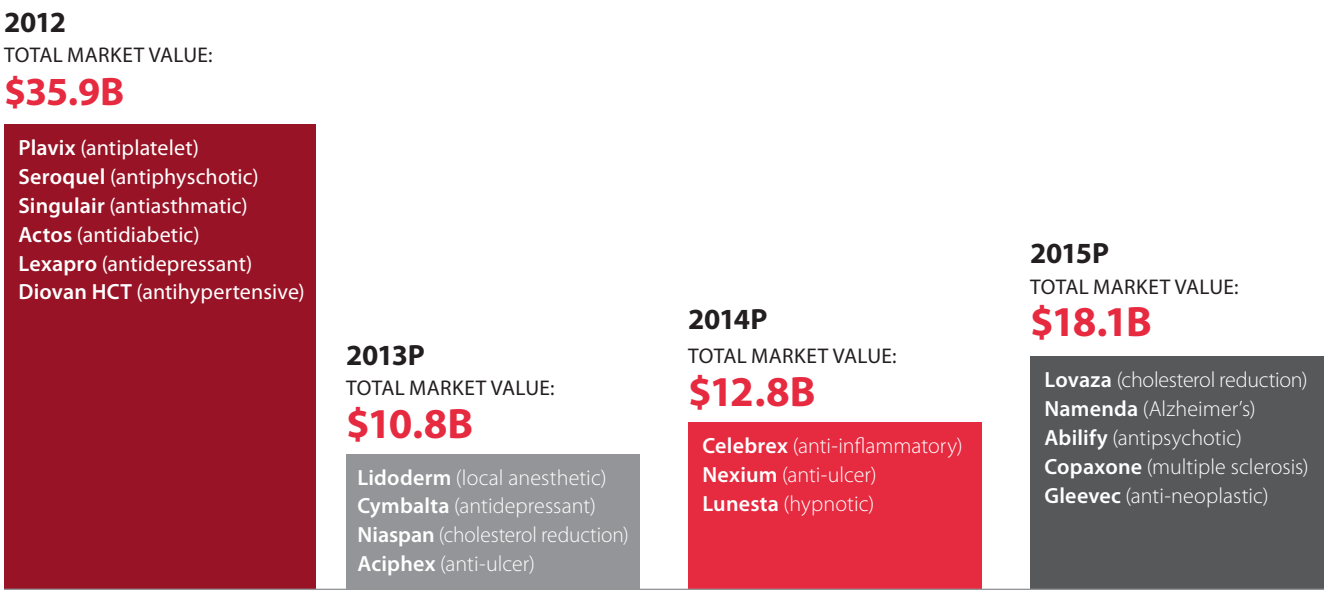
When launched with exclusivity, generics are generally priced about 10 percent less than the reference brand. Atorvastatin's launch with a limited number of generic options was a key factor affecting price trend for generics in 2012, when AWP trend for generics rose to 2.7 percent, compared to a negative 0.1 percent in 2011.

Brand manufacturers also negotiate with generic manufacturers to delay the launch of generics for a period of time in exchange for payment. "Pay for delay" deals are on the rise, despite challenges from the Federal Trade Commission and proposed legislation to prohibit such deals. The FTC estimates such deals cost payors and consumers $3.2 billion.

Drug mix moderated non-specialty trend in 2012 BOB GDR:
77.4%

BRAND PATENT EXPIRATIONS

Figure 5



Information related to prospective drug launches is subject to change without notice due to market events and other factors.

Implications of a market shift to generics

Brand manufacturers also protect their market share with direct-to-consumer incentives in the form of copay assistance for their medications. By one count, copay coupons were available for nearly 400 brands in 2012, and 28 percent of commercial retail prescriptions were processed with a copay card, up from 14 percent in 2010.[23]

Coupons may reduce the member cost for a specific brand to less than their generic copay. What many members don't realize is that while reducing their own cost, they are increasing their plan's cost by possibly hundreds of dollars per prescription. Moreover, a plan's ability to influence the selection of lower-cost products through the cost incentives built into their benefit design is compromised when manufacturers use copay assistance programs to boost sales of their brands.

