



BENEFIT *Advisor*

In This Issue

In this fourth issue of the McGrawWentworth Benefit Advisor for 2006, we will discuss prescription drug benefits. Costs have risen substantially for pharmacy benefits in the last decade. Pharmacy benefits is an area where employers tend to make more changes and require employees to share a greater portion of the cost.

In this Advisor, we will examine prescription drug benefit plan options in detail. We will discuss many strategies employers can use to better control their pharmacy benefit cost.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“Managing Pharmacy Benefit Costs”

Pharmacy benefit costs have increased substantially over the last decade. Between 2000 and 2004, the average annual increase in prescription drug expense according to Segal was 17%. Last year, the cost increases slowed for many, but they are still expected to remain in the double digits. According to Mercer, health plans saw an 11.5% increase in prescription drug cost for 2005. Prescription drug costs now account for an estimated 17% of total health care spending for active employees.

Even though pharmacy expenses are increasing at a lesser rate, organizations still need to exercise vigilance when it comes to their pharmacy benefits. One of the fastest increasing cost elements are biotech medications. These new blockbuster medication therapies have significant impact on the quality of life for plan participants. However, these medications are very expensive so they also will have a significant impact on an organization’s bottom line.

Managing pharmacy benefits means understanding a bit about the development of pharmaceutical treatment therapies. When new medications are approved by the FDA to be introduced to the market, the manufacturer has period of exclusivity in the marketplace, generally, it is roughly twenty years. During this period of exclusivity, the

cost of the new medication is relatively high as manufacturers look to recoup their research and development costs and also generate a profit on the medication.

This Advisor examines the following issues in depth and provides useful suggestions to help your organization maximize your pharmacy benefit dollar:

- Trends in the pharmaceutical market
- Encouraging generic drug use
- Self-funding pharmacy benefits
- Maximizing network discount arrangements
- Value-based pharmacy plan designs
- Medical management programs
- Plan design and PBM (Pharmacy Benefit Managers) contract provisions



Trends in the Pharmaceutical Market

Over the last several years, three key areas in the pharmacy market have affected employer sponsored plans. First, many manufacturers have lost their exclusive rights to blockbuster

medications. Big name medications, including Allegra, Zithromax, Oxycontin, Procrit, Zolof, Lupron, Zocor and others have lost their exclusivity rights over the last several years. The loss of exclusivity has brought a unique opportunity for employer plans to increase generic utilization significantly.

Medco Health Solutions monitored the dispensing rates for four prescription drugs that recently lost their patent protections (Allegra, Zithromax, Aravad, and Amaryl). The Medco study reviewed retail pharmacies and found that within the first 30 days after a generic alternative was available, the demand for the generic increased by more than 87%. This high rate of substitution so quickly after a generic is introduced shows that education and incentives can go a long way in encouraging individuals to use less expensive medications.

Several years ago, a 45% generic utilization rate was considered successful for many plans. Today, generic drug use can reach 65% or even higher if an employer strongly encourages employees to use these drugs.

Employers need to be aware of the process of introducing generics to the market. The process allows one manufacturer a six-month period of exclusivity for the first generic marketed. This generic tends to be introduced at a higher price than the generics introduced after the 6-month period. Employers should understand that as multiple generics are introduced to the market, some generics will be more cost effective than others.



Specialty pharmaceuticals will be the next wave of blockbuster medications that may have serious impact on employee health and pharmacy benefit plan cost. Specialty pharmaceuticals are sometimes referred to as biotech medications. Many medications now being developed are in this category. These medications generally have special handling or special administration requirements. Ninety percent of the 80 approved biotech currently available are injectibles designed to treat a host of conditions including multiple sclerosis, hepatitis, arthritis, cancer and others. The average monthly cost for these types of medications is \$1,170. For most health plans, this amount represents only about 3% of the current drug spend. However, the cost and use of these medications are projected to rise between 20% and 40% a year.

Finally, some medications have been withdrawn from the market. Bextra and Vioxx were two popular pain medications. Vioxx, in particular, was one of the top 25 medications used in many organizations. The withdrawal of these medications, called COX II inhibitors, had an effect on the use of a third popular COX II inhibitor, Celebrex. Celebrex use declined when Vioxx and Bextra were removed from the market because individuals taking Celebrex were concerned about its long term effects. Thus the use of COX II inhibitors declined for most health plans.

