STATE OF MICHIGAN

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Pharmacy
Provider Class Plan Determination
Report pursuant to Public Act 350 of 1980
_____/ No. 06-006-BC

Issued and entered
This 19th day of December 2007
by Ken Ross
Acting Commissioner

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to Public Act 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of the Office of Financial and Insurance Services (Commissioner) issued Order No. 05-045-BC on September 15, 2005, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of her intent to make a determination with respect to the pharmacy provider class plan for calendar years 2003 and 2004.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.

2. BCBSM has complied with all applicable provisions of the Act.

3. All procedural requirements of the Act have been met.

4. The staff reviewed relevant data pertaining to the pharmacy provider class plan as discussed in the attached report, including written comments received during the input

period on the provider class plan. The input period was designed to provide the public with an opportunity to present data, views, and arguments with respect to the pharmacy provider class plan.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

III

ORDER

Therefore, it is ORDERED that:

1. The attached pharmacy provider class plan determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the pharmacy provider class plan for the calendar years 2003 and 2004.

2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.

3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.

Ken Ross
Acting Commissioner

PHARMACY

PROVIDER CLASS PLAN

DETERMINATION REPORT

for calendar years 2003 and 2004

Office of Financial and Insurance Services

State of Michigan

PHARMACY

PROVIDER CLASS PLAN

DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to Public Act 350 of 1980, this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Nonprofit Health Care Corporation Reform Act for calendar years 2003 and 2004. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 2003-2004 pharmacy provider class plan annual report, additional data requested of BCBSM, and information on file with respect to this provider class plan. This material was supplemented as necessary by data from published sources. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balance among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to pharmacy services whenever necessary. In analyzing BCBSM's performance on the access goal, consideration was given to the formal participation rates of pharmacies, the mail order program and access to high-tech, high cost medications. BCBSM was able to maintain a 100% formal participation rate throughout Michigan during 2003 and 2004. BCBSM's mail order program grew in popularity during the review period and accounted for 37% of total prescription drug payments in 2004. BCBSM provided a two percent reimbursement incentive to pharmacies willing to supply high cost/high tech medications. Based on these facts, it is determined that BCBSM met the access goal during 2003 and 2004.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for pharmacy services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 2003 and 2004, BCBSM continued to monitor pharmacy provider qualification standards, and implemented and maintained a variety of quality control standards and utilization management initiatives. BCBSM kept the lines of communication open with pharmacy providers with regular meetings of the Pharmacy Advisory Committee as well as regular communications with providers through its monthly publication of the *Record*, provider manuals and appeal processes. It is therefore determined that BCBSM met the statutory goal for calendar years 2003 and 2004.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated to be 3.6% for the period under review. As the rate of change in the total corporation payment per member for the pharmacy provider class has been calculated to be an increase of 18.4% over the two years being reviewed, BCBSM did not meet the cost goal stated in the Act for 2003 and 2004.

Overall Balance of Goals

In summary, although BCBSM did not substantially achieve one of the three statutory goals for the pharmacy provider class plan for the two year period under review, a change in the plan is not required because, as discussed in the body of this report, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve all of the goals is reasonable, due to factors listed in Section 509(4).

Determination Report
Order No. 06-006-BC

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the pharmacy provider class plan for the calendar years 2003 and 2004.

In addition to the final determination, this report will: define a provider class plan, explain the statutory review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings, which support that determination.

Provider Class Plans - Legal Background

Section 107(7) of the Act, defines a provider class plan as "a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers includes not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for services provided to a BCBSM member.

2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.

3. BCBSM must compensate providers in accordance with reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Section 509(4) of the Act requires the Commissioner of Financial and Insurance Services (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM, which pertain to each respective provider class;

2. Comments received from subscribers, providers, and provider organizations;

3. Health care legislation;

4. Demographic, epidemiological and economic trends;

5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations pursuant to Section 510(1) of the Act:

(a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.

(c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. If after six months or such additional time as provided for in Section 512, BCBSM has failed to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the Pharmacy Provider Class Plan

The pharmacy provider class for BCBSM covers prescription drug benefits such as "by prescription only" drugs and state-controlled drugs; injectable insulin; disposable syringes and needles when dispensed with insulin or with a chemotherapeutic drug; and compound drugs containing at least one "by prescription only" drug. Prescription drug benefits do not include therapeutic devices or appliances or contraceptive medications or devices (unless the customer requests such coverage be included as part of a benefit plan or the member has prescription drug coverage that excludes contraceptive medication but such medication is used instead to treat a medically necessary condition); drugs prescribed for cosmetic purposes, or medications not requiring a prescription, except insulin and diagnostic agents.

For the period 2003-2004, payments to pharmacy providers represented an average of 52.4% of the total benefit payments made to health care providers on behalf of BCBSM members. Retail claims comprised 33.1% of the total benefit payments made to pharmacy providers and 19.3% of the total benefit payments were made to mail order pharmacies.

For the purpose of provider class plan reviews by the Office of Financial and Insurance Services (OFIS), paid claims data are categorized by nine geographic regions. A map, which depicts these geographic regions, is included in Attachment A.

BCBSM's qualification standards for retail pharmacies include licensure by the state of Michigan with a Michigan location and a current Drug Enforcement Agency registration. BCBSM's qualification standards for mail order pharmacies are licensure by the state in which they are located with a current Drug Enforcement Agency registration.

Although the Act requires BCBSM to only report information pertaining to BCBSM's traditional benefit program, BCBSM has reported information pertaining to its Preferred Rx program for the pharmacy provider class because it is unable to separate traditional membership from PPO membership for the pharmacy provider class. During the review period, reimbursement to retail pharmacies varied depending upon whether the BCBSM member was enrolled in BCBSM's traditional or Preferred Rx program. The reimbursement formula for pharmacy services dispensed for traditional program members was the sum of the drug product cost plus the dispensing fee, minus the member's copay amount, plus any applicable incentive payment. The reimbursement formula for pharmacy services dispensed for the Preferred Rx program members was the sum of the drug product cost and dispensing fee, which includes any applicable incentives, minus the member's copay amount. BCBSM reimburses participating mail order pharmacies for covered mail order brand name and generic drugs the lesser of the discounted average wholesale price or the submitted ingredient cost, plus a dispensing fee, minus any specific member copayment.

During the review period, pharmacy providers could participate with BCBSM only under its formal participation program. A formally participating provider has signed an agreement to accept BCBSM reimbursement as payment in full, excluding applicable co-payments or deductibles, for all covered services rendered to BCBSM members by the provider. Members who receive covered drugs from a nonparticipating pharmacy in the United States are directly reimbursed at 75% (100% for emergency pharmacy services) of the pharmacy's charge minus the member's copay amount. For covered drugs obtained from a nonparticipating pharmacy outside the United States, BCBSM reimburses the member for the drug product cost and dispensing fee, minus the member's copay amount.

BCBSM is required to include as part of each provider class plan its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the pharmacy provider class plan are as follows:

Access:

- To ensure adequate availability of the high quality pharmacy services, throughout the state, at a reasonable cost to BCBSM subscribers.

Quality of Care:

- To ensure provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for pharmacy provider participation.

Cost:

- To strive toward limiting the increase in the total pharmacy providers' payments per member to the compound rate of inflation and real economic growth as specified in Public Act 350, giving special consideration to Michigan and national health care market conditions.

- To provide reimbursement to pharmacy providers in return for high quality services which are medically necessary and delivered to BCBSM subscribers at a reasonable cost.

History of the Pharmacy Provider Class Plan

BCBSM had an existing reimbursement arrangement with pharmacists in effect when the Act took effect on August 27, 1985. BCBSM first filed the pharmacists' provider class plan

with OFIS pursuant to Section 506(1) of the Act on August 17, 1987. Section 506(2) states:

"Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."

Section 506(2) further states:

"For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the pharmacists' provider class plan met the filing requirements of Section 506 of the Act stated above, OFIS notified BCBSM by letter on September 3, 1987 that the pharmacies' provider class plan was placed into effect and retained for the commissioner's records pursuant to Section 506(4).

On November 5, 1987, BCBSM amended all of its provider class plans, including the pharmacists' plan, to include an appeal process for utilization review audits performed by the corporation. This amendment to the pharmacists' provider class plan was made by BCBSM in accordance with Section 508(1) of the Act.

Prior to December 9, 1993, the name of this provider class plan was the pharmacists' provider class plan. BCBSM renamed the plan to the pharmacy provider class plan inasmuch as the provider contract is between BCBSM and the pharmacy, not BCBSM and the individual pharmacists. Other changes to the plan filed on December 9, 1993 included changes to the reimbursement methodology, the participation agreement and the addition of a mail order pharmacy participation agreement.

The pharmacy provider class plan was modified by BCBSM on February 23, 1995, November 4, 1996 and December 26, 1997. The various modifications BCBSM made to the plan included the to implementation of a participation contract for mail order providers, and changes in the reimbursement methodology used to pay pharmacy providers and the appeal process available to non-hospital, non-physician providers.

BCBSM also modified the pharmacy provider class plan on August 30, 2005. BCBSM updated its language regarding reimbursement, and reformatted the provider class plan to reflect the current mail order pharmacy program.

Role of the Physician in the Health Care System

Physicians are the primary decision makers in the level of care and the volume of services that are provided to their patients. Physician practice patterns therefore not only affect the utilization and related costs for the physician provider classes, but also impact on each of the other provider classes. Many patients are insulated from the real costs of the treatment, procedures or medications prescribed by physicians because they have health care coverage to pay the cost of these services. These patients tend to demand the latest medications on the market when a less expensive medication or procedure may do the job just as well. These patient driven decisions have a negative effect on utilization and cost.

The manufacturers of health care equipment, products and medications undoubtedly influence physicians, as they rely upon the information presented and/or provided to them by the manufacturers' representatives that routinely visit their practices. Physicians relying extensively on the information provided to them by pharmaceutical representatives may be totally unaware of the costs associated with the new extended release drugs like Effexor XR or for lifestyle drugs like Viagra.

The pharmaceutical industry continues to play a major role in how physicians prescribe treatment and medications to their patients. However, in recent years, companies providing health care coverage, like BCBSM, as well as their customer groups have instituted a variety of policies with respect to the types of drugs physicians can prescribe to their patients in an effort to control spiraling prescription drug costs. Examples of these policies include the use of drug formularies and tiered copay levels based on generic and brand name drug usage. The implementation of these policies find physicians paying more attention to the efficacy of generic drugs and what medications are covered by their patient's health coverage before they write out prescriptions for some of the brand name drugs requested by their patients because of what they may have seen or read in an advertisement by pharmaceutical companies.

Review Process

On September 15, 2005, the Commissioner issued Order No. 05-045-BC, which provided written notice to BCBSM, health care providers, and other interested parties of her intent to make a determination with respect to the pharmacy provider class plan for the calendar years 2003 and 2004. Order No. 05-045-BC also called for any person with comments on matters concerning the provider class plan to submit such comments to OFIS in accordance with Section 505(2) of the Act. Section 505(2) requires the Commissioner to establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. Requests for testimony on BCBSM's pharmacy provider class plan were sent

to all those of OFIS' interested persons list for the pharmacy provider class and posted on OFIS' website, providing interested parties three months to prepare and submit testimony.

Summary of Testimony and Input:

Although requests for testimony regarding the pharmacy provider class plan were sent to those on OFIS' interested persons list, including the Michigan Pharmacy Association, and posted on OFIS' website, no testimony regarding the pharmacy provider class plan was received during the review period.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act states that "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to pharmacy services covered under the terms of that member's certificate whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIS staff examined several aspects of how access to pharmacy services could be obtained, including the formal participation rates of providers, to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

The following information, supplied to OFIS in September 2005, by BCBSM, shows the number of Michigan participating pharmacies and membership by geographic region for calendar years 2003 and 2004:

Pharmacy Provider Class Plan
Formal Participation Rates

	2003			2004		
	No. of Par Providers	Total Providers	Par Rate %	No. of Par Providers	Total Providers	Par Rate %
Region 1	1,024	1,024	100%	1,065	1,065	100%
Region 2	107	107	100%	107	107	100%
Region 3	137	137	100%	136	136	100%
Region 4	104	104	100%	107	107	100%
Region 5	209	209	100%	213	213	100%
Region 6	249	249	100%	250	250	100%
Region 7	158	158	100%	162	162	100%
Region 8	125	125	100%	132	132	100%
Region 9	65	65	100%	63	63	100%
Statewide	2,178	2,178	100%	2,235	2,235	100%

BCBSM states that it maintained an average statewide formal participation rate of 100% during 2003 and 2004. BCBSM did not deny participation to any provider who met its qualification standards for participation.

Two Toledo, Ohio pharmacies also participate with BCBSM but are not included in the participation percentages calculations because they are not Michigan based pharmacies. These two pharmacies have participated with BCBSM for many years; however, current BCBSM policy no longer permits additional out-of-state pharmacies to participate with BCBSM. The above participation rates do not include pharmacy providers such as inpatient hospital pharmacies, nuclear pharmacies, prison pharmacies, veterinary hospital pharmacies or clinic pharmacies associated with other insurers.

The number of participating pharmacies increased from 2003 to 2004. OFIS requested a breakdown of chain and independent pharmacies by region for the time period under review. BCBSM was not able to produce an accurate breakdown of both pharmacy types for 2003 and 2004 so instead provided a current breakdown through January 2006. This data reveals chain pharmacies overall make up 58% of BCBSM's participating pharmacies with independent pharmacies making up 42%. Many of the chain pharmacies are located in the more developed central and southern Michigan areas, with more independent pharmacies available to serve BCBSM members in northern Michigan and the Upper Peninsula.

