

Prescription Drug Benefit Design

The Building Blocks and Their Impact on Cost

by Frank Kopenski, ASA, MAAA

Before changing plan design to address the problem of rising prescription drug benefit cost, employers must understand and periodically revisit the pharmacy benefit building blocks. Ultimately, aligning all aspects of the pharmacy benefit is the best and only way to help control drug benefit costs and, at the same time, promote greater employee satisfaction. This article describes how the pharmacy benefit building blocks of delivery (dispensing), provider contracting, drug products and benefit design all have to work together to produce a more effective pharmacy benefit program.

Prescription drug benefit designs in the group insurance market change so frequently that it's hard to tell what, if anything, is working to reduce prescription drug costs. Despite a recent slowdown in annual drug cost trends, for most employers, the percentage of total health care expenditures due to prescription drug utilization continues to grow.

If one looks for a cost-containment solution by focusing only on benefit design, one is working out of order. The more fundamental problem is understanding the prescription drug benefit building blocks and how they fit together.

So, what are the basic building blocks that go into prescription drug benefit design? They are multiple delivery channels, complex provider contracting and a vast range of drug products.

Admittedly, they are not that basic, but a better understanding of these fundamentals can lead to better design decisions and a prescription drug benefit that

is cost-effective for employers and beneficial to employees.

Benefit changes alone, unfortunately, are not sufficient for solving the problem of cost. This article describes how delivery (dispensing), provider contracting, drug products and benefit design all have to work together to produce a more effective pharmacy benefit program.

PRESCRIPTION DRUG DELIVERY CHANNEL

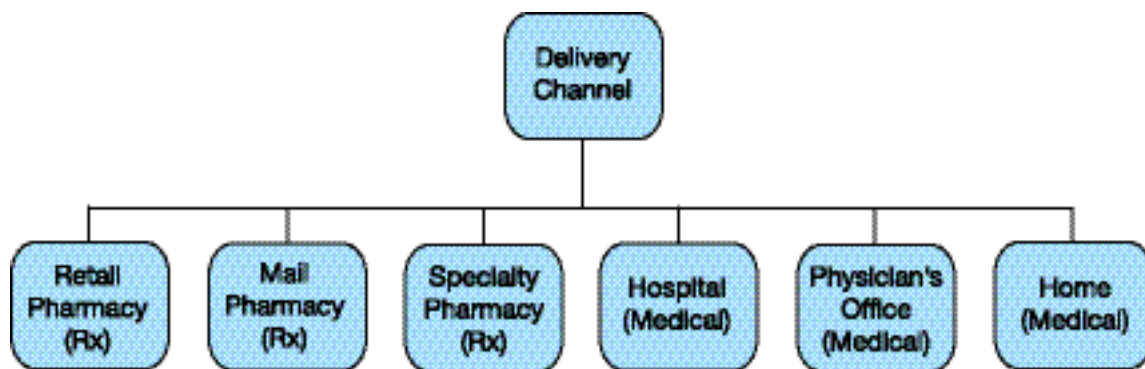
The delivery channel, the physical location where the prescription is dispensed, may include any and all of the following: retail pharmacy, mail pharmacy, specialty pharmacy, hospital, physician's office and home.

The cost of prescription drugs varies widely by delivery channel, so delivering drugs through the lowest cost channel(s) can decrease overall costs.

As shown in Figure 1, the retail/mail/specialty delivery channels are generally included in the prescription drug benefit, while the hospital/physician's of-

FIGURE 1

THE PRESCRIPTION DRUG BENEFIT MULTIPLE POSSIBLE DELIVERY CHANNELS



Home delivery channels are generally included in the medical benefit. It is important to look at the resulting net cost to the plan from each delivery channel when benefits are eventually established. Just because the pharmacy discount appears favorable doesn't mean the plan cost is minimized.

Mail-order pharmacies typically provide deeper discounts and lower dispensing fees, particularly for brand medications. However, many prescription drug benefit designs encourage members to utilize mail dispensing by lowering member cost sharing too much, in some cases making mail order more costly to the plan than retail.