It used to be uncommon for medications to be withdrawn from the market. However, it is now happening more often. In fact, the FDA has issued warnings about several medi-

cations currently under review including:

- **Severent and Advair** – these medications are used to treat asthma and have been linked to 13 deaths; the entire drug category is at risk.
- **Viagra, Cialis and Levitra** – these medications are used to treat erectile dysfunction and may cause sudden vision loss.
- **Elidel and Protopic** – these medications are used to treat eczema and may cause skin cancer.

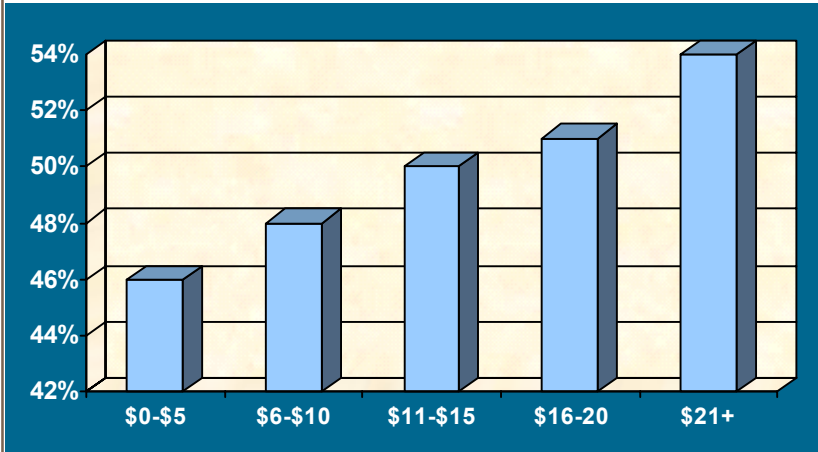
Although the FDA is not currently reviewing Ritalin, many people are concerned about its widespread use and its long term effects. In addition, there is concern over the usage of anti-depressants approved for adults with teenagers.

Increasing drug costs affect employer-sponsored health plans. Organizations need to understand the pharmacy market in order to manage their drug plans more effectively.

Maximizing Generic Utilization

With the increase of generics available for many leading medications, organizations should focus on increasing generic utilization. One of the best ways to encourage employees to seek generic alternatives is through financial incentives. Express Scripts recently released the results of a study that examined the impact of copay differentials on generic fill rates. The data examined the 2004 retail experience. The study found the following **generic-fill rates** by the various brand name copay differentials with average generic copays between \$5 and \$9.

Continued on Page 3



The table above shows clearly that a significant copay difference between generic and brand name drugs motivates employees to choose the generic. However, you should consider your employees' income when you set the copay difference. For low earners, a \$15 difference may be enough incentive. For higher incomes, a larger differential may be appropriate.

Increased use of generic drugs does affect plan costs. It is estimated that for every 1% increase in generic drug use, plans can expect to save 1% to 2% in claim cost. This makes sense. According to the National Association of Chain Drug Stores, in 2004, the average cost of a generic medication was \$28.74 and the average cost for a brand name medication was \$96.01.

Average copays for prescription plans have increased steadily since 2000. According to the 2005 Employee Health Benefits Survey conducted by the Kaiser Foundation, the average prescription drug copays for 2000 - 2004 are shown in the table to the right.

While the copays have increased over the last five years, the difference between brand name copays and generic copays has not increased dramatically.

Some organizations in an effort to increase generic utilization have implemented "mandatory generic" plan designs. These plans will only cover a generic medication when one is available. If the patient requests the brand name drug and even if the physician writes "dispense as written" on the prescription, the plan will only cover the generic. The patient will be responsible for the cost difference between the generic and brand name drug.

Self-Funding Benefits

Many organizations fully insure their prescription plan with the carrier that insures their medical benefits. Other employers have considered self-funding their prescription coverage using a pharmacy benefit manager. For many organizations, this approach is less expensive. The sav-