Michigan Pharmacies by Region and Status as of January 2006

Region	Chain	Independent	Total
1	696	391	1,088
2	58	50	110
3	91	47	141
4	58	48	110
5	98	111	214
6	159	101	266
7	82	81	170
8	53	80	141
9	19	44	72
Total	1,314	953	2,267

The following data was reported by BCBSM with regard to the number of both chain and independent pharmacies, by region, that opened and closed during the two-year review period:

	Chains			Independents			
Region	Opened	Closed	Net Gain/ Loss	Opened	Closed	Net Gain/ Loss	Total Net Gain/Loss
1	43	50	(7)	61	37	24	17
2	6	2	4	1	8	(7)	(3)
3	6	9	(3)	3	3	0	(3)
4	4	5	(1)	1	6	(5)	(6)
5	7	5	2	8	7	1	3
6	15	5	10	7	10	(3)	7
7	7	5	2	7	5	2	4
8	4	4	0	7	2	5	5
9	2	0	2	3	5	(2)	0
Total	94	85	9	98	83	15	24

This data reveals the overall number of changes in the availability of chain and independent pharmacies available throughout the state during the two-year period under review were similar.

Since 1994, BCBSM's mail order drug program has provided an additional source of access to BCBSM members. BCBSM contracts with one vendor to manage the mail order

program. BCBSM's mail order provider is required to comply with all applicable legal and regulatory requirements governing its mail order operations, including licensure, Drug Enforcement Agency registration, sufficient liability insurance, fiscal soundness and the absence of inappropriate utilization practices, fraud and illegal activities.

Eligible members may use the mail order program to obtain almost any drug covered under BCBSM's prescription drug plans. Mail service is most often used and most beneficial for obtaining drugs prescribed on a long-term basis for chronic conditions like high blood pressure, high cholesterol, heart disease, or stomach disorders. Eligible members can obtain up to a 90-day supply of prescription drugs by mail instead of the maximum standard 34-day supply a local pharmacy is allowed to dispense. In 2003, mail order prescriptions accounted for 24% of payments and 11% of utilization. In 2004, mail order prescriptions represented 37% of total prescription drug payments and 19% of total prescription drug utilization.

Provisions in BCBSM's traditional pharmacy agreement requires all participating retail pharmacies to use their best efforts to obtain or assist members in obtaining prescribed medications, including high cost or high tech drugs that are not routinely stocked. BCBSM offers an additional two percent reimbursement incentive to those pharmacies that supply high cost or high tech drugs to assure customer access to drugs not readily available due to the cost of supplying them. BCBSM believes access to all pharmaceutical drugs has improved because of an increased number of participating pharmacies, the increase in use of the mail order option and the incentives in place for pharmacies to make high cost drugs available to BCBSM members. No testimony was received during the review period indicating BCBSM members have had difficulties obtaining access to high cost/high tech medications.

BCBSM states its goal is to make it easy for providers to work with BCBSM by providing them with the tools and information needed to render quality care using the best available technologies. One way BCBSM believes it meets this goal is by having a payment policy that provides incentives for high-quality and cost-effective care. BCBSM's reimbursement policies for the traditional, preferred and mail order prescription drug programs are described on page 3 of this report.

BCBSM states its reimbursement levels were reviewed as necessary during the reporting period. On January 1, 2003, BCBSM states it reduced the Preferred Rx pharmacy dispensing fee by $.50 per script. Along with this decrease, BCBSM offered pharmacies an enhanced generic incentive rate. In order to receive the enhanced incentive, pharmacies had to complete the Institute for Safe Medication Practices (ISMP) ambulatory/community survey described in the quality of care section of this report.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered pharmacy services. During the 2-year period under review, BCBSM participated with all Michigan retail pharmacies. Access to BCBSM participating providers actually increased during the period under review as a result of the addition of 57 new pharmacy locations. As such, it is evident that BCBSM members had no difficulty obtaining reasonable access to retail pharmacy services. BCBSM also provided incentives to participating pharmacies to supply high cost/high tech drugs. BCBSM members were also able to obtain prescription medications through BCBSM's mail order pharmacies. Based on the information analyzed during this review, it is therefore determined that BCBSM met the access goal stated in the Act for calendar years 2003 and 2004.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, OFIS staff examined BCBSM's achievement of its quality of care objective, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's methods of communication with pharmacies. We reviewed these factors to assure that BCBSM not only encouraged provider compliance with the expected standards of pharmacy services, but also that it kept abreast of new technological advances available to treat those BCBSM members that require such services. All of the above factors impact the quality of outpatient pharmacy services delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review period, are described below.

BCBSM has taken a twofold approach to achieving its quality of care objectives for the pharmacy provider class. First, BCBSM attempts to promote the quality of health care delivered by providers through the enforcement of provider qualifications and utilization review programs and by assessing patterns of care in Michigan pharmacies and providing pharmacies with incentives to improve the quality of care. Second, BCBSM strives to forge strong relationships with participating providers by designing programs directed toward effective servicing and communication.

To ensure acceptable levels of care are provided by pharmacies providers, BCBSM requires that these providers meet the participation qualifications and performance

standards listed on page 3 of this report. BCBSM states that provider qualification status is continually monitored to ensure subscriber access to competent providers who are not involved in fraud or illegal activities.

BCBSM states pharmacy providers must maintain documentation for all claims based on BCBSM guidelines. The guidelines ensure the appropriate medically necessary prescription drug information is included before a prescription is filled. Documentation must be legible, dated, signed with professional credentials noted and prepared as soon as possible after the service is performed. Documentation guidelines for specific types of service are included in the *Guide for Pharmacists*. General requirements include dosage, quantity and refill instructions; dispense as written instructions; physician signature; the DEA number of the physician writing the prescription; and, the date of the prescription.

BCBSM managed drug utilization through prospective, concurrent and retrospective drug utilization initiatives. These initiatives are designed to identify and avoid adverse drug interactions before, during and subsequent to the prescription being dispensed. BCBSM maintains a drug formulary that provides intervention on prescription medications before a drug is ever dispensed to a BCBSM member. The BCBSM drug formulary is a list of FDA-approved prescription drugs the BCBSM/BCN Pharmacy and Therapeutics Committee have determined to be high quality and cost effective for patient care. BCBSM's Pharmacy and Therapeutics Committee is comprised of 14 physicians (eight are BCBSM employees), seven pharmacists (five are BCBSM employees) and two consumer advocates (neither employed by BCBSM). The committee members represent West Michigan, Mid-Michigan and Southeast Michigan. The Upper Peninsula and Northern Lower Peninsula are not represented on the committee at this time.

The formulary selected by BCBSM's Pharmacy and Therapeutics Committee is based on clinical effectiveness, safety and cost. BCBSM states the formulary represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health.

During most of the two-year period under review, BCBSM used the Drug Risk Analysis Message System (DRAMS) for prescription drug dispensing. Drug information was processed through an online, real-time drug claim system designed to alert pharmacists to quality issues such as potential contraindications and drug-to-drug interactions. The DRAMS system detects potential problems before the drug is dispensed.

In 2003, the top five-drug interaction edit categories identified through DRAMS were high dose alert, over-maximum dosage, drug pregnancy precaution, cumulative days supply limit and controlled substance within 14 days. These categories accounted for 72% of all drug interaction edits.

In November 2004, BCBSM replaced DRAMS with MedImpact, a new drug claim processing system for claims processed in Michigan. MedImpact has many features quite similar to DRAMS, but also offers more managed care options. MedImpact offers better utilization management tools and safety features such as severe drug interactions, monitoring minimum and maximum dosing, and prior authorization and step therapy. Prior authorization is a process requiring a physician to obtain approval from BCBSM before prescribing select prescription drugs with a potential for alternative use or misuse. In order to be eligible for coverage of any of these classes of drugs, the member must have experienced the failure or intolerance to alternative drugs. Examples of drugs needing prior authorization include Pravachol (cholesterol lowering medication), Celebrex (arthritis medication), Strattera (ADHD medication) and Singulair (asthma medication).

Step therapy is a form of prior authorization. It requires a member to try less expensive drugs before BCBSM will cover a non-formulary brand name drug. Thus, for those groups having step therapy as part of their benefit package, a member would be required to first try a generic equivalent to the prescribed drug (if there is one). If the generic drug did not work or caused side effects, then the member would be required to try an available formulary brand name drug. If the formulary brand name drug did not work or caused side effects, then the non-formulary brand name drug will be covered. In step therapy, a BCBSM member will be required to try only drugs in the same therapeutic class as the originally prescribed drug. BCBSM contends the MedImpact system improves quality of care, prevents adverse drug reactions and ensures that selected drugs are used appropriately.

BCBSM has implemented several innovative programs geared toward better quality care through patient compliance and the effective and safe dispensing of medication. One such program is the DOSE pilot program. The pilot phase of the Dosing, Optimally, Simply, Effectively (DOSE) Program was completed in January 2002. The program was developed to increase compliance and optimize therapeutic outcomes by assisting patients in converting from twice daily dosing to once-daily dosing. Once a patient has reached the therapeutic goal on a specific medication, therapy is reviewed to identify the simplest regimen. Adjusting a multiple dose regimen can improve patient adherence to the regimen and reduce costs.

BCBSM states the pilot program resulted in a 42% conversion rate and a follow-up survey with physicians identified that over 90% of the physicians felt patient compliance was enhanced through dose optimization without sacrificing quality of care. The pilot has shown that dose optimization is an intervention that maintains or improves quality of care while addressing prescription drug costs. BCBSM states the direction of the DOSE program has recently changed. BCBSM's initial intent was to put edits in the system at the point of sale to require pharmacies to contact the physician asking the physician to consider converting the prescription from a multiple daily dosage to a single daily dosage.

As pharmacies have expressed concerns having such edits at the point of sale may cause disruption to the member, BCBSM states the next phase of this program is to automatically send letters to prescribers of targeted drugs, asking that they consider converting the prescription from multiple to single daily dosing before involving the member. BCBSM continues to assess how best to implement its intent to add hard code edits to its systems at the point of sale.

Another BCBSM initiative is the Generic Drug Incentive Program. BCBSM continues to bring awareness to its members about the quality, value and safety of generic drugs through its education and generic incentive programs. During 2003, BCBSM mailed letters and preferred generic drug coupons to members identified as receiving targeted brand-name drugs. The members were offered an incentive to switch to a generic prescription drug. In 2003, BCBSM targeted 12,437 members, and of that number, 749 redeemed a coupon and converted to a generic drug. BCBSM did not mail any incentive coupons in 2004, but states it is in the preliminary stage of developing a new program that would waive the first fill copay for members that convert from brand name to generic drugs.

BCBSM currently sends generic incentive letters to each pharmacy participating in its Preferred Rx Network on a quarterly basis. These letters inform pharmacies of the upcoming quarterly generic incentive rate. BCBSM also provides physicians with educational materials to share with their patients that describe the safety and effectiveness of generic drugs.

During the review period, BCBSM's physician prescribing pilot was in effect during this reporting period. The program focused on generic substitution and dose optimization. Patient quality was addressed by allowing physicians to maintain utilization levels at or above baseline levels for nine therapeutic classes of medications where there is accepted use of evidence-based medicine. The program assigns each participating physician organization a dedicated member of the BCBSM physician education team. The team consists of clinical pharmacists trained as "counter-detailers" to bring physicians unbiased information pertaining to the physician's specific prescribing habits. The program has been successful using a process of "gradual acceptance" that introduces the concept of intervention to physicians, garners their endorsement, and then provides physicians with information that allows them to change their practice patterns.

According to the Journal of the American Pharmaceutical Association, the average pharmacist makes four errors in filling prescriptions every day. BCBSM states it created an alliance with Michigan's pharmacy regulatory agency and the Institute for Safe Medication Practices (ISMP) to promote the ISMP medication safety self-assessment survey tool. The tool is designed to assess the safety of medication practices in the pharmacy, identify opportunities for improvement and compare a pharmacy's experience with the aggregate experiences of demographically similar community pharmacies around the nation. The

ultimate goal is to make them aware of best practices. The survey assesses staff competency, education, quality processes and risk management. By the end of 2004, a total of 1,698 pharmacies, comprising 75.3% of BCBSM participating pharmacies, completed the self-assessment survey. BCBSM states it also has made changes to its Preferred Rx Networks to increase emphasis on quality and member safety by requiring the completion of the ISMP safety self-assessment tool in order to participate in the new generic incentive program.

Further, BCBSM has partnered with the Michigan Pharmacist Association to form the Michigan Medication Safety Coalition to reduce prescription drug errors through education. The coalition is currently involved in several initiatives that impact patient safety in the community such as electronic prescribing, bar coding of prescriptions and federal and state regulations. The coalition served as a catalyst to address causes of errors in community pharmacies and to share strategies to prevent future errors.

BCBSM also joined the Michigan for Affordable Pharmaceuticals (MAP) Coalition with other health care plans, employers, union groups and health care providers to address pertinent legislative issues that will contain pharmaceutical costs while ensuring access and overall improved health care. The goal of the coalition is to increase awareness by legislators of issues impacting the affordability of prescription drugs with the intent of changing laws. MAP is currently focusing on the timely availability of generic medications, direct-to-consumer advertising guidelines, drug safety and over-the-counter conversion of prescription drugs. BCBSM notes that legislation was introduced in Congress that was intended to ensure that less costly medications are made available to consumers in a timelier manner. Senate Bill 54 entitled, "Greater Access to Affordable Pharmaceuticals Act of 2003", would have amended the Federal Food, Drug and Cosmetic Act to revise provisions concerning the timing of generic drug availability. The bill was introduced early in 2003 and referred to the Senate Committee on Health, Education, Labor and Pensions but never saw any floor action. BCBSM states that many of the bill's provisions were rolled into the Prescription Drug and Medicare Improvement Act of 2003 that was enacted.

To promote high-quality cost-effective prescribing of prescription medication, BCBSM also partnered with ePocrates, a provider of internet-based technology, to provide its prescription drug formulary information on a personal digital assistant. The ePocrates Rx formulary tool is an internet-based hand-held drug reference guide that allows physicians and pharmacists' ease of access to a combined formulary that includes BCBSM and other health plan formularies. The tool also provides access to generic alternatives, drug-to-drug interactions, adverse effects, dosing and contraindications. The tool is designed to streamline the prescription writing process and reduce the incidence of medication errors. BCBSM and Blue Care Network launched ePocrates in June 2002 and as of fourth quarter 2004; there were 8,805 users in Michigan of which 4,482 were physicians.