A specialty pharmacy is a pharmacy mainly equipped to dispense injectable products, often biotech, which require special handling and storage. It has become a portal for moving drugs from the medical benefit to the prescription drug benefit. This results in significant savings when treating people with high-cost conditions, such as rheumatoid arthritis, multiple sclerosis and cancer.

Pharmacy products obtained through the physician's office, hospital outpatient facility or home health care professional (where these injectable drugs typically have been dispensed) have generally been excluded from provider fee schedules and thus could be significantly overpriced. Specialty pharmacy programs are an attractive alternative.

However, some prescription drug benefit designs discourage member use of the specialty pharmacy by increasing member cost sharing too much. Does it make sense to have an out-of-pocket limit for drugs as part of the medical benefit but not as part of the prescription drug benefit? This issue is debatable. There is no debate, however, that most of these drugs are expensive when compared to the average drug cost and therefore are a concern to benefit managers.

By not understanding and managing the delivery channel, money is often wasted on prescription drugs. Benefit design decision making can be misaligned.

PROVIDER CONTRACTING

Provider contracting determines the amount paid to obtain the drug product from various delivery channels. This becomes more complex when a pharmacy benefit management (PBM) company is involved.

Pharmacy contracts under the prescription drug benefit will have varying reimbursement provisions based on the delivery channel (Figure 2). When contracting through a PBM, the pharmacy reimbursement may include some of the cost for additional services the PBM provides to the employer, or it may include only the cost of the drug with applicable dispensing cost. The two approaches are often referred to as *lock-in* and *pass-through* pricing.

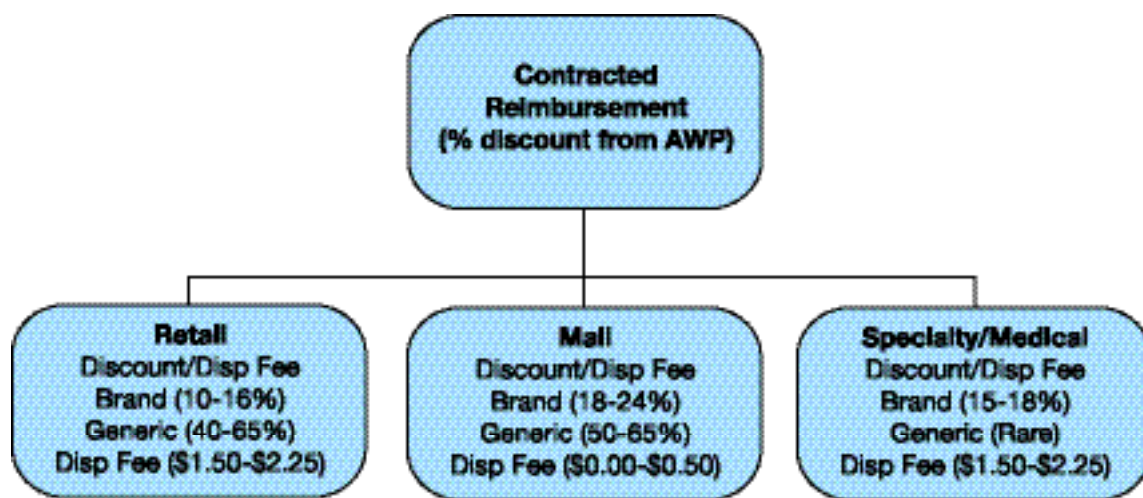
Actual contracting is much more detailed, but Figure 2 puts discounts and dispensing fees into some perspective.

Pharmacy contracts typically have deeper discounts and dispensing fees for generic and mail-order drugs. But it is essential to look beyond comparisons of average wholesale price (AWP) discounts. Many variables make high-level comparisons unreliable, including usual and customary pricing, maximum allowable cost pricing, and copayments that exceed the cost of the drug and dispensing fee (zero-balance claims).

In addition, recent legal issues with AWP, repackaging of products and dispensing portions of larger package sizes mean detailed scrutiny is required. A thorough review of the various reimbursement measures to be used by the contracting vendor can help minimize undesirable surprises down the road.