Despite all these efforts, the number of blockbuster, non-specialty brands is dwindling, and plans are well advised to review their long-term pharmacy benefit strategy. The tiered formularies most plans use allow CVS Caremark to negotiate with manufacturers for the lowest net cost, including drug discounts. These discounts are paid back in the form of rebates after the drug is dispensed. Based on current trends, CVS Caremark projects that by 2015, 85 percent of claims will be in tier one—typically generics—nine percent of claims will be in tier two—preferred products—and six percent of claims will be in tier three—non-preferred.[24] As the number of brand claims dwindles, so does the opportunity to negotiate discounts with manufacturers.

Given all these market shifts, including the dominance of specialty as a trend driver, it makes sense for plans to maximize the generic opportunity as broadly as possible. Formulary and step therapy approaches are crucial elements of trend management. Seventy percent of our plan sponsors are using generic step therapy or considering it. The corresponding application of a dispense-as-written penalty helps to contain costs while preserving member access to effective therapy.

INSIGHTS

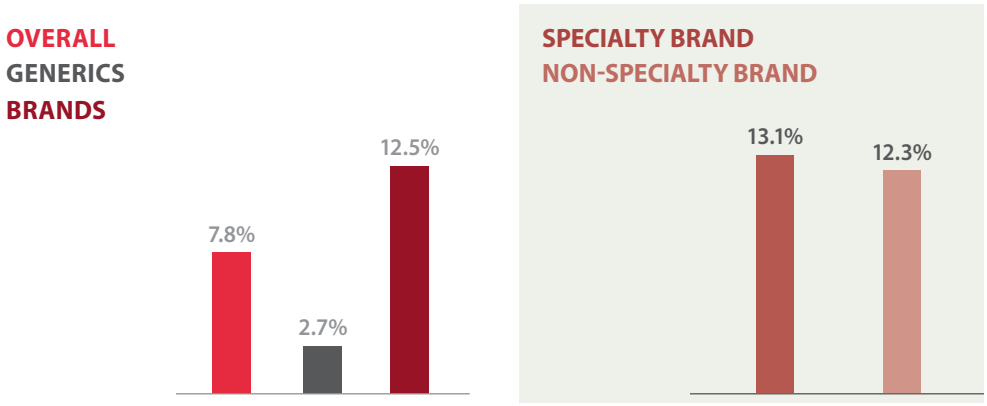
Figure 6

2012 BOB TOP THERAPEUTIC CATEGORIES

Category	Examples of Top Drugs	Gross Trend	Util Trend	Dec. GDR
HMG CoA Reductase Inhibitors (cholesterol reduction)	Atorvastatin (Lipitor), Crestor, simvastatin (Zocor)	-20.4%	0.5%	82.1%
Proton Pump Inhibitors (anti-ulcer)	Nexium, omeprazole, Aciphex	-12.5%	2.0%	72.1%
Insulin	Lantus, Novolog, Humalog	17.7%	2.6%	0.0%
Multiple Sclerosis	Copaxone, Avonex, Rebif	17.6%	0.1%	0.0%
Sympathomimetics (asthma)	Advair Diskus, ProAir HFA, Symbicort	5.8%	-0.3%	15.1%
Anti-TNF-alpha Monoclonal Antibodies (rheumatoid arthritis, Crohn's disease)	Humira, Simponi	23.1%	9.0%	0.0%
SNRI Antidepressants	Cymbalta, venlafaxine, Pristiq	-3.8%	0.7%	43.9%
Antiretrovirals (HIV)	Truvada, Isentress, Viread	10.7%	2.3%	6.1%
Antihypertensive Combinations	Diovan HCT, Benicar HCT	-10.2%	-4.8%	70.1%
Soluble Tumor Necrosis Factor Receptor Agents (rheumatoid arthritis)	Enbrel	11.8%	0.3%	0.0%

2012: BRAND PRICE INFLATION DRIVES AWP TREND

Figure 7



AWP: Average Wholesale Price. AWP trend based on Vendor AWP and includes new brand and generic drugs. Brand AWP trend represents both specialty and non-specialty brands. All trend calculations are based on a trend cohort group.

