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PRESCRIPTION DRUG PLANS

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- o Controls on utilization
- o Eligibility control
- o Pricing considerations
- o Benefit design
- o Mail order programs
- o Physician dispensing

MR. STEPHEN D. BRINK: This panel will address prescription drug plans -- what they are and how they work. There is a variety of prescription drug plans currently being used. We will look at prescription drugs from both a medical and a clinical perspective. We will talk about how prescription drug programs can be managed and about some of the new, innovative techniques that are being used to control prescription drug costs. We will also discuss actuarial pricing considerations and experience monitoring techniques.

Prescription drugs represent a $1 billion industry in the U.S. This is equivalent to approximately 0.7% of the U.S. GNP while total medical care costs are 11% or 12% of the GNP. Prescription drug costs are rising as fast, if not faster, than overall medical care costs.

MR. ROBERT W. FIELD: I will start my discussion with how drug coverage is provided. Drug coverage may be provided in any of the following ways: (1) through a major medical plan; (2) a stand-alone benefit under a reimbursement or indemnity prepaid, card-type plan; (3) a combination major medical/mail service plan; or (4) a combination card/mail service plan.

I will provide a few key definitions that will be used throughout my presentation:

1. Brand Name -- The trademark name of the drug that appears on the packaged label. This is the original drug as it is brought to the Food and Drug Administration (FDA) and patented.
2. Generic Drug -- Used to identify non-brand name drugs sold at typically lower cost. This is when the drug is no longer under patent protection and can be manufactured by multiple sources.
3. Single Source Drug -- A drug marketed or sold by only one manufacturer or labeler. It is the brand drug during its patent protection period.
4. Multi-Source Drug -- A drug marketed or sold by two or more manufacturers or labelers. This is after a drug's patent protection period when it is available in generic form.
5. Average Wholesale Price (AWP) -- The published average cost of a drug product paid by the pharmacist to the wholesaler. It is becoming more of a list price and less indicative of what pharmacists are actually paying for drugs.
6. Ingredient Cost -- The cost of the drug product as stated on the drug claim or as Pharmaceutical Card System (PCS) would calculate it by multiplying the quantity of the drug dispensed by its unit cost.

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7. Dispensing Fee -- This is the amount added to the ingredient cost of a drug to compensate the pharmacist for dispensing the prescription.
8. Copay -- The amount paid by a member to the pharmacist for each prescription.

I will now discuss a few marketplace parameters. There are almost 61,000 pharmacies in the U.S. Our organization has about 56,500 member pharmacies. The value of drugs dispensed in 1988 was $25 billion. The number of outpatient prescription drugs dispensed was about 1.5 billion. In just our U.S. business, PCS paid approximately 67 million claims in 1988.

Table 1 summarizes experience from our database for both third quarter and fourth quarter 1988 actual average claims. This is the ingredient cost plus the dispensing fee before the acopay has been deducted.

TABLE 1

Average Claim
Ingredient Cost & Dispensing Fee
1988

	3rd Quarter	4th Quarter
Average All Claims	$20.79	$20.77
Single Source Claims	29.55	30.05
Multi-Source Brand	17.28	16.98
Multi-Source Generic	8.73	8.63

The average of all claims during the third quarter was $20.79. The average single source claim was $29.55. Therefore, those drugs that are under patent protection are still very high priced. This shows that the drug manufacturers are developing new products which are very high priced in order to recoup research and development costs and to maximize their profit while they are under protection.

The average multi-source brand drug was only $17.28. There is a substantial difference between the brands during patent protection and the older brands that are no longer under patent protection. Finally, the average multi-source generic was only $8.73.

The fourth quarter data are also summarized in this table in order to compare the two quarters. The average of all claims for the fourth quarter actually went down two cents. This is surprising since we are in a period of relatively high drug inflation, but this reflects some of the cost management things that we have been doing on subsets of our business. Even though many of our clients have not instituted cost management features, enough of them have so that inflation in the quarter was counteracted. However, single source claims did increase reflecting the fact that as new drugs are developed they tend to be increasingly higher priced. Multi-source generic and multi-source brand costs decreased, reflecting that the multi-source marketplace is becoming increasingly competitive on prices.

Table 2 shows the increase in the average claim, or ingredient cost plus dispensing fee, for the last four years. The ingredient cost and dispensing fee are only two of the four components of a drug claim. The other two are the administration cost and the utilization factor, which will be discussed later.

TABLE 2

Percentage Increase
In Average Claim
(Ingredient Cost + Dispensing Fee)

1985	8.0%
1986	9.0
1987	9.0
1988	10.5

I will now discuss attacking plan costs through new technology. Historically, each method of delivering a drug benefit has some limitations. Major medical, for instance, has the following limitations:

1. It is difficult to manage what is not known.
2. Drug claims in many major medical systems are not identified. Some claims are included in deductible satisfaction and drug claims are often combined with other medical expenses.
3. There are reserving problems, since it is not known when claims will be submitted.
4. There are processing inefficiencies, because typical major medical systems are not set up to process high volume, low cost drug claims.
5. There are also processing shortcomings that are more in the fraud and abuse area.

Card or prepaid plans also have limitations, such as the following:

1. These benefits continue to be used after eligibility ceases.
2. Prepaid or card plans in the past have typically been first dollar benefits only.
3. As plans become more complex, it becomes more difficult to educate providers.

There are also limitations of mail service plans:

1. They are only usable for maintenance drugs.
2. The mail service firm typically does not have a complete profile of the drug history of the user, because they are not filling or dispensing the acute drugs.
3. There are some difficulties in maximizing generic substitution.

Our organization has spent the last five years developing "point of service claims processing." Point of service processing is not only eligibility verification and on-line data capture, it also includes complete adjudication of the claim at the point of service. We think this is the technology of the future. Many organizations are pursuing this technology today. This allows you to do many things that you could not do in the past under a prepaid environment. The following list summarizes the enhanced capabilities of our point of service clams processing:

1. Separate annual deductibles
2. Separate annual drug plan maximums
3. Provider assistance, including
   a. more complex plans with percentage copays and annual deductibles and maximums are more easily administered, and
   b. formularies and generic substitution
4. Concurrent drug utilization review

The current status of this technology is that many organizations are moving in this direction. The status of our organization is that of approximately 56,500 pharmacies, a little over 33,000 have actually contracted for our new network of on-line pharmacists. Just under 23,000 pharmacies are currently submitting claims on-line which comprises about 40% of our current claims volume, or about 3.5 million claims a month. I believe that by 1993 this will be the U.S. standard.

I would like to discuss what I would call "attacking plan costs in the managed care environment." Many of the things that I will discuss are certainly applicable to the indemnity type of plans as well as to a managed care environment. I will discuss participant contributions, reimbursement levels, plan design considerations, drug utilization review and mail service. Historically, card or prepaid plans have had a flat deductible or flat copay. We are now seeing those flat copays increasing dramatically. About ten years ago the average deductible was probably about $1.10. Today, the average deductible is about $3.38.

Percentage copays are becoming increasingly popular because they offer one very significant advantage. During periods of high inflation, they allow you to share the inflation with the beneficiary by using a percentage copay instead of a flat copay.

A split copay -- split between generic and brand -- has become very popular. Under this scenario, when the generic drug is dispensed, it carries a lower copay than a brand name drug. We have seen about a 20% increase in a group's generic substitution rate due to the split copay. However, this difference depends on the difference between the generic copay and the brand copay.

Annual deductibles are starting to become more popular. We are administering several of these plans. The Medicare legislated benefit will be an annual deductible and we believe this is a good way to enjoy the benefits of a prepaid plan without necessarily having to increase claim costs for that type of benefit.

Finally, current copays average about $3.38. This is somewhat misleading because we have many old accounts that have been on the books a long time. The union negotiated business tends to be very slow to adjust their copay levels. Much of the new business is starting at split copays of $3/$5, $4/$6, or $5/$7 for generic/brands.