FIGURE 2

DIFFERENT DELIVERY CHANNELS' VARYING REIMBURSEMENT PROVISIONS



Pharmacy contract terms should be revisited at least every two years, and employers should research what other organizations are receiving in terms of pharmacy reimbursement and pharmacy cost-management programs. The annual Pharmacy Benefit Management Institute (PBMI) drug trend study produced by Takeda is one good source for such information.¹

DRUG PRODUCTS

During and after contracting, it is essential to focus on what drug products are available. The *drug product* designation denotes Federal Drug Administration (FDA) patent protection status and whether a drug can be dispensed without a prescription.

Generic and over-the-counter (OTC) drugs are cheaper than multisource brand drugs, which are generally cheaper than single-source brand drugs (Figure 3). Competition drives price, so when there is no competition, whether biological or therapeutic, a manufacturer can demand a higher price for that drug product. Some single-source brand drugs, including biotech/specialty products, may cost considerably more than the typical single-source brand drugs.

Maximizing generic dispensing should produce lower overall pharmacy costs, excluding the impact of manufacturer rebates. Most PBMs have a number of pharmacy cost-management programs designed to maximize generic utilization. In addition, *formularies* (a list of preferred or nonpreferred medications by

drug therapy class) can reduce the average amount spent on brand medications.

But one cannot take these programs for granted. For instance, when a brand drug loses patent protection and litigation issues are cleared, the first generic manufacturer typically has a six-month exclusivity period. It may actually be more costly to the employer if members are encouraged to change to the generic product during this period. In addition, a formulary is not written in stone; the drug marketplace is continuously changing. What appears to be a clinically effective and cost-effective strategy today may be an ineffective strategy tomorrow. Regular monitoring is recommended.

BENEFIT DESIGN

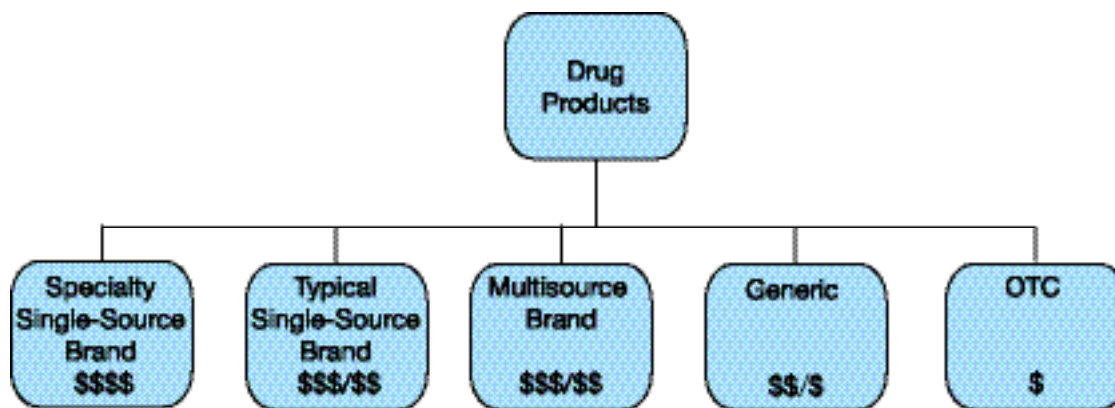
After studying these fundamental building blocks, a good benefit design can be developed. Benefit

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Frank Kopski is an associate actuary with Milliman in Milwaukee. He conducts much of the firm's pharmaceutical research and develops related tools for Milliman consultants and clients. His knowledge of prescription drugs extends to benefit design, cost guidelines and cost management for commercial, Medicare and Medicaid populations.

FIGURE 3

GENERAL PRICE DIFFERENCES BY DRUG PRODUCT TYPE



design should not be used as a means to correcting delivery-channel or contracting issues, as is too often the case. To develop an effective benefit design, keep the following goals in mind.