A carefully planned formulary strategy can be highly effective at containing costs and maintaining member satisfaction. In 2012, plans with our Value Formulary achieved GDRs close to 90 percent. To implement formulary changes, CVS Caremark employs a behaviorally based communication approach to ease the transition. Members and physicians learn about the formulary changes prior to their effective date with a proactive communication campaign that includes mailings and call center and online support. Half of members have transitioned with our pre-implementation communication campaign alone.

Perhaps most importantly, our own research demonstrates that the appropriate use of generic medications is among the most cost-effective ways to prevent chronic diseases and many of the adverse events associated with them, thereby potentially reducing overall costs.[25] Maximizing use of generics could help manage both pharmacy and health care trend.

Price has driven trend in both traditional and specialty pharmaceuticals for several years. In its analysis of national health spending, CMS cited prescription spending as one of the only areas of growth in 2011 (latest NHE data available), and attributed that growth specifically to increasing prices, not increases in utilization. Furthermore, CMS analysts pointed out that spending on new brand-name drugs more than doubled from 2010 to 2011. The growth was driven by "the largest one-year increase in the number of new medicines introduced over the past decade, including breakthrough therapies for several types of cancer, multiple sclerosis, hepatitis C and cardiovascular conditions."[26] Over the next several years, the number of FDA approvals could rise even higher.

New branded products, whether specialty or non-specialty, are typically introduced with a premium price. Manufacturers of competitive products may increase their prices to keep pace, driving trend for the entire category.

Similarly, generics launched with exclusivity face little competition and may be priced as little as ten percent less than the reference brands. As noted earlier, several generic versions of high profile brands launched with little competition in 2012. These launches accounted for highest AWP trend for generics in several years.

Our commercial clients saved

$643 million

in 2012 due to improved Rx adherence and closure of gaps in care.

Medicare and Medicaid: The Year Ahead

Significant changes are on the way for Medicare and Medicaid, which together account for about 20% of the federal budget.[27]

Medicare serves about 50 million Americans, and enrollment is growing as the U.S. population ages. The Congressional Budget Office projects that Medicare will account for about 16 percent of the entire federal budget in 2013, and spend for the program is expected to exceed $1 trillion by 2021.[28] Curbing growth in Medicare spending has been a central concern in budget negotiations for years.

Proposals to reduce Medicare costs have included increasing costs for wealthier beneficiaries, reducing payments to some health care providers, raising the enrollment age, and expanding competitive bidding. However, it's been difficult for lawmakers to come to agreement on any budget proposals.

This year spending will decline due to an enforcement provision in The Budget Control Act of 2011. If legislation was not enacted to reduce projected deficits by $1.5 trillion by 2021, across-the-board cuts in federal spending—sequestration—would occur. Congress failed to approve the required cuts, and on March 1, 2013, President Obama issued the sequestration order with reductions slated to occur within 30 to 60 days.

The spending reductions must total $1.2 trillion over nine years, from 2012 through 2021. Half each year is to be drawn from defense functions. The other half is to be drawn from a variety of programs including Medicare. Medicare reductions, which are capped at two percent, will primarily affect hospitals, physicians and other health care providers and health plans including Medicare Advantage (MA), MAPD, and PDP plan sponsors. Payments for Part B medications administered in physician offices, such as chemotherapy drugs, are included in the cuts.

Part D plans face reductions in the monthly capitation payments they receive from CMS. However, the subsidies that health plans receive for low-income beneficiaries are exempt, as are reinsurance payments. These reductions apply to all Medicare Part D plans, including self-funded EGWP and the CVS Caremark SilverScript Medicare Part D programs. Under budget sequestration, beneficiary premiums and cost-sharing arrangements are protected.

Payment reductions went into effect April 1, 2013. At that point in the plan year, of course, formularies, prescription utilization management strategies and benefit plans are in place. Any changes that could help reduce costs this year would require CMS review and approval.

If Congress and the Administration are able to come to agreement on how to achieve the necessary savings, sequestration could end. Agreement is not likely to come easily, and changes to Medicare are sure to figure prominently in the debate and solution.