I will now discuss reimbursement levels in terms of the ingredient cost and the dispensing fee. Typically, plans have reimbursed an ingredient cost up to the published AWP price. In addition, plans have paid a dispensing fee approximating the state Medicaid fee. There have been some exceptions, most notably the big three auto makers, who have been paying acquisition cost plus a higher dispensing fee. In the current marketplace clients with market clout are discounting either the dispensing fee or AWP.

One of the reasons they are discounting AWP is that they know pharmacists are not paying AWP for the drug. There are some trade-offs, however. For example, in California the Medicaid dispensing fee is $4.05, but in New York it is only $2.65. If you compare two plans that are paying the Medicaid fee and you reduce the ingredient cost to the pharmacist to 90% of the AWP, you have made a bigger reduction to the actual profit of the New York pharmacist than you have to the California pharmacist. Plans have been successful at discounting the AWP or lowering dispensing fees, but plans need to look at their beneficiaries and need to take different approaches in different parts of the country.

Now we will discuss plan design considerations. Typically, covered items have been all federal legend drugs and insulin, with the possible exception of oral contraceptives. Another part of plan design is generic substitution savings. Savings are substantial for generic substitution. We have already discussed split copays and I will discuss our maximum allowable cost or MAC program, which tends to maximize generic substitution savings, a bit later.

Another plan design consideration is a formulary, which is simply a list of covered drugs. Actually, the typical plan covering all legend drugs is, in effect, a formulary, but I am referring to a more restrictive formulary where there may also be a specific list of drugs covered. Under a formulary you have a group of professionals who would look at drugs and decide which drugs deliver the most cost-effective medicine.

The next item I will talk about is drug utilization review. There are two types of drug utilization review -- quantitative and qualitative. Quantitative utilization review involves looking at patterns of usage by numbers. This would involve how many drugs are used over a certain period of time, how many narcotic drugs are used, putting pharmacies in peer groups and looking at their activity, how many generic drugs are dispensed compared with their peer group, how many are refills versus new drugs and so on.

Qualitative utilization review can be either concurrent or retrospective. Qualitative review involves looking at actual patterns of health care delivery. For instance, a qualitative issue would be a person who has been taking an anti-arthritic drug for six months and now needs an anti-ulcer drug because the anti-arthritic drug was either the wrong drug or too high a dosage and may have caused the person to need an ulcer drug.

Mail service can also be an important part of a prescription drug program. The promise of mail service is that it would maximize generic substitution and, in fact, mail service has significantly raised the level of generic substitution over the typical program as it existed four or five years ago. Mail service firms provide low unit costs because they buy large quantities of drugs and, therefore, can buy at discounted prices. Finally, the mail service firms say that they will dispense maintenance drugs for a longer period of time for one fee which also results in savings.

Today's reality is that mail service programs have not lived up to their promises. There are higher rates of generic substitution with community pharmacies on our MAC program than in the mail service programs.

Dispensing periods may be too long under mail service. Outside actuarial firms have done studies for us and 90 days of maintenance drugs is not necessarily the most cost-effective medicine.

Finally, the discounts which mail service programs provide are not significantly better than community pharmacy discounts. The AWP is becoming more of a list price and there is quite a bit of gaming taking place, especially as more drugs become multi-source drugs and generic houses do various things to make purchasing their drugs attractive.

Now I will talk about purchase considerations for mail service. First of all, we have found that those eligible who have a mail service option and use it, do like the service. They like the convenience of the mail service. It is not a very high percentage of people, but those people who utilize it consistently, like the convenience.

It is necessary to examine dispensing period controls. A flat 90 days for all maintenance drugs is not cost-effective.

You also need to look at unit cost prices, not discounts. The reason for this is that drugs have different prices based on the package size in which they are sold. Also, as I mentioned, some manufacturers inflate the AWP more than others. Basically, the AWP is a manufacturer list price. So when comparing different mail service funds it is important to look at unit cost prices, not discounts off the AWP. Finally, it is also important to look at the rates of generic substitution.

I would now like to discuss our maximum allowable cost or MAC program. The maximum allowable cost is the highest unit price that will be paid for a drug. The MAC program sets up limits on the payment for generically equivalent drugs that are available from multiple manufacturers.

An example of how this program works is Motrin. The generic form of that drug is ibuprofen. Since that was made available in a multi-source form, 18 companies are now producing it. The cost for other generically equivalent, therapeutically equivalent drugs is as low as $9.38. In this case we set our MAC price at $12.15. So if a pharmacist, for instance, was to use the Purepac drug at $10.50, he would get reimbursed the ingredient cost he submitted up to $10.50. If, however, he was to use the Rugby drug at $14.94, the maximum reimbursement he would receive is $12.15, which is also what he would receive if he used Motrin at $24.56. The most he could get is $12.15. The only exception to this is if the doctor writes "dispense as written" on the prescription so that the pharmacist cannot substitute. That only happens about 5% of the time. We have shown that there are some potentially large savings available about 95% of the time when a multi-source drug is available.

I will shift gears now and discuss some actual cost modeling we have done for clients. Table 3 summarizes the experience of a group with about 16,000 eligible cardholders for the twelve month period ending September 1988.

TABLE 3

OCTOBER 1987 THROUGH SEPTEMBER 1988 CLAIMS

		TOTAL	
Actual claims cost	-	$5,427,298	100%
Actual copayments	-	1,001,946	
Average copay	-	3,263	

	MODEL						
	A		B		C		
	90% AWP		MAC		90% AWP and MAC		
$3.26 Copay (Present Level)							
Recast claim cost	$4,938,218		$4,935,387		$4,523,972		
Recast copayments	1,001,946		1,001,946		1,001,946		
Recast savings	489,080	9%	491,911	9%	903,326	17%	

We readjudicated the actual claims based on alternate types of programs. In Column A the reimbursement of the ingredient cost was limited to 90% of the AWP. The second column was readjudicated using the MAC program. The third column utilized both of those features. As you can see, under both Column A and Column B, 9% savings would have occurred in that year. The combination of the two features is not quite additive as the savings in Column C are 17%.

Table 4 is basically the same information but models different copay levels.

This shows that if we raise the copay for this group from an average of about $3.26 to $4, $5 or $6, we can realize even greater savings. For example, in Table 4A, if we went to a flat $5 copay, we would save 26% instead of only 17%. If we were to go to a split copay, shown in Table 4B, such as $4/$6, the savings would be 28%. Finally, if we went to a percentage copay of 20%, Table 4C, we can see that the savings for both the 90% of the AWP and the MAC would have been 34%.

TABLE 4A

	A 90% AWP		B MAC		C 90% AWP and MAC	
$4.00 Copay						
Recast claim cost	$4,711,736		$4,708,905		$4,297,490	
Recast copayments	1,228,428		1,228,428		1,228,428	
Recast savings	715,562	13%	718,393	13%	1,129,808	21%
$5.00 Copay						
Recast claim cost	$4,404,629		$4,401,798		$3,990,383	
Recast copayments	1,535,535		1,535,535		1,535,535	
Recast savings	1,022,669	19%	1,025,500	19%	1,436,915	26%
$6.00 Copay						
Recast claim costs	$4,097,522		$4,094,691		$3,683,276	
Recast copayments	1,842,642		1,842,642		1,842,642	
Recast savings	1,329,776	25%	1,332,607	25%	1,744,022	32%