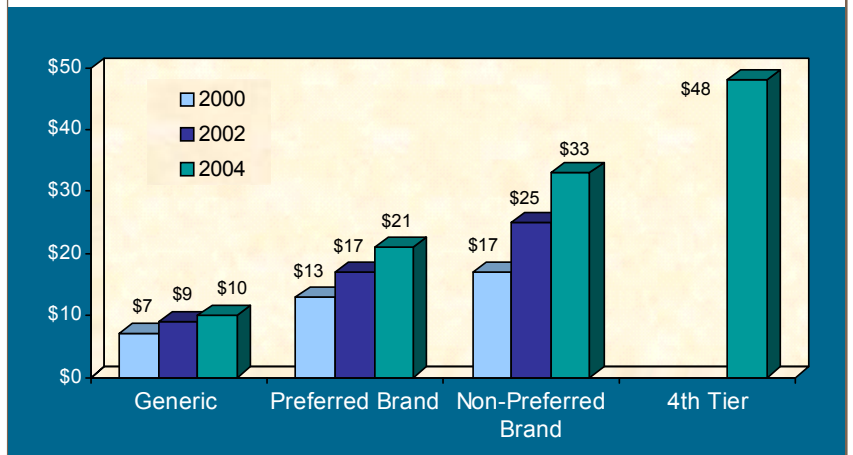
ings can come from a number of areas:

- Pharmacy benefit managers have more flexibility when they manage pharmacy plans. Organization can decide which medications to cover and also add limitations.
- Pharmacy benefit managers have programs to help manage prescription drug costs more effectively.
- Self-funding may save money for community-rated plans if employee demographics are better than the pool arrangement.

However, there is no guarantee self-funding the benefit will reduce costs. Self-funding is a risky proposition, especially if your organization does not have the data necessary to project the potential cost. Consider the following issues when you decide whether to self-fund prescription coverage:

- The benefit cost becomes less predictable. Instead of paying a monthly insurance premium, your organization will pay the actual claims. If your organization has cash flow problems, self-funding pharmacy benefits may be difficult because you

Continued on Page 4



cannot exactly predict the monthly cost.

- Unless your organization self-funds the medical program as well, stop loss coverage on stand alone pharmacy benefits is not common. Stop loss coverage is important because it does set a maximum liability on your pharmacy costs. If your organization self-funds the medical plan, your stop loss vendor may allow you to include prescriptions under the covered expenses for stop loss coverage. In general, adding prescription benefits to the stop loss plan will significantly increase your premium.
- Separating prescription coverage from medical coverage can have unintended effects on your carrier's disease management programs. These programs usually involve data mining. Your carrier reviews both medical and prescription claim data seeking ways to help employees manage their chronic medical conditions. The data is also used to determine whether there are any gaps in care for plan participants managing chronic conditions. Removing the prescription coverage from your health plan vendor could have a serious effect on these disease management initiatives.

Many organizations have discovered self-funding prescription coverage

can save money. However, for some organizations self-funding this benefit has increased the cost. If you don't know the number of prescription claims your employees submit, you may find self-funding pharmacy benefits is a bit like jumping into a pool without knowing how deep the water is – it can be dangerous. It is also important to consider the potential impact on the effectiveness of your disease management program. Your disease management program will probably be less effective if it does not have access to integrated health and prescription drug data.

Before you decide to self-fund your pharmacy benefits, make sure you can return to a fully insured arrangement during the plan year if employees submit an excessive number of claims. It may not be easy to switch back to your insured arrangement, but if your experience is poor, you need to make sure that this option is available.



Maximizing Network Discount Arrangements

One of the responsibilities of your pharmacy benefit manager is to deliver competitive pricing for the medications covered by the plan. One of the PBMs key functions is to negotiate aggressive discounts on behalf of your plan. Many employers assume the network they use is the most aggressively discounted

network offered by their PBM. That may not be so. Many PBMs offer several network options from which an employer can choose. The broadest network in general will offer the least aggressive discounts and a more limited network may offer more aggressive discounts.

With the glut of national chain pharmacies in most populated areas, your organization may want to choose a more limited network. Ask your PBM which networks are available and the relative price differences for using the different network options. PBMs can usually compare the pharmacies in the more restrictive network to the pharmacies your employees primarily use to determine whether your employees

will experience any disruptions. Using a more restrictive network can save money without shifting more cost to your employees.

When you discuss network options with your PBM, it also is a good idea to discuss the price agreements your PBM has with various chain pharmacies. For example, if your PBM has negotiated lower drug prices with CVS, you can encourage your employees to use CVS. If your plan offers a coinsurance based plan design, employees will tend to choose the least expensive participating pharmacy.

