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Session 91IF
Prescription Drug Update

Track: Health

Moderator: GEOFFREY C. SANDLER
Panel: LISA BEHNKE†
CAROL J. MCCALL
JEFF SANDERS‡
Recorder: GEOFFREY C. SANDLER

Summary: Prescription drug trends continue to outpace other medical cost trends. These costs are a major driver of the return to double-digit medical care premium increases and renewed interest in Congress to add prescription drug coverage to Medicare. Panelists look at the following issues for both the commercial and Medicare markets:

- *Recent trends in prescription drug costs*
- *Factors behind these trends*
- *Expectations for future trends*
- *Strategies insurers and health plans are using to manage prescription drug costs*

Panelists provide their insights on these prescription drug issues. Attendees are encouraged to share their experiences and give their thoughts about controlling drug costs in the commercial and Medicare markets.

Mr. Geoffrey C. Sandler: We'd like to accomplish a number of things, but most importantly, we'd like to bring a broad perspective from people with different disciplines on what's happening with prescription drugs today.

This session is an information forum. We'll have a chance to hear from each of the panelists independently. We want this to be a more informal session than a regular panel discussion, so the panelists will be interacting with each other. We want to have ample opportunity for audience interaction as well. We hope this session ends up with a free flow of ideas and we're hoping that this informal set-up will help us come up with a session that's a cross between "Washington Week in Review" and "Politically Incorrect."

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I'm from Empire Blue and Cross Blue Shield. I'm responsible for pricing Empire's HMO products. We are fortunate to have a really great panel. They bring a diverse perspective to the prescription drug discussion.

I'd like to introduce the co-panelists. Lisa Behnke is chief medical officer of Benchmark Physician Organization, which is a 1,600-member physician organization affiliated with Continuum Health Partners in New York. Previously, she was vice president of Care Management at St. Vincent's Medical Center and Health System in Bridgeport, Connecticut, where she was responsible for quality management and case management. Prior to joining St. Vincent's, she was a director in the health care consulting practice at PricewaterhouseCoopers and senior medical director in the managed care division of Empire Blue Cross and Blue Shield in New York. She is board certified in internal medicine and gastroenterology. She is a member of the American College of Physician Executives, the American College of Health Care Executives, and the Health Care Financial Management Association.

Carol McCall is executive vice president of managed care and informatics at Allscripts. She joined Allscripts just recently, and prior to that, she was vice president of pharmacy management for Humana, where she was responsible for all aspects pharmacy, including benefit design and pricing, formulary strategies and manufacturer contracting, pharmacy benefit manager (PBM) relationships and pharmacy operations, and clinical pharmacy programs and informatics. Prior to joining Humana, Carol was a consulting actuary for Milliman & Robertson. She is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. She also has a B.S. degree in actuarial science from the University of Iowa.

Jeff Sanders is senior vice present of Value Development for PCS Health Systems. He oversees product development, pharmacy networks, strategic account development, and analytic functions. He joined PCS in 1993 and assumed his current responsibilities in October of 1996. Previously, he served for three years as Director of the Office of Legislation and Policy of the Health Care Financing Administration (HCFA) in Washington. He has worked extensively on health care reform issues with Congress and the Administration, chairing White House task forces on health care data and electronic data interchange. He has also held posts with the United States Budget Committee and the Office of Management and Budget. He received his bachelor's degree in urban studies and economics from Cleveland State University, and a master's degree in public policy from the University of Chicago.

Let's start the session with a look at the current landscape for prescription drugs. I'm going to turn the discussion over to Jeff Sanders and ask him to make some comments on what he sees as the key issues.

Mr. Jeff Sanders: I imagine the reason the room is full has to do with the fact that drug trends, if left unfettered, are in the 20% range. If your population is older, you probably wish you were seeing 20% because they are well above 20%. There's a real struggle with what to do about this. Are these trends a good thing or

a bad thing? Overall, for healthcare, there's certainly a problem for people trying to rate plans and compete in the marketplace.

Later, we'll get into some of the driving components of what generates that 20%. One of the important landscape features is that from 1990 until about 1998, there was a very clear trend in this country to cover more prescription drugs with insurance, so more people got prescription drug coverage, and those who had prescription drug coverage got more generous prescription drug coverage. In 1990, on average, patients paid about 70% of the drug benefit. By 1998, they paid only about 17% of the drug benefit. This is nationally.

The current environment is kind of a wild struggle to reverse that trend and to have patients share more of the drug costs. So one of the important features is looking at ways to get patients to share more of the drug benefit.

Ms. Carol J. McCall: We wanted to talk about the current environment for prescription drugs. One of the big things that we see out there is a benefit design shift to try to take into account the fact that there has been a declining member percentage of the entire bill cost. You see a lot of shift toward three-tier benefits. Can I see a show of hands of how many health plans are looking at, or actually implementing, three-tier plans? Wow, that's at least half. So the general trend is to expose members to a greater share of the cost to get that 17% back up in the 20–30% range. What I'd be interested to know is, while there is a general trend toward using three-tier designs, the two questions that I have are number one, how is it going in terms of member experience? Is it working or is it not working? Second, what are some things that you are seeing from the PBM perspective? What are some of the different things coming out in terms of benefit design?

Mr. Sanders: I'd ask another question you might not be as close to. Of those who raised their hand that they were going to a three-tier benefit and set goals for a percentage of your membership to be in a three-tier benefit, how many of you have actually hit the goals that you set to get your membership into a three-tier benefit? It looks to me like about one-fourth of the people who raised their hands were going to a three-tier benefit. It is very clear to us that there have been challenges in actually moving employers and clients to three-tier. It is clearly happening. The trend is very strong, but it is much less than would have been forecasted a year or two ago. The best data we have show that only about 15% of the membership in the country today is under a three-tier benefit.

With a two-tier benefit, historically, many entities had members pay a single co-pay for all generic drugs and a different higher co-pay for all branded products. That was the typical benefit structure that existed. A three-tier benefit means you pay a price for generics, and then there are two different co-pays for brands, depending on what's preferred on the formulary. So you might have a $5 co-pay for generics, a $15 co-pay for preferred brands, and a $30 or $35 co-pay for nonpreferred brands. There are a lot variations on that, but overall, that's what we mean by three-tier benefit.

Mr. Sandler: First, in terms of moving to a three-tier co-pay, we actually withdrew our two-tier co-pay products, so we now offer only a three-tier co-pay, and that's how we migrated our membership. Second, there are the beginnings of a trend, even for four-tier co-pay products. In the fourth tier, certain drugs are not covered at all.

Ms. McCall: What sort of drugs do you see in terms of future benefit design?

Mr. Sanders: As Geoff mentioned, people are working on adding fourth tiers to the benefit, and some of them are not covered and some of them have $50 or $60 co-pay tiers. So you have $5, $15, $30 and then $60 co-pay tiers. We see tremendous growth in the pharmacy benefit deductibles, which were extremely rare three or four years ago and now are starting to grow. We also see a lot of people looking to move back to percentage co-insurance. So instead of having a flat amount, plans are asking people to pay 20%. What we see happening more in the market than just moving from a flat co-pay environment to 20% for all drugs is you might have a $5 co-pay for generics, a $15 co-pay for preferred brands, and a $15 co-pay plus 20% for non-preferred brands.