BCBSM states it also reviews patient claim information on a retrospective basis to ensure the member received the most appropriate drug therapy. Current medical literature findings, including legislative and FDA materials for drug safety issues are continuously monitored by BCBSM. If it is determined through such a review that prior drug therapy was inappropriate, an analysis of patient history is performed, and depending on the results of the review, BCBSM may contact the providers.

During the two-year period under review, BCBSM conducted drug utilization review activity on the following topics:

- Appropriate medication use in the elderly
- Identification of inappropriate monitoring of prescription drugs (e.g. assessing liver function before initiating medication therapy)
- The promotion of over-the-counter Claritin and Prilosec
- Targeting non-formulary use of statin drugs

BCBSM also made personal visits to physicians through its academic detailing initiative. BCBSM's clinical pharmacists had face-to-face visits with physicians to promote appropriate and efficient prescribing patterns for generic drugs, to discuss dose optimization and to address formulary issues. BCBSM states it made approximately 1,700 physician visits during 2003 and 2004 for inappropriate drug therapy and academic detailing. These visits focused on the following:

- Increasing prescribers' generic dispensing rate
- Showing the physicians their DOSE opportunities
- Educating prescribers on the BCBSM formulary
- Sharing clinical guidelines with prescribers
- Promotion of over the counter products

BCBSM also evaluated medical necessity and the quality of care provided to BCBSM members through its audit program. The audit process is designed for BCBSM to validate that contractual agreements were met, high quality care was given to subscribers as well as to recover overpayments paid to pharmacies by BCBSM.

BCBSM's auditors review records to ensure compliance with BCBSM documentation guidelines. Information in providers' medical and financial records is compared with the information reported on claims. Pharmacy providers were typically selected for review based on referrals and risk indicators. Risk indicators included the pharmacy's income level, generic dispensing rate, dispense as written (DAW) rate, average quantity per prescription, and average cost per prescription.

BCBSM conducted 48 field audits in 2003 and 74 in 2004 to recover overpayments made in error. BCBSM states the top audit findings were as follows:

- Over billed quantities
- No orders or unauthorized orders
- Expired orders
- Unauthorized refills
- Dispensed brand when a generic substitute should have been dispensed
- Non-funded cancelled scripts (scripts were not picked up payment should have been voluntarily returned)
- Partial refills

A summary of BCBSM's audit activity for the pharmacy class is listed below.

	2004	2003
Number of audits	74	48
Initial identified savings	$2,944,498	$1,746,755
Finalized recoveries	372,493	516,740
Pending recoveries	$1,098,345	$17,668
Referred to Corporate Financial Investigation	2	4

Another measure of BCBSM's achievement of the quality of care goal includes BCBSM's ability to effectively communicate with providers. Given that the quality of care goal defined in the Act requires that "providers meet and abide by reasonable standards of health care quality," it is necessary for providers to be made aware of BCBSM's standards, for BCBSM to verify that its providers adhere to such standards and that BCBSM is responsive to provider inquiries, input, and appeals, as all of these factors impact the quality of pharmacy services given to BCBSM members.

BCBSM states that it maintains open communications with pharmacy providers through its monthly publications, provider manuals, regular meetings of the Pharmacy Advisory Committee and its formal appeal process. All participating pharmacy providers currently receive BCBSM's monthly publication, the *Record*. This publication contains current information relating to billing, benefit changes, patient education and other provider-specific

issues. BCBSM states the issues discussed in this publication are those that often impact providers' practice patterns and the achievement of utilization performance standards. BCBSM also has regional field services representatives that are available for on-site, individualized provider education and to address problems and concerns.

As part of the review process, OFIS examined a copy of BCBSM's pharmacy provider manual. The current basic provider manual, updated through 1998, is entitled the *Guide for Pharmacists (Guide).* The *Guide* includes information pertaining to pharmacies, such as program requirements, member eligibility requirements, benefits and exclusions, criteria and guidelines for services, documentation guidelines, claim submission information, utilization management and sections describing how to obtain information from BCBSM's provider inquiry department and claims appeals processes. BCBSM states a new updated manual was almost completed but was not issued, as it became apparent BCBSM would shortly thereafter need to redo the manual to include pertinent information about the Medicare Part D program. In the meantime, BCBSM published numerous articles in the *Record*, including articles on the Generic Drug Initiative and patient safety goals, policies on dispense as written (DAW) prescriptions and compounded medications, revisions to the Preferred Rx participation agreement, formulary changes, electronic billing, changes in prescription drug claim processing systems, audit policies and pharmacy questionnaires being mailed to BCBSM members for feedback. BCBSM states it hopes to complete the updated *Guide* by third quarter 2006. Information pertaining to Medicare Part D was mailed to pharmacies in December 2005.

BCBSM states it offers pharmacists the option of speaking with provider service representatives through the DRAMS help desk. BCBSM also held an audit seminar at the Michigan Pharmacists Association's (MPA) convention. Other BCBSM seminars were conducted that were open to pharmacists' participation during the review period.

There are a variety of other avenues available to pharmacists to obtain information. The BCBSM Web site has a section for providers with information on benefits and eligibility, contact numbers, and continuing education. The site also contains hyperlinks to the Michigan Health and Safety Coalition, the Institute for Safe Medication Practices and the Council for Affordable Quality Healthcare. Other avenues pharmacists could access for information includes CAREN+ and Web-DENIS. CAREN+ is an integrated voice response system that provides information on eligibility, benefits, deductibles and copays. Web-DENIS is a computerized provider inquiry program that provides member contract eligibility coverage, benefits, coordination of benefits, claims tracking and facility claim correction. Web-DENIS also provides claims status information and offers historical eligibility.

BCBSM's Pharmacy Advisory Committee is a collaborative council made up of representatives of the Michigan Pharmacists Association (MPA), BCBSM, BCN and providers from both independent and chain pharmacies. The committee meets quarterly,

thereby offering pharmacists the opportunity to discuss issues with BCBSM on a regular basis. It also gives MPA advance notice of what BCBSM is planning on implementing that will affect pharmacies so MPA can properly advise pharmacy providers when they receive calls regarding BCBSM program changes. Topics discussed during the two year period under review included the generic dispensing fee calculation, the generic coupon program, custom formulary changes, HIPAA compliance, BCBSM's automated pharmacy audit systems, the ISMP survey, removal of the critical drug list, BCBSM's transition to MedImpact, UAW negotiated contract changes, handheld technology, and step therapy and prior authorization.

BCBSM also maintains a provider appeal process for pharmacy providers. The purpose of the appeal process is to resolve claim or audit disagreements. Pharmacies are informed of the appeal process through the *Record*. Information about the appeals process is also included in the *Guide* and both the Traditional Rx Pharmacy Participation Agreement.

There are many different levels of the appeals process. The provider starts with a routine inquiry to BCBSM and can follow with a written complaint asking for a reconsideration review. If the provider is not satisfied with the reconsideration, he or she may submit a written request for a Managerial-Level Review Conference. During this conference, BCBSM and the provider discuss the dispute in an informal setting and explore possible resolutions of the dispute.

If the provider is dissatisfied with the managerial-level review, the provider can continue with BCBSM's appeal process, appeal to OFIS, initiate legal action, or if medical necessity issues are in dispute, request an external peer review for medical necessity issues. If an external review is requested by the provider and decided in favor of BCBSM, the provider will pay the costs of the external review. If the review is decided in favor of the provider, BCBSM pays the costs. The decision of the external review organization on medical necessity disputes is final and binding on both the provider and BCBSM.

If the provider is dissatisfied with the managerial-level review, the provider can request an external peer review for medical necessity issues. If this review is decided in favor of BCBSM, the provider will pay the costs of the external review. If the review is decided in favor of the provider, BCBSM pays the costs. This step ends the appeal process for all medical necessity issues.

For disputes involving administrative and/or billing and coding issues, a provider may request a review by an internal review committee. BCBSM's Internal Review Committee is composed of three members of BCBSM senior management. If providers are unhappy with the Internal Review Committee decision, they can appeal to BCBSM's Provider Relations Committee. The Provider Relations Committee is a subcommittee of the

BCBSM Board of Directors composed of BCBSM participating professionals, community leaders and BCBSM senior management.

Providers that go through BCBSM's appeals process and remain dissatisfied can appeal to OFIS for an informal review and determination. If the provider remains dissatisfied, they can move to a contested case hearing pursuant to Section 550.1404(6) of the Act. Contested case hearing decisions are subject to appeal in the circuit court. At any time after the written complaint or reconsideration review and informal managerial conference steps, the provider may appeal to OFIS or initiate legal action to resolve the issue.

BCBSM states there were 42 appeals filed by pharmacies during 2003. A total of 25 were settled during the reconsideration or managerial level conference phases of the appeal process with 17 others pending at year-end 2003. During 2004, BCBSM received 58 appeal requests. Thirty of these requests were settled during the reconsideration or managerial level conference phase of the appeal process with 28 requests still pending at year-end 2004. During 2004, one audit appeal case from 2002 was settled after a pharmacy appealed BCBSM's audit findings to OFIS. BCBSM contends approximately 90% of all pharmacy appeals are settled during the reconsideration or managerial level conference phases of the appeal process.

Findings and Conclusions - Quality of Care

In order to meet the quality of care goal, the provider class plan must assure that "providers will meet and abide by reasonable standards of health care quality." During calendar years 2003 and 2004, BCBSM continued to monitor pharmacists' qualification standards, implemented and maintained a variety of quality control standards and utilization management initiatives and maintained communication with pharmacy providers through provider relations, including quarterly meetings of the Pharmacy Advisory committee, its monthly publication of the *Record*, provider manuals and appeal processes. Based on the information analyzed during this review, it is determined that BCBSM met the quality of care goal stated in the Act for the calendar years 2003 and 2004.

Cost Goal:

The cost goal in Section 504(1) of the Act states "[P]roviders will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

After application of the cost formula found in Section 504 of the Act and using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure that will be used to determine BCBSM's achievement of the cost goal shall be as follows:

> The rate of change in the total corporation payment per member for the pharmacy provider class for calendar years 2003 and 2004 shall not exceed 3.6%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + REG)]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percentage change in the implicit price deflator for GNP over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage change in per capita Gross National Product (GNP) in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the December 2004 population data obtained from population reports (Series P-25) published by the Bureau of Census, as obtained to OFIS from the U. S. Census Bureau (www.census.gov/popest/national/NA-EST2004-01.hmtl), and economic statistics for the GNP and implicit GNP price deflator published in the October 2005 edition of "Economic Indicators" prepared for the Joint Economic Committee, by the Council of Economic Advisers (www.gpoaccess.gov/indicators/index.html) the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

% change in implicit GNP price deflator	
2004	2.0
2003	2.6
2 yr. average	2.3

REG = Real Economic Growth as defined in the cost goal formula:

	% change in per capita GNP in constant dollars
2001	(0.3)
2002	0.6
2003	1.7
2004	3.2
4 yr. average	1.3

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 3.6%, as shown below:

Inflation = 2.3

Real Economic Growth = 1.3

$$\frac{[(100 + 2.3) \times (100 + 1.3)]}{100} - 100 = 3.63\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to OFIS, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4).

As stated in Section 504(2)(e) of the Act, the "'[R]ate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination." The cost and membership data for the pharmacy provider class plan for the calendar years 2003 and 2004, as filed with OFIS by BCBSM, are presented below on a combined basis as well as broken down by retail and mail order payments. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

Total Pharmacy Payment Experience

BCBSM Retail and Mail Order Payments	2002	2003	2004	Average Yearly Rate of Change
Total Payments	$1,928,298,957	$2,054,082,510	$2,368,548,347	10.9%
Total Members	2,535,310	2,373,472	2,227,018	(6.3)%
Cost Performance				
Payments/1000 Members	$760,577.19	$865,433.64	$1,063,551.51	**18.35%**
Rate of Change (%)		13.8%	22.9%	**18.35%**

The two-year arithmetic average increase for the pharmacy provider class plan equals 18.4%.

Since the experience for retail and mail order pharmacy payments was dramatically different, it warrants examining retail and mail order data separately. For many years, BCBSM members could only obtain prescription medication at a retail pharmacy. Now many employer groups mandate that their employees use mail order pharmacies for all maintenance drug purchases. This change in customer usage has created quite a variance in retail and mail order payments and utilization.

During the review period, as shown below, retail pharmacy utilization remained relatively flat, with the price per script increasing 6.6%. Payment and use data for retail pharmacies represent prescription medication dispensed in a 34-day supply or less.

Total Utilization and Payment Experience – Retail Claims

BCBSM Retail Pharmacy Data	2002	2003	2004	Average Yearly Rate of Change
Total Payments	$1,495,545,095	$1,561,581,943	$1,496,750,461	0.1%
Total Members	2,535,310	2,373,472	2,227,018	(6.3)%
Cost Performance				
Payments/1000 Members	$589,880.48	$657,931.48	$672,087.28	**6.85%**
Rate of Change (%)		11.5%	2.2%	**6.85%**
Total Scripts	30,647,126	29,917,262	26,744,851	
Per 1,000 members	12,088.12	12,604.85	12,009.27	(0.2)%
Rate of Change (%)		4.3%	(4.7)%	(0.2)%
Payment/Script	$48.80	$52.20	$55.96	7.1%
Rate of Change (%)		7.0%	7.2%	7.1%

Mail order claims had a significant jump in utilization in 2004 as compared to 2003 due to customer group mandates that the mail order program be used for routine maintenance drugs. Although mail order costs more per script, it is actually less expensive per pill per day because it represents a 90-day supply rather than a 34-day maximum supply required with retail claims. BCBSM states mail order prescriptions saved approximately $118 million based on a comparison of the average prices in the same top ten therapeutic classes in the retail segment. The cost and use experience for mail order claims is shown below.

Total Utilization and Payment Experience – Mail Order Claims

BCBSM Mail Order Pharmacy Data	2002	2003	2004	Average Yearly Rate of Change
Total Payments	$432,753,862	$492,500,567	$871,797,886	45.4%
Total Members	2,535,310	2,373,472	2,227,018	(6.3)%
Cost Performance				
Payments/1000 Members	$170,690.71	$207,502.16	$391,464.23	**55.15%**
Rate of Change (%)		21.6%	88.7%	**55.15%**
Total Scripts	3,479,695	3,789,676	6,345,859	
Per 1,000 members	1,372.49	1,596.68	2,849.49	47.4%
Rate of Change (%)		16.3%	78.5%	47.4%
Payment/Script	$124.37	$129.96	$137.38	5.1%
Rate of Change (%)		4.5%	5.7%	5.1%

The two-year arithmetic average increase for the pharmacy provider class plan for mail order claims equals 55.2%.

