OEA COLLECTIVE BARGAINING & RESEARCH Bulletin

Prescription Drug Plans
2012

Estimates from the National Health Expenditures dataset of the Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov/NationalHealthExpendData/) indicate that while pharmaceutical drug spending represents a relatively small portion of total health care expenditures in the United States, its cost growth rate is quite high relative to medical inflation. This growth rate is associated with the value that drugs offer in the clinical management of patients: a well-designed drug benefit can reduce hospital admissions, decrease hospital length of stays, reduce the need for more invasive therapies, prevent disease and improve a patient's quality of life (Thomas, Larson & Bell, 1996, 3)[1]. Four factors have been identified as prescription drug cost drivers: increased utilization, changes in the types of drugs used by patients, advertising by drug manufacturers and the profitability of firms associated with the creation of drugs and drug therapies (Kaiser Family Foundation, 2006)[2].

Pharmaceutical drug benefit plans can arise as a component of a traditional medical insurance plan, as part of a managed care medical insurance plan, or as a stand-alone plan. In a traditional medical insurance plan, participants must satisfy a deductible and coinsurance requirements. The participant pays for the cost of the drug at the pharmacy, and seeks reimbursement through a claim form. Claims that are not submitted for reimbursement form the basis of the "shoebox effect", a condition in which participants fail to get reimbursed because they do not send in the proper claim forms on time.

Service-card plans cover prescription drug costs at retail pharmacies through a card. At network pharmacies, participants show the card and pay a co-payment. At non-network pharmacies, participants pay the cost of the drug then seek reimbursement through a claim form. Typical co-payments are $10 for generic drugs, $20 for a brand-name formulary drug, and $35 for a brand-name non-formulary drug. Mail order prescription programs offer coverage for maintenance drugs typically for 90-day prescriptions at 2.5X (or less) the retail co-payment. These plans can be added to traditional medical insurance or managed care insurance plans. Substantial savings can be achieved through higher discounts and lower dispensing fees.

A formulary is a list of drugs covered by a health plan. Formularies are used by health plans to manage and influence drug selection and to facilitate the appropriate and cost-effective use of pharmaceuticals. Closed formularies restrict plan participant reimbursement to a list of

[1] Thomas, N., Larson, L.N. & Bell, N.N. (1996). Pharmacy benefits management. Brookfield, WI: International Foundation of Employee Benefit Plans.

[2] Kaiser Family Foundation (2006). *Prescription drug trends*. http://www.kff.org/rxdrugs/upload/3057-05.pdf (accessed April 11, 2007).

drugs, while partial formularies cover a portion of drug charges for non-formulary drugs if directed by a physician and given prior health plan approval.

Generic drugs are lower cost versions of a brand name drug that become available when patent protection expires on a brand-name drug. They are less expensive due to the fact that the costs associated with research and development and marketing are borne by the company that brought the brand-name drug to market; typically, the unit cost of a generic drug are 30 to 80 percent lower than the brand-name drug it seeks to replace (Snow, 2007)[3]. Generic drugs are designed to be bioequivalent to the brand-name drug that it seeks to duplicate, meaning that the active ingredients are the same. Like brand-name drugs, generic drugs are regulated by the Food and Drug Administration (FDA). While every brand-name drug doesn't have a generic alternative, many have a generic equivalent that has been approved by the FDA. Due to their lower costs, generic drugs are preferred over brand-name drugs within a pharmaceutical drug plan. Two metrics track generic drug utilization.

A plan's generic dispensing rate (GDR) identifies the relative percentage of generic drugs that are being utilized within the retail or mail-order portion of a pharmaceutical drug plan. Similarly, a plan's generic substitution rate (GSR) estimates the rate at which generic drugs were chosen over brand-name drugs when a generic drug was available to the consumer. For a pharmaceutical drug benefit program to operate efficiently, both percentages must be tracked in the pursuit of continuous improvement.

A variety of approaches to pharmaceutical cost containment have been examined in the literature, including direct limits, utilization management, cost sharing, utilization review, education, pricing and regulatory strategies (Hoadley, 2005)[4]. The effectiveness and efficiency of each of these various approaches within any plan will be impacted by a variety of factors unique to a variety of plan, organization and pharmaceutical plan participant variables.

Retail prescription drug insurance plans typically offer coverage for 30-day prescriptions. Mail-order prescription drug insurance plans typically cover drugs with a 90-day prescription. According to SERB's health insurance data, the most common retail pharmaceutical drug plan designs offered by school districts and educational service centers as of January 1, 2012 is a tiered formulary program with increasing patient cost-sharing from tiers 1 to 3. Here, retail drugs required a patient copayment of $10 for tier 1 (generic) drugs, $20 for tier 2 (preferred) drugs, and $35 for tier 3 (non-preferred) drugs. Mail-order drugs required a patient copayment of $20 (tier 1), $40 (tier 2) and $60 (tier 3).

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[3] Snow, D.B. Jr. (2007). Maximizing generic utilization: The power of pharmacy benefit management. *Journal of Generic Medicines, 5*, 27-38.

[4] Hoadley, J. (2005). *Cost containment strategies for prescription drugs: Assessing the evidence in the literature*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

To provide context to the retail prescription drug insurance program, the SERB survey instrument included questions on the cost management provisions of each prescription drug insurance plan offered to employees. Four cost management provisions were tested in the survey instrument on retail prescription drug plans.

Survey recipients were asked if the retail prescription drug plan excluded any specific drug class from coverage (e.g., cosmetic, hair-loss, fertility, and weight-control drugs); 84% of plans (n = 766) had such exclusions. When asked if the plan featured any prior authorization requirements, 56 percent (n = 511) of plans reported such a requirement. Prior authorization procedures are often established to require pharmacy benefit management approval for certain classes of drugs or to limit drug access to patients with a certain condition or history. When asked if the plan featured any step therapy (fail-first) requirement, 43 percent were found to have such a requirement. Step therapy programs limit access to certain drugs unless other drug therapies have been tried first. Lastly, 38 percent of plans included a penalty (or ancillary charge) associated with using a formulary or brand-name drug when a generic drug was available. Of these cost management provisions, significant differences between medical/pharmaceutical plan costs were found between those which included a penalty or ancillary charge and those that did not do so. Thus, while each cost management feature is important to consider in pharmaceutical plan design, penalties should be strongly considered in this context to drive cost savings to employees and employers.

Questions and comments regarding this report should be directed to OEA Research.