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In This Issue

In this eighth issue of the McGraw Wentworth Benefit Advisor for 2009, we examine pharmacy benefit costs. Most group health plans offer coverage for prescription medications. Employers have many options to consider to keep these costs in check.

In 2010, health plan costs will continue to challenge employers. A well-managed pharmacy benefit program is a key component to managing health plan costs.

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 McGraw Wentworth web site at www.mcgrawwentworth.com.

"Managing Pharmacy Benefits"

As companies struggle to keep health plan costs in check, one area of health care cost that offers some glimmer of hope is prescription drug benefits. Early in this decade, prescription drug benefits caused a large part of the annual double digit increases in health care cost. Although new blockbuster medications significantly improved health and quality of life, they were very expensive. Most health plans top 25 drug lists included blockbuster drugs such as statin medications to control cholesterol, allergy medications, proton pump inhibitors for acid reflux and antidepressants. Fortunately, generics are now available to replace many of these drugs. Injectible medications were also gaining traction at the beginning of the decade. These drugs were very effective in treating serious illnesses such as multiple sclerosis, rheumatoid arthritis and cancer; however, they were very expensive as well.

Over the last ten years, the prescription drug market has changed considerably. Organizations need to understand the prescription drug market so that they can control prescription drug costs. Understanding the market will help your organization make the best decisions.

This Advisor provides:

- An Overview of the Changes in the Prescription Drug Market
- Copay Plan Design Options to Consider
- Medical Management Program Discussion
- Self-Funded Plan Contract Considerations
- Specialty Drug Review
- Value-Based Program Overview
- Concluding Thoughts

McGraw Wentworth's Mid-Market Benefit Survey shows employers in Southeast Michigan are finally changing the cost-sharing provisions in their medical plans. With 2010 likely to force even more difficult decisions, tightening your prescription drug coverage may help your organization achieve difficult budget targets.

An Overview of the Changes in the Prescription Drug Market

The prescription drug market has changed drastically in the last decade. These changes have been fairly visible to employees because some of the

Continued on Page 2

changes have directly affected the medications they take.

Generic Availability

Many more generic alternatives to popular, expensive brand-name prescriptions have become available especially in the last five years. As the number of generic drugs has increased, many employers are strongly encouraging their health plan participants to use them. For employers, convincing participants has not been as easy as it sounds. Many employers have had to combat employees' preconceived notions that generics are not as good as the brand-name drugs. Employers are continually encouraging employees to ask their providers whether a generic is available. All this work does pay off, however. It is generally estimated that every 1% increase in generic drug use results in a 1% to 2% decrease in cost.

According to Walgreen's *2009 Drug Trend Report*, the generic dispensing rate on their book of business increased from 61.3% in 2007 to 65.6% in 2008. The focus on using generics, whether through copay incentives or medical management programs, has reduced plan cost:

- Brand-name drugs cost roughly five times more than their generic counterparts in 2008.
- The gap in average ingredient cost between brand and generic medications widened from $100 in 2007 to $120 in 2008.
- Generics accounted for two-thirds of all prescriptions dispensed in 2008, but represented just over a fifth of the overall drug spend.
- Even with an approximate 5% decline in brand-name prescription drug use from 2007 to 2008, the drug spend for brand name medications increased by 4.2% for each member over the year.

Health plans can still increase generic use. According to ExpressScripts' *2009 Drug Trend Report*, a number of drug categories have a potential generic fill rate significantly higher than the actual generic fill rates. These categories include oral contraceptives, anti-depressants, antihyperlipidemics, gastrointestinal medications and antihypnotics.

Medications Move to Over-the-Counter Status

Several very popular medications are now sold over the counter. This change should have been a cost-saving development for many health plans since most plans do not cover over-the-counter medications. Unfortunately, in many cases, over-the-counter drugs cost more than the employees' drug copay amounts. Because they have to pay more, it is not uncommon for employees to return to their physicians and request a prescription drug so their cost will be limited to the plan's copay amount.

As a result, instead of seeing a decline, employers are now seeing an increase in prescribed alternatives for over-the-counter drugs. Many employers today are considering plan provisions that will encourage employees to opt for the least expensive drug, even if that means employers will cover specific over-the-counter medications.