You may also want to discuss biotech drugs with both your PBM and your medical plan vendor. Many PBMs are partnering with special networks to discount biotech drugs. However, you need to discuss these medications with your health plan vendor as well. It is possible that

Continued on Page 5

NOTABLE THOUGHTS

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SIR WINSTON CHURCHILL

your health plan covers some specialty drugs because of special administration requirements. For example, if a medication needs to be administered in a physician's office, your medical plan vendor may already cover it. You need to know which plan is covering which medications and the discounts each vendor offers. It makes sense to choose the vendor that offers the best discount.

You may have more options than you are aware of when it comes to networks. A more restrictive network that offers better discounts may cause relatively little disruption to your employees and save money for your organization.

Value-Based Pharmacy Plan Designs

One area that has received a lot of press lately is "value-based" benefit designs. Value-based benefits, in general, offer lower copays for drugs with high clinical value and solid evidence-based success in treating a condition.

This approach is counter intuitive to how most employers are managing their pharmacy programs today. Today, employers looking to manage cost typically shift more of the cost to the employee. At some point, there is concern that if the cost is increased too much, employees will discontinue some of their treatments because they simply cannot afford the additional cost. This strategy may increase cost on the medical plan side if the individual experiences complications by not following the prescribed treatment regime.

A new study released in the January issue of the *American Journal of Managed Care* finds that eliminating patient copays for chole-

sterol-lowering statin drugs could actually save insurers more than a billion dollars a year in hospitalization costs. The study found that patients at risk for heart problems were more likely to take statin drugs which reduced the potential for more costly medical care. Patients with copayments of just \$10 per month for statin drugs were 6% to 10% more likely to follow their drug regime than patients with copayments of \$20 per month.

Pitney Bowes implemented a value-based benefits program and had similar results. When Pitney Bowes lowered the cost for diabetes and asthma medications, overall medical plan cost decreased and patient compliance increased.

This approach is on the cutting edge of what organizations are implementing as cost control measures. One of the concerns with this approach is determining which medications should be offered for lower copays. The list of lower cost medications should be targeted to the needs of your population and should treat chronic conditions. In addition, there should be clear and convincing evidence that adherence to drug therapies has significant impact on the medical condition. The therapeutic effectiveness of the medication must be strongly established. Value-based programs typically include cholesterol-lowering drugs, high blood pressure medications, diabetes and asthma medications.

The other challenge to this approach is finding a vendor that can manage this type of program. There are vendors in the market that can administer this type of benefit if your organization is interested.

Medical Management Programs

Many PBMs offer medical management programs designed to ensure that employees are using the most cost-effective medications. Medical management programs include:

- **Step-Therapy:** As new medications are produced to treat various ailments, there is no requirement that the "latest and greatest" medication be any more effective than the previous generation medication. And in many cases, new medications are no more effective than treatment options that have been around for years. Step therapy protocols focus on requiring patients to try established treatment options before the plan will cover a higher cost brand name treatment. For example, both Prilosec and Nexium treat frequent heartburn. Both drugs are members



of the same class of drugs, Proton Pump Inhibitors (PPIs). Prilosec has been on the market for many years and recently

was granted "over the counter" status. For many patients with frequent heartburn, Prilosec may just be just as effective Nexium. However, Prilosec costs approximately \$10 and Nexium is approximately \$80. The purpose of step therapy is to try less costly, more established treatment regimes before using the newer, more expensive options. With several drugs over the past few

years being granted over-the-counter status, many step therapy programs will cover the over the counter drug in full to offer a financial incentive to the patient to try the previous generation medication first.

- **Prior authorization:** These programs require a patient to provide doctor authorization for the treatment regime before the plan will cover the medication. Prior authorization requirements are only applied to certain medications. Typically, they are high cost medications or



medications that have a history of being used for a non-approved treatment. For example, injectable growth hormones are very expensive and many plans cover these medications. They are used to treat a specific medical condition, which is a deficit of a necessary growth hormone that occurs naturally in the body. Some parents may think their child needs growth hormone treatment if they are not developing as quickly as other children. A doctor may prescribed a growth hormone for the child, but your plan only wants to cover this medication when it is used to treat children who do not have the necessary hormone. The prior authorization requirement can be used to make sure your plan only covers medications for your plan approved use, not an off-label use.