TABLE 4B

	A 90% AWP		B MAC		C 90% AWP and MAC	
$3.00/$5.00 Copay						
Recast claim cost	$4,483,699		$4,600,056		$4,188,641	
Recast copayments	1,456,465		1,337,277		1,337,277	
Recast savings	943,599	17%	827,242	15%	1,238,657	23%
$4.00/$6.00 Copay						
Recast claim cost	$4,176,592		$4,292,949		$3,881,534	
Recast copayments	1,763,572		1,644,384		1,644,384	
Recast savings	1,250,706	23%	1,134,349	21%	1,545,764	28%
$5.00/$7.00 Copay						
Recast claim cost	$3,869,485		$3,985,842		$3,574,427	
Recast copayments	2,070,679		1,951,491		1,951,491	
Recast savings	1,557,813	29%	1,441,456	27%	1,852,871	34%

TABLE 4C

	A 90% AWP		B MAC		C 90% AWP and MAC	
$5.00/$8.00 Copay						
Recast claim cost	$3,601,913		$3,777,864		$3,366,449	
Recast copayments	2,338,251		2,159,469		2,159,469	
Recast savings	1,825,385	34%	1,649,434	30%	2,060,849	38%
$5.00/$5.00 + 30% Copay **						
Recast claim cost	$3,148,405		$3,165,752		$2,874,754	
Recast copayments	2,813,438		2,750,170		2,630,843	
Recast savings	2,278,893	42%	2,261,546	42%	2,552,544	47%
20% Copay **						
Recast claim cost	$4,752,131		$4,749,866		$4,420,734	
Recast copayments	1,188,033		1,187,467		1,105,184	
Recast savings	675,167	12%	677,432	12%	1,006,564	34%

** Recap only

Table 5, shown below, contains a list of drugs that are not considered to be medically necessary. For instance, Retin A can be used to reduce wrinkles in women over age 55. This has nothing to do with the treatment of acne, for which Retin A is authorized.

Desi drugs are drugs that were labeled as safe to take before the FDA stated that a drug did what it was supposed to do. Desi drugs have never been proven to be cost-effective, only that they will not hurt you. Some plans are starting to eliminate these drugs now.

Included below is a summary of the claim dollar changes that would have occurred had an alternative benefit plan been in place.

TABLE 5
PLAN DESIGN

Drug Class	$ Paid 10/87 -- 9/88
Accutane	$12,613
Anorectics	26,407
Desi Drugs	13,720
Nicorette Gum	23,946
Retin A	12,475

Tables 6 and 7 show the results of one other cost modeling example.

TABLE 6
JULY 1987 THROUGH JUNE 1988 CLAIMS

		TOTAL	
Actual claims cost	-	$7,313,849	100%
Actual copayments	-	$1,732,504	
To Date 3.845			

MODEL

	A 90% AWP		B MAC		C 90% AWP and MAC	
$3.84 Copay (Present Level)						
Recast claim cost	$6,646,072		$6,749,743		$6,178,052	
Recast copayments	1,732,504		1,732,504		1,732,504	
Recast savings	667,777	9%	564,106	8%	1,135,797	16%

This is a group almost twice the size of the first group (Tables 3 and 4) with a 16% savings for the 90% AWP and MAC program and an average copay of $3.84. Table 7 shows what happens if we raise the copay levels.

TABLE 7A

	A 90% AWP		B MAC		C 90% AWP and MAC	
$4.00 Copay						
Recast claim cost	$6,576,132		$6,679,803		$6,108,112	
Recast copayments	1,802,444		1,802,444		1,802,444	
Recast saving	737,717	10%	634,046	9%	1,205,737	16%
$5.00 Copay						
Recast claim cost	$6,125,521		$6,229,192		$5,657,501	
Recast copayments	2,253,055		2,253,055		2,253,055	
Recast savings	1,188,328	16%	1,084,657	15%	1,656,348	23%
$6.00 Copay						
Recast claim cost	$5,674,910		$5,778,581		$5,206,890	
Recast copayments	2,703,666		2,703,666		2,703,666	
Recast savings	1,638,939	22%	1,535,268	21%	2,106,959	29%

TABLE 7B

	A 90% AWP		B MAC		C 90% AWP and MAC	
$3.00/$5.00 Copay						
Recast claim cost	$6,241,507		$6,519,878		$5,948,187	
Recast copayments	2,137,069		1,962,369		1,962,369	
Recast savings	1,072,342	15%	793,971	11%	1,365,662	19%
$4.00/$6.00 Copay						
Recast claim cost	$5,790,896		$6,069,267		$5,497,576	
Recast copayments	2,587,680		2,412,980		2,412,980	
Recast savings	1,522,953	21%	1,244,582	17%	1,816,273	25%
$5.00/$7.00 Copay						
Recast claim cost	$5,340,285		$5,618,656		$5,046,965	
Recast copayments	3,038,291		2,863,591		2,863,591	
Recast savings	1,973,564	27%	1,695,193	23%	2,266,884	31%

TABLE 7C

	A 90% AWP		B MAC		C 90% AWP and MAC	
$5.00/$8.00 Copay						
Recast claim cost	$4,947,667		$5,313,388		$4,741,697	
Recast copayments	3,430,909		3,168,859		3,168,859	
Recast savings	2,366,182	32%	2,000,461	27%	2,572,152	35%
$5.00/$10.00 Copay						
Recast claim cost	$4,162,431		$4,702,852		$4,131,161	
Recast copayments	4,216,145		3,779,395		3,779,395	
Recast savings	3,151,418	43%	2,610,997	36%	3,182,688	44%
30% Copay **						
Recast claim cost	$5,865,003		$5,937,573		$5,537,389	
Recast copayments	2,513,573		2,544,674		2,373,167	
Recast savings	1,448,846	20%	1,376,276	19%	1,776,460	24%

** Recap only

I will conclude by discussing the effective management of costs. Under the indemnity approach one of the advantages is claim reimbursement avoidance or non-filing of claims. There are claims that go toward deductible satisfaction and possibly some prescriptions that never get filled. The disadvantages are that there is no control over price, administrative cost is typically high, there is a lag in claims processing, and there is a lack of good, timely data.

Under a stand alone or a prepaid drug plan the advantages are more control over price, lower administrative costs, drug specific data, and timely data. The disadvantages are that there is no claim reimbursement avoidance and no non-filing of claims. Deductible satisfaction also does not occur, but with the new point of service technology it is possible to have annual deductibles.

DR. CARL F. MYERS: My presentation will cover how physicians react to managed care plans and some of the cost containment efforts being used in prescription drug plans. Many companies have professed to become managed care companies and I am not sure they really understood what it takes to manage care. From my perspective I believe a well-executed managed care plan depends on the ability of the operations people to understand the physicians and to interface between the administration of a plan and the physicians.

To manage care one must understand the physician's perspective -- how they view their own professional roles. Physicians play various roles, including those of patient advocate and businessman. Most physicians, without a doubt, are physician advocates. Managed care plans need to understand physicians' sensitivity in this area of patient advocacy and try to work with, not against, the physicians in this role.

The majority of physicians see their second role as independent businessmen. This is a secondary role, a role that is necessary in order to fulfill their primary role. This does not mean that they don't expect a good income. They rationalize a good income because of their education, the importance of their job, and other reasons. It is also important for people who are designing plans to remember that this is really a secondary role, at least in the way the physician looks at himself. There are physicians I would call entrepreneurial, but I think they are the exception rather than the rule.

The third role is one that some physicians play fairly easily, that of societal advocate. These are the physicians who will speak in community forums on many health care issues, trying to improve the general community health standards. This third role is much less well-accepted than the patient advocate or businessman roles.

The final role a physician plays is as third-party liability advocate in the managed care industry, a role the physicians do not relish at all. We often ask them to consider more than their patient advocacy role and take on this role of the payor.

Obviously these different roles can sometimes come into conflict. When I ask a physician to do something because it is more cost-effective and the patient really would feel more comfortable in the hospital for another day, then the physician's roles come into conflict. The patient advocate says "Keep the patient in an extra day," and the third-party liability advocate says "Send the patient home and save some money." Even though it is medically acceptable to send the patient home, the patient would be more comfortable with an extra day in the hospital. We are asking physicians to mix up these roles in order to save money.