A number of factors affect BCBSM's cost goal performance. Many of these factors are described below:

In 2004, BCBSM payout under the mail order program increased 89% largely due to customer groups mandating the mail order drug program for their employees. BCBSM had ten mail order riders approved during this period. Eligible members may use mail order drugs to obtain almost any drug covered under the members' drug plans. Mail service is most often used and most beneficial for obtaining drugs prescribed on a long-term basis for chronic conditions like high blood pressure, high cholesterol, heart disease, diabetes, and stomach disorders. Eligible members could obtain up to a 90-day supply of prescription drugs by mail instead of the standard 34-day supply dispensed at a local pharmacy. In 2003, mail order prescriptions accounted for 24% of payments and 11% of utilization. In

2004, mail order prescriptions accounted for 37% of total prescription drug payments and 19% of total prescription drug utilization.

Exhibits A and B illustrate BCBSM's statewide 2 year change in payment per member in comparison to the 2 year change in payment per member for the top 50 therapeutic classes for both retail and mail order claims, by total BCBSM payout, based on data BCBSM provided to OFIS in September 2005. Also shown are average changes in payment per prescription and prescriptions per member. A therapeutic class of drugs is a group of brand and generic drugs that are prescribed for similar illnesses. For example, diabetic therapy includes all drugs used to address all types of diabetes (e.g. type I or 2) for adults and children.

BCBSM states the top ten therapeutic classes by payout were the same for both the retail and mail order segments but in different order. The top ten drug classes were mainly considered maintenance drugs used in treating chronic illness rather than infectious diseases. Given the mail order option providing a 90-day supply versus the 34-day supply for retail prescriptions, it is logical that the payout for the top ten drug classes represents 77% for mail order versus 59% for retail prescriptions. BCBSM states the top ten therapeutic classes in total payout also experienced the highest increases in use except for the antihistamine drug class, where many antihistamine drugs became available over-the-counter.

Exhibits A and B reveal that cholesterol medication accounts for the highest payout by BCBSM in both retail and mail order segments. It is a well-established fact that risk factors such as obesity, lack of exercise and unhealthy diets increase the risk of diabetes, hypertension, heart disease as well as overall medical costs. BCBSM cites an April 8, 2004 Michigan Healthy 2010 report as reporting Michigan ranks third worst among states for rates of obesity and has been among the top ten states with the heaviest populations for the past 14 years.

There is a therapeutic class of drugs BCBSM designates as "unclassified drug products" which includes medications that still have yet to be assigned to a therapeutic class. The types of drugs falling into this class include medications for multiple sclerosis, erectile dysfunction, osteoporosis, chronic irritable bowel syndrome and kidney, liver and heart transplants. These drugs had a combined payout of $467.9 million during the reporting period, accounting for 7.4% of the total payout. This is a significant increase compared to the 1994-1996 reporting period when the payout was $47.8 million, accounting for 2% of the total payout. These drugs also had the highest increase in payment during the current reporting period. BCBSM contends advertising and advanced technology impacted some of the increases seen for this drug class as advertisements for erectile dysfunction used to focus on older men and now focus on middle-aged healthy men.

Many other drugs in this therapeutic class help people with serious conditions such as multiple sclerosis; transplants and osteoporosis survive or live better lives. Although the

value these drugs have on quality of life is tremendous, the technology and research done to develop these drugs hugely impact the increase in prescription drug costs. BCBSM cites as an example that there are 2.5 million people worldwide with multiple sclerosis. In the United States alone, health care costs to treat this condition are estimated to be $10 billion per year. According to an April 1, 2005 paper entitled, "Therapy for the Treatment of Multiple Sclerosis, published at www.drugdevelopment-technology.com, multiple sclerosis is the second most common neurological disability to affect young and middle aged adults. Many new drugs have revolutionized treatment for multiple sclerosis patients. One such example is the drug Copaxone, a brand name drug with an average payment per script of $1,045 and a total three-year payout of over $20 million.

While "unclassified drug products" had a major impact on the net increases in payout, other therapeutic classes also exhibited increase in payment during the reporting period. These classes include anticonvulsants, narcotic pain relievers, anticoagulants and antidepressants. An anticonvulsant mediation drug called Neurontin used to treat seizures (epilepsy) and shingles largely contributed to the increases in both the mail order and retail segments with a total payout of $30 million. The pain reliever therapeutic class increased $10.8 million because of increased use of Oxycontin with a 20.7% increase in use during the two-year period under review. Oxycontin offers an extended release to help relieve moderate to moderately severe pain. The anticoagulant therapeutic class exhibited increases in payment due to the increase in stent placement surgeries to manage coronary artery disease. Anticoagulant medication is used to prevent clots typically associated with stent placement. BCBSM states it is also seeing an increased use of low molecular weight heparins that are being used to allow patients to leave the hospital setting more quickly after hip and knee replacement surgeries.

BCBSM states not all of the top therapeutic classes of medications that experienced increases in payout in the retail segment also experienced increases in payment per member. The antiulcer, antihypertensive, cardiovascular and antihistamine classes had large decreases in payment per member. Drugs in the antiulcer and antihistamines classes had patents that expired since the last review of this provider class plan. Many of these drugs become available over-the-counter, such as Zantac and Claritin, explaining the decreases in these therapeutic classes.

On the mail order side, BCBSM states payout increased 89% in 2004 largely due to customer groups mandating the mail order drug program be used by their employees. BCBSM filed and had ten mail order riders approved during the review period. The top therapeutic classes impacting increases in total payout for the mail order segment included blood fat reducers (e.g. Lipitor), antiulcer medications, antiarthritis, antihypertensions and "unclassified drug products". BCBSM contends since the mail order program is a growing program, there is insignificant data relating to the two year period under review to report regarding decreases in payment.

Prevacid is a proton pump inhibitor that blocks the production of acid in the stomach. Other drugs in the antiulcer therapeutic class include Aciphex, Prilosec, Protonix and Nexium. All of these drugs are in the top 50 by payout and represent 7.5% of the total payout in the retail segment and 9.9% of the total payout in the mail order segment.

The Federal Drug Administration (FDA) approved 11 of the drugs in the top 50 by payout during the years 2001-2004. Newly approved FDA drugs usually have a higher cost associated with them due to the research and development cost associated with manufacturing them. These drugs have 17-year patents to help the pharmaceutical manufacturers recoup their research and development costs.

Payout for blood fat reducers was highest among the top 50 therapeutic classes for both retail and mail order segments. Blood fat reducers are cholesterol-lowering medications that inhibit the production of cholesterol by the liver. These medications lower overall blood cholesterol as well as blood LDL cholesterol levels. LDL is considered to be the "bad" cholesterol primarily responsible for the development of coronary artery disease. Lowering a person's LDL cholesterol levels retards the progression of, or may reverse, coronary artery disease. Popular medications in this therapeutic class include Lipitor, Mevacor, Zocor and Pravachol, all of which are in the top 50 drugs by payout for both the retail and mail order segments. Whereas these drugs help decrease hospital and surgical costs and improve quality of life for people who otherwise may experience a heart attack, stroke or the need for bypass surgery, the costs of such medication negatively affect BCBSM's ability to meet the cost goal prescribed by the Act.

Several antiarthritis drugs included in the top 50 drugs by payout, including Celebrex, Enbrel, Humira, Bextra, and Vioxx. All these drugs treat pain and arthritis, with Enbrel and Humira treating rheumatoid arthritis through injections. Three of these drugs received FDA approval during the period under review. Vioxx was pulled from the market in late 2004 when it was determined this drug caused adverse cardiovascular episodes such as heart attack and stokes in certain individuals.

Six of the top 50 drugs in the retail segment fell into the unclassified drug products therapeutic class. This class had the highest increase in payment of $14 million during the reporting period. Fosamax, Evista and Actonel treat osteoporosis by slowing down the rate at which the bone is dissolved and increases the amount of new bone. Another "unclassified" drug is Viagra. Medical conditions such as diabetes and other neurological and urological conditions largely cause impotency with some men experiencing impotency due to psychogenic causes. Another unclassified drug in the top 50 is Flomax, a drug used in the treatment of men who have difficulty with urination due to benign prostatic hyperplasia. Copaxone, used in the treatment of multiple sclerosis, is the final drug in this "unclassified" class in the top 50 by payout with an average payment per prescription of $1,045.

Other medications in the top 50 by payout include Neurontin which is used to treat seizures and shingles; Oxycontin, a narcotic pain reliever and cough suppressant; and Plavix, which inhibits the ability of platelets to clump together and form a blood clot that may cause a heart attack or stroke. The antidepressant medications Effexor XR and Lexapro, approved by the FDA during the review period, are also included in the top 50 by payout, as well as Zoloft.

Exhibits E and F show the changes in use for the top 50 drugs for both the retail and mail order segments. The two-year average utilization of prescription drugs per 1000 members in the retail segment was virtually flat while the mail order segment increased 47.4%. As these exhibits illustrate, many multiple source drugs are listed by use rather than by payout given generic drugs are less expensive than brand name drugs. For example, the generic equivalent of Lopressor, a cardiovascular drug, had an average price of $4.12, compared to Toprol XL, an extended release cardiovascular drug available only as a single source brand name drug, with an average payment per script of $21.50.

Generic drugs comprised 45.6% of the total drugs dispensed during the review period compared to only 12% during the last review period. BCBSM's attributes this increase in generic drug usage to its efforts to lower costs by promoting generic drugs as safe alternatives to high cost brand name drugs through a statewide public awareness campaign. Also, BCBSM offered its customer groups a variety of lower copay options to encourage member use of generic drugs instead of brand name drugs. The average cost of a generic drug in 2004 was $19.48, compared to $108.82 for a brand name drug.

Lipitor, a cholesterol-lowering drug, was the highest utilized drug for both retail and mail order segments. Cholesterol lowering agents are a highly dispensed drug despite the fact that lowering cholesterol levels can be achieved in many people through diet and exercise. Lipitor in the retail segment had an average payment per script of $84.01, whereas a three-month supply obtained by mail order cost $148.56 per script, or $49.52 per month.

BCBSM states mail order was a convenient method of obtaining maintenance drugs like Lipitor and offered a cost savings in premiums for the customer and lower copays for the member. Mail order prescriptions increased 70% in scripts per 1000 members in 2004 from 2003, but represented less than half of the total prescriptions dispensed during this reporting period. Mail order prescriptions had an overall increase in use per 1000 members of 78.5% between 2003 and 2004. All but one of the top 50 drugs dispensed under the mail order program experienced a two-year average increase.

BCBSM's attempts to control prescription drug costs included its Pharmacy/Manufacturer-Focused Cost Control program, varied prescription drug benefit options, the Generic Drug Incentive program, and Physician Prescribing Pilot program.

BCBSM's pharmacy-focused cost control initiatives included negotiated discounts with pharmacies and maximum allowable cost ceilings. The MAC (maximum allowable cost)

program sets a ceiling on the amount paid for a given generic drug. MAC takes advantage of the fact that pharmacies are able to obtain some generic drugs at deeply discounted prices. MAC pricing is applied to approximately 88% of all generic drugs. For example, when the patent for the drug Prozac expired, the generic equivalent fluoxetine became available in August 2001. Initially priced at $2 per unit, the price rapidly dropped to $.19 per unit as a function of market conditions. The MAC initiative took advantage of these dynamic market conditions.

BCBSM's efforts on cost controls also included obtaining rebates from drug manufacturers. Rebates vary by drug and are often based on the market share achieved by the drug in question within its therapeutic class.

BCBSM offers cost sharing options with a variety of fixed dollar or percentage copay amounts that help control overall drug costs. Tiered prescription drug benefit plans are also available that require lower member copays for generic drugs, higher member copays for brand name drugs with no generic alternatives and even greater copays for brand name drugs with generic equivalents. These programs lessen cost growth by providing a financial incentive to the member to purchase generic or other lower cost drugs instead of perhaps a name brand drug they have seen advertised on television.

BCBSM's mail order options allow eligible members to obtain a 90-day supply of prescription drugs by mail instead of the standard 34-day supply dispensed at a local pharmacy. Mail order generally offers lower ingredient costs and dispensing fees than retail pharmacies so it is a more cost effective way to obtain maintenance drugs. The 2003 auto negotiations limited members to three retail refills of certain maintenance drugs and then the member was required to use the mail order program or be responsible to pay for the full cost of the maintenance medication.

BCBSM embarked on a major initiative in 2001 to reduce prescription drug costs by increasing generic drug use among BCBSM members and other Michigan residents. Generic drugs must meet the same FDA standards for safety and performance as the heavily advertised brand name prescription drugs, yet generic drugs cost from 20-65% less. Generic drugs offer the same medical benefits as brand name drugs but cost less because they do not incur the extensive research, development and marking costs like brand name drugs because the efficacy of the medication has already been proven.

Many common prescriptions already have generic equivalents. BCBSM states that consumers' awareness and choice of therapeutically equivalent drugs was minimal prior to 2001. According to the November 2, 2002 article entitled, "Generic Drug Sales Flourish Thanks to Big Companies", in the New York Times, an increase in generic usage only gained momentum with the introduction in 2001 of generic equivalents of three popular drugs for Prozac (antidepressant), Glucophage (diabetes treatment) and Zestril/Prinovil (hypertension).

BCBSM states its goal for the generic initiative is to not only increase the public's awareness of generic drugs but also to encourage competition among pharmacies to increase the percentage of prescriptions filled with generic drugs. BCBSM developed a web site so the public could compare the prices of frequently prescribed brand name drugs with their generic equivalents.

The initiative has been successful as the portion of BCBSM's members' prescriptions being filled with generics has increased over 10% since the inception of the program. BCBSM estimates its savings through 2004 were estimated at $179 million, with $23.5 million being directly realized by members through reduced copays.