The reason for that is a few years back you rarely saw a commonly used drug introduced for more than $80 or $90 for a 30-day course of therapy. Today, you are occasionally seeing drugs introduced at anywhere from $120 up to nearly $200 for a 30-day therapy. So what seemed like a very high co-pay of $20 is not covering a significant portion of that cost.

Ms. McCall: I've seen this kind of combined benefit design, with co-pay plus co-insurance. I've seen companies begin to create a fourth or even a fifth tier with respect to biotech drugs. What they'll do is they'll have some carve-out arrangement that says if you are on this particular type of medicine, there will be a completely different structure for that. When it comes time to price some of these benefits, sometimes it was actually more expensive from an actuarial value standpoint to get rid of the entry fee or the flat co-pay and go straight co-insurance. For some of the cheaper $10, $15, and $20 medications, if you drop down to a 25% co-insurance, there are a lot of drugs you're going to find yourself paying for that you didn't pay for or for which you paid a smaller share. So it's tough to give up the actuarial value of that initial co-pay. I think that that's another reason why a lot of health plans are, in fact, considering that type of design.

Mr. Sanders: Carol, the other question you asked is, how is this going? It's very uneven out there. Obviously, patients, members and enrollees want everything free with no management techniques, and the implementation of a three-tier co-pay is typically adding a higher co-payment. It's not typically being neutral to the members. It's a way to shift cost to them.

So education is very important. Competitive dynamics in the marketplace are very important. How well you run the education is extremely important. We have seen three-tier co-pays go in place as absolute disasters. Employers fire insurers over it. There is a great deal of member dissatisfaction.

By the way, the pharmacy benefit tends to be the thing that members are most satisfied with today, so it's kind of a takeaway if its not handled right. I will tell you, a three-tier benefit handled appropriately is one of the least offensive takeaways you can give to a membership. They still can have a low-cost benefit if they work with their doctors, understand the information, and choose the preferred products. But they have to understand it, and there has to be good education for that to happen. We've seen a number of instances, hopefully not with us, where education wasn't so good, and you end up with a pretty significant backlash from the membership.

Ms. McCall: So benefit design obviously is a huge changing dynamic within the current environment. Another thing that we'd like to talk about is what's happening with manufacturers—direct-to-consumer advertisements (DTC) and the marketing to physicians. This has been one of those things that has been an exponential climb for some time. The estimate for the year 2000 was that they'd spend, just on DTC, $2 billion. Is that right, Jeff?

Mr. Sanders: That's right.

Ms. McCall: Jeff, do you see any shifts? Is that going to continue to increase? Is it going to drop off? Will we see more shift from direct marketing to more niche marketing? What do you see happening there?

Mr. Sanders: First, it's grown to $2 billion from literally nothing four years ago. But the forecasts a year ago were that that number was not going to be $2 billion. Predictions were that it was going to be $2.5 billion to $3 billion. In many cases, manufacturers are not seeing the return for direct consumer advertising. Why doesn't it feel like that to anyone?

I'll tell you where you're going to see it. I think it's going to continue to grow. You're going to see it in symptomatic diseases where the patient can feel something. That would be pain medications, antihistamines, and migraine medications.

You're not going to see very much of it in medications for asymptomatic disease: ACE inhibitors, high blood pressure, and that sort of stuff. This is a forecast, not a fact. The reason is that members weren't going to ask their doctors about medications when they had asymptomatic diseases. They weren't going to ask their doctors about asymptomatic diseases, but they were going to ask about symptomatic issues. So what you've seen is a clear shift towards spending on the symptomatic diseases, of which there are fewer than asymptomatic diseases.

The other thing to remember is $2 billion seems like a huge number to spend for consumer advertising. They spend well over $20 billion on physician advertising. So this is a small fraction of their overall advertising budget.

Dr. Lisa Behnke: To give you an idea of one example of a symptomatic disease, there's a new drug on the market for irritable bowel syndrome. It has been well documented that only about 10% percent of the people with irritable bowel

syndrome ever see a physician for this disease. They know what the problem is. They know how to deal with it. There has never been a drug that they have wanted to use to treat the disease that didn't have extensive side effects that patients preferred not to bother with.

If they see an advertisement on television, they suddenly think, "Oh, gee, maybe I should go to the doctor about this." That disease is a diagnosis of exclusion, so when patients go to a doctor with those symptoms, they will need a workup. That could have a tremendous impact on the medical costs for that particular disease and many of those patients may not end up taking that drug for the long term. They may take a one-month supply, so the manufacturer doesn't really see that this is a return on investment, yet it has had a significant impact in medical costs.

Ms. McCall: It really has. A survey was done in 1997. Granted, we're much farther out and much more mature in our direct-to-consumer advertising. Nevertheless, there was a study that showed that of the 35 million people that actually saw a DTC ad, ten million of them asked their physicians about a specific drug as a result, and seven-and-a-half million people walked away with the drug. Now I'm sure a lot of those were, in fact, symptomatic diseases. But also for that same study, the increase in the office visits for diagnoses that were related to those drugs was 11%, whereas overall office visits had just a 2% overall increase. The law of averages would show that for some of the other things, it had to be declining. So it really does have an impact on physician work load and what's happening in the other parts of the spending, even if it is an indirect impact.

There are a couple of other things that we wanted to talk about in the current environment, and one of them was, in addition to big changes in benefit design shifts and the ongoing onslaught of advertising, the current political discussions around a prescription drug benefit for Medicare. So I'm going to ask Jeff, given his background in public policy and his connections on the Hill, what he thinks is going to happen there.

Mr. Sanders: It's going to be a hot issue. I was actually working on the Hill the last time the prescription drug debate got as hot as it is right now. I watched a bill get enacted and then get repealed about three years later.

It is extremely complex to provide prescription drug coverage for the Medicare beneficiaries. First, about 65% of the population of the Medicare-eligible population has drug coverage, and it's paid for through a variety of sources, mostly employers. So how do you concoct a benefit that doesn't have employers withdraw their coverage? It's extremely complicated. They want to create a competitive environment so that PBMs beat each other up to lower costs. That involves a whole set of risk selection issues, which I will tell you, are one of the most hotly debated issues underneath this whole thing. Carol has been involved in some of those discussions. There's a debate about whether this is focused on low-income seniors versus universal coverage. There's a debate about whether this is market oriented or controlled by HCFA. These things are complex.

My guess is you won't see anything enacted for a couple years and nothing will roll into place for about four or five years. So if you're someone who's working with employers to control their drug spending and their retiree population, I think you won't lose that consulting gig anytime soon.

Ms. McCall: I'm not even sure you'll lose it at all. Simply because you pass it off, doesn't mean it's suddenly controlled, as we all know.