Next I will discuss three examples of pharmaceutical decision making and how the different roles of a physician might impact on making a decision.

The first case is a 4-year-old child with an earache and you have three different possibilities. Drugs A and B, although they are different drugs in different classes, have the same effectiveness, curing 92% of the patients with 5% side effects. These side effects are minor, more of an annoyance than a major problem. The third drug looks like a better drug. It cures 98% and there is only a 3% rate of minor side effects. In this case, the drugs of choice, independent of expense, happen to be Drugs A and B.

Physicians know that as you frequently use an antibiotic, the bugs become resistant to the antibiotics. In this particular case, physicians would use Drug C only if the problem cannot be

cured with either Drug A or Drug B. In this case the standard is that the physician does not give the best drug for the individual patient, but is acting as a societal advocate by giving either Drug A or B. Interestingly enough, Drug C is extremely expensive, so in this case a managed care plan also has a problem with a physician initially prescribing Drug C.

Here is another example of how a physician makes a decision depending on which role he is playing. This is a 35-year-old healthy man, a non-smoker, who gets a cold and then also develops a bronchitis, or an infection of the bronchial tubes, and is coughing up sputum. He goes to the physician's office and the medical answer to this would be that he really does not need an antibiotic, he does not need a prescription. What he needs to do is take a lot of fluids and get more rest than usual and in three to four days he will be feeling better. However, the result of this kind of contact with the physician often is a prescription, in order to please the patient. He has gone to the physician and he has had something done about his problem. He has the antibiotic prescribed and he gets well in three or four days, the same time as if he had not seen the physician.

Physicians talk about this type of situation fairly frequently. I do not tell my patient the whole truth, because what happens is you have an unhappy patient when you do not write a prescription for him. You can explain for ten minutes what a virus is and how a virus is not helped by an antibiotic and the patient is still unhappy after that ten minutes. On the other hand, it takes two minutes to write a prescription and tell a patient how to use it. The patient does not pay for the prescription because the third-party payor does and the patient is happy. So you can see why the physician writes the prescription to save time and make the patient happy. This is also part of the business role because you want to make your patients satisfied so they will come back.

The third example is one that is more difficult to explain. Drugs A and B are completely equivalent. They have similar side effects. There is about a 50/50 market share for these drugs and one is quite a bit cheaper than the other. However, the physicians show a very significant resistance to changing the drug for economic reasons. This drug is usually given episodically, so it is not as if the reason for not changing drugs is that the patient had become comfortable with the drug. There seems to be something more in this kind of case than "if it is cheaper, then why not change?"

If the patient is paying for this particular drug, the physician would be more likely to choose the cheaper drug. When I first started practice I remember the sage of our clinic, who started the clinic some 30 years earlier, advising me never to give a patient free samples or a cheap drug, because if I used a cheap drug or gave samples I would lose the placebo effect. That does not explain it entirely, but there is a wide variety of thoughts, from a physician standpoint, beyond the actual therapeutic reasons behind prescribing practices.

My definition of the value of a drug is that effectiveness is independent of price. You need a minimum level of effectiveness in a certain therapeutic situation to be able to prescribe something and without that minimum effectiveness, no matter what the price is, you should not prescribe it.

One area where we are currently having trouble is in growth hormone. Growth hormone costs about $14,000 per year. One potential indication for the use of the drug is that with genetically short patients one might pick up two or three inches by taking growth hormone. Six years of treatment at $14,000 per year is quite expensive to gain two or three inches. In this situation, the managed care industry is saying that this is a drug that is appropriate for the person who is definitely growth hormone deficient, but not effective enough for the person who is constitutionally short.

In the last example I pointed out the difficulty in determining who should get growth hormone. Should the patient's physician make the decision? We have endocrinologists across the country who would like to be able to give growth hormone to all people who are constitutionally short. This would amount to about 0.5% of the GNP. We cannot let the endocrinologists do that.

A Professional Standards Committee can define the acceptable value, which would be dangerous if somebody else is paying for it. If you are the parent of a child who is going to be five foot two and you want that child to be a basketball player and somebody else will pay for the growth hormone, you would probably consider it. I know of some employers who would like to be able to define the minimum acceptable level of effectiveness, but it does take some expertise. Very often

the employer is willing to have the insurance carrier define what is a minimum acceptable level for a therapeutic situation. We need to have a combination of all of the players decide together what is the minimum acceptable level of health care value.

Here is another example of the complexity of prescribing drugs. I frequently participate in a pharmacy and therapeutics committee and we can spend four or five weeks on one drug. A drug that we talked about recently was a drug that lowers cholesterol and has been proven to decrease non-fatal myocardial infarctions, or heart attacks. The largest study done showed that there were 26 fewer heart attacks in 4,000 patients, 2,000 of whom were treated and 2,000 were the control group. The drug costs for each saved myocardial infarction comes to $225,000. If that was all the information we had, there would be a lot of contention about whether or not this was an effective enough drug. The kicker in this case is that the overall death rate was actually higher, although not significantly, for the treated group than for the control group. That makes it very difficult to understand what should be done. You have a patient with high cholesterol. You have this drug that is effective in decreasing myocardial infarction. You have to make a decision as to whether or not the plan will cover this drug or even promote it as quality care. This is a rhetorical question for which I certainly do not know the answer. It is just an example of how difficult it is to define what a formulary should be and what your recommendations to your physicians should be.

Why does a particular physician choose a particular drug? The first reason may be the physician's familiarity with the drug. There are situations where there may be 6 or 7 different drugs that are very similar and can be used interchangeably. The physician will use the one that he is most familiar with. He may revert back to his residency 5 or 10 years earlier. That may have been the drug that the attending physician used and, therefore, he has used that drug ever since. He is comfortable with that drug. It becomes very difficult when you give physicians a formulary and tell them these are the drugs they should use. The physician is not familiar with every drug in that situation. He does not use the drug very often. Exactly what have you done to quality care when you have asked him to switch to another drug that he is not familiar with? He may not know the side effects or the potential drug interactions.

Some drugs are prescribed based on a patient request. This is becoming more common and I believe it is one reason that drug costs are rising so rapidly. One particular drug advertisement that I saw in Florida was a commercial that showed a very convincing elderly lady with pain in her abdomen. The commercial suggested that antacids no longer work for ulcers and you should go to your doctor and get a pill if you have this type of pain. I expect this ad has caused many patients with similar pains to go to their physician and ask for a prescription instead of using an antacid.

In conclusion, I believe there are dramatic potential savings in managing pharmaceutical practices but I do not think that there is any quick fix. I think there is probably a discretionary choice to the physician in about 90% of the time a drug is prescribed. In other words, given a situation in which a physician might prescribe a drug, there is a choice involved 90% of the time. Convincing the physicians through education, peer review and formulary work that they should be making cost-effective decisions would result in significant savings.

MR. PAUL GIOVANNELLO: In discussing The Guardian's involvement with prescription drug card programs I believe it is important to first describe our group operations, since this will put our involvement in its proper perspective.

Throughout the more than 30 years of our group insurance operations, The Guardian has focused primarily on employer groups at the lower end of the size spectrum, meaning groups less than 100 lives. Our annualized premium revenues crossed the $1 billion mark this past year. Of this amount approximately 85% is attributable to groups of under 100 lives. In fact, our concentration of business is found at even lower size levels, with a particular specialty in the individually underwritten, less than ten lives market. Here we have approximately 39,000 groups covering more than 145,000 employees and generating annualized premiums on the order of $250 million. The bulk of our group insurance premiums fall into the major medical category.

We believe that we are among the leaders in the small group market, and a good part of our success has come from our attentiveness to our planholders' needs and desires, within the constraints of prudent underwriting practices. As prescription drug card programs developed, they

were perceived as attractive benefits by both employers and their insured employees. It is in the context of this growing benefit popularity that The Guardian began to offer this type of benefit program to our planholders back in 1979. After some initial investigations and experimentation, we decided to utilize the services of Pharmaceutical Card Systems, or PCS, for these programs.