BCBSM states the increase in generic usage is due to several factors:

- More "blockbuster" drugs such as Paxil, Prilosec, Prozac and Glucophage have generic equivalents, with Prilosec now being obtainable as an over-the-counter medication.
- BCBSM continues to work with Michigan physicians to increase generic drug prescribing.
- BCBSM's generic drug consumer advertising and promotional campaign raised awareness of generic drugs' therapeutic effectiveness and their lower costs. In 2003, BCBSM began the Preferred Generic Coupon Pilot that offered a coupon that waived the first copay when members switched to generic equivalents of certain brand-name drugs.
- Congress and the FDA recently made changes to remove unnecessary obstacles to generic drug development and marketing.

In August 2000, BCBSM initiated a Physician Prescribing Pilot program. Through this program, a BCBSM pharmacist provided unbiased information to a physician with respect to his or her specific prescribing habits. Interventions resulting from this information exchange focused on generic utilization and substitution and dose optimization. Dose optimization refers to the premise that one "double" dose daily in place of two regular doses would offer substantially lower product cost and high patient medication compliance. BCBSM pharmacists also reviewed manufacturers' recommendations and price comparisons of comparable drugs with the physicians in the program. BCBSM states this program rewarded physicians for reducing costs, with savings through 2004 totaling nearly $1.3 million.

Other programs pursued by BCBSM were a partnership with the Regence Group to jointly administer several pharmacy benefit management functions, such as volume contracting with pharmaceutical manufacturers for rebates, rebate collection and clinical reviews of covered drugs called formularies.

In August 2004, BCBSM changed its reimbursement procedures for compounded medications. Compounded medications are made up of multiple ingredients that are mixed

together at a pharmacy according to a doctor's specific instructions. Changes by the FDA made it possible for BCBSM participating pharmacies to electronically submit claims for compounded medications. Electronic claims are more cost effective than BCBSM's previous reimbursement policy that required members to pay for their compounded medications up front and submit claims to BCBSM for reimbursement.

BCBSM contracted with a new pharmacy network vendor in November 2004 to handle claims processing and help design cost-saving programs in both the retail and mail order business segments. Advantages of the new arrangement include flexible benefit designs, greater network discounts, improved prescription dispensing, medication safety features such as checking for severe drug interactions, better tracking of group drug utilization and daily eligibility updates. This new arrangement also features more managed care options including prior authorization and step therapy where less expensive or generic medications must be explored prior to using higher-cost drugs.

In fourth quarter 2004, BCBSM sent questionnaires to some members asking them to review and verify a list of selected prescription claims that were billed to BCBSM by their pharmacies. The results of the questionnaires helped BCBSM to determine if further investigation is necessary for certain pharmacies. The results also helped identify questionable practices such as product substitution schemes, brand/generic switching and "phantom" billings (fraud) – all of which increases costs.

Lastly, BCBSM identified members with more than one health plan in order to coordinate drug benefits with other payers.

Membership declined 6.3% during the two-year period under review while average utilization per 1000 members for increased 12.8%. BCBSM cites a loss of a significant customer group and the corporate downsizing on the part of some of its other customer groups for the membership loss. BCBSM states females represented a higher percentage in both retail and mail order segments, at 56%, and utilization, at 59%, compared to males. BCBSM's data for females aged 20-44, typically the reproductive years, showed more than double than the utilization than males in the same age group, at 11% compared to 5%.

Children are the fastest-growing population segment using prescription drugs. According to the Medco Health Solutions 2002 Drug Trend Report, spending on prescription drugs for children under age 19 nationwide increased by 85% in five years, with spending in some categories of pediatric prescriptions soaring by as much as 1,000%. BCBSM's data show children enrollees declining 5.3% from 1996 to 2004, while medication use increased 68% per 1000 members and payment per 1000 members increasing 131%.

Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM did not meet the cost goal stated in the Act for the pharmacy provider class during the two year

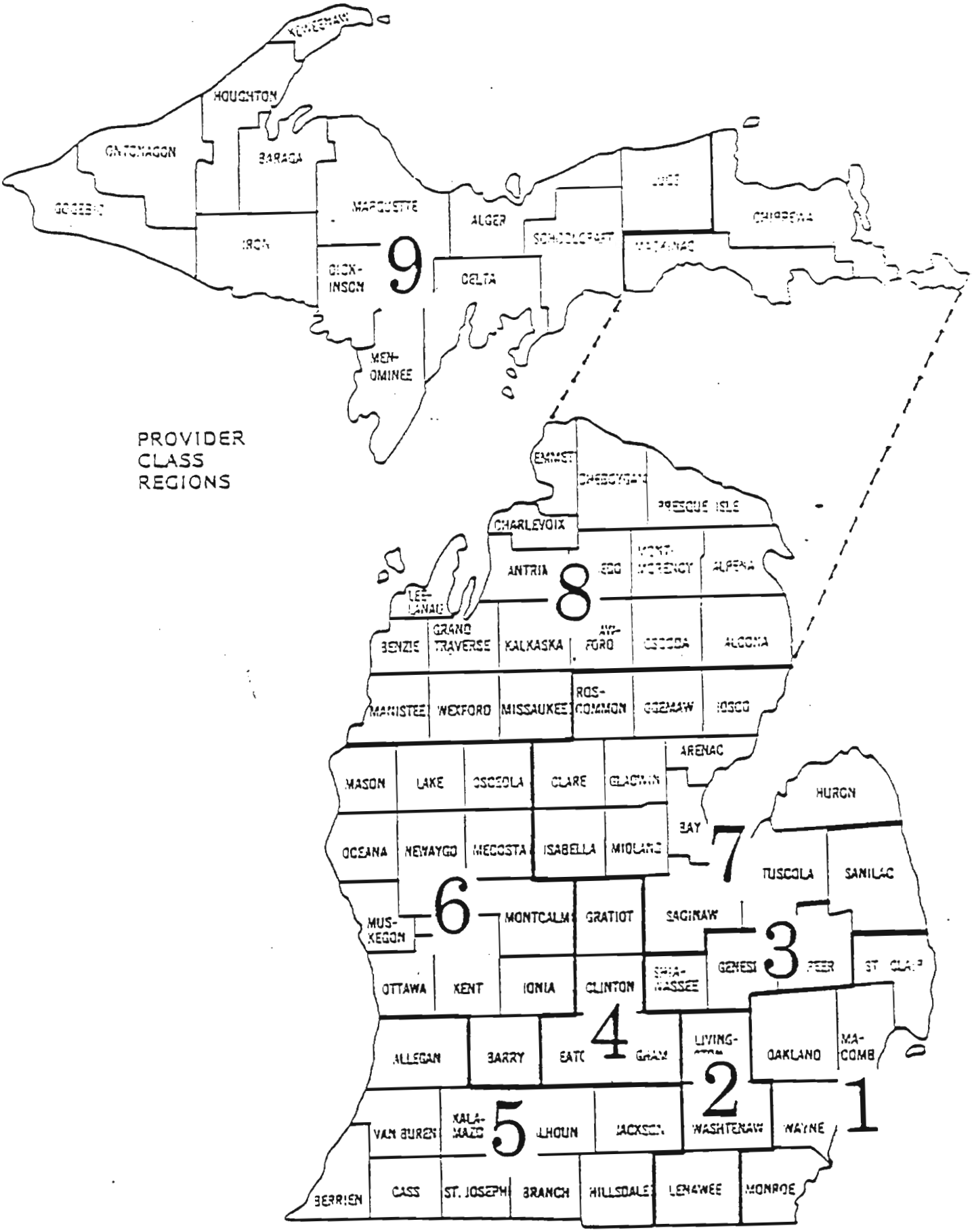
period under review. This decision is based on the fact that the rate of change in the total corporation payment per member to the pharmacy provider class has been calculated to be 18.4% over the two years being reviewed and therefore exceeded the compound rate of inflation and real economic growth of 3.6%.

BCBSM implemented a variety of programs in an effort to control prescription drugs costs during the two-year period under review, including its generic drug initiative, contracting with a new pharmacy benefit manager, reviewing prescribing patterns with physicians. Many customers groups adopted a mandatory mail order use requirement for their members to obtain maintenance medications. Despite this, many factors affect BCBSM's ability to contain costs within the constraints of the cost goal specified in the Act. These factors include an increased use of drugs relating to health conditions of Michigan's overweight and obese residents, new drugs available to treat chronic illnesses such as multiple sclerosis that prolong life, high research and development costs of drugs recently approved by the FDA, expansion of benefits by customer groups to cover life style drugs, and the continued advertisement of drugs by major pharmaceutical companies to encourage consumers to request new, expensive brand name drugs.

Because of this, it is not necessary to require that a change to the current pharmacy provider class plan be filed pursuant to Section 511 of the Act. BCBSM is encouraged to continue its efforts to find new, innovative programs that instill responsible cost controls so that all the goals and objectives of the corporation can be achieved.

Determination Summary

In summary, BCBSM generally achieved two of the three goals of the corporation during the two-year period under review for the pharmacy provider class. Although the pharmacy provider class plan did not substantially achieve the cost goal, a change in the plan is not required because, as outlined above, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve the cost goal was reasonable, due to factors listed in Section 509(4).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ST. JOSEPH
BRANCH
HILLSDALE
LENAWEE
MONROE

ATTACHMENT B

BLUE CROSS BLUE SHIELD OF MICHIGAN
PROVIDER APPEAL MECHANISMS
PERTAINING TO THE
PHARMACY PROVIDER CLASS

Pharmacists are informed of their right to appeal individual claim disputes or audit determinations through BCBSM's internal appeal process. The appeal process is described in the BCBSM participation agreement and provider manual. The first step requires the pharmacy file a written complaint and/or reconsideration of the audit determination within 30 days of completing BCBSM's routine written inquiry procedures. Within 30 days of its receipt of the provider's written complaint/reconsideration review request, BCBSM shall provide a written explanation to the provider outlining all of its reasons for the actions taken by BCBSM with regard to the provider's dispute.

If the provider is not satisfied with BCBSM's response, the provider can submit a written request for a managerial-level review conference within 60 days of the provider's receipt of BCBSM's written explanation. BCBSM will schedule the informal conference and communicate the results to the pharmacy in writing within 30 days of receipt of the provider's request for such a conference. This conference permits the provider the opportunity to present his/her case to BCBSM via the telephone or in person.

Within 30 days after the provider's receipt of BCBSM's managerial level review conference determination, the provider may opt to appeal BCBSM's proposed resolution. If the dispute concerns issues of medical necessity, the pharmacy may send such a request for review by an external peer review organization to BCBSM's Director of Pharmacy. The pharmacy will be notified of the determinations made by the review organization within 60 days of submission of the records to the peer review organization. Such a determination will be binding upon the provider and BCBSM. If BCBSM's findings are upheld on appeal, the pharmacy will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld and reversed. If the provider remains unsatisfied at the conclusion of this appeal step, the pharmacy may appeal to the Office of Financial and Insurance Services or initiate an action on those issues in court.

For disputes involving administrative and/or billing and coding issues, the pharmacy provider may submit a written request for a review by the BCBSM Internal Review Committee. This committee is made up of three members of BCBSM senior management. The request for an internal review committee hearing shall be filed within 30 days of receipt of BCBSM's response to the managerial-level conference and specify the reasons why the BCBSM policy in dispute is inappropriate or has been wrongly applied. Within 60 days of the request, a meeting will be held which the pharmacy may attend. BCBSM will communicate the determination of the committee within 30 days of the meeting date.

If dissatisfied with the decision of the Internal Review committee, the pharmacy may, within 30 days of receipt of the decision, submit a written request for a review to the Provider Relations Committee. The Provider Relations Committee is a subcommittee of the BCBSM Board of Directors and is composed of BCBSM participating professionals, community leaders and BCBSM senior management. BCBSM will acknowledge the receipt of the request and schedule a meeting with the committee within 90 days. The pharmacy must represent themselves at this appeal level and submit a position statement in advance. The decision of the committee may or may not be rendered at the conclusion of the hearing. BCBSM will communicate, in writing, the committee's determination within 30 days of the committee's determination.

Alternatively,

Alternatively, after BCBSM's decision of the Internal Review or Professional Relations Committees, the provider may submit a request to the Office of Financial and Insurance Services for a review and determination or initiate litigation in the appropriate court. The provider may initiate an informal review and determination of the dispute by submitting a written complaint to OFIS within 120 days of receipt of BCBSM's determination and should specify which provisions of Sections 402(1) and 403 of the Act that BCBSM has violated. The informal review and determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of OFIS. OFIS shall issue its determination in a timely manner after its receipt of position papers requested of the parties.

If dissatisfied with the review and determination by OFIS, either the provider or BCBSM may ask the Commissioner to hear the matter as a contested case under the Michigan Administrative Procedures Act. A contested case must be requested in writing within 60 days after the review and determination is issued. Either the provider or BCBSM may appeal the contested case result to the Ingham County Circuit Court.