2012 MEDICAID TOP 10 THERAPEUTIC CATEGORIES BY COST

Figure 8

Rank	Category	Top Drugs by Cost	Util Trend	Gross Trend
1	Antiasthmatics, Bronchodilators	Proair HFA, Flovent HFA, Singulair	1.0%	3.5%
2	Antivirals	Atripla, Truvada, Incivek	8.3%	27.5%
3	Antidiabetics	Lantus, Novolog	2.1%	14.8%
4	ADHD, Anti-narcolepsy, Anti-obesity, Anorexiants	methylphenidate ER, Vyanse	3.1%	7.4%
5	Antipsychotics, Anti-manic Agents	Abilify, olanzapine, Seroquel XR	8.6%	-9.6%
6	Analgesics, Opioid	Suboxone, hydrocodone acetaminophen	-2.0%	0.9%
7	Dermatologicals	permethrin, Lidoderm	3.2%	19.5%
8	Analgesics, Anti-inflammatory	Humira, Enbrel	4.0%	16.2%
9	Endocrine and Metabolic Agents	Tev-tropin (hgh), Acthar HP (MS)	-2.2%	25.8%
10	Psychotherapeutic and Neurological Agents	Copaxone, Rebif	10.5%	16.8%

Medicaid covers about 62 million low-income Americans, including one in three children. It covers people in long term care and those with disabilities and complex needs.[29] It also provides extra assistance to some Medicare beneficiaries, (the "dual eligibles"). Benefits and eligibility vary widely from state to state. Under health care reform, Medicaid eligibility was to be expanded to people under 65 with incomes at or below 138 percent of the federal poverty level. The Supreme Court ruling on the ACA, delivered in 2012, made that expansion optional for the states.

Twenty-seven states had committed to move ahead with the expansion by early April. Nineteen have determined they will not expand. The rest are weighing their options. The ACA provided that the federal government would fund most of the Medicaid expansion for the states; this expansion is exempted from sequestration, although other cost-sharing subsidies for people buying insurance on the exchanges would be affected.

Medicaid is one of the largest single purchasers of prescription drugs in the country, accounting for about 10 percent of the $250 billion U.S. market in 2009.[30] Each state determines how to manage the prescription benefit under managed Medicaid plans. In some states, prescribers can bypass utilization management procedures for certain categories, such as behavioral drugs. Some states carve out specific categories, mandate that a specific formulary be used, or put caps on the number of prescriptions they will cover. These regulations have an impact on trend management, and trend results vary widely among the various Medicaid plans.

In our 2012 analysis, top-spend drugs for Medicaid plans included medications used for asthma and diabetes as well as complex conditions such as HIV, hepatitis C, multiple sclerosis, and rheumatoid arthritis. It's expected that when and where eligibility is expanded, the Medicaid populations will be more diverse and include more adults. The expanded population is likely to present a different set of pharmaceutical needs and management challenges.

Like Medicare, Medicaid will continue to be a focus of cost- and deficit reduction efforts. Additional changes as part of eventual budget resolution cannot be discounted.

Medicaid, accounts for about 10% of U.S. prescription utilization.[30]

Market Trends and Forecasts

In 2014, the ACA's individual mandate goes into effect: most Americans will need to have health insurance. That mandate, along with a host of other provisions, has precipitated change across the country. Key trends include:

Shifting benefit design. The share of Americans with employer-sponsored insurance has been slowly declining for a decade.[31] Most employers are expected to continue to offer coverage, but many may change how they structure it. Many are considering a defined contribution plan, wherein employees would receive a set amount of money to purchase their own insurance. This allows employers to set a threshold on their contribution and better control cost growth.

New markets. The ACA mandates that each state have an insurance exchange, a marketplace for those seeking coverage. It's estimated that over 20 million people will be accessing the exchanges to purchase insurance. To serve this market, private exchanges are also being launched across the country.