Medications Pulled from Market

Prescription drug plans are also affected when the FDA or the manufacturer pulls medications from the market. Before Vioxx was pulled from the market, it was commonly found on most employers' top 25 drug use lists. Most prescription plans saw a marked decrease in the use of Celebrex, a similar medication, when Vioxx was pulled from the market. Celebrex remains on the market, but physicians and patients use it very sparingly.

When drugs are pulled from the market, employers have a great opportunity to teach employees a bit about the prescription marketplace. Most people are not aware that the government relaxed testing requirements a couple of decades ago in an effort to bring medications to the market more quickly. We see the results of the less rigorous testing requirements every time a medication is pulled from the market. In some cases these drugs have caused severe complications or even death. While television ads may tout a new medication as the best treatment for a health issue, people may be safer using a more established drug.

Retail Generic Programs

Companies such as WalMart, Kmart, Target, and Meijer have retail generic drug programs offering specific generics for very low copays. In many cases, the copays are even less than many health plan generic copays. These programs offer genuine savings. Retail pharmacies offer these deals as loss leaders. Retailers entice customers into the store

Continued on Page 3

to get a prescription filled hoping they will buy other items as well. The store then makes money on the additional items it sells.

Many employers are encouraging employees to find out whether they can obtain any of their medications through these retail programs. In fact, a local pharmacy benefit manager, 4D, has recently launched a web tool that allows people to enter their medications and dosages. The tool will then search the various retail programs to find the best price. The website address is www.medtipster.com. The tool is still being tested so errors may occur, but this tool may be very useful for your employees.

Overall, these changes in the drug market have slowed down the double digit cost increases so common at the beginning of this decade. For several years employers have generally had very low cost increases for their prescription drug plans. The good news is that these low trend rates are expected to continue as more generics become available and prescription drug plans encourage employees to request the least expensive prescription drugs. However, the threat looming in the prescription drug market is specialty medications. Employers will need to manage specialty medication coverage to keep prescription drug costs in check.

Copay Plan Design Options to Consider

Copays are the out-of-pocket amounts your plan requires participants to pay for their prescriptions. It was not uncommon just ten years ago to have a flat copay for prescription drugs under a health plan. When prescription drugs were less expensive, a flat copay made sense. Now, with so many prescriptions available, health plans must ensure their members become more involved in prescription costs and decisions.

Many plans offer two-tier copays to get employees to consider the cost of their prescription choices. A two-tier copay design has one copay for generic drugs and a higher copay for brand-name drugs. To successfully steer employees to generic medications, the gap between the cost for a generic medication and a brand name drug needs to be large enough to encourage participants to ask for generic alternatives. It is generally believed the difference should be at least $20; some plans may go as high as $30 or even $40.

Nationally, many employers have adopted three-tier copays—one copay for generic medications, a higher copay for preferred brands and an even higher copay for non-preferred brands. It is always best if your employee can use a generic medication but, in some cases, a generic alternative may not exist. The brand-name pharmaceutical market is fairly complicated. In many cases, more than one brand name medication is available and the cost of the various brand name medications can vary widely. In addition, most pharmacy benefit managers have preferred prices for a number of brand medications. The three-tier copays encourage employees to use the least expensive brand-name drug. If your plan cost is based on drug use, your cost savings will depend on which drugs your employees use. If the majority of the drugs they are already using are preferred brand medications, your plan will save very little by moving to a three-tier program.

Very progressive plans are moving to four-tier copay arrangements. Adding a fourth copay involves an even higher copay for specific medications. Included in the fourth tier might be drugs such as lifestyle, specialty, and injectible medications.

Coinsurance for prescription drugs is another copay tactic some employers are embracing. Under this arrangement plan participants share an actual percentage of the cost. The more expensive the medication, the higher the cost is paid by both the plan and the participant. Employers can be very flexible with coinsurance arrangements. Some employers require a flat copay for generic prescriptions and then have coinsurance in the second tier or even the third tier. A few employers are adding a fourth tier with coinsurance. Some plans have straight coinsurance but others add a minimum and maximum amount of coinsurance. For example, the participant pays 25% of the cost for brand name medications with a minimum copay of $30 and a maximum copay of $75.

Coinsurance motivates participants to find the least expensive medication. However, these plans have not become particularly popular. Employees do not like coinsurance because they do not know up front what the cost will be to fill the prescription. They can't discuss alternative drugs with their physicians because they don't realize cost may be an issue until they arrive at the pharmacy with a prescription.