- **Pill-Splitting Programs:** More and more plans are looking

into the possibility of offering pill splitting programs. One of the oddities of the prescription market is that there is very little pricing break for higher dose medications. For example, a 60 mg tablet and 120 mg tablet may cost the same even though the active ingredient is double. With certain medications, not all of them, if a doctor prescribed 60 mg of a medication twice a day, the patient could buy a 120 mg tablet and take half in the morning and half in the evening. The 120 mg tablet will cost almost 50% less than

two 60-mg tablets. Splitting pills responsibly can cut costs. However, in some cases, a split 120 mg tablet may not have the same effect as two 60-mg tablets.

PBMs are getting more involved in programs to assist employers in effectively managing their pharmacy program. Not only are the above options available, many PBMs work with patients and physicians to help increase generic utilization through various communication efforts.

It may make sense to have a meeting with your PBM to see what programs are available to help more efficiently manage your pharmacy plan.

Plan Design and PBM Contract Provisions

Organizations can usually change plan design to control costs. Plan design options your organization can consider include:

- **3 or 4-tier copay options:** According to the 2005 Mercer survey, 3-tier drug plans remain the most prevalent with 68% of large employers offering them. Other employers are adding a fourth tier with coinsurance or a higher copay for high cost and lifestyle medications.
- **Reference-based pricing:** This approach is similar to setting a reasonable and customary limit on drug prices. In reference-based pricing, the plan selects the best value drug in a therapeutic class and bases the maximum reimbursement on the best value drug coverage. For example, many "statin" drugs are now available. Typically, Lipitor is the least expensive. Crestor, Zocor and others cost more. In reference-based pricing, the plan will cover Lipitor for the brand copay. If the patient uses any of the other drugs in this class, the patient would be responsible for the copay and also the difference in cost.
- **Coinsurance:** More and more employers are considering coinsurance arrangements. In the Mercer survey, 14% of all large employers offered a coinsurance prescription plan, up from 11% in 2004. One of the benefits of coinsurance arrangements is subscribers share directly in the cost of their medications. This strong incentive motivates employees to ask for the least expensive drug. Another benefit of coinsurance is employees share inflationary cost increases. Employers need not adjust copays for inflation with a coinsurance arrangement because employees are already paying a percentage of any inflationary increases. However, the drawback is that subscribers do not know how much a drug will cost

Continued on Page 7

until they buy it. For individuals that live paycheck to paycheck, it may be difficult to afford expensive medications. Employers can set minimums and maximums on the coinsurance copayments.

- **Mandatory mail order:** Mandatory mail order programs got a great deal of press several years ago when GM implemented a mandatory mail order plan. For some plans, mandatory mail programs may be a cost saver; however, it very much depends on your copay levels.

Mail order programs generally offer better discounts than retail pharmacies. Many employers when they initially launched mail order programs offered a 90-day supply of a maintenance medication for a one month copay. Employers wanted employees to use the mail order program and the lower copay compelled employees to use the mail order program.

As copayments for pharmacy plans have increase dramatically over the last five years, employers are finding mail order is not as cost-effective as it once was. This is because the deeper discount of the mail order pharmacy is no longer offsetting the loss of revenue for accepting only one copay for a 90-day supply. In general, the higher your retail copays, the less likely a mandatory mail order will save significant cost. In many cases, employers are moving to 2 or 3 copays to secure the 90-day supply through mail order.



Review your PBM contract at least once every few years to make sure it is still competitive and you understand the payment provisions. PBM contracts are complicated and your organization may be able to negotiate more favorable terms in many areas. Also, contract provisions are not always clear and payment amounts to pharmacies and amounts charged to plans can be very different. To learn more about key areas in your contract, please review our *Benefit Advisor* on optimizing your PBM pricing at http://www.mcgrawwentworth.com/Benefit_Advisor/2004/BA_Issue10.pdf.

Making sure your organization has a competitive plan design and competitive contract provisions will help make pharmacy benefit programs more affordable.

Conclusion

Prescription drug costs now account for an estimated 17% of total health care spending for active employees. We expect prescription drug costs to continue increasing at a rate well above inflation.

It is important to understand the trends in the prescription drug market. Key areas of your pharmacy benefit plan to review include specialty pharmaceuticals, generic utilization, self funding opportunities, network discount arrangements, value-based benefit options and medical management programs. Also, given the level of vendor consolidation and changes in the PBM market, it is important to regularly review your PBM contract provisions to insure they remain competitive.

If you have any questions, please contact your McGraw Wentworth Account Director. **MW**