During the next few years, we restricted the marketing of this product to groups of ten or more employees as an optional benefit, with a separately identifiable price. Through calendar year 1985 we made a modest marketing effort with regard to the drug card program, and our inforce business grew at a nominal rate.

The Guardian's significant involvement with the prescription drug card program actually commenced midway through 1986, in connection with the upgrading and redesign of our small group product for groups of less than ten employees. After much discussion, it was decided to incorporate the drug card benefit as a standard part of the plan design partly because of administrative concerns and partly because of concerns of potential anti-selection in connection with an optional approach on very small groups. Based on the results of some actuarial studies commissioned by PCS and allowing for the unique design of The Guardian's major medical indemnity reimbursement level, we believed that we could provide the following drug card benefit designs without any increase in overall premium levels.

For an underlying major deductible of $100, a $3 per prescription copayment was required. For a $200 deductible major medical plan the drug copayment was $4 and for a $300 deductible plan a $5 copay was required.

There was also a desire to incorporate the drug card program for group plans with $500 major medical deductibles, but the projected break-even copay level was believed to be too high and unattractive. We took the approach of utilizing the same $5 copay as for the $300 deductible plans and loading the overall premium rates for the $500 deductible plan by the projected shortfall. Unlike the situation with groups of ten or more, there was no separately identifiable premium rate element attributable to the prescription drug card piece.

The drug card benefit was immediately incorporated into all newly written, under ten life business and phased into such inforce groups over a one-year period at time of renewal. The introduction of the standard PCS program on our smallest groups made our group salesmen and brokers more aware of the product, and sales of optional drug card benefits on groups of ten or more accelerated significantly.

To give you some idea of our present involvement in the area of prescription drug card plans, we currently have approximately 200,000 insured employees with such benefits. During calendar year 1988, prescription drug payments by PCS for our claimants totalled approximately $26 million.

For just a moment I would like to touch on administrative considerations. Because of the necessity of getting the drug cards to the eligible insureds, and only to those insured, accurate and timely enrollment data, including adds and deletes, must be provided by the carrier or plan to the drug card vendor. This becomes particularly important when large volumes of lives are involved, particularly in the environment of the individual underwriting in the small case market. As our business with PCS grew rapidly, paper transactions gave way to daily tape submissions from The Guardian to PCS. It is likely that some time in the future we may go to direct electronic transfer of enrollment data. Similarly, hard copy claim listings from PCS to The Guardian have given way to the providing of claim tapes, since the volume of payments became a substantial portion of our overall business, requiring significant actuarial analysis.

I should stress that the administration is an extremely important concern. We have a great deal of sensitivity to our planholders' concerns and administrative foul-ups such as missing or delayed cards impinge upon our credibility as a provider of quality service. When very large numbers of plans and insured individuals are involved, even a small error percentage can translate into a fair number of unhappy clients, all of whom seem to have access to our president's telephone number.

We were aware that the prescription drug card benefit was an attractive one. What we did not know was just how much our planholders and insureds would love this benefit. They loved it to the extent of doubling our previously experienced drug claim levels virtually overnight! This can be illustrated by the following graph charting the history of prescription drug claims on $100

deductible comprehensive major medical coverage written on groups of less than ten employees. Graph 1 shows drug claims as a percentage of total major medical plan costs. As you can see, throughout the early and mid 1980s prescription drug claim costs escalated at a level in excess of that for the aggregate major medical coverage and continually represented a higher portion of the total costs. However, with the phase-in of our drug card program during 1987 and with the complete impact being experienced by the first half of 1988, the 1986 percentage of total was approximately doubled; this with a required copayment per prescription which we had initially expected to produce a break-even, or no incremental cost, situation.

We also examined the experience for our comprehensive major medical plans with other deductibles, as well as that for our two types of supplemental major medical plans -- wrap-around plans over Blue Cross and superimposed plans over both Blue Cross and Blue Shield -- and found remarkably similar results. Similarly, we did a comparison of the relative drug claim costs on true group cases (which we define as covering ten or more employees) with and without the optional drug card coverage. After adjusting for plan differentials, we again found relative drug claim costs on groups with the card to be approximately double the costs on cases without it.

The question arises as to why aggregate drug claim costs run twice as high under a card program than under the conventional major medical approach. The reimbursement formula to the pharmacist under the PCS program actually produces lower unit cost per prescription than a straight retail basis by about 5-10%. Therefore, it appears that claim frequency is the culprit. I use the term "appears" because we really do not have a precise measurement of drug frequencies under The Guardian's conventional major medical programs. This is attributable to the nature of our claim coding which records a check payment for drugs as one event even if multiple prescriptions are involved. Nevertheless, from both the process of elimination and general reasoning, drug claim frequencies are the most likely cause of the doubling of this element of cost.

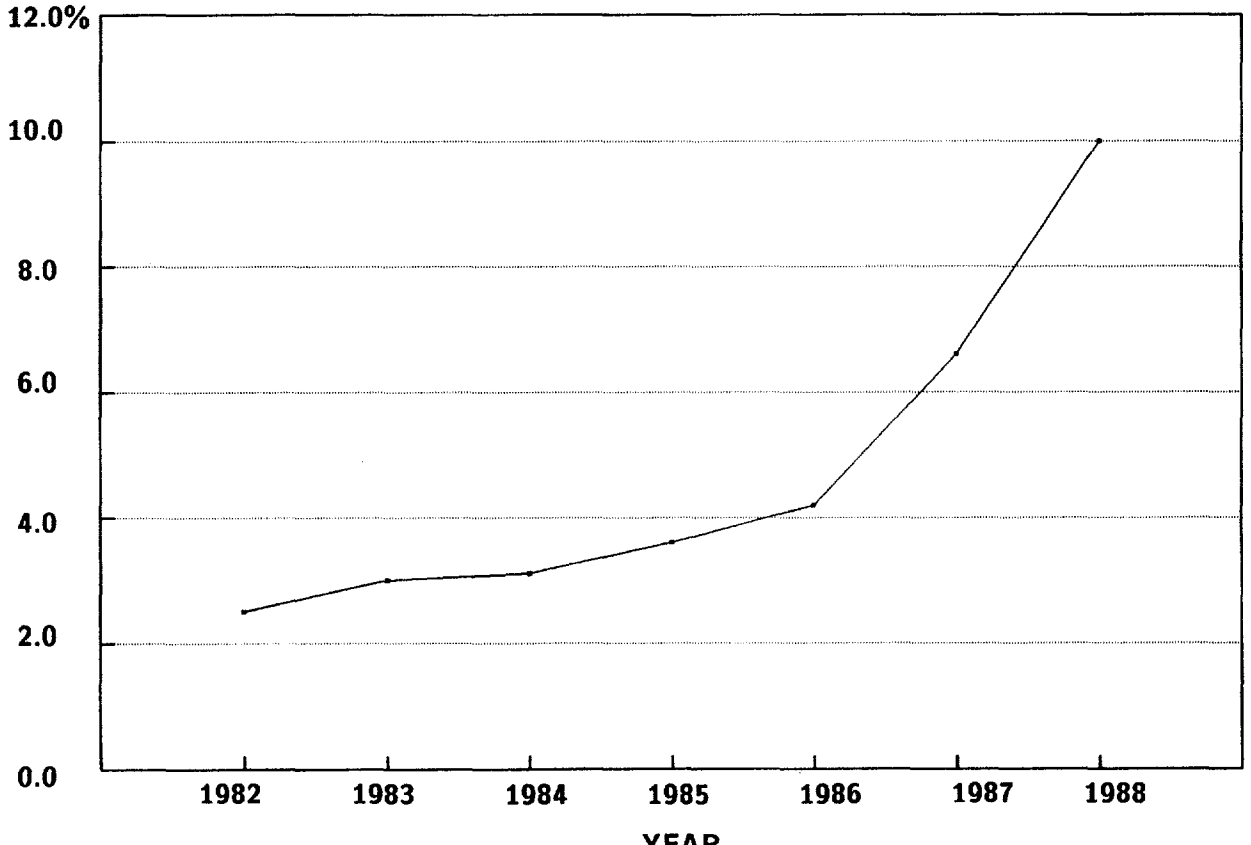
We believe that the frequency factor is made up of two elements. The first of these elements is what I call the "plastic" factor, and it can be thought of as being analogous to your last trip to the shopping mall. Somehow the existence of plastic in your wallet seems to take the financial pain out of shopping, at least on an immediate basis. Many people purchase far more than they need or can comfortably afford when they do not have to come up with the cash up front. Now imagine what would happen to sales if you could avoid the MasterCard or Visa bill in exchange for a bit of up-front pocket change. In essence, that is often what a drug card arrangement can be and why it is viewed as such a desirable benefit. I have heard this from our friendly local pharmacist who tells me that when a drug card claimant comes in with a physician's prescription permitting a number of refills, these refills are almost always exhausted in rapid succession.