Appealing to the new buyer. Health plans are working to shift their

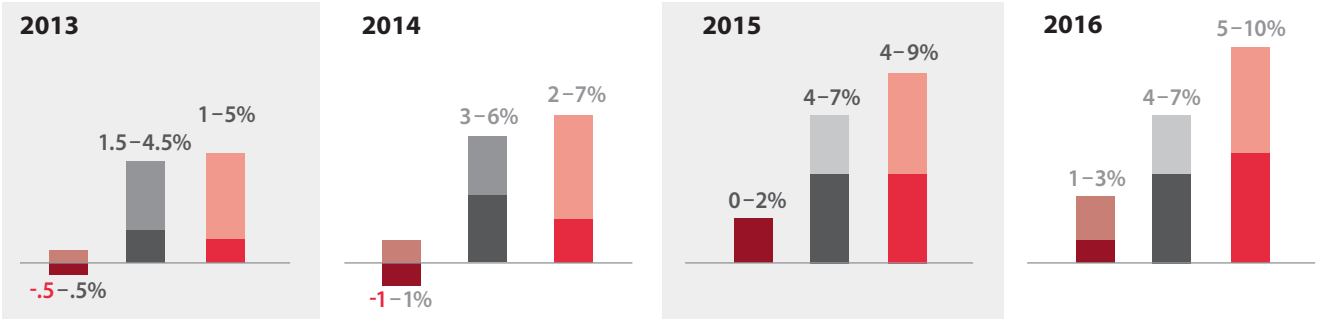
INSIGHTS

CVS CAREMARK DRUG TREND FORECASTS

Figure 9

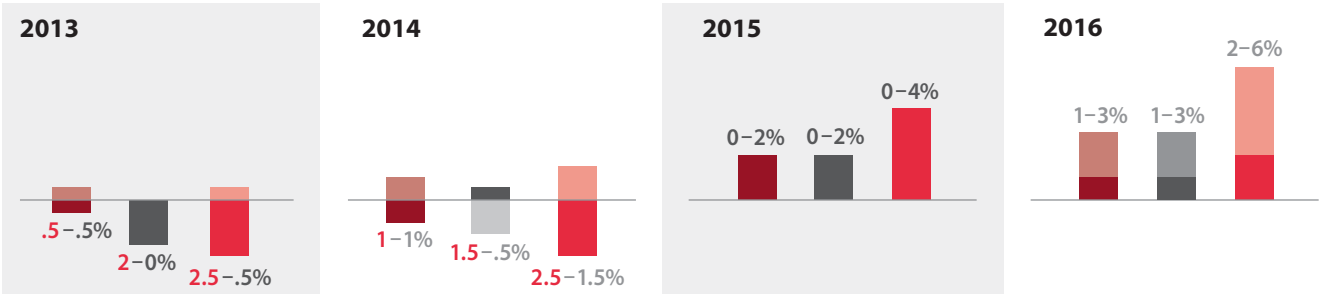
Overall Drug Trend PMPY

UTILIZATION RATE PRICE/DRUG MIX RATE TOTAL



Non-Specialty Drug Trend PMPY

UTILIZATION RATE PRICE/DRUG MIX RATE TOTAL



business model to serve the new individual market. Plans recognize that buyers will be highly cost conscious. Many will be willing to accept narrower networks, limited formularies and tighter care management in exchange for lower costs.

Value over volume. Plans are working with providers to improve cost control and outcomes, often collaborating on new delivery models that provide incentives for quality of care.

Government's role. According to CMS estimates, federal, state and local health care spending is projected to be nearly 50 percent of national health expenditures by 2021.[32]

Forecasting Prescription Benefit Trend. The forecasts provided here look at underlying secular drug trend—the PMPY gross cost increase that would prevail if no plan design or demographic changes occur—for health plan and employer accounts. We've taken projected drug launches into account, including projected first-time generic entrants. After 2015, with fewer high-impact generic launches, we expect that drug mix will become less of a moderating influence.

The newly insured are expected to access more health services, leading to a sharp increase in prescriptions in 2014. However, analysts looking at overall utilization of health care services expect continued slow growth, largely due to economic concerns. We agree; utilization of non-specialty pharmaceuticals will continue to be slow.

Economic concerns have less impact on specialty utilization. Moreover, the rush of new specialty drug launches is expected to continue with 43 potential launches in 2013. These new launches will drive price and utilization trend. Specialty will continue to be the major driver of overall trend.