Continued on Page 4

Copay strategies are popular options employers use to help control health plan cost. Remember, as you look at copay strategies look at alternatives that will encourage employees to make smart decisions about the prescription drugs they use.

Medical Management Program Discussion

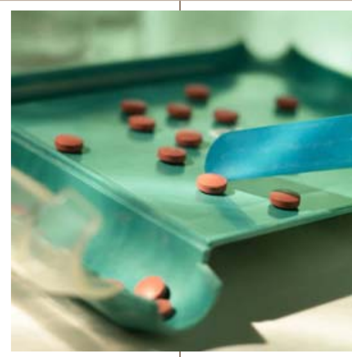
Medical management programs restrict the prescriptions the plan covers. These programs focus on making sure participants are using the least expensive medications. If your plan is fully insured, your organization may be limited in the medical management programs your plan can adopt. Some carriers will simply implement these medical management programs. If your plan is self-funded, your organization will have much more flexibility, but your pharmacy benefit manager will likely charge additional fees for various medical management programs.

Step Therapy

Step therapy programs recognize that pharmaceutical manufacturers introduce new therapies that may not always offer improvements over previous medications. Step therapy is a medical management program that requires participants to use the least expensive medication available.

These programs work differently with different vendors, so it makes sense to discuss step therapy with your pharmacy benefit manager. In general, the health plan may fill the prescription for a limited time, anywhere from 30 to 90 days. When the patient fills the prescription, the plan sends a letter to the patient and the physician stating the plan does not cover that specific medication, unless the patient tries the lower cost alternative. If the low-cost alternative works, both the patient and the plan benefit from using a less expensive drug. Most programs do include a physician override if the less expensive medication is not effective.

Step therapy can effectively motivate employees to use less expensive medications. However, be forewarned that employees do not always like step therapy programs. Some employees will see these programs as employers interfering with their physicians' recommendations. Before they implement a step therapy program, employers should inform employees about the pharmaceutical marketplace. Not all employees understand that many conditions can be treated just as effectively with many different, less expensive drugs. Also, they need to understand that pharmaceutical manufacturers use very effective marketing efforts to influence physicians' drug choices.



Prior Authorization

Prior authorization is a medical management program requiring the pharmacy benefit manager to authorize coverage for a specific medication. Prior authorization usually applies when physicians want to prescribe expensive medications the FDA has not approved for that patient's condition or when less expensive, equally effective drugs exist. In many cases, the pharmacy benefit manager will verify with the physician that the FDA has approved the use of the drug for that condition. For example, physicians prescribe human growth hormones for children with medical conditions stunting their growth; however, they also prescribe these hormones for a number of off-label conditions. Most plans do not want to pay for these medications when they have not been prescribed for an FDA approved purpose.

When less expensive, equally effective drugs exist, the health plan may review the physician's treatment protocol to ensure the patient has tried them before it pays for a very expensive alternative.

Pill-Splitting

One of the more aggressive strategies to control prescription drug plan cost is requiring or even recommending pill splitting. For some prescription drugs, increasing the number of milligrams in a single tablet does not necessarily increase the cost. Therefore, a 40 mg tablet can cost about the same as an 80 mg tablet of the same medication.

If a doctor prescribes 80 mg of a medication a day, 40 mg in the morning and 40 mg in the evening, the typical approach would be to write a 30-day prescription for sixty 40 mg tablets to cover the twice a day requirement. However, with some medications, not all, a patient could split an 80 mg tablet, taking half a tablet in the morning and the other half in the evening. If medication could be split, a physician could write a prescription for a 30-day supply of the 80 mg tablets. The cost for the 80 mg tablets would be about half of the sixty unit, 40 mg supply.

Continued on Page 5

Pill-splitting has become popular with cost conscious seniors. It is an aggressive approach, but it can help control cost. Employers do need to make certain the medication effectiveness is not compromised when dosages are split.

Therapeutic Alternatives

Generic alternatives are not available for all brand name medications. However, in some cases, although an effective generic medication may be available, it may not be a generic of the specific brand name drug prescribed. Therapeutic alternative programs focus on looking for an effective generic rather than a specific substitute for an expensive brand name medication.