There's another session at this meeting (112OF "Medicare Reform: A Presentation by the Academy's Medicare Reform Task Force,") in which there will be a discussion about some of the various monographs that the American Academy task force has been putting together. One of those monographs that I have had the opportunity to be involved in is on prescription drugs, and so we'll talk in a little more depth about what's happening on the Hill. In general, I would echo Jeff's sentiments and say that it is very complex.

I've had the opportunity to put together some projection models that show a couple of things. Number one, the prevalence toward anti-selection in a pharmacy stand-alone benefit is tremendous. When you create an insurable benefit, you want a couple of things. You want it to be pretty low frequency, and you want it to be real in high cost, and something that you can't manipulate. All of those things get violated to a certain degree with respect to pharmacy coverage. It's a very frequent, very predictable type of occurrence, especially in the elderly who are put on medications for chronic illness, sometimes for the rest of their lives. Most of them tend to be relatively low cost in the grand scheme of things. It doesn't mean the cost is not a burden, but relative to, say, homeowner's insurance or losses of that type of magnitude, they're much lower. These people are paying for these medications today. If I present you with a premium, you can calculate whether or not you think you're going to come out ahead, versus if you just went it alone, as you do with many other types of traditional insurance coverage. So it is fraught with opportunities for anti-selection and that's something that would need to get worked through.

Mr. Sandler: That also brings up the issue of whether a proposed drug benefit should cover the low end of the drug claim continuum, or whether it should be a catastrophic benefit. That's another element of the debate.

Ms. McCall: Correct.

Mr. Sandler: There's one other element that is more purely political, and that is that the discussions around changes to the Medicare program for prescription drugs are divided into political camps, some of which are more focused on the specifics of the drug benefit all by itself. Others want to address prescription drugs in the broader context of Medicare reform and are pushing for more comprehensive Medicare reform proposals.

Mr. Sanders: We could talk about Medicare and we probably will come back and touch on it, but maybe we should just pause and give our perspectives on what are the driving forces on the 20%. Many plans look at this as a price times utilization

multiplier. If you have 20%, people are looking at price increases and average cost per script being more than half of that and utilization being a little bit less than half of it.

There's an important component of this price driver, though. The biggest part of price is not products getting a price increase from one year to the next. That represents a three-percentage-point increase. In other words, manufacturers are increasing their prices year over year, but it's not that significant. What is happening is more expensive products are being substituted for less expensive products, and, on average, you see tremendous increases in the average cost of a script as a result. So it's a substitution effect.

Many of these products are better for some patients, or a little better for many patients. The challenge from a managed care perspective is how do you distinguish which patient needs a more expensive, and better product, and which patient is fine on a lower cost generic product. There are many, many examples of this and they're too numerous to count. But there's just a huge number of patients moving from what was a $15 product to a new product that costs $120 a month, and they're getting 12 of these a year.

Ms. McCall: I think a good example of that is right up your gastrointestinal alley. So I'm going to ask a few questions of the good doctor. I think a really good example is the Prilosec/Prevacid proton pump inhibitor (PPI). How many people have seen advertisements for Prilosec on TV? "Purple magic" is what we call it. And TAP, actually in Chicago, which is a subsidiary of Abbott, is building a new world headquarters. We lovingly call it, "The House that Prevacid Built." That drug is taking over some of the generics and some of the older drugs, like Zantac and Tagamet. My question to the doctor is, what happens to prescribing patterns when these new drugs come on the market? How do doctors feel about them, and how do they tend to change their use?

Dr. Behnke: Certainly Prilosec, when it came on the scene, created a great stir. There were numerous patients who were taking Tagamet or Zantac and really not getting much relief. But Prilosec came out with an eight-week restriction. You were not to take it for more than eight weeks because of the fear of side effects that were not yet fully displayed, so I had a tremendous number of referrals from people who had taken it. Patients who had been on it for eight weeks felt perfect, and now wanted to take it forever and, of course, were told that they couldn't.

Interestingly, though, I think marketing has such an impact on this. When Tagamet became an over-the–counter medication, I had people who had been on Prilosec for long periods of time come to me and say, "Oh I heard about this new drug. Can I try it?" It just has such a tremendous impact.

But if you're a physician and you see the purple pill advertisement, it's very upsetting. That really is a drug that should be reserved for a certain group of patients. However, it is a quick fix. It is much more powerful. It will take care of symptoms much more dramatically, and I actually found that I had patients that had symptoms once a month that did very well on it because they needed only one

pill and they were fine. I would give them one prescription for Prilosec and that would last an entire year. If I was giving them Zantac or Tagamet, they'd be getting a new prescription every month, so there is some tradeoff there. It's a very powerful medication that should not be used as frequently and as commonly as it is.

However, for the physician whose main goal is satisfying a patient, it's very difficult to say no to somebody. When the doctor wants to put the patient back on a medication that is more cost effective, but that doesn't work as well for him or her, it is very tough to say no.

Mr. Sanders: Let me give one more example and it may start to move us into what you can do about this. I believe Mevacor was, at one point, the second biggest-selling drug in the world. It was a very effective cholesterol-lowering product. I think it will lose its patent status in 2000. The manufacturer of that product quickly developed a new statin. In fact, it is a more powerful statin. Most people believe that if you have serious cholesterol problems, there are better products on the market than that one.

Of course, many and many people on these cholesterol-lowering agents don't have serious cholesterol problems. They have moderate cholesterol problems. This manufacturer is going out and detailing, that is, talking to doctors, against their own product. That is a very powerful marketing message. "You shouldn't be using Mevacor; it's an inferior product. You should be using Zocor. It's our new product. By the way it's cheaper than Mevacor."

The issue is that it has patent status for another six or seven years. Mevacor, at the end of this year, is going to cost $10 a month. Zocor costs $80 or $90 a month. As payers, we're going to have to decide, whether we want to take that on or not because there have been very few blockbusters that have gone generic for the past three or four years. Since Zantac went generic, there have been no blockbusters going generic. In the next three years, there are about ten major products going generic, almost all of which have a strategy to move patients off those drugs from pharmaceutical manufacturers onto different products.

Dr. Behnke: If I could just comment on that. There have been very few drugs going generic recently, and there are so many new drugs that have a better side effect profile, a better safety profile, and less frequent dosing. A rule of thumb we teach all medical students is for every additional dose you have to take in a day, compliance decreases by 25%. So, if you can put patients on a drug that must be taken once a day, they will take their medicine. If you have them on something that needs to be taken four times a day, they'll only take it 25% of the time. Physicians have gotten used to newer drugs coming along that are better and they've forgotten about generics. There are very few patients that are on generic drugs that physicians are prescribing on a regular basis. This is a huge problem in terms of reeducating physicians about generics. It has just become something that's not on the radar screen anymore.