Exhibit A

Pharmacy Provider Class - Retail
2002-2004 Top 50 Therapeutic Classes by Payout

Therapeutic Class	2-Yr Avg Chg per 1000 Members Payments	Scripts	Price	2004-2002 Payments	2004-2002 Scripts	Avg Pymt/ Script	Percent of Total Payout	Scripts
Blood fat reducers	8.9%	7.3%	1.4%	$ 457,669,380	4,410,186	$ 103.78	10.1%	5.1%
Antiulcer	1.7%	-0.6%	2.3%	$ 404,006,801	4,008,873	$ 100.78	8.9%	4.6%
Antidepressants	11.2%	5.7%	5.3%	$ 320,715,063	5,388,624	$ 59.52	7.0%	6.2%
Unclassified drug products	14.2%	6.4%	7.4%	$ 311,785,532	3,851,175	$ 80.96	6.8%	4.4%
Antiarthritis	10.0%	-3.0%	13.3%	$ 282,233,510	4,281,094	$ 65.93	6.2%	4.9%
Antihypertensives	-2.3%	0.1%	-2.2%	$ 194,493,819	5,972,338	$ 32.57	4.3%	6.8%
Diabetic therapy	6.2%	-1.2%	7.6%	$ 189,627,291	3,420,245	$ 55.44	4.2%	3.9%
Cardiovascular	-1.6%	-2.9%	1.1%	$ 189,171,497	5,335,534	$ 35.46	4.2%	6.1%
Bronchial dilators-asthma	15.0%	3.9%	10.6%	$ 162,781,972	2,665,115	$ 61.08	3.6%	3.1%
Antihistamines	-15.6%	-13.1%	-2.8%	$ 154,238,552	3,236,712	$ 47.65	3.4%	3.7%
Pain relievers, narcotic	20.0%	4.7%	14.7%	$ 137,902,075	4,473,209	$ 30.83	3.0%	5.1%
Anticonvulsants	22.7%	8.0%	13.6%	$ 118,774,726	1,463,315	$ 81.17	2.6%	1.7%
Anticoagulants	23.0%	9.4%	12.4%	$ 103,103,517	1,410,957	$ 73.07	2.3%	1.6%
Antianxiety agents	8.9%	1.4%	7.1%	$ 97,450,871	2,146,540	$ 45.40	2.1%	2.5%
Pain relievers	4.0%	-3.8%	8.1%	$ 93,685,456	708,121	$ 132.30	2.1%	0.8%
Hematinics	0.9%	-3.0%	4.5%	$ 81,149,866	249,766	$ 324.90	1.8%	0.3%
Other hormones	11.1%	-4.0%	15.7%	$ 79,324,657	262,348	$ 302.36	1.7%	0.3%
Antivirus	7.4%	2.5%	4.8%	$ 78,580,736	509,865	$ 154.12	1.7%	0.6%
Anticancer	6.0%	-1.1%	7.3%	$ 74,189,669	429,825	$ 172.60	1.6%	0.5%
Dermatologicals	17.6%	6.1%	11.0%	$ 68,696,004	841,822	$ 81.60	1.5%	1.0%
Fungicides	4.2%	-2.3%	6.6%	$ 63,022,129	1,179,152	$ 53.45	1.4%	1.4%
Nose and ear	5.7%	-2.5%	8.4%	$ 60,064,691	1,346,514	$ 44.61	1.3%	1.5%
Glucocorticolds	-0.2%	-2.0%	1.8%	$ 56,021,624	2,203,036	$ 25.43	1.2%	2.5%
Hormones, estrogens	-23.8%	-26.4%	3.4%	$ 54,355,726	1,621,856	$ 33.51	1.2%	1.9%
Antibiotics, erythromycins	1.1%	-0.3%	1.4%	$ 51,232,242	1,602,290	$ 31.97	1.1%	1.8%
Eye preparation	5.0%	-1.3%	6.4%	$ 48,000,759	1,398,165	$ 34.33	1.1%	1.6%
Antibiotics, other	-9.5%	-4.7%	-4.0%	$ 43,602,281	826,597	$ 52.75	1.0%	0.9%
Antibiotics, pneicillins	-5.1%	-2.7%	-2.2%	$ 40,800,931	2,293,364	$ 17.79	0.9%	2.6%
Contraceptives, oral	16.1%	9.1%	6.7%	$ 40,780,290	1,753,794	$ 23.25	0.9%	2.0%
Antibacterials, urinary	10.1%	4.6%	5.2%	$ 38,071,511	632,594	$ 60.18	0.8%	0.7%
Antinauseants	24.3%	-0.9%	25.3%	$ 36,315,718	471,681	$ 76.99	0.8%	0.5%
Sedative, non-barbiturate	21.1%	7.2%	13.0%	$ 35,125,418	762,016	$ 46.10	0.8%	0.9%
Stimulants	13.8%	-1.0%	14.9%	$ 31,800,415	543,032	$ 58.56	0.7%	0.6%
Parasympathetic agents	16.9%	11.6%	4.7%	$ 31,397,669	273,524	$ 114.79	0.7%	0.3%
Antibiotics, cephalosporins	-5.0%	-1.6%	-3.5%	$ 29,583,920	972,369	$ 30.42	0.6%	1.1%
Thyroid preparations	0.3%	1.0%	-1.2%	$ 25,181,321	1,964,154	$ 12.82	0.6%	2.2%
Muscle relaxants	24.0%	2.7%	20.3%	$ 23,011,282	794,438	$ 28.97	0.5%	0.9%
Diuretics (water pills)	-2.0%	-0.7%	-1.5%	$ 17,489,682	2,599,907	$ 6.73	0.4%	3.0%
Antibiotics, tetracyclines	21.1%	-3.3%	25.0%	$ 17,313,406	551,528	$ 31.39	0.4%	0.6%
Amphetamine -weight loss	28.6%	15.7%	11.2%	$ 17,044,767	246,508	$ 69.14	0.4%	0.3%
Antiobesity	-12.9%	-10.4%	-2.8%	$ 16,055,607	256,501	$ 62.59	0.4%	0.3%
Electrolytes and nutrients	1.0%	-5.2%	6.5%	$ 15,989,541	833,032	$ 19.19	0.4%	1.0%
Antiparkinson	1.5%	-1.3%	3.1%	$ 15,917,414	242,931	$ 65.52	0.3%	0.3%
Hormones, androgens	21.9%	12.3%	8.5%	$ 12,890,704	88,253	$ 146.07	0.3%	0.1%
Vasodilators, coronary	-14.9%	-10.9%	-4.9%	$ 10,294,886	884,893	$ 11.63	0.2%	1.0%
Medical supplies	0.9%	-0.3%	1.2%	$ 9,417,028	388,561	$ 24.24	0.2%	0.4%
Cough and cold	-1.9%	-4.9%	2.9%	$ 8,862,078	561,338	$ 15.79	0.2%	0.6%
Anesthetics, local	47.3%	7.6%	36.9%	$ 7,548,707	195,807	$ 38.55	0.2%	0.2%
Biolgicals	36.4%	15.6%	17.6%	$ 7,127,627	3,609	$ 1,974.96	0.2%	0.0%
Antispasmodic	211.6%	30.0%	113.4%	$ 7,102,201	311,223	$ 22.82	0.2%	0.4%
Top 50 Total	**6.9%**	**0.0%**	**6.9%**	**$ 4,471,002,568**	**82,868,331**	**$ 53.95**	**98.2%**	**94.9%**
Grand Total	**6.8%**	**-0.2%**	**7.1%**	**$ 4,553,877,499**	**87,309,239**	**$ 52.16**	**100.0%**	**100.0%**

Exhibit B

Pharmacy Provider Class – Mail Order
2002-2004 Top 50 Therapeutic Classes by Payout

Therapeutic Class Name	2-Year Avg % Chg per 1000 Members Payments	Scripts	Price	2002-2004 Payments	2002-2004 Scripts	Avg Pymt/ Script	Percent to Total Payout	Scripts
Blood fat reducers	67.0%	61.8%	2.9%	$ 286,651,263	1,405,089	$ 204.01	16.0%	10.3%
Antiulcer	45.3%	45.8%	-2.2%	$ 209,004,139	817,074	$ 255.80	11.6%	6.0%
Unclassified drug products	55.1%	48.0%	5.0%	$ 156,086,237	748,278	$ 208.59	8.7%	5.5%
Antiarthritis	50.7%	38.1%	9.2%	$ 150,656,354	727,639	$ 207.05	8.4%	5.3%
Antihypertensives	62.1%	55.7%	3.1%	$ 119,082,873	1,485,241	$ 80.18	6.6%	10.9%
Diabetic therapy	57.2%	51.7%	4.1%	$ 114,570,647	796,109	$ 143.91	6.4%	5.8%
Antidepressants	46.6%	44.3%	1.9%	$ 106,070,972	691,244	$ 153.45	5.9%	5.1%
Cardiovascular	61.9%	55.6%	3.0%	$ 101,361,864	1,366,659	$ 74.17	5.6%	10.0%
Bronchial dilators-asthma	69.5%	52.9%	11.0%	$ 75,153,342	409,914	$ 183.34	4.2%	3.0%
Antihistamines	22.9%	24.3%	-3.0%	$ 57,791,620	414,865	$ 139.30	3.2%	3.0%
Anticoagulants	97.5%	69.7%	15.7%	$ 51,692,488	320,807	$ 161.13	2.9%	2.4%
Anticonvulsants	67.7%	54.8%	8.9%	$ 41,349,549	195,602	$ 211.40	2.3%	1.4%
Anticancer	56.8%	37.3%	12.3%	$ 24,576,077	75,810	$ 324.18	1.4%	0.6%
Antianxiety	67.1%	55.4%	8.2%	$ 23,996,169	202,477	$ 118.51	1.3%	1.5%
Nose and ear	43.7%	32.4%	8.3%	$ 22,022,872	187,074	$ 117.72	1.2%	1.4%
Pain relievers	36.0%	29.6%	5.1%	$ 21,819,312	67,831	$ 321.67	1.2%	0.5%
Hormones, estrogens	14.6%	-0.3%	13.6%	$ 19,120,070	382,978	$ 49.92	1.1%	2.8%
Eye preparation	80.4%	55.1%	15.4%	$ 16,766,343	140,471	$ 119.36	0.9%	1.0%
Antivirus	43.9%	32.9%	8.4%	$ 14,158,846	31,546	$ 448.83	0.8%	0.2%
Parasympathetic agents	80.0%	71.7%	4.7%	$ 14,098,556	45,569	$ 309.39	0.8%	0.3%
Other hormones	34.5%	22.3%	12.2%	$ 13,136,047	35,568	$ 369.32	0.7%	0.3%
Glucocorticolds	30.0%	25.6%	2.6%	$ 12,814,337	151,496	$ 84.59	0.7%	1.1%
Pain relievers, narcotic	70.7%	57.1%	6.9%	$ 11,907,420	160,951	$ 73.98	0.7%	1.2%
Sedative, non-barbiturate	75.4%	52.9%	14.3%	$ 10,371,590	85,883	$ 120.76	0.6%	0.6%
Hematinics	69.7%	52.8%	12.8%	$ 9,585,467	24,231	$ 395.59	0.5%	0.2%
Antiparkinson	45.2%	44.6%	0.5%	$ 8,341,821	47,811	$ 174.47	0.5%	0.4%
Thyroid preparations	29.1%	47.7%	-10.3%	$ 7,599,257	497,805	$ 15.27	0.4%	3.7%
Vasodilators, coronary	38.5%	44.8%	-4.6%	$ 6,914,536	187,804	$ 36.82	0.4%	1.4%
Fungicides	36.1%	26.4%	7.5%	$ 6,853,361	45,124	$ 151.88	0.4%	0.3%
Diuretics (water pills)	34.4%	56.1%	-15.2%	$ 6,519,893	646,318	$ 10.09	0.4%	4.7%
Dermatologicals	58.3%	37.9%	14.1%	$ 6,203,226	46,783	$ 132.60	0.3%	0.3%
Electrolytes and nutrients	58.3%	54.0%	2.3%	$ 5,804,106	195,564	$ 29.68	0.3%	1.4%
Muscle relaxants	57.0%	45.2%	7.7%	$ 5,730,364	58,390	$ 98.14	0.3%	0.4%
Antispasmodic	796.2%	155.2%	157.4%	$ 5,286,382	53,672	$ 98.49	0.3%	0.4%
Hormones, androgens	68.3%	51.1%	12.0%	$ 4,760,297	12,677	$ 375.51	0.3%	0.1%
Cholesterol reducers	29.8%	20.9%	7.3%	$ 4,142,328	19,947	$ 207.67	0.2%	0.1%
Contraceptives, oral	17.6%	24.3%	-5.8%	$ 3,744,955	92,966	$ 40.28	0.2%	0.7%
Antinauseants	71.0%	53.2%	12.0%	$ 3,487,728	38,591	$ 90.38	0.2%	0.3%
Antiobesity	39.8%	25.3%	9.3%	$ 3,397,128	17,255	$ 196.88	0.2%	0.1%
Medical supplies	46.5%	39.2%	4.6%	$ 2,776,380	70,066	$ 39.63	0.2%	0.5%
Antibiotics, tetracyclines	42.0%	22.6%	15.7%	$ 2,330,070	23,039	$ 101.14	0.1%	0.2%
Stimulants	61.9%	44.4%	12.4%	$ 2,091,805	12,311	$ 169.91	0.1%	0.1%
Enzymes	37.1%	40.2%	0.4%	$ 1,910,043	4,890	$ 390.60	0.1%	0.0%
Antimalaria	41.0%	40.2%	1.9%	$ 1,835,380	39,681	$ 46.25	0.1%	0.3%
Anesthetics, local/topical	126.0%	86.6%	25.8%	$ 1,790,275	6,779	$ 264.09	0.1%	0.0%
Cough suppressents	7.4%	-4.7%	12.6%	$ 1,767,055	21,209	$ 83.32	0.1%	0.2%
Antibiotics, other	17.3%	20.3%	-2.3%	$ 1,693,553	15,219	$ 111.28	0.1%	0.1%
Bile therapy for digestion	52.3%	48.7%	2.4%	$ 1,515,564	4,979	$ 304.39	0.1%	0.0%
Amphetamine-weight loss	87.9%	73.6%	7.7%	$ 1,076,393	5,753	$ 187.10	0.1%	0.0%
Aldosterone antagonists	83.3%	65.8%	5.8%	$ 1,008,699	39,483	$ 25.55	0.1%	0.3%
Top 50 Total 2002-2004	**55.5%**	**48.0%**	**4.9%**	**$ 1,782,425,051**	**13,174,522**	**$ 135.29**	**99.2%**	**96.8%**
Grand Total 2002-2004	**55.1%**	**47.4%**	**5.1%**	**$ 1,797,052,315**	**13,615,230**	**$ 131.99**	**100.0%**	**100.0%**