A therapeutic alternative program informs patients and physicians of other generic drugs available. If a patient receives a prescription for a specific medication when a generic alternative exists, the health plan will send a letter to both the physician and the patient. The letter to the physician will encourage the physician to consider prescribing the generic if the physician feels it can treat the patient effectively. The patient and the physician can then discuss the potential savings.

Self-Funded Plan Contract Considerations

Effectively managing self-funded plans is a bit more complicated. The contract dictates not only how drugs are covered but also how they are discounted. Because these contracts are so complex, you need to know how your contract is administered:

- ***Maximum Allowable Cost (MAC)***: MAC pricing applies to generic medications. Many plans focus on the price of brand name medications, but because generics are being prescribed more and more, employers need to know how they are priced as well. MAC pricing aggressively discounts prices for specific generics and each pharmacy benefit manager has a different MAC list. In some cases, a list may have a very aggressive discount; however, if it only discounts a few medications, it may not be as favorable as another MAC list offering a smaller discount for far more medications. The best MAC list for your organization is one that offers a greater discount on the generic medications your employees use.
- ***Average Wholesale Price (AWP)***: Brand name prescription drug discounts vary depending on the average wholesale price. Average wholesale price, however, is a misleading term. Pharmacy programs may use a variety of sources to derive an average wholesale price, but these averages are not determined scientifically and different PBMs use different numbers. Hopefully, at some point, the pharmacy benefit managers will have a better benchmark to use in setting prices. Some very large organizations are setting discounts, for example, based on wholesale acquisition cost. This figure may more truly represent actual cost; however, PBMs rarely use that indicator in price setting.

- ***Lowest Cost Option***: In some cases, the pharmacy charges less than your contract's set price. In these instances, the PBM charges your plan the contractually agreed upon amount and pays the pharmacy the amount it charges. The PBM will keep the difference, sometimes referred to as the "spread." Check to see whether your contract uses the term "lowest cost option." If it does, the plan pays the lower price rather than the set price.
- ***Rebates***: Your drug discount lowers your costs significantly, but rebates can also help. PBMs may receive rebates on specific medications, brand name medications, or all medications. Drug companies offer rebates based on the volume of medications purchased. The PBM may then pass these rebates back to the plan or it may keep part of the discount. Although many PBMs want to focus on rebates in their contracts, rebates should be only one consideration. In addition, PBMs are notorious for passing rebates back to the plan without documenting how the rebates are calculated. Ask your PBM to explain how it calculates rebates and whether your organization can audit those calculations.
- ***Transparent Pricing***: Some PBMs are transparent; they disclose all the funds they receive from all sources. In some cases, these PBMs charge a higher fee for administrative services, but they pass all

Continued on Page 6

discounts and savings directly to the plan. While this sounds good, you need to analyze these arrangements carefully. Sometimes PBMs that keep part of the discount may be more cost effective than transparent PBMs that charge higher administrative fees.

- ***Network Options***: PBMs often have more than one network available for their customers. The networks will differ based on pharmacies in network and the discounts available. In some cases, a narrower network may deliver much better discounts. If multiple networks are available, review the other options. Your PBM should be able to identify the employees who will be adversely affected if they have to change pharmacies. Ask your PBM which pharmacies deliver the best discount. Your plan can then encourage employees to use the least expensive pharmacies.

If your organization is seeking a new pharmacy benefit manager, have competing vendors reprice your plan's actual prescription drug use to assess discounts. Discounts are important when you compare vendors, but you need to ensure the discounts they offer are the best for the specific drugs your plan participants use.

Specialty Drug Review

Specialty medications are going to be a large part of prescription drug expenses in the next decade if all the predictions are correct. Specialty drugs are medications that:

- Require special storage or administration.
- Are injected, infused or taken orally.
- Tend to have real impact on the diseases they treat.
- Tend to be very expensive.

These medications usually need to be used in a specific way. When the medications are not used properly or a patient does not complete the full therapy or misses treatments, the medication may not be as effective. Since these drugs are very expensive, the health plan should make sure the participant follows directions carefully.

In 2008, the American Health Insurance Plans published some alarming statistics on specialty medications:

- Only 1% of patients use specialty medications, but they account for 20% of drug spending ($54 billion annually).
- By 2010 Americans are expected to be spending $99 billion on specialty drugs.
- The cost for a specialty medication can range from $10,000 to $750,000 annually.
- Currently 600 specialty drugs are in the biotechnology pipeline – in recent years approximately one-third of all new drugs have been specialty drugs – by 2010, that figure is expected to grow to half of all new drugs.