Ms. McCall: Let's talk just a little bit about the life cycle of a drug. Drugs do not gain patent protection the moment that they hit the shelf. It's much earlier in their life cycle, and the patent protection lasts about 17 years. After the drug makes it through phase one, phase two, and then phase three, it can actually hit the shelves at the pharmacy. There's approximately seven years left on the patent protection in the life cycle of the drug. And it is only during that period of time that pharmaceutical manufacturers have an opportunity to reap back all of the development costs that they've sunk into a drug. So when the life cycle of a drug draws to a close, that, as Jeff Sanders said, is when manufacturers try to come up with a new strategy to either extend the life of that patent or perhaps to go ahead and try to kill the drug itself and try to move everybody who is on the drug to a brand new drug.

Drugs that lose their patent protection are then eligible. Manufacturers of generics can come in and then manufacture drugs that are bioequivalents of the drug that just lost coverage. They are much cheaper and eventually become just a fraction of the cost of what the originator's drug was worth.

I think one of the drivers of trend has been the fact that there have not been as many drugs coming off of patent, while, at the same time, there has been this big boom in terms of blockbusters. So, to Jeff's point, there are going to be a lot of drugs coming off patent. Some are big ones like Prilosec, Prozac, Mevacor, and Zestril. These are all very big drugs. Claritin is coming off patent if it doesn't actually become an over-the–counter drug, which we'll talk about. And so those are things that you need to talk about with the people in your pharmacy management areas. What is the strategy for trying to deal with some of those drugs that are coming off patent, and what is the formulary status going to be?

Mr. Sanders: One point of correction. On average, Carol is exactly right. Products have, by the time they hit the market, an average of seven years. It varies product by product. Manufacturers are using supercomputers to speed up their development time. In addition, the FDA added a lot of staff to speed up its approval time. Now there is an average of ten years left on the patent cycle, which of course adds to cost. The longer something is patented, the higher the cost is. So one of those subtle drivers of cost increases is the fact that a drug used to have seven years of patentable life, and now it has an average of ten years.

Ms. McCall: Another thing on top of the increased life expectancy is what happens when a drug hits the market. The demands for certain drugs is almost instantaneous. For certain drugs, like Viagra, Celebrex and Vioxx, the demand and almost the pre-marketing campaigns for some of these drugs is so intense that by the time the drugs actually hit the market, they absolutely explode out of the chutes and the demand is overwhelming. As a physician, do you see that demand right away?

Dr. Behnke: Absolutely. There is so much pre-marketing to the physicians. The prescription is the great patient satisfier. Every patient wants to leave the doctor's office with a prescription. When physicians know that something is coming out, they contribute to that demand because they talk to the patient and say, "It will

only be a couple of months. Then you'll be able to get this new medication, and it's going to be wonderful. It'll solve all your problems." The patient keeps coming back, until that drug hits the market. Then there are others who see the direct-to-consumer ads and they're calling the physicians on the phone and demanding a prescription immediately without even coming in for an office visit. There's a tremendous impact on physicians, and they see that demand instantaneously.

Mr. Sandler: There's another issue that's related to drugs coming off of patent. It concerns moves by companies like Wellpoint to go to the FDA directly to request that certain drugs like Claritin be approved as over-the-counter drugs. That has a slightly different but similar chain reaction effect to drugs losing patents, but it's not exactly the same. I wonder if Carol or Jeff could comment about that.

Mr. Sanders: It has a similar effect, depending on how they price the over-the-counter product. In other words, think of it as a payer. If Claritin is available over the counter, but it's also still available as a prescription, the member is going to pay a $10 co-pay as a prescription, and they're going to pay $25 as an over-the-counter product. They're going to ask their doctor to write them a prescription and, as Lisa has acknowledged, it is unlikely the doctor will say no. Some of them will, but most of them won't, which is something that, as plans, you have to look at very carefully. Don't give patients an incentive, when something is available over the counter, to get it through a benefit, if you're trying to save money. If you're trying to benefit the patient, maybe you do that. It's a matter of market positioning.

Mr. Sandler: Don't forget that they have to pay an office co-pay to go to the doctor.

Dr. Behnke: Not necessarily, because they'll just call up and ask for it over the phone. They won't go in.

Mr. Sandler: Right.

Dr. Behnke: This is a perfect example of how physicians need help from the plan. I can't tell you how many times a patient calls up and says, "I called Member Services, and I can have this, as long as you say it's medically necessary." There's so much pressure put on the physicians. If the plan made a rule and said Claritin is no longer available, and no longer covered in our prescription drug plan, then the physician will say, "I'm sorry. You have to buy it over-the-counter." The physician is no longer the bad guy. You can't ask physicians to be the bad guys.

Mr. Sanders: The FDA is now committed to actively reviewing about 10% of the drug spending, to move it to over-the-counter. Two big blocks of that are the statins, or cholesterol-lowering agents, and Claritin, both of which are quite safe medications. The review will be whether they are completely safe without a doctor's oversight. That's what the FDA's review will be about.

Ms. McCall: For me the takeaway, if I were still working for a health plan, would be to go back and look at contract language and see what, in fact, it says about drugs that are available over-the-counter and available by prescription. Let's see

what sort of options you'll have if the FDA decided to make not only Claritin but all the non-sedating antihistamines, like Allegra and Zyrtec, over-the-counter drugs.

Mr. Sandler: Carol, I think a plan design recommendation was buried in there.

Ms. McCall: It's not so much even a matter of needing a recommendation, but it is certainly something for you to decide how you want to position. Again, it's market positioning. There are options in there for you. Do you want to cover something that is available over the counter? Do you want to give members an option? Those are things that you're going to have to look into and try to decide.

Mr. Sandler: Another issue that's somewhat related to that is lifestyle drugs. We talked about that just briefly a few minutes ago, but maybe we could spend a couple minutes talking more specifically about lifestyle drugs. What are the options that health plans have, and what are some of the other complicated issues like medical necessity? Maybe we'll start with medical necessity. I'll ask Lisa to comment on that.

Dr. Behnke: Viagra was the big issue right away. Some of these drugs are lifestyle drugs, but the way I see it, plans have used prescription drug coverage as a great satisfier the same way physicians have used their prescription pad, so it definitely was something that was considered.

When Viagra came out, I immediately received calls from everyone I knew at health plans saying, "Do you know if anyone else is going to cover it?" There were actually conferences that went on deciding who would cover it.

When you get down to medical necessity, it's again very difficult to just say this prescription will be covered when it's medically necessary, as determined by a physician. The physician needs to help. The physician needs some guidelines to use, because otherwise it's just them and the patient. The patient is saying, "As long as you say it's medically necessary, I can have it." The physician is going to have a hard time saying no. If there are set criteria and the physician says, "Here's the criteria I need to follow. It's medically necessary if x, y, and z are true," then they have something to talk to the patient about without dissatisfying that patient.

Ms. McCall: One of the trends we talked about initially when we started this afternoon was benefit design. One of things that I see as the impetus of three-tier and four-tier co-insurance is that benefit design is a way to get out of making those medical necessity decisions.

A traditional benefit design might have had a generic co-pay and a brand co-pay, but it also might have had a closed formulary. What that means is that for drugs that were not on the formulary, you could only get access to them if they were medically necessary, which meant picking up the phone and having a dialog between the health plan and the physician and trying to hammer that out.