1. Select benefit designs that do not undermine the cost-saving strategies put in place by the earlier building blocks.
 - As a rule of thumb, mail copayments should be at least 2.5 times retail copayments to prevent mail dispensing from costing the employer more than retail dispensing.
 - If the objective is to maximize the specialty pharmacy delivery channel to take advantage of the significantly better point-of-sale pricing, compare medical and pharmacy benefits for similar drugs to develop a pharmacy benefit strategy that is more attractive to employees.
 - Use varying deductibles, copayments and coinsurance as a steering mechanism to get employees to use specific drug types (i.e., generic, preferred brand, nonpreferred brand and specialty) or specific drug products (e.g., Lipitor®, OTC Prilosec®, etc.).
 - Determine employee cost-sharing penalties and levels of cost sharing based on what the employee can control. It is not the employee's fault if there is only one treatment option and it is necessary and expensive.
2. Be aware of benefit designs that can create employee out-of-pocket cost sharing in excess of some threshold (e.g., \$1,000, \$1,500) and consider implementing out-of-pocket limits as you would with medical benefits. Or,

as an alternative, use maximum copayment limits per prescription.

3. Benefit designs should be structured to achieve desired employer and employee funding objectives.
 - As with any purchased product, determine the goal amount to spend and then determine what those funds will buy in terms of benefits.
 - Consider benefit designs that will limit annual cost trend leveraging by changing the member cost sharing automatically.
 - Weigh the difference between increased member cost sharing and increased member funding (i.e., member contribution to premium or self-insured working rate).
4. Benefit designs should be explained in detail to employees so cost-saving objectives can be achieved.
 - Employees and retirees and their families cannot be expected to make good consumer choices if they don't understand the benefits or the ramifications of their decisions.
 - Prescription drug purchasing is one of the few health care services that relies on the choices of the individual patient rather than the health care professional.
5. Be aware of the impact of benefit design and benefit-design changes on the average member and especially on employees with unusual levels of annual expenditure. Benefit changes that seem to have a minimal impact on the average employee may have a significantly negative impact on employees with high-cost

TABLE**SAMPLE DISTRIBUTION OF GROSS ANNUAL PRESCRIPTION DRUG EXPENDITURES**

Annual Cost	% of Members	Gross Per Member Year	Average Annual Scripts/Member	Generic Script as % of Total
\$0-\$500	72.9%	\$ 76.41	3.1	65.8%
\$501-\$1,000	11.3%	\$ 86.71	14.1	51.1%
\$1,001-\$2,500	10.1%	\$171.12	23.5	46.1%
\$2,501-\$5,000	3.8%	\$132.94	38.3	43.4%
\$5,001-\$10,000	1.4%	\$ 93.12	56.0	43.6%
\$10,001-\$50,000	.5%	\$ 83.40	62.1	44.7%
\$50,001-\$100,000	.0027%	\$ 2.46	68.7	33.6%
\$100,001+	.0005%	\$ 1.30	38.8	32.3%
Total	100.0%	\$647.46	8.8	51.3%

Source: 2006 Milliman Health Cost Guidelines With Rating Assumptions.

conditions, as well as other unexpected cost-shift consequences.

The table illustrates the cost characteristics of members with varying annual pharmacy expenditures.

Benefit changes will affect the behavior of roughly 25% of the total membership (in blue above). Little will be saved from people who have \$0 to \$500 in expenditures, while people with more than \$10,000 are best served by disease management or medication therapy management programs. Members whose annual expenditures exceed \$10,000 generally have high-cost conditions over which they have little control and limited alternatives. The burden of unlimited cost sharing can be significant for these members.

6. Individual market benefit designs (e.g., Medicare Part D) may not be acceptable choices in the group employer market setting.

- One of the keys to success in the individual marketplace is to attract the best risks and

structure products to avoid high-risk individuals.

- As an employer, the first priority is to attract the best employees and then retain them. Benefits are not usually structured to exclude high-risk individuals from a health care cost perspective.

Prescription drugs are a complex and difficult part of health care benefits and should be treated as such. Employers would do well to understand and revisit the pharmacy benefit building blocks periodically before changing plan design. Ultimately, aligning all aspects of the pharmacy benefit is the best and only way to help control drug benefit costs and, at the same time, promote greater employee satisfaction. ◀

Endnote

1. PBMI's 2006 *Prescription Drug Benefit Cost and Plan Design Survey Report* is available at www.pbmi.com/product.asp.

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