GDR Forecast, BOB

2013: 79%-83%

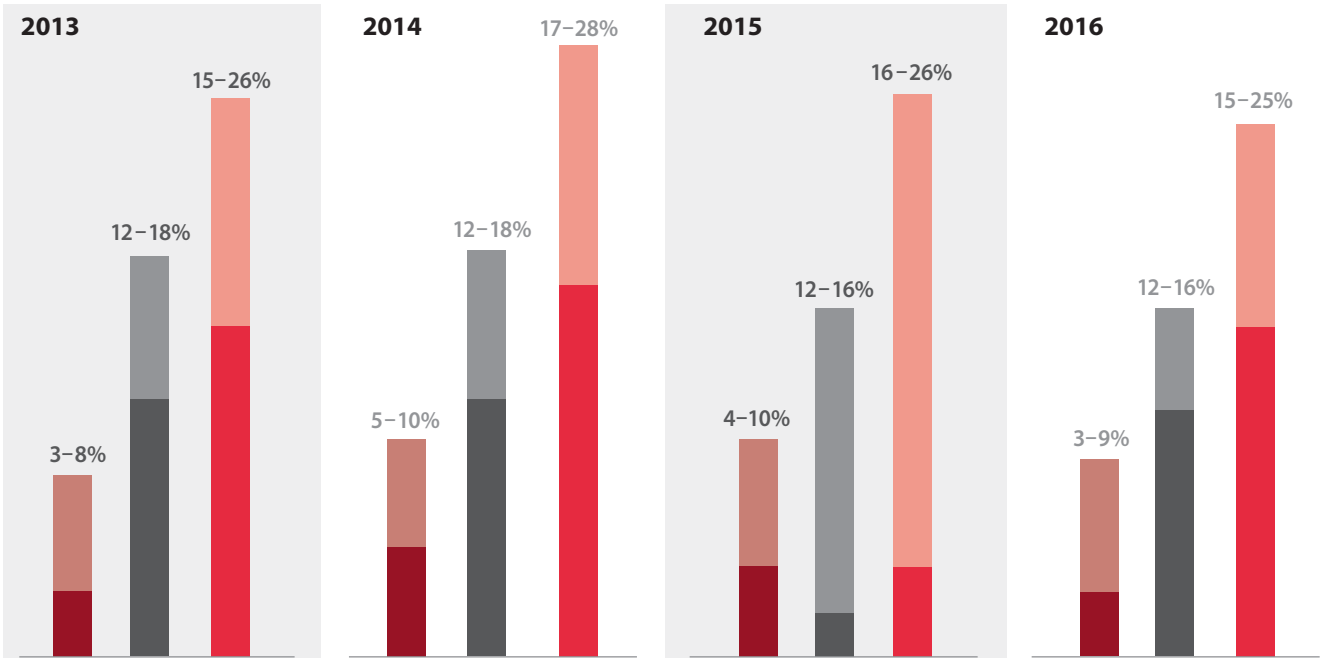
2014: 80%-84%

2015: 82%-86%

2016: 83%-87%

Figure 10

Specialty Drug Trend PMPY



This analysis is an estimate for informational purposes only. These estimates do not represent an existing or future contractual guarantee provided by CVS Caremark.