One of the things that three-tier designs are intended to do is to stop that dialog from having to take place. You set the co-pay differentials at a level where,

hopefully, the health plan is at least more immunized if not completely immunized against the choice between those two drugs, whether one's preferred or not.

I hope the health plan will get out of the middle of making some of those decisions. Given how HMOs are being almost demonized today in terms of getting involved in the delivery of care, this is a mechanism that a lot of them are using to back away from medical necessity decisions.

From the Floor: I'm an independent consultant. About a week ago, I read an article in a senior magazine in California, and it talked about, I think, Senate Bill 393. I'm not sure about the number. But evidently, in California, since February 1, seniors and people on Medicare can present their card when they're buying a drug, and they're entitled to get the MediCal negotiated rate for the drugs. Can you talk about this a little bit? They said in the article that it was like a 10–40% discount.

Mr. Sanders: Yes. In PBM lingo, we call this a "consumer card," and it's an unfunded benefit that gives individuals the benefit of our negotiated discounts. In drugs, unlike a lot of other medical care, the person who is charged the absolute most for drugs is the uninsured patient. They generally are charged what we call full average wholesale price (AWP) for a drug. Our typical contract discounts, and there are dynamics that can make this even lower, are that our network is charging payers under 50% of AWP for generic products and about 13% off branded products. You can better both of those things. These are easily available discounts. There is a deal with the pharmacies that the cash-paying customer gets this discount. The retail pharmacies don't like it, but how can you say a low-income senior can't receive the same discounts that the big buyers do. This is very common. We have a program at PCS that we run with AARP that is offered to its membership.

Ms. McCall: These discount card programs are common, and the people paying full retail are actually paying above AWP.

Mr. Sanders: There's one more thing I'd like to mention about lifestyle. As for Viagra, there's some debate as to whether that's a lifestyle drug or occasionally medically necessary. That's an easy issue compared to when you get into what's lifestyle.

If I want to be a tough guy, and believe me we have plenty of customers who want to be that, I can claim huge proportions of the drug budget are lifestyle. Let me give you an example: there are ACE inhibitors for high blood pressure, which are going generic. These are going to be $5 products for a month's supply, and they're terrific products. They dry out your mouth and they cause you to cough and people wake up at night. There's a whole new class of ACE inhibitors that patients are being moved onto, but they don't cause the dry cough. They're good products. I don't say this in rooms of doctors because I get beat up, but the issue is–whether it is lifestyle, or a core medical benefit. The product feels like it is a core medical benefit. The drug is preventing high blood pressure or heart events, and you clearly get better compliance with it if the patient doesn't have a dry cough. If

there's a limit on dollars, how do you think about those things? I don't have an answer.

Dr. Behnke: You're right. From a physician perspective, getting people to take the drugs you prescribed is a huge issue. The lower the side effect profile, the more likely the patient is to take the drug, and the more likely the physician is to prescribe it, because you don't want to get the call in the middle of the night saying, "I have a cough." To me, those are not lifestyle drugs, those are drugs that make the benefit of that medication available to a larger percentage of the population. There's clearly a benefit from ACE inhibitors.

Mr. Sandler: Let's talk about some of things that we think we can do going forward on prescription drugs costs. There are some broader issues that we can think about from different perspectives. One of things that we were thinking about as an issue in terms of the future of prescription drug costs is on the financial side. More specifically, we were looking at the possibility of PBMs taking more financial risk. How feasible is that, and can it work at all? I'll ask Jeff to comment on that.

Mr. Sanders: I'm going to give this in a two-part answer. First of all, if we were given control of the things that drive drug costs, it might be a fair question. Even if we were, I'm not sure we would want to do it. But we don't have doctor contracts, which are one of the most important drivers of drug benefits. We also tend not to get control over whether we're going to have "prior authorization." Prior authorization is forcing a doctor to call in to get approval for a drug before it is prescribed.

Many of the things that you can do to control drug costs are in areas that we're not given control over. I think there are good reasons for plans not to give us control over those things. It's the core of what they're doing. Those are the things that drive cost. Absent those things, PBMs really can't take drug risk or at least hold drug risk. Even if we have those things, just like you, we're leery of having that as a stand-alone benefit outside of the rest of the medical care.

Ms. McCall: The same issues that will be present in the Medicare debate would be present here, and they are going to be present there for PBMs because I think part of the proposals include looking at PBMs as a mechanism to not only administer the benefit but maybe to take some sort of partial risk sharing there.

Mr. Sandler: It seems like there might be some regulatory issues related to whether PBMs need to be licensed somehow as insurance companies to take risks as well.

Mr. Sanders: We don't throw that up. PCS is not an insurance company. A couple of our competitors are. But we would need, as a cost of doing business, to get an insurance license, were we to take full risk in all the states.

Mr. Sandler: So that means more than one insurance license.

Mr. Sanders: Absolutely. Or, you must buy one that covers all 50 states, if you want to get in the market fast. I think partial risk or certain types of guarantees are much more plausible scenarios for a PBM.

I can't speak for the whole industry. I can speak for PCS. I think our thinking is not a lot different from others. Partial risk could mean straight PMPM things, but we have 25% or 33% of it. Those things scare us, too, but at least we're not at odds with the health plan, which is supposed to be our customer, if we're sharing risk in that way.

Ms. McCall: I think it makes things more aligned. Maybe you can tell me, in partial risk, do you need to have an insurance license in those situations?

Mr. Sanders: It is ambiguous. In California, I think you have to have an insurance license to put your big toe in the state. The rest of the country has some clear rulings stating that some arrangements don't need insurance licenses. In most states, it's ambiguous.

Mr. McCall: Let's go back to Medicare and the recent proposals. Do you have an opinion one way or the other on the single PBM versus the competitive PBM model that's being tossed about in some of the proposals?

Mr. Sanders: There is no single PBM model. People call it a single PBM model, but a single PBM is a subcontractor of HCFA, just like for any of you who are in Blues plans. If you win a bid to administer Medicare in the fee-for-service program, you are a subcontractor of Medicare. You get these rafts of instructions as to what you'll do with this toenail and that. It gets incredibly detailed. You are an administrative agent, and it is inconceivable to me, if you have a single PBM, that we are not a subcontractor of HCFA. Now you can still say it's PCS, but we'll be an administrative arm, not a management agent. That's what I mean by that. We prefer to be a PBM; therefore we would like to compete in regions, although we acknowledge that there are lots of selection issues.

Ms. McCall: Let's talk a little bit about physicians taking risk.

Dr. Behnke: It's very difficult to segregate the prescription drug benefit from other benefits. Certainly, in some cases, where a prescription cost might be higher, some other medical costs might be lower, but usually not in the same year. For the most part, physicians really can't control pharmacy costs any better than anyone else can, even though they are the ones writing the prescription.

There are so many different variables involved, and patient satisfaction is a huge one. The physician-patient relationship has changed dramatically since managed care began. It's much easier now for a patient who's dissatisfied to leave and go to another physician because there's this whole book that tells them who else they can choose from.