Exhibit C

Pharmacy Provider Class
2002-2004 Top 50 Retail Drugs by Payout

Brand Name	2-Year Avg % Chg per 1000 Members			2004-2002 Payments	2004-2002 Scripts	Avg Pymt per Script	% To Total Payout	% To Total Scripts
	Payments	Scripts	Price					
Prevacid	6.5%	1.6%	4.7%	$ 108,670,243	848,099	$128	2.4%	1.0%
Prilosec *	-29.2%	-19.0%	-12.7%	$ 87,673,501	750,086	$117	1.9%	0.9%
Lipitor 10mg	0.2%	-5.6%	6.2%	$ 86,928,084	1,034,754	$84	1.9%	1.2%
Lipitor 20mg	5.9%	0.5%	5.2%	$ 78,819,979	606,662	$130	1.7%	0.7%
Celebrex	-5.7%	-8.0%	2.5%	$ 76,721,990	827,891	$93	1.7%	0.9%
Nexium	37.8%	27.9%	7.8%	$ 74,294,680	623,674	$119	1.6%	0.7%
Zocor 20mg	-3.5%	-8.8%	5.7%	$ 70,993,723	428,956	$166	1.6%	0.5%
Plavix	28.7%	20.7%	6.7%	$ 59,573,101	601,653	$99	1.3%	0.7%
Enbrel	41.8%	31.8%	7.8%	$ 59,317,386	50,983	$1,163	1.3%	0.1%
Vioxx	-13.1%	-16.5%	4.1%	$ 47,840,229	669,203	$71	1.1%	0.8%
Zocor 40mg	17.3%	11.9%	4.9%	$ 41,937,580	257,251	$163	0.9%	0.3%
Protonix	29.4%	21.0%	6.5%	$ 38,613,264	420,373	$92	0.8%	0.5%
Singular	21.4%	16.2%	4.5%	$ 36,780,840	420,837	$87	0.8%	0.5%
Fosamax	9.2%	3.7%	5.5%	$ 36,151,127	681,330	$53	0.8%	0.8%
Aciphex	11.1%	3.4%	7.7%	$ 35,113,027	300,275	$117	0.8%	0.3%
Pravachol	3.6%	-1.1%	4.9%	$ 31,734,405	194,153	$163	0.7%	0.2%
Zoloft 50mg	5.2%	0.6%	4.7%	$ 30,901,888	448,389	$69	0.7%	0.5%
Advair Diskus 250-50mcg	28.8%	22.3%	5.3%	$ 30,305,623	259,092	$117	0.7%	0.3%
Lipitor 40mg	7.2%	6.3%	1.0%	$ 29,966,629	222,067	$135	0.7%	0.3%
Allegra	26.3%	19.9%	5.4%	$ 29,385,293	525,600	$56	0.6%	0.6%
Zyrtec	3.0%	0.6%	2.5%	$ 28,608,819	626,333	$46	0.6%	0.7%
Zoloft 100mg	9.4%	3.8%	5.4%	$ 25,755,740	350,954	$73	0.6%	0.4%
Norvasc 10mg	-0.3%	-0.8%	0.6%	$ 24,389,732	348,156	$70	0.5%	0.4%
Effexor XR 75 mg	33.1%	20.0%	11.0%	$ 23,831,833	230,313	$103	0.5%	0.3%
Epogen, Procrit	-3.6%	-5.0%	1.7%	$ 23,630,871	11,830	$1,998	0.5%	0.0%
Ambien PAK	27.2%	15.7%	9.9%	$ 23,551,386	390,893	$60	0.5%	0.4%
Lamisil	14.7%	6.3%	8.0%	$ 23,103,559	100,306	$230	0.5%	0.1%
Zithromax	2.0%	-0.7%	2.8%	$ 23,086,841	785,482	$29	0.5%	0.9%
Norvasc 5mg	-1.5%	-6.0%	4.8%	$ 22,492,075	452,625	$50	0.5%	0.5%
Levaquin	6.4%	3.9%	2.3%	$ 22,478,794	299,020	$75	0.5%	0.3%
Viagra	2.5%	-1.1%	3.5%	$ 22,458,255	303,907	$74	0.5%	0.3%
Neurontin *	4.8%	3.5%	1.2%	$ 20,580,737	208,389	$99	0.5%	0.2%
Copaxone	17.7%	5.7%	11.6%	$ 20,043,104	19,178	$1,045	0.4%	0.0%
Actos 40mg	5.7%	-1.3%	7.0%	$ 19,225,710	129,027	$149	0.4%	0.1%
Flonase	7.3%	1.7%	5.6%	$ 19,106,200	397,316	$48	0.4%	0.5%
Tricor	30.7%	13.7%	14.6%	$ 18,841,727	259,214	$73	0.4%	0.3%
Actos 30mg	4.7%	-1.6%	6.5%	$ 18,602,692	136,931	$136	0.4%	0.2%
Evista	3.1%	-5.2%	8.7%	$ 18,444,340	298,742	$62	0.4%	0.3%
Oxycontin *	24.4%	20.7%	3.0%	$ 17,866,236	20,858	$857	0.4%	0.0%
Clarinex	38.6%	21.9%	12.8%	$ 17,602,700	331,316	$53	0.4%	0.4%
Allegra-D 12 Hour	18.1%	11.8%	5.7%	$ 17,292,979	348,674	$50	0.4%	0.4%
Flomax	8.6%	4.4%	3.6%	$ 17,168,384	344,888	$50	0.4%	0.4%
Effexor XR 150 mg	32.2%	18.0%	12.0%	$ 16,683,540	180,039	$93	0.4%	0.2%
Advair Diskus 500-50mcg	24.4%	16.5%	6.6%	$ 15,577,296	92,462	$168	0.3%	0.1%
Advair Diskus 100-50mcg	22.3%	16.5%	4.9%	$ 15,456,326	172,318	$90	0.3%	0.2%
Bextra	109.3%	97.6%	5.8%	$ 13,184,263	176,320	$75	0.3%	0.2%
Lexapro	523.5%	503.2%	2.6%	$ 11,998,349	231,600	$52	0.3%	0.3%
Zetia	2690.2%	2677.5%	5.0%	$ 11,901,101	208,222	$57	0.3%	0.2%
Actonel	229.8%	219.6%	4.7%	$ 10,678,554	205,105	$52	0.2%	0.2%
Humira	119.5%	102.5%	8.4%	$ 9,047,241	7,058	$1,282	0.2%	0.0%
Total of Top 50	11.3%	6.7%	4.4%	$ 1,664,411,977	17,838,804	$93	36.5%	20.4%
Grand Total	6.8%	-0.2%	7.1%	$ 4,553,877,499	87,309,239	$52	100.0%	100.0%

Note: The top 50 drugs from 2004 were used as a basis for selecting the 2003 and 2002 drugs used in this table. Drugs with asterisks are generic and drugs bolded were FDA approved within 2001-2004.

Exhibit D

Pharmacy Provider Class
2002-2004 Top 50 Mail Order Drugs by Payout

MOPD Brand Name	2-Year Avg % Chg per 1000 Members: Payments	Scripts	Price	2004-2002 Payments	2004-2002 Scripts	Avg Price per Script	% To Total Payout	% To Total Script
Prevacid	72.2%	66.1%	3.6%	$ 51,429,553	153,452	$ 335.15	2.9%	1.1%
Celebrex	41.5%	37.3%	2.6%	$ 49,951,467	201,989	$ 247.30	2.8%	1.5%
Zocor 20mg	41.9%	37.8%	2.9%	$ 49,643,597	167,374	$ 296.60	2.8%	1.2%
Prilosec *	-24.1%	5.5%	-29.3%	$ 46,274,036	209,398	$ 220.99	2.6%	1.5%
Lipitor 10mg--	53.1%	45.5%	4.5%	$ 45,475,023	306,129	$ 148.55	2.5%	2.2%
Nexium--	126.0%	111.2%	6.9%	$ 44,152,422	140,573	$ 314.09	2.5%	1.0%
Lipitor 20mg	63.3%	58.7%	2.9%	$ 43,631,607	189,453	$ 230.30	2.4%	1.4%
Plavix	108.2%	94.1%	6.9%	$ 39,904,607	145,014	$ 275.18	2.2%	1.1%
Zocor 40mg	67.8%	62.5%	3.1%	$ 31,769,840	107,125	$ 296.57	1.8%	0.8%
Fosamax	53.0%	45.8%	4.7%	$ 25,644,617	179,891	$ 142.56	1.4%	1.3%
Vioxx	17.4%	12.9%	4.0%	$ 24,309,308	128,902	$ 188.59	1.4%	0.9%
Enbrel	67.1%	56.0%	7.1%	$ 23,637,041	7,838	$ 3,015.70	1.3%	0.1%
Protonix	94.1%	82.0%	6.7%	$ 20,266,210	82,787	$ 244.80	1.1%	0.6%
Lipitor 40mg	65.4%	67.3%	-2.0%	$ 19,340,383	81,349	$ 237.75	1.1%	0.6%
Singulair	71.3%	63.1%	4.6%	$ 17,551,867	92,057	$ 190.66	1.0%	0.7%
Advair diskus 250-50mcg	85.2%	73.0%	7.0%	$ 15,820,358	50,078	$ 315.91	0.9%	0.4%
Pravachol 40mg	73.7%	66.1%	3.8%	$ 15,607,496	52,834	$ 295.41	0.9%	0.4%
Aciphex	82.9%	73.5%	5.2%	$ 14,490,378	46,120	$ 314.19	0.8%	0.3%
Actos 45mg	58.6%	49.1%	6.0%	$ 14,233,682	36,077	$ 394.54	0.8%	0.3%
Evista	40.2%	29.5%	8.2%	$ 14,003,820	87,604	$ 159.85	0.8%	0.6%
Norvasc 5mg	62.7%	52.8%	5.5%	$ 14,001,634	138,100	$ 101.39	0.8%	1.0%
Tricor	97.1%	72.9%	13.9%	$ 13,787,921	69,831	$ 197.45	0.8%	0.5%
Actos 30mg	60.4%	51.3%	5.7%	$ 13,559,087	37,267	$ 363.84	0.8%	0.3%
Norvasc 10mg	82.4%	78.2%	0.8%	$ 13,282,465	95,849	$ 138.58	0.7%	0.7%
Allegra	77.2%	70.0%	4.2%	$ 13,111,603	88,874	$ 147.53	0.7%	0.7%
Zyrtec	43.5%	40.4%	1.8%	$ 12,717,785	101,702	$ 125.05	0.7%	0.7%
Flomax	61.8%	55.7%	4.2%	$ 11,713,074	87,029	$ 134.59	0.7%	0.6%
Zoloft 50mg	47.5%	40.8%	4.5%	$ 11,706,222	64,019	$ 182.86	0.7%	0.5%
Avandia 8mg	51.3%	43.5%	4.9%	$ 11,281,529	31,921	$ 353.42	0.6%	0.2%
Zocor 10mg	22.3%	19.4%	2.3%	$ 10,361,503	63,915	$ 162.11	0.6%	0.5%
Zetia	13197.3%	13085.3%	7.5%	$ 10,083,923	65,675	$ 153.54	0.6%	0.5%
Copaxone	53.8%	38.1%	11.5%	$ 10,080,648	3,326	$ 3,030.86	0.6%	0.0%
Zoloft 100mg	55.2%	45.9%	6.0%	$ 9,882,670	49,975	$ 197.75	0.5%	0.4%
Detrol LA	65.8%	54.5%	6.9%	$ 9,662,088	49,281	$ 196.06	0.5%	0.4%
Avandia 4mg	57.3%	51.4%	3.4%	$ 9,599,529	40,826	$ 235.13	0.5%	0.3%
Neurontin *	44.5%	52.7%	-4.5%	$ 9,438,564	38,502	$ 245.14	0.5%	0.3%
Flonase	46.3%	37.4%	6.0%	$ 8,918,743	73,179	$ 121.88	0.5%	0.5%
Advair diskus 500-50mcg	76.5%	65.7%	6.4%	$ 8,357,398	18,544	$ 450.68	0.5%	0.1%
Pravachol 20mg	42.7%	33.1%	6.8%	$ 8,345,975	43,455	$ 192.06	0.5%	0.3%
Clarinex	140.1%	122.8%	8.5%	$ 7,835,382	54,711	$ 143.21	0.4%	0.4%
Effexor XR	75.8%	62.7%	8.1%	$ 7,739,780	28,520	$ 271.38	0.4%	0.2%
Bextra 20mg	218.8%	202.5%	5.8%	$ 7,409,326	36,692	$ 201.93	0.4%	0.3%
Bextra 10mg	113.1%	100.5%	6.3%	$ 7,312,383	35,538	$ 205.76	0.4%	0.3%
Actonel	307.8%	298.2%	4.3%	$ 7,233,607	52,202	$ 138.57	0.4%	0.4%
Zocor 80mg	62.0%	56.3%	3.6%	$ 7,049,894	24,208	$ 291.22	0.4%	0.2%
Cozaar	51.7%	41.7%	5.9%	$ 7,014,149	60,169	$ 116.57	0.4%	0.4%
Ambien PAK	84.8%	65.7%	10.8%	$ 6,681,309	41,670	$ 160.34	0.4%	0.3%
Advair diskus 100-50mcg	68.6%	57.8%	6.7%	$ 6,641,260	27,533	$ 241.21	0.4%	0.2%
Polyonic *	92.2%	84.6%	3.8%	$ 5,926,087	18,837	$ 314.60	0.3%	0.1%
Humira	250.1%	190.5%	20.5%	$ 4,904,889	1,494	$ 3,283.06	0.3%	0.0%
Total of Top 50	60.0%	54.7%	2.7%	$ 892,777,737	4,008,888	$ 222.70	49.7%	29.4%
Grand Total	55.1%	47.4%	5.1%	$ 1,797,052,315	13,615,230	$ 131.99	100.0%	100.0%

Note: The top 50 drugs from 2004 were used as a basis for selecting the 2003 and 2002 drugs used in this table. Drugs with asterisks are generic and drugs bolded were FDA approved within 2001-2004.