The second of the two frequency elements is the degree of reporting of actual insured claim charges. Conventional major medical plans generally require the insureds to keep track of paper, and some of these items never get reported to the insurer. Some receipts are lost while others may not be submitted because the claimant has not met his overall yearly deductible, forgets about these expenses, or perhaps does not understand that these charges are potentially reimbursable by the insurer. With a drug card program, however, each filled prescription is automatically recorded and, therefore, finds its way back to the insurer.

While we at The Guardian could not perform a before and after study of prescription drug frequencies, we were able to conduct an interesting analysis of our drug card claim frequencies under our small group program already described. The analysis focused on the first half of calendar year 1988, and measured total monthly prescriptions filled per covered employee, with the prescriptions coming from both the employees and their dependents. The resulting frequencies for comprehensive major medical coverage are shown below:

Underlying Major Medical Plan Deductible	Drug Card Copay Per Prescription	Monthly Frequency Per Covered Employee
$100	$3	.747
200	4	.568
300	5	.549
500	5	.473

PRESCRIPTION DRUGS AS A PERCENTAGE OF TOTAL CLAIM COSTS COMPREHENSIVE MAJOR MEDICAL -- $100 DEDUCTIBLE GROUPS OF LESS THAN 10 LIVES



Frequencies significantly diminish as combined major medical and drug card plans require greater out-of-pocket expenses on the part of the insureds. Because of our unique benefit design on this small group product, we have not been able to isolate the impact of the drug card deductible. For example, in the environment of a fixed annual major medical deductible, both general reasoning and a brief analysis of our experience on somewhat larger groups indicate that a $1 or $2 increase in the drug card copay will have only a modest downward impact on prescription drug utilization. A more important factor, however, appears to be the magnitude of out-of-pocket expenses required under the major medical plan, particularly the size of the annual deductible. Our belief is that with higher major medical deductibles, marginal visits to the physician for relatively minor acute conditions tend to diminish. Less frequent office visits result in fewer prescriptions being written and, therefore, fewer prescriptions being dispensed. The impact on the relative frequencies can best be seen in examining the $300 and $500 deductible plan figures shown above. Although both plans incorporate a per prescription copay of $5, the frequency for the $500 deductible plan is significantly lower than for the $300 deductible plan.

A logical follow-up question to this analysis is whether the marginal prescriptions avoided are of the same magnitude as those still being reimbursed. For example, does the difference in frequencies reflect the actual bottom line claim dollar savings attributable to the different levels of required out-of-pocket expenses? To answer this question we examined the average cost per prescription filled under the two major medical plans. The results of this analysis are shown below:

Underlying Maj. Med. Deductible	Drug Card Copay Per Prescr.	Monthly Frequency Per Employee	Average Charge Per Prescr.	Monthly Claim Cost Per Employee
$300	$5	.549	$14.46	$ 7.94
500	5	.473	14.96	7.08

The table shows that a 13.8% reduction in frequency translates into a 10.8% savings in overall drug claim costs.

The Guardian's adoption of the prescription drug card approach for a major segment of business has generated a number of beneficial by-products. First of all, the available information from the claim coding is a significant improvement over what we have for the conventional situation. We have more information with which to perform various actuarial analyses. We now have readily available information with respect to the type of drug utilized and the bodily system involved. For example, we can easily tabulate data on azidothymidine (AZT) in order to help measure the prevalence and impact of acquired immune deficiency syndrome (AIDS) situations on our overall claims experience.

The drug card claims data can also be a valuable tool for our underwriters. The data can be matched against original application information on recently underwritten insureds in order to better identify preexisting condition situations and possibly situations calling for recision of coverage. We have found more than one individual with such circumstances who did not submit any medical claims directly to The Guardian, but who utilized the PCS drug card. We have been experimenting with this on only a limited basis over the past year, but we are aware of at least one major group carrier on the west coast which has done this type of analysis extensively over the last few years, apparently with a good deal of success.

In closing, we at The Guardian view the availability of the drug card program as a very important part of our product portfolio; one which better enables us to attract and retain business. However, it is a product which requires a great amount of attention and care from both the administrative and actuarial sides of the house.

MR. BRINK: I would like to talk about prescription drug pricing and experience monitoring generally and from a more global perspective. We have been fortunate to have access to PCS data. It is the single largest drug database in the country. They process several billion dollars worth of claims annually and they have asked us to put together several studies for their clients.

One of those studies is an annual claim cost study intended to help plan sponsors estimate the cost of a prescription drug card program. The study was based on calendar year 1987 data and

included 71 million drug claims with more than $1 billion worth of ingredient costs. We examined the experience in the U.S. and Canada separately. We also studied the experience separately for fee-for-service programs and managed care programs (HMOs and PPOs). We found the overall experience under managed care programs did not differ significantly from fee-for-service programs after adjusting for age and sex differences. I am sure that part of the reason for the similar experience is that the employees and their dependents are using the same type of card system.

I will not go through all of the details of completing the study, but I will share some of the results with you (Table 8). We developed starting per employee claim costs. We examined the annual utilization and the ingredient cost for plans that included contraceptives and plans that excluded contraceptives.

TABLE 8

STARTING MONTHLY CLAIM COST CARD PROGRAM
EMPLOYEE

	Including Contraceptives	Excluding Contraceptives
Annual Utilization	5.580	5.269
Ingredient Cost	$17.12	$17.00
Monthly Claim Cost	$ 7.96	$ 7.46

Claim costs and utilization levels were calculated separately for spouses and children (Table 9). Spouses have a higher frequency of claims and higher average claim costs, particularly when contraceptives are included. Children had much lower frequency and lower average costs than employees.

TABLE 9

SPOUSE/CHILD ADJUSTMENTS

	Including Contraceptives	Excluding Contraceptives
Employee	1.00	1.00
Spouse	1.18	1.17
Child	.36	.37

We found a significant difference in the average charges by state. At first we were a little surprised because the payment basis was a percentage of the AWP plus dispensing fee which you would expect to be fairly uniform across the country. This was not the case and, after further investigation, we determined that the difference was primarily due to the prevalence of generic substitution by state. There may also be some differences in dispensing patterns as well, but we think that the difference was primarily due to generic substitution.

To estimate the monthly claim cost you first estimate ingredient cost, add the dispensing fee, add the administrative cost, and subtract the amount of copay (Table 10).

This process can get more complicated. If you have a split copay, you will need to estimate the composite copay for both general and brand name prescriptions. A percentage copay is relatively straightforward to price. However, for an annual deductible plan, you need to estimate the annual effect.