There are also a number of issues related to the physician just not having good information. When a physician doesn't have good information at the point of care,

they really can't manage that care and they will go for something they know they can manage right there at the point of care, which is how satisfied that patient is.

In general, most of the current literature is telling physicians not to take risk for pharmacy. If you have to take it, at least count on losing your shirt. Most risk arrangements with physicians have not worked out well because of the fact that they are sitting face to face with the patient, and it makes it very difficult to make decisions.

Ms. McCall: One more thing on physician risk, and then we'll move on to talking about utilization management techniques. At Humana, we did have a number of physicians that were at risk for pharmacy costs and, in some, but not all instances they did fairly well. But the majority of the time they also struggled with taking that risk, and part of that is how the risk pools were actually managed. With all of this aside, and because of everything we've said so far, it is extremely important, but, as actuaries, you have to look at how you fund those pools. So if you create separate pools for inpatient funds and physician funds and pharmacy funds, it's really important that the pharmacy fund reflect the particular dynamics that are going on there.

If you have some magic formulas that we all do where those different pools are funded in a kind of aggregate way, then it can also be very easy to make it look like a physician is losing money on a pharmacy fund, just because the trend and the underlying dynamics are fundamentally different than what's happening overall across all types of care. So that's something for you to think about if you do have docs that are taking risk. Pay attention to how those things are actually funded.

Mr. Sanders: What are the techniques that are available to change the trend or control the costs? I think that there are, almost on a philosophical vein, two different things payers can do. And it's not about doing one or the other; it's what the mix of them is.

The first is, shift the decision-making and the economic incentives to the consumer. The doctors care more about the consumer than they do about the health plan. A fairly effective way to get the doctor involved is to have the patient involved. So this would be an example of the three-tier benefit designs going to four-tiers. Get co-insurance involved so that you get out of the medical management, you acknowledge that there are zillions of these transactions, and it's hard to get into them. It is hard to know exactly what's right in each circumstance, but you make people, in essence, pay for their choices. It is very complex to do. You need lots of patient education.

The other thing is to go into medical management. The medical management techniques that occur in the general medical benefit all exist within the pharmacy benefit. They've existed for a long time. They're getting more and more sophisticated. This ranges from prior authorization for expensive products or unsafe products. Have the doctors call in. Limit drugs in the adjudication system and the payment system to what's on the label. For example, there are products that are supposed to be taken for three months. Look at the patient's record. If the

patient is on it for the fourth month, you deny the claim. There are huge opportunities to do those types of things. When a product goes generic, if you see the patients moving to some other expensive branded product, you could choose simply not to pay for that expensive branded product unless the doctor calls in and gets an approval. That second technique, medical management, is very intrusive to patients, and it's very intrusive to doctors. Neither one of them like it.

Both of those things are available and it's a mix of the two. I will tell you that medical management or the economic incentives are really important if you're going to change your trend. The wave of new things is still out there but there is currently a lot of opportunity to save money because there are a lot of products going generic and a lot of low-cost alternatives. So it is possible to do. It's really tough work and it trades off against member satisfaction.

Dr. Behnke: We've all used prescription drug benefits and prescription pads as a patient satisfier. Is that getting us into trouble now because drugs have gotten a lot more expensive? What about the biotechs potentially coming on the market? Is this really the time to start talking about medical management and pharmacy when we're taking it away from so many of the medical benefits. The medical necessity review is decreasing not increasing, and isn't the potential cost once the biotechs are on the scene, much greater? Isn't this when we should be putting economic incentives in place and getting consumers to be economically aware of their choices?

Mr. Sanders: I agree with you. Just so you know, I'm trying to give options to people. I think there needs to be more emphasis placed on the economic incentives. Maybe we don't need it in the medical management area, but a lot more emphasis should be placed on the economic incentives and the technology. I think there are technological revolutions that allow members to understand complex plan designs better than they could have before. Now that's not accomplished overnight, but use of the Internet can help steer members through plan designs in ways that were inconceivable a few years ago. So we clearly think you have to have the economic incentives underlying this. Then, if you do medical management, it feels to the members like you're actually helping them by getting them onto a lower-cost product instead of fighting with them. So the two can work together. But I didn't mean to say that those are neutral. I actually agree with you.

Dr. Behnke: On the technology side, there are lots of developments underway that will help physicians also because physicians are managing 14 or 15 different formularies, let alone benefit plan designs. Most patients don't really understand that their physician has to deal with so many different things. They just automatically think that the physician knows all of those things.

I've seen tremendous acceptance on the part of physicians of the handheld devices that are now becoming available. Even physicians that will not use the Internet or that will not put in a computer in their office, are clamoring to get this little device that will tell them what the formulary drug is for this patient. I think that this one

thing will make a huge difference in terms of getting technology into the hands of physicians.

Ms. McCall: Allscripts, the software company that I work for, produces electronic prescribing devices for physicians. One of the things that physicians really like about them is they show physicians what the formulary drugs are. Health plans also like them because of the types of generic substitutions that they can help create for the patients. So there's a much higher generic prescribing percentage that you get because it is so hard to keep track of which drugs do, in fact, have a generic equivalent. It's much easier to tell the doctor that a generic is available, and so they'll go ahead and prescribe it, if they know.

Dr. Behnke: Even within a therapeutic class, if there's no generic available, these devices will tell a physician there is a lower-cost alternative, and ask if he or she would you like to know what it is. So, it's putting the decision-making information right there at the point of care, and that makes a huge difference.

Mr. Sandler: We talked a little bit about looking toward the future—the use of the Internet, biotech drugs, and so on. There's more that we could say but I think that at this point we want to make sure that we have plenty of opportunity to get questions from the audience, so we're going to start with questions.

Mr. David William Dickson: I have more of a comment on a different kind of a plan design that I used at a different company when I was on the direct side, and I call it "back to the future." We had your typical $5, $10, and $15 co-pay, two-tier structure, which is very popular in our urban areas. The company had a very large market share, primarily in a rural area, but there were some major metropolitan areas, too.

But, in the rural areas, and especially the small group market, we had another product that we'd had for years, which was a calendar-year drug-only deductible with either an 80/20 or a 50/50 co-insurance with no out-of-pocket max. It was fairly popular. Even in 1994–96, drug costs were starting to escalate, and it started picking up in popularity. And then we got together with our PBM and we tacked on the consumer card, too. We gave them a drug card. They took it to the pharmacy and got a discount. They paid the discounted price at the pharmacy—the pharmacist handed them a claim form, and they had to file the claim themselves. So you got the benefit of the shoebox effect, as well.

I'll just give you some general cost comparisons of a $10/$15 regular traditional drug co-pay plan to a $100 calendar year drug only with a 50/50 co-insurance. The cost difference was about 50%, and about 5–10% of that was the shoebox effect. It was our fastest-growing drug benefit at that time.