1. CVS Caremark Enterprise Analytics, 2012.
2. CVS Caremark Enterprise Analytics, 2012.
3. 2011 New England Opinion focus group of specialty patients, calls to 150 retail pharmacies (CVS and competitors) on January 13-15, 2012.
4. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates, *Health Affairs*, July 2012.
5. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Spending in 2011: Overall Growth Remains Low, But Some Payers and Services Show Signs of Acceleration, *Health Affairs*, January 2013.
6. Robert Wood Johnson Foundation, Consumer Attitudes on Health Care Costs: Insights from Focus Groups in Four U.S. Cities, January 2013.
7. PwC Health Research Institute, Top Health Industry Issues of 2013, January 2013.
8. New York Times, "In Hopeful Sign, Health Spending is Slowing Down," April 29, 2012.
9. PwC Health Research Institute, Top Health Industry Issues of 2012: Connecting in Uncertainty, November 2011.
10. Health Affairs Blog, by David Muhlestein, February 19, 2013, "Continued Growth of Public and Private Accountable Care Organizations"
11. Robert Wood Johnson Foundation, Consumer Attitudes on Health Care Costs, January 2013.
12. Analysis based on CVS Caremark BOB Data, CMS, IMS Health Report, Credit Suisse, Buck Consultants, National Health Spending Projections.
13. http://specialty.phamacytimes.com/publications/:::issue:::/2012/February-2012/Orphan-Drugs-Small-Markets-Big-Opportunity, accessed 2/26/13.
14. Hepatitis C information for health professionals. Atlanta, GA: Centers for Disease Control and Prevention; 2011.http://www.cdc.gov/hepatitis/hcv/index.htm.
15. http://www.hepatitiscmsg.org/hep-c-facts--stats.html.
16. http://health.usnews.com/health-news/articles/2012/08/21/the-cdc-wants-baby-boomers-tested-for-hepatitis-c-now-what.
17. http://www.cdc.gov/hepatitis/hcv/pdfs/hepcgeneralfactsheet.pdf.
18. National Multiple Sclerosis Society.
19. Castelli-Haley J, Lage MJ, Oleen-Burkey MKA, Johnson KP. Glatiramer acetate versus interferon beta-1a for subcutaneous administration: comparison of outcomes among multiple sclerosis patients. Adv Ther. 2008; 25(7):658–673.
20. http://americannewsreport.com/cost-of-multiple-sclerosis-drugs-soaring-8816051.
21. http://www.medicinenet.com/multiple_sclerosis/article.htm. Accessed March 2012.
22. Drugs.com, accessed March 14, 2013.
23. Sector & Sovereign Research LLC, "Copay Cards: A Bottle for the Drug Pricing Genie," Aug 7, 2012.
24. Projected 2012-2015 metrics are based on CVS Caremark BOB data assuming no formulary changes.
25. William H. Shrank, Niteesh K. Choudhry, Joshua N. Liberman, Troyen A. Brennan, The Use Of Generic Drugs In Prevention Of Chronic Disease Is Far More Cost-Effective Than Thought, And May Save Money, *Health Affairs*, July 2011.
26. National Health Spending in 2011: Overall Growth Remains Low, But Some Payers and Services Show Signs of Acceleration, *Health Affairs*, January 2013.
27. Center on Budget and Policy Priorities, Policy Basics: Where Do Our Federal Tax Dollars Go?, revised August 13 2012.
28. "Analysis: Obama may turn Medicare reform into wider health debate," Reuters, January 6, 2013.
29. Kaiser Family Foundation, Medicaid: A Primer 2013.
30. Kaiser Commission on Medicaid and the Uninsured, September 2011.
31. Gould, Elise, "A decade of decline in employer sponsored health insurance coverage," Economic Policy Institute, February 23, 2012
32. Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates," *Health Affairs*, published online June 12, 2012.

2012 Trend Methodology

All trend calculations are based on a trend cohort group. The trend cohort includes funded clients with retail claims for the calendar year and includes clients in the commercial segments (health plan and employer), Medicare and Medicaid. To be included in the trend cohort, clients need to have at least 24 months of continuous claim activity. Average eligibility must be within ±20 percent period over period for the commercial clients; for Medicare and Medicaid, average eligibility must be within ±25 percent period over period. The 2012 CVS Caremark trend cohort consists of 23.8 million members.

Specialty trend includes all claims for drugs from the universal specialty drug list, regardless of dispensing pharmacy, dispensed in the 24-month period. Non-specialty trend is based on claims for all drugs excluding the universal specialty drug list.

AWP trend is based on vendor AWP.

Subscribe to Receive Future Issues of INSIGHTS

Roles and strategies are evolving rapidly in health care today. Future issues of INSIGHTS will provide timely updates on new approaches to pharmacy management and its role in health care cost reduction. Subscribe online to receive notification when future issues are released: tinyurl.com/bnbtk4l

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.
© 2013 Caremark. All rights reserved.

CVS CAREMARK

Caremark.com

©2013 Caremark. All rights reserved. 106-27893a 040513