Exhibit E

Pharmacy Provider Class
2002-2004 Top 50 Retail Drugs by Use

Brand Name	2-Year Avg % chg per 1000 Members			2004-2002	2004-2002	Avg Pymt	% To Total	% To Total
	Scripts	Payments	Price	Scripts	Payments	Per Script	Scripts	Payout
Lipitor 10mg	-5.6%	0.2%	6.2%	1,034,754	$ 86,928,084	$ 84.01	1.2%	1.9%
Amacodone *	5.2%	20.7%	14.2%	956,631	$ 1,685,845	$ 1.76	1.1%	0.0%
Prevacid	1.6%	6.5%	4.7%	848,099	$ 108,670,243	$ 128.13	1.0%	2.4%
Celebrex	-8.0%	-5.7%	2.5%	827,891	$ 76,721,990	$ 92.67	0.9%	1.7%
Zithromax	-0.7%	2.0%	2.8%	785,482	$ 23,086,841	$ 29.39	0.9%	0.5%
A-Cillin *	1.8%	6.0%	4.1%	773,801	$ 998,856	$ 1.29	0.9%	0.0%
Darvocet-N 100 *	-2.7%	-3.7%	-1.3%	764,885	$ 5,947,808	$ 7.78	0.9%	0.1%
Prilosec *	-19.0%	-29.2%	-12.7%	750,086	$ 87,673,501	$ 116.88	0.9%	1.9%
Hydrocodone *	10.7%	10.9%	0.1%	727,211	$ 4,620,976	$ 6.35	0.8%	0.1%
Fosamax *	3.7%	9.2%	5.5%	681,330	$ 36,151,127	$ 53.06	0.8%	0.8%
Vioxx	-16.5%	-13.1%	4.1%	669,203	$ 47,840,229	$ 71.49	0.8%	1.1%
Ventolin	1.6%	-8.9%	-10.2%	668,862	$ 8,149,973	$ 12.18	0.8%	0.2%
Zyrtec	0.6%	3.0%	2.5%	626,333	$ 28,608,819	$ 45.68	0.7%	0.6%
Nexium	27.9%	37.8%	7.8%	623,674	$ 74,294,680	$ 119.12	0.7%	1.6%
Lipitor 20mg	0.5%	5.9%	5.2%	606,662	$ 78,819,979	$ 129.92	0.7%	1.7%
Plavix	20.7%	28.7%	6.7%	601,653	$ 59,573,101	$ 99.02	0.7%	1.3%
Allegra	19.9%	26.3%	5.4%	525,600	$ 29,385,293	$ 55.91	0.6%	0.6%
Aceta w/Codeine*	-6.6%	-6.4%	0.0%	522,830	$ 2,027,499	$ 3.88	0.6%	0.0%
IB Pro *	0.3%	-3.0%	-3.5%	496,128	$ 1,656,299	$ 3.34	0.6%	0.0%
Atenolol 50mg *	-4.4%	48.5%	50.8%	493,909	$ 3,851,529	$ 7.80	0.6%	0.1%
Biocef *	3.5%	8.8%	4.4%	460,921	$ 3,225,334	$ 7.00	0.5%	0.1%
Norvasc 5 mg	-6.0%	-1.5%	4.8%	452,625	$ 22,492,075	$ 49.69	0.5%	0.5%
Detue *	-3.9%	34.9%	37.2%	451,972	$ 1,005,447	$ 2.22	0.5%	0.0%
Zoloft 50mg	0.6%	5.2%	4.7%	448,389	$ 30,901,888	$ 68.92	0.5%	0.7%
Dyazide *	-0.8%	-4.5%	-3.8%	444,987	$ 4,261,036	$ 9.58	0.5%	0.1%
Carozide *	13.6%	16.9%	3.9%	432,316	$ 430,626	$ 1.00	0.5%	0.0%
Sarafem	-6.1%	-26.7%	-21.4%	431,189	$ 12,832,320	$ 29.76	0.5%	0.3%
Zocor 20mg	-8.8%	-3.5%	5.7%	428,956	$ 70,993,723	$ 165.50	0.5%	1.6%
Singulair	16.2%	21.4%	4.5%	420,837	$ 36,780,840	$ 87.40	0.5%	0.8%
Protonix	21.0%	29.4%	6.5%	420,373	$ 38,613,264	$ 91.85	0.5%	0.8%
Toprol XL	4.5%	12.0%	7.1%	415,912	$ 8,943,522	$ 21.50	0.5%	0.2%
Lopressor *	-1.9%	-9.7%	-8.3%	400,812	$ 1,650,868	$ 4.12	0.5%	0.0%
Flonase	1.7%	7.3%	5.6%	397,316	$ 19,106,200	$ 48.09	0.5%	0.4%
Eltroxin 100mcg *	-3.1%	-3.0%	-0.4%	396,242	$ 4,979,970	$ 12.57	0.5%	0.1%
Alprazolam .25mg *	-0.7%	43.6%	42.1%	394,402	$ 2,231,975	$ 5.66	0.5%	0.0%
Glucophage *	5.8%	-18.6%	-22.4%	392,563	$ 6,637,635	$ 16.91	0.4%	0.1%
Ambien Pak	15.7%	27.2%	9.9%	390,893	$ 23,551,386	$ 60.25	0.4%	0.5%
Prinivil	2.5%	-39.0%	-39.2%	373,547	$ 5,172,499	$ 13.85	0.4%	0.1%
Atenolol 25mg *	-4.4%	71.7%	75.4%	366,283	$ 3,119,013	$ 8.52	0.4%	0.1%
Trinessa	-9.3%	1.9%	12.5%	360,973	$ 9,247,021	$ 25.62	0.4%	0.2%
Zoloft 100mg	3.8%	9.4%	5.4%	350,954	$ 25,755,740	$ 73.39	0.4%	0.6%
Norvasc 10mg	-0.8%	-0.3%	0.6%	348,156	$ 24,389,732	$ 70.05	0.4%	0.5%
Flomax	4.4%	8.6%	3.6%	344,888	$ 17,168,384	$ 49.78	0.4%	0.4%
Clarinex	21.9%	38.6%	12.8%	331,316	$ 17,602,700	$ 53.13	0.4%	0.4%
Eltroxin 50mcg *	1.9%	0.2%	-2.4%	322,691	$ 3,139,293	$ 9.73	0.4%	0.1%
Zestril 20mg *	2.3%	-17.3%	-18.2%	316,792	$ 7,002,347	$ 22.10	0.4%	0.2%
Alprazolam .5mg *	3.1%	61.0%	53.5%	312,960	$ 4,000,873	$ 12.78	0.4%	0.1%
Lexapro	503.2%	523.5%	2.6%	231,600	$ 11,998,349	$ 51.81	0.3%	0.3%
Zetia	2677.5%	2690.2%	5.0%	208,222	$ 11,901,101	$ 57.16	0.2%	0.3%
Actonel	219.6%	229.8%	4.7%	205,105	$ 10,678,554	$ 52.06	0.2%	0.2%
Total of Top 50	3.3%	6.3%	2.7%	25,239,216	$ 1,206,506,385	$ 47.80	28.9%	26.5%
Grand Total	-0.2%	6.8%	7.1%	87,309,239	$ 4,553,877,499	$ 52.16	100.0%	100.0%

Note: The top 50 drugs from 2004 were used as a basis for selecting the 2003 and 2002 drugs used in this table.
Drugs with asterisks are generic and drugs bolded were FDA approved within 2001-2004.

Exhibit F

Pharmacy Provider Class
2002-2004 Top 50 Mail Order Drugs by Use

Brand Name	2Year Avg % Chg per 1000 Members			2004-2002		2004-2002	Avg Pymt	% To Total	% To Total
	Scripts	Payments	Price	Scripts		Pyaments	Per Script	Scripts	Payout
Lipitor 10mg	45.5%	53.1%	4.5%	306,129	$	45,475,023	$ 148.55	2.2%	2.5%
Prilosec *	5.5%	-24.1%	-29.3%	209,398	$	46,274,036	$ 220.99	1.5%	2.6%
Celebrex	37.3%	41.5%	2.6%	201,989	$	49,951,467	$ 247.30	1.5%	2.8%
Lipitor 20mg	58.7%	63.3%	2.9%	189,453	$	43,631,607	$ 230.30	1.4%	2.4%
Fosamax	45.8%	53.0%	4.7%	179,891	$	25,644,617	$ 142.56	1.3%	1.4%
Zocor 20mg	37.8%	41.9%	2.9%	167,374	$	49,643,597	$ 296.60	1.2%	2.8%
Prevacid	66.1%	72.2%	3.6%	153,452	$	51,429,553	$ 335.15	1.1%	2.9%
Plavix	94.1%	108.2%	6.9%	145,014	$	39,904,607	$ 275.18	1.1%	2.2%
Nexium	111.2%	126.0%	6.9%	140,573	$	44,152,422	$ 314.09	1.0%	2.5%
Norvasc	52.8%	62.7%	5.5%	138,100	$	14,001,634	$ 101.39	1.0%	0.8%
Vioxx	12.9%	17.4%	4.0%	128,902	$	24,309,308	$ 188.59	0.9%	1.4%
Lasix 40mg *	61.3%	43.0%	-13.8%	123,754	$	526,024	$ 4.25	0.9%	0.0%
Tenormin 50mg *	46.2%	48.7%	1.8%	121,451	$	3,218,326	$ 26.50	0.9%	0.2%
Toprol XL 50mg	68.0%	89.5%	11.1%	119,283	$	5,267,747	$ 44.16	0.9%	0.3%
Hydrodiuril 25mg *	71.0%	44.6%	-21.8%	116,173	$	44,780	$ 0.39	0.9%	0.0%
Synthroid 100mcg *	41.8%	22.3%	-11.5%	107,854	$	1,532,307	$ 14.21	0.8%	0.1%
Zocor 40mg	62.5%	67.8%	3.1%	107,125	$	31,769,840	$ 296.57	0.8%	1.8%
Zyrtec	40.4%	43.5%	1.8%	101,702	$	12,717,785	$ 125.05	0.7%	0.7%
Premarin *	-7.9%	9.4%	17.7%	101,311	$	5,056,095	$ 49.91	0.7%	0.3%
Norvasc	78.2%	82.4%	0.8%	95,849	$	13,282,465	$ 138.58	0.7%	0.7%
Singulair	63.1%	71.3%	4.6%	92,057	$	17,551,867	$ 190.66	0.7%	1.0%
Dyazide 37.5-25mg *	46.0%	34.8%	-10.4%	91,515	$	721,669	$ 7.89	0.7%	0.0%
Lopressor *	63.7%	66.1%	-1.1%	88,920	$	1,859,292	$ 20.91	0.7%	0.1%
Allegra	70.0%	77.2%	4.2%	88,874	$	13,111,603	$ 147.53	0.7%	0.7%
Parathyroid	57.0%	43.1%	-10.4%	88,075	$	5,007,295	$ 56.85	0.6%	0.3%
Evista	29.5%	40.2%	8.2%	87,604	$	14,003,820	$ 159.85	0.6%	0.8%
Flomax	55.7%	61.8%	4.2%	87,029	$	11,713,074	$ 134.59	0.6%	0.7%
Tenormin 25mg *	47.9%	52.4%	3.1%	84,785	$	2,124,465	$ 25.06	0.6%	0.1%
Zestril 10mg *	52.2%	26.7%	-21.5%	82,907	$	2,971,366	$ 35.84	0.6%	0.2%
Protonix	82.0%	94.1%	6.7%	82,787	$	20,266,210	$ 244.80	0.6%	1.1%
Lipitor 40mg	67.3%	65.4%	-2.0%	81,349	$	19,340,383	$ 237.75	0.6%	1.1%
Synthroid 50mcg *	54.1%	32.3%	-12.1%	80,697	$	927,285	$ 11.49	0.6%	0.1%
Zestril 20mg *	58.3%	32.8%	-20.8%	80,045	$	3,445,483	$ 43.04	0.6%	0.2%
K-Dur 20meq *	60.6%	48.7%	-7.8%	79,257	$	1,791,753	$ 22.61	0.6%	0.1%
Flonase	37.4%	46.3%	6.0%	73,179	$	8,918,743	$ 121.88	0.5%	0.5%
Toprol XL 100mg	73.2%	90.9%	8.9%	70,277	$	5,156,124	$ 73.37	0.5%	0.3%
Lasix 20mg *	63.3%	48.8%	-13.2%	69,993	$	175,364	$ 2.51	0.5%	0.0%
Tricor	72.9%	97.1%	13.9%	69,831	$	13,787,921	$ 197.45	0.5%	0.8%
Ventolin	49.5%	47.0%	-3.3%	68,056	$	2,102,442	$ 30.89	0.5%	0.1%
Zetia	13085.3%	13197.3%	7.5%	65,675	$	10,083,923	$ 153.54	0.5%	0.6%
Zantac *	25.9%	19.7%	-4.9%	65,325	$	5,972,642	$ 91.43	0.5%	0.3%
Synthroid 75mcg *	55.4%	36.3%	-9.9%	65,023	$	868,861	$ 13.36	0.5%	0.0%
Zoloft	40.8%	47.5%	4.5%	64,019	$	11,706,222	$ 182.86	0.5%	0.7%
Coumadin 5mg *	49.3%	52.7%	0.4%	62,708	$	1,524,997	$ 24.32	0.5%	0.1%
Cozaar	41.7%	51.7%	5.9%	60,169	$	7,014,149	$ 116.57	0.4%	0.4%
Lanoxin 0.125mg *	46.4%	56.1%	-0.1%	59,890	$	184,401	$ 3.08	0.4%	0.0%
Clarinex	122.8%	140.1%	8.5%	54,711	$	7,835,382	$ 143.21	0.4%	0.4%
Imdur MS	57.1%	50.3%	-4.8%	53,243	$	2,000,978	$ 37.58	0.4%	0.1%
Pravachol 40mg	66.1%	73.7%	3.8%	52,834	$	15,607,496	$ 295.41	0.4%	0.9%
Actonel	298.2%	307.8%	4.3%	52,202	$	7,233,607	$ 138.57	0.4%	0.4%
Total Top 50	52.6%	56.3%	1.8%	5,157,813	$	722,842,057	$ 140.15	37.9%	40.2%
Grand Total	47.4%	55.1%	5.1%	13,615,230	$	1,797,052,315	$ 131.99	100.0%	100.0%

Note: The top 50 drugs from 2004 were used as a basis for selecting the 2003 and 2002 drugs used in this table. Drugs with asterisks are generic and drugs bolded were FDA approved within 2001-2004.