Mr. Sanders: I think we're going to see more of things like that just as people get frustrated with the rising cost of drugs and yet don't want to withdraw it. Not everyone gets choices, but patients confronted with choosing actuarially equivalent plans will choose flat co-pays over percentage co-insurance. They'll choose a three-tier over percentage co-insurance, and they will choose anything that doesn't

have a deductible or a stop-loss. Having said that, people have to do something about the costs.

Mr. Dickson: Right. And that was true. In the urban areas and at the bigger employers, they all went with the co-pay product. But in the rural areas, and at the smaller employers, who were really cost conscious, they went with the alternative, back-to-the-future plan.

Mr. Timothy Michael DiLellio*: I also have questions about co-pays and deductibles because it seems to me that the only way you're ever going to really communicate the true costs of these drugs to people is to have co-insurance percentages.

The president of my company likes to give this little spiel. He talks about how, if you go to the mall, and everything you buy costs you $5, it doesn't really matter what you buy. You're going to get all the greatest stuff that's there. You're going to go for the wool suit and the satin ties. The price doesn't matter. That's a real problem with the drug plans right now.

So, I think we need to get at that problem. I guess the question is, what kind of obstacles do we have? It seems like there are obvious obstacles in terms of patient and employer satisfaction. Are there other obstacles in terms of insurance departments blocking this kind of thing?

Some of these $5 and $10 plans that are out there are fundamentally flawed, too, because when I've looked at some of these data, what I found is that a $5 co-pay on a generic drug is roughly half the cost of the ingredient anyway. The $10 on the brand name might be 20% of the cost.

So we're not doing a good job by having a $5/$10/or whatever plan and asking them to share in the costs of the brand-name stuff. We're asking them to pay a lot of the generic, and then, particularly if you have something like a $10/$15 plan, a lot of times you're asking them to pay more than the ingredient costs for the generic, so I think that's a real issue.

Ms. McCall: Is there a problem, from a state standpoint, with respect to co-insurance? In the times that we were looking at co-insurance, we did not find any. I think that you'll end up having state legislatures or state departments of insurance begin to look at differentials. If, in fact, you use co-insurance on preferred that is different from nonpreferred, they will begin to pay attention to that. Think of it as an in- and out-of-network benefit. So the types of things that you run into on in- and out-of-network benefits, you're going to run into here, so you have to pay attention to how far apart they get.

I don't believe there are any technological challenges. When I was at Humana and PCS was, and still is, Humana's PBM, there wasn't anything that we threw at them, from a co-insurance or deductible perspective, that was not technically feasible.

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* Mr. DiLellio, not a member of the sponsoring organizations, is Chief Actuary at Lifeguard in San Jose, CA.

Mr. Sanders: They tried, though.

Ms. McCall: So we did a few things, but co-insurance and deductibles were not on the list, so technically, all the infrastructure is there. This is really an issue of how we worked ourselves into a situation, from an expectation standpoint, on the part of patients and consumers, that we have to work our way out of.

There's something a little bit different about pharmacy benefits. Unlike the trip to a hospital, or physician office visit, if there is, in fact, a co-insurance to be paid, you normally don't pay it when you leave. That is not, in fact, the case at the pharmacy counter. They will expect you to pay that money before you walk away and people don't like not knowing how much to show up with. They like knowing that if they show up with $10, they will get their pills. They don't know that they need to show up with $19.42.

Everyone is a little bit different, so a lot of this has to do with a psychological difference, and some of it is very real in terms of member impact. You just have to work your way through it.

Mr. Sanders: I want to comment on the regulatory aspect of that. Let me give you a little story. I've seen plans that are looking at $50 third tier co-pays for high-cost products and have regulators telling them that they can't do that because that's tantamount to a closed formulary and they haven't advertised that. There is no problem with saying you charge 30% across the board even when there's a $200 product and it's $60.

I think one of the cleanest things from a regulatory standpoint is flat co-insurance, and I agree with every other comment you made. The challenge is patient satisfaction.

Mr. Sandler: I'll add one possible regulatory issue and that is just make sure that you understand clearly upon what dollar amount the co-insurance is calculated.

Mr. Thomas G. Butzen: One of the financial benefits of the three-tier drug plan was the rebates you got from the pharmaceutical companies. What is the future forecast of those rebates? A number of labor groups would ask about mail order as a possible savings method. Do you see future savings from the mail order programs? How would you price such a product? In mail order, you often have a three-month supply.

Mr. Sanders: Let me tie this back to something that Geoff said. Manufacturers will rebate the more controlled a plan is and they very much tie control to plan design. So they'll generate the highest rebates for a closed formulary, but they'll generate very close to the same for a three-tier benefit, as long as there's enough difference between the second and third tier.

That is one of the challenges with co-insurance. Manufacturers are unlikely to pay high rebates on co-insurance, and that's what you meant by what does the co-insurance go against. There are regulators who say that if you're going to do a co-

insurance plan, you have to net out the rebates first, which is a technological challenge, although not impossible to deal with, at least as a close approximation.

So three-tier benefits are strong generators of rebates. Absent legislative backlash against rebates, and there's certainly some talk about that, they look like a sustainable proportion of your drug spend. In other words, they'll grow with drug spending. That would be our forecast right now.

Mail order, deeper discounts, you have to be careful that you don't drive people to use mail order and create waste of products that are inappropriate to mail order. Absent that, it's just a deeper discount and therefore you're saving a little bit of cost in the product. If you set up the wrong incentives, you can actually generate product waste as an offset. So you just have to be careful there.

Ms. McCall: I'll talk on each one of those, as well. With respect to benefit design and rebate, it's good to hear that you think that they're going to stick around because companies like Humana and other managed care plans count on those. With some of the traditional mechanisms that I know we used, they generated fairly high rebates.

One way around that, in terms of co-insurance, is if you use a combination approach, which is like a three-tier approach or a tiered approach. I don't know how many there would be with co-insurance. You can accomplish two things. Number one, you still have a design that manufacturers say drives share, and what they mean is, drive market share of my drug. But what co-insurance does that co-pays do not do is it sensitizes people to the actual pharmaceutical pricing strategy. One of the problems is that some companies will use a very high pricing strategy with a very deep rebate, while other companies won't price a drug quite as expensively but the rebate isn't as big either. If you look at net versus net, you'd see that they are the same cost, but what you can do is, through co-insurance, expose some of that cost if it's a very high-cost drug, because the patients don't get the rebates. When you expose them to the high-cost strategies, you can actually try to begin to steer them to a lower AWP pricing strategy. So that's real important to do. You might be able to have a little bit of your cake and eat it too.

With respect to mail order, one of the things to pay attention to is the actual co-pay incentives. You can get deeper discounts from a mail order house, but if you had to give up a co-pay to do it, then you might have actually spent more money than you saved. That wasn't true when co-pays were low, but when co-pays are high, getting three points on a drug might not make up for a $15 or $20 giveaway in a co-pay. So pay attention to that when you're pricing it.