We found that the overall PCS experience was fairly representative of group major medical experience when that experience was available. The big problem in evaluating experience under a major medical plan is under-reporting which I will address a little later.

PRESCRIPTION DRUG PLANS

TABLE 10

SAMPLE RATE DEVELOPMENT CARD PROGRAM
EMPLOYEE

		Including Contraceptives	Excluding Contraceptives
Annual Utilization		5.580	5.269
Ingredient Cost		$17.12	$17.00
Professional Cost	+	3.25	3.25
Administrative Cost	+	.75	.75
Copay	-	5.00	5.00
Monthly Claim Cost		$7.50	$7.03

We also developed an offset study for PCS. This study was similar to Dick Sieben's washpoint study which you may have seen. When you initiate a drug card program you want to be able to estimate the overall cost impact on current major medical costs and adjust your rates accordingly. Some of the key assumptions made in this study involve the claim submission level, the claim administration expense, the discount off retail charges, if any, and the impact on the major medical deductible.

Under a major medical plan we know that not all claims are submitted. Some of the reasons for non-submission include: total claims are just below the annual deductible, the amounts are small and not perceived to be worth the effort, receipts are lost and ease of claim submission.

Little hard data are available on the proportion of claims not submitted under a major medical plan. Therefore, we identified high, medium and low submission level assumptions to let the user pick the appropriate levels. Under a high submission level the amount of claims not submitted is 12%, that is, 88% of total claims are submitted. This number of claims is roughly equivalent to about 80% of the dollars. In a low submission situation roughly half of the claim dollars are not submitted.

We have heard from many companies similar to The Guardian that their claim volume doubled when they put in a card program on their Multiple Employer Trust (MET) block of business. Other companies indicated that drug claims used to run 2-5% of total claims and now run 7-10% with the card program. This change indicates a significant under-reporting of prescription drug claims, which appears to be much heavier in the small group/MET industry. Because of the high turnover in these groups, they may not be used to submitting claims, whereas large groups tend to have employee benefits departments to educate the employees as to their benefits, distribute the claim forms and sometimes assist in the filing of claims. Also, with a low turnover group employees have been through the claim payment process before. Consequently, different markets have different characteristics which can lead to different claim submission levels.

We made some fairly radical assumptions in order to develop the various claim submission levels. We used our probability distributions to separate claims into three different categories. For the high submission level we assumed that 80% of total annual claims under $200 were submitted, 87% of the $200 to $500 claims were submitted, and 92% of the more than $500 claims were submitted. Then we assumed that a large annual dollar amount of claims was much more likely to be submitted than smaller amounts. For the low submission level, we had to make some fairly radical assumptions. We assumed that only 20% of the total annual claims less than $200 were submitted and only 68% of claims more than $500 were submitted. This was the only way that we could get an overall submission rate of 50% within the context of our study.

Another important assumption in estimating the effect of prescription drug card programs is the claim administration expense (Table 11). Most companies do not know what their claim administration expense is for major medical plans because they are processing drug claims along with other medical claims. Therefore, we identified a range of assumptions and identified the cost of the card program.

TABLE 11

ADMINISTRATION EXPENSES PER CLAIM

Major Medical:	$1, $4, $7, $10, $13
Card Programs:	$.75

Many of the card programs can have a substantial discount off retail charges because of their reimbursement policies with participating pharmacies. PCS experience has shown that they have about a 5-10% discount off retail charges. We identified a range of assumptions (0%, 5% or 10%) so the users could use a retail discount appropriate for their situation.

Lastly, we looked at the impact on the major medical deductible when prescription drug claims are removed from the major medical program. As you pull the prescription drug claims out of a traditional major medical plan, the deductible is worth a little bit more. We used probability distributions which included prescription drugs and distributions that excluded prescription drugs to get the marginal value of the deductible. The results show the major medical deductible is worth an additional 1% or 2%, which is significant considering the relative size of the medical claims.

We then calculated the offsets for our mid-range assumptions which include the medium level of submission, a $4 major medical administrative cost, and a 5% retail discount (Table 12). Adjustments were calculated for other assumptions. The mid-range results are as follows:

TABLE 12

MAJOR MEDICAL OFFSET
REGULAR COPAY PLANS

	Major Medical Deductible				
Copay	$50	$100	$150	$200	$250
$3	92%	91%	89%	88%	86%
4	98	96	94	94	91
5	104	103	101	100	97
6	112	110	108	107	104
7	120	118	116	115	112

Thus, for a $100 major medical plan, a $3 copay card plan would offset 91% of the cost. In other words, a $3 copay plan will result in an additional cost of about 9% of the drug cost. For a $100 deductible plan, a $7 copay card plan, will reduce the overall prescription drug expense.

We also calculated the offsets for a split copay plan (Table 13). For example, the cost of a split copay plan of $2/$5 is roughly equivalent to the cost of a $100 major medical program. The value of a split copay tends to be driven by the brand deductible, although the offset is slightly less.

TABLE 13

MAJOR MEDICAL OFFSET
SPLIT COPAY PLANS

	Major Medical Deductible				
Copay	$50	$100	$150	$200	$250
$2/5	102%	100%	98%	97%	95%
3/5	103	101	99	98	95
4/6	110	108	106	105	102
5/7	118	116	114	113	110
4/10	142	140	137	136	132

We also estimated the offsets for plans with different coinsurance percentage levels and developed offset factors for those situations as well. Then, we looked at the effect of an annual deductible

with 80% coinsurance. This type of card program has a significant impact on total annual drug costs (Table 14). A separate annual deductible and coinsurance applied to the drug claims can significantly reduce the overall drug cost.

TABLE 14

MAJOR MEDICAL OFFSET
ANNUAL DEDUCTIBLE PLANS

Card Deductible With 80% Coinsurance	Major Medical Deductible $50	$100	$150	$200	$250
$25	110%	108%	106%	105%	102%
50	122	120	118	117	113
75	134	132	129	129	125
100	146	144	141	140	136

I want to talk just briefly about experience analysis. If you do put in a card program, what is the best way to evaluate the actual experience and what should you expect? Experience analysis incorporates many of the same concepts that I just addressed. You should expect that the volume of claims will increase, substantially in some cases. It may even double because you will see 100% of claims as there will be no under-reporting. You must look at the impact on the major medical deductible and also look at the administrative expenses and the retail charge level differences.

If you are trying to offset major medical costs, the time period is important because the costs of a fixed dollar copay plan are leveraged by inflation, just like major medical deductibles. But the leveraging on a fixed copay plan may be greater, because the copay tends to cover a greater proportion of the overall costs. Drug trends are at least as great as major medical trends, which also compounds the cost difference over time. Therefore, if your objective is to keep the offsets constant over time, the copays must be periodically increased.

Table 15 is an example to illustrate the type of analysis you could do. It is based on 1,000 employees and the mid-range assumptions already discussed. Using the starting annual frequency assumption, 5,500 prescription drug claims are expected in a particular year. As we know, under a major medical plan only 4,125 will be submitted. The average cost per claim is assumed to be $20. Estimated covered charges after deductibles and coinsurance are $60,000. Including administrative expenses, the total sponsor cost is $76,500.

TABLE 15

MAJOR MEDICAL PLAN EXAMPLE

	Prescription Drugs	Non-Drugs	Total
Eligible Claims	5,500		
Submitted Claims	4,125		
Average Cost/Claim	$20.00		
Covered Charges	$60,000	$667,700	$727,700
Administrative Expense	$16,500	55,100	71,600
Total Sponsor Cost	$76,500	$722,800	$799,300

Table 16 shows the overall effect on these costs if a card program is adopted.