Specialty drugs cost more today and they trend much higher than regular medications. Annual increases for specialty medications are expected to run at 20% for the next several years.

Your plan may not have been hit with a specialty medication claim yet. But if it has, that claim can certainly throw cost estimates out the window. Many employers are taking steps to manage this growing concern in the pharmacy market. Consider the following strategies to handle specialty medications:

- Look for a separate pharmacy network specializing in these medications. In fact, your PBM may already contract with a specialty network. If not, find out how your vendor is currently handling specialty medications and whether alternate networks are available.
- Add a separate tier to your prescription program to cover these medications. Because these medications are so expensive, some employers set coverage as a coinsurance in this tier with a high dollar maximum. If your employees share part of the cost, they will make sure that the medication is necessary and there are not any less expensive alternatives.

Continued on Page 7

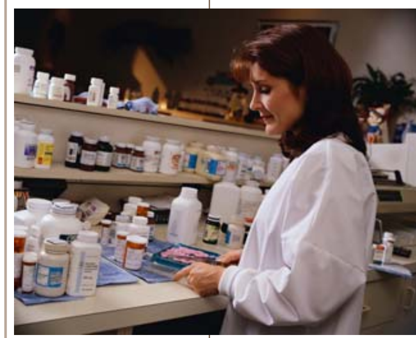
- Add a medical management program that specializes in these medications. The PBM will contact the patient's physician and conduct a medical review to determine whether the medication is necessary and whether an alternative drug exists. In addition, if the patient must take the drug properly for the medication to work, the PBM will monitor the situation to be sure the patient is complying with the protocol. Medical management programs can also ensure the medication is being used only for an FDA approved purpose. Some of these medications are commonly used for "off label" purposes and your plan may not want to cover these expensive medications for such purposes.

Your PBM may have even more ideas to help keep specialty medication cost in check. You may want to schedule a meeting with your PBM to discuss the cost control options that make sense for your plan.

Value-Based Program Overview

Value-based plan options have received a lot of press, but very few employers in Southeast Michigan have adopted this plan design. Value-based plans recognize that certain medications have a proven impact on health and are effective in treating specific conditions. For example, insulin or glucophage is very effective in treating diabetes. Diabetics who take medications as prescribed and manage their health have fewer complications. As employers increase copays for various medications, some employees will stop taking medications they can no longer afford. Employers do not want to create financial barriers preventing employees from taking effective and proven medications, like insulin. In a value-based program, employers lower copays for certain proven medications.

The most commonly used medications used to treat chronic conditions such as diabetes, asthma, high blood pressure and high cholesterol will be considered "high value" medications. Employers certainly pay higher pharmacy costs for plans that cover these drugs at lower copay amounts. However, these drugs can reduce or eliminate complications. Thus employees will have fewer expensive emergency room visits and hospital stays. Although you are spending more on cost effective prescription medications, you are spending less on total health plan costs.



Value-based prescription drug plans are still being discussed as one way to help manage overall health care cost. On a practical level, many pharmacy benefit managers cannot manage a value-based pharmacy program effectively, but as interest grows, perhaps more PBMs will be able to administer this plan design.

Some employers are adopting a modified form of a value-based arrangement. These employers will waive or lower copays for specific medications, if the employee or dependent will participate in a disease management program for a specific condition. These programs focus on teaching employees how to manage their conditions and improve their lifestyle choices.

Concluding Thoughts

Health care cost will continue to trouble employers in 2010. Unfortunately, much of the health care reform debate has turned away from practical ideas to help control health care costs. Employers need to keep a handle on these costs in this difficult economy.

Many employers will try to control pharmacy costs this year using a variety of options. If your plan's generic utilization rate is less than 70%, your plan should focus on encouraging employees to use the generic options whenever possible. You can also, review potential medical management programs that motivate employees to use the least expensive drug. If your plan is self-funded, review your PBM contracts every two or three years to make sure the financial arrangements remain competitive.

Good luck with managing health plan cost in 2010. If you have any question regarding managing pharmacy cost, please contact your McGraw Wentworth Account Director. MW

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