Mr. Harry L. Sutton, Jr.: In all the discussions early in the game about all the things to do to reduce to cost, I don't believe any one of you talked about putting a limit on the total payment for drugs for a year or whatever. Medigap has limits, almost all the Medicare proposals have had limits. I don't think the under-65 market has limits because the cost, in aggregate, hasn't been high enough over the years. Are any of the big employers thinking of putting in limits? When writing the Academy monograph, we're talking about the effect of limits all the time.

The other question is more general. The drug industry says you should be happy to pay more money because if we have a little more drugs, nobody will ever be hospitalized again. Is there any rational proof, other than the mental health cases, specifically in the case of Prozac, that all these drugs actually reduce other medical costs and more than offset them?

Mr. Sandler: I haven't seen any proof on your last point. That is an issue that comes up all the time. Regulators bring it up, and employers bring it up. I think one of things that we as actuaries need to do going forward is to see whether we can demonstrate that kind of effect or not. It may actually tie back to something that Carol referred to earlier, which is that there might well be a tradeoff, but the tradeoff might be in a future year, and that brings up a whole set of other issues.

Mr. Sanders: Let's start on that second question. Maybe we can go back to your first one. I'd like to turn to Lisa because I think that there is more evidence out there that shows drugs have eliminated hospitalization. We tend to think in short snippets of time, like five years. But if you go back and compare what people were hospitalized for 25 or 30 years ago versus what they are hospitalized for now, it has changed. I'd ask you to comment on ulcers. How many people were hospitalized because of ulcers before versus now?

Dr. Behnke: Exactly. That's one good example. And there are two examples just in the GI field.

Helicobacter pylori is another example. In treating Helicobacter pylori, I saw people with true recurrent duodenal ulcer disease who were hospitalized at least every other year with bleeding. They would receive transfusions, were in the hospital for a week, and were not able to go back to work for another two or three weeks because they were too weak to stand. Those people were completely cured. So that's one example. That has a shorter-term payoff.

Hepatitis C is another example. A very high percentage of those patients develop cirrhosis, and end up getting liver transplants at some point down the road. There are drugs that will cure a percentage of those patients, but the payoff in terms of cost is ten years. So, in some cases, there are drugs that certainly have made an impact.

It's difficult to separate out the difference between what is drug related and what is just medical management related because there was so much fat in the system as far as hospital stays were concerned. There certainly are a number of infections that were treated with extensive hospital stays that now, because of antibiotics that can be given less frequently, are treated in the home setting. There are also some that are treated intravenously through home health care professional, so that adds a cost. Certainly, the administrative infrastructure of managing all of these things has contributed to the cost as well. So we haven't seen a dramatic difference across the board.

There are a number of drugs that are being used effectively to reduce second heart attacks in those who have had one heart attack. Those are also a longer-term

payoff. But it's really hard to tell which patient would have had another heart attack and which one wouldn't, to measure these things.

Ms. McCall: Harry, you had a first part to your question which had to do with benefit maximums. There are a number of techniques that are available. We did not have an opportunity to talk in detail about every different drug utilization management technique that can be used, but obviously capping the benefit is something that certainly cuts off the per member, per month (PMPM) costs. There's no doubt about it. Those are the types of benefit design issues that you must work through as a company and as a health plan. If that's the type of benefit that you think you can, in fact, sell to maintain what you believe is a good relationship with your members and with your providers, by all means, that type of product is going to cap your costs as well as your trend.

Mr. Sandler: But going back more specifically to Harry's question, at least at my own company, we haven't seen in our commercial business a large number of employers coming to us and asking for it.

Mr. Sanders: It's stronger than that. In today's economic environment, that could change. For large employers and competitive industries, there is absolutely no interest. We not only wait for them to come to us; we ask. There is no interest in capping the drug benefit. They're much more interested in putting a front-end deductible in and saving the same amount. But employers in this country still believe, for their current employees, that they need to be taking care of them, and those are the people who need it more than anyone else.

Dr. Behnke: From a physician perspective, a cap is very unattractive because you have this patient who has been taking a medication for six months. He needs it, he's well controlled on it. When he can no longer afford it, what do you do? That's a real problem from a physician perspective. It is much better to make a decision up front to use a less expensive medication because the cost is there up front. The economic impact on the patient is there up front.

Mr. Garry M. Eckard: From an overview and probably a political standpoint, would you comment on whether I'm overlooking something here. When a new drug is developed, the company that developed it, in effect, has a monopoly with no competition for at least seven years on the market. It appears that they price them to maximize their profits with no control whatsoever, or no addressing of what the research and development costs were, and also no consideration that a large proportion of the population cannot afford the drugs at those prices. Is that a correct description of where we are in our system right now?

Mr. Sanders: It's correct that they seek to maximize their profits and their business. It's not correct that they ignore people who are not able to afford it, because if people can't afford it, they're not going to sell the product and they're not going to maximize their profits. I think the pricing of pharmaceuticals has become an issue because, 15 years ago, on average, 70% of the products were sold where the patient had a financial interest in that product. Today, the patients have a financial interest in less than 30% of the products. But what do I mean by

that? They have a flat co-pay. The gentleman said earlier that it's five or ten dollars. What difference does it make? I think pricing is an issue because it's so easy for the pharmaceutical manufacturers to price high because only 30% of the patients care. But if it is 70%, they'd make different decisions. I think they actually do think about those who can't afford it. It's just a smaller number these days.

Dr. Behnke: When it's a smaller number, manufacturers can provide samples to the physicians and certainly every manufacturer has indigent-care programs where you can write a letter and say my patient really needs this drug and he can't buy it, and they will send it to you. Most consumers, though, would never tolerate pricing the way it is done now, if they knew about it. They just don't care.

From the Floor: I have a question that's unrelated to benefit design. It's more back to the risk sharing with physicians and other providers. One of the things a lot of HMOs have done is sub-capitate their mental health, but pharmaceuticals are usually not included in that sub-capitation. One of the thoughts that I've been having is, can we do risk sharing but by therapeutic class, and are people looking at that for risk sharing on pharmacy?

Mr. Sanders: You start to get into it class by class. The mental health carve-outs see patients who have certain diagnoses. That represents only 30% of the class of (antidepressant) selective serotonin reuptake inhibitors (SSRIs). So they can't manage the class of drugs because that's not what the class is being used for. So that raises some different issues. I think it does make sense to look at this class by class, but it's very complicated. I know people are looking at mental health.

Mr. Randall S. Edwards: I was wondering if you could dissect the 20% trend increase.

Ms. McCall: Into three components?

Mr. Sanders: On average, it's 8% utilization. That's more prescriptions, and more pills. There are 3% or 4% price increases from the same products that you were on last year if you had a fixed index. It's about an 8% price increase that represents higher-cost products being substituted for lower-cost products. We use the term "intensity" because there's a whole bucket of things. It's very hard if you're looking for how much is DTC cost. It's very hard to parse that stuff out. It shows up partly in intensity and it shows up partly in more pills.

You want to know whether there's headroom for more prescriptions. How many years can you have 20%? We use many fewer prescriptions in this country than the rest of the industrialized world. There's a lot of headroom left.