TABLE 16

MAJOR MEDICAL WITH DRUG CARD EXAMPLE

	Prescription Drugs	Non-Drugs	Total
Eligible Claims	5,500		
Submitted Claims	5,500		
Average Cost/Claim	$ 18		
Covered Charges	$77,000	$663,100	$740,100
Administrative Expense	$ 4,100	55,100	59,200
Total Sponsor Cost	$81,100	$718,200	$799,300

Under the drug card program the same number of eligible claims is present, but there is no under-reporting. The average cost per claim is reduced due to the retail discount, but total covered charges are increased by 28%. Administrative costs are lower, but the total sponsor cost for prescription drugs is increased by about $5,000. The value of the non-drug portion, however, decreases slightly because of the increased value of the major medical deductible. The overall result is the same total costs for drugs and non-drugs combined.

It is important to identify the basis under which costs are evaluated. Covered drug charges will increase significantly under a card program even though the total overall sponsor cost is the same. Covered drug charges as a percentage of total costs will also increase. In the above example, covered drug charges as a percentage of total covered charges increased from about 8% to 10%.

MR. G. ERIC SHUGART: I have a question about who makes the decision on generic substitutions. From Dr. Myers I got the impression that the physician makes the decision 90% of the time and through Mr. Field I got the impression that the pharmacist decides 95% of the time. I would like a comment.

DR. MYERS: The physician has veto power in many states by writing "no substitution" and that would take away the pharmacist's decision. I think Bob said that only 5% of the time does a physician write no substitution, which leaves the decision with the pharmacist.

My figure of 90% referred to situations in which the physician has a legitimate choice of a drug. In most situations, roughly 90% of the time I would guess, a physician can choose which drug to use, and that does not include generic in that decision. I am referring to deciding between two different brand drugs.

MR. FIELD: I agree with that answer and let me add that where the physician does have a lot of discretion is if he is going to prescribe an anti-arthritic drug for someone; there are many different generic drugs that are anti-arthritics. He can prescribe a drug that is a multi-source drug where the pharmacist then will have the ability to substitute. Or, he can prescribe a single source drug where, under the MAC program, the pharmacist really has no choice because there is no substitute for that drug.

MR. LOUIS A. KENT: What is the economic incentive for the pharmacist to steer the patient coming to the counter with a request for a particular drug? In effect, some of the recent studies seem to indicate there is a qualitative difference between generic and brand name drugs in some particular areas. As a third part to this question, it is curious to me that a drug may fall into the generic category in one prescription card service and on another prescription card service that particular drug may be reimbursed as a brand drug.

MR. FIELD: First of all, when PCS started the MAC program, we looked only at drugs that had been determined by the FDA to be Class A drugs. Class A drugs are drugs that the FDA has said are bio-equivalent. They are therapeutically equivalent, so there is no quality difference

whatsoever. We have no drugs on our list that are Class B drugs which are usually therapeutically the same, but not always the same. So you have to be careful on how you set up your program.

If you talk about five or six years ago, there was no incentive for the pharmacist to use generic under a third-party plan, because the patient paid the same amount either way and, in fact, what we found was that rates of generic substitution under third-party plans or cards plans were actually lower than the general cash-paying public. I think that started to shift when people started going to split copay plans, where the employee was going to be penalized for using a brand, which has caused employees to ask both physicians and pharmacists for the generic. The MAC program would take that a step further, which basically limits the pharmacist's reimbursement unless the prescription says "dispense as written."

I am not a pharmacist and I am not sure I can give you the best answer to the question of how a drug could be both a generic and a non-generic drug. I would say where that comes into play is where a drug was developed by an innovator. There was an innovator drug and that drug is no longer manufactured by the innovator. You have to determine whether the drugs being produced by various manufacturers are brand name or generic. In one sense you could say that they are all generic. In another sense you would find that one or two of the drugs are priced very much like the innovator drug might normally have been priced and the rest are priced much lower, like a generic. I think that is where the dispute comes.

MR. KENNETH S. AVNER: We find that pharmacists will fill with a brand name drug even when a generic is available and we will consider that a generic substitution, because they can get it at a generic price.

I am wondering if there is something going on with AWP trends. You mentioned that they are not real numbers anymore. They are kind of "book" numbers and you talk about a 10% discount. Can I expect to see increasing discounts now that people know that more of us are paying attention to those numbers as prices? Can I expect to negotiate increasing discounts? If I got 10% last year, can I expect to get 11% next year?

MR. FIELD: That is a very difficult issue. First of all, what we are finding is that no matter what percentage you pick, an across-the-board percentage is wrong for a lot of the drugs. I will give you an example of why this is true. There is a mail service firm that advertises 35% off the AWP. When we checked our database and compared the prices from the mail service firm with retail pharmacists' submissions for the same drugs, it was the same price. What we found was that the generic manufacturer was posting a price that was roughly 50% higher than they were selling it for. Therefore, a standard sales price was 35% less than the published AWP. I certainly think that our organization feels that a better methodology needs to be found and until that better methodology is found I think we will all struggle along with the AWP. Discounts from the AWP may become more sophisticated in the future, including looking at the AWP on a manufacturer-by-manufacturer basis and maybe on a drug-by-drug basis. It is necessary to look at the actual acquisition costs versus the published AWP, because there will be more gaming going on in this whole situation.

MR. AVNER: I wonder if some of that is happening because of the people who use those prices and set those prices. Also, it may be due to the difference between the acquisition trend and the AWP trend becoming more significant and getting wider apart.

MR. FIELD: There is definitely a greater difference than there was five years ago. However, if you took a look at our claims history, you will find that dispensing fees (which are supposed to reimburse the pharmacist for his overhead and his profit, his operational expenses, etc.) have increased less than 3.5% per year over the last five years. What has happened is there has been an increasing gap on the ingredient cost side, but dispensing fees have not increased. If I were a buyer of health care I would not want to give false incentives, so I would rather get rid of all of those differentials on the ingredient cost side and truly reimburse the pharmacist on the dispensing fee side. We are trying to find ways to do that and to push our clients in that direction, because we think that will be a better system over the long term. We don't have the answer today, and I don't think anyone else does either.

MR. AVNER: I think you talked about programs where there was an option to take drug coverage as opposed to a program where it was mandatory and the under ten lives market where you just

gave it to everybody. Might you be able to comment on the selection when it is an option as opposed to when it's mandatory?

MR. GIOVANNELLO: The reason we did that was that we are very concerned about the anti-selection on our small group block. The administrative reason was also a big factor. A baby group block is sold as a package to minimize expenses. There are very few options and we actually made everyone take it. We mandated the benefit as part of the overall baby group package, whereas on larger groups you really cannot do that.

MR. AVNER: Any qualification of how much of a load there would be if there is an option to take it as opposed to forcing somebody to take it?

MR. GIOVANNELLO: No, but it would be substantial. We did not quantify it.

MR. VAUGHN W. ROBBINS: How do you handle these split copays for generic and non-generic for single source drugs? Do you treat them as a generic or as a non-generic?

MR. FIELD: More than 90% of our clients who go with a split copay have elected to call a single source drug a brand and, therefore, it carries the higher copay. The reason for that quite simply was that it was another way to have a hidden copay increase. We have had a couple of clients, very employee oriented, come to us and say, "that is really not fair," and we actually are administering a couple of plans where the single source drug gets the lower copay. There are a couple of things wrong with that. The most important thing wrong with that is that in many cases a doctor has a choice between writing for a single source drug and a multi-source drug in some instances. If you treat the single source drug as a low copay, you are certainly not going to get the patient to ask the doctor to prescribe a drug that has a generic substitute.

MR. ROBBINS: In cases where you have treated it as a brand name, has there been much feedback from employees regarding the fact that they are paying a higher copay when they have no choice?

MR. FIELD: We really have not had negative feedback toward the split copay.

MR. ROBBINS: I have one more question on the offsets that were developed in the split copay plans. Was there any assumption used that there would be a shift in utilization towards the generic when you developed these?

MR. BRINK: We did include an assumption that there would be a 4-5% shift to the